Philippines: Urban Family Health Services

Ex-post evaluation

OECD area of promotion	12220 - Basic Health Care Services	
BMZ project numbers	1994 05 011 (Investment in fixed assets)	
Project-executing agency	Department of Health (DoH)	
Year of evaluation	**2003**	
	Project appraisal (planned)	**Ex-post evaluation (actual)**
Start of implementation	1994	1994
Financing, of which Financial Cooperation (FC) funds	EUR 7.21 million (FC EUR 2.97 million)	EUR 6.08 million (FC EUR 2.97 million)
Other institutions/donors involved	GTZ	GTZ
Performance rating	**5**	
• Significance/relevance	5	
• Effectiveness	5	
• Efficiency	6	

Brief Description, Overall Objective and Project Purposes with Indicators

The original purpose of the FC/TC cooperation project was to improve the supply of family health services in urban poverty areas. The overall objective was to make a contribution to improving the health of the urban poor in the Cavite, Quezon and Agusan del Norte provinces.

The indicators to measure the achievement of the project goals were defined as follows: Three years after the beginning of the FC component

- the quantity of basic medicines sold corresponds to at least 80% of the estimated demand;
- for every two Barangays (town or city quarters with approx. 3,000 to 3,500 residents) in the project region there is at least one adequately equipped health station (stock of basic medicines and contraceptives) with at least one midwife or one properly rained voluntary health worker (Barangay health workder - BHW) as well as one BHW for every 60 families;
- the revolving fund contains at least EUR 1.28 million (which corresponds to the annual demand for basic medicines of 300,000 persons);
- the contraceptive prevalence rate (CPR) is increasing.

Project Conception / Major Deviations from the original Project Appraisal and their main Causes

The TC component of the project started in 1993. Until the first delivery financed from FC funds arrived the project design had been considerably altered several times. According to the original supply-oriented project concept the monthly delivery of a so-called family health basket to needy households had been planned. In this context the GTZ supported the establishment of a health information system administered by the communities, which was to provide the basis for a socio-economic classification of the target group and a resulting graduation in selling prices (social price system). The idea was that better-off households subsidize the extremely poor target groups by paying comparatively higher prices for medicines. The difference between purchase and sales prices was to be paid into revolving funds established at the local level with the aim of ensuring the sustainable supply of the target population with low-price drugs. The drugs were to be delivered through a three-tier distribution system consisting of FAMUS pharmacies at the provincial level as well as satellite pharmacies and FAMUScies (FAMUS pharmacy/ drugs sales point) at the community level. The FAMUScies were operated jointly by voluntary Barangay Health Workers, community organisations and newly established drugs cooperatives.

The complex system of means testing turned out to be very time and cost consuming and thus proved to be a major obstacle to the distribution of medicines. Furthermore, the establishment of new distribution structures (drugs cooperatives, FAMUS pharmacies, community organisations) proved to be too time-consuming. And finally, the huge dependence of the distribution system on mainly unpaid voluntary workers was found not to be practicable.

The FC measure started at the end of 1995. Due to problems with the registration of imported drugs the FC deliveries had to be intermediately stored in Germany and reached the Philippines with great delay in 1997. At the end of 1998 a large share of the FC-financed deliveries were still in the FAMUS store. Obviously the absorptive capacity of the FAMUScy distribution network had been overestimated and the logistic support required for the distribution been underestimated. The absorptive capacity of the project organisation, which at the time consisted of only about 30 distribution points (FAMUScies), was too low to deliver the supplied drugs to the users before the expiration date. This led to ad-hoc adjustments to the distribution system: The concept of the so-called family health basket was given up. The project area was extended from originally 3 to 20 provinces, the focus on the urban poor was given up in favour of a broad-based poverty orientation and, by ensuring the participation of 4 NGOs, the distribution structure was enlarged to comprise around 945 local distribution points.

The project implementation was marked by the following deficiencies:

- At the beginning of the FC deliveries the capacities of the distribution structure were too small to make the medicines available to the target groups in an acceptable period of time. The main reasons were the supply-oriented distribution concept and its components of target group segmentation and price differentiation. The problem was even aggravated by delayed deliveries and imminent expiration dates.
- By making NGOs participate it was possible to reduce the share of drugs beyond expiry date to below 3%. However, the ad-hoc expansion of the project caused problems relating to quality, quality control and sustainability of the measure. It must be concluded that the NGO staff was not, or not sufficiently, trained for the distribution of drugs. In consequence it cannot be excluded that the lack of advice given to the target groups caused improper use of the drugs (e.g. wrong dosage of antibiotics).

