

Palma, Alexander Michael G.

Working Paper

Assessment of the Absorptive Capacity for Government and Donor Funding: The Case of the DOH

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Assessment of the Absorptive Capacity
for Government and Donor Funding:
The Case of the DOH

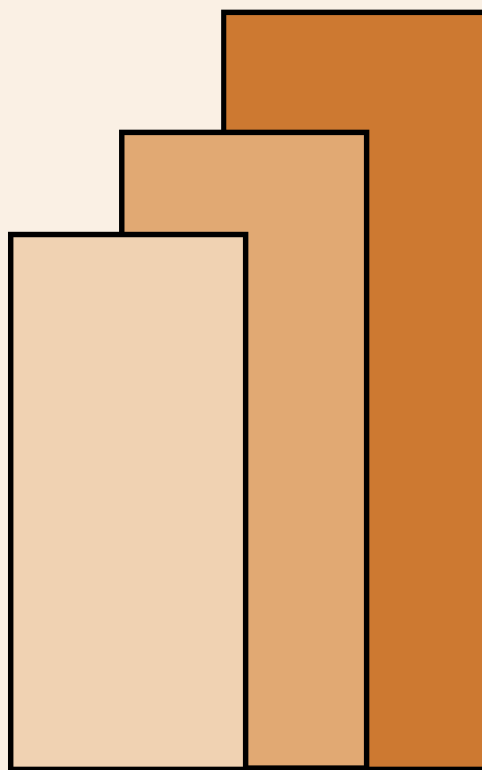
Alexander Michael G. Palma

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For comments, suggestions or further inquiries please contact:

The Research Information Staff, Philippine Institute for Development Studies
3rd Floor, NEDA sa Makati Building, 106 Amorsolo Street, Legaspi Village, Makati City, Philippines
Tel Nos: 8924059 and 8935705; Fax No: 8939589; E-mail: publications@pidsnet.pids.gov.ph
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TABLE OF CONTENTS

	<u>Pages</u>
1. INTRODUCTION	
1.1 Background and Rationale of the Study	2
1.2 Objective of the Study	2
1.2.1 General Objective	
1.2.2 Specific Objectives	
1.3 Hypotheses of the Study	3
1.4 Organization of the Study	3
1.5 Coverage and Scope of the Study	4
1.6 DOH in Perspective	4
1.7 Organizational Structure (Existing)	5
2. ANALYTICAL FRAMEWORK	
2.1 Measures of Absorptive Capacity	6
2.1.1 Budget Programming Index	
2.1.2 Agency Utilization Index	
2.1.3 Agency Absorptive Capacity	
2.1.4 Appropriation Utilization Index	
2.2 Case Study Approach	7
2.3 Organization of Baseline Index	8
3. ANALYSIS OF DOH BUDGET ALLOCATION	
3.1 Distribution of Health Care Expenditure	9
3.2 DOH Budgetary Allocation and Major Program Focus	9
3.3 Regional Focus	11
4. ASSESSMENT OF BUDGET PERFORMANCE	
4.1 Programmatic Activities	13
4.1.1 Public Health Services	
4.1.2 Hospitals and Facilities Services	
4.1.3 Primary Health Care	
4.1.4 Health Facility Standards, Regulations and Licensing	
4.1.5 Management Service	
4.2 Projects	17
4.3 General Administration and Support Services	18

4.4	Regional Budget Performance	19
5.	DOH HEALTH PROGRAMS-TARGETS AND ACCOMPLISHMENTS	
5.1	Prenatal and Postpartum Care vs. Maternal Child Health Services	21
5.2	Expanded Immunization Program	22
5.3	Control of Diarrheal Diseases	22
5.4	Acute Respiratory Infection (ARI)	22
5.5	Nutrition Program	23
5.6	Family Planning	23
5.7	Dental Health Service	23
5.8	Tuberculosis Control Program	24
5.9	Leprosy Control Program	25
5.10	Schistosomiasis Program	25
5.11	Rabies Control Program	25
5.12	Filariasis Program	25
5.13	Malaria Control Program	26
5.14	Sexually-Transmitted Diseases (STD)	26
5.15	Environmental Health Program	26
6.	BUDGET UTILIZATION TYPICAL CONTINUING DOH PROGRAM	
6.1	A Vertical Health Service: The Case of the Expanded Immunization Program (Horizontal)	27
6.1.1	Fund Allocation and Utilization	
6.1.2	Regional Accomplishments	
6.1.3	Factors Influencing Sustainability	
6.2	An Integrated Health Service: The Case of the Tuberculosis Control Program	31
6.2.1	Fund Allocation and Utilization	
6.2.2	Regional Accomplishments	
6.2.3	Issues on Delivery of TB Control Services	
6.3	Program Administration and Its Effect on Utilization And Accomplishment	34
7.	BUDGET UTILIZATION OF A REGIONAL-ASSISTED PROJECT: A CASE STUDY OF THE WOMEN'S HEALTH AND SAFE MOTHERHOOD PROJECT	
7.1	Project Objectives	36
7.2	Project Components and Sub-components	36

7.3	Factors Influencing Utilization	37
7.3.1	Compliance to Technical Standards in Procurement/ Contracts	
7.3.2	Financial Management Requirements	
7.3.3	Systemic Limitations	
7.3.4	Institutional of Project Outputs	
7.4	Financial Utilization	40
7.4.1	Loan Disbursement	
7.4.2	Grant Disbursement	
8.	ISSUES, FUTURE ORGANIZATIONAL CONCERNS AND RECOMMENDED MEASURES	
8.1	Issues and Future Organizational Concerns	42
8.1.1	Procurement Issues	
8.1.2	Complications in Functional Deconcentration/ Devolution	
8.1.3	LGU Commitment and Participation	
8.1.4	Rationalization of Manpower Complement	
8.1.5	Cost Overruns	
8.2	Recommended Measures	46
8.2.1	Addressing Procurement Delays	
8.2.2	Affirmation of LGU Resource Commitment	
8.2.3	Institutional Alignment in Healthcare Monitoring	
8.2.4	Consolidation of Monitoring Efforts in Project Implementation of Foreign-Assisted Projects	

REFERENCES

ANNEXES

List of Annexes

- | | |
|-----------|---|
| Annex 1 | Growth Rate of National Government Expenditures 1996-1999 |
| Annex 2 | National Government Expenditures as a Proportion of GNP, 1996-1999 |
| Annex 3 | Budget Performance on Government Funding, 1996-1999 Summary of Budget Levels and Absorptive Indices |
| Annex 4 | Targets and Accomplishments of DOH Health Programs, 1996-1998 |
| Annex 5 | Utilization Measures and Accomplishments of DOH Health Programs, 1996-1998 |
| Annex 6 | Performance Targets and Accomplishments, Immunization Program 1996-1999 |
| Annex 7 | Regional Utilization and Accomplishments, Immunization Program 1996/1998/1999 |
| Annex 8 | Performance Targets and Accomplishments: Tuberculosis Control Program, 1996-1999 |
| Annex 9. | Women's Health and Safe Motherhood Project: ADB Disbursements |
| Annex 10. | Women's Health and Safe Motherhood Project: IBRD Disbursements |
| Annex 11. | Women's Health and Safe Motherhood Project" KfW Grant Schedule |
| Annex 12. | DOH Budget Item Classification under Re-engineering. |

ABSTRACT

Agencies tasked to carry out a social agenda have distinct experience in the utilization of available resources. The issues that confront the DOH in the delivery of healthcare services support the need to look at the utilization of both government and donor funding in the implementation of its programs, projects and regular functions.

The study attempted to provide measures for absorptive capacity of a line agency, or its capacity to utilize its legislated budget. The measures for absorptive capacity were determined for each of the public health programs, and correlated to the extent of accomplishments.

Case analysis of two continuing DOH programs were made, each having different modes not only in program implementation, but in fund utilization as well. Another case study of a typical foreign-assisted project was offered, validating the observed general downtrend in foreign and domestic funding utilization.

To serve as basis for future measures, institutional requirements and some insights on policies that may directly or indirectly influence utilization were identified.

EXECUTIVE SUMMARY

There are numerous factors that affect the manner and extent over which available government and donor funding are utilized for programs and projects in the health sector. In the social services sector, these factors include the external environment conditions, such as institutional mechanisms and the prevailing demand for services, as evidenced from morbidity and mortality rates. Looking at the major public health programs of the Department of Health, particularly the accomplishments in terms of cases treated and served, it can be said that not only is the magnitude of financial resources important, but so is the timing of fund release and its accessibility from various sources.

Parameters that attempt to measure absorptive capacity were derived in the study to determine how the expenditure target for a particular budget year of the DOH was met, taking into account the levels of allocation and obligation in each of the budget items. Current year appropriations of the Department of Health have marginally increased from 1996 to 1998, despite the onset of the crisis years starting in 1997. The thrust to reinforce devolution of programs can be reflected in the significant share of the regions from the total budget. An increasing trend in the shares was established over the past four years despite the crisis years.

The trend of accomplishment in the delivery of most public health programs follows the increases in absorptive capacity indices recorded. The likelihood of such correlation only proves that budget utilization has a considerable effect on the delivery of services. On the other hand, utilization in both locally and foreign-assisted projects has been plagued by a spectrum of issues relating to implementation problems. This is evident in the low utilization ratios derived from 1996 to 1999. Because of the peculiar experiences in every project, comparative analyses were made showing that vertically-administered projects such as the expanded immunization program has posted high allotment ratios relative to appropriation (BPI). In contrast, integrated health service like the tuberculosis control program has greater utilization of funds relative to its legislated/spending target (AUI). The difference in the degree of involvement of LGUs in both types of projects, appear to impinge on the utilization of available funding.

Measures to make efficient the procurement process have been cited as major institutional improvements needed. Likewise, consolidation of financial reports as a tool for monitoring utilization by FAPs, rather than as mere object for compliance with donor institutions should be considered in the light of existing efforts to unify project management offices. The duration of time involved in critical areas such as procurement calls or good costs tracking and cost control management. To reinforce an effective devolved set-up in the delivery of major services, reconfirmation of counterpart resources from LGUs may have to be determined at the inception stage of a given project.

The historical trends in utilization ratios supports the reasonable and realistic appropriation and allotment levels for public health services that may be determined, and provides an alternative basis to identify priority areas, especially with given budgetary constraints.

Final Report

ASSESSMENT OF THE ABSORPTIVE CAPACITY FOR GOVERNMENT AND DONOR FUNDING: The Case of the Department of Health (DOH)

Alexander Michael G. Palma

1. INTRODUCTION

The delivery of social services by the relevant branches of government was reported to have been affected the manner and magnitude, by which given financial resources were utilized. This finding is evident from available statistics that point out to the number of direct beneficiaries in a particular period of a program, or simply from the trends in the rates of utilization of available government and donor funding in many priority projects and programs. In the case of the health sector however, utilization rates need to be examined relative to the physical accomplishment of a specific project at any given time. Unlike other services such as provision of physical infrastructure, accomplishments in healthcare delivery are not readily measurable. Thus, a favorable utilization rate may not necessarily be the cause for better attainment of performance targets. Conversely, lower utilization rates may be due to a diffused prioritization, brought about by decreasing mortality rates from previous periods. It is very important therefore, to look into specific projects, the stage at which objectives are attained at a given time, and the conditions by which they were implemented. The conditions vary from the region or locality. A specific program may be targeted at a geographic region with higher level of incidence of disease. Furthermore, other factors also merit consideration like the existence or absence of basic infrastructure. Potable water supply and reliable distribution systems for example, need to be investigated at the time of program implementation.

For the purpose of this study, utilization rates of domestic and foreign funding sources will be examined, and to be verified through actual experience of accomplishment by the appropriate implementing units of the Department of Health (DOH).

Major health programs to be examined can be classified into: 1) Policy-related programs; 2) Information-related and Public Health Awareness programs; 3) Training programs of Health Personnel; 4) Institutional Strengthening programs (such as monitoring systems of local government), and; 5) Health Services programs. The Health Services programs on targeted health areas will be subjects of review leading to the utilization of funds.

As mentioned earlier, the periods under review are also crucial in studying the fund utilization by the DOH. Equally important as the stage of implementation of a project are the macroeconomic conditions during these periods. The effects of the Asian

currency crisis for example in 1998 and the fiscal move to cut on government spending have made conditions in appropriation, allotment, obligation and disbursement rather irregular. The conditions in these periods will be cited, especially on how they create an impact on the social reforms and programs in the health sector.

1.1 Background and Rationale of the Study

A review of available literature shows the growing concern over the extent of utilization of available financial resources from national government, as well as funds earmarked for approved projects extended by many bilateral and multilateral sources. The general downtrend in fund utilization reported by the National Economic Development Authority (NEDA) in its 7th ODA Portfolio Review, suggests the need to look into the absorptive capacity of agencies in relation to the dispensation of their resources.

Agencies tasked to carry out a social agenda, may have an experience on program implementation distinct from other government institutions with different mandate. Thus, the issues that confront DOH in efficiently utilizing its budgetary resources must be identified before any policy recommendation is made. An incisive look at the external environments is also crucial as these may affect both the amount of resources, and their availability.

1.2 Objectives of the Study

The distinct objectives of the study are embodied in the following:

1.2.1 General Objective

The overall objective is: to assess the absorptive capacity of a government agency, as applied to a specific case, the Department of Health, specifically in the utilization of both government and donor funding in the implementation of its programs, projects, and regular functions.

1.2.2 Specific Objectives

From the given overall objective, the study will attempt to achieve the specific objectives as follows:

- 1.2.2.1 To evaluate the existing institutional framework of the Department of Health, particularly in its use of resources to implement local and foreign-funded programs and projects. Such evaluation will include the impact of the institutional mechanisms in enhancing the effectiveness of the DOH in its delivery of services to the social sector;

- 1.2.2.2 To derive indicators from available financial and statistical data, measures of institutional absorptive capacity. These indicators should ideally reflect the utilization of available resources, including the manner of release, and relate these to the extent of accomplishment given a set of performance standards;
- 1.2.2.3 To identify the strengths and weaknesses in project management and implementation, as well as the sustainability of programs and projects. These may include extraneous factors inherent to the entire system of budget and release process;
- 1.2.2.4 To formulate recommendations on how to strengthen the capacity of the DOH in the aspect of financing, manpower support, funds programming, and in areas that impinge on the efficient delivery of services to the social sector.

1.3 Hypotheses of the Study

The hypotheses of this study are framed following the conventional analysis of institutions, which involves an initial probe into their resource utilization, and the level of its effectiveness as an institution serving a specific mandate. However, the level of bureaucracy involved in a budget process has to be factored in as it inevitably poses an external influence. Thus, not only should internal procedures be examined, but also external forces that dictate on the agency's capability to use resources.

The first question to be addressed is whether the DOH has achieved the required absorptive capacity (based on parameters to be derived) given the availability of approved government and donor funding. In the social sector, especially in the Philippines, it is safe to say that demand for health services far exceeds the availability of public funds. A second hypothesis is whether, absorptive capacity is influenced more significantly by so-called external factors such as the budget process, disbursement policies, availability of funds, policies of multilateral and funding agencies on fund release, etc. rather than simply, the availability of funds at an appropriate level.

1.4 Organization of the Study

The main body of this paper consists of seven parts. The next chapter outlines the framework of analysis used in the study. The derived indicators used in this study were aligned with the derivations of Mercado (2000) tackling the same topic as applied to the another line agency of the government, the DPWH. The application of these indicators to each of the budget items of DOH is tackled in Chapters 3 and 5. Chapter 4 attempts to correlate the targets and accomplishments in each of the health programs, with the rates of utilization of the financial resources made available.

Three case studies following the line of analysis made in the preceding chapters will be presented. Two of the continuing programs of DOH (i.e. the Expanded

Immunization Program and the Tuberculosis Control Program) will be reviewed, and a typical foreign-assisted project (i.e. the Women's Health and Safe Motherhood Project).

Lastly, the issues that confront the budget situation in the health sector are identified, the possible reforms that could be initiated, and the measures to improve rates of utilization.

1.5 Coverage and Scope of the Study

The study offers an analysis of the utilization of the budgetary resources of the Department of Health using a derived set of indicators. One can only relate the accomplishments in each health program with the use of financial resources. However, there is a wide spectrum of factors affecting efficiency in utilization. The framework of analysis also covers institutional parameters, as well as the external environments and their conditions such as existing policies and regulations. Interpretation of data is done to both aggregate data, and disaggregated data. The former includes the general level appropriation, allotment, and obligation of major budget items indicated in the annual General Appropriations Act (GAA). Regional data in the two case studies represents an example of disaggregated data, as well as utilization ratios derived for each of the health programs.

The time frame is expected to capture the financial climates of the pre-crisis and post-crisis periods, that is, from 1996 to 1999. Whenever possible, data were explored in these years, but some focused discussions took sample years, whenever information is limited or unavailable.

1.6 DOH in Perspective

The Department of Health underwent several organizational changes in recent years. At present, DOH thrust is embodied in its mandate to provide adequate healthcare, and ensure its accessibility to the entire populace. This mandate also covers policy-making and regulatory functions pertaining to all health-related issues. The organizational changes may be attributed partly to varying conditions of the external environment. Even prior to the devolution of healthcare services to the local government units, there were already imminent issues confronting the efficiency of delivery, which were met with some institutional changes.

Looking at the significant events that have formed the DOH as a national agency, it can be noted that from its creation on June 23, 1898 as Department of Public Works, Education and Hygiene, the primary groundwork of the organization changes has been directed towards broadening the locational scope of the agency. Since its establishment in 1898, several decrees and acts have been passed to ensure a wider reach of the agency's mandate at the local level. A Board of Health was formed on September 29, 1898 under General Order No.15. Following this development, Provincial and Municipal Boards of Health were already conceived through Acts Nos.

307,308 and 309. In 1906, reorganization also gave way for the Office of District Health Officer under the provincial Board of Health.

From 1912 to the present, organizational changes at the DOH entailed institutional strengthening through the creation of attached bodies and agencies. These changes resulted to the encompassing coverage of the DOH governance over other health institutions like hospitals, dispensaries and clinics, quarantine services, charitable and relief agencies, city health departments, research laboratories, etc. In 1958, eight regional offices were opened giving way to two Undersecretary posts. These posts were carried over to the present time aiming to better manage the growing role of the agency.

The full implementation of the Local Government Code or Republic Act No. 7160 has shifted the DOH role from one of program implementation, to policy-oriented and program supervision. The Office of Public Health Services branched out to form the Office for Special Concerns, and Office of Hospital Facilities, Standards and Regulations was integrated into one, from two separate units.

1.7 Organizational Structure (Existing)

There are five main groups that are under the supervision and guidance of the Secretary of the Department of Health, aside for the attached agencies namely, the Philippine Health Insurance Corporation and the Dangerous Drugs Board.

The **Office of the Chief of Staff** is comprised of the Financial Operations and Frontline Services Audit, and; Public Information and Health Education Service. The Finance Service and, Procurement and Logistics Service were also subsumed under this office (the latter unit used to be under the Office of Management Services).

The **Office of the Management Services** is staffed by one Undersecretary and one Assistant Secretary, and is basically tasked with the agency's legal affairs, administration, internal planning, budget, management advisory, and coordination of foreign assistance.

The different health bureaus are under the direct supervision of the Office for **Standards and Regulations**. These health bureaus are Bureau of Licensing and Regulations, Bureau of Research and Laboratory, Bureau of Foods and Drugs, National Quarantine Office, and Biologicals Production Service. One Undersecretary and one Assistant Secretary are likewise supervising this group. The Office for Hospital and Facilities Services is another major group in charged of all types of hospitals--public, private and special hospitals. One Undersecretary and Assistant secretary supervise this group.

The **Office for Public Health Services** is organized to administer the priority health programs of the DOH. Unlike the other major groups, the Office of Public Health Services has two Undersecretaries and two Assistant Secretaries taking care of the health programs.

2. ANALYTICAL FRAMEWORK

2.1 Measures of Absorptive Capacity

For the purpose of the study, the agency's absorptive capacity shall refer to the extent by which the Department of Health maximize the utilization of its available financial resources, sourced from the national government's annual budgetary allocation to all public agencies and institutions, including ODA.

In general, absorptive capacity can be measured by the extent to which an agency utilized the appropriations made in its favor in the General Appropriations Act. In this sense, the agency's legislated budget, i.e. appropriations, is regarded as its expenditure target for a particular budget year. Alternatively, absorptive capacity may be defined in terms of an agency's ability to use the allotments released by the DBM. Here, the total allotment advice from DBM may be viewed as further delimiting what can actually be spent of the statutory spending authorization.

Given this perspective, the following indices are defined:

$$2.1.1 \text{ Appropriation Utilization Index (ApUI}_y\text{)} = \frac{\text{Obligation}}{\text{Appropriation}}$$

This index indicates an agency's ability to utilize funds relative to the legislated/statutory spending target. In principle, the index takes on values that range from 0 to 1. At one end of the scale, an index = 1.0 would imply full achievement of the target. At the other end, extremely poor performance would yield an index = 0. In practice, however, the index for a specific program (or agency) may exceed unity. This happens when specific items in the GAA are realigned in favor of said program (or agency).

It should be emphasized that the ApUI_y are influenced by factors that are not fully under the control of the agency concerned. Specifically, ApUI_y reflects the joint effect of the agency's ability to utilize resources and the central government's ability to provide adequate funding support (i.e. raise revenues) for the various programs in the GAA.

$$2.1.2 \text{ Budget Programming Index (BPI}_y\text{)} = \text{Allotment/Appropriation}$$

Basically, this index shows the extent to which the legislated budget (appropriation) for the agency for the year has been prioritized by the fiscal authorities given the actual availability of funds from domestic and external sources. In comparison with the BPI of other agencies, this index indicates the relative importance given to the agency's programs, activities and projects (PAPs) by the Development and Budget Coordination Committee (DBCC) acting through the DBM in its programming of government funds.

In principle, what is appropriated cannot be allotted so that allotment does not exceed appropriation. Consequently, BPI normally varies from 0 to 1. To a large extent, BPI is driven by the government's ability to attain its revenue target. In periods where the revenue shortfall is large, the BPI for most agencies and the central government, in general, would fall below 1.0 as the fiscal oversight agencies struggle to keep the fiscal deficit in check.

However, in practice, situations may arise which warrant the issuance of supplementary funding support to the agency in the course of the budget year. For instance, the occurrence of calamities may increase the overall allotment given to a specific agency or to the agency's programs. At the same time, the agency's budget may be realigned drawing money away from some program in favor of others. In cases like these, the BPI will exceed unity.

2.1.3 Allotment Utilization Index (AUI_y)= *Obligation/Allotment*

AUI_y shows the extent to which an agency effectively utilizes the available resources at a given time. DOH has been faced with a lot of institutional challenges paving the way to reforms. However, there are issues that are yet to be addressed contributing to the agency's inability to post improved utilization rates. These are particularly relevant with respect to foreign-assisted projects.

2.1.4 Overall Absorptive Capacity Index ($OACI_y$)= AUI/BPI

This measures the congruence between agency's ability to utilize the allotments it received (AUI) with the relative priority given to the agency by the fiscal managers (BPI). $OACI_y$ exceeds unity if the allotment utilization rate is greater than the relative priority given to the agency by DBM. An $OACI_y > 1$ suggests that the agency can still absorb more funds if it were given more funds than what it actually did. Conversely, $OACI_y$ falls short of unity if the allotment utilization rate is lower than the relative priority given to the agency by DBM. An $OACI_y < 1$ indicates that the DBM programmed more funds for the agency than what it can absorb. On the other hand, an $OACI_y = 1$ represents the happy middle that is achieved when budget programming matches the agency's capacity for fund absorption.

2.2 Accomplishments vis-à-vis Absorptive Capacity Results

Chapter 5 looks at the accomplishments in the Public Health Services, as an integral part of DOH programs in the field. The study took into consideration the components of each of the programs, and the measurable accomplishments in relation to a targeted segment of the population. These measured accomplishments were then compared to applicable utilization ratios. The comparative analyses were done from 1996 to 1998, as official field statistics for 1999 are yet to be validated.

Consolidated regional data were used to look at the utilization picture in the regional level. These data are limited to appropriation, allotment and obligation in every

region, and do not have detailed breakdown according to expenditure items. It was only in 1998 that consolidated financial reports in the regions were required, but data have been aggregated and rather limited before that.

2.3 Case Study Approach

Separate treatment was made to measure absorptive capacity in projects or components thereof, that have foreign funding and requiring counterpart local funding. The same approach was applied to locally funded programs with different manner of delivery. The Expanded Program in Immunization involves the control of the central office over the release of funds, as well as the actual delivery to targeted beneficiaries. The other mode involves a horizontally integrated program, which operates in the Tuberculosis Control Program. In this case, the central office concerns itself primarily on the targets of assistance or beneficiaries rather than on the manner of implementation.

2.4 Organization of Baseline Data

Baseline data were culled from documented secondary sources, field reports and budget reports of DOH. Interviews served to validate the indicative findings, as well as primary sources for updated rules, regulations, and the policies that govern them.

In the derivation of measures of budget utilization, data from 1996 to 1999 were used. The data are broken down according to expenditure items for every budget item comprising of the General Administration, Support to Operations, Operational Programs, and Projects (Locally-funded and Foreign-Assisted). Results of the derived measures of utilization are summarized according to the major budget items. Analyses of the activities that comprise the program were made to explain the trends in the utilization ratios.

3. ANALYSIS OF DOH BUDGET ALLOCATION

3.1 Distribution of Health Care Expenditure

With the transfer of basic health services, including hospital services to the local government in 1993, total health expenditure (both central and local governments) experienced leaps and bounds. A 9% growth in expenditure was posted during that year (from P10.69 billion to P11.62 billion). The highest recorded growth in total health expenditure was in 1996 to as much as 26% (P15.58 billion) from the preceding year's expenditure. On the other hand, in relation to entire national government expenditures, the health sector's share dropped substantially from 1995 growth of 34.6% to 6.2% in 1999 (**See Annex 1**). During the crisis years of 1997 to 1998, negative growth was posted (-6.03%). It was also during this time when a marginal growth in health expenditures of only 1% was recorded. Health expenditures as a proportion of GNP averaged at only 0.46% from 1996 to 1999 (**See Annex 2**).

Regional allocation as will be shown later, has consistently dominated the national budget. Numerous studies reflect disparities in health resource allocation favoring urbanized areas (National Health Plan, 1995). The National Capital Region received a dominant share with highest per capita government and private health expenditures. Since there was an established variation in the per capita health expenditure by income class, it would seem that allocation is largely hinged on the financial capacity of a given population to sustain demand for medical goods and services.

