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EDITOR'S NOTE

Differences in health status among various sectors and regions of Filipinos have widened in recent years. These disparities may indicate deficient economic and social policies, showing the need to reprioritize interventions to promote equity, fairness and immediate action. Unnecessary and unfair differences in the health care delivery system which deprive certain sectors and areas (especially the poor and the far-flung areas) of basic services must be reduced so that the highest possible health standards may be shared among the widest majority, given the limited resources allocated for health. This thematic issue of Public Policy on health will discuss various issues that affect the health of these sectors.

Annual check-ups have been an important part of the health care delivery system, wherein apparently well members of society seek health examinations and tests to determine the early stages of the presence of disease. For schools, this allows the healthy status of students to prevent the spread of infectious conditions common in the young age group. For the labor force, wellness is one of the requirements for acceptance and for renewal employment. For some employees who occupy high positions in business and industry, the annual check up is more comprehensive, earning the monicker of the "executive check-up". This expanded screening of disease conditions and illnesses utilizes more examinations in the apparently well, taking up hospital resources and bed space, which may deny or displace actual patients from using them. The paper of Morales, Dans, et al describes the situation and the process by which possible local solutions may be set in place.

In recent years, the public has become more aware of the problems of domestic child abuse and familial rape. So sensitive are these issues that many cases were left unreported. With the establishment of Child Protection Units in many hospitals and regions of the country and the development of various processes in dealing with a victim of child abuse, there is now a better system concerning this problem. The legal problem of giving justice to the victim of familial rape involves punishing the senior relative, be it parent or another relative. The issues surrounding the death penalty in these cases, and their effects on the familial and psychological health of the victim are discussed by Madrid and Castillo who are among the foremost advocates of the care of the abused child in the country.

Medical missions are very common in the country, and seem to be common only in this country. The paper by Almario, Nanagas et al describes this phenomenon of providing health services to various groups and regions in the country. While it would seem to have some high profile and impact on the population, many questions are raised by this practice. The issue of sustainability and conflict with existing local health care systems at times leads to problematic situations whenever these medical missions take place, especially if these are sponsored by politicians and foreign groups or individuals.

The Department of Health remains the most important policy making body for health matters in the country and has a vital role in providing most of the important supplies and equipment for the key health institutions such as hospitals and other health units. Procurement of supplies and equipment are expected to be more efficient using a central system, with less need for expert consultancies and a greater reliance on bulk orders. Inherent problems such as transport and actual utility and preference in the specific local setting exist and are highlighted in the paper by Galvez-Tan et al.

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Effective Screening for Diseases Among Apparently Healthy Filipinos: A Need for Philippine Guidelines on Periodic Health Examinations (PHEX)

Dante D Morales, Antonio Miguel L Dans,
Felix Eduardo R Punzalan and Mario R Festin

INTRODUCTION

Prevention

The importance of intervening early in the course of disease or even before disease develops is well known and considered ideal by many physicians. The benefits of incorporating prevention into medical practice have become apparent with the decline in incidence of diseases like poliomyelitis and rubella as a result of childhood immunization, with stroke reduction attributed to earlier detection and

treatment of hypertension, and with reduction of morbidity and mortality from coronary heart disease due to control of modifiable risk factors.

Clinicians have always intuitively understood the value of prevention. On the other hand, many patients consult health care providers only when they have signs and symptoms which, in some conditions, means that the disease is already in the advanced stage. Often, cure is then difficult and more costly. Primary care providers prefer earlier consultation with examinations potentially detecting earlier stages of disease so that appropriate and simpler interventions can be instituted. In the United States, the benefits of incorporating prevention into medical practice have become apparent in the last few decades, as previously common and debilitating conditions have declined in incidence following the introduction of effective clinical preventive services. Diseases include specific cancers, degenerative diseases and especially, infectious diseases. (Report, 1989)

From the public health point of view, the development and use of guidelines prove that appropriate prevention works. In the United States, the Assistant Secretary of Health stated that the guidelines developed by the Task Force of the Preventive Health Services helped save lives, improved the quality of life and made wise use of America's limited health care resources. The U.S. Department of Health and Human Services has committed to improving the quality and delivery of preventive services with practitioners and patients working together, basing their decisions on the best scientific evidence available. (Lee, 1996)

In the mid-90's in the United States, the Department of Health and Human Services' umbrella initiative to improve prevention was "Healthy People 2000"—a national strategy for preventing chronic illnesses, injuries and infectious diseases. That strategy included programs such as the public-private partnership "Put Prevention into Practice," which gave doctors and nurses important tools to provide effective prevention for their patients. The Task Force report represented a significant landmark on the road toward a healthier nation. Its science-based recommendations sharpened and refocused America's preventive services, helping practitioners provide the best possible care to their patients. (Lee, 1996)

screening

The World Health Organization (1994) defines screening as the use of presumptive methods to detect unrecognized health risks or asymptomatic disease in apparently healthy individuals in order to permit prevention and timely intervention. Screening is performed to categorize members of the general public into those with higher or lower probability of disease, with the former group being urged to seek medical attention for definitive diagnosis and treatment. (Sackett, 1985)

Screening refers to the performance of tests, in an organized manner, among apparently healthy asymptomatic individuals who are invited to undergo the examinations. The screening test must be safe to be acceptable. (Peters, et al, 1996) An example of this is the annual physical examination as part of the employment requirements in many companies. ***Case-finding*** is similar to screening, wherein certain laboratory tests are performed during an examination for *other* problems. A common example of this is the blood pressure examination to detect hypertension during a prenatal or antenatal checkup.

The screening test must be able to detect the target condition earlier than had screening not been done. It must be of sufficient accuracy to avoid producing large numbers of persons being told that they have abnormal test results but actually do not have the disease (false-positive results), and persons being told they have normal test results but actually have the disease (false-negative results). The screening test should improve the likelihood of favorable health outcomes like reduced morbidity and mortality. As such, early detection of the disorder is of little clinical value if the condition is not treatable. Available efficacious treatment is fundamental for an effective screening test.

Both screening and case - finding use various diagnostic tests. Diagnostic testing involves the application of a single or a variety of examinations to patients who have actively sought health care services to identify the exact cause of their complaints. (Sackett and Holland, 1975) Screening and diagnostic tests are not mutually exclusive, with the distinction being whether or not the individual sought services for that particular problem. Diagnostic tests are also applied to persons who

seek medical care because of positive or suspicious findings resulting from a screening test. (Peters, et al, 1996)

Locally, most periodic health examinations take the form of an annual physical examination (Annual PE) or the Executive Check-Up (ECU). In local practice, the routine annual performance of an appropriate history and physical examination remains and should be an important part of these examinations. After these are performed, one would also undergo preset tests and procedures. In the Philippines, as in only very few other countries, this practice has been and is still considered an important aspect of early diagnosis through screening. Many companies offer these as part of their employment benefits, with a certain number of tests for the regular employees, but a more comprehensive panel of sophisticated tests being offered for the executives and officers of the company, i.e., the "*executive check-up*."

There are distinct advantages to early diagnosis.

There are distinct advantages to early diagnosis. These include the protection of patients, the protection of economic wagers, the protection of contacts from communicable diseases and the establishment of baseline values. Health is vital to the day - to - day activities and function of an individual, and being labeled as sick or infirm may disallow the individual from continuing with his/her daily activities. If the illness is contagious because of bacteria or viruses, the spread of the infection should be controlled early, otherwise this may lead to more individuals being sick with the disease. Patients must also be protected from acquiring other conditions, either by spread of infectious agents or from complications of an earlier condition.

EFFECTS OF EARLY DIAGNOSIS

When is it appropriate to seek an early diagnosis? There are some recommended criteria for planning a program of early diagnosis through screening: 1) The burden of illness must be significant, 2) The test must be accurate (to minimize "labeling"), 3) Early treatment must be proven effective, and 4) Both the test and the treatment must be proven effective. (Sackett, 1991)

Early diagnosis is not without hazards. Table 1 below presents the possible consequences of screening such as test effects, "labeling", "diagnostic traps" and

institution of wrong treatment. Some people will have true-positive results (a^1 and a^2) a proportion of which will have clinically significant disease (a^1), who may benefit from screening (depending on the effectiveness of treatment and the severity of the detected disease). Taking an example from a specific screening program, children found to have phenylketonuria (a congenital/inborn metabolic disease) will experience large, long-lasting benefits. Other people will have true-positive results with inconsequential disease (a^2). They may experience the consequences of "labeling," investigation and treatment for a disease or risk factor that otherwise never would have affected their lives. Consider, for instance, a man in whom screening reveals low-grade prostate cancer. This person will most likely die instead from coronary artery disease before his prostate cancer becomes clinically manifest. Thus, he may have been "labeled", advised to undergo unnecessary treatment for prostatic cancer and may have experienced associated adverse effects.

People with false-positive results (b) may be adversely affected by the compulsion to do subsequent investigation(s)/further work-up for the screen - detected abnormality (the "diagnostic trap") and the risks associated with such tests. People with false-negative results with clinically important disease (c^1) may experience harm if false reassurance results in delayed presentation or investigation of symptoms; some also may be angry when they discover they have a disease despite having negative screening test results.

In contrast, patients with false-negative results but with inconsequential disease (c^2), are not harmed by their "disease" being missed because it was never destined to affect them. Patients with true-negative results (d) may experience benefits associated with an accurate reassurance of being disease- free, although they may also experience inconvenience, cost and anxiety.

Labeling takes place when a patient is given a "label" or a sign that makes him or her different from other individuals. This was clearly illustrated in a randomized trial of hypertension in an industrial setting which studied whether an earlier retrospective finding, i.e. the "labeling" of patients as hypertensive, resulted in increased absenteeism from work. After screening and referral, it was found that the rates of absenteeism rose by 5.2 ± 2.3 days per year (mean $\pm$ 1 S.E., $p < 0.025$). This 80

per cent increase greatly exceeded the 9 per cent rise in absenteeism (adopting the sick role) in the general employee population during this period. The main factors associated with increased absenteeism were the awareness of the condition ($p < 0.01$) and low compliance with treatment ($p < 0.001$). Subsequent absenteeism among patients unaware of their hypertension before screening was not related to the degree of hypertension, whether the worker was started on therapy, the degree of blood-pressure control achieved or exposure to attempts to promote compliance. Other effects included decreased psychological well-being, decreased work satisfaction and decreased marital satisfaction. These results have major implications for hypertension screening programs, especially since absenteeism rose among those previously unaware of their condition, regardless of whether antihypertensive therapy was begun or not. (Haynes RB, et al, 1978)

TABLE 1. Summary of Benefits and Risks of Screening by Underlying Disease State

	Reference Standard Result		
Screening Test Result	**Disease or Risk Factor Present**		**Disease or Risk Factor Absent**
Positive	True Positives (a)		b
	a^1	a^2	False Positives
	Significant disease	Inconsequential disease	
Negative	False Negatives (c)		d
	c^1	c^2	True Negatives
	Significant disease	Inconsequential disease	

a^1 – Disease or risk factor that will cause symptoms in the future (significant disease)
a^2 – Disease or risk factor asymptomatic until death (inconsequential disease)
b – False Positive Results
c^1 – Missed disease that will be significant in the future
c^2 – Missed disease that will be inconsequential in the future
d – True Negative Results

Note: Sensitivity = a/ a+ c
Specificity = d / b + d

Cadman and co-workers in 1987 conducted a randomized controlled trial of a public health and education screening program aimed at all 4,797 four to five year old children registering for kindergarten in three school districts of southern Ontario, Canada. Children received either 1) the Denver Developmental Screening Test (DDST) with a community health intervention program for positive screenees, 2) the DDST with no intervention for positive screenees or 3) no screening test. The intervention program consisted of referral to the child's physician for assessment, a review conference between the child's teacher and the school health nurse, parent counseling and monitoring of the child in school by the school health nurse. At the end of the third school year, no differences in individual academic achievement, cognitive and developmental tests were found between positive screenees in the community health intervention group and the "no intervention" groups. Parents' reports revealed no differences in children's mental, social and behavioral well-being between groups. However, parents of the intervention program children were more worried about their child's school progress, suggesting a potentially harmful labeling effect. In comparison with a random sample of children with normal DDST results or a random sample of children who had randomly not been screened, the children with positive preschool DDSTs had substantially more school problems three years after screening. (Cadman, 1987)

EVOLUTION OF PERIODIC HEALTH EXAMINATIONS (PHEX)

Annual Physical Examination or Executive Check - Ups: Origin and Evolution into PHEX

Annual Physical Examinations (APE) were first proposed in 1922 by the American Medical Association (AMA). For many years, doing routine physical examinations and comprehensive laboratory testing was common practice by doctors for many asymptomatic individuals. However, they were not found to be a clinically effective approach to disease prevention. It became increasingly clear that while routine visits with the primary care physician are important, performing the same interventions on all patients and performing these as frequently as every year are not the most clinically effective approaches to disease prevention. Rather, both the

frequency and the content of the health examination need to be tailored to the unique health risks of the individual patient and should take into consideration the quality of the evidence that specific preventive services are indeed clinically effective. At that time, the conduct of health examinations was generally the individual decision of health care givers. (Report, 1989)

In the 1970's, this indiscriminate practice was challenged by several experts. Their evaluation revealed that the use of most of the screening tests included in these packages was not rooted in solid evidence. (Antman, 1992) In the Philippines, this practice is more popularly known as the Executive Check-up. Many local hospitals continue to provide screening packages which include the same tests previously questioned by foreign investigators.