- The preventive project approach laid down in the project appraisal report with a strong focus on advice and education was given up in the course of project implementation in favour of a pure curative approach.
- Until 2001 the procurement and the distribution of drugs had shown great information and control deficits mainly at the level of regional stores and local FAMUScies.
- The TC concept of price differentiation and thus of cross-subsidization turned out not only to be impracticable but also made the system complicated and intransparent and thus has encouraged possibilities of mismanagement.
- Cooperation between the project, communal health services and the NGO was inadequate and together with insufficient monetary incentives (the staff in the drugs distribution points worked either on a voluntary basis or for very low wages) this lead to a lack of ownership on the part of the Philippine side.

Key Results of the Impact Analysis and Performance Rating

As a consequence of the numerous conceptual changes in the TC component it was no longer possible to reach the objectives specified in the project appraisal report and the indicators were no longer suitable for a target-performance comparison. So far the request made in 1999 in the context of the final inspection reports to the DOH and the GTZ, i.e. to define new appropriate objectives and indicators for the project until the beginning of 2000, has not been complied with. At the time of the final inspection it was no longer possible to obtain sufficient data on the target groups actually reached and the impact of the project on their health situation.

At the end of 2002 the situation of the Revolving Drug Fund (DRF) was as follows: In the period from 1997 to 2001 basic medicine in the total amount of 143.1 million Philippine pesos (PhP) was supplied, of which 80% was provided from FC funds, 19.7 from funds of the Department of Health and 0.3% from TC funds. Moreover, the purchase of new medicines was financed from sales proceeds of PhP 2.6 million.

Of the total volume of drugs available until December 31, 2002 in the value of PhP 145.7 million 51.1% had been sold, 33% had to be distributed free of charge because of the imminent expiry date and 2.5% had to be disposed of because the drugs were past the expiry date. On the date of reference drugs in stock accounted for 4%. The whereabouts of the remaining almost 10% of the drugs (a value of PhP 14.1 million) cannot be traced unequivocally today. According to the current project management reasons might be inventory valuation problems, arbitrary and non-uniform price-setting practices and mistakes in the revenue accounting in the past. However, misuse can equally not be excluded.

If the return flows of PhP 2.6 million, which have been reused, is put into relation to the original capital of the Fund (PhP 143.1 million) the revolving rate is only 1.8%. Even more problematic is the difference between the value of medicine sold in theory (PhP 73.9 million) and the amount of money which actually went back into the Fund (PhP 27 million). In the final analysis, this means that only PhP 27 million (EUR 462,000) or just 19% of the original capital of PhP 143.1 million (EUR 2.5 million[1]) is still available. According to the project management the main reasons are the system of cross-subsidization, which is not functioning, incorrect price-setting and classification of the use of medicines, inadequate book-keeping and mismanagement. Moreover, due to inflation the Fund lost about 36% of its value.

[1]Exchange rate at the time of the ex-post evaluation

In the project appraisal report the target group had been defined as the population in urban poverty areas, in particular women, infants, children and youths in the three project provinces. The monthly family income of the target group was set below the official poverty line in the Philippines. After three years about 60% of the target population, this is about 530,000 persons (or 98,000 households) were to be reached under the project.

It is no longer possible today to determine the number of households actually reached. According to estimates provided by the current project management about 80% to 90% of the population reached is poor. This is concluded from the locations of the distribution points in communities with a high percentage of poor people, however the figure cannot be supported by any other data. Until 2001 the project was represented in 20 provinces. Since 2001, however, the project has gone through a phase of consolidation, as a result of which the number of local distribution points was reduced from 945 to 250 in only 8 remaining provinces. The project management does not exclude a further reduction in the number of sites.

The following risks were identified at the project appraisal:
a) a lack of voluntary health workers for the sale of family health baskets (high risk),
b) sustainability risk due to a lack of participation of the population (medium risk),
c) improper use of drugs and contraceptives (low risk),
d) improper prescription of antibiotics (low risk) and
e) in the medium term, an insufficient own contribution of the Philippine side (high risk).

The idea was to reduce the probability of occurrence of these risks through the TC component. The risks described under a), b) and e) actually occurred. As regards the risks mentioned under c) and d), due to the rapid distribution of the drugs at very many sales points without the staff having received any adequate training, it has to be assumed that these risks have also actually occurred. But no specific information is available on this item, which is not least due to the inadequate monitoring.