The National Health Plan from 1995 to 2020 prescribed the thrusts of the health agency to provide cost-effective and preventive health care activities. This also meant directing investments to needed health facilities in strategic locations that will be accessible to a maximum number of people. It may be recalled that most of the government hospitals used to be operated by the DOH. With the advent of the Local Government Code, of the 587 hospitals operated by the DOH, 534 were devolved, and 53 consisting of medical centers, special and regional hospitals were retained. The National Health Plan likewise forecasted the corresponding increase in the budgetary allocation of local governments following the heightened delegation in the delivery of major public health services to them.

3.2 DOH Budgetary Allocation and Major Program Focus

Current year appropriations of the Department of Health have marginally increased from 1996 to 1998, despite the onset of the crisis years starting in 1997. While other line departments of the government have experienced a reduction in their budgetary allocations, DOH budget was somehow maintained at a certain level during the period under review. It may be noted however, that a decline in 1999 of about 13% from preceding year's allocation was recorded. Previous years show that allocations have been up by 18% (**Refer to Table 1**).

By expenditure item, Maintenance and Other Operating Expenditures capture the biggest share along with Personal Services, which together constitute the bulk of the annual budget, averaging at 83% of the total. The share of capital outlay, a very important component that includes procurement of hard goods for the delivery

of medical services ranged from 19% to 22% from 1996 to 1998. It is interesting to note that this share dropped to 8% in 1999, which also coincided with the reduced budget in that year.

Table 1. DOH Appropriation, By Expenditure Item, 1996-1999

	Personal Services	MOOE	Capital Outlay	Total DOH Appropriation
1996	3,370,752,000	4,089,307,000	1,777,494,000	9,237,553,000
1997	3,965,000,000	4,537,828,000	2,435,029,000	10,937,857,000
1998	4,967,983,000	5,435,953,000	2,539,281,000	12,943,217,000
1999	5,042,874,000	5,300,903,000	922,061,000	11,265,838,000
TOTAL By Expenditure Item	17,346,609,000	19,363,991,000	7,673,865,000	44,384,465,000

It is reasonable to expect that the dominant shares of each of the budget items above, are accounted for by DOH Operations, which cover the major programs and activities of the agency. Examination of the budget items uncovers the major program focus, some of which are regular and recurring activities, while others are either new program undertaking or part of annual budget only for specific years. In the case of the locally-funded projects (LFPs) and foreign-assisted projects (FAPs), local funding counterpart may or may not have been provided in certain budget years. Therefore, budget data may not be considered indicative of any conclusive findings, much so as to the performance of a project. While utilization data may be derived, a further review of the project's implementation needs to be done. The case studies for a typical LFP and FAP will attempt to identify common issues that may explain any trend in the utilization data.

DOH annual budgetary resources have been geared heavily on Health Facilities, Maintenance and Operations, which comprise the budget for operations. **(Refer to Table 2).** This includes a significant portion going to regional allocation for hospital operations, which included specialty hospitals, medical centers, clinics, laboratories, sanitarium, a herbal processing plant and subsidy to indigent patients. In 1999 alone, this item already accounts for 79% of the total DOH budget for the year. This share increased from previous years' average of 70%.

A far second as a major budget item is the share of General Administration and Support services rendered by the central office. This include general management and supervision, a provision for the implementation of the Magna Carta of Public Health Workers (R.A. 7305), assistance to the local government units for the Magna Carta for Devolved Public Health Workers. These budget provisions are all for personal services, which include part of national government's contribution to the initiatives of devolution in the healthcare sector.

Support to Operations are comprised of health education and intelligence services, human resource development, policy-related programs, researches, and monitoring systems. These include allocation for personal services and MOOE allocation amounting to P255.6 million in 1999, yet its share of the budget outweighs the provision for the LFPs and FAPs (P159.41 million) in the same year, excluding loan proceeds.

From 1996-1998, LFPs and FAPs managed to get a formidable share of the annual budget, ranging from 12% to 16%. During the period, loan proceeds from donor agencies for the FAPs started to inch its way in to fund particular project components. This has compelled the agency to prepare counterpart funding. It interesting to investigate the causes of the sudden drop in the allocation for projects. In 1999, the share declined to a low 5.5% of the total budget. Locally-funded projects appear to have been severely affected by this decline because its share of total allocation for projects dipped to 9% in 1999 from an average of 35% recorded in the preceding three years.

Table 2. DOH Appropriation, By Budget Item, 1996-1999

	1996	1997	1998	1999
A. PROGRAMS & ACTIVITIES				
I. Gen. Administration and Support	1,227,835,000	1,271,955,000	1,482,856,000	1,463,680,000
II. Support to Operations	205,143,000	233,180,000	273,659,000	255,605,000
III. Operations	6,603,079,000	7,741,612,000	8,680,018,000	8,898,178,000
Sub-Total, A	8,036,057,000	9,246,747,000	10,436,533,000	10,617,463,000
B. PROJECTS				
I. Locally-Funded Projects	485,913,000	515,564,000	871,350,000	56,000,000
II. Foreign-Assisted Projects	715,583,000	1,175,546,000	1,635,334,000	568,630,000
Sub-Total, B	1,201,496,000	1,691,110,000	2,506,684,000	624,630,000
GATT Appropriation				23,745,000
GRAND TOTAL	9,237,553,000	10,937,857,000	12,943,217,000	11,265,838,000

3.3 Regional Focus

Detailed data show that DOH is working towards a *regional focus* having earmarked a substantive amount of budget to special hospitals, regional medical centers, and regional hospitals, etc. In total, the budget that goes to these institutions represents over 90% of the total provision for health facilities, maintenance and operations.

The study segregated all expenditure items accounted for by the regional offices, hospitals, and all other types of healthcare units in the regions. This is to examine whether the recent strides in devolving functions to the local government units, or decentralized central office activities have translated to efficient utilization of the agency's budget. The annual regional budget is comprised mainly of: a) institutional support/hospital-based; b) assistance to direct beneficiaries such as subsidies to indigent patients, and; c) public health programs. Of the three, the biggest chunk of the budget involves assistance to institutions, which include special hospitals, regional medical centers, regional laboratories, herbal processing plant, and sanatoria, fund for primary health care and centers for wellness programs in regular and special hospitals in the LGUs. This also includes support assistance to DOH-declared priority provinces. Examples of programmatic activities are programs on malaria, filariasis and schistosomiasis., and regional fund for drugs and micronutrients.

As earlier mentioned, a substantial part of the budget for Health Facilities, Maintenance and Operations is directed to the regions. Looking further down to the

budget items relative to the entire annual budget, one gets the picture that DOH operations are limited to the regions. From 1996 to 1998, the budget share of the regions is about half of the total annual appropriation. In 1999, the share even went as high as 70%. **Table 3** tabulates the respective share of the three major items that goes to the regions. Support to regional health institutions cover institutional support, programmatic activities, and assistance to direct beneficiaries. This constituted an average of 53% over the past four years. General Administration and Support have grown to over a billion pesos in 1999, possibly as a consequence of intensified decentralization efforts of DOH to expand its geographical coverage. Training and development receives a rather minimal share of the total. Available literature however, pointed out that these regional shares are concentrated in the National Capital Regions, especially for specialized hospitals. This concentration of regional allocation to the NCR started in 1994, with a share of more than 40% of the total budget, or more than a billion pesos each year. The public health programs on the other hand, are rather geographically determined with existence of demand or where morbidity rates are high, which have led to such dominant share.

Table 3. Regional Share of the Total DOH Appropriation, 1996-1998

	1996	1997	1998	1999
General Admin.& Support	636,666,000 6.89%	262,907,000 2.40%	985,747,000 7.62%	1,010,105,000 8.97%
Support to Regional Health Training Centers	35,496,000 0.38%	42,966,000 0.39%	59,589,000 0.46%	55,527,000 0.49%
Support to Regional Health Institutions	4,294,171,000 46.48%	5,971,325,000 54.59%	6,445,440,000 49.80%	6,849,906,000 60.80%
TOTAL	4,965,333,000 53.75%	6,277,198,000 57.39%	7,490,776,000 57.87%	7,915,538,000 70.26%

Note: Percentage figures refer to the share of the budget item to total DOH Appropriation for a given year.

4. ASSESSMENT OF BUDGET PERFORMANCE

The measures of budget utilization were derived and summarized in **Annex 3**, and classified according to the Programs and Projects as they appear in the annual GAA. The analyses are made based on the major programs that comprise the DOH operations. Budget performance of projects, both locally-funded and foreign-assisted, general administration and support services, management services (support to operations) will all be assessed using the same four parameters of BPI, AUI, OACI, and ApUI. Based on consolidated budget data from the regions, which make up the great bulk of the agency's budget, utilization will be gauged and the issues that accompany the regional budget performance.

4.1 Programmatic Activities

4.1.1 Public Health Services

Public health services involve the delivery of public health programs, which include the department's routine and regular services. Apart from this, the Office of Public Health Services also renders staff functions to the Secretary of DOH, which include providing advice on the relevant regulatory issuances, department orders, and rules consistent with DOH policies.

From 1996 to 1997, BPI decreased from 84% to 76%, and this was due to the disproportionate reduction in the allotment level. This was reversed in 1998 when a high 92% was recorded for BPI. This can be explained by the noticeable uptrend in allotment from P960.77 million in 1997 to P1.22 billion in 1998, with only a slight increase in appropriation.

The year 1998 may be considered a banner year for public health services due to the many accomplishments particularly of the so-called vertical programs whose implementation has been delegated to the regional hospitals, or through the regional health offices or RHOs.

In terms of the agency utilization indices, increased level of spending can be noted in 1997 when AUI rates rose from 73% to 131%. This was partly due to the low allotment level during the year. During this year, high expenditure level was observed for most of the general programs under the public health services (131%), particularly Maternal and Child Health Service (92%), and almost uniform AUI of about 89% for Immunization Program, Malaria Control, and Nutrition Service.

Low rates of obligations over allotment were observed for most non-communicables, especially for Blindness Prevention Program, Cancer Control and National Preventive Mental Health Program. In contrast to the public health programs, the National Disease Programs (consisting of both Communicable and Non-communicable Disease Control) have not been as heavily demanded at the LGU level, except probably for Tuberculosis control whose relative low allotment proved to be constraining because of significant number of cases.

In the ensuing years, AUI plunged to a low of 39% in 1998 and recovered somewhat to 46% in 1999. It is interesting that despite the full allotment recorded for diarrheal control, this program posted among the lowest AUI rates in 1998,

considering that its expenditure item was limited to maintenance and other operating expenses. This scenario was reversed in the following years on account of lower allotment level in 1999. Programs that had dismal rates of expenditures in 1998 but significantly improved in 1999 are Maternal and Child Health Service (from 38% to 87%), and control of acute respiratory infection/integrated child care management, which surged from 56% to 99% from 1998 to 1999. However, certain programs like the Immunization Program, National Tuberculosis Control Program, and Rabies Control Program continue to have lackluster fund utilization, thus pulling down the average AUI for Public Health Services in 1999.

In 1999, Communicable Disease Control program, particularly the utilization of available resources for tuberculosis control was the lowest at 20%. This low rate also holds true for programs on rabies control and leprosy prevention. Derived values for OACI show that the DOH had greater capacity to absorb greater level of allotment for this type of service in 1996 and 1997. The agency's high absorption capacity, particularly in the delivery of public health services is reflected in the high AUI values in said years (0.86 and 1.72). This slowed down in 1998 when OACI fell to 0.43, and marginally recovered the following year at 0.73. The decline in 1998 happened despite an increase in allotment, and the relative increase of OACI in 1999 came because of a big sudden drop in allotment by 70%. This is a typical case where wide fluctuations in allotment result in similar variations in OACI.

In 1997, expenditure level comes closest to a given appropriation when ApUI for public health services scaled 0.99. In this year, the amount spent for public health services (P624,437,510) came close to the amount of allotment (P960,772,050), and almost met the targeted level of appropriation of P1.26 billion. ApUI is lowest in 1999 when obligation is less than allotment by more than a half, and allotment far below appropriation at the same degree.

4.1.2 Hospitals and Facilities Services

Hospitals and Facilities Services cover the formulation of policies, development of standards, monitoring of programs, and assistance in the actual operations of hospitals and management of health facilities. A significant portion of the DOH budget goes to these types of services, which are largely allocated to the regions.

Health Facilities, Maintenance and Operations (HFMO) in Annex 3 refer to the allocation, excluding the budget for the regions.

Allotment has significantly grown to more than twice in 1997 from the preceding year. Allotment's share of the total appropriation was 81% in the said year compared to only 33% in 1996. It went up further to 87% in 1998 and plunged to a low 28% in 1999. The BPI remained high in 1998 even as substantial amount of sub-allotments were made to the regions^{1/}, while the drop in 1999 was mainly attributed to the low allotment for hospital operations and management service, whose appropriation was only P17.44 million. In 1996, the low BPIs were registered for hospital epidemiology and baby-friendly hospital initiatives.¹

¹ In the computation of BPI, sub-allotments to regions were included, while AUI was computed net of sub-allotments

The consistent growth in BPI was sustained even during the crisis period because maintaining allotment levels were secured for institutional support, especially for the operations of hospitals at the national and regional levels.

Expenditure was highest in 1999 when BPI was at its lowest (AUI=98%). It was during this year that substantial accomplishments were recorded. The HFMO has facilitated the re-nationalization of two devolved hospitals, and developed the standards on manpower requirements for hospitals. The budget for Hospitals Facilities Maintenance was a record high in 1998 at P307.14 million. From 1996 to 1998, both retained and devolved DOH hospitals were provided preventive maintenance. There were a total of 112 visits to hospitals in the Luzon area, and 1,941 equipment checked and repaired.

In 1998, it must be noted that AUI registered the lowest at 43%, but allotment (net of sub-allotments) increased from P83.78 million in 1997 to P127.05 million. This only means that expenditure level did not grow proportionately with allotment.

OACIs have been very high in 1996 and 1999 owing to the fact that allotments in these years in relation to the levels of appropriation (BPI=33% and 28%, respectively) were at their lowest. In 1996 and 1999, the indices were recorded greater than unity at 2.23 and 3.56 suggesting that HFMO as a service could have been utilized more had allotment levels been raised further.

An upward trend was observed in ApUI until 1997. Expenditure for this service came closest at meeting the government's appropriation target in the said year thus, registering still low ApUI of 0.39. The lowest ApUI was in 1999 (0.27) because of the big disparity between appropriation and allotment.

4.1.3 Primary Health Care

Primary health care is geared towards developing strategies and adopting these to enhance people-centered programs on community health and development that are initiated by both the government and private sectors.

In comparison to other budget items, the appropriation of primary health care has not been as significant especially in 1996 (P51.7 million), and 1997 (53.1 million).² During these periods, BPI almost remained unchanged (from 88% to 87%), but there was a reverse trend in AUI because the magnitude of increase in expenditure did not correspond to the increased amount of allotment. Appropriations were reduced by about half in the succeeding years, leading to improved BPI. The allotment in 1999 was fully obligated, thus, resulting in an OACI of 1.33.

² Primary health care is basically comprised of policy-oriented activities and not field programs explaining its relative smaller share of the entire agency's budget.

4.1.4 Health Facility Standards, Regulations and Licensing

The budget allocation of the Office for Standards and Regulations will be taken up here, but it should be made clear that the jurisdiction over the implementation of regulatory policies and standards in the health sector rests primarily in the regions. The GAA has distinctly classified this item as part of the Central Office budget and as such should be related to the holistic budget of the DOH. This item would cover the budget of the attached agencies of DOH and other operational units, such as the Bureau of Foods and Drugs, and the Mini Food and Drug Testing Laboratory, Biological Production Services, Bureau of Licensing and Regulations, National Quarantine Services, Radiation Health Services, and the Bureau of Research and Laboratories.

There was a 60% drop in budget for these services in 1997 accompanied by a low release, explaining a BPI rate of only 12%. The allotment in the preceding year was only 8% higher with an appropriation of P676.2 million, the highest given in the four-year period under review. Allotment averaged only at around P31 million, way below the given appropriation. Appropriation did not consistently grow from 1996, and so were allotment levels. The Bureau of Food and Drugs, and Mini Food and Drug Testing Laboratory have the lowest releases among the agencies/units. BPI only increased because of the continuous drop in appropriation throughout the years.

Despite the low BPI recorded, the level of spending given the released budget consistently grew from 1996 to 1999. Allotment experienced leaps and bounds from 1996 to 1999. The high rate of obligation from allotment of 93% only coincided with the reduced allotment in that year.

High OACI is expected to register for this budget item given the trends in allotment and obligation, and a declining appropriation. The high 11.76 index in 1996 can be attributed to the highest appropriation recorded of P676.2 million.

It is not surprising to see less than 10% in ApUI for this budget item from 1996 to 1999. Even with the diminished level of appropriation, allotments and obligations have not really progressed. Allotments averaged to only 10% of the appropriation during the entire period.

4.1.5 Management Services

Management services involve supervision, control and coordination functions of the six services units in DOH. GAA has categorized these services as a support to operations. These services include: 1) Health information and health education services; 2) Health human resource development system; 3) Health Policy and development program; 4) Department Legislative and Executive Liaison and Coordination; 5) National Drug Policy; 6) Essential National Health Research, and 7) Local Government Assistance and Monitoring System (LGAMS).

In general, management services follow an upward trend in the appropriation levels averaging at around P193.5 million. BPI rates were generally high (more than 90%) throughout 1996 to 1999, with the most favorable rates recorded for health

human resource development system, health policy and development program, and program under the Department Legislative/ Executive Liaison and Coordination. Health information and health education services received 84% of its appropriation, and improved the following years especially in 1999 when BPI surged to 100 percent. Among the activities under this program that register high BPIs are public information and health education services, and health intelligence services. In 1999, a realignment of the budget was made in favor of the former indicating its relative importance to the program. The realignment held true for the entire budget item in said year, when BPI registered greater than unity.

Actual spending levels appeared to approximate the allotments, particularly in 1996 and 1998. Four programs have high AUI (more than 90%) in 1996. In 1997, there was a slowdown in utilization of allotment as AUIs went down with the exception of programs on National Drug Policy, Essential National Health Research, and LGAMS. For example, LGAMS' AUI recovered from 64% in 1996 to 96% in 1997.³ In 1998, with the exception of health policy and development program (AUI=45%), fund utilization was substantial. The 1998 DOH annual report recorded significant accomplishment of an estimated P448 million worth of deliveries, and issued an estimated P407 million worth of goods.

Overall, the AUI and BPI hew closely with each other. Thus, OACI hovered around unity in 1996-1998. This indicates the agency's success in matching budget programming with fund utilization capability for support to operations.

4.2 Projects

Allotment and obligation data are not available for 1998 and 1999, and there have been only recent initiatives to unify project management for foreign-assisted projects. Because of the varied nature of projects, both locally-funded and foreign-assisted, actual experiences are best captured in individual reports, interviews, milestone accomplishments, ODA reports, etc. The case studies of typical projects will cover the discussion of these experiences.

Figures for both LFPs and FAPs in 1996 and 1997 show that much is to be desired, as far as budget releases are concerned. In 1996, only 56% of the appropriation was actually released for LFPs, but this dropped to 26% in 1997. The release of funds for locally-funded projects, which involved the construction, improvement, repair/rehabilitation, renovation and equipment purchase for regional hospitals was slow in 1997. Recorded data for 1998 show that the ratio of allotment over appropriation of 7% was no departure from previous years' data. For FAPs, allotment was 25% of appropriation in 1996, and declined the following year to 8%. The BPI rates have been poor despite the increase in appropriation for both types of projects. Appropriation for LFPs grew by 4% from 1996 to 1997 (from P485.9 million to P505.6 million), while FAPs experienced a hefty 75% increase in its appropriation (from P374.7 million to P657.9 million). Such increases were countered by continually diminishing allotments until 1999.

³ Utilization in LGAMS have been high because of central office's activities that are geared towards strengthening healthcare delivery systems in the LGUs.

FAPs had higher allotment utilization rate (AUI=92%) than LFPs (AUI=46%) in 1996. AUI significantly dropped to 26% and 28%, respectively the following year. This indicates that the level of expenditures really deteriorated, because the degree of increase in obligation did not grow as much as the increase in allotment. It was observed that monitoring of FAPs has been reinforced through the years because of the perceived need to improve utilization. Procurement problems partly explain the big drop in expenditures in 1997 by more than half. To date, DOH is still fine tuning its procurement procedures to lessen the delays, which in turn, leads to cost overruns and backlogs. Low AUI rates for LFPs can be attributed to the termination of some activities, because of derailed implementation. Among the reasons cited for the delay, the most significant has been the inability to mobilize committed local government resources.

The OACI figures indicate that locally-funded projects could have absorbed more than 6 times given the allotments in 1998, as the allotment level was extremely low. In contrast, foreign-assisted projects' expenditures could have improved significantly had allotment been higher in the same year. In 1997, OACIs for LFPs and FAPs of 0.99% and 3.28%, respectively indicate good match in funds programming and utilization.

ApUI were expectedly very poor for both types of projects. Comparatively, the ApUI declined in 1997 because obligations even went down with the increased appropriation even as allotment levels remained low. Most of the donor institutions have cited the slow utilization of donor funding because it is partly hinged on the availability of counterpart funding necessary to attain significant accomplishment results.

4.3 General Administration and Support Services

This budget item includes procurement activities, implementation of Magna Carta of Public Health Workers, assistance to local government units in the enforcement of Magna Carta for Devolved Public Health Workers, administration of incoming foreign and local commodities, and employee benefits.

The crisis years have affected release of allotments for General Administration and Support Services even with declining appropriation levels in 1996-1998. Thus, BPI fell to 26% in 1997 and 42% in 1998, except for employee benefits the allotment for which has well been fixed. BPI has then increased to 63% in 1999. The movement in BPI was largely driven by trend in allotment level as appropriations were fairly constant.

From 1996 to 1998, AUIs have been more than 90%, but it slipped to 52% in 1999. Personal services and other employee benefits have caused the high AUIs for this budget item.

The overall absorption capacity indices in 1996 were high ranging from 1.5 to 6.0. In contrast, OACI for 1999 suggested low absorptive capacity of the agency at 0.74.

The drop in both obligation and allotment levels in 1997 resulted in a low ApUI of 0.17, the lowest registered in the four-year period. This was due to the combined effects of budgetary restrictions during the crisis years, and non-payment of productivity incentives. Nevertheless, ApUIs in other years were not really high indicating that expenditures were far from achieving government's target. Because of increased allotment in 1999, ApUI improved from 32% to 36%, but obligations remained rather low. The present move to streamline the organizational structure of the central office and redeployment of existing number of personnel to the regions can be traced back even in earlier years. The intensified programs in the regions have also translated to the need for counterpart health personnel. This direction can partly explain why allotment did not revert back to its 1996 level, and current level was maintained from what was provided in 1998.

4.4 Regional Budget Performance

DOH appropriation for the regions has experienced an increasing trend over the past four years indicating the more decentralized approach taken by the Department. The highest increases were posted at 26% and 19%, respectively, in 1997 and 1998. However, actual budget releases increased at slower rate starting in 1997, as reflected in the BPI values (**See Table 4**). The Allotment Utilization Index (AUI) remained high but have declined starting 1998, suggesting some deterioration in fund utilization of regional offices. It appears that the Asian financial crisis took its toll in 1998 causing some stringent measures taken by the Budget department such as budget reduction amounting to 25% of the budget as an agency's mandatory savings. AUI was lowest in 1999 when appropriation was at its peak, because of decline in BPI.

Table 4. Consolidated Regional Appropriations, Allotments and Obligations

YEAR	Appropriation	Allotment	Obligation	ApUI	AACI	AUI	BPI
1996	4,965,333,000	4,406,518,000	4,689,273,000	0.9444	1.1991	1.0642	0.8875
1997	6,277,198,000	5,229,204,000	6,790,184,978	1.0816	1.5588	1.2985	0.8330
1998	7,490,776,000	5,429,784,651	4,982,874,422	0.6652	1.2660	0.9177	0.7249
1999	7,915,538,000	6,260,736,078	5,320,787,187	0.6722	1.0745	0.8499	0.7909

There are also implementation problems of programs in the regions. This may partly explain why AUI decreased starting 1998, because regional budget suffered from the delayed releases. For example, one of the major public health service programs, the National Primary Health Care Service cited the delayed release of funds at the national and regional levels beyond the last quarter of the calendar year as cause to the hampered implementation of the program.

The budget reduction equivalent to 25% as mandatory savings imposed in 1998 explains why the diminished rates in BPI followed the decline in AUI rates after said year. This imposition along with the incidence of delayed releases, have only compounded problems that have affected the efficient utilization of budgetary resources. This is also supported by high OACI in 1998 (1.2660) indicating the capacity of DOH to absorb more funds for its programs and projects.

While regional appropriation and allotment have increased in absolute terms from 1996 to 1999, utilization ratios got smaller, except in 1997. There was a considerable amount of sub-allotments made to the regions in 1997 leading to the substantial releases and expenditures.

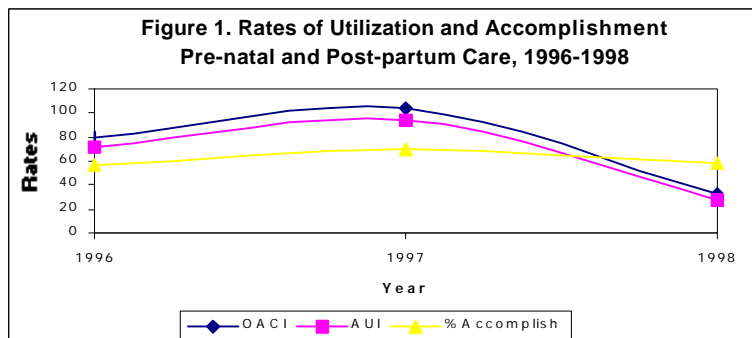
5. DOH HEALTH PROGRAMS..TARGETS AND ACCOMPLISHMENTS

Aside from the operation of health facilities and institutions, which as earlier discussed comprises a significant portion of the entire DOH budget, public health services are the regular annual health programs considered another important budget item. These programs intended to reduce morbidity and mortality rates are targeted to a certain percentage of the population. The information on these programs is largely obtained from the field, through the Field Health Service Information System.

The measures of budget utilization derived for the individual program activities were used and compared to the agency's annual targets and accomplishments (**See Annex 4**). The purpose is to deduce some findings in the comparative analysis that would relate to the relationship between the extent of resource utilization and the amount of accomplishment in a target year. **Figures 1-2** show a graphical presentation of the trends in utilization and accomplishment in two typical programs namely, the expanded immunization and Tuberculosis control. The hypothesis is that the former impinges on the latter, in a way that financial resources have always been crucial in the delivery of physical outputs for the programs. One can only relate to the weight of the accomplishments as a percentage of targets, and compare any improvements, or the lack of it to the budget ratios and indices (**See Annex 5**). This is because one program may have one or more components, the targets of each were set as a reasonable percentage of the population in a geographic region. Therefore, for one program we can have two or more rates of accomplishment, which on the average gives a picture of a program's coverage of a target population.

5.1 Prenatal and Postpartum Care vs. Maternal and Child Health Service

The target population for prenatal and postpartum care has been 3.5% of total throughout 1996 to 1998. The trend of accomplishment in the delivery of prenatal and postpartum care follows the increases in absorptive capacity indices recorded from 1996 to 1997 (**See Figure1**). In said years, allotment and obligations both increased notwithstanding the big plunge in appropriation in 1997 (from P53.9 million to P26.8 million). Alongside with the recorded increases in allotment and obligations, accomplishment also grew from 56% to 69%. This meant that 56% and 69% of total target population had three or more prenatal visits to public health facilities.



In 1998 when accomplishment suffered a decline to 59%, AUI was at its lowest at 27% because expenditures were not as high in relation to allotment increase in the said year. The remaining segment of the population not covered in the accomplishment is taken to have had their visits with private health facilities and those that have not made visits at all. It can be noted that Region 1 have provided the greatest number of pregnant women with the most number of prenatal care visits from 1996 to 1998.

5.2 Expanded Immunization Program

There was a marked increase in the AUI from 41% in 1996 to 89% in 1997 despite slight dip in the record of accomplishment in the said period (from 90% to 89%). This was due to remarkable expenditure amounts, which increased by more than 100% in 1997. Unlike the prenatal and postpartum care, there seems to be very little effect of financial utilization to the delivery of services to actual number of people. This may be attributed to the many problems encountered in the distribution of vaccines such as the geographical distance, and lack of commitments of some LGUs to shoulder accompanying expenses. In 1999, the further deterioration of AUI to 25%, respectively still yielded accomplishment rate of 85%. The level of obligation has registered its lowest during this year to only P376,569 from the preceding year's P66.4 million. In 1997 for example, only 37% of infants were given 3 doses of Hepatitis B, which is a coverage way lower from what has been achieved the preceding year. The areas with the most coverage of immunization program vary every year. In 1996 to 1997, Region 6 recorded the highest coverage at 96% and 97.9%, respectively, while the National Capital Region covered the most number in 1999 at 94% for children in less than one year old bracket.

5.3 Control of Diarrheal Diseases

There have been very low AUIs and OACIs recorded for the control of diarrheal diseases program, from 4% in 1996 to less than 1% in 1997 and 1998. This was caused by the continued deterioration in allotment levels accompanied by a sudden drop in the amount of expenditures in the latter year. At the same time, there has been no significant growth in the level of accomplishment recorded averaging to only 32% over the three-year period. Improved utilization ratios can serve as a good test to better coverage rates. There seem to be a likely relationship between utilization ratios and accomplishment because diarrheal diseases at 1,273 person per 100,000 population remained to be the leading cause of morbidity in 1998. Given the substantial number of affected segment of the population, and the relatively lower level of accomplishment and AUI rates, it can be generalized the number of delivered services in this program are influenced by utilization rates.

5.4 Acute Respiratory Infection (ARI)

It can be observed that AUI lowered drastically from 1996 to 1998, indicating the very low expenditure levels for ARI. For example, obligation was way down to only P206,025 in 1997 from P17.8 million in the previous year. This was further aggravated by the very

sharp decline in allotment, from P20.2 million to only P2.1 million in the same period. On the other hand, accomplishment rates did not differ much, averaging to about 61 %. This is due to a rather good rate of coverage throughout the years. Of the positively identified population of children 0-59 months with pneumonia, 88.9% were given treatment in 1996, 10% in 1997 and 0.09% in 1998. It appears that accomplishments have declined, but not as much as the downturn in AUI.

5.5 Nutrition Program

In the case of the Nutrition program, high AUI rates were accompanied by lower rates of accomplishment, except for the program component catering to children (12-59 months) given Vitamin A. From 1996 to 1997, obligations were almost at par with the given allotments. High AUI rates in 1999 however, were primarily due to the sudden drop in allotment by 57.5% (from P66.8 million to P31.8 million).

On a general scale, it seems that based on the trends, the amount of budget is not sufficient to establish a good coverage. Field data suggest low coverage for moderately underweight children (6-59 months), initiated food supplementation and follow-up food supplementation, which averaged at 16% in 1996 and down to 15% and 10% in the following two years. Rates of rehabilitation for undernourished children have likewise been low, to less than 10% of the affected population. For the same age bracket but are classified as severely malnourished, the same trend in accomplishments holds, although slightly higher.

For pregnant women given complete iron dosage, coverage remained at almost the same level (40%,47%,41%). Target coverage has likewise been the same for childbearing age women (15-49 years) given iodine supplements but accomplishments plunged from 21% in 1996 to only 4% in 1998.

As mentioned earlier, the Vitamin A program for both children and lactating mothers have recorded modest rates of accomplishment compared to the utilization rates. For children 12-59 months, an averaged coverage of 92% was posted, while 50% of the targeted number of lactating mothers benefited from the program.

5.6 Family Planning

There are two family planning methods being adopted for both new acceptors, and continuing users, these are the traditional method and modern method. Understandably, accomplishments have been greater for those subscribing to the modern method than the traditional method because of more measurable parameters in terms of medical goods delivered. For continuing users a high average of 97% was accomplished, and 94% for the new acceptors. Those adhering to the traditional method have stabilized to 6% for new acceptors, and 3% for continuing users. In 1997, AUI was highest only because allotment was low in that year. Accomplishment appears to be less influenced by rates of utilization, although the growing trends for both suggest otherwise. A more in-depth study should be made because the

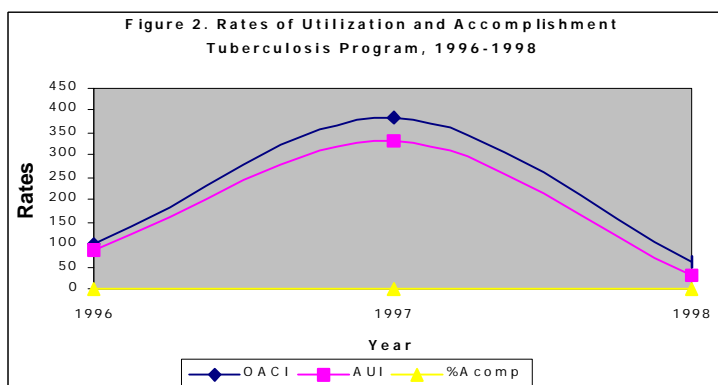
variations in annual allotments seem not to concur with the rather stable results in accomplishment.

5.7 Dental Health Services

This service can be classified according to preventive and curative treatment. AUIs were high in 1996 and 1997, and were down in 1998. The high rates in initial years were due to improved expenditure levels along with the almost two-fold increase in allotment. The low utilization rates in 1998 were caused by a drop in obligation, despite the marginal increase in allotment. But accomplishments remained rather same throughout the years. For example, preventive treatment for schooling population was undertaken to more than 100% of the target, while curative treatment covered only 5% to 6% of the population. In contrast, preventive (60%) and curative treatment (45%) for pregnant women were done at rather stable pace. Looking at allotment data, the low performance in 1998 can really be attributed to low expenditures thus, the need for improved utilization in areas with low treatment coverage, as earlier cited.

5.8 Tuberculosis Control Program

It is surprising to find that the unusually high AUI rates in 1996 and 1997 for the Tuberculosis Control Program still yielded very low (less than 1 %) accomplishment. During these years, there was a consistent growth in both allotment and obligations. It was also during these periods that allotment posted the highest, averaging about P170 million annually. Starting 1998, allotment declined and utilization rates have not improved. Like the diarrheal control program, tuberculosis ranked among the leading causes of morbidity in 1998. Therefore, the cost of diagnosis and treatment to a substantial number of affected persons could explain why utilization ratios were high but accomplishment remained low. However, the trend in accomplishments follows utilization, by magnitude just like in the case of immunization program. More importantly, unlike the other programs the total population base considered will expectedly make the accomplishment low. It is worthwhile to look into the increase in treatment and diagnosis numbers as we relate this to AUI.



There is no significant growth that can be observed between the total TB cases recorded, TB symptomatics given sputum exam and those found new sputum positive which received initial treatment. Given this, and the low 29% AUI recorded in 1998 only suggests the absence of any relationship between the manner of utilization and accomplishment. 1998 data for Tuberculosis Control Services showed that the low 29% AUI was due to low expenditures, particularly MOOE (25%) despite a 76% allotment provision from total appropriation. The National Tuberculosis Control Program also suffered from a very low AUI of only 4%, despite only 43% allotment release. The Philippine Tuberculosis Society was the only component that registered full utilization, comprising only of MOOE.

5.9 Leprosy Control Program

Another disease control program, which has the total population as its target base is the Leprosy Control Program. The low accomplishment rate is attributable to this large target base. Accomplishment has been .02% over the three-year period. In 1996 and 1997, AUI was recorded at 67% and 58%, respectively and experienced a downturn to 13% in 1998. The dismal performance in 1998 may have been partly due to the very small percentage of appropriation (25%) released. In contrast, 56% of the allotment was obligated in 1997, and this was entirely allocated for MOOE, yet accomplishment representing prevalence rate remained the same. Of the 4,606 new cases diagnosed in 1998, 9,261 have been under continuing treatment while 3, 738 complete their treatment.

5.10 Schistosomiasis Program

No. of cases diagnosed were at a low 4% and 5% in 1996 and 1998, but cases given treatment were high up to 100% in 1997. The trends in AUI follow the number of cases treated. The almost static level of obligation, accompanied by a continued increase in allotment from 1996 to 1998 caused AUI rates in these years. Cases treated reached to 100% when AUI was at 68%. When accomplishment slightly declined to 65%, AUI was 96%. An interesting subject of research is determining the desirable level of expenditure given a good accomplishment rate, that is, assuming that the targeted number of affected population is reasonably set. This could contribute in determining a methodological approach in allotment setting, should budgeting be based on performance of a specific program.

5.11 Rabies Control Program

This program is measured by the number of cases with animal bites, and given post exposure immunization. The improving rate of accomplishment is accompanied by increasing rates in AUI. Allotments grew in minimal proportions, and so with the obligations explaining the very narrow difference in AUI rates. The unusually low obligation incurred in 1999 led to the big drop in AUI.

5.12 Filariasis Control Program

Filariasis control program is another typical case where rate of accomplishment increases with the improvement in AUI. Improvement in the delivery of services from 45% to 68% in 1996 and 1998 was accompanied by growth in AUI from 90% to 94%. The decline in allotment in 1998 was accompanied by a slowdown in expenditures resulting to high AUI rate. In other years, utilization rates were reasonably high because of joint increases in obligations and allotment. However, unlike the rabies control program, the decline in accomplishment in 1998 to 29% and a corresponding drop to 72% of AUI. Therefore, there is a need to look into the specific types of expenditure items that may have considerable effect on accomplishment since the MOOE is the single expenditure item that the program is consist of.

5.13 Malaria Control Program

The number of clinically-diagnosed, and those given treatment increased from 41% to 88% in 1996 to 1997. AUI in the said years have also risen from 57% to 94%. Despite the lowering of allotment in 1997, expenditure further improved from the preceding year resulting to high AUI. But after said year, expenditure was markedly low compared to the initial years. The lower accomplishment of 51% in 1998 was accompanied by corresponding drop in AUI, which was the lowest recorded at 70%.

5.14 Sexually- Transmitted Diseases (STD)

Like the Tuberculosis Control Program, accomplishment rates have been rather constant and low because of large target population base. AUIs were particularly good in 1996 (99%) and 1997 (97%), but a marked decline in diagnosed cases was reported. During these years, allotment and obligation levels approximate each other, but marked declines have been posted in the following two years, cutting expenditures by more than half in 1999 (P12.8 million) from the highest recorded in 1997. Low AUI in 1998 resulted to even lower accomplishment rates but not to a significant extent. Based on this, it seems that greater utilization of funds will pave the way for improved accomplishment rates, but there is a need to look into the expenditure levels to examine why good utilization in some years have resulted to even lower accomplishment.

5.15 Environmental Health Program

The program is geared at providing households access to safe water supply, sanitary toilets, satisfactory garbage disposal, and other sanitation facilities. AUI was highest in 1997 (97%), and slightly dropped to 72% the following year, but accomplishment generally improved. The drop in AUI in 1998 was brought about by the increased allotment, but expenditures did not respond in a similar manner. It is interesting to note that like the malaria control program.

Accomplishments were higher for food establishments than for households, but the trend remained the same relative to the AUI.

6. BUDGET UTILIZATION IN TYPICAL CONTINUING DOH PROGRAMS

Two types of continuing health programs of the DOH will be taken as cases in studying the different experiences in budget utilization. National health programs with significant share of the budget, but with differing manner of implementation are the expanded immunization program, and the tuberculosis program. Following the method of analyses done in earlier chapters, accomplishments of each program will be reviewed along with the derived rates of utilization. For accomplishment indicators, detailed regional information will be used. It is noted that the field health statistics for 1999 are still subject for validation, pending confirmation of consolidated data for Regions 1,2, 3, 4, 5, 6, 12, CAR, ARMM, and the NCR.

6.1 A Vertical Health Service: The Case of the Expanded Immunization Program

The objective of the expanded program on immunization (EPI) is to reduce morbidity and mortality of childhood tuberculosis, diphtheria, pertussis, tetanus, measles, poliomyelitis and hepatitis B, by providing BCG, DPT, OPV, Hepa B and measles vaccine to children before they reach one year of age; and tetanus toxoid to pregnant mothers, and women of reproductive age to protect newly-borns from tetanus.

Utilization rates derived in Chapter 4 will be revisited, and will be compared to the accomplishments of the program down to the regional level. This program is categorized as a vertically-administered program, which means that implementation is delegated to the regional health offices or through the local government units, but control from the top central office is still maintained, particularly in the aspect of procurement, policy directions, and setting of targets. This is in contrast with horizontal (integrated)-administered programs where the central office concerns itself primarily on the targets of assistance or beneficiaries, rather than on the implementation mechanisms.

6.1.1 Fund Allocation and Utilization

The decrease in allotments in 1998 was very insignificant, but all other years posted relatively good allotment ratios over appropriation or BPI. This has been the scenario since 1994 when top DOH management at that time, acknowledged the need to continue the program even after several donor assistance have lapsed.

Table 5 shows the relative shares of the GOP and funding agencies to EPI.

Table 5. EPI Budget by Funding Source, 1994-1997 (In Pesos)

Funding Agency	1994	% Share	1995	% Share	1996	& Share	1997	% Share
WHO	1,906,350	0.5	1,095,004	0.4	520,000	0.2		
USAID	13,710,578	3.4	-		-			
UNICEF	13,326,935	3.3	19,433,132	6.3	989,380	0.3	2,381,600	0.7
RI	34,148,643	8.4	607,900	0.2	2,000,000	0.6		
CIDA	27,385,552	6.8	36,707,375	11.9	32,400,000	10.4		
GOP	313,429,328	77.6	251,534,550	81.3	274,424,000	88.4	359,381,000	99.3
Total	403,907,386	100.0	309,377,961	100.0	310,333,380	100.0	361,381,600	100.0

Source: EPI Program Review (DOH, 1998-1999)

Since the program became a major line item in the budget, the expanded immunization program became a nationally-administered health program targeting an average of 3% (for children immunization), and 0.88% (for immunization of pregnant women) of the entire population each year. It is surprising to see low AUI in 1998 and 1999 (0.2153 and 0.0012), and this may be due to the effect of the amount of allotments, particularly in 1998 when substantial reductions brought about by the 25% mandatory savings took into effect. In the same years, ApUIs were just as low showing the great disparity in the level of expenditures in contrast to allotments, most especially to appropriation. This is surprising because the program, as indicated in many studies, require substantial financial support because it has graduated from the status as a donor-driven program to a major public health program. Second, the importation scheme of procuring vaccines demands an advanced six-month schedule of payment enabling the procurement agent (UNICEF) to develop a revolving fund to support future purchases. This would translate incurring obligations under normal circumstances.

6.1.2 Regional Accomplishments

The expanded immunization program is comprised of two components, namely immunization given to children, and pregnant women given TT2+. The expanded component of the program is the dispensation of a third dose of Hepatitis B vaccine. For the full immunization to children, DOH target since 1996 was 3.5% of total eligible population statistically spread over the population base in each region.

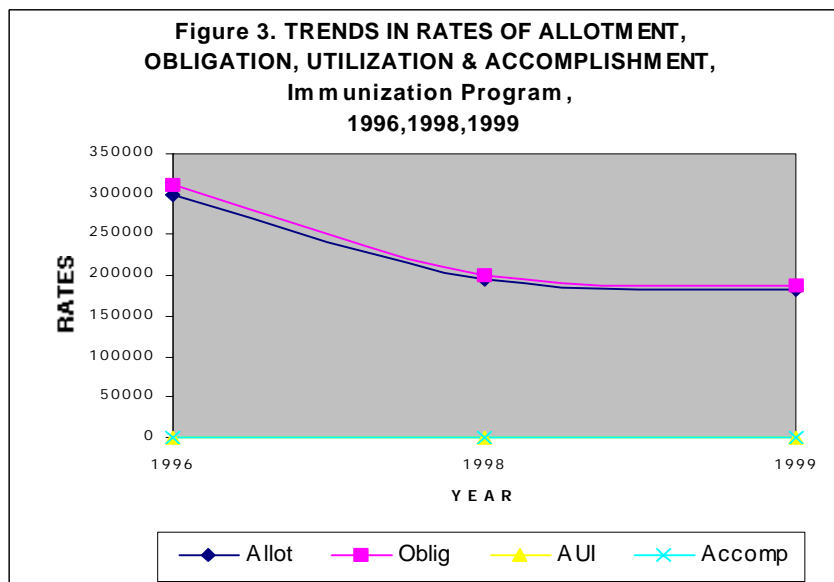
Since the delivery of services under the program has become devolved, it is interesting to examine the accomplishments in every region in relation to their allotment levels and expenditures. Furthermore, derived AUIs across regions, and their accomplishments for the children immunization program were compared to establish some correlation.

EPI involves a vertical administration of funds, in which the budget amounts and its control are determined at the central office. This is in contrast to horizontal administration when funds are sub-allotted directly to the regions.

Looking at the trends in the accomplishments for the two components of the program (**See Annex 6**), the number of cases served in the regions throughout the years were rather homogenous for children immunization. For children immunization, regional accomplishment averaged at about 90% in 1996, and experienced slight decline in the following years to 89% (1997) and 85% (1998). For pregnant women targets, accomplishments have been only about half. The exceedingly low AUI rates in 1998 (0.2153) and 1999 (0.0012) could explain such diminished rates in accomplishment. There have been reports in the past that the program had difficulty meeting the targets because of high cost of certain types of vaccines.

Annex 7 presents a matrix of the regional allotment, obligation, AUI, and accomplishment in the years 1996, 1998, and 1999. As shown in **Figure 3**, the declining trend in the average allotment and obligations levels saw a corresponding diminishing rates in utilization and accomplishment in the three-year period. It would seem that the expanded immunization program is largely hinged on the amount of

resources that is made available annually. This can be expected since the bulk of the expenditure goes to procurement of vaccines and other drugs.



6.1.3 Factors Influencing Sustainability

EPI Program Review for 1998 and 1999 identified the issues that confront the program's sustainability. Sustainability for this program has revolved around issues related to resource utilization, more than institutional. These factors are: 1) vaccine procurement; 2) vaccine production and storage, and 3) sharing of EPI cost.

6.1.3.1 Vaccine Procurement

Government's commitment to sustain EPI through the creation of a line budget for vaccine procurements was reflected in the growth of allocation to about P1.6 billion annually until 1998, from an initial P250 million in 1994.

Procurement is a single major factor that has affected low utilization rates, especially in 1998 and 1999. UNICEF as a procurement channel, through the Vaccine Independence Initiative (VII) Program, is believed to have drastically improved availability of vaccines since 1994. Under the VII Agreement between UNICEF and DOH, forecasts of vaccine requirements and capital for a revolving fund will be provided by the former. At the start, the DOH has been paying UNICEF in advance for its orders of vaccines. In 1996, the DOH was unable to pay UNICEF because of Section 88 of P.D. 1445, which prescribed that "government shall not be obliged to make advance payment for materials pending delivery, without prior approval from the President". Bulk order through UNICEF however, has led to the lowering of prices, and preventing foreign currency drain since these orders are paid for in local currency. Procurement was also beset with controversies prompting the central office to resort to stricter evaluations, and stringent measures, which have only caused further delays. The substantial amount of cost involved in the

procurement of drugs and medicines for example, is believed to be prone to external influences. This is the reason why price and technical evaluations have to be tight in the process.

6.1.3.2 Vaccine Production and Storage

In an assessment of the country's vaccine requirement, it was indicated that vaccine supplies should be a combination of imported and locally-procured ones (CVI, 1994). The Biologicals Production Services of the DOH used to produce BCG and TT vaccines, but ceased production because production machinery and storage capacity have aged thus, failing to adhere to the acceptable production standards. Furthermore, upgrading seemed not a viable alternative because it is not cost-effective to work on the outdated facilities. In 1997, half-a-billion allocation was earmarked for the modernization of BPS, and purchase of new production machineries. Equipment for BCG vaccine production have been acquired, except for TT vaccines. With the purchase of new vaccine manufacturing equipment, there is a corresponding need to train or re-train personnel on its use and acquire skills in production and quality assurance techniques (EPI Program Review, 1999). However, while there has been an allocation, the plan was stalled because of other unresolved problems in the construction of production site and its bid-out.

It is the opinion of many that certain types of vaccines that can be produced locally should be identified, especially where quality is less prone to interferences, such as across types of hepatitis vaccine (recombinant vs. plasma-derived).

6.1.3.3 Cost-Sharing of EPI

The priority given by government in terms of budget cannot be considered substantial in relation to other expenditure items. Herrin (1993) noted that health expenditure from 1985 to 1991 was estimated at only 2 percent of the Gross National Product (GNP). With the devolved set-up adopted since 1993 for health service delivery, cost sharing with the local government became a plausible arrangement that could have made resources readily available for utilization. The arrangement also became reasonable with the increased responsibility of LGUs, particularly in the provision of local health workers, shaping and fine tuning of health care and services to local health demands. The remaining responsibilities for the DOH included policy formulation, health sector planning, development and implementation of health standards, enforcement of health regulations, education and training, resource augmentation, and monitoring and evaluation (EPI Program Review, 1998).

Similar to the experience of other health programs, LGUs participation has been heavy in taking on the wages and salaries of health workers, travel allowances for outreach health activities for EPI, as well as financial support in the form of additional supplies, food and training of volunteers. These forms of participation to a large extent, are only dependent on the Internal Revenue Allocation (IRA) as primary source for bankroll devolved services for most LGUs, particularly municipalities (DOH LGAMS, 1993). The limited IRA relative to the overall local priorities only constrains the ability of LGUs to assume their participation to the EPI. Field health workers complain that some district hospitals even refuse the storage of vaccines because of electricity expenses, while some simply does not have the available storage facilities. The remote distance of some areas also poses as barrier to the

timely delivery of health goods and services. Transporting these goods and services had to compete with the other priorities of the local government.

One scheme that should be considered by LGU is charging user's fees for some health services to cover at the very least, the overhead expenses that accompany under-funded health programs such as immunization, health education, prenatal and maternal care. It is also argued that this will provide as an incentive for many NGOs, and other privately-run cooperatives to cooperate in rendering their services. A consortium between LGU and NGO has been explored and found workable in Negros province and Naga City, which involved entering into a contract with the local health boards to deliver maternal and child care services on an "operate-on-a-cost recovery" basis.

Ramos-Jimenez, et al (DOH Report, 1994) reported that the user fee scheme was adopted in Malalag, Davao del Norte in 1994, through the passage of an ordinance. A survey among 2,000 mothers nationwide regarding the acceptability of the scheme for immunization was made, and 60% were in favor of paying minimal charges. The same arrangement was found very productive in Tagbilaran City and Lake Sebu in South Cotabato.

6.2 An Integrated Health Service: The Case of the Tuberculosis Control Program

The National Tuberculosis Control Program aims to control the disease through information, diagnosis, treatment, and drugs made available via multi-sectoral channels. The goal is the reduction of mortality and morbidity rates through early detection and treatment. The program has basically focused itself in making services available, such as sputum microscopy services, x-ray, among others.

Tuberculosis ranked sixth among the leading causes of morbidity in 1998 at a rate of 179.6 per 100,000 population. The shift in approach to Direct Observed Treatment of Short Course (DOTS) in Chemotherapy saw a marked decline in curative rate from 50% to about 78-80 percent at present. The previous approach has been towards increasing the efficiency of case-finding activities. In contrast, DOTS is a comprehensive strategy adopted globally not only to detect, but also to guide cure of the disease. DOTS simply calls for health counseling, guiding patients in taking the right dose of medicines, and monitoring health progress. It is noteworthy to mention that this strategy is applied to cases found positive with sputum tests. The very limited funds for tuberculosis control has prompted the DOH to focus supply of drugs and medicines to sputum-positive patients because it is believed to be the most effective means to lower morbidity.

6.2.1 Fund Allocation and Utilization

Admittedly, the budget for tuberculosis control is far from being sufficient to cover the annual total number of TB cases. Only 0.4% of total cases are examined and treated on the average. NCR and Region 6 have posted the highest accomplishment in 1996 to 1997, but have aligned themselves with other regional rates in the succeeding years. In the past, utilization of funds has been concentrated on early detection, with very little left for treatment of cases. However, the DOTS approach, which was piloted in 11 areas was found most effective given

the fund constraints. DOTS also paved the way for reinforcing LGU participation by forging agreement with them to implement their share of many preventive and treatment programs.

There are three program vehicles for tuberculosis control receiving annual budget allocations, these being the Tuberculosis Control Services, Philippine Tuberculosis Society, and the National Tuberculosis Program. The allocation to Philippine Tuberculosis Society only constitutes assistance to its operation. We shall examine comparative allocation and utilization for the two other programs, as presented in **Table 6**.

Table 6. Comparative Budget for NTBCP and TB Control Service

YEAR	National TB Control Program			TB Control Service		
	Amount Released	Amount Utilized	% of Utilization	Amount Released	Amount Utilized	% of Utilization
1996	140,365,800	124,372,008	85.72%	439,200	401,914	91.51%
1997	145,068,300	124,372,008	85.73%	6,637,500	6,392,387	96.31%
1998	127,555,900	122,059,634	95.69%	5,144,000	3,778,713	73.46%
1999	145,896,801	130,788,136	89.64%	5,533,000	5,516,693	99.71%

The National Tuberculosis Program comprises about 82% of the entire appropriation for Tuberculosis Control Program in 1999, and a bulk 46% of the total appropriation for the Communicable Disease Control Program. This solely consists of MOOE. Annual utilization averaged at around 89% with the highest utilization posted in 1998, but this rate is due more to the diminished amount released from the preceding year by 12%.

The TB Control Service has comparatively lower funding, especially in 1996 with a released amount of P439,200, this being only 7% of the amount released in the following year. The increased budget starting 1997 has been accompanied by even higher rates of utilization, except in 1998 with only 73.46% of the P5.14 million utilized. In 1998, a drop in percentage of utilization to 73.46% can be attributed to a decline of almost twice in the level of allotment and obligation.

Looking at the detailed expenditure items of the National TB Control Program, about 94.5% on the average was accounted for supplies and materials, which largely consisted of drugs and medical supplies. On the other hand, TB Control Service's expenditures have been highest for travelling and transportation, training and seminar, supplies and materials. Other services also take a big chunk, because these involve all services that have been focused on disease prevention.

6.2.2 Regional Accomplishments

Aside from providing program directions, DOH central office sub-allots the limited annual funds on the basis of regional accomplishments, starting from the latter part of 1998. The composition of the annual regional budget is primarily composed of drugs and supplies. The amount of funds that a region gets is largely determined by its ability to deliver the required services, or its capacity to make use or dispose of the previous year's funds. This has made efficiency in fund utilization a primary criterion in the allocation of resources, rather than prioritizing regions with

greater prevalence of disease. There are regions, which cannot provide the necessary counterpart finding for the program but have higher incidence of cases that may require relatively higher allocation than other regions. **Table 7** exhibits the distribution of sub-allotments to the regions. It is expected to see accomplishments (**See Annex 8**) to be quite uniform across regions because the experience has always been full utilization. Therefore, if any marginal increase in funds is accompanied by the growth in total number cases, and full fund utilization, resulting accomplishment remains the same.

Table 7. Status of Sub-alloted Drugs for TB Drugs, 1999

Region	Sub-alloted Funds (In P)	Percentage Share of Total
Region 1	5,058,910	4%
Region 2	4,904,075	4%
Region 3	12,794,005	10%
Region 4	15,888,011	12%
Region 5	9,545,164	8%
Region 6	7,688,718	6%
Region 7	6,915,343	5%
Region 8	6,141,781	5%
Region 9	7,069,997	6%
Region 10	4,130,513	3%
Region 11	7,998,394	6%
Region 12	4,285,355	3%
CARAGA	3,821,156	3%
NCR	24,195,798	19%
ARMM	3,047,781	2%
CAR	3,666,502	3%
TOTAL	127,151,503	100%

Source: TB Control Service

Performance targets and accomplishments of the National TB Program appears rather constant throughout the past four years. TB symptomatics given sputum exam have ranged from 1 to 2 percent of the total target. Cases found sputum positive and were given treatment have been swinging between 0.1% to 0.2% since the onset of DOTS in 1996. Diagnostic treatments of total affected population have been highest in the NCR, Regions 2, 6, and 10, but accomplishment rates are only playing around the vicinity of 0.2% to 0.4%. As earlier noted, the amount of limited funds relative to the total number of cases grows in a rather similar rate.

6.2.3 Issues on Delivery of TB Control Services

Unlike immunization, tuberculosis control programs are not by nature preventive. Delivery of tuberculosis services is also not perceived as mandatory as immunization to children or pregnant women. These differences have produced a totally distinct set of issues for TB control services. While sustainability remains to be an issue for TB control, delivery of effective and efficient service appears to be most expedient amidst funding constraints.

6.2.3.1 TB Drugs Procurement

For a time, procurement of TB drugs has been difficult because of the intricacies involved in bidding procedures. Until recently, the combined scheme of having a national bidding, with the procurement done on a regional basis has been reported to be more efficient compared to the past procedures. The combined scheme was piloted to TB drugs because of the flaws noted in schemes earlier adopted. The status of deliveries in the regions was examined six months after a national bidding. It was found out that, rates of deliveries vary across types of drugs. For most of the standard drugs, only a little over 50% was delivered after six months. The reasons were either from the end of the suppliers or from regional offices, which have failed to issue purchase orders after indicating their requirements. **Table 8** shows that only PZA was the only drug with recorded full deliveries, and Type II drug posting the lowest at 39.6%.

Table 8. Status of Delivery, Anti TB Drugs, In Units

Items	Regional Allocation	Delivery	% Delivery
Type I	1,297,801	703,279	54.19
Type II	2,072,750	820,868	39.60
PZA	11,574	13,599	117.50
Streptomycin	570,968	340,708	59.67
Ethambutol	142,403	77,328	54.30

Source: TB Control Service

6.2.3.2 LGU Involvement

LGUs involvement in the campaign has become indispensable with the devolution of health care delivery. The Comprehensive Health Care Agreement (CHCA) entered into between the DOH Central Office and the relevant local government serves a blueprint of the involvement each LGU. The degree of such commitment is arbitrarily determined depending on the capacity of the municipality, in terms of logistical support, financial, technical etc. The limited funding for tuberculosis programs has prompted the central office to present to the LGUs a valuation on all forms of services they provide, to bargain for the counterpart services or finances. Counterpart services may take the form of transportation of health field workers, or financing their compensation. Some medical supplies such as needles, syringes, cottons are oftentimes requested to be borne by the municipal government. But there are some LGUs, which refuse to assume expenditures on said items for lack of allocation. According to the field health workers from central office dispatched to the regions, the ideal LGU share is 40% of total expenditures. Municipal personnel view this not only to sustain the activities, but also to guarantee continued involvement. However, the experience has been far from ideal because the use of Internal Revenue Allocation (IRA), the source of LGU funds, needs to be apportioned to a full range of priorities, health being just one of them.

6.3 Program Administration and its Effect on Utilization and Accomplishment

This chapter aimed to establish the existence of any relationship between the manner of program implementation with utilization and accomplishment. Given the two case studies with different approaches in program administration, it can be said that vertical administration of a project such as the Expanded Immunization Program

is likely to be influence utilization and accomplishment. In vertical programs where control by the central office is dominant, program accomplishments in relation to the funds to be utilized may readily be determined. Given the target population and disease prevalence in a region, not only are activities easily programmed but so is the level of funding. Thus, we see how a slight dip in AUI rates resulted to a corresponding decline in accomplishment rates of the immunization program in 1998. However, with some other external influences such as delays in procurement of drugs and supplies, which is a very important component of this program, effect on accomplishments may not readily reflect. A six-month buffer fund serves to insulate the program from any delay in fund release. On the other hand, It would be interesting to further examine how accomplishment rates, despite the good utilization ratios are affected by the lag in the arrival of vaccine drugs.

For horizontally-administered projects whereby program implementation rests heavily on the different local government units, and the availability or absence of counterpart funding, accomplishments are hinged on the ability to provide program requirements. Accomplishments in this case are dictated more by the ability of both the central office and LGUs to successfully carry the project. The Tuberculosis Control Program is rather unique in the sense that demand progressively grows in stages. Therefore, the approach itself is crucial to maximize the very limited fund. In other words, it is difficult to generalize that horizontally-administered programs considerably affect movement in AUI and accomplishment rates. This is understandable because of the fact that there exist too large a target population, and relative independence over the utilization of approved funding to a given region.

7. BUDGET UTILIZATION OF A FOREIGN-ASSISTED PROJECT: A CASE STUDY OF THE WOMEN'S HEALTH AND SAFE MOTHERHOOD PROJECT (WHSMP)

Budget utilization of foreign-assisted projects has often been regarded as complex primarily because of the conditions that dictate on the magnitude and manner by which resources are used. The Women's Health and Safe Motherhood Project (WHSMP) is a good case subject of study of a foreign-assisted project for several reasons. First, the project is a multi-donor undertaking with the Government of the Philippines (GOP) thus, deriving various perspectives on donor funding experiences. Second, there have been various experiences that dealt with the utilization of financial resources since its implementation. Lastly, the duration of WHSMP, which commenced from 1996 to present is considerable to effect a budget review. A walk-through the issues related to budget utilization will be made, as well as the overall status in the utilization of counterpart GOP funds and loan proceeds.

7.1 Project Objectives

The overall objective of the project is to improve the health, nutrition and family status of women, particularly those within the reproductive age thereby, reducing morbidity and mortality rates in women. In order to appreciate the more measurable parameters in each of the project's components, the following specific objectives need to be cited:

- To improve the quality and range of women's health and safe motherhood services;
- To strengthen the capacity of LGUs to manage the provision of these services, and of the DOH to provide policy, technical, financial and logistical support;
- To enhance the effectiveness and sustainability of health interventions through the participation of local communities, and non-government organizations, and;
- To expand the knowledge base upon which to draw policy and technical guidance for women's health programs.

7.2 Project Components and Sub-components

WHSMP has total project cost of US\$128.5 million with five external donors namely, the Asian Development Bank (ADB), the International Bank for Reconstruction and Development (IBRD), the Australian Agency for International Development (AusAid), the European Union (EU), and the Kreditanstalt für Wiederaufbau (KfW). The project has four major components as follows:

- **Service Delivery** in the areas of: (a) maternal care, and (b) other women's health services including family planning, diagnosis and treatment of RTIs and STDs, and detection and treatment of cervical cancer;
- **Institutional Development including** (a) information, education and communication to promote attitudes and practices that would improve women's health, (b) training for public sector health care workers involved in delivering

women's services, (c) development and installation of a national public health logistics system for the DOH that would ensure the efficient procurement and delivery of commodities to end-users, and (d) support to the DOH in project management;

- **Community Partnerships**, which would support local communities and NGOs working with LGUs and the DOH in planning and implementing community-based women's health services; and
- **Policy and Operations Research** to conduct studies on women's health and related service delivery questions.

7.3 Factors Influencing Utilization

The Joint Donor Review Mission on March 13 to 21' 2000 has identified the conditions that have affected and is affecting the implementation of project activities and consequently, the efficient utilization of financial resources. Inasmuch as the utilization ratios cannot be derived based on the agency's statement of allotment and obligations, this section attempted to make use of project reports that provide amounts on both donor and government funding. These conditions are classified herein, with specific mention on how these impinge on the project components and sub-components. The factors that have molded the issues confronting utilization are then integrated in the next chapter.

7.3.1 Compliance to Technical Standards in Procurement/Contracts

One of the common causes for delay in the procurement of goods, and final contract payments is the failure to adhere to the technical standards as prescribed in relevant government procedures. In the aspect of civil works, there seems to be an apparent need for DOH to strictly monitor the quality of work done by strengthening its supervision of construction works. The mission noted the difference in the standards of work done between regions. The DOH, and the Project Management Office (PMO) in particular, needs to exercise contract provisions on quality assurance prior to final contract payments.

The Services Delivery component, specifically the activities in maternal care and family planning sub-component were for a while impeded because of the sub-standard quality in completed civil works. This was remedied when regional-based civil engineers were hired by the PMO as part of the team organized to take charge of civil works management and supervision. The new team is responsible, inter alia, for checking the completeness of legal papers necessary before putting up new facilities funded under the Project, carrying out civil works supervisions, taking corrective actions, reviewing and validating work progress, and processing all documentation for completion (Aide Memoire, 2000). The action plan indicated that, frequency of visit by PMO engineers should be six provinces a week (with focus on provinces encountering contract problems), and one province per week by the Regional Engineer.

Of the 41 ADB-assisted civil works packages contracted out at the end of 1999, the overall current physical completion was 64.8%. In contrast, physical accomplishment for WB-assisted civil works is estimated at 96.7%, with the final completion of works, as well as rectification of deficiencies expected by September 2000. The difference in the rate of completion is not reflective of any difference in the donor institutions' contract approaches, but on the timing between contracts.

In the aspect of drugs procurement, it appears that having a procurement agent in lieu of centralized DOH procurement does not always result to efficiency. Procurement by UNICEF of about US\$1.5 million worth of STD/RTI supplies, cervical cancer supplies and equipment has been delayed. While advance payment to the amount of US\$275,461.79 has already been made to UNICEF for the procurement of reagents, supplies and microscope, no delivery has yet been effected. Reason cited was technical specifications especially of substitutes, which was later remedied by providing the DOH with technical information and price comparisons of alternative goods. Another constraint was the lack of suppliers for the originally specified items.

From the donor institution's front, request for a re-allocation of loan proceeds to other expenditure items exceeding the amount of US\$600,000 takes time to be acted upon, especially in the light of the cancellation of US\$ 4.9 million in 1999. The delay in processing of contracts is not only affected by constraints in adhering to technical standards, but other technicalities in the release of allocated funds. Additional works in the installation of health facilities for example, were stalled by the following:

- i) non-release of Allotment advise (AA) from DBM due to delay in signing of the FY 2000 GAA. This was caused by the non-issuance of SAA (sub-allotment advise), specifically in the implementation of additional works in ten provinces namely, Ilocos Norte, La Union, Laguna, Davao Oriental, Davao Norte, Davao Sur, S. Cotabato, Saranggani, Albay and Camarines Norte.
- ii) DOH Regional VII Auditor's position against awarding contracts in excess of the AA.
- iii) Lack of interest by contractors to participate in NCB procurement due to the small scale of works, not to mention the dispersed and isolated location of the project.

Remedial measures to address the above problems took the form of requesting for budget re-alignment of PhP4.5 million of capital outlays funds in 1999 civil works fund. Lack of contractors' interest was alleviated by waiving the

donor agency's requirement, of securing quotations from a minimum of three qualified contractors.

7.3.2 Financial Management Requirements

In its status report dated March 2000, the WHSMP reported issues that surfaced during a Review Mission in August 1999, among these include,

- i) absence of proper control of properties or inventories for supplies/drugs purchased;
- ii) individual ledgers are not being maintained for fixed assets acquired nor is there a periodic reconciliation of physical existence of these assets with recorded accountability;
- iii) there is no financial staff at the regions who administers project funds resulting in slow liquidation of funds; and
- iii) the system is manual, and there is lack of computers.

The PMO has then established and disseminated inventory ledgers in recording of supplies/drugs and equipment to the regional health offices. Also, an inventory has since been conducted within the DOH Central office.

Another measure recommended even by the donor agencies is the hiring by RHOs of financial analysts, the tasks of which are distinct from ordinary operational staff. These tasks involve maintaining book of accounts, preparation of financial transactions, maintenance of books of accounts, preparation of financial reports including statement of expenditures and liquidation documents, and serve as liaison between the RHO and the PMO-Finance Unit.

Compliance with the financial reporting to donor institutions, as embodied in loan agreements became a major concern, as this also causes delay on the part of the donor institutions to act on subsequent request such as, re-allocation of proceeds, etc. It appears that a line agency such as the DOH needs to keep the Commission on Audit in the loop as to the full auditing objectives and reporting requirements, as stipulated in the loan agreements for it to provide opinions other than those rendered on audited accounts and financial statements. As a recommendation, the PMO was asked to provide detailed analytical, semi-annual reports, and quarterly progress reports to the financiers.

7.3.3 Systemic Limitations

There are also inherent problems that may be considered systemic in nature. A clear example posed is the apparent shortage of pathologists in the country, which is a critical concern in the delivery of services for cervical cancer

sub-component. The sustainability of services amidst said shortage was partly addressed through economics. It was a surprise to the mission to find out that there is a processing fee for reading slides in public health facilities. The mission however feels that this practice is not sustainable in the long-run, thus they are proposing to train non-medical health personnel with supervision.

Systemic limitations only reinforce the need for the institutionalization of training. The training activities under the WHSMP have progressed well in comparison to the other project outputs. Geographical and demographical limitations also pose as other systemic problems in the manner of serving an economically viable demand. Far-flung areas with the very insignificant level of per capita income and a very small population base, understandably, have more difficult access to medical care, which is partly being addressed through information campaign, education and communications. Peace and order situation in Basilan and ARMM provinces is also expected to cause further delay in the civil works.

7.3.4 Institutionalization of Project Outputs

Like all other foreign-assisted projects, the issue of sustainability always comes up at the lapse of any form of assistance. A phase-out plan detailing the specific responsibility and accountability of project partners (i.e. DOH Central Office, RFO, and LGUs) in continuously applying, maintaining, and improving project systems and facilities developed under the project (Aide Memoire, 2000).

As mentioned earlier, there are project components that need institutionalization to ensure continuity of implementation. For example, training development must later be backed up by a solid institutional structure that will guarantee the application of all training output. For example, the findings of the Review Mission about training implementation are deeply rooted in the lack, if not the absence of these institutional mechanisms. It was observed that there is no clear responsibility for supervision and follow-up on trainees to ensure application of new competencies. Another finding was the apparent lack of budget assurance from LGUs to enable Provincial Health Offices to conduct future training programs, not to mention the lack of equipment and supplies to enable training graduate to apply the skills acquired. Lastly, specific to the AusAid component is the turnover of training responsibilities from trainers sponsored by the donor agency to provincial/regional trainers. On a general scale however, the accomplishment rates maybe considered satisfactory. Cumulative training accomplishment recorded ranges from 58% to 132%.

In the area of logistics, the proposed Central Distribution System (CDS) and its application to pilot regions (Regions I, VI, X, and CARAGA) will also require institutional arrangements. A DOH Central office counterpart staff for example was designated. An Administrative/Department Order was also necessary to institutionalize CDS.

WHSMP's third component is establishing community partnerships for women's health, which calls for the strengthening of coordination of RHOs with the project inputs of the different donors so as to integrate the health delivery systems developed through the project.

7.4 Financial Utilization

Apart from the derived utilization indices and ratios, it is worthwhile to review the financial utilization of WHSMP as it nears its completion within the year. To date, the remaining funds for project operations stand at PhP518.8 million for the ADB components, and PhP305.7 million representing available funds for the World-Bank components. The breakdown is as follows:

	ADB	World Bank
GAA 2000		
Loan Proceeds	P 358.2	P169.3
Government of the Philippines	101.7	60.5
Sub- Total	P 459.9	P229.8
Carry-over from 1999		
Loan Proceeds	P 23.9	P 60.7
Government of the Philippines	35.0	15.2
Sub- Total	P 58.9	P 75.9
Grand Total	P 518.8	P305.7

7.4.1 Loan Disbursement

ADB Component. From 1 August to 31 December 1999, loan disbursement amounted to US\$3.32 million bringing cumulative disbursements to US\$12.8 million. This represents an availment rate of 91.4% of the targeted disbursement of US\$14 million.

Loan disbursement has dramatically improved compared to the project's initial years. For the first two months of the year 2000, total applications submitted to ADB has already reached US\$1.19 million against a quarterly target of US\$1.73 million. Actual disbursements made by the Bank was US\$0.67 million, bringing the cumulative disbursements from the loan to US\$13.47 million (33.7%) as of the end of February 2000, with time elapsed of 75.8% (Aide Memoire, 2000). Pending applications with Bank amounts to US\$0.52 million.

Annex 9 shows ADB Disbursements by category.

IBRD Component. For the period 1 August to December 1999, loan disbursements amounted to US\$1.88 million, closing the cumulative disbursements to US\$5.38 million (against target of US\$6.6 million) at the end of the year. This produced an availment rate of 81.5% relative to the revised target set for the year.

From January to February of 2000, applications already submitted to the World Bank have reached US\$0.59 million against a quarterly target of US\$1.0 million. Actual disbursements made by the Bank for the same period amounted to US\$85,453 bringing cumulative disbursements from loan to US\$5.46 million (39.8%) as of February 2000, with time elapsed of 69.4%. Balance of pending applications at the bank is placed at US\$0.50 million.

IBRD Disbursement by category is exhibited in **Annex 10**.

7.4.2 Grant Disbursement

Of the total grant allocation extended by KfW amounting to DM 24.2 million, cumulative disbursements was 48%, or DM 11.612 million as of March 2000.

Disbursement schedule is shown in Annex 11 for the period covering 1997 to 2001.

8. ISSUES, FUTURE ORGANIZATIONAL CONCERNS AND RECOMMENDED MEASURES

There are several issues that confront the re-engineering of DOH crucial to the effective and efficient utilization of its resources. Most of these issues are largely institutional in nature and would call for organizational mechanisms to be put in place.

8.1 Issues and Future Organizational Concerns

8.1.1 Procurement Issues

One major concerns believed to have hindered the required expenditure level at a given schedule, is the slow pace in the procurement of medical goods and services. This holds true not only for the regular DOH programs, but for locally-funded and foreign-assisted projects as well. Needless to say, failure to expend timely affects the delivery of medical goods and services to the beneficiaries. This is probably why we see high values of OACI and lower accomplishment rates in Chapter 5. Looking at the details of the data, AUIs display were very low for some programs, but annual allocation continues to be set in the same amount. In the 8th ODA Portfolio Review for the Department of Health by the National Economic Development Authority, procurement concern appears to be the crux of most discussion, as it is viewed to be an important ingredient to the successful devolution of operations.

The backlog in procurement activities must have been that substantial causing procurement activities to be suspended in 1998. The ODA Portfolio Review indicated that the backlogs are particularly most evident with the foreign-assisted projects. For example, the Women's Health and Safe Motherhood Project (WHSMP), and the Urban Health and Nutrition Project (UHNP) adopted interim procurement measures only to fastrack implementation of the projects' activities. Donor institutions appointed themselves as procurement agents, and made this a pre-condition to their assistance. In the case of the Integrated Community Health Services Project (ICHSP), PS-DBM served as the procurement agent, but complying with documentation requirements prescribed by the donor agency like the ADB proved rather constraining to a timely procurement process.

Among the causes commonly cited is the delayed approval of contracts from the Office of the President. For locally-funded programs and projects, acquisitions that pass through the Project Bids and Awards Committee (PBAC) are often delayed due to failure of project bidders to comply with the requirements. DOH has partly addressed the problem by creating a separate PBAC for its ODA projects, although the concern is to sustain these initial efforts in the light of the devolution. A devolved set-up may call for decentralization of critical functions such as procurement as paramount to expedient delivery of services. Administrative Order 13-C, series 1999 embodies the Procurement Guidelines for Drugs and Medicines, and is meant to respond to the comprehensive decentralization of procurement of drugs and medicines. There are inherent advantages and disadvantages of each of these measures, but experience as to the suitability of any under a devolved setting is yet to be cited.

8.1.1.1 Procurement Procedures

Administrative Order 13-C, series 1999 serves to complement other procurement guidelines still in effect (such as Administrative Order 14-b dated August 1, 1997), but this recent order addresses the manner by which procurement will be carried out in a decentralized environment. There are three main schemes that dictate the manner of decentralized procurement, each of these presents issues that are subject of continuing measures, which a special body within DOH, the Procurement Reform and Advisory Team (PRAT) is looking into.

The first scheme is **Regional Procurement and Distribution**, which involves bidding and distribution being undertaken by the RHOs using sub-allotments from the Services at the Central Office, or through RHO's own budget. This manner of procurement represents the real essence of decentralized procurement. However, price differential of procured goods widens, as monitored by the central office. Price differences are caused by several factors. The most common cause arises from the volume of the requirement, if orders are taken by region. Transportation cost is also major factor causing price differentials, as well as the presence of distributors in a particular locality.

A second scheme entails **Central Procurement and Distribution through a Procurement Agent or through the Procurement and Logistics Service (PLS)**. As a general practice, procurement is done through PLS. The services of an agent are usually sought in the case of FAPs, especially if this is prescribed by the donor institution. The greatest advantage of central procurement and distribution is the ability of pooling the requirement to come up with a substantial volume thus, commanding a lower price.

Procurement and Distribution through the LGUs is resorted to whenever existing government accounting and procurement rules and regulations permit it. This covers decentralizing the procurement of drugs and medicine.

Other schemes include a variation of the accepted schemes described above. This takes the form of **Centralized Bidding and Regional Procurement and Distribution**. The advantage of this measure is in keeping prices low through pooled volume requirement. Purchase orders are confirmed by each of the regions prior to actual delivery. This scheme has been initially tested in the procurement of tuberculosis drugs and vaccines. Under this scheme, bidding is done at the central office, and a price list is then provided to the RHOs and hospitals.

The last type involves **Central Procurement and Distribution by the PLS with the Procurement Committees and End-User Services**, and is least utilized because of tediousness in procedures. However, it remains to be an option if found most advantageous to the government.

8.1.2 Complications in Functional Deconcentration/Devolution

The re-engineering of DOH finds its basis from the current thrust to devolve operations to the regions, enhance the disease control and health facilities

development program, and increase the scope and access to health financing. Given these new directions, the devolved set-up is also expected to present some complications.

8.1.2.1 Budget Releases and Monitoring

In the aspect of financial management, only recently was the central office required to consolidate expenditures of hospitals and other health facilities in the regions. Some of these hospitals and health facilities receive direct releases while others receive their allocations through the regional health offices. This directive to the central office by the Commission on Audit compelled the regional health offices to align financial reporting of hospitals and health institutions with the accepted standards prescribed. While at present this practice poses no problem, the autonomy in operations of these hospitals and health institutions makes it at times difficult for RHOs to request for the financial information, especially from those receiving direct releases.

While the regions submit detailed financial statements, the consolidation leaves very little purpose for monitoring performance, much less for future financial planning. Although regional expenditures can be derived on a per budget item basis, consolidated statements are too aggregate for performance results to be generated, integral to project monitoring.

8.1.3 LGU Commitment and Participation

With the devolution, DOH needs to be assured of the commitment from local government units to participate in the health programs. This commitment includes providing counterpart requirements, especially for foreign-assisted projects. The 8th ODA Portfolio Review (NEDA, 1999) cited as examples, the deeds of donation for some civil work projects under the ICHSP and the EU-assisted Construction of La Union Provincial Hospital that have yet to be provided. The annual review also mentioned the contract for civil works for Abra under the ADB-assisted WHSMP, which has been pending for almost a year due to protracted negotiations with the LGUs.

The earlier experiences in the devolution of healthcare services were far from having fully attained its original objectives. The operations of many devolved hospitals such as district hospitals have deteriorated owing to the lack of attention and resources, resulting to their failure to meet the minimum standards for licensure and accreditation. The Local Government Code of 1991 failed to integrate the promotional, preventive, curative and rehabilitative services that the health sector is expected to deliver. The Health Sector Reform Agenda is set to introduce changes in health service delivery, health regulations and health financing that would help alter the experiences in the past. The re-organization and so-called re-engineering of the DOH is one of the most significant reforms necessary to carry out the changes.

Once involvement of LGUs at the project planning stage is reinforced, the MOA between the implementing agency and LGU will strengthen the commitment for resource contributions from the LGUs. The integrated area development projects of the DOH are concrete examples of these workable arrangements, particularly in

three health projects involving P5.9 billion in investments. These projects are, The Women's Health and Safe Motherhood Project, Urban Health and Nutrition project, and the Integrated Community Health Project. While LGU's participation from a project's conception may prove to be useful, it may also be the cause for some unnecessary delays. The delays in projects requiring MOA with LGUs have been experienced resulting from: a) the length of time involved before an MOA is approved, and ; b) the inability of the LGUs to deliver its commitment to take on the needed resources to implement activities. These were in fact the same reasons that have stalled the start of the three health projects mentioned.

8.1.4 Rationalization of Manpower Complement

Another bold move involved in the re-engineering process, is the rationalization of the agency's current manpower complement. The call for reinforcing regional operations necessitates the movement of a significant number of employees from the central office to the different regional health offices. The initial step was to solicit voluntary detailing to the RHOs, after which a mandatory assignment is about to take place.

As of February 2000, the number of warm bodies totaled 2,630. This is just 11% of the current number of personnel in the RHOs (23,417). The breakdown of the manpower complement at the central office is as follows:

Office of the Chief of Staff	359	(14%)
Office of the Public Health Services	425	(16%)
Office for Standards and Regulations	784	(30%)
Office of Hospital Facilities Services	153	(5%)
Office for Management Services	550	(21%)
Office of the Secretary (Medical Pool)	146	(6%)
Contractual Personnel	213	(8%)
TOTAL	<u>2,630</u>	

The Office for Standards and Regulations comprises 30% of the total manpower of the DOH, followed by the Office of Management Services (21%) in charged with Finance, Administrative and the Procurement and Logistics Service. The Public Health Services office, which is in charge of the regular DOH programs, only has 16% of the total personnel.

The deployment of central office personnel to reinforce regional operations will be accompanied by a modification of the central office's organizational structure as well. The re-engineering aims to regroup the organization into four clusters consisting of sub-clusters. The Health Operations Cluster basically comprises the public health services in the original set-up, as well as the health facility development programs. The other clusters are the Health Regulations cluster, External Coordination cluster, and Sectoral and Management Support Service.

The rationalized structure then demands a regrouping of the budget items as currently classified under the GAA. **Annex 12** shows this regrouping of budget items, and the functional reclassification. In the absence of any budget amount, the reclassification already reflects the agency's program priorities.

8.1.5 Cost Overruns

Like all other foreign-assisted projects, the gestation period involved before the project is implemented results to the need for some revisions in the original cost estimations. This cost overruns further cause the delay in the release of funds, because request for revised cost estimates is dealt with caution by the approving bodies. The shortfalls in the finances as a result of cost overruns, have to be financed either through increased share of government counterpart funds or obtaining additional external financing.

The issue on cost overruns heightened during the Third Annual ODA Portfolio Review when it was observed that a great number of the projects of various agencies have cost revisions reaching to as high as more than 100% of the original estimates. For the DOH, there were two projects with cost overruns, one of which is World Bank-funded, and the other an ADB-assisted project. These represent a total cost overrun of P478.93 million, with an average overrun rate of 15.3% for both projects. The breakdown is as follows:

Cost Overruns for DOH*, 1995

	Total Cost (In PM)		Cost Overrun (In PM)	%
	Original	Revised		
1. ADB-Assisted				
-2 nd Palawan IAD	104.97	133.90	28.93	27.6
2. WB-Funded				
-Health Development Project	2,276.00	2,591.00	315.00	13.8
-First Water Supply, Sewerage and Sanitation Project	756.20	891.20	135.00	17.9

*Based on Third Annual ODA Portfolio Review

Given the occurrence of inevitable cost adjustments, implementing agencies were instructed to institute measures that are basically anchored on the existence of an efficient monitoring system. The monitoring mechanism should include good cost tracking and cost control management. Major contracts with cost overruns have to be reported to INFRACOM, and action plan to be submitted to ICC on how to contain and finance cost differences.

8.2 Recommended Measures

8.2.1 Addressing Procurement Delays

As earlier noted, the various procurement approaches have yet to be tested under a devolved setting. The central office should further examine the most suitable procurement procedure with due consideration to price, quality, efficiency in delivery and the segmented demand from the different regions.

The guidelines governing the combined method of centralized bidding and regional procurement and distribution needs to be reviewed and strengthened.

8.2.2 Affirmation of LGU Resource Commitment

Assurance of commitment from the LGUs may involve a strategy that can be rooted from project planning stages. DOH as a clearing house for proposed projects, should conduct consultations and institutionalize project management processes together with the LGUs. This not only serves as manifestation of their approval of the project at the initial stages, but can also a venue to discuss the resources that can be offered along with national funds. Based on experience, it would seem imperative for both the LGU and DOH to thresh out the ability of the former in providing counterpart financing, and mobilizing staff resources (relative to number and availability of skills) to administer project components, and maintaining them even after the project's completion.

8.2.3 Institutional Alignment in Healthcare Monitoring

Both national and local agencies have to be aligned institutionally. For example, LGU's participation to compel hospitals under their jurisdiction, to work closely with RHOs on a well placed monitoring system is extremely crucial to make available reports generated at the regional level. The proposed External Affairs Office, which is one of the four clusters under the DOH re-engineering can consider this measure. The said office will focus on projects and health systems development work and shall be supervised by an Undersecretary. It will spearhead the RHOs and shall be at the frontline of implementation and technical assistance provision.

8.2.4 Consolidation of Monitoring Efforts in Project Implementation of Foreign-Assisted Projects

DOH has contemplated on adopting several strategies to improve performance in the implementation of projects. One such strategy is to unify the several project management offices (PMOs) under one group supervised by one Undersecretary. The group will oversee the extent of accomplishments of each project. The integration also calls for a standard reporting format on project accomplishments. This move is part of the objective to revitalize and reconfigure FAPs with the organic DOH personnel taking full management control, rather than the contractual PMO personnel. This was already done for the Women's Health and Safe Motherhood Project, and the Urban Health and Nutrition Project.

External to DOH are measures, which will help strengthen the agency's internal monitoring system. This would include incorporating the task of Results Monitoring and Evaluation in the approval process of the Investment Coordination Committee (ICC). MOA signing should also be made a prerequisite to ICC approval to avoid undue delays. Moreover, the timeliness of the delivery of services, and sustainability upon project's completion remains to be bigger issues that need to be addressed.

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Annex 1
GROWTH RATE OF NATIONAL GOVERNMENT EXPENDITURES
By Sectoral Classification, 1996-1999
In Percentage (%)

	1995-96	1996-97	1997-98	1998-99
GRAND TOTAL	4.76	17.95	12.59	9.77
Total Economic Services	1.20	27.66	-25.85	20.84
Agriculture	23.07	52.64	-38.73	30.75
Agrarian Reform	12.42	44.92	63.75	27.39
Natural Resources	14.41	65.98	-37.49	2.99
Industry	9.61	2.04	-31.54	21.98
Trade	33.66	3.83	-17.07	35.83
Tourism	47.45	28.48	-37.21	9.75
Power and Energy	-78.19	120.59	-50.62	-55.66
Water Resources Dev't	25.87	18.57	-86.12	232.12
Transportation & Comm.	3.59	19.48	-17.39	20.69
Other Economic Services	-16.20	-15.59	-89.07	-2.94
Total Social Services	25.49	21.73	11.28	6.90
Education	20.45	27.28	11.39	6.32
Health	34.56	26.17	-6.03	6.19
Social, Welfare, Labor & Employment	42.95	10.97	31.33	10.47
Housing & Community Development	55.23	-47.24	-10.81	10.08
National Defense	13.02	20.22	2.91	3.23
Total Public Services	22.63	14.62	7.37	1.67
Public Administration	21.52	14.99	7.22	-1.07
Peace and Order	25.34	13.74	7.73	8.17
Other	6.43	22.32	46.73	13.62
Debt Service	-14.29	6.72	33.65	9.65
MEMO ITEM:				
IRA	8.75	25.54	2.59	32.77
Grand Total-Debt Service	13.5	21.85	6.20	9.82

Annex 2
NATIONAL GOVERNMENT EXPENDITURES AS A PROPORTION OF GNP
By Sectoral Classification, 1996-1999
In Percentage (%)

	1996	1997	1998	1999
GRAND TOTAL	20.23	21.35	21.78	21.29
Total Economic Services	3.77	4.31	2.90	3.12
Agriculture	0.67	0.92	0.51	0.59
Agrarian Reform	0.14	0.18	0.26	0.29
Natural Resources	0.25	0.37	0.21	0.19
Industry	0.12	0.11	0.07	0.07
Trade	0.01	0.01	0.01	0.01
Tourism	0.03	0.04	0.02	0.02
Power and Energy	0.05	0.10	0.04	0.02
Water Resources Dev't	0.04	0.05	0.01	0.02
Transportation & Comm.	2.19	2.34	1.75	1.88
Other Economic Services	0.27	0.21	0.02	0.02
Total Social Services	4.46	4.85	4.89	4.66
Education	3.25	3.71	3.74	3.54
Health	0.46	0.52	0.44	0.42
Social, Welfare, Labor & Employment	0.54	0.53	0.64	0.63
Housing & Community Development	0.21	0.10	0.08	0.08
National Defense	1.37	1.48	1.38	1.27
Total Public Services	2.82	2.90	2.82	2.55
Public Administration	1.98	2.04	1.98	1.75
Peace and Order	0.84	0.86	0.83	0.80
Other	2.59	2.84	3.77	3.82
Debt Service	5.21	4.97	6.02	5.88
MEMO ITEM:				
IRA	2.50	2.81	2.61	3.09
Grand Total-Debt Service	15.02	16.38	15.75	15.41
Infrastructure before BOT	2.28	2.49	1.80	1.92
Infrastructure after BOT	3.77	4.32	3.52	

Annex 3
BUDGET PERFORMANCE ON GOVERNMENT FUNDING, 1996-1999
Department of Health
Summary of Budget Levels and Absorptive Capacity Indices

Budget Item	1996			1996				1997			1997			
	Appropriation	Allotment	Obligation	ApUI	OACI	AUI	BPI	Appropriation	Allotment	Obligation	ApUI	OACI	AUI	BPI
PROGRAMS														
1. General Administration & Support	592,169,000	381,692,272	166,571,194	0.9179	2.2092	1.4240	0.6446	462,861,000	118,784,679	70,717,798	0.1528	2.3197	0.5953	0.2566
a. General Admin. & Support Services	592,169,000	381,692,272	114,578,209	0.6314	1.5196	0.9795	0.6446	410,868,000	70,604,679	68,486,948	0.1667	5.6447	0.9700	0.1718
b. Productivity Incentive Benefits			51,992,985					51,993,000	48,180,000	2,230,850	0.0429	0.0500	0.0463	0.9267
2. Support to Operations	169,647,000	141,637,200	90,657,156	0.7012	1.0060	0.8399	0.8349	190,214,000	168,046,700	95,723,958	0.6849	0.8775	0.7752	0.8835
a. Health Information and Health Education Services	87,846,000	73,723,950	38,985,161	0.6591	0.9358	0.7854	0.8392	95,023,000	82,728,900	40,050,633	0.6258	0.8256	0.7188	0.8706
b. Health Human Resource Dev't System	22,566,000	21,691,350	17,031,510	0.8662	0.9374	0.9011	0.9612	39,814,000	39,126,300	23,082,358	0.7045	0.7295	0.7169	0.9827
c. Health Policy and Dev't Program	4,232,000	3,820,400	3,472,828	0.8206	1.0069	0.9090	0.9027	4,787,000	4,314,050	2,303,029	0.5673	0.6985	0.6295	0.9012
d. Dept. Legislative & Exec.Liaison and Coordination	1,345,000	1,210,500	1,132,316	0.8419	1.0393	0.9354	0.9000	1,345,000	1,210,500	991,285	0.7370	0.9099	0.8189	0.9000
e. National Drug Policy	20,998,000	16,748,100	10,899,587	0.6961	1.0942	0.8727	0.7976	20,807,000	17,065,500	8,387,243	0.7412	1.1018	0.9037	0.8202
f. Essential National Health Research	23,574,000	16,231,100	14,979,928	0.6710	1.4155	0.9746	0.6885	19,800,000	16,827,250	15,395,101	0.8336	1.1542	0.9809	0.8499
g. Local Gov't Assistance & Monitoring System	9,086,000	8,211,800	4,155,826	0.5772	0.7066	0.6386	0.9038	8,638,000	6,774,200	5,514,309	0.7562	1.2296	0.9643	0.7842
3. Operations	2,179,056,000	1,236,272,191	703,616,895	0.4135	1.2848	0.7289	0.5673	1,782,381,000	1,184,950,800	1,300,592,633	0.8052	1.8219	1.2112	0.6648
a. Public Health Services	1,243,866,000	1,051,566,601	615,060,118	0.6188	0.8659	0.7320	0.8454	1,262,059,000	960,772,050	1,209,989,510	0.9971	1.7205	1.3098	0.7613
b. Primary Health Care Program	51,700,000	45,760,900	18,761,382	0.5446	0.6952	0.6153	0.8851	53,131,000	46,287,900	21,162,702	0.8144	1.0730	0.9348	0.8712
c. Health Facilities, Maintenance & Operations	142,497,000	47,552,395	31,084,998	0.2484	2.2307	0.7444	0.3337	143,600,000	116,998,750	39,852,618	0.3875	0.5837	0.4756	0.8148
d. Health Facility Standards, Regulations & Licensing	676,187,000	35,507,750	19,378,282	0.0324	11.7612	0.6176	0.0525	273,006,000	32,712,100	24,738,218	0.0945	6.5789	0.7883	0.1198
e. Drugs and Medicines	64,806,000	55,884,545	19,332,115	0.7768	1.0446	0.9008	0.8623	38,491,000	27,991,000	4,849,585	0.2941	0.5561	0.4044	0.7272
f. Women and Children Protection Program								12,094,000	189,000	-	-	-	-	0.0156
Sub-Total, Programs	2,940,872,000	1,759,601,663	960,845,245	0.4830	1.3493	0.8073	0.5983	2,435,456,000	1,471,782,179	1,467,034,389	0.6736	1.8446	1.1147	0.6043
PROJECTS														
1. Locally-Funded Projects	485,913,000	272,438,162	31,092,293	0.2562	0.8151	0.4570	0.5607	505,564,000	132,886,080	20,680,426	0.0686	0.9930	0.2610	0.2628
2. Foreign-Assisted Projects	374,721,000	92,668,862	31,092,293	0.2235	3.6551	0.9039	0.2473	657,926,000	55,286,395	15,242,447	0.0232	3.2809	0.2757	0.0840
Sub-Total, Projects	860,634,000	365,107,024	62,184,586	0.0723	0.4015	0.1703	0.4242	1,163,490,000	188,172,475	35,922,873	0.0432	1.6515	0.2671	0.1617
GRAND TOTAL	3,801,506,000	2,124,708,687	1,023,029,831	0.4518	1.4464	0.8084	0.5589	3,598,946,000	1,659,954,654	1,502,957,262	0.4779	2.2464	1.0361	0.4612

Annex 3
BUDGET PERFORMANCE ON GOVERNMENT FUNDING, 1996-1999
Department of Health
Summary of Budget Levels and Absorptive Capacity Indices

Budget Item	1998			1998				1999			1999			
	Appropriation	Allotment	Obligation	ApUI	OACI	AUI	BPI	Appropriation	Allotment	Obligation	ApUI	OACI	AUI	BPI
PROGRAMS														
1. General Administration & Support	497,109,000	208,287,000	189,936,988	0.3961	2.2561	0.9453	0.4190	497,109,000	311,251,427	211,161,316	0.4289	1.0940	0.6850	0.6261
a. General Admin. & Support Services	445,116,000	156,294,000	137,944,003	0.3252	2.6378	0.9262	0.3511	445,116,000	311,251,427	159,168,331	0.3610	0.7384	0.5163	0.6993
b. Productivity Incentive Benefits	51,993,000	51,993,000	51,992,985	1.0000	1.0000	1.0000	1.0000	51,993,000		51,992,985				
2. Support to Operations	214,070,000	166,342,000	92,696,958	0.6223	1.0307	0.8009	0.7770	200,078,000	222,191,708	115,123,402	0.7341	0.5952	0.6610	1.1105
a. Health Information and Health Education Services	107,108,000	83,232,000	42,252,084	0.6071	1.0054	0.7813	0.7771	100,066,000	100,233,468	52,694,496	0.7501	0.7475	0.7488	1.0017
b. Health Human Resource Dev't System	52,007,000	46,378,250	33,010,790	0.8202	1.0313	0.9197	0.8918	50,544,000	46,555,000	38,327,425	0.8341	0.9832	0.9056	0.9211
c. Health Policy and Dev't Program	4,335,000	3,140,000	1,331,096	0.3262	0.6218	0.4504	0.7243	3,902,000	3,153,000	2,762,237	0.7997	1.2248	0.9897	0.8080
d. Dept. Legislative & Exec.Liaison and Coordination	1,250,000	925,000	716,698	0.5734	1.0470	0.7748	0.7400	1,125,000	775,000	766,391	0.6812	1.4355	0.9889	0.6889
e. National Drug Policy	18,357,000	9,907,000	4,526,209	0.3411	1.1712	0.6321	0.5397	16,527,000	14,436,000	9,551,149	0.7882	1.0331	0.9024	0.8735
f. Essential National Health Research	20,480,000	14,960,000	8,320,282	0.6208	1.1635	0.8499	0.7305	18,432,000	53,363,240	8,810,750	0.5666	0.0676	0.1957	2.8951
g. Local Gov't Assistance & Monitoring System	10,533,000	7,799,750	2,539,799	0.3814	0.6956	0.5151	0.7405	9,482,000	3,676,000	2,210,954	0.3728	2.4804	0.9616	0.3877
3. Operations	2,137,953,000	1,616,786,321	460,716,462	0.3006	0.5256	0.3975	0.7562	2,002,125,000	1,013,210,245	394,303,408	0.2452	0.9574	0.4845	0.5061
a. Public Health Services	1,342,576,000	1,229,716,500	373,465,587	0.3601	0.4292	0.3931	0.9159	1,245,933,000	781,844,347	306,489,384	0.2892	0.7343	0.4608	0.6275
b. Primary Health Care Program	26,826,000	18,814,500	4,689,927	0.2463	0.5007	0.3512	0.7014	24,313,000	18,314,171	18,314,170	0.7533	1.3276	1.0000	0.7533
c. Health Facilities, Maintenance & Operations	307,144,000	268,661,721	54,619,742	0.3760	0.4915	0.4299	0.8747	292,888,000	81,019,586	41,480,633	0.2722	3.5568	0.9839	0.2766
d. Health Facility Standards, Regulations & Licensing	373,335,000	33,417,250	24,910,546	0.0691	8.6191	0.7715	0.0895	334,768,000	28,639,000	26,638,101	0.0796	10.8745	0.9303	0.0855
e. Drugs and Medicines	75,581,000	65,563,600	3,030,660	0.0724	0.0963	0.0835	0.8675	104,223,000	103,393,141	1,381,120	0.0230	0.0234	0.0232	0.9920
f. Women and Children Protection Program	12,491,000	612,750	-					10,696,000	58,576,000					5.4764
Sub-Total, Programs	2,849,132,000	1,991,415,321	743,350,408	0.3521	0.7206	0.5037	0.6990	2,699,312,000	1,546,653,380	720,588,126	0.3185	0.9702	0.5559	0.5730
PROJECTS														
1. Locally-Funded Projects	955,050,000	58,090,000	23,418,216	0.0245	6.6273	0.4031	0.0608	56,000,000	31,000,000		-	-	-	0.5536
2. Foreign-Assisted Projects	824,555,000							103,407,000						
Sub-Total, Projects	1,779,605,000	58,090,000	23,418,216	0.0132	12.3502	0.4031	0.0326	159,407,000	31,000,000	-				
GRAND TOTAL	4,628,737,000	2,049,505,321	766,768,624	0.2232	1.1387	0.5042	0.4428	2,858,719,000	1,577,653,380	720,588,126	0.2996	0.9837	0.5429	0.5519

Annex 4
TARGETS AND ACCOMPLISHMENTS OF DOH HEALTH PROGRAMS
No. of Persons, 1996-1998

Health Programs	1996		Percentage Accomplishment	1997		Percentage Accomplishment	1998		Percentage Accomplishment
	Target	Accomplishment		Target	Accomplishment		Target	Accomplishment	
1. Pre-natal and Postpartum Care -Pregnant women with three or more prenatal visits	2,454,549	1,377,596	56%	2,103,900	1,450,185	69%	2,580,103	1,532,753	59%
2. Fully Immunized Children -Infant given 3rd dose of Hepa B -Pregnant women given TT2+	2,103,900	1,888,432	90%	2,158,818	1,910,790	89%	2,211,517	1,876,157	85%
	1,683,120	1,046,278	62%	1,727,054	632,489	37%	1,765,997	659,062	37%
	2,454,549	1,202,676	49%	2,518,621	1,314,485	52%	2,580,103	1,296,228	50%
3. Control of Diarrheal Diseases -Diarrhea cases given ORS	2,846,130	1,010,434	36%	2,921,600	920,949	32%	2,992,919	851,064	28%
4. Acute Respiratory Infection -Pneumonia cases (0-59 mos) given treatment	1,016,475	694,341	68%	1,043,429	664,906	64%	1,068,900	556,629	52%
5. Nutrition Food Supplementation among 6-59 months children	8,465,564	1,145,936	14%	8,720,608	861,556	10%	8,993,501	696,092	8%
-Moderately Underweight -Severely Underweight	1,145,936	185,350	16%	861,556	127,838	15%	696,092	71,812	10%
	333,170	95,212	29%	142,174	29,205	21%	111,965	16,748	15%
Pregnant women given complete iron dosage	2,453,560	973,312	40%	2,514,014	1,173,924	47%	2,580,103	1,065,598	41%
Women (15-49) given iodized oil capsule	17,525,429	3,727,259	21%	17,957,240	3,077,932	17%	18,218,428	720,594	4%
Children (12-59 months) given Vitamin A	7,715,658	7,254,709	94%	8,059,587	7,507,677	93%	8,256,329	7,393,776	90%
Lactating mothers given Vitamin A	2,066,694	1,074,704	52%	2,158,818	1,075,767	50%	2,211,517	1,085,916	49%

Annex 4
TARGETS AND ACCOMPLISHMENTS OF DOH HEALTH PROGRAMS
No. of Persons, 1996-1998

Health Programs	1996		Percentage Accomplishment	1997		Percentage Accomplishment	1998		Percentage Accomplishment
	Target	Accomplishment		Target	Accomplishment		Target	Accomplishment	
6. Family Planning									
New Acceptors									
-Modern Method	1,087,945	1,020,003	94%	1,167,946	1,099,065	94%	1,072,925	1,028,327	96%
-Traditional Method	1,087,945	67,942	6%	1,167,946	68,881	6%	1,072,925	44,598	4%
Continuing Users									
-Modern Method	3,358,765	3,250,727	97%	4,056,242	3,950,210	97%	3,704,639	3,609,700	97%
-Traditional Method	3,358,765	108,038	3%	4,056,242	106,032	3%	3,704,639	94,939	3%
7. Dental									
Provided curative treatment									
-Preschoolers	1,906,358	644,378	34%	1,957,072	662,594	34%	1,958,486	678,035	35%
-Schoolers	19,962,413	1,256,813	6%	20,493,458	1,076,849	5%	20,508,269	1,106,545	5%
Schoolers provided preventive treatment	1,985,790	3,262,321	164%	2,038,616	3,187,526	156%	2,040,090	3,792,945	186%
Pregnant women provided									
-Preventive treatment	850,662	515,830	61%	876,247	526,570	60%	884,766	530,248	60%
-Curative treatment	833,649	369,838	44%	858,722	389,189	45%	867,071	405,486	47%
8. TB Control									
-TB Symptomatics with sputum exam	70,101,714	1,188,160	2%	71,960,594	1,124,011	2%	73,717,220	969,283	1%
-Total TB cases	70,101,714	271,882	0.39%	71,960,594	199,665	0.28%	73,717,220	157,871	0.21%
-New sputum positive initiated treatment	70,101,714	87,075	0.12%	71,960,594	82,799	0.12%	73,717,220	70,249	0.10%
9. Leprosy Control Program									
-Prevalence rate	70,260,079	14,390	0.02%	71,960,594	16,523	0.02%	73,229,284	17,605	0.02%
10. Schistosomiasis Program									
-No. of stool found positive	374,263	15,293	4%	262,103	13,625	5%	314,129	13,679	4%
-No. of positive cases given treatment	15,293	12,795	84%	13,625	13,625	100%	13,679	13,065	96%
11. Rabies Control Program									
-No. of animal bites given post exposure immunization	35,790	10,669	30%	60,788	23,677	39%	63,325	29,848	47%

Annex 4
TARGETS AND ACCOMPLISHMENTS OF DOH HEALTH PROGRAMS
No. of Persons, 1996-1998

Health Programs	1996		Percentage Accomplishment	1997		Percentage Accomplishment	1998		Percentage Accomplishment
	Target	Accomplishment		Target	Accomplishment		Target	Accomplishment	
12.Filariasis Control Program -No. of Filaria cases given treatment	1,504	673	45%	2,351	1,593	68%	4,787	1,394	29%
13.Malaria Control Program -No. of continued cases -No. of clinically-diagnosed given treatment	59,732,304 323,139	50,687 131,012	0.08% 41%	60,616,307 282,804	54,335 249,198	0.09% 88%	59,216,054 326,887	50,710 166,146	0.09% 51%
14.Sexually-Transmitted Diseases -No. of women with vaginal discharge -No. of menstruation and urethral discharge -No. of men/women with genital ulcers	16,981,968 16,981,968 33,963,936	20,761 4,514 1,809	0.12% 0.03% 0.01%	17,990,149 17,990,149 35,980,297	28,166 5,357 960	0.16% 0.03% 0.003%	18,425,760 18,425,760 36,851,520	22,841 3,169 462	0.12% 0.02% 0.001%
15.Environmental Health Program -No. of household with access to safe water supply -No. of household with sanitary toilet -No. of household with satisfactory garbage disposal -No. of household with complete sanitation facilities -No. of food establishments with sanitary permit -No. of food handlers with health certificates	11,573,379 11,573,379 11,573,379 11,573,379 466,400 781,404	8,023,038 6,999,365 5,312,993 4,818,107 328,370 695,266	69% 60% 46% 42% 70% 89%	12,330,052 12,330,052 12,330,052 12,330,052 497,150 852,668	9,321,457 8,185,832 5,741,146 5,112,238 368,122 770,881	76% 66% 47% 41% 74% 90%	12,381,780 12,381,780 12,381,780 12,381,780 517,298 907,684	9,546,502 8,692,500 6,353,374 5,548,426 440,573 792,651	77% 70% 51% 45% 85% 87%

Annex 5
UTILIZATION MEASURES AND ACCOMPLISHMENTS OF DOH HEALTH PROGRAMS
1996-1998

Health Programs	OACI	1996 AUI	% Accomp.	OACI	1997 AUI	% Accomp.	OACI	1998 AUI	% Accomp.
1. Pre-natal and Postpartum Care -Pregnant women with three or more prenatal visits	79%	71%	56%	103%	94%	69%	33%	27%	59%
2. Fully Immunized Children -Infant given 3rd dose of Hepa B -Pregnant women given TT2+	52%	41%	90% 62% 49%	100%	89%	89% 37% 52%	25%	22%	85% 37% 50%
3. Control of Diarrheal Diseases -Diarrhea cases given ORS	4%	4%	36%	0.50%	0.50%	32%	0.70%	0.70%	28%
4. Acute Respiratory Infection -Pneumonia cases (0-59 mos) given treatment	98%	88%	68%	100%	10%	64%	20%	0.09%	52%
5. Nutrition Food Supplementation among 6-59 months children -Moderately Underweight -Severely Underweight Pregnant women given complete iron dosage Women (15-49) given iodized oil capsule Children (12-59 months) given Vitamin A Lactating mothers given Vitamin A	118%	100%	14% 16% 29% 40% 21% 94% 52%	114%	96%	10% 15% 21% 47% 17% 93% 50%	66%	56%	8% 10% 15% 41% 4% 90% 49%
6. Family Planning New Acceptors -Modern Method -Traditional Method Continuing Users -Modern Method -Traditional Method	235%	87%	 94% 6%	82%	0.90%	 94% 6%	72%	58%	 96% 4% 97% 3%

Annex 5
UTILIZATION MEASURES AND ACCOMPLISHMENTS OF DOH HEALTH PROGRAMS
1996-1998

Health Programs	OACI	1996 AUI	% Accomp.	OACI	1997 AUI	% Accomp.	OACI	1998 AUI	% Accomp.
7. Dental	104%	88%		109%	94%		59%	55%	
Provided curative treatment									
-Preschoolers			34%			34%			35%
-Schoolers			6%			5%			5%
Schoolers provided preventive treatment			164%			156%			186%
Pregnant women provided									
-Preventive treatment			61%			60%			60%
-Curative treatment			44%			45%			47%
8. TB Control	102%	87%		383%	333%		59%	29%	
-TB Symptomatics with sputum exam			2%			2%			1%
-Total TB cases			0.39%			0.28%			0.21%
-New sputum positive initiated treatment			0.12%			0.12%			0.10%
9. Leprosy Control Program	87%	67%	0.02%	161%	58%	0.02%	52%	13%	0.02%
-Prevalence rate									
10. Schistosomiasis Program	186%	95%		115%	68%		120%	65%	
-No. of stool found positive			4%			5%			4%
-No. of positive cases given treatment			84%			100%			96%
11. Rabies Control Program	113%	96%	30%	92%	81%	39%	75%	72%	47%
-No. of animal bites given post exposure immunization									
12. Filariasis Control Program	123%	90%	45%	122%	94%	68%	111%	72%	29%
-No. of Filaria cases given treatment									
13. Malaria Control Program	66%	57%		108%	94%		80%	70%	
-No. of continued cases			0.08%			0.09%			0.09%
-No. of clinically-diagnosed given treatment			41%			88%			51%
14. Sexually-Transmitted Diseases	300%	99%		135%	97%		100%	58%	
-No. of women with vaginal discharge			12%			0.16%			0.12%
-No. of menstruation and urethral discharge			0.03%			0.03%			0.02%
-No. of men/women with genital ulcers			0.01%			0.00%			0.00%

Annex 5
UTILIZATION MEASURES AND ACCOMPLISHMENTS OF DOH HEALTH PROGRAMS
1996-1998

Health Programs	1996			1997			1998		
	OACI	AUI	% Accomp.	OACI	AUI	% Accomp.	OACI	AUI	% Accomp.
15.Environmental Health Program	117%	84%		141%	97%		95%	72%	
-No. of household with access to safe water supply			69%			76%			77%
-No. of household with sanitary toilet			60%			66%			70%
-No. of household with satisfactory garbage disposal			46%			47%			51%
-No. of household with complete sanitation facilities			42%			41%			45%
-No. of food establishments with sanitary permit			70%			74%			85%
-No. of food handlers with health certificates			89%			90%			87%

Annex 6
PERFORMANCE TARGETS AND ACCOMPLISHMENTS
Immunization Program
1996-1999

Health Program	1996			1997			1998			1999		
	Performance Target	Actual Accomplishment	% Accomplish.	Performance Target	Actual Accomplishment	% Accomplish.	Performance Target	Actual Accomplishment	% Accomplish.	Performance Target	Actual Accomplishment	% Accomplish.
1. Fully Immunized Children												
-Infant given 3rd dose of Hepa B (3% of Elig. Popn.)	2,103,900	1,888,432	90%	2,158,818	1,919,128	89%	2,211,517.00	1,878,157.00	85%	2,242,373.00	1,967,833.00	88%
National Capital Region	293,362	276,346	94%	303,551	287,824	95%	314,214.00	295,415.00	94%	306,276.00	299,058.00	98%
C.A.R.	38,308	34,568	90%	38,989	33,901	87%	39,689.00	34,840.00	88%	41,180.00	33,651.00	82%
Region 1	115,574	103,654	90%	117,051	99,278	85%	118,548.00	98,113.00	83%	122,267.00	100,725.00	82%
Region 2	77,246	73,904	96%	78,431	70,681	90%	79,634.00	71,071.00	89%	82,249.00	71,600.00	87%
Region 3	212,575	192,747	91%	217,293	185,235	85%	222,134.00	189,770.00	85%	226,170.00	206,103.00	91%
Region 4	308,962	264,957	86%	320,105	290,601	91%	331,748.00	294,302.00	89%	331,201.00	314,852.00	95%
Region 5	132,287	119,594	90%	134,865	113,005	84%	137,495.00	108,238.00	79%	139,974.00	118,415.00	85%
Region 6	171,714	164,894	96%	177,960	174,201	98%	180,339.00	138,150.00	77%	186,422.00	147,401.00	79%
Region 7	152,982	127,538	83%	155,576	134,144	86%	158,219.00	134,580.00	85%	163,044.00	135,025.00	83%
Region 8	103,028	94,527	92%	105,097	88,847	85%	107,215.00	94,655.00	88%	110,047.00	91,578.00	83%
Region 9	85,897	76,969	90%	88,009	72,486	82%	90,177.00	68,706.00	76%	92,385.00	77,492.00	84%
Region 10	76,230	70,256	92%	78,011	69,052	89%	79,840.00	71,560.00	90%	81,432.00	73,458.00	90%
Region 11	141,830	120,065	85%	145,661	127,141	87%	149,615.00	108,369.00	72%	153,205.00	127,078.00	83%
Region 12	72,807	59,211	81%	74,880	63,592	85%	77,014.00	62,947.00	82%	77,955.00	63,087.00	81%
CARAGA	59,368	50,539	85%	60,484	51,060	84%	61,631.00	50,317.00	82%	64,034.00	50,085.00	78%
ARMM	61,730	58,663	95%	62,856	58,080	92%	64,005.00	55,124.00	86%	64,534.00	58,225.00	90%
2) Pregnant women given TT2- (3.5% of Elig. Popn.)	2,454,549	1,202,676	49%	2,518,621	1,315,547	52%	2,580,103.00	1,296,228.00	50%	2,616,103.00	1,549,898.00	59%
National Capital Region	342,255	123,355	36%	354,143	154,834	44%	366,583.00	171,779.00	47%	357,322.00	208,752.00	58%
C.A.R.	44,693	18,504	41%	45,487	20,434	45%	46,303.00	20,301.00	44%	48,043.00	22,068.00	46%
Region 1	134,836	77,912	58%	136,560	78,061	57%	138,306.00	75,174.00	54%	142,645.00	88,190.00	62%
Region 2	90,121	59,519	66%	91,502	62,514	68%	92,906.00	62,490.00	67%	95,957.00	74,106.00	77%
Region 3	248,004	121,639	49%	253,508	125,526	50%	259,156.00	132,424.00	51%	263,865.00	154,828.00	59%
Region 4	360,455	166,516	46%	373,456	173,074	46%	387,039.00	187,444.00	48%	386,401.00	252,319.00	65%
Region 5	154,335	76,492	50%	157,343	75,979	48%	160,411.00	70,187.00	44%	163,303.00	77,584.00	48%
Region 6	200,333	87,697	44%	207,620	108,272	52%	210,395.00	77,800.00	37%	217,492.00	102,580.00	47%
Region 7	178,479	95,038	53%	181,505	109,109	60%	184,589.00	102,198.00	55%	190,218.00	113,086.00	59%
Region 8	120,200	69,218	58%	122,613	69,449	57%	125,084.00	65,549.00	52%	128,388.00	74,515.00	58%
Region 9	100,213	52,616	53%	102,677	52,480	51%	105,206.00	62,297.00	59%	107,782.00	65,318.00	61%
Region 10	88,936	36,790	41%	91,013	43,836	48%	93,147.00	47,675.00	51%	95,004.00	54,243.00	57%
Region 11	165,468	90,918	55%	169,938	101,693	60%	174,550.00	96,908.00	56%	178,739.00	114,775.00	64%
Region 12	84,942	38,529	45%	87,360	48,626	56%	89,850.00	42,291.00	47%	90,947.00	52,495.00	58%
CARAGA	69,262	30,927	45%	70,565	36,250	51%	71,903.00	34,757.00	48%	74,706.00	39,574.00	53%
ARMM	72,018	57,006	79%	73,332	55,410	76%	74,672.00	46,954.00	63%	75,289.00	55,465.00	74%

Annex 7

REGIONAL UTILIZATION AND ACCOMPLISHMENTS

Immunization Program

1996-1999

Region	1996				1998				1999			
	Allotment	Obligation	AUI	Accomplish	Allotment	Obligation	AUI	Accomplish	Allotment	Obligation	AUI	Accomplish
National Capital Region	213,583	241,674	1.13	0.94	266,302	205,697	0.77	0.94	353,420	236,690	0.67	0.98
C.A.R.	292,106	280,205	0.96	0.90	220,714	207,266	0.94	0.88	397,070	341,119	0.86	0.82
Region 1	253,789	307,066	1.21	0.90	397,073	370,809	0.93	0.83	523,094	462,260	0.88	0.82
Region 2	262,432	299,710	1.14	0.96	397,073	370,809	0.93	0.89	429,615	349,176	0.81	0.87
Region 3	378,898	361,461	0.95	0.91	335,782	301,728	0.90	0.85	543,164	501,793	0.92	0.91
Region 4	455,808	488,611	1.07	0.86	422,415	389,375	0.92	0.89	608,316	518,422	0.85	0.95
Region 5	304,855	331,171	1.09	0.90	477,005	459,686	0.96	0.79	544,189	485,366	0.89	0.85
Region 6	389,109	402,441	1.03	0.96	506,349	465,565	0.92	0.77	564,809	448,595	0.79	0.79
Region 7	397,414	406,787	1.02	0.83	472,647	438,442	0.93	0.85	211,024	164,710	0.78	0.83
Region 8	268,193	321,581	1.20	0.92	510,646	456,749	0.89	0.88	336,780	266,795	0.79	0.83
Region 9	278,956	240,668	0.86	0.90	276,965	245,157	0.89	0.76	364,469	319,924	0.88	0.84
Region 10	274,740	318,510	1.16	0.92	274,814	260,166	0.95	0.90	351,204	316,712	0.90	0.90
Region 11	478,839	414,243	0.87	0.85	284,890	264,087	0.93	0.72	551,426	511,868	0.93	0.83
Region 12	213,048	252,868	1.19	0.81	439,619	408,967	0.93	0.82	247,287	224,983	0.91	0.81
CARAGA	-	-	0.00	0.00	112,602	90,919	0.81	0.82	234,869	173,038	0.74	0.78
ARMM	22,219	22,277	1.00	0.95	112,535	112,535	1.00	0.86	0	0	-	0.00
Average	298,933	312,618	1.06	0.90	367,162	336,530	0.97	0.90	417,382	354,763	0.84	0.85

Annex 8
PERFORMANCE TARGETS AND ACCOMPLISHMENTS
Tuberculosis Control Program
1996-1999

Health Program	1996			1997			1998			1999		
	Performance Target	Actual Accomplishment	% Accomplish.	Performance Target	Actual Accomplishment	% Accomplish.	Performance Target	Actual Accomplishment	% Accomplish.	Performance Target	Actual Accomplishment	% Accomplish.
1. TB Symptomatics with sputum exam (No.of cases/Total Popn x 100)	70,101,714	1,188,160	2%	71,960,594	1,124,011	2%	73,717,220	969,283	1%	74,745,756	839,258	1%
National Capital Region	9,778,723	154,642	2%	10,118,382	204,509	2%	10,473,802	177,369	2%	10,209,193	113,408	1%
C.A.R.	1,278,938	18,523	1%	1,299,638	20,302	2%	1,322,950	17,291	1%	1,372,668	16,418	1%
Region 1	3,852,470	82,653	2%	3,901,704	71,210	2%	3,951,601	66,859	2%	4,075,569	48,249	1%
Region 2	2,574,881	57,870	2%	2,614,355	56,819	2%	2,654,467	43,947	2%	2,741,618	46,217	2%
Region 3	7,057,564	171,119	2%	7,243,098	174,463	2%	7,404,469	152,088	2%	7,538,992	138,485	2%
Region 4	10,298,718	98,159	1%	10,670,172	91,007	1%	11,058,269	76,324	1%	11,040,036	73,094	1%
Region 5	4,409,568	109,473	2%	4,495,515	100,872	2%	4,583,179	84,440	2%	4,665,812	69,244	1%
Region 6	5,723,786	95,887	2%	5,931,987	81,663	1%	6,011,296	43,634	1%	6,214,068	55,394	1%
Region 7	5,099,401	71,112	1%	5,185,851	67,104	1%	5,273,975	40,827	1%			
Region 8	3,434,273	77,660	2%	3,503,229	75,255	2%	3,573,829	53,208	1%			
Region 9	2,863,224	45,011	2%	2,933,618	43,547	1%	3,005,889	41,679	1%	3,079,490	37,517	1%
Region 10	2,541,015	47,106	2%	2,600,358	40,844	2%	2,661,347	49,009	2%	2,714,412	40,516	1%
Region 11	4,727,657	62,715	1%	4,855,363	3,600	0.1%	4,987,157	49,633	1%	5,106,837	45,611	1%
Region 12	2,426,901	28,378	1%	2,495,989	32,516	1%	2,567,132	25,839	1%	2,598,484	28,973	1%
CARAGA	1,978,924	30,517	2%	2,016,138	25,069	1%	2,054,361	20,626	1%	2,134,454	22,814	1%
ARMM	2,057,671	37,335	2%	2,095,197	35,231	2%	2,133,497	55,124	3%	2,151,128	25,106	1%
2) Total TB Cases	70,101,714	271,882	0.4%	71,960,594	199,665	0.3%	73,717,220	157,871	0.2%	74,745,756	143,493	0.2%
National Capital Region	9,778,723	49,405	1%	10,118,382	36,125	0.4%	10,473,802	30,153	0.3%	10,209,193	18,919	0.2%
C.A.R.	1,276,938	5,119	0.4%	1,299,638	3,551	0.3%	1,322,950	2,495	0.2%	1,372,668	2,462	0.2%
Region 1	3,852,470	17,735	0.5%	3,901,704	12,849	0.3%	3,951,601	10,722	0.3%	4,075,569	9,082	0.2%
Region 2	2,574,881	9,664	0.4%	2,614,355	5,810	0.2%	2,654,467	5,753	0.2%	2,741,618	5,870	0.2%
Region 3	7,057,564	25,819	0.4%	7,243,098	20,808	0.3%	7,404,469	18,288	0.2%	7,538,992	17,423	0.2%
Region 4	10,298,718	31,901	0.3%	10,670,172	21,640	0.2%	11,058,269	18,916	0.2%	11,040,036	19,780	0.2%
Region 5	4,409,568	16,344	0.4%	4,495,515	10,450	0.2%	4,583,179	9,026	0.2%	4,665,812	8,061	0.2%
Region 6	5,723,786	30,913	1%	5,931,987	21,070	0.4%	6,011,296	12,133	0.2%	6,214,068	12,545	0.2%
Region 7	5,099,401	10,824	0.2%	5,185,851	10,036	0.2%	5,273,975	7,227	0.1%			
Region 8	3,434,273	14,059	0.4%	3,503,229	12,272	0.4%	3,573,829	5,517	0.2%			
Region 9	2,863,224	9,656	0.3%	2,933,618	7,267	0.2%	3,005,889	5,591	0.2%	3,079,490	6,518	0.2%
Region 10	2,541,015	10,637	0.4%	2,600,358	5,558	0.2%	2,661,347	6,735	0.3%	2,714,412	4,817	0.2%
Region 11	4,727,657	13,815	0.3%	4,855,363	9,828	0.2%	4,987,157	10,674	0.2%	5,106,837	9,287	0.2%
Region 12	2,426,901	9,414	0.4%	2,495,989	10,008	0.4%	2,567,132	6,299	0.2%	2,598,484	5,884	0.2%
CARAGA	1,978,924	8,232	0.4%	2,016,138	5,179	0.3%	2,054,361	3,661	0.2%	2,134,454	3,965	0.2%
ARMM	2,057,671	8,345	0.4%	2,095,197	7,214	0.3%	2,133,497	4,681	0.2%	2,151,128	4,200	0.2%
3) New sputum positive initiated treatment	70,101,714	87,075	0.1%	71,960,594	82,799	0.1%	73,717,220	70,249	0.1%	74,745,756	73,309	0.1%
National Capital Region	9,778,723	18,433	0.2%	10,118,382	15,638	0.2%	10,473,802	12,293	0.1%	10,209,193	7,572	0.1%
C.A.R.	1,276,938	1,382	0.1%	1,299,638	991	0.1%	1,322,950	953	0.1%	1,372,668	907	0.1%
Region 1	3,852,470	5,455	0.1%	3,901,704	4,414	0.1%	3,951,601	4,101	0.1%	4,075,569	4,111	0.1%
Region 2	2,574,881	4,022	0.2%	2,614,355	2,809	0.1%	2,654,467	2,889	0.1%	2,741,618	3,017	0.1%
Region 3	7,057,564	10,722	0.2%	7,243,098	8,893	0.1%	7,404,469	9,934	0.1%	7,538,992	9,782	0.1%
Region 4	10,298,718	6,168	0.1%	10,670,172	6,390	0.1%	11,058,269	6,538	0.1%	11,040,036	8,404	0.1%
Region 5	4,409,568	7,552	0.2%	4,495,515	4,920	0.1%	4,583,179	5,170	0.1%	4,665,812	4,885	0.1%
Region 6	5,723,786	5,670	0.1%	5,931,987	5,495	0.1%	6,011,296	4,968	0.1%	6,214,068	6,658	0.1%
Region 7	5,099,401	5,372	0.1%	5,185,851	4,816	0.1%	5,273,975	4,627	0.1%			
Region 8	3,434,273	4,980	0.1%	3,503,229	6,509	0.2%	3,573,829	2,873	0.1%			
Region 9	2,863,224	2,810	0.1%	2,933,618	2,035	0.1%	3,005,889	1,953	0.1%	3,079,490	3,125	0.1%
Region 10	2,541,015	3,153	0.1%	2,600,358	2,577	0.1%	2,661,347	3,352	0.1%	2,714,412	3,008	0.1%
Region 11	4,727,657	3,762	0.1%	4,855,363	6,919	0.1%	4,987,157	3,478	0.1%	5,106,837	4,551	0.1%
Region 12	2,426,901	2,194	0.1%	2,495,989	4,166	0.2%	2,567,132	2,980	0.1%	2,598,484	3,000	0.1%
CARAGA	1,978,924	2,145	0.1%	2,016,138	2,045	0.1%	2,054,361	1,980	0.1%	2,134,454	2,676	0.1%
ARMM	2,057,671	3,255	0.2%	2,095,197	4,182	0.2%	2,133,497	2,160	0.1%	2,151,128	2,074	0.1%

Annex 9
Women's Health and Safe Motherhood Project: ADB Disbursements
(all amount in US\$)

Expense Category/Component/Activity	Loan Allocation	Contracted Amount As of 29 Feb. 2000 (Loan Portion only)	New Contracts		Total Contracts	Disbursement						Loan Balance at End of Project
			Mar-Dec 2000	2001		As of 29 Feb. 00	Mar-Jun 2000	3Q2000	4Q2000	2001	Total	
01 Civil Works	7,162,751	9,194,257	660,000	0	9,854,257	4,983,780	3,885,051	886,883	98,543	0	9,854,257	-2,691,506
Additional variation orders			660,000							0		
02 Equipment	3,187,505	1,811,608	1,283,340	0	3,094,948	1,568,326	92,500	92,500	892,886	448,736	3,094,948	92,557
Blood Bnk Ref (90 units Exclusive + 2 units)		441,724	15,000			441,724			14,250	750		
Laboratory Ref (26 units Himex + 22 units)		65,504	70,000			65,504			66,500	3,500		
Furniture		149,826	190,174			16,767				323,233		
Emergency Transport		61,834	308,166			6,247	92,500	92,500	92,500	86,253		
Anesthesia Machine (58 Draeger + 30 units)		1,092,720	700,000			1,038,084			719,636	35,000		
03 Medical Supplies	13,809,740	5,136,886	7,866,941	0	13,003,827	2,668,353	275,243	1,957,472	3,723,463	4,379,297	13,003,827	805,913
1996 Medical Supplies												
Iodized Capsules		545,548				545,548						
1997 Medical Supplies												
Vitamin A Capsules (Vince Lee Pharma)		47,413				47,413						
Disposable OB Kits (Medical Center)		975,066				975,066						
1998 Medical Supplies												
Vitamin A Capsules		56,000				56,000	0					
Iodized Capsules		286,870				272,526	14,344					
Safe Home Delivery Supplies		344,000				326,800	17,200					
1999 Medical Supplies												
Vitamin A Capsules (UNICEF)		49,500					4,950	44,550				
Iodized Oil Capsules (UNICEF)		1,109,000					110,900	499,050		499,050		
Iron Tablets (UNICEF)		361,462	722,924				36,146	325,316	72,292	650,632		
Emergency OB Supplies (UNICEF)		334,097	1,644,017				33,410	300,687	164,402	1,479,615		
Safe Home Delivery Supplies (UNICEF)		279,000	1,500,000				27,900	251,100	150,000	1,350,000		
Provision of HBMR Forms (Anssel)		303,930					30,393	136,769	136,769			
Year 2000 requirement (DOH procured)												
Vita A (130,000,000 Tablets)			400,000					40,000	320,000	40,000		
Vita A (3,000,000 capsules)			40,000					4,000	32,000	4,000		
Iron tablets (920,000,000 tab)			2,300,000					230,000	1,840,000	230,000		
Emergency OB Supplies			1,260,000					126,000	1,008,000	126,000		
Fees of UNICEF		445,000				445,000						

Annex 9
Women's Health and Safe Motherhood Project: ADB Disbursements
(all amount in US\$)

Expense Category/Component/Activity	Loan Allocation	Contracted Amount As of 29 Feb. 2000 (Loan Portion only)	New Contracts		Total Contracts	Disbursement						Loan Balance at End of Project
			Mar-Dec 2000	2001		As of 29 Feb. 00	Mar-Jun 2000	3Q2000	4Q2000	2001	Total	
04 Consulting Services	2,713,842	2,080,613	583,117	49,403	2,713,133	1,805,418	203,447	209,974	190,568	303,727	2,713,133	709
Project Mgt. Specialists (Ramos)		123,750				123,750	0					
PCPD (Adjusted as terminated)		1,365,745				1,365,745						
Lifecycle Approach (Alayka)		97,940				88,265	9,675					
Expansion of LCA			225,000					67,500	67,500	90,000		
Civil Engineer (JB)		49,500				22,500	9,000	6,750	6,750	4,500		
Project Mgt. Specialists (OMC)		47,520	64,800			43,560	20,160	16,200	16,200	16,200		
Financial Mgt. Specialist (JBE)		47,520	64,800			43,560	20,160	16,200	16,200	16,200		
Other individual consultants		165,622	142,517	29,403		62,147	79,602	37,386	19,980	138,427		
Maternal Care GIS		127,125	46,000				50,850	51,938	51,938	18,400		
Convenor		4,501				4,501						
Maternal care (Other related expenses)		42,706	20,000	10,000		42,706	7,000	7,000	6,000	10,000		
Quality Assurance (Other related expenses)		8,684	20,000	10,000		8,684	7,000	7,000	6,000	10,000		
05d IEC Materials and Activities	4,696,767	1,173,213	3,565,288	22,500	4,761,001	713,333	442,737	849,925	1,190,800	1,564,206	4,761,002	-64,235
AKAP Survey		50,802				50,802	0					
Various Expenditures		113,001				113,001	0					
IEC Regional Advocacy Consultant/Staff		18,840	37,288	22,500	18,840	9,008	27,419	8,384	8,384	25,434		
Dev. Of IEC Materials (Women's Media Circle)		317,250				230,297	86,953					
Nationwide Advocacy Program (WHPI)		522,027				235,106	286,921					
Breast Self Exam Progress			67,500						67,500			
Baseline Post Tracking Survey (SOFRES FSA)		151,293				75,119	22,694	22,694	22,694	8,092		
IEC Production			1,581,750					526,723	526,723	528,305		
Social Marketing			1,575,000					236,250	472,500	866,250		
Healthbelt Publication			56,250				18,750	18,750	18,750			
Others (New Proposals)			247,500					37,125	74,250	136,125		
05f Project Management Support	902,701	589,496	107,102	206,102	902,701	589,496	70,201	90,001	30,601	122,403	902,701	0
Various Expenditures 0002		589,496	107,102	107,102		589,496	30,601	30,601	30,601	122,403		
BME (APMC)				99,000			39,600	59,400				
Service Charge	1,573,790	142,251	269,224	144,002	555,477	142,251	63,922	76,946	128,357	144,002	555,477	1,018,313
Unallocated	5,850,016											5,850,016
Special Account	103,819											
Grand Total	40,000,931	20,128,324	14,335,012	422,007	34,885,343	13,470,958	5,033,101	4,163,700	6,255,216	5,962,369	34,885,344	5,115,587

Annex 10
Women's Health and Safe Motherhood Project: IBRD Disbursements
(all amount in US\$)

Expense Category/Component Item	Loan Allocation	Contracted Amt. (LP) as of end Feb. 2000	New Contracts		Total Contracts (LP Portion)	Disbursement								Total	Balance Loan at End of Project
			March-Dec 00	2001		As of Feb-00	2000			2001					
							Mar-Jun	3Q	4Q	1Q	2Q	3Q	4Q		
1. Civil Works	1,300,000	800,162	499,838	0	1,300,000	767,407	223,253	148,836	86,088	24,806	49,611	0	0	1,300,001	0
2. Good (Equip./Furn., Supplies)	2,608,727	1,101,187	1,828,841	0	2,930,028	819,702	218,876	274,566	546,577	814,286	256,022	0	0	2,930,028	-321,301
furniture		31,937	252,549		284,486	31,937	116,235	116,235	20,080						
microscope	Paramedic	95,324			95,324	95,324									
refrigerator	Gen Mercantile	20,256			20,256	20,256									
autoclave	Practika	35,341			35,341	35,341									
colposcope	Mircrolab	52,052			52,052	52,052									
LAN	Micro Circuit	61,494			61,494	61,494									
UPS	Datamerge	8,008			8,008	7,621	387								
waterbath	Golden Bath	2,846			2,846	2,846									
heated incubator	Levins	9,749			9,749	9,749									
laptop	TriCom	2,752			2,752	2,618	134								
rotator	Harnwell	9,986			9,986	9,986									
computer/supplies	Printersmate	7,142			7,142	7,142									
reimbursable goods	FACE	76,185			76,185	23,884	23,875	12,000	10,000	6,426					
reimbursable goods	JSI	178,241			178,241	20,832		64,043	75,000	9,183	9,183				
reimbursable goods	UP-Wstudies		1,333		1,333		1,333								
cryol/LEEP/microtome	estimated amt.		459,118		459,118					367,294	91,824				
cancer reagents/supp	estimated amt.		150,000		150,000					120,000	30,000				
microscope CxCa	estimated amt.		140,000		140,000					112,000	28,000				
examining table RTI	estimated amt.		125,000		125,000					100,000	25,000				
vehicle	estimated amt.		31,250		31,250					25,000	6,250				
training models	Exclusive	155,111			155,111	155,111									
reagents & supplies	New Life	10,257			10,257	10,257									
reagents & supplies	Jerr Mktg	273,251			273,251	273,251									
training equipment # 1	Hytech	4,879			4,879		3,903	488	488						
training equipment # 2	Hytech	3,315			3,315		2,652	332	332						
training equipment # 3	Hytech	16,635			16,635		13,308	1,664	1,664						
training equipment # 4	Hytech	870			870		696	87	87						
training equipment # 5	John & David	5,870			5,870		4,696	587	587						
training equipment # 6	John & David	11,077			11,077		8,862	1,108	1,108						
training equipment # 7	Micro Data	6,367			6,367		5,094	637	637						
training equipment # 8	EcoStar	13,585			13,585		10,868	1,359	1,359						
training equipment # 9	Phil Fuji	7,521			7,521		6,017	752	752						
training equipment # 10	Anstans	1,022			1,022		818	102	102						
training equipment # 11	Anstans	113			113			113							
trng/log equipment# 12	estimated amt.		10,000		10,000			8,000	1,000	1,000					
LMIS	estimated amt.		500,000		500,000				400,000	50,000	50,000				
vehicle/supplies	c/o RITM		125,765		125,765		20,000	40,000	30,000	20,000	15,765				
table centrifuge	Zephil		33,826		33,826			27,061	3,383	3,383					

Annex 10
Women's Health and Safe Motherhood Project: IBRD Disbursements
(all amount in US\$)

Expense Category/Component Item		Loan Allocation	Contracted Amt. (LP) as of end Feb. 2000	New Contracts		Total Contracts (LP Portion)	Disbursement								Total	Balance Loan at End of Project
				March-Dec 00	2001		As of Feb-00	2000			2001					
								Mar-Jun	3Q	4Q	1Q	2Q	3Q	4Q		
3. Reagents/supplies for RTI		1,596,297	1,310,519	285,778	0	1,596,297	1,211,922	98,597	0	28,578	228,622	28,578	0	0	1,596,297	0
wooden scraper	New Life		35,905			35,905	35,905									
reagents & supplies	Medical Center		158,719			158,719	127,453	31,266								
TPHA	BioCare		4,907			4,907	4,355	553								
reagents & supplies	Jerr Marketing		65,007			65,007	32,174	32,833								
reagents & supplies	estimated amt.			285,778		285,778			28,578	228,622	28,578					
reagents & supplies	c/o RITM		5,099			5,099	5,099									
various goods	UNICEF		1,040,882			1,040,882	1,006,936	33,946								
4. TA/Logistics Training		6,478,524	4,829,594	770,667	186,990	5,787,251	1,817,758	995,440	797,330	534,606	240,440	1,020,049	35,893	345,735	5,787,251	691,273
LGEDDS	John Snow		3,521,759			3,521,759	1,077,216	704,352	528,264	176,088		704,352		331,488		
LMIS				150,000	50,000	200,000		15,000	75,000	60,000	25,000	25,000				
PCPD			98,287			98,287	88,758			9,529						
Cs Ca screening options	FACE		654,087			654,087	448,012	65,409		65,409		75,257				
Intervention on VAWC	UP-Women's		66,456			66,456		26,582	9,968	9,968	6,646	6,646	6,646			
Trng. Of Cytoscreeners	UP-PGH			45,486		45,486		22,743	22,743							
Trng. Of Cytoscreeners	estimated amt.			45,486		45,486		22,743	22,743							
RTI/STD Prevalence	estimated amt.			370,000		370,000				125,000	122,500	122,500				
AntiMicrobial Surveil	RITM		260,233			260,233		52,047	52,047	52,047	52,047	52,047				
Fx consultants, LCA, etc.			228,772			228,772	203,772	25,000								
Reg/I/PMO Consultants				34,695	36,990	71,685		11,565	11,565	11,565	9,248	9,248	9,248	9,248		
Monitoring/WS/etc.				125,000	100,000	225,000		50,000	75,000	25,000	25,000	25,000	20,000	5,000		
5. TA/Services/Training		1,416,452	456,471	682,670	175,000	1,314,141	456,471	89,489	106,250	150,000	125,000	125,000	150,000	111,931	1,314,141	102,311
PHC Training (including RTI, Cx, Ca and women's health)			456,471	626,420	125,000	1,207,891	456,471	89,489	100,000	125,000	100,000	125,000	125,000	86,931		
training exp. (supplies	estimated amt.			6,250		6,250			6,250							
training evaluation	estimated amt.			50,000	50,000	100,000				25,000	25,000		25,000	25,000		
6. Special Account							390,429								-390,429	0
7. Unallocated		300,000														300,000
Total Loan		13,700,000	8,497,934	4,067,793	361,990	12,927,717	5,463,689	1,625,655	1,326,981	1,345,848	1,433,154	1,479,260	185,893	457,666	13,318,145	381,855

Annex 11

Women's Health and Safe Motherhood Project: KFW Grant Schedule

KFW Goods	Delivery Date	1997	1998			1999			2000										2001	
		0 5	0 9	1 1	0 6	0 9	1 0	0 2	0 3	0 4	0 5	0 6	0 7	0 8	0 9	1 0	1 1	1 2	0 1	0 2
1. Major OB/Gyne Equipment																				
1.a. ADB Provinces - PH/DH/LIC/MWH	Sept-Oct 2000														1	1	1	1	1	1
1.b. ADB Provinces - RHU/BHS	June-July 2000											1	1	1	1	1	1	1	2	2
1.c. IBRD Provinces - RHU/BHS	June 2000				1	1	1												2	2
2. Minor OB/Gyne Equipment																				
2.a. Minilaparatomy Set - 156	Oct. 1999						1	1												
2.b. IUD Insertion Set -1,600	Oct. 1999						1	1												
2.c. Caesarian Section Set - 134	Sept-Oct 2000														1	1	1	1	1	1
2.d. Laparatomy Set - 39	Sept-Oct 2000														1	1	1	1	1	1
2.e. D & C Set - 133	Sept-Oct 2000														1	1	1	1	1	1
3. Ultrasound Machines																				
3.a. ADB Provinces - 40 units	Sept. 1999					1	1													
Basic Training Course	Sept-Oct 1999					3	3	3	3											
3.b. Additional 6 units	July 2000												1	1						
Advance Training Course	July 2000												3	3						
4. RTI/STD Drugs																				
4.a. Batch 1 (approx. 40%)	Feb. 2000							1	1											
4.b. Batch 2 (approx. 40%)	Aug. 2000													1	1					
4.c. Batch 3 (approx. 10%)	Feb. 2001																		1	1
5. Cephalosporines																				
5.a. Batch 1 (approx. 40%)	Sept. 1999					1	1													
5.b. Batch 2 (approx. 40%)	Aug. 2000													1	1					
5.c. Batch 3 (approx. 10%)	Feb. 2001																		1	1
6. Midwifery and TBA Kits																				
6.a. Batch 1 - 500 kits	May 1997	1	1																	
6.b. Batch 2 - 1,010 kits	Sept. 1998		1	1																
6.c. Batch 3 - 3,704 kits	Nov. 1998			1	1															
6.d. Batch 4 - 2,745 kits	April 2000									1	1									
7. Additional Equipment for Tendering																				
7.a. Colposcopes - 20	Sept-Oct 2000														1	1	1	1	1	1
7.b. Examination Stools - 517	Sept-Oct 2000														1	1	1	1	1	1
7.c. Pick-up Forceps - 434	Sept-Oct 2000														1	1	1	1	1	1
7.d. Airconditioning Units - 159	April 2000									1	1									
7.e. On-Line UPS - 47	April 2000									1	1									

1 = Delivery to Destination; 2 = Installation; 3 = Training

Annex 11a
KFW Detailed Progress Report

Hospital Equipment, Drugs, Midwifery & TBA Kits	Target End of Project	Delivered	% Delivered
Multipurpose Operating Tables	92		
Delivery/Gynecological Table	470		
Examination Table	191	144	75%
Operating Light for Major OR (Ceiling)	92		
Operating Light for Minor OR (Ceiling)	129		
Examination Light/Drop Light	864	144	17%
Suction Machine, Electric	184		
Coagulator/Cautery Machine	92		
Autoclave, Steam High Pressure	102		
Steam Sterilizer, Electric	164		
Steam Sterilizer, Fuel	414	144	35%
Doppler Machine with Monitor	102		
Ultrasound Machine	47	41	87%
Wheel Chair with IV Stand	194		
Stretcher with Side Railing	209		
Transport Incubator	37		
Stationary Incubator	92		
Ultraviolet Lamp, room sterilization	92		
Ultraviolet Lamp, photo therapy	92		
War Bed, collapsible w/side railings	675		
Doppler Machine with Monitor	102		
IV Stand with Roller	1,248	144	12%
Combi bag, adult and pediatric	92		
Kelly Pad	771	144	19%
Sphygmomanometer with Stand for children	144	144	100%
Sphygmomanometer with Stand for Adult & Child	567	144	25%
Sphygmomanometer in Metal Box, Portable	1,544	288	19%
Instrument Tray, Rectangle, Stationery	772	144	19%
Instrument Tray, Rectangle, Mobile	772	144	19%
Graves Vaginal Speculum, Small	1,063	214	20%
Graves Vaginal Speculum, Medium	1,536	284	18%
Cusco Vaginal Speculum, Virgin	680	144	21%
Weighing Scale for Infant and Adult	772	144	19%
Weighing Scale for Infant	628		
Weighing Scale for Adult	628		
Simpsons Forceps	92		
Piper Forceps	92		
Stethoscope (Adult/Children) Convert.	1,123	214	19%
Stet. Adult (bell/diaphragm)	909		
Stet. Pedia (diaphragm only)	680		
Gloves, Surgical, Sterile, 100/box	6,793	6,793	100%
Colposcopes	20		
Examination Stools	517		
Pick-up Forceps	434		
UPS On-line	47		
Generator, 10 KVA	92		
Portable Light, Rechargeable	1,176	288	24%
Air conditioning Unit, 2HP	251		
Instrument Set			
General Laparotomy Set	37		
Ceasarian Section Set	129		
IUD Set	1,600	1,600	100%
D & C Set	129		
Minilaparotomy/Tubal Ligation	156	156	100%
Midwifery Kits	3,057	2,027	66%
TBA Kits	4,902	3,187	65%
RTI/STD Drugs			
Doxycycline	5,724,834	2,299,000	40%
Erythromycin	3,750,521	1,610,000	43%
Metronidazole	5,322,552	2,298,000	43%
Clothimazole	1,330,638	527,000	40%
Benzathine	92,835	37,150	40%
Cephalosporines			
Cefriaxone	120,685	40,280	33%
Cefixime	804,572	321,810	40%

OFFICE/SERVICE/PROGRAM

A. PROGRAMS

1. GENERAL ADMINISTRATION AND SUPPORT SERVICES
 - a. General Administration & Support Services
 1. Central Office
 - a. General Management and Supervision
 - A.1.a.1.a. General Management & Supervision
 - A.1.a.1.b. Administration of Incoming Foreign and Local Commodities
 2. Centers for Health Development
 - a. General Management and Supervision
 - A.1.a.2. Regional Offices
 1. Center for Health Development for Metro Manila
 - A.1.a.2.a.1. National Capital Region
 2. Center for Health Development for Ilocos
 - A.1.a.2.a.2. Region I
 3. Center for Health Development for Cordillera
 - A.1.a.2.a.3. Cordillera Administrative Region
 4. Center for Health Development for Cagayan Valley
 - A.1.a.2.a.4. Region II
 5. Center for Health Development for Central Luzon
 - A.1.a.2.a.5. Region III
 6. Center for Health Development for Southern Tagalog
 - A.1.a.2.a.6. Region IV
 7. Center for Health Development for Bicol
 - A.1.a.2.a.7. Region V
 8. Center for Health Development for Western Visayas
 - A.1.a.2.a.8. Region VI
 9. Center for Health Development for Central Visayas
 - A.1.a.2.a.9. Region VII
 10. Center for Health Development for Eastern Visayas
 - A.1.a.2.a.10. Region VIII
 11. Center for Health Development for Western Mindanao
 - A.1.a.2.a.11. Region IX
 12. Center for Health Development for Northern Mindanao
 - A.1.a.2.a.12. Region X
 13. Center for Health Development for Southern Mindanao
 - A.1.a.2.a.13. Region XI
 14. Center for Health Development for Central Mindanao
 - A.1.a.2.a.14. Region XII

Annex 12
DOH Budget Item Classification Under Re-engineering

OFFICE/SERVICE/PROGRAM

- 15. Center for Health Development for Caraga
- A.1.a.2.a.15. Caraga Region

II. SUPPORT TO OPERATIONS

A. Cental Office

- 1. Health Policy, Planning and Research
 - a. Health Policy Development and Planning
 - A.II.a.1.a. National Health Planning and Program Development
 - A.II.a.1.b. Policy Development Program
 - b. Essential National Health Research
 - A.II.a.2. Essential National Health Research
- 2. Health Information Systems and Technology Development
 - A.II.a.3. Health Information Technology and Systems Development
- 3. Health Human Resource Development
 - A.II.a.4.a. Health Human Resource Development
- 4. Health Emergency Management
 - a. Health Emergency Preparedness and Response (including Poison Control)
 - A.II.b.3. Health Emergency Preparedness and Response Program
 - b. Provision of Drugs and Medicines, Medical and Dental Supplies
 - New PPA

B. Centers for Health Development

- 1. Support to Internal and Sectoral Planning, Human Resource Development, including Operations of Collaborating Centers
 - A.II.b.1. Advisory to the Local Health Management and Development and Support to Local Health Board
 - a. Center for Health Development for Metro Manila
 - A.II.b.1.a. National Capital Region
 - b. Center for Health Development for Ilocos
 - A.II.b.1.b. Region I
 - c. Center for Health Development for Cordillera
 - A.II.b.1.c. Cordillera Administrative Region
 - d. Center for Health Development for Cagayan Valley
 - A.II.b.1.d. Region II
 - e. Center for Health Development for Central Luzon
 - A.II.b.1.e. Region III
 - f. Center for Health Development for Southern Tagalog
 - A.II.b.1.f. Region IV

Annex 12
DOH Budget Item Classification Under Re-engineering

OFFICE/SERVICE/PROGRAM	
g. Center for Health Development for Bicol	
A.II.b.1.g. Region V	
h. Center for Health Development for Western Visayas	
A.II.b.1.h. Region VI	
i. Center for Health Development for Central Visayas	
A.II.b.1.i. Region VII	
j. Center for Health Development for Eastern Visayas	
A.II.b.1.j. Region VIII	
k. Center for Health Development for Western Mindanao	
A.II.b.1.k. Region IX	
l. Center for Health Development for Northern Mindanao	
A.II.b.1.l. Region X	
m. Center for Health Development for Southern Mindanao	
A.II.b.1.m. Region XI	
n. Center for Health Development for Central Mindanao	
A.II.b.1.n. Region XII	
o. Center for Health Development for Caraga	
A.II.b.1.o. Caraga Region	
III. OPERATIONS	
A. Health Regulation	
1. Regulation of Food and Drugs including National Pharmaceutical Policy, Food Fortification and Salt Iodization	
A.III.a.1.a. Food and Drugs Standards and Regulation including Salt Iodization	
A.III.a.1.b. National Pharmaceutical Policy	
2. Regulation of Health Facilities and Services	
A.III.a.3. Health Facility Standards, Licensing and Regulation	
A.III.a.4. Laboratory Licensing and Regulation	
A.III.a.6. Environmental and Occupational Health	
3. Regulation of Health Devices and Technology	
A.III.a.5. Radiation Standards and Regulation	
A.III.a.6. Environmental and Occupational Health	
B. External Affairs	
1. Quarantine Services and International Health Surveillance	
A.III.a.2. Quarantine Services Regulation	
2. International Health Cooperation	
A.I.a.1.a. (Under General Management and Supervision)	
3. Local Health Systems Development	

Annex 12
DOH Budget Item Classification Under Re-engineering

OFFICE/SERVICE/PROGRAM	
<ul style="list-style-type: none"> a. Local Health Systems and Local Health Financing Development Program <ul style="list-style-type: none"> A.II.a.6.b. Primary Health and Community Care Service A.II.a.6.c. Local Government Assistance and Monitoring Service b. Health Human Resource Deployment Program <ul style="list-style-type: none"> 1. Provision for a pool of 60 resident physicians <ul style="list-style-type: none"> A.II.a.6.a.1. Provision for a pool of 60 resident physician 2. Provision for a pool of 136 MS II (Part-time) and 10 MS II (Full time) <ul style="list-style-type: none"> A.II.a.6.a.2. Provision for a pool of 136 MS II (Part-time) and 10 MS II (Full-time) 3. Doctors to the Barrios and Rural Health Practice Program <ul style="list-style-type: none"> A.II.a.6.a.3. Doctors to the Barrios Program A.II.a.4.a. (under Health Human Resource Development) c. Quality Improvement Program for Government Health Facilities New PPA 	
C. Health Operations	
<ul style="list-style-type: none"> 1. Epidemiology Disease Surviellance and Laboratory Network <ul style="list-style-type: none"> A.II.a.5.a. Field Epidemiology Training Program A.II.a.5.b. National Reference Laboratories for Disease Control A.III.a.4. Laboratory Licensing and Regulation 2. Disease Prevention and Control <ul style="list-style-type: none"> a. Formulation of Health Policies and Support Mechanisms for Disease Prevention and Control <ul style="list-style-type: none"> A.III.c.1. Formulation of Health Policies and Provision of Assistance and Support Mechanisms for the Implementation of Disease Prevention and Control Programs b. Tuberculosis Prevention and Control Program <ul style="list-style-type: none"> 1. Tuberculosis Control Program <ul style="list-style-type: none"> A.III.c.1.a. Infectious Diseases Prevention and Control Programs including Tuberculosis, Reproductive Tract Infections/STD/AIDS (with P20 million assistance for PNAC actiivities), Dengue, Leprosy. Expanded Program on Immunization and Other Programs Addressing Reemerging Infectious Diseases. 2. Assistance to Philippine Tuberculosis Society (PTS) <ul style="list-style-type: none"> A.III.c.1.a. Infectious Diseases Prevention and Control Programs including Tuberculosis, Reproductive Tract Infections/STD/AIDS (with P20 million assistance for PNAC activities), Dengue, Leprosy, Expanded Program on Immunization and Other Programs Addressing Reemerging Infectious Diseases. 	

Annex 12
DOH Budget Item Classification Under Re-engineering

OFFICE/SERVICE/PROGRAM	
c.	Malaria Prevention and Control Program
A.III.c.1.a.	Infectious Diseases Prevention and Control Programs including Tuberculosis, Reproductive Tract Infections/STD/AIDS (with 20 million assistance for PNAC activities), Dengue, Leprosy, Expanded Program on Immunization and Other Programs Addressing Reemerging Infectious Diseases.
e.	Vaccine-Preventable Disease Control Program
1.	Expanded Program on Immunization
A.III.c.1.a.	Infectious Diseases Prevention and Control Programs including Tuberculosis, Reproductive Tract Infections/STD/AIDS (with 20 million assistance for PNAC activities), Dengue, Leprosy, Expanded Program on Immunization and Other Programs Addressing Reemerging Infectious Diseases.
2.	Vaccine Self-Sufficiency Program
A.III.c.1.c.	Vaccine Self-Sufficiency Program
f.	Programs Addressing Emerging and Re-emerging Infectious Diseases (including Dengue, Leprosy, Filariasis, Rabies, Food and Water-Borne Diseases. Soil Transmitted Helminthiasis, Acute Respiratory Infections, CDD, STD/AIDS and other Reproductive Tract Infections, Dental Diseases and Other Infectious Diseases)
A.III.c.1.a.	Infectious Diseases Prevention and Control Programs including Tuberculosis, Reproductive Tract Infections/STD/AIDS (with 20 million assistance for PNAC activities), Dengue, Leprosy, Expanded Program on Immunization and Other Programs Addressing Reemerging Infectious Diseases.
g.	Operation of the Philippine National AIDS Council (PNAC) including its Secretariat
A.III.c.1.a.	Infectious Diseases Prevention and Control Programs including Tuberculosis, Reproductive Tract Infections/STD/AIDS (with 20 million assistance for PNAC activities), Dengue, Leprosy, Expanded Program on Immunization and Other Programs Addressing Reemerging Infectious Diseases.
h.	Degenerative Diseases Prevention and Control Programs (including Cardiovascular Diseases, Cancer, Diabetes, Asthma, Kidney Diseases)
A.III.c.1.b.	Degenerative Diseases Prevention and Control Programs including Cardiovascular, Cancer, Asthma, Diabetes and other Programs Addressing Reemerging Degenerative Diseases.
i.	Family Health and Primary Health Care Programs
A.III.c.3.	Family Health and Primary Care Program
j.	Environmental and Occupational Health Programs (including Operations of the Inter-Agency Committee on Environmental Health)
A.III.a.6.	Environmental and Occupational Health Program
3.	Health Promotion
A.II.a.4.b.	National Health Campaigns

Annex 12
DOH Budget Item Classification Under Re-engineering

OFFICE/SERVICE/PROGRAM	
4.	Health Facility Planning, Operation and Infrastructure Development
A.III.b.1.	Hospital and Facilities Management and Development Program
5.	National Voluntary Blood Services Program
A.III.b.2.	National Voluntary Blood Services Program
6.	Operation of Special Hospitals, Medical Centers and Institutes for Disease Prevention and Control
A.III.c.2.	Centers for Infectious and Degenerative Diseases and Other Health Concerns
a.	Jose Reyes Memorial Medical Center
A.III.c.2.a.	Jose Reyes Memorial Medical Center
b.	Rizal Medical Center
A.III.c.2.b.	Rizal Medical Center
c.	East Avenue Medical Center
A.III.c.2.c.	East Avenue Medical Center
d.	Quirino Memorial Medical Center
A.III.c.2.d.	Quirino Memorial Medical Center
e.	Tondo Medical Center
A.III.c.2.e.	Tondo Medical Center
f.	Jose Fabella Memorial Hospital
A.III.c.2.f.	Jose Fabella Memorial Hospital
g.	National Children's Hospital
A.III.c.2.g.	National Children's Hospital
h.	National Center for Mental Health
A.III.c.2.h.	National Center for Mental Health
I.	Philippine Orthopedic Center
A.III.c.2.i.	Philippine Orthopedic Center
j.	San Lázaro Hospital
A.III.c.2.j.	San Lázaro Hospital
k.	Research Institute for Tropical Medicine
A.III.c.2.k.	Research Institute for Tropical Medicine
I.	"Amang" Rodríguez Medical Center
A.III.c.2.I.	"Amang" Rodríguez Medical Center
D.	Health Care Assistance
1.	Assistance to Indigent Patients for Confinement in Specialty Hospitals and use of specialized equipment, etc. not available in government hospitals (including Philippine Heart Center, National Kidney and Transplant Institute, Lung Center of the Philippines, and Philippine Children's Medical Center)
A.III.c.4.	Subsidy to Indigent Patients Confinement in the four (4) Specialty Hospital

Annex 12
DOH Budget Item Classification Under Re-engineering

OFFICE/SERVICE/PROGRAM	
2.	National Government Assistance for Indigent Households for Social Insurance A.III.c.5. Subsidy to Indigent Patients in Various Government Hospitals
E.	Operation of Centers for Health Development A.III.d. Regional Operations
1.	Center for Health Development for Metro Manila A.III.d.1. National Capital Region
a.	Health Regulations, Standards and Licensing A.III.d.1.a. Enforcement and Implementation of Public Health Standards, Hospital Licensing and Food and Drug Laws.
b.	Health Operations including TB Operations and Disease Prevention and Control, Health Promotion and Other Health Operations A.III.d.1.b. Promotions, Assistance and Monitoring for Priority Health Thrust
c.	Local Health Assistance including Local Health Systems Development, Provision of Logistic Support to Local Health Programs and Assistance Funds to Support Quality Assurance in LGUs A.III.d.1.c. Support to Local Public Health Systems/Inter-LGU Collaboration and Cooperation
d.	Support for Social Health Insurance & Other Community Health Care Financing Initiatives A.III.d.1.e. Subsidy to Indigent Patients for Confinement in Private Hospitals
e.	Health Facilities - Direct Service Delivery A.III.d.1.e.1. Health Facilities - Direct Service Delivery
1.	Valenzuela General Hospital A.III.d.1.e.1. Valenzuela General Hospital, Secondary (A-100), Valenzuela, Metro Manila
2.	Las Piñas District Hospital A.III.d.1.e.2. Las Piñas District Hospital, Secondary (A-50), Las Piñas, Metro Manila
3.	Taguig-Pateros District Hospital A.III.d.1.e.3. Taguig-Pateros District Hospital
4.	San Lorenzo Ruiz Special Hospital for Women A.III.d.1.e.4. San Lorenzo Ruiz Special Hospital for Women
2.	Center for Health Development for Ilocos A.III.d.2. Region I
a.	Health Regulations, Standards and Licensing A.III.d.2.a. Enforcement and Implementation of Public Health Standards, Hospital Licensing and Food and Drug Laws.

Annex 12
DOH Budget Item Classification Under Re-engineering

OFFICE/SERVICE/PROGRAM	
<ul style="list-style-type: none"> b. Health Operations including TB Operations and Disease Prevention and Control, Health Promotion and Other Health Operations <ul style="list-style-type: none"> A.III.d.2.b. Promotions, Assistance and Monitoring for Priority Health Thrust c. Local Health Assistance including Local Health Systems Development, Provision of Logistic Support to Local Health Programs and Assistance Funds to Support Quality Assurance in LGUs <ul style="list-style-type: none"> A.III.d.2.c. Support to Local Public Health Systems/Inter-LGU Collaboration and Cooperation d. Support for Social Health Insurance and Other Community Health Care Financing Initiatives <ul style="list-style-type: none"> A.III.d.2.d. Subsidy to Indigent Patients for Confinement in Private Hospitals e. Health Facilities - Direct Service Delivery <ul style="list-style-type: none"> A.III.d.2.e. Health Facilities - Direct Service Delivery <ul style="list-style-type: none"> 1. Mariano Marcos Memorial Hospitals and Medical Center <ul style="list-style-type: none"> A.III.d.2.e.1. Mariano Marcos Memorial Hospitals and Medical Center, Tertiary-Medical Center (A-200), Batac, Ilocos Norte 2. Region I Medical Center <ul style="list-style-type: none"> A.III.d.2.e.2. Region I Medical Center, Tertiary-Medical Center (A-300), Dagupan City 3. Ilocos Training and Regional Medical Center <ul style="list-style-type: none"> A.III.d.2.e.3. Ilocos Training and Regional Medical Center, Tertiary-Regional (A-200), San Fernando, La Union 	
3. Center for Health Development for Cordillera	A.III.d.3. CAR
<ul style="list-style-type: none"> a. Health Regulations, Standards and Licensing <ul style="list-style-type: none"> A.III.d.3.a. Enforcement and Implementation of Public Health Standards, Hospital Licensing and Food and Drug Laws. b. Health Operations including TB Operations and Disease Prevention and Control, Health Promotion and Other Health Operations <ul style="list-style-type: none"> A.III.d.3.b. Promotions, Assistance and Monitoring for Priority Health Thrust c. Local Health Assistance including Local Health Systems Development, Provision of Logistic Support to Local Health Programs and Assistance Funds to Support Quality Assurance in LGUs <ul style="list-style-type: none"> A.III.d.3.c. Support to Local Public Health Systems/Inter-LGU Collaboration and Cooperation d. Support for Social Health Insurance and Other Community Health Care Financing Initiatives <ul style="list-style-type: none"> A.III.d.3.d. Subsidy to Indigent Patients for Confinement in Private Hospitals e. Health Facilities - Direct Service Delivery <ul style="list-style-type: none"> A.III.d.3.e. Health Facilities - Direct Service Delivery 	

Annex 12
DOH Budget Item Classification Under Re-engineering

OFFICE/SERVICE/PROGRAM	
1. Baguio General Hospital and Medical Center	
A.III.d.3.e.1.	Baguio General Hospital and Medical Center, Tertiary-Medical (A-400), Baguio City
2. Luis Hora Memorial Regional Hospital	
A.III.d.3.e.2.	Luis Hora Memorial Regional Hospital, Tertiary Regional (A-100), Bauko, Mountain Province
3. Conner District Hospital	
A.III.d.3.e.3.	Conner District Hospital, Conner, Apayao Province
4. Far North Luzon General and Training Hospital	
A.III.d.3.e.4.	Far North Luzon General and Training Center (A-100), Luna, Apayao Province
4. Center for Health Development for Cagayan Valley	
A.III.d.4.	Region II
a. Health Regulations, Standards and Licensing	
A.III.d.4.a.	Enforcement and Implementation of Public Health Standards, Hospital Licensing and Food and Drug Laws.
b. Health Operations including TB Operations and Disease Prevention and Control, Health Promotion and Other Health Operations	
A.III.d.4.b.	Promotions, Assistance and Monitoring for Priority Health Thrust
c. Local Health Assistance including Local Health Systems Development, Provision of Logistic Support to Local Health Programs and Assistance Funds to Support Quality Assurance in LGUs	
A.III.d.4.c.	Support to Local Public Health Systems/Inter-LGU Collaboration and Cooperation
d. Support for Social Health Insurance and Other Community Health Care Financing Initiatives	
A.III.d.4.d.	Subsidy to Indigent Patients for Confinement in Private Hospitals
e. Health Facilities - Direct Service Delivery	
A.III.d.4.e.	Health Facilities - Direct Service Delivery
1. Cagayan Valley Medical Center	
A.III.d.4.e.1.	Cagayan Valley Medical Center, Tertiary-Medical Center (A-400), Tuguegarao, Cagayan
2. Veterans Regional Hospital	
A.III.d.4.e.2.	Veterans Regional Hospital, Tertiary-Regional (A-200), Bayombong, Nueva Viscaya
3. Southern Isabela General Hospital	
A.III.d.4.e.3.	Southern Isabela General Hospital, Tertiary (A-25), Santiago City, Isabela
4. Batanes General Hospital	
A.III.d.4.e.4.	Batanes General Hospital, Tertiary (A-75), Basco, Batanes

Annex 12
DOH Budget Item Classification Under Re-engineering

OFFICE/SERVICE/PROGRAM	
5.	Center for Health Development for Central Luzon
A.III.d.5.	Region III
a.	Health Regulations, Standards and Licensing
A.III.d.5.a.	Enforcement and Implementation of Public Health Standards, Hospital Licensing and Food and Drug Laws.
b.	Health Operations including TB Operations and Disease Prevention and Control, Health Promotion and Other Health Operations
A.III.d.5.b.	Promotions, Assistance and Monitoring for Priority Health Thrust
c.	Local Health Assistance including Local Health Systems Development, Provision of Logistic Support to Local Health Programs and Assistance Funds to Support Quality Assurance in LGUs
A.III.d.5.c.	Support to Local Public Health Systems/Inter-LGU Collaboration and Cooperation
d.	Support for Social Health Insurance and Other Community Health Care Financing Initiatives
A.III.d.5.d.	Subsidy to Indigent Patients for Confinement in Private Hospitals
e.	Health Facilities - Direct Service Delivery
A.III.d.5.e.	Health Facilities - Direct Service Delivery
1.	Dr. Paulino J. Garcia Memorial Research and Medical Center
A.III.d.5.e.1.	Dr. Paulino J. Garcia Memorial Research and Medical Center, Tertiary-Medical Center (A-400), Cabanatuan city
2.	Talavera Extension Hospital
A.III.d.5.e.2.	Talavera Extension Hospital, Secondary (A-10), Talavera, Nueva Ecija
3.	Jose B. Lingad Memorial General Hospital
A.III.d.5.e.3.	Jose B. Lingad Memorial General Hospital, Tertiary-Regional (A-250), San Fernando, Pampanga
4.	Mariveles Mental Hospital
A.III.d.5.e.4.	Mariveles Mental Ward (A-500), Mariveles, Bataan
5.	Bataan General Hospital
A.III.d.5.e.5.	Bataan Provincial Hospital Tertiary (A-300), Balanga, Bataan
6.	Center for Health Development for Souther Tagalog
A.III.d.6.	Region IV
a.	Health Regulations, Standards and Licensing
A.III.d.6.a.	Enforcement and Implementation of Public Health Standards, Hospital Licensing and Food and Drug Laws.
b.	Health Operations including TB Operations and Disease Prevention and Control, Health Promotion and Other Health Operations
A.III.d.6.b.	Promotions, Assistance and Monitoring for Priority Health Thrust

Annex 12
DOH Budget Item Classification Under Re-engineering

OFFICE/SERVICE/PROGRAM	
<ul style="list-style-type: none"> c. Local Health Assistance including Local Health Systems Development, Provision of Logistic Support to Local Health Programs and Assistance Funds to Support Quality Assurance in LGUs <ul style="list-style-type: none"> A.III.d.6.c. Support to Local Public Health Systems/Inter-LGU Collaboration and Cooperation d. Support for Social Health Insurance and Other Community Health Care Financing Initiatives <ul style="list-style-type: none"> A.III.d.6.d. Subsidy to Indigent Patients for Confinement in Private Hospitals e. Health Facilities - Direct Service Delivery <ul style="list-style-type: none"> A.III.d.6.e. Health Facilities - Direct Service Delivery <ul style="list-style-type: none"> 1. Batangas Regional Hospital <ul style="list-style-type: none"> A.III.d.6.e.1. Batangas Regional Hospital, Tertiary-Regional (A-250), Batangas City 2. Dr. Jose N. Rodriguez Memorial Hospital <ul style="list-style-type: none"> A.III.d.6.e.2. Dr. Jose N. Rodriguez Memorial Hospital, Sanitaria (A-2000), Tala, Caloocan City 3. Culion Sanitarium and Balala Hospital <ul style="list-style-type: none"> A.III.d.6.e.3. Culion Sanitarium and Balala Hospital, Sanitaria (A-600), Culion, Palawan 4. Ospital ng Palawan <ul style="list-style-type: none"> A.III.d.6.e.4. Ospital ng Palawan, Tertiary (A-50), Puerto Princesa City, Palawan 	
7. Center for Health Development for Bicol	A.III.d.7. Region V
<ul style="list-style-type: none"> a. Health Regulations, Standards and Licensing <ul style="list-style-type: none"> A.III.d.7.a. Enforcement and Implementation of Public Health Standards, Hospital Licensing and Food and Drug Laws. b. Health Operations including TB Operations and Disease Prevention and Control, Health Promotion and Other Health Operations <ul style="list-style-type: none"> A.III.d.7.b. Promotions, Assistance and Monitoring for Priority Health Thrust c. Local Health Assistance including Local Health Systems Development, Provision of Logistic Support to Local Health Programs and Assistance Funds to Support Quality Assurance in LGUs <ul style="list-style-type: none"> A.III.d.7.c. Support to Local Public Health Systems/Inter-LGU Collaboration and Cooperation d. Support for Social Health Insurance and Other Community Health Care Financing Initiatives <ul style="list-style-type: none"> A.III.d.7.d. Subsidy to Indigent Patients for Confinement in Private Hospitals e. Health Facilities - Direct Service Delivery <ul style="list-style-type: none"> A.III.d.7.e. Health Facilities - Direct Service Delivery 	

Annex 12
DOH Budget Item Classification Under Re-engineering

OFFICE/SERVICE/PROGRAM	
1. Bicol Medical Center	
A.III.d.7.e.1.	Bicol Medical Center, Tertiary-Medical Center (A-300), Naga City
2. Bicol Regional Training and Teaching Hospital	
A.III.d.7.e.2.	Bicol Regional Training and Teaching Hospital, Tertiary-Regional (A-250), Legaspi City
3. Bicol Sanitarium	
A.III.d.7.e.3.	Bicol Sanitarium, Sanitaria (A-200), Cabusao, Camarines Sur
8. Center for Health Development for Western Visayas	
A.III.d.8.	Region VI
a. Health Regulations, Standards and Licensing	
A.III.d.8.a.	Enforcement and Implementation of Public Health Standards, Hospital Licensing and Food and Drug Laws.
b. Health Operations including TB Operations and Disease Prevention and Control, Health Promotion and Other Health Operations	
A.III.d.8.b.	Promotions, Assistance and Monitoring for Priority Health Thrust
c. Local Health Assistance including Local Health Systems Development, Provision of Logistic Support to Local Health Programs and Assistance Funds to Support Quality Assurance in LGUs	
A.III.d.8.c.	Support to Local Public Health Systems/Inter-LGU Collaboration and Cooperation
d. Support for Social Health Insurance and Other Community Health Care Financing Initiatives	
A.III.d.8.d.	Subsidy to Indigent Patients for Confinement in Private Hospitals
e. Health Facilities - Direct Service Delivery	
A.III.d.8.e.	Health Facilities - Direct Service Delivery
1. Western Visayas Medical Center	
A.III.d.8.e.1.	Western Visayas Medical Center, Tertiary-Medical Center (A-400), Iloilo City
2. Western Visayas Regional Hospital	
A.III.d.8.e.2.	Western Visayas Regional Hospital, Tertiary-Regional (A-400), Bacolod City
3. Western Visayas Sanitarium	
A.III.d.8.e.3.	Western Visayas Sanitarium, Sanitaria (A-300), Sta. Barbara, Iloilo
4. Don Jose S. Monfort Memorial Medical Center Extension Hospital	
A.III.d.8.e.4.	Don Jose S. Monfort Memorial Medical Center Extension Hospital, Tertiary-Medical Center (A-10), Barotac Nuevo, Iloilo
9. Center for Health Development for Central Visayas	
A.III.d.9.	Region VII

Annex 12
DOH Budget Item Classification Under Re-engineering

OFFICE/SERVICE/PROGRAM	
a. Health Regulations, Standards and Licensing	
A.III.d.9.a.	Enforcement and Implementation of Public Health Standards, Hospital Licensing and Food and Drug Laws.
b. Health Operations including TB Operations and Disease Prevention and Control, Health Promotion and Other Health Operations	
A.III.d.9.b.	Promotions, Assistance and Monitoring for Priority Health Thrust
c. Local Health Assistance including Local Health Systems Development, Provision of Logistic Support to Local Health Programs and Assistance Funds to Support Quality Assurance in LGUs	
A.III.d.9.c.	Support to Local Public Health Systems/Inter-LGU Collaboration and Cooperation
d. Support for Social Health Insurance and Other Community Health Care Financing Initiatives	
A.III.d.9.d.	Subsidy to Indigent Patients for Confinement in Private Hospitals
e. Health Facilities - Direct Service Delivery	
A.III.d.9.e.	Health Facilities - Direct Service Delivery
1. Vicente Sotto Sr. Memorial Medical Center	
A.III.d.9.e.1.	Vicente Sotto Sr. Memorial Medical Center, Tertiary-Medical Center (A-400), Cebu City
2. Gov. Celestino Gallares Memorial Hospital	
A.III.d.9.e.2.	Gov. Celestino Gallares Memorial Hospital, Tertiary-Regional (A-225), Tagbilaran City
3. St. Anthony Mother and Child Hospital	
A.III.d.9.e.3.	St. Anthony Mother and Child Hospital, Secondary (A-25), Cebu City
4. Eversley Childs Sanitarium	
A.III.d.9.e.4.	Eversley Childs Sanitarium, Sanitaria (A-500), Mandaue City
5. Talisay District Hospital	
A.III.d.9.e.5.	Talisay District Hospital, (A-25), Talisay, Cebu
6. Don Emilio del Valle Memorial Hospital, (A-50), Ubay, Bohol	
7. BFAD Satellite Laboratory	
New PPA	
10. Center for Health Development for Eastern Visayas	
A.III.10.	Region VIII
a. Health Regulations, Standards and Licensing	
A.III.d.10.a.	Enforcement and Implementation of Public Health Standards, Hospital Licensing and Food and Drug Laws.
b. Health Operations including TB Operations and Disease Prevention and Control Health Promotion and Other Health Operations	
A.III.d.10.b.	Promotions, Assistance and Monitoring for Priority Health Thrust

Annex 12
DOH Budget Item Classification Under Re-engineering

OFFICE/SERVICE/PROGRAM	
<ul style="list-style-type: none"> c. Local Health Assistance including Local Health Systems Development, Provision of Logistic Support to Local Health Programs and Assistance Funds to Support Quality Assurance in LGUs <ul style="list-style-type: none"> A.III.d.10.c. Support to Local Public Health Systems/Inter-LGU Collaboration and Cooperation d. Support for Social Health Insurance and Other Community Health Care Financing Initiatives <ul style="list-style-type: none"> A.III.d.10.d. Subsidy to Indigent Patients for Confinement in Private Hospitals e. Health Facilities - Direct Service Delivery <ul style="list-style-type: none"> A.III.d.10.e. Health Facilities - Direct Service Delivery 	
<ul style="list-style-type: none"> 1. Eastern Visayas Regional Medical Center <ul style="list-style-type: none"> A.III.d.10.e.1. Eastern Visayas Regional Medical Center, Tertiary-Medical Center (A-250), Zamboanga City 2. Schistosomiasis Control and Research Hospital <ul style="list-style-type: none"> A.III.d.10.e.2. Schistosomiasis Hospital, Secondary-Medical Center (A-25), Palo, Leyte 	
<ul style="list-style-type: none"> 11. Center for Health Development for Western Mindanao <ul style="list-style-type: none"> A.III.d.11. Region IX 	
<ul style="list-style-type: none"> a. Health Regulations, Standards and Licensing <ul style="list-style-type: none"> A.III.d.11.a. Enforcement and Implementation of Public Health Standards, Hospital Licensing and Food and Drug Laws. b. Health Operations including TB Operations and Disease Prevention and Control Health Promotion and Other Health Operations <ul style="list-style-type: none"> A.III.d.11.b. Promotions, Assistance and Monitoring for Priority Health Thrust c. Local Health Assistance including Local Health Systems Development, Provision of Logistic Support to Local Health Programs and Assistance Funds to Support Quality Assurance in LGUs <ul style="list-style-type: none"> A.III.d.11.c. Support to Local Public Health Systems/Inter-LGU Collaboration and Cooperation d. Support for Social Health Insurance and Other Community Health Care Financing Initiatives <ul style="list-style-type: none"> A.III.d.11.d. Subsidy to Indigent Patients for Confinement in Private Hospitals e. Health Facilities - Direct Service Delivery <ul style="list-style-type: none"> A.III.d.11.e. Health Facilities - Direct Service Delivery 	
<ul style="list-style-type: none"> 1. Zamboanga City Medical Center <ul style="list-style-type: none"> A.III.d.11.e.1 Zamboanga City Medical Center, Tertiary-Medical Center (A-250), Zamboanga City 2. Mindanao Central Sanitarium <ul style="list-style-type: none"> A.III.d.11.e.2. Mindanao Central Sanitarium, Sanitaria, (A-450), Pasalobong, Zamboanga City 	

Annex 12
DOH Budget Item Classification Under Re-engineering

OFFICE/SERVICE/PROGRAM	
3. Sulu Sanitarium	A.III.d.11.e.3. Sulu Sanitarium, Sanitaria (A-130), San Raymundo, Jolo, Sulu
4. Labuan Public Hospital	A.III.d.11.e.4. Labuan Public Hospital (A-10), Labuan, Zamboanga City
5. Basilan Provincial Hospital	A.III.d.11.e.5. Basilan Provincial Hospital, Tertiary (A-25), Isabela, Basilan
6. Dr. Jose Rizal Memorial Hospital	A.III.d.11.e.6. Dr. Jose Rizal Memorial Hospital, Tertiary (A-75), Dapitan City, Zamboanga City
7. Margosatubig Regional Hospital	A.III.d.11.e.7. Margosatubig Regional Hospital, Tertiary-Regional (A-50), Margosatubig, Zamboanga City
8. Provision for maintenance of two floating clinics	A.III.d.11.e.8. Provision for maintenance of floating clinic
12. Center for Health Development for Northern Mindanao	A.III.d.12. Region X
a. Health Regulations, Standards and Licensing	A.III.d.12.a. Enforcement and Implementation of Public Health Standards, Hospital Licensing and Food and Drug Laws.
b. Health Operations including TB Operations and Disease Prevention and Control Health Promotion and Other Health Operations	A.III.d.12.b. Promotions, Assistance and Monitoring for Priority Health Thrust
c. Local Health Assistance including Local Health Systems Development, Provision of Logistic Support to Local Health Programs and Assistance Funds to Support Quality Assurance in LGUs	A.III.d.12.c. Support to Local Public Health Systems/Inter-LGU Collaboration and Cooperation
d. Support for Social Health Insurance and Other Community Health Care Financing Initiatives	A.III.d.12.d. Subsidy to Indigent Patients for Confinement in Private Hospitals
e. Health Facilities - Direct Service Delivery	A.III.d.12.e. Health Facilities - Direct Service Delivery
1. Northern Mindanao Medical Center	A.III.d.12.e.1. Northern Mindanao Medical Center, Tertiary-Medical Center (A-3000), Cagayan de Oro
2. Mayor Hilarion A. Ramiro Sr. Regional Training and Teaching Hospital	A.III.d.12.e.2. Mayor Hilarion A. Ramiro, Sr. Regional Training and Teaching Hospital, Tertiary-Regional (A-150), Ozamis City
3. Camiguin General Hospital	A.III.d.12.e.3. Camiguin General Hospital, Tertiary (A-100), Mambajao, Camiguin

Annex 12
DOH Budget Item Classification Under Re-engineering

OFFICE/SERVICE/PROGRAM	
13. Center for Health Development for Southern Mindanao	
A.III.d.13.a. Region XI	
a. Health Regulations, Standards and Licensing	
A.III.d.13.a. Enforcement and Implementation of Public Health Standards, Hospital Licensing and Food and Drug Laws.	
b. Health Operations including TB Operations and Disease Prevention and Control Health Promotion and Other Health Operations	
A.III.d.13.b. Promotions, Assistance and Monitoring for Priority Health Thrust	
c. Local Health Assistance including Local Health Systems Development, Provision of Logistic Support to Local Health Programs and Assistance Funds to Support Quality Assurance in LGUs	
A.III.d.13.c. Support to Local Public Health Systems/Inter-LGU Collaboration and Cooperation	
d. Support for Social Health Insurance and Other Community Health Care Financing Initiatives	
A.III.d.13.d. Subsidy to Indigent Patients for Confinement in Private Hospitals	
e. Health Facilities - Direct Service Delivery	
A.III.d.13.e. Health Facilities - Direct Service Delivery	
1. Davao Medical Center	
A.III.d.13.e.1. Davao Medical Center, Tertiary-Medical Center (A-600), Davao City	
2. Davao Regional Hospital	
A.III.d.13.e.2. Davao Regional Hospital, Tertiary-Regional (A-200), Tagum, Davao del Norte	
3. BFAD Satellite Laboratory	
New PPA	
14. Center for Health Development for Central Mindao	
A.III.d.14. Region XII	
a. Health Regulations, Standards and Licensing	
A.III.d.14.a. Enforcement and Implementation of Public Health Standards, Hospital Licensing and Food and Drug Laws.	
b. Health Operations including TB Operations and Disease Prevention and Control Health Promotion and Other Health Operations	
A.III.d.14.b. Promotions, Assistance and Monitoring for Priority Health Thrust	
c. Local Health Assistance including Local Health Systems Development, Provision of Logistic Support to Local Health Programs and Assistance Funds to Support Quality Assurance in LGUs	
A.III.d.14.c. Support to Local Public Health Systems/Inter-LGU Collaboration and Cooperation	
d. Support for Social Health Insurance and Other Community Health Care Financing Initiatives	
A.III.d.14.d. Subsidy to Indigent Patients for Confinement in Private Hospitals	

Annex 12
DOH Budget Item Classification Under Re-engineering

OFFICE/SERVICE/PROGRAM	
<ul style="list-style-type: none"> e. Health Facilities - Direct Service Delivery <ul style="list-style-type: none"> A.III.d.14.e. Health Facilities - Direct Service Delivery <ul style="list-style-type: none"> 1. Amai Pakpak Medical Center <ul style="list-style-type: none"> A.III.d.14.e.1. Amai Pakpak Medical Center, Tertiary-Medical Center (A-200), Marawi City, Lanao del Sur 2. Cotabato Regional and Medical Center <ul style="list-style-type: none"> A.III.d.14.e.2. Cotabato Regional and Medical Center, Tertiary-Medical Center, (A-400), Cotabato City 3. Cotabato Sanitarium <ul style="list-style-type: none"> A.III.d.14.e.3. Cotabato Sanitarium, Sanitaria (A-250), Cotabato City 15. Center for Health Development for Caraga <ul style="list-style-type: none"> A.III.d.15. Caraga Region <ul style="list-style-type: none"> a. Health Regulations, Standards and Licensing <ul style="list-style-type: none"> A.III.d.15.a. Enforcement and Implementation of Public Health Standards, Hospital Licensing and Food and Drug Laws. b. Health Operations including TB Operations and Disease Prevention and Control Health Promotion and Other Health Operations <ul style="list-style-type: none"> A.III.d.15.b. Promotions, Assistance and Monitoring for Priority Health Thrust c. Local Health Assistance including Local Health Systems Development, Provision of Logistic Support to Local Health Programs and Assistance Funds to Support Quality Assurance in LGUs <ul style="list-style-type: none"> A.III.d.15.c. Support to Local Public Health Systems/Inter-LGU Collaboration and Cooperation d. Support for Social Health Insurance and Other Community Health Care Financing Initiatives <ul style="list-style-type: none"> A.III.d.15.d. Subsidy to Indigent Patients for Confinement in Private Hospitals e. Health Facilities - Direct Service Delivery <ul style="list-style-type: none"> A.III.d.15.e. Health Facilities - Direct Service Delivery <ul style="list-style-type: none"> 1. Caraga Regional Hospital <ul style="list-style-type: none"> A.III.d.15.e.1. Caraga Regional Hospital, Tertiary-Regional (A-150), Surigao City 2. Adela Serra Ty Memorial Medical Center <ul style="list-style-type: none"> A.III.d.15.e.2. Adela Serra Ty Memorial Medical Center, (A-100), Tandang Surigao del Sur 	
B. PROJECTS	
<ul style="list-style-type: none"> I. Locally Funded Projects <ul style="list-style-type: none"> a. Strengthening of Standards, Licensing and Regulations <ul style="list-style-type: none"> 1. Upgrading of pharmaceutical public health facilities 	

Annex 12
DOH Budget Item Classification Under Re-engineering

OFFICE/SERVICE/PROGRAM
II. Foreign Assisted Project(s) <ul style="list-style-type: none">a. Women's Health and Safe Motherhood Proejct (ADB Loan)b. Women's Health and Safe Motherhood Proejct (IBRD Loan)c. Women's Health and Safe Motherhood Proejct (EU Loan)d. Waste Water Treatment Program (Austrian Loan)e. Rural Water, Sanitation, Sewerage Sector Project (ADB)f. Integrated Community Health Service Project (ADB)g. Integrated Community Health Service Project (AUS)