Frame and Carlson in 1975 used a systematic approach to determine the helpfulness of doing a periodic health examination. Thirty-six diseases were selected based on their incidence and prevalence, progression with or without treatment, risk factors associated with development of the disease and availability of screening tests. The feasibility of screening for the selected diseases was analyzed and justification for screening was based on several criteria, ranging from the diseases' effect on length and quality of life to the availability of tests to detect the disease in asymptomatic patients. If a single criterion was not met by either the disease or the test, the disease was considered ineligible for screening. Application of these criteria led the investigators to propose that physicians select the examination procedures in relation to age and sex.

...the use of most of the screening tests was not rooted in solid evidence.

Another study by Breslow and Somers in 1977 was prompted by the desire of health care providers to veer away from such broad and ill-defined concepts as the annual check-up, and instead approach disease prevention with more emphasis on specific chronic illnesses and current risk factors. A series of "packages" of effective individual preventive procedures was recommended and termed the "Lifetime Health Monitoring Program." This was based on an individual's life span, with his changing lifestyles, health needs and problems, for greater reference to health maintenance medicine rather than the usual complaint-response medicine. The authors

applied eight clinical and epidemiological criteria which were appropriate to the health goals of the relevant age group.

In 1976, one of the most comprehensive efforts to examine this issue was undertaken by the Canadian government which convened the Canadian Task Force on Periodic Health Examinations (CTFPHE). The expert panel adopted a highly organized approach to evaluating the effectiveness of clinical preventive services. The panel developed explicit criteria and judged the quality of evidence from published clinical research. Uniform decision rules were used to link the strength of the recommendations for or against a given preventive service to the quality of the underlying evidence. The Canadian Task Force examined preventive services for 78 target conditions, releasing the recommendations in a monograph published in 1979. The Task Force then published recommended preventive services based on evidence of effectiveness. Subsequent revisions came out in subsequent years. (Report, 1989)

As early as 1983, the American Medical Association (AMA) withdrew support for the standard APE which has been a model for the local APE or ECU. Instead, it emphasized periodic health examination, composed of individual periodic health visits with evidence for clinical effectiveness. A similar initiative was taking place in the United States in 1984 when the Department of Health and Human Services commissioned the U. S. Preventive Services Task Force to develop recommendations for clinicians on the appropriate use of preventive interventions, based on a systematic review of the evidence of clinical effectiveness. (Lawrence, 1987) With a similar methodology and in collaboration with the CTFPHE, it reviewed the evidence, developed recommendations on preventive services and published the Guide to Clinical Preventive Services, a landmark report and premier reference source on the effectiveness of clinical preventive services. The Guide is now on its third edition.

The U.S. Preventive Services Task Force (USPSTF) at the onset outlined some major areas where research is needed to define the appropriate use of specific screening tests, counseling interventions, immunizations and chemoprophylaxis. Areas of particular importance included research to: (1) Identify effective and practical primary care interventions for modifying personal health practices of patients, especially around issues such as diet, exercise, alcohol and drug use, and risky sexual behavior; (2) Clarify the optimal periodicity for certain screening tests and counsel-

ing interventions; (3) Identify practical ways to allow patients to share decision-making about preventive care, especially for services of possible but uncertain benefit; (4) Examine the most sensitive and efficient ways to identify high-risk groups who may need different services than the average population; and (5) Expand the use of decision-analysis and cost-effectiveness analysis to help identify optimal use of clinical preventive services. (Atkins, 1998)

The methodology followed a structured and scientific search and assessment of literature and formation of guidelines. The conditions or diseases targeted were selected based on the frequency and severity as leading causes of death and disability and their potential for prevention through clinical interventions. Topics included project organization (analytic philosophy, project sponsorship, panel composition, topic selection); the review of evidence (selecting outcome measures for judging effectiveness, constructing "causal pathways," searching the literature, rating the evidence, synthesizing the results); crafting recommendations (extrapolation, assessing magnitude, balancing risks and benefits, addressing costs, dealing with insufficient data, separating science from policy); peer review; collaboration with other groups; evaluating impact on clinicians' knowledge, attitudes and behavior; updating recommendations; and defining a research agenda. The lessons learned suggest potential refinements in the future work of the task force and other groups engaged in guideline development. (Woolf, 1996)

The US Preventive Services Task Force has come up with criteria on choosing tests for screening purposes. These are enumerated as follows:

1. The target disease should either be so common or so severe as to warrant routine screening in asymptomatic patients;
2. The target disease must have a well-understood natural history with a long pre-clinical latent period during which it can be screened;
3. The screening method must have acceptable performance parameters, detecting the disease at an earlier stage than would be possible without screening;
4. Efficacious treatment for the target illness must be available;
5. Early detection must improve disease outcome; and
6. Cost, feasibility and acceptability of screening and early treatment should be affordable.

(Report, 1989)

Cost Effectiveness

As medical technology continues to expand and the cost of using all effective clinical services exceeds available resources, decisions about health care delivery may increasingly rely on assessing the cost-effectiveness of medical services. Cost-effectiveness is particularly relevant for decisions about how to implement preventive services because these decisions typically represent major investments in the future health of large populations. As such, decisions regarding the implementation of preventive services frequently involve, implicitly if not explicitly, consideration of costs. Cost-effectiveness analysis summarizes the expected benefits, harms and costs of alternative strategies to improve health and has become an important tool for explicitly incorporating economic considerations into clinical decision-making.

Acknowledging the usefulness of this tool, the third U.S. Preventive Services Task Force (USPSTF) initiated a process for systematically reviewing cost-effectiveness analyses as an aid in making recommendations about clinical preventive services. This paper focuses on clinical preventive services namely screening, counseling, immunizations and chemoprevention in which the framework developed should be broadly portable to other health care services. (Saha, 2001)

Recommended Evidence-Based Preventive Measures

For the asymptomatic general adult population, there are only a few specific interventions considered and recommended for periodic health examination. For the adult age group up to 64 years for example, the only eight screening tests found to meet the criteria are height and weight, blood pressure, total cholesterol, Pap smear, fecal occult blood, mammogram, assessment for drinking problem and rubella serology for women. (Report, 1989)

For the asymptomatic but high risk population, only 12 tests identifying high risk for which preventive interventions have been shown to be effective are thus recommended.

Because of the tremendous costs and the potential for harm, there have been many attempts to lay down guidelines for the conduct of periodic health examinations [3-7]. The Canadian Task Force on Periodic Health Examination proposed 3

criteria for deciding whether a medical condition should be sought during a periodic health examination: 1) availability of an effective treatment for the asymptomatic condition, 2) a high burden of illness caused by the condition if untreated or undetected, and 3) good quality of the proposed screening procedure (i.e. high sensitivity and specificity, low cost, safety and acceptability to patients and physicians) [5]. Most of these guidelines emphasize the need for selectivity in ordering tests to avoid unnecessary and potentially harmful diagnostic testing and treatment.

Despite the absence of local guidelines based on scientific evidence, executive check-ups (ECUs) have been used as an integral part of health services by medical practitioners and patients in the Philippines. The purpose of this paper is to review the local practice of periodic health examination, the results of which may later serve as the basis for designing appropriate guidelines for the rational and efficient utilization of screening tests.

In the Philippines, two studies have also investigated some aspects of the periodic health examination. In a study done at the Philippine Heart Center, Recto et. al. found no significant difference in the number of abnormal findings after executive check-ups for both symptomatic and asymptomatic patients [8]. A survey conducted by Valdez J at the Medical Center Manila found that while more symptomatic patients underwent an executive check-up, these patients had generally normal findings and laboratory results [9].

THE PRACTICE OF EXECUTIVE CHECK-UPS

Hospital Admissions for Executive Check-ups

A survey by Cabigon and Salud was conducted in 1996 to review the practice of executive check ups in 9 Metro Manila hospitals. The objectives of the study were as follows: 1) To determine the frequency of admissions for executive check-ups to hospitals in Metro Manila; 2) To determine the usual screening tests requested during these admissions; 3) To determine the usual costs for the patients;

and 4) To compare ECU practice with the recommendations of the US Preventive Services Task Force.

This study was a retrospective, descriptive study on the conduct of executive check-ups in Metro Manila hospitals from the period of January to December 1996. Hospitals included in the study were those officially listed under the Philippine Hospital Association, with at least a 200-bed capacity, and which offered official executive check-up packages.

The hospitals that satisfied the inclusion criteria were sent a formal letter addressed to the Medical Director or Administrator explaining the purpose of the study and requesting access to hospital records. Only those hospitals that consented to be part of the study were visited for the purpose of records review. The names of the hospitals included in the study were concealed to assure confidentiality.

The data gathered from each hospital included 1) the number of executive check-up admissions, 2) the types of executive check-up packages, 3) the tests performed per package type, 4) the cost per package and 5) the usual duration of confinement of patients admitted for executive check-up. The total numbers of admissions per hospital were taken from the 1996 annual report submitted to the Bureau of Licensing and Regulation, Department of Health.

The costs of specific individual screening tests were procured from each hospital by telephone. In order to obtain the 1996 estimates, the Philippine Institute for Development Studies (PIDS) was consulted for the Consumer Price Index for services in the National Capital Region.

Frequency of Admissions for Executive Check-Up

The total number of admissions in these nine Metro Manila hospitals from January to December 1996 was 197,296. Of these admissions, a total of 6,214 (3.15%, range 0.4% to 9.8%) were admitted for executive check-ups. This comprised 7.44% (range 0.18% to 16.90%) of the total admissions to departments of adult medicine (Table 2).

TABLE 2. Number and Frequency of Executive Check-up Admissions among 9 Metro-Manila Hospitals

Hospital	Number of Executive Check-ups	Number of Total Admissions	Percentage	Number of Total Adult Admissions	Percentage
A	102	9642	1.05	6248	1.63
B	668	19392	3.44	8600	7.77
C	58	46877	0.12	13674	0.35
D	2348	34034	6.90	13897	19.90
E	1097	11102	9.80	8458	12.97
F	208	12184	1.71	4293	4.84
G	4	9288	0.04	2250	0.18
H	378	22703	1.66	7879	4.80
I	1351	32074	4.21	15462	8.74
Total	**6214**	**197296**	**3.15**	**83461**	**7.44**

Executive Check-up Packages

The hospitals offered various packages to fit various budgets. One hospital provided a total of 17 packages with varying laboratory tests and subspecialty examinations according to organ systems (e.g. cardiology, nephrology, urology, gastroenterology, gynecology, endocrinology, neurology, etc.). Patients had the option of choosing from an out-patient package or admission package. Screening tests in comprehensive packages included blood examinations, various x-rays and special subspecialty examinations (Table 3).

Table 3. Example of an Executive Check-up Package:

1. Urinalysis – urine examination to look for infections and other by-products of body metabolism
2. Fecalysis - examination of the stool to look for parasites and bleeding
3. Hemoglobin – examination of the blood to test for anemia
4. White Cell Count – examination of the blood to detect high counts indicative of disease
5. Platelets - examination of the blood to detect high counts indicative of disease
6. Blood Urea Nitrogen - blood test to detect kidney function
7. Creatinine – blood test to detect kidney function
8. Fasting Blood Sugar – blood test to detect presence of possible diabetes
9. Uric Acid - blood levels would suggest presence of risk factor for rheumatism and kidney stones
10. Total/HDL/LDL/Triglycerides Cholesterol – blood levels to detect risk factor for heart disease
11. SGOT, SGPT, DB, IB, TB, Alkaline Phosphatase – various blood tests for liver function
12. HBsAg – blood test for hepatitis B presence
13. Rapid Plasma Reagin – screening test for previous infections with syphilis
14. Electrocardiogram - electrical test for heart function
15. Stress Test - test on heart's reaction to exercise
16. Proctosigmoidoscopy – instrumental examination of the rectum and large intestine to look for tumors and disease
17. Pap Smear - cytologic test for women's reproductive tract for infections, tumors and hormonal imbalance
18. Ultrasound of the Hepato-biliary Tract – imaging test of the liver and biliary tract
19. Ultrasound of the Prostrate – imaging test of the male's prostrate
20. Ultrasound of the Kidney – imaging test of the kidney to look for tumors or stones
21. Chest Xray –to detect presence of infections (tuberculosis) or tumors
22. Upper GI Series - several successive x-ray examinations of the esophagus, stomach and upper intestine to test for ulcers and tumors
23. Barium Enema – several successive x-ray examinations of the rectum, lower intestine and colon to test for ulcers and tumors
24. Mammography – x-ray examination of the female breast to test for tumors
25. IVP (Optional, 10% Discount) – special x-ray of the kidney, bladder and ureters to detect kidney function
26. T3/T4 – blood tests for thyroid function

The tests common to all the packages in the different hospitals were the following: complete blood count, urinalysis, stool exam, fasting blood sugar determination, uric acid, cholesterol determination, chest x-ray, barium enema, resting electrocardiogram and proctosigmoidoscopy. The number of tests requested ranged from as few as 14 to as many as 32, depending on the hospital executive check-up package requested. Specialty consultations were not included in Table 3, but were nonetheless offered to patients. These consultations were limited to a certain number depending on the desired plan or package. For a comprehensive plan, the number of subspecialty consultations that could be availed of ranged from 4 to 8 specialties. Clients were confined for executive check-ups for a day (overnight) to 3 days, depending on the package.

TABLE 4. Average and Range of Costs of Executive Check-up Packages

Hospital	Number of Executive Check-ups	Range of Costs (PhP)	Average Costs (PhP)	Total Costs (PhP)
A	102	3265.00 to 12,500.00	8062.50	822,375.00
B	668	4100.00 to 10,200.00	7150.00	4,776,200.00
C	58	5810.00 to 9360.00	7585.00	439,930.00
D	2348	7670.00 to 21,170.00	14,420.00	33,810,160.00
E	1097	5000.00 to 13,600.00	9300.00	10,202,100.00
F	208	8925.00 to 11,800.00	10,362.50	2,155,400.00
G	4	6,900.00	6,900.00	27,600.00
H	378	6815.00 to 11,000.00	8907.50	3,307,035.00
I	1351	11,350.00 to 25,300.00	18,325.00	24,757,075.00
Total	**6214**	**6,685.33 to 13,536.67**	**10,112.50**	**62,839,075.00**

The sets of tests were composed of 23 to 40 tests and procedures. The costs involved then ranged from PhP 6,685.33 to PhP13,536.67 for a 1-3 day confine-

ment. This is in sharp contrast to the recommended evidenced-based 8 screening tests, the total expense of which would have been only around PhP1,200 in 1996.

Costs of executive check-ups varied from plan to plan and from hospital to hospital. Table 4 shows the range of costs of these plans. Out-patient packages were excluded from this tabulation. The overall expenditure for executive check-ups in the nine hospitals was PhP 63 million with an average cost of PhP 10,000 per check-up. Moreover, this figure may be an underestimate of the real cost since some hospitals did not include room fees in their package price.

TABLE 5. Recommended Screening Tests for Adult Female, 1996

Screening Intervention	Age Group	Average Cost
Height and Weight	25 years old and above	Single cost of scale and height ruler
Blood Pressure	25 years old and above	Single cost of blood pressure apparatus
Papanicoulou Smear	Upon initiation of sexual activity	Php 188.75
Total Blood Cholesterol	45 years old and above	Php 161.11
Fecal Occult Blood Test or Sigmoidoscopy	50 years old and above	Php 88.67
Mammogram + Clinical Breast Examination	50 to 69 years old	Php 760.70
Auditory Testing	65 years old and above	None

Of the 12 hospitals that satisfied the inclusion criteria, only 9 agreed to be part of the study. This may have led to an underestimation of the frequency and cost of executive check-up packages. A number of examinations were commonly used despite the lack of scientific evidence to support their use as routine screening examinations. Conversely, Pap smears and mammograms, two screening tests that met the criteria, were found to be underutilized.

...the establishment of these criteria marks the need to re-evaluate the current executive check-up system in the Philippines.

Unfortunately, the average cost of PhP 10,000 per check-up is prohibitive for the typical Filipino family. This defeats one purpose of preventive medicine - the reduction of health care costs. Given the wide variation in tests requested and costs incurred, there is a need to come up with guidelines to standardize the care given to patients. Clearly, the establishment of these criteria marks the need to re-evaluate the current executive check-up system in the Philippines. Guidelines are needed for the efficient use of patient and hospital resources.

Limitations and Challenge

There are limitations to the aforementioned recommendations since all possible preventive interventions have not been examined nor studied. There are gaps in our current knowledge which should be filled via more research.

The big challenge now is twofold. One is validation and application of foreign data considering not only the frequency and severity of diseases and conditions but also our local studies and experiences. The second is the incorporation of the "science and art" of disease prevention and its implementation in our clinical practice.

DEVELOPMENT OF PHILIPPINE GUIDELINES

Convened by the Philippine College of Physicians and the Philippine Clinical Epidemiology Network, a group of physicians is finalizing the development of national guidelines on PHEX for Filipino patients addressing screening. In recent years, many Clinical Practice Guidelines have been developed in the Philippines to address the problem of new information in the medical field emerging at a very fast rate so that some standardization is urgently needed.

The emergence of practice guidelines both here and abroad has heralded the evolution of several guideline development techniques. There are three basic ap-

proaches: an evidence-based approach, a consensus-based approach or a combination of the two. (Fink, et al, 1984)

The evidence-based approach utilizes a systematic synthesis of the literature and makes recommendations according to the strength of evidence. This means that the medical literature is objectively and comprehensively searched and critically appraised. Data obtained are then statistically combined, when feasible, before coming up with specific recommendations. (Dans, 1996) This approach is credited with enhancing scientific rigor of practice guidelines. However, its main disadvantage is its inability to produce recommendations in the absence of acceptable evidence.

Consensus statements, on the other hand, are produced using various techniques. These are classified into formal and informal methods. The informal consensus technique usually consists of assembling the framers in a single meeting to come up with the panel's recommendations. Although this process is easy, fast and free of complex analytic procedures, the resulting statements reflect the global subjective judgment of its framers, the "experts". (Fink, 1984) The "decibel factor" (dominance of those with loud voice/s) exerts a strong influence on the results of the proceedings. Other disadvantages include: 1) difficulty in the assessment of the guides' validity. 2) limitations to validity of experts' opinions and 3) dependence on personalities and affiliations. (Fink, 1984)

Formal consensus techniques are characterized by their structured methodology in obtaining inputs from the guideline framers, e.g. orderly discussions and equal participation rather than dominance of "experts".

The combined use of the evidence-based approach and formal consensus techniques is increasing in popularity. Advantages include the following: a) validity can be measured, b) personalities and affiliations exert less influence, c) evidence beyond experts' opinions can be included and d) acceptance is almost assured. Major setbacks include time and cost constraints, as well as the difficulty of the process.

Table 6 below describes the various methods used in guideline development.

Table 6 Characteristics of the Different Approaches to Guideline Development

	Features	Strengths	Weaknesses
1. Evidence-Based Approach	Entails systematic synthesis of literature; recommendations are based on evidence.	Enhances scientific rigor of practice guidelines	Unable to give recommendations in the absence of acceptable evidence.
2. Consensus-Based Approach			
a. Informal	Informal meeting of "experts".	Free of complex analytical procedures; fast; less costly.	Reflects subjective judgment of dominant voice of "experts"; difficult to assess validity.
b. Formal	Structured methodology.	Validity can be measured; less influence of personalities.	Time and cost constraints.
b.1 Delphi Method	Consensus obtained thru self-administered questionnaires.	No geographical constraints; impersonal expression of views.	Time constraint, may exhaust panelists.
b.2 Nominal Group Technique	Step-wise en-banc meeting for obtaining consensus on issues presented.	Equal participation among panelists; output generated is independent of personalities.	Time constraint; requires skilled facilitators.

In the development of the guidelines, the Philippine task forces identified, retrieved and appraised relevant data, both foreign and local. Based on the burden of the disease, accuracy of the tests, availability of treatment and cost effectiveness data, an evidence-based recommendation was drafted. The draft was modified by a series of multi-sectoral meetings and correspondence thru the Delphi method technique. Factors considered in the modifications were local issues, applicability of the data to practice and clinician's experience.

Basis for Recommending Screening Tests – Evidence-Based Medicine Tools

We should decide what rating system and level of evidence we will adopt for the local PHEX. The ones here seem better and more practical than what we use.

The determination of the quality of evidence was based on a systematic consideration of these 3 criteria: 1) incidence or prevalence of the condition; 2) characteristics of the intervention and 3) the effectiveness of the intervention as demonstrated in published clinical research.

The following rating system was used for **quality of evidence**:

I : Evidence obtained from at least one properly randomized controlled trial (RCT) or meta-analysis of RCTs.

II-1 : Evidence obtained from well-designed controlled trials without randomization.

II-2 : Evidence obtained from well-designed cohort or case-control analytic studies, preferably from more than one center or research group.

II-3 : Evidence obtained from multiple time series with or without the intervention. Dramatic results in uncontrolled experiments could also be regarded as this type of evidence.

III : Opinions of respected authorities, based on clinical experience, descriptive studies and case reports or reports of expert committees.

The recommendations of the Task Forces were influenced largely by only one factor, that of scientific evidence. Thus, the recommendations were graded based on the strength of evidence as follows:

Grades of Recommendations

A. There is good evidence to support the recommendation that the condition be specifically considered in periodic health examination.
B. There is fair evidence to support the recommendation that the condition be excluded from consideration in periodic health examination.
C. There is insufficient evidence to recommend for or against the inclusion of the condition in a periodic health examination but recommendations may be made on other grounds.
D. There is fair evidence to support the recommendation that the condition be excluded from consideration in a periodic health examination.
E. There is good evidence to support the recommendation that the condition be excluded from consideration in a periodic health examination.

Criteria for evaluating screening tests

1. Effectiveness of treatment for the asymptomatic condition must have been assessed by well-designed randomized controlled trial(s) evaluating the effect of treatment on clinical outcomes.
2. The prevalence of the asymptomatic condition must be based on locally conducted community-based studies.
3. The accuracy and reliability of the screening test must be based on validation studies done in the community.
4. Cost-effectiveness of the screening test and the treatment should be evaluated in properly conducted economic analyses.

Level of Evidence

Level 1 – Recommendation satisfies all the above criteria
Level 2 – Recommendation satisfies #1 only, but not all of #2, #3 and #4
Level 3 – Recommendation satisfies #2, #3 or #4 but not #1
Level 4 - Recommendation satisfies none of the criteria

Grades of Recommendation

Grade A: Based on the current evidence, the consensus is that the test should be used for mass screening.

Grade B: Based on the current evidence, a consensus could not be reached; the test may or may not be used for mass screening.

Grade C: Based on the current evidence, the consensus is that the test should not be used for mass screening.

For the asymptomatic general population which is not at high risk for diseases, only screening tests based on strong evidences were recommended for the different age groups. A similar approach was made for counseling, immunization and chemoprophylaxis. We should really do this for the local PHEX. For individuals at high risk for cardiovascular diseases, the only evidences in the literature were screening for asymptomatic coronary artery disease, high cholesterol, hypertension, asymptomatic carotid artery disease, peripheral arterial disease and for abdominal aortic aneurysm. Recommendations were made based on the strength/level of evidence. The Clinical Practice Guidelines on Periodic Health Examinations will be published by UP Manila.

Although the recommendations of the Task Forces were most heavily influenced by the strength of scientific evidence, in some instances, issues of applicability, desirability and the "art" of medicine influenced the framing of some of the final recommendations ("Consensus Issues").

Problems and Barriers to Guideline Development

The Filipino medical community is beset with problems not only in keeping pace with progress but also with barriers to guideline development. These barriers may present as threats to validity, reliability, feasibility or acceptability of any set of guidelines.

Validity Threats. In the local setting, "experts" strongly influence the beliefs and practices of the less experienced practitioners. This may be traced to the Filipinos' inherent value of "respect for elders". Thus, questioning the voice of "authority" is at times not acceptable. In informal guideline development, "experts" usually dominate the discussions. This biases consensus towards what experts think. In effect, guidelines may not be consistent with the current evidence and also may not reflect true consensus.

...“experts” strongly influence the beliefs and practices of the less experienced practitioners.

Another validity threat concerns the existence of "political" rifts that exist within some local medical societies and organizations [8]. Subjective assessment of the data lead to recommendations based on individual or social affiliations rather than on the evidence itself.

The third validity problem deals with the inaccessibility of many publications in local libraries, which is traced to economic problems in a developing country. Immediate access to new and important evidence is thus hindered.

The last validity threat concerns involvement of the pharmaceutical industry in the guideline development process. This may happen in 3 circumstances: first, if any panelist is connected with these companies; second, presence of anyone connected with the industry in the voting process; lastly, if financial support for the guideline development is provided with no explicit rules on conflict of interest.

Reliability Threats. The Filipinos' "*ningas-kugon*" mentality poses a threat to reliability in guideline development. This trait is characterized by starting a task with much enthusiasm but, in the process, fervor and enthusiasm begin to decline and result in decreased numbers of participants by the end of a process. Guideline development can be a tedious and demanding endeavor, thus, interest may be lost

in the middle of development. A high drop-out rate could also threaten validity of the ensuing guidelines. Moreover, this "*ningas-kugon*" mentality may also be considered as one of the feasibility problems threatening accomplishment of a guideline (see below).

Feasibility Threats. Economic constraints are not unique to a developing country like the Philippines. Guideline development incurs expenditures which the local community may find hard to finance. This results in participants who probably will not receive compensation for time spent despite the opportunity costs. Thus, this may further result in the non-participation of key persons.

Another factor which threatens feasibility concerns geographical constraints. Participants in guideline processes usually come from the urban setting which may marginalize other important stakeholders due to geographic inaccessibility.

Acceptability Threats. Acceptability, in contrast to validity, reliability and feasibility, is a measurement issue unique to guideline development. In order that guidelines effect changes in physician behavior and practices, they must be acceptable/palatable to the physicians concerned. The political rifts among local societies may prevent some sectors from accepting guidelines proposed by an organization they are not connected with or whose leadership they oppose. Even in the absence of political rifts, a significant number of clinicians may still not accept a document as "credible" if their views were not represented during the development process. Lastly, doubts about the objectivity of the guideline development process may also hinder its acceptability.

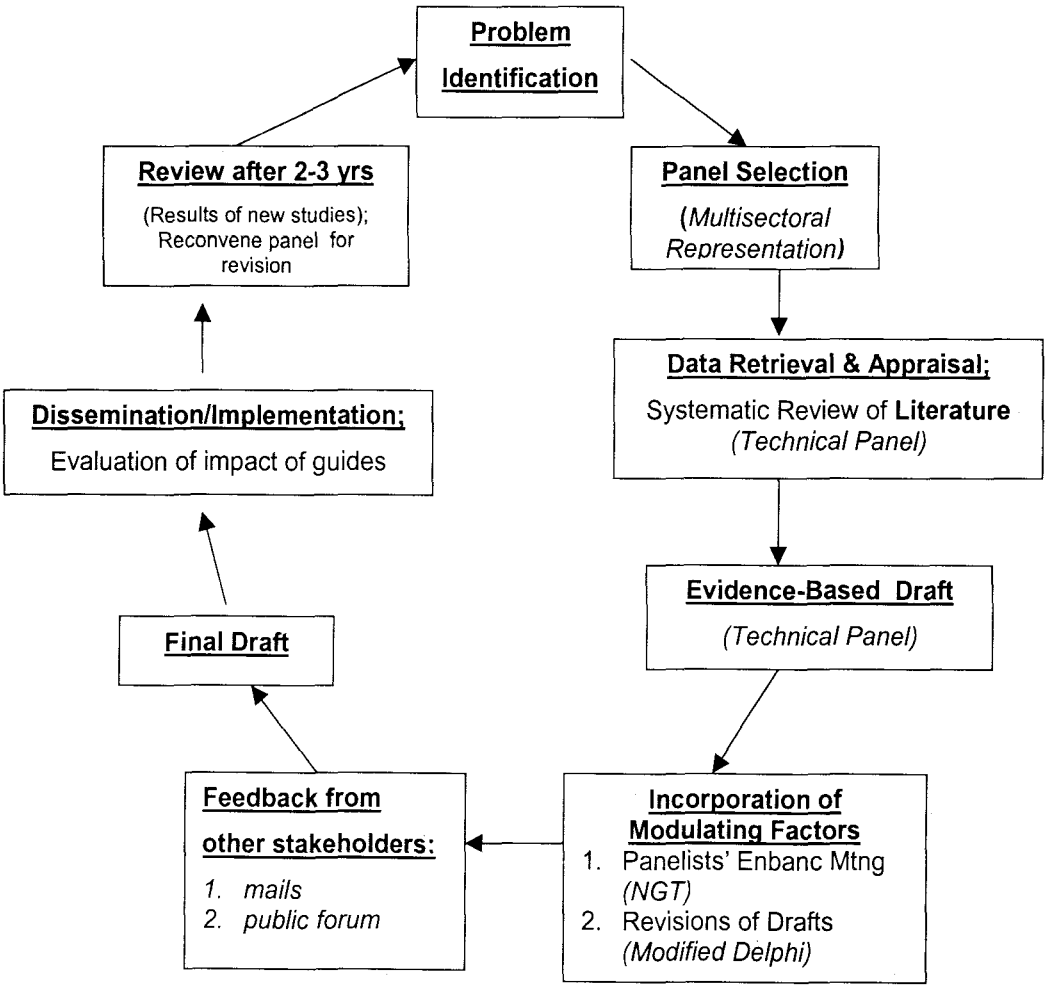
TABLE 7. Measurement Issues in Guideline Development

Measurement Issue	Specific Problems
1. Validity Threats	"Respect for elders", presence of "political" rifts, absence of publications, influence of pharmaceutical companies; high drop-out or attrition rate during Delphi circulation
2. Reliability Threats	Declining panel participation.
3. Feasibility Threats	Financial, geographical constraints.
4. Acceptability Threats	Scope and credibility of panel, relation to pharmaceutical industry.

These problems threaten the success of guideline development in developing countries such as the Philippines. The methodology adopted should therefore address these problems to increase the probability of success. In the methods section of this proposal, we describe a guideline development protocol which tackles these concerns.

THE GUIDELINE DEVELOPMENT CYCLE

Figure 1 illustrates the development cycle that will be used in the Periodic Health Examination Guidelines Development project.



The **guideline development cycle** utilizes both the evidence-based approach and formal consensus techniques (nominal group & modified Delphi techniques). The use of the evidence-based approach was adopted due to its inherent advantage of coming up with recommendations based on the results of studies with acceptable qualities. Combining this approach with the use of formal consensus techniques will enable the panel members to discuss issues on generalizing the evidence to the local scenario as well as other issues which may not be covered by the existing body of evidence. The modified Delphi technique enables the panelists to express their views anonymously. This process allows continuity of the discussion without having to sit en-banc. Lastly, the multi-sectoral representation of the panel members offers an opportunity to work with different stakeholders that are important components in clinical decision-making.

In summary, the various tools employed in answering each of these threats in guideline development are shown in Table 8.

Table 8. Threats to Guideline Development Process

Threats	Measures to Counteract Threats to Guideline Development
1. Validity	a) Use of Systematic Reviews b) Grading recommendations according to study strength c) Consensus voting using the Nominal Group Technique(NGT)
2. Reliability	Modified Delphi process decreases attrition
3. Feasibility	Use of modified Delphi process decreases funds required for travel.
4. Acceptability	Evaluation of guideline development process by panelists; acceptance of guideline need by individual physicians and societies or organizations; evaluation of impact of guidelines in physicians' practices.

LESSONS

Although the primary aim of the Task Force was to reach specific conclusions about individual preventive services, we also formed some general impressions about current approaches to prevention as a whole.

First, it is vitally important for prevention to address patients' personal health practices. A great deal of science supports the conclusion that the choices people make about their own lifestyles and behaviors strongly affect their health — much more strongly than anything medicine alone can do. The main enemies of life and health — the avoidable enemies — are behaviors such as smoking, unwise dietary practices and abuse of alcohol and other drugs. Health care practitioners can help patients avoid these enemies by counseling them to make sound choices and by providing them information to support those choices.

...the choices people make about their own lifestyles and behaviors strongly affect their health.

Second, clinicians and patients should share decision-making about preventive services. Decisions about whether to have a test or procedure require balancing patient preferences along with the scientific evidence. For example, a fully informed patient is in the best position to decide whether an uncomfortable screening test is worth the discomfort. Whether a prenatal screening test should be done depends a lot on what a family would do based on the results of the test. No simple review of science can answer all the important questions about which preventive practices to use. The relationship between the clinician and the patient, not a printed research article, is still the best foundation for good health care.

Third, clinicians should be selective in providing preventive services. Health care is under great pressure today to control costs, and managed care organizations and others are struggling with ways to do so while maintaining or improving quality of care. We think that our findings can help in that direction. Science-based prevention can save money — and provide high-quality care — by avoiding unnecessary tests and procedures. Many of the preventive practices we reviewed, such as routine screening electrocardiograms and widespread electronic fetal moni-

toring, simply do not stand up to scientific scrutiny. We identify even more opportunities to tailor prevention to specific vulnerable groups. *In choosing a prevention package, one size does not fit all.*

Fourth, the work suggests that every encounter with a clinician is an opportunity for prevention. Children can safely receive needed immunizations even on visits for minor illnesses; adults can be advised to stop smoking while being treated for minor injuries; inquiries about alcohol abuse can be made and appropriate counseling begun in emergency departments. This is most crucial for people who, because they lack health insurance or a stable source of care, appear in the medical system only sporadically, and rarely for a preplanned "checkup."

Fifth, for some health problems, community-level interventions may be more effective than clinical preventive services. Our research suggests that while the clinician's office is a powerful site for prevention, community-level interventions can be even more powerful for pursuing aims such as injury prevention or smoking cessation. In today's rapidly changing health care system, two improvements are crucial: reducing costs and improving health. Is it possible to do both at the same time? The experiences with the Task Forces in the United States and in Canada over the years say it is. Costs can be reduced by conscientiously avoiding preventive practices that do not help, and instead focusing resources where the evidence says we should. If that is done, and if there are more effective preventive methods, there would be a tremendous opportunity to save years and years of life and to help people live better during those years. Prevention has great promise and prevention grounded in science has the greatest promise of all. (Berwick, 1996)

...prevention grounded in science has the greatest promise of all.

Limitations

Screening tests are ubiquitous in contemporary practice, yet the principles of screening are widely misunderstood. Screening is the testing of apparently well people to find those at increased risk of having a disease or disorder. Although an

earlier diagnosis generally has intuitive appeal, earlier might not always be better or worth the cost. Four terms describe the validity of a screening test: sensitivity, specificity and predictive value of positive and negative results. For tests with continuous variables — eg, blood glucose—sensitivity and specificity are inversely related; where the cutoff for abnormal values is placed should indicate the clinical effect of wrong results. The prevalence of disease in a population affects screening test performance: in low-prevalence settings, even very good tests have poor predictive value positives. Hence, knowledge of the approximate prevalence of disease is a prerequisite to interpreting screening test results. Tests are often done in sequence, as is true for syphilis and HIV-1 infection. Lead-time and length biases distort the apparent value of screening programs; randomized controlled trials are the only way to avoid these biases.

Screening can improve health; strong indirect evidence links cervical cytology programs to declines in cervical cancer mortality. However, inappropriate application or interpretation of screening tests can rob people of their perceived health, initiate harmful diagnostic testing and squander health-care resources.

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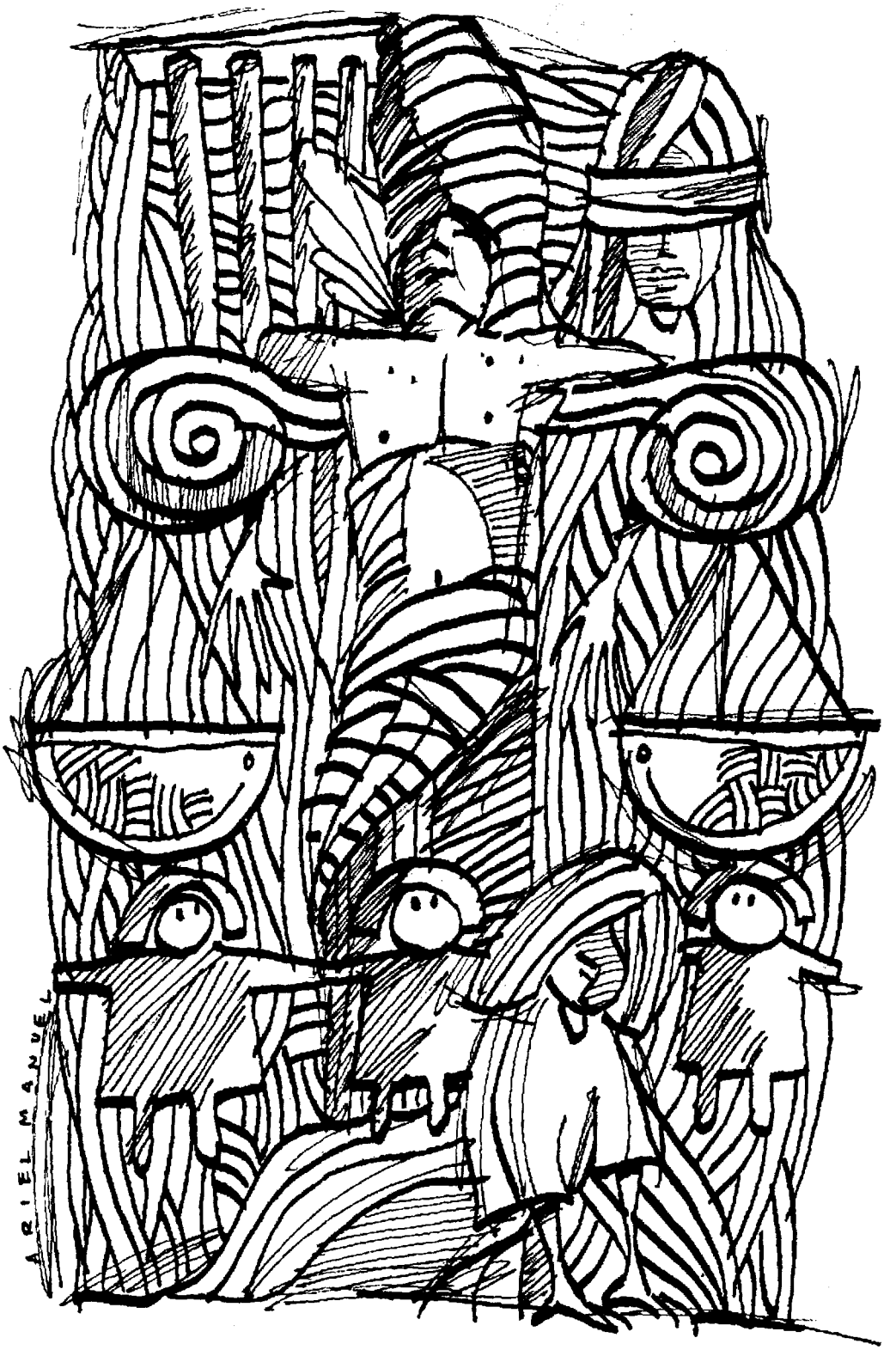
ARIEL MANUEL

The Mandatory Death Penalty for Perpetrators of Incestuous Rape: The Point of View of Child-Survivors

Bernadette J Madrid
and Mariella Sugue-Castillo

INTRODUCTION

There is increasing awareness of the problem of child abuse in the Philippines. Reports to agencies such as Department of Social Welfare and Development (DSWD) have been increasing significantly through the years. In 1998, the DSWD reported 3098 cases of sexual abuse. In 2002, the number of reported sexual abuse cases nationwide rose to 4129 (DSWD Statistics). The Child Protection Unit of the Philippine General Hospital has also seen an increasing number of sexually abused children since 1997. The average increase in the number of sexually abused children seen per year was approximately 20% in its first four years. From 1997 to

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Note: For convenience, the pronoun "she" is used for victims while the pronoun "he" is used for offenders in this article. While majority of victims of rape are females and majority of offenders in rape cases are males, the authors acknowledge that male victims and female sex offenders also exist.

2002, the CPU has evaluated a total of 2669 patients who were sexually abused (CPU Annual Reports, 1997-2002).

Clearly, the number reported by agencies such as the DSWD or the CPU represents the tip of the iceberg of sexually abused children all over the country. In the absence of a nationwide reporting system, the number of children who are sexually abused can be estimated from a community-based survey of adolescents conducted in 2000 (BSNOH Survey, 2000). In this study, 4% of adolescents reported experiencing sexual molestation with 1.7% reporting forced sex or rape. From previous studies, an average of 10.4% of Child Sexual Abuse is perpetrated by close family members (Fergusson, 1999). These cases of familial child rape would have to be managed at various Child Protection Units established at various health institutions in the country since 1997.

The existence of a mandatory death sentence for familial child rape forces physicians and other health professionals working within the continuum of care for child maltreatment to routinely face this issue and its impact on children and families. While there seems to be public acceptance of the death penalty for the crime of incestuous rape, health professionals working directly with abused children often hear mixed reactions from their patients and their family members about the imposition of this penalty on their own kin. Many have accepted that death is the appropriate penalty because it is stated in the law and has been public debated many times. Yet, not a few have verbalized that the penalty of death for familial child rape is too extreme. Still others come to the Child Protection Unit mouthing "*bitay*" without comprehending the full meaning of their words. Many are preoccupied with the possible consequences stemming from the death of the family breadwinner.

... the penalty of death for familial child rape is too extreme.

There remain many different beliefs and opinions on the imposition of the death penalty for familial child rape. Given this equipoise about the appropriateness and acceptability of the mandatory death penalty, there is a need to examine the imposition of capital punishment for familial child rape from the medical perspective. There is also a need to present clinical "lessons learned" regarding its effect as gathered by physicians and child abuse professionals and the families they serve.

The general objective of this paper is to examine the prescription of the mandatory death penalty for familial child rape using standards applied in clinical decision-making. Specifically, the objectives are:

1. To examine the effectivity of the death penalty in deterring incest / sexual offenses
2. To examine the effectivity of therapy for sexual offenders
3. To describe the effects of the death penalty on the child victim-survivors of sexual abuse perpetrated by a family member

HISTORICAL CONTEXT:**The History of the Death Penalty Worldwide**

The death penalty was widely applied in ancient times throughout the world. Among ancient Egyptians (IV millennium BC to the IV century AD), the death penalty was applied to those who broke Maat, the Universal Law. The crimes included murder, theft, sacrilege, attempt on the Pharoah's life and spying. Among the Babylonians under the Code of Hammurabi (1792-1750 BC), the death penalty was provided for 25 crimes such as theft, murder and wrongs at work, etc. In the 5th century BC, the punishments attending to the Roman Law of the Twelve Tables included beheading, flogging till death, crucifixion, drowning and burning alive.

In Europe, in the middle ages, the death penalty continued to be used by kings, emperors and feudatories for crimes ranging from murder, theft, high treason to sacrilege. The following centuries would hardly be any different. During the reign of Henry the VIII, 72,000 people were estimated to have been executed (Randa, 1977).

> ...the certainty of punishment, not its severity, was the key to deterring crime...

The modern movement for the abolition of the death penalty began in the 18th century with the writings of European theorists Montesquieu and Voltaire. The most famous work at this time was that of Italian jurist, Cesare Beccaria. In his essay, On Crimes and Punishment (1767), Beccaria theorized that there was no justification for the state's taking of a life (Schabas, 1997). Beccaria claimed that the certainty of punishment, not its severity, was the key to deterring crime, and that capital punishment was less helpful in preventing murder than life

imprisonment at hard labor (Haines, 1996). One of the first to abolish the death penalty was Tuscany in 1786.

Countries in general can be classified into abolitionist or retentionist with regard to their stand on the death penalty. "Abolitionist" for ordinary crimes means that the death penalty has been abolished for all ordinary offenses committed in time of peace such as those contained in the national criminal code or those recognized in common law (e.g., for murder, rape and robbery with violence). In these countries, however, executions have taken place within the past 10 years (for possession of illicit drugs for sale, etc.) and the death penalty is retained for exceptional circumstances such as those that may apply in times of war, e.g., for military offenses or for crimes against the State, including treason or armed insurrection. "De facto abolitionist" means that while the death penalty is in the statutes and death sentences may continue to be imposed, executions have not taken place for a long time – 10 years at least. "Retentionist" countries are those wherein death sentences have been imposed and executions have taken place within the past 10 years. Today, more than half the countries in the world have abolished the death penalty in law or practice (www.deathpenaltyinfo.org/dpicintl.html).

The following are the numbers for abolitionist and retentionist countries as of 2002:

Abolitionist for all crimes: 76
Abolitionist for ordinary crimes only: 15
Abolitionist de facto: 20

TOTAL - Abolitionist in law or practice: 111

Retentionist Countries: 84

Most executions occur in a handful of countries including China, Iran, Saudi Arabia and the United States. In 1977, the United Nations General Assembly affirmed a formal resolution that throughout the world, it is desirable to "progressively restrict the number of offenses for which the death penalty might be imposed, with a view to the desirability of abolishing this punishment" (www.newsbatch.com/deathpenalty.htm).

The Application of the Death Penalty In The Philippines

The body of criminal law in the Philippines is based on the Spanish *Codigo Penal* of 1898. Capital punishment was introduced in the country during the American Regime when a major revision of the criminal law in 1932 called for capital punishment for the crimes of kidnapping, murder, parricide, piracy, rape and robbery with homicide. After World War II, espionage was added to the list of capital offenses. The aftermath of World War II saw the creation of a new Anti-Subversion Law which called for the Death Penalty for all communist leaders. Between 1946 to 1965, 35 people were executed for offenses which the Supreme Court labeled as crimes of "senseless depravity" or "extreme criminal perversity."

During the Marcos Years (1965-1986), the Communist Party of the Philippines (CPP) and its armed wing, the New People's Army (NPA) grew considerably. Subversive crimes such as possession of firearms and arson were added to capital offenses, with deterrence touted as the official justification. One highly publicized execution during this time was that of a Filipino-Chinese drug dealer.

When President Cory Aquino came into power, a Constitutional Convention was held incorporating a strong Bill of Rights into the Philippine Constitution. During the Aquino years (1986 – 1992), the Philippines became a signatory to major human rights treaties. In 1987, the Philippines became the first Asian country in modern times to abolish the death penalty. However, only one year after its abolition, the military began lobbying for the restoration of the death penalty for crimes committed by the CPP/NPA.

In response to public clamor against widely publicized "heinous crimes," President Fidel Ramos restored the Death Penalty via Republic Act 7659 which took effect on 1 January 1994. Treason, murder, rape, kidnapping and selected drug-related crimes were among those listed as capital offenses. In 1997, the new Rape Law, Republic Act 8353, imposed the death penalty specifically "when the victim is under 18 years of age, and the offender is a parent, ascendant, step-parent, guardian, relative by consanguinity, or affinity within the third civil degree, or the common-law spouse of the parent of the victim."

In 1998, the year that President Joseph Estrada assumed office, the number of death penalty sentences imposed from 1998-1999 increased by 25%. President

Estrada then created a "Conscience Committee" in 1999 to review Death Penalty convictions, granting several reprieves.

Calls to repeal the Death Penalty were formalized with the filing of House Bill 8844 in Congress by Representative Roan Libarios in 2000. It was in the same year that the highly publicized first execution by lethal injection was done on Leo Echegaray who was convicted of raping his stepdaughter "Baby." Towards the end of the year, President Estrada imposed a moratorium on the Death Penalty in honor of Jesus' 2000th birth anniversary.

APPROACHING DEATH PENALTY FROM THE MEDICAL PERSPECTIVE

There is a need to examine the impact of the mandatory death penalty through three layers of perspective that health professionals involved in the fields of child protection and child advocacy must use in any clinical decision-making. There are three pertinent guiding tenets in the approach to children who are victims of child abuse:

1. Ethical principles: first do no harm

One of the most recognized ethical principles or dictums that governs the practice of medicine is the prescription to "first do no harm." This principle of **beneficence** refers to "the duties to avoid harm as well as to advance the welfare of others." However, this ancient nostrum is widely perceived to be only half-complete, as no intervention is without any risk of harm, and most medical decision-making is made by weighing the benefits against risks. Applying this same dictum to the application of the mandatory death penalty in incestuous child abuse requires a consideration of whether the potential benefit (severance of the perpetrator's access to the child) is worth the potential harms or risks (psychological distress, economic displacement, disruption of the family unit, etc.).

2. "Best interest of the child"

On August 21, 1990, the Philippines became the 31st country to ratify the UN Convention on the Rights of the Child (UNCRC). By signing the Convention, the Philippines is bound to implement the principles set forth during the convention and to provide all the rights enumerated in this instrument within the country's socio-economic, political and cultural context.

The UNCRC has 41 articles that stipulate the rights of all children. These rights are grouped into four broad areas: survival, development, protection and participation. **Survival rights** include the right to life, to an adequate standard of living, to health and to parental care and support. These rights are often threatened when the perpetrator of incest is also the breadwinner of the family. **Development rights** refer to those the child needs in order to achieve her full potential in all aspects of her being: mental, spiritual, social and emotional. To respect developmental rights requires a holistic view of the child. Taken in the context of survivors of familial sexual abuse, it is recognizing that her needs go beyond the medical or legal, and that appropriate management should consider the child's social, educational, spiritual and other needs. **Protection rights** refer to those that the child needs to be protected from abuse, neglect and exploitation in all forms. This includes the right to preservation of identity, to family reunification, against illicit transfer and non-return; and to protection from abuse. **Participation rights** are the most novel of children's rights enumerated. These recognize that children *can and should* be part of any decision-making concerning their welfare and development. Article 12 of the UNCRC states that *State Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.* The child's participation is based on his or her evolving capacity.

...children *can and should* be part of any decision-making concerning their welfare and development.

Aside from this declaration of rights, the UNCRC has four general guiding principles, namely: **best interest of the child, survival and development, par-**

ticipation and non-discrimination. The first is especially relevant to the issue at hand. Article 3 of the UNCRC enjoins all that "actions concerning children, whether undertaken by public or private social welfare institutions, court of law, administrative authorities or legislative bodies, the best interest of the child shall be a primary consideration." For decisions to be in the best interest of the child, they should recognize the child's unique individuality, evolving capacity and contextual features. Therefore, any and all decisions affecting the child should be *individualized and tailored to identified needs.*

3. Evidence-based medicine

The third and newest layer of lenses through which clinical decisions filter is the paradigm of Evidence Based Medicine (EBM). EBM provides the clinician the necessary tools to traverse the maze of medical literature to "determine the benefits and risks of alternative patient management strategies, and to weigh those benefits and risks in the context of an individual patient's experiences and values," so that these principles may be applied in the clinical care of patients. In evidence-based clinical practice, the "hierarchy" of evidence is recognized, for example, large randomized controlled trials provide the best evidence of causation while case-control studies provide, at best, evidence of association. The practice of EBM involves the finding and appraisal of the best evidence available in literature to guide one's clinical decision making. This implies knowledge of the strength of the evidence as well as the degree of uncertainty offered by such. In literature on clinical interventions, for example, one looks for evidence that the intervention in question results in a "benefit" without causing or causing the least "harm" for the patient. In addition, the clinician examines the results for methodological rigor to help him decide how much salt to take with the conclusions put forward.

METHODOLOGY

In "traditional" EBM parlance, "population" consists of sex offenders convicted to receive the death penalty and children who are the victim-survivors of their crime, while the "intervention" being studied is the mandatory death penalty for incestuous rape. The "outcomes" of interest are the following:

1. Deterrence of criminals from doing the crime which should logically manifest as changes in the crime rate, preferably a decline;
2. Recidivism rate of sex offenders, defined as repeating or committing another sexual offense following the index sexual abuse; and
3. Effects on the quality of life of the child-victim.

Given that the nature of the intervention and outcome variables of interest do not lend themselves to "traditional" EBM principles, this paper uses the following methodology to assess the evidence:

1. Presentation of integrative studies, in this case, narrative reviews on the effectivity of the death penalty; and
2. Case studies of sexually abused children seen in the Child Protection Unit (CPU) whose perpetrator is a family member who has been convicted and sentenced to receive the death penalty or stands to receive said penalty if convicted.

"Study Setting:" The PGH Child Protection Unit

The Child Protection Unit (CPU) of the Philippine General Hospital (PGH) is the first Multi-disciplinary unit of its kind in the country providing "sustainable comprehensive services for abused children and their families." Launched in 1997, the CPU sees more than 700 children each year from all over the country for allegations of child abuse. Majority of the children evaluated (approximately 60% to 70%) are diagnosed to have been sexually abused (CPU Annual Reports 1997 to 2002).

The CPU team is made up of doctors, nurses, social workers and mental health professionals. The doctors are usually pediatricians who conduct the medico-legal evaluation and testify in court on their findings and as expert witnesses. Social workers put together a comprehensive family profile on each patient at the time of the evaluation and conduct risk and safety assessments on subsequent home visits. The CPU social worker may also be the case manager of selected patients to help them access many needed social services. Child psychiatrists on the team provide mental health screening and therapy both for the child victim and for family members. The length of involvement of the CPU for each patient is not set and largely depends on whether the child still has need for services that the CPU can provide. All disciplines working in the CPU have confidential patient forms to record every encounter. Record keeping is centralized in the CPU office.

DOES THE DEATH PENALTY WORK IN DETERRING INCEST / SEXUAL OFFENSES?

The use of the death penalty has been a hotly debated topic for centuries. The main arguments by death penalty proponents are deterrence and retribution. On the other hand, those who wish to abolish the death penalty argue that it does not actually deter crime but instead violates human rights, discriminates against the poor and in some instances, may result in the deaths of the innocent.

Does the death penalty really deter crime?

A study done by Isaac Ehrlich in 1975 claimed that each execution between 1933 and 1969 had prevented seven to eight homicides. This led him to conclude that the death penalty had a substantial deterrent effect. In 1985, Stephen Layson, a student of Ehrlich's, used a similar methodology to update Ehrlich's analysis and estimated that each execution deterred approximately 18 homicides (Fox, 1989). However, the methodologies of these 2 studies have been criticized i.e. inferring micro trends from macro data and the utilization of aggregate data of all states (Albert, 1999). Sociologist William C. Bailey conducted within-state analyses of the deterrence hypotheses in the late 1970's and early 1980's by analyzing the ef-

fect of executions within a single state (California, Oregon, Utah, North Carolina and Ohio). His results showed no deterrent effect in any of the states examined (Bailey, 1998).

Recent studies in the late 1990's show that the death penalty does not have a deterrent effect and may have a brutalization effect instead. (RECAP Newsletter, National Death Penalty Developments, 12/99) A study by William Bailey (1998) comparing the murder rates and sub-types of murder before and after the resumption of executions in Oklahoma between 1989 and 1991 found there was no deterrent effect. What he found was a significant increase in stranger killings and non-felony stranger killings when Oklahoma resumed executions following a 25-year moratorium. In his study of criminal homicides in Los Angeles before and after the resumption of executions, Thompson (1999) found slight increases in homicides during the first 8 months following the first execution after a 25-year moratorium. Harries and Cheatwood (1997) studied differences in homicides and violent crime in 293 matched pairs of counties in the US who shared a contiguous border but differed on the use of capital punishment. They found no support for a deterrent effect of capital punishment at the county level. A survey by the New York Times (New York Times, 9/22/00) found that states without the death penalty have lower homicide rates than states with the death penalty. The homicide rates in the last 20 years of states with the death penalty have been 48%-101% higher than those of states without the death penalty.

The murder rate in the United States is three times the murder rate of European countries that have banned capital punishment (New York Times, May 11, 2002). In Canada, the homicide rates fell after the abolition of the death penalty. Statistics Canada reports that the number of homicides in Canada in 2001 (554) was 32% lower than the number of homicides in 1975 (721), the year before the death penalty was abolished (www.IssuesDirect.com).

Supporters of the death penalty contend that at the very least, the offender is prevented from committing a repeat offense. Executions, according to the retentionists, maximize public safety through a form of incapacitation and deterrence. The possibility of execution would give a potential offender pause before committing a crime out of fear of the consequences. Statistical measurements will

always be challenged because there is no way to survey would-be offenders. One famous quote is by John McAdams of Marquette University/Department of Political Science:

> *"If we execute murderers and there is in fact no deterrent effect, we have killed a bunch of murderers. If we fail to execute murderers, and in doing so would in fact have deterred other murders, we have allowed the killing of a bunch of innocent victims. I would much rather risk the former. This, to me, is not a tough call."*

A lot of supporters of the death penalty do not view it as a deterrent but rather as a just punishment for a heinous crime. (www.facts.com) It is an expression of society's outrage at a crime so grievous that an adequate response should be the penalty of death. Retentionists claim that the death penalty serves an important purpose in promoting the stability of a society governed by law. In doing so, it prevents anarchy and vigilante justice. Massive media coverage of violent crime promotes images of subhuman, remorseless killers and rapists, promoting fear and anger against violent crime. People then adopt a "tough-on-crime" stance that favors the death penalty based on retributive grounds alone. This has resulted in the death penalty becoming a mainstay of political campaigns (Dieter, 1993).

The general public and most professionals really know little about the death penalty. The opinion of an informed public would certainly differ significantly from that of a public unaware of the effects and consequences of the death penalty. Most people express doubts about the death penalty when they come to know the problems facing its implementation. The probability of executing innocent people is a reality that has been discussed extensively in recent studies. Radelet et.al. (1992) discuss over 400 cases in which the defendant was wrongly convicted of a crime punishable by death. At least 23 cases have resulted in the execution of innocent people. Scheck, Neufeld and Dwyer (2000) reported that DNA testing in 18,000 criminal cases excluded more than 25% of prime suspects prior to trial. Because the great majority of criminal cases do not produce biological material to be tested and DNA testing is not yet part of routine forensic investigation in the

Philippines, one can only speculate as to the error rate in death penalty cases pending before Philippine courts. The Innocence Project in the United States found that mistaken identification was the most common reason for wrongful conviction in the US, figuring in 61 of 110 cases (Tan, 2002). The other reasons identified by the Innocence Project were: errors in serological tests (40), police misconduct (38), prosecution's misconduct (34), defective/fraudulent science (26), bad lawyering (23), false witnesses (17), mistakes in microscopic hair comparisons (21), use of informants/snitches (16) and false convictions (15). (Tan, 2002).

A national survey (1993) conducted by the polling firms of Greenberg/Lake and the Tarrance Group in the United States on people's opinions about the death penalty revealed that support of the death penalty drops below 50% when sentence of life without parole, coupled with a requirement for restitution, is offered as an alternative (Dieter, 1993). It is sometimes argued by death penalty supporters that the death penalty is necessary to assuage the grief suffered by the family of the murdered victim. That may by true for some families. However, many families of murdered victims are also opposed to the death penalty.

DO INTERVENTIONS OTHER THAN CAPITAL PUNISHMENT SUCH AS THERAPY WORK? Evidence on therapy for sexual offenders

A series of analyses was done comparing the recidivism rate for 10,988 treated and untreated sex offenders in 79 studies that met inclusion criteria. Recidivism rates were investigated according to age of offender, age of victim, offense type, type of treatment, location of treatment, decade of treatment and length of follow-up. The analysis was designed to detect patterns in the data and the relative strength of patterns using three criteria formulated specifically for the study.

Many treated sexual offenders had recidivism rates below 11%, fulfilling the study cut-off for a positive treatment outcome. Treatment specific for Recidivism Prevention was also found to have positive outcomes, regardless of offender type, including rapists. When analyzed according to the type of sexual offender, juveniles and treated incest perpetrators had lower recidivism rates compared to their untreated counterparts, in contrast to treated non-incest perpetrators, child molesters and adult rapists.

It is interesting to note that incest perpetrators may have a lower risk re-offense to start with. In a study comparing the recidivism rate of child molesters according to the relationship of the victim with the perpetrator, the category of "stranger" displayed a higher risk for re-offense compared to perpetrators who offended against biological children or stepchildren. The percentage of men who were subsequently charged with any type of criminal offense and who offended against their biological children (19%) was smaller than men who offended against their children where the relationship is an extended family member (40%), acquaintance (35.9%) or stranger (45.2%). In addition, this study suggests that the risk for recidivism is not stable over time. The "predominant risk" for re-offending appears to be the first 5 years post release.

...there is evidence that directed and specific interventions to lower reabuse rates exist.

While these study findings should not be misconstrued as an advocacy for leniency for offenders in low risk categories such as incest perpetrators, the practical implication is that if the child's safety from re-abuse is the overarching concern, there is evidence that directed and specific interventions to lower reabuse rates exist. There is also documentation that incest perpetrators are not more "dangerous" compared to other types of sexual offenders. There is therefore no basis for imposing the mandatory death penalty only for incestuous rape.

What are the effects of the death penalty on the child victim-survivors of sexual abuse perpetrated by a family member?

The available studies on a child sexual abuse victim's mental health vis-à-vis legal outcome examine the effect of certain aspects of the legal process such as courtroom testimony, length of litigation and status of the case on behavioral and psychological symptomatology (Kendall Tackett, 1993). At present, there are no studies on the effect of the death penalty on the victims of convicted incest offenders, mainly because we are the only country with a MANDATORY death penalty.

Drawing upon the experience of the PGH-CPU in treating children and families affected by familial child rape, we report a series of cases illustrating the different

effects and reactions to the crime and its potential penalty. These were gathered from the patient records of the CPU and from newspaper reports (Cases #4 and #5).

CASE STUDY REVIEW: 1997 – 2002

Upon analysis of the cases handled in the PGH-CPU wherein the incident disclosed warranted the death penalty if convicted, we enumerate four recurrent themes:

- **Conflicting Reactions**
  Children and their families exhibit conflicting reactions to the death penalty for familial perpetrators of child rape

- **Case-Specific Mandates**
  Different reactions to and the impact of the punishment of death for the crime of familial child rape demand case-specific intervention and causality management

- **Mandatory Death Penalty Can Deter Reporting**

- **Mandatory Death Penalty Can Add Stress to the Family Unit**

We present four case studies to illustrate the conflicting reactions of CPU patients to the potential application of the death penalty in their cases. The different outcomes suggested in these cases demonstrate the need for clinical practitioners to be aware of the implications of the death penalty in cases of familial child rape and to treat each case uniquely.

Case #1 below shows that despite abuse, many children decline to pursue cases against their relatives. For children like Carol and Jego, the attachment to their families is stronger than the desire for justice.

Case Example #1

Children Choose Not to File Case Against Brother

"Carol and Jego"

Ages: 14 and 16

Alleged Perpetrator: Brother

Abuse Type: Sexual

CASE HISTORY	CASE STATUS
• Carol is a high-school student while Jego is in first year college, taking a computer technician course • Both sexually abused by their half-brother from their mother's previous relationship • Both are studious and dedicated to finishing school and getting good grades	• Children refused to file a case as long as brother is sent away ("dahil maapektuhan kami... basta makalayo na lamang sa amin") • Brother is sent away and has no contact with the children • Children back to pre-abuse functioning, back in school • Father initially wanted perpetrator-son to experience being jailed but decided otherwise because of fear that perpetrator's wife may have a nervous breakdown • Father said he favored the death penalty for others but not for his own son ("hindi ako pumapayag sa Death Penalty para sa anak ko pero sa ibang tao payag ako")

Maricel in Case # 2 sought retribution against her perpetrator but faced many difficulties in the end.

Case Example #2

A Child Seeks the Death Penalty
"Maricel"
Age: 15
Alleged Perpetrator: Stepfather
Abuse Type: Sexual

CASE HISTORY	CASE STATUS
• Maricel has been repeatedly raped by her stepfather, a much older man with grown children from his first wife • Mother initially disbelieving but became supportive of Maricel through legal process • Maricel's stepsiblings throw her, her younger sibling and her mother out of their house • Mother loses source of income which was her sari-sari store	• Maricel was able to testify in court after initial difficulty • Stepfather received death penalty • Maricel feels sorry for her stepsiblings but says her stepfather deserved what he got because it is what the law says *("naaawa ako sa kanila pero iyon ang karapatdapat na makuha niya...ayon sa batas")* • Maricel still in school but not getting good grades, often truant • Mother looking for other means of livelihood • Maricel never received civil damages

Some children like Felice in Case #3 below retract their stories because they are uncomfortable with pursuing a case.

Case Example #3

A Child Does Not File Case Because Death Penalty is Too Harsh

"Felice"

Age: 11

Alleged Perpetrator: Uncle

Abuse Type: Sexual

CASE HISTORY	CASE STATUS
• Felice comes from a southern province and was raised by adoptive parents since birth • Adoptive Mother had many partners • Ran away from home to come to Manila to work as domestic helper • In Manila, stayed with an uncle who is a policeman • Uncle sexually abused her, threatening her with his gun	• Felice does not file a case and is placed in a shelter *("...hindi po ako handa mag-file ng kaso.")* • *"Naaawa po ako sa Uncle ko dahil hindi naman po siya ganoon kasama at ayaw kong maparusahan ng Death Penalty"* • *"Kung may kasalanan tayong tao, dapat tayong magpatawad dahil sabi ng Panginoon"* • *Kahit gaano kasama ang isang tao, may pag-asa pa itong magbago"* • Felice is well-adjusted at the center

In Case #4, below, Sabrina and Justina appealed for clemency when they learned of the death penalty sentence for their father.

Case Example #4

Children Plead for Clemency
"Sabrina and Justina"
Ages: 13 and 15
Alleged Perpetrator: Father
Abuse Type: Sexual

CASE HISTORY	CASE STATUS
• Sabrina and Justina are sisters both sexually abused by their father • Their father is arrested and the daughters pursue a case • The father is found guilty of rape and sentenced to death	• Sabrina and Justina express regret upon learning that their father will be put to death • The daughters write to the presiding judge to appeal for clemency and a commutation of the death sentence • The judge has not changed his decision. Article 266-B does not allow for exceptions to the punishment of death in familial child rape convictions.

Although not a patient of CPU, we also cite here the reaction of the girl whose father was the first person executed for the heinous crime of familial child rape to show the full spectrum of reactions to the death penalty imposition. In this highly publicized case, Baby, profiled below in Case #5, sought retribution against the perpetrator, her stepfather.

Case Example #5

A Child Seeks the Death Penalty
"Baby"
Age: 10
Alleged Perpetrator: Stepfather
Abuse Type: Sexual

CASE HISTORY	CASE STATUS
• Stepfather, Leo Echegaray, is convicted and sentenced to death • Echegaray is the first person to be sent to death under Article 335 • Baby campaigns for the execution of her stepfather • When the execution is temporarily stayed by the government, Baby suffers bouts of depression • Baby announces that she wants to see the death penalty applied • Baby expresses her frustration with public opinion and the Catholic Church for encouraging the stay in Echegaray's execution	• Leo Echegaray is executed • Baby expresses that she believes justice was achieved

Mandatory Death Penalty can deter reporting

Child sexual abuse cases that reach the courts grossly underestimate the true prevalence of the problem. As it is, most ongoing sexual abuse is never disclosed Summit, 1983). Many clinicians in the field attribute non-disclosure to the Child Sexual Abuse Accommodation Syndrome (CSAAS, see below). Disclosure is typically an outgrowth of overwhelming family conflict, incidental discovery by a third party or sensitive outreach and community education by child protective agencies. Among the few who do disclose, only an even smaller percentage makes it all the way to the court. Particularly in the case of incest, the child is put on the defensive or attacking the credibility of a trusted adult and for creating a crisis of loyalty that defies comfortable resolution. Thus, treated, reported or investigated cases are the exception, not the norm (Fergusson, 1999).

In the CPU experience, only approximately 15% of sexually abused patients file cases that reach the point of going to trial (CPU Annual Reports, 1997 to 2000).

Clinical practitioners provide corroboration that the death penalty for familial child rape can deter children from reporting abuse. Given its seriousness, death penalty litigation could further traumatize child rape victims and perpetrators could use the specter of execution to dissuade children from reporting sexual abuse.

> ...the death penalty for familial child rape can deter children from reporting abuse.

Dr. Barbara Snow, a clinical social worker and co-author of "How Children Tell: The Process of Disclosure in Sexual Child Abuse" explains that should a sexually abused child be aware of the possibility that the perpetrator may be put to death as a punishment for the crime, the effect would be chilling and largely decrease the number of cases reported. Often, the child is already experiencing excessive self-blame and guilt; compounded by the knowledge that disclosure of the abuse could result in the death of the parent or relative, the emotional burden may be too overwhelming for the child to make a full emotional recovery from the abuse episode.

At this point, it is important to know about Child Sexual Abuse Accommodation Syndrome to better understand the dynamics of why children do not easily disclose sexual abuse.

Child Sexual Abuse Accommodation Syndrome

Child Sexual Abuse Accommodation Syndrome describes the way in which sexually abused children cope with abuse (Summit 1983). The characteristics of CSAAS span many cultures and ages, suggesting a nearly universal response to sexual abuse. CSAAS is characterized by the following behavior patterns which become the sexually abused child's way of coping with abuse:

- *Secrecy:* child is afraid to disclose abuse.
- *Helplessness:* child is unable to prevent abuse and thereby develops a feeling of helplessness during abusive episodes.
- *Entrapment and accommodation:* child begins to feel trapped by abuse, blames herself and accommodates the abuse; at this time, a child may begin to develop serious psychological problems.
- *Delayed, conflicting and unconvincing disclosure:* by the time a child decides to disclose, she has usually been through the three previous traumatic stages of CSAAS. Therefore, disclosure can be confusing and unconvincing, as secrecy, helplessness, entrapment and accommodation affect her disclosure.
- *Retraction:* without the proper support, most children will retract their disclosure of abuse. Summit reports:

  "Unless there is special support for the child and immediate intervention to force responsibility on the father, the girl will follow the "normal" course and retract her complaint."

CSAAS can manifest itself in any case, regardless of the punishment for the crime, and it is a constant clinical concern for physicians. However, in cases where the punishment for the crime is death, it is possible that CSAAS becomes more common and leads to greater secrecy, retractions and possible long-term psycho-

logical complications. Children suffering from CSAAS not only risk medical complications; their condition also limits their ability to offer "rigorous testimony" about the abuse episodes.

Although we cannot estimate the precise number of children who do not report because of fear of retribution from their families or remorse from the perpetrator, the PGH-CPU has had experience with a number of patients who rescinded complaints or refused to file charges because of the death penalty. The case that follows is illustrative. Some of the cases cited earlier are also illustrative of the manifestations of CSAAS in its different stages.

Case Example #6

A Child Does Not File a Case due to the Death Penalty

"Gina"

Age: 15

Alleged Perpetrator: Biological Father

Abuse Type: Sexual

CASE HISTORY	CASE STATUS
• Father sexually abuses Gina and her sisters but Gina is the only one who discloses • Mother does not believe Gina; family ostracizes her for bringing discord to their home • Gina decides on her own not to file a case because *"kailangan po siya ng family ko- financially dahil may trabaho ho siya, bus driver"* • Gina is particularly worried that if Father is arrested, medications and treatment her sister with chronic heart disease needs will be discontinued	• Gina decides not to file a case because her Father is the breadwinner • Gina became depressed but received therapy at CPU • Gina remains in a shelter run by nuns who continue her education. She is presently a 1st year college student. • Gina has no contact with perpetrator • Gina has expressed her desire to see her mother again and has visited her home with the nuns on one occasion. Family members do not visit her at the shelter.

- **Mandatory Death Penalty can add stress to the family unit**

Despite disparate reactions to the mandatory death penalty for familial child rape, one common thread in all family and child reactions to the existence of the death penalty is that of additional stress and complexity rather than the normalization of the family unit.

Case # 7 below highlights the elaborate measures some families must take in order to ensure children's safety and simultaneously avoid the death penalty.

Case Example #7

A Family Seeks its Own Alternative

"Elma"

Ages: 13

Alleged Perpetrator: Brother

Abuse Type: Sexual

CASE HISTORY	CASE STATUS
• Elma is 13 and mentally retarded • Father is a farmer and Mother is a teacher • Elma is left alone with her brother, Jun who is a 16-year old high school student with average grades • Mother discovered that Jun was sexually abusing Elma • Jun confesses and is remorseful	• Parents said they love their children and would not file a complaint nor can they bear to put their son in jail • Parents initially wanted to transfer Jun to an aunt's house. After much convincing, brother was placed in a shelter for boys and underwent therapy. He continued school while in the shelter. • Elma remained at home with the parents. She continued to be enrolled in SPED.

Alternatively, some families, as illustrated in Case #8, may abandon the abused child. Cases such as these indicate that the death penalty has the potential to cause more stress for families than to facilitate recovery.

Case Example #8

A Child Abandoned by Her Family
"Cynthia"
Age: 15
Alleged Perpetrator: Biological Father
Abuse Type: Sexual

CASE HISTORY	CASE STATUS
• Cynthia's parents are separated. She grew up with her mother while her father served a prison sentence for another crime. Mother since remarried. • Cynthia finally meets her biological father at age 15 when she visits him in prison. • Father rapes her and vows to marry her once he gets out of prison • Mother dissuades her from filing a case because she is afraid of Cynthia's father, who is a violent man • Mother does not want Cynthia to stay in her home for fear that she and her second family will be hurt by Cynthia's father • Mother endorses Cynthia to the care of the school guidance counselor	• Guidance counselor brings Cynthia to the CPU • Cynthia diagnosed with severe psychiatric and behavioral problems. Therapist recommends prioritizing psychiatric problems over filing a case. • Cynthia is placed in a non-government shelter • Cynthia undergoes intensive therapy as an outpatient with some improvement of symptoms. • She remains in the shelter with no visits from her mother. Cynthia often verbalizes her desire to see her mother and her stepfamily to shelter staff.

Case #9 below illustrates two sisters' retraction due to CSAAS. Unfortunately, many children find themselves in similar situations where it is easier to retract than to pursue a case against the perpetrator.

Case Example #9

Children Give Delayed Disclosure then Retract due to CSAAS

"Vina and Cherry"

Ages: 9 and 7

Alleged Perpetrator: Father

Abuse Type: Sexual

CASE HISTORY	CASE STATUS
• Vina and Cherry ran away from home in Metro Manila and disclosed to local Social Worker that they were being sexually abused by their father for the past 2 years • Both were brought to the CPU for evaluation then placed in a shelter • Mother was able to get children out of the shelter by saying that the girls would live with a relative. Mother did not believe they were abused.	• Mother and Father brought children to an island province to hide from authorities. Warrant of arrest issued for the father in Metro Manila. • The children were traced to the island province one year later through the efforts of the CPU Social Worker. Father was arrested and brought back to Manila. • Mother brings children back to Manila. Mother is combative and hostile; did not allow anyone to talk to the children and upheld Father's innocence. • Children were interviewed with their mother present and both denied the abuse. • Court orders the children placed in protective custody. • The children received therapy while in the shelter. After 3 months, they disclose that their father truly sexually abused them.

These illustrative cases demonstrate at best different reactions to the imposition of the Death Penalty, with the majority not in favor of it.

CONCLUSION

Using reasonable standards in clinical decision-making, is the mandatory death penalty for familial child rape beneficial for the child victims?

1. Dictum: "First do no harm"

Mandatory death penalty permanently bars access of a convicted familial child rapist from his victim. However, the death penalty itself or even the specter of its potential imposition also exerts "harmful" effects, including non-disclosure, retraction, psychological sequelae, family stress and abandonment of child, among others.

2. Dictum: Best interest of the child

The evidence cited above illustrates how a child's safety from reabuse cannot be guaranteed by the imposition of the mandatory death penalty. Clearly, an "intervention" that is not uniformly beneficial and may even be harmful necessitates looking for alternatives to ensure the child's safety from reabuse.

The death penalty does not answer needs for the healing and development of the child and her family. From a medical perspective – medical diagnosis with a prescribed health care plan – the mandatory death penalty is not indicated as an integral component of intervention and the reintegration health care plans for children diagnosed with familial child rape (sexual abuse).

In most countries around the world, care of children and families surviving familial child rape is managed without the use of the death penalty. Medically indicated care for sexually abused children requires integrated multidisciplinary care plans characterized by the following:

- Physical health care: treat all medical conditions
- Mental health care: counsel child, family and perpetrator

- Preventive health care: coordinate with law enforcement and social work services to ensure that the child is safe from further abuse
- Child development care: monitor child's development and act on any abnormalities
- Reintegration health care: follow-up health care; monitor sequelae, facilitate reintegration of child into family, foster home or adoptive care

The mandatory imposition of the death penalty is not cognizant of the right of children to participate in any decision-making affecting them. One cannot presume that all children who are victims of familial child rape clamor for their perpetrators to be put to death. The refusal to file charges or to pursue charges filed may be considered the children's expressions of their different reactions to the abuse, in the context of their life situation at that point in time and their evolving capacities to process the abuse and its aftermath.

The mandatory imposition closes the door to alternatives...

Mandatory imposition does not allow the flexibility that the individualized, holistic approaches to management of child abuse cases require.

3. Dictum: Using best available evidence

There is no (conflicting) evidence for the effectiveness of the death penalty in deterring offenders. A measure as absolute and as irreversible as taking the life of a person requires no less than clear undisputed evidence of benefit.

The mandatory imposition closes the door to alternatives that have evidence of efficacy.

RECOMMENDATIONS

Current Alternatives to Mandatory Death Penalty for Familial Child Rape

In an earlier treatise by the first author (Madrid 2001) on the Mandatory Death Penalty, the following alternatives were recommended. Two years later, the recommendations remain sound.

1. Modify the mandatory death penalty for incest rape to life imprisonment without parole.
2. Grant a moratorium on Death Penalty executions until the appropriate multidisciplinary management of familial child rape is determined.
3. Give judges discretion in meting out death penalty sentences.
4. Make the penalty for familial child rape consistent with the penalty for non-familial child rape.

Future Research Focus

The multidisciplinary approach to determine strategies to address the causes and attendant problems of familial child rape need to be studied. Specific areas needing answers from future research efforts include the following:

1. What are some alternatives to the mandatory death penalty for familial child rape?

   Prison based
   Example: Life imprisonment for Perpetrator: What is the impact on the abused child? On the family? On the perpetrator? Can the court order the perpetrator and his family to pay for imprisonment costs and continued child support?

   Non-Prison-based
   Example: Sex Offender Management Programs: Are these effective? Can they be utilized in the Philippines?

2. What are the long-term effects of the Death Penalty on the surviving family, specifically on their child-victims?
3. What is the full range of reasons why children desist from filing?
4. How adequate and appropriate are present investigative techniques and forensic technology for capital offenses?
5. What is the true, i.e., community-based, prevalence of Child Sexual Abuse? Most prevalence data are based on reported cases which have been shown to underestimate the actual prevalence. How can the present trend of decreased reports of sexual abuse be explained?
6. What are the characteristics of sibling incest? What is its prevalence? What are the effects of the death penalty on the victims? ...on perpetrators?

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Assessment of the Effectiveness of Medical and Surgical Missions in the Philippines

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I. INTRODUCTION

Medical/surgical missions are temporary health care services, of short duration, usually given free to underserved communities by the initiating or sponsoring entity. This sponsor may be a government unit or agency, a government official, a private philanthropic individual or group, a private non-government and non-profit institution or even a for-profit institution that uses its resources for a philanthropic purpose. Foreign-based organizations also conduct medical/surgical missions. These missions provide medical, surgical and dental services or a combination of services such as medical/surgical or medical/dental care.

More than 30 years ago, missions were already being conducted by civic organizations, professional groups, non-government organizations (NGOs) and local politicians to provide health services to poor areas. No official document has been

found formally endorsing these missions. The earliest reference appears in Department of Health (DOH) Order No. 184-A, s.1988 on the National Medical/Surgical Outreach Program which aimed to enhance health care services in the countryside through a series of medical/surgical outreach nationwide. Medical and surgical teams from DOH Metro Manila hospitals would be sent to host provincial hospitals to render medical consultations and perform surgical procedures that cannot be routinely done locally. The impact of such policy, however, was never evaluated, and despite an absence of policy evaluation, missions have become more frequent through the years.

In 2000, DOH Regional Offices reported a total of 398 medical missions, except for Regions V, VI and XII that did not provide information (Table 1). Cagayan Valley and Central Luzon attracted the most number of missions, followed by Northern Mindanao and Southern Mindanao. Far-flung and poor areas such as the Cordillera Autonomous Region, Eastern Visayas and the Autonomous Region of Muslim Mindanao do not seem to attract as many missions, despite these missions' stated objective of reaching out to underserved areas. In 2001, a database of institutions and individuals with interest, mandate or capacity to conduct missions yielded 974 names, out of which 170 were identified to have actually sponsored a mission.

TABLE 1: Number of Medical/Surgical Missions Held by Region, 1999-2000

Region	Medical/Surgical Missions	Population (In Million)	No. of Missions Per Population
I – Ilocos	10	4.2	1 per 420,000
II – Cagayan Valley	95	2.8	1 per 30,000
III – Central Luzon	111	8.0	1 per 72,000
IV – Southern Luzon	36	11.8	1 per 328,000
National Capital Region	19	9.9	1 per 523,000
V – Bicol Region	6	4.7	1 per 779,000
VI – Western Visayas	12	6.2	1 per 517,000

Region	Medical/Surgical Missions	Population (In Million)	No. of Missions Per Population
VII – Central Visayas	7	5.7	1 per 814,000
VIII – Eastern Visayas	5	3.6	1 per 722,000
IX – Western Mindanao	12	3.1	1 per 258,000
X – Northern Mindanao	32	2.7	1 per 859,000
XI – Southern Mindanao	29	5.2	1 per 179,000
XII – Central Mindanao	n.a.	2.6	n.a.
XIII – CARAGA	13	2.1	1 per 161,000
Cordillera Autonomous Region	8	1.4	1 per 171,000
Autonomous Region of Muslim Mindanao	3	2.4	1 per 804,000
Total	398	76.5	1 per 186,000

Note: Total figures in the second and fourth columns exclude Central Mindanao. Sources: RHO/Pahinungod Database, 1999-2000; National Statistical Coordination Board, May 1, 2000.

II. DESCRIPTION OF MEDICAL/SURGICAL MISSIONS

A. Rationale of Missions

Most mission sponsors aim "to provide community service" (28.4% of the respondents) or "to conduct medical missions" as part of their overall program (17.1%), according to the 2001 Institutional Survey undertaken by the Center for Economic Policy Research (see below for details). A few have mandates to promote the