In a summarized assessment of all project impacts and risks that have been described we arrived at the following rating of the project's developmental effectiveness:

Effectiveness
The project temporarily ensured the supply with purely curative basic medicines of a group of persons which cannot be clearly defined. Moreover, it cannot be clearly proven whether the drugs delivered in the context of FC reached the target groups. However, due to the lacking or inadequate advice to the target groups, the curative project approach which dominated during the project implementation and the high percentage of analgesics in the drug deliveries one cannot say that the project made an effective contribution to improving the health situation of the target groups. Since the TC component did not succeed in establishing a functioning distribution structure one equally cannot say that the project measures were sustainable. Therefore, we judge the project's **efficiency** as **clearly inadequate** (partial evaluation: **rating 5**).

Relevance/significance:
Until 2001 the project was represented with 945 distribution points in altogether 20 provinces. At the time of the ex-post evaluation, however, only about 250 distribution points in 8 provinces were operating and the number was still declining. Of the original capital of the RDF only just under 19% are still available for a revolving use. Overall, the cooperative project did not succeed in making a sustainable contribution to establishing family health services. Therefore, we judge the project's **efficiency** as **clearly inadequate** (partial evaluation: **rating 5**).

Efficiency

FC funds of just under EUR 3.0 million compare with TC funds of EUR 2.4 million, which means a relatively high TC/FC ratio. Considering that the procurement of the drugs was inefficient, the advisory services were not successful, the supply oriented concept (with price differences and cross-subsidization) was not satisfactory, the concept was altered repeatedly, there was no functioning distribution structure and the loss of value of the RDF, the project is rated as **not efficient** (partial evaluation: **rating 6**).

After weighing its **effectiveness**, **efficiency** and **significance/relevance** we assess the project **overall** as having **clearly insufficient developmental effectiveness (rating 5)**. The project is largely considered as a failure.

Recommendations for management and operation

As regards the implementation of the "social franchising" concept, too fast an expansion of the system should be avoided. The concept was developed only at the end of FAMUS I and, accordingly, is still in the phase of establishment. From the current perspective, the following prerequisites have to be met before the project can be continued in a second phase:

- Due to the fact that the Revolving Drug Fund (RDF) is administered by the Department of Health the access of the National Pharmaceutical Foundation to the funds is very bureaucratic. A complete transfer of the RDF from the Department of Health to the NPF has been agreed, but has so far not been implemented. The actual transfer should be effected as soon as possible, that is in any case before the second phase starts.
- Substantial progress has to be made when granting the sales points official admission as HealthPlus- pharmacies. Currently only three HealthPlus-outlets have been licensed.
- A three-tier distribution network is considered as very expensive. Distribution costs must be cut or at least there should be the perspective of a medium-term cost reduction. Moreover, market-economy structures should be admitted in the distribution.
- Overall, the new system should be carefully expanded and tested. The still available RDF funds are sufficient for this purpose.

General Conclusions applicable to all Projects

In the course of FAMUS I KfW has mainly concentrated on the financing of drugs and left the further conceptual development of the project to the GTZ. Especially in view of the considerable problems with the implementation of the project concept a stronger conceptual involvement by KfW is required also in cases where the GTZ has taken on the overall management of the cooperation project. Finally it has to be made sure that the cooperation agreement is actually implemented and the mutual flow of information is ensured (here: coordination and acknowledgement of the reporting of the cooperation partner).

Legend

Developmentally successful: Ratings 1 to 3	
Rating 1	Very high or high degree of developmental effectiveness
Rating 2	Satisfactory degree of developmental effectiveness
Rating 3	Overall sufficient degree of developmental effectiveness
Developmental failures: Ratings 4 to 6	
Rating 4	Overall slightly insufficient degree of developmental effectiveness
Rating 5	Clearly insufficient degree of developmental effectiveness
Rating 6	The project is a total failure

Criteria for the Evaluation of Project Success

The evaluation of a project's "developmental effectiveness" and its assignment during the final evaluation to one of the various levels of success described below in more detail concentrate on the following fundamental questions:

- Are the **project objectives** reached to a sufficient degree (aspect of project **effectiveness**)?
- Does the project generate sufficient **significant developmental effects** (project **relevance** and **significance** measured by the achievement of the overall development-policy objective defined beforehand and its effects in political, institutional, socio-economic and socio-cultural as well as ecological terms)?
- Are the **funds/expenses** that were and are being employed/incurred to reach the objectives appropriate and how can the project's microeconomic and macroeconomic impact be measured (aspect of **efficiency** of the project conception)?
- To the extent that undesired **(side) effects** occur, are these tolerable?

We do not treat **sustainability**, a key aspect to consider for project evaluation, as a separate category of evaluation but instead as a cross-cutting element of all four fundamental questions on project success. A project is sustainable if the project-executing agency and/or the target group are able to continue to use the project facilities that have been built for a period of time that is, overall, adequate in economic terms or to carry on with the project activities on their own and generate positive results after the financial, organizational and/or technical support has come to an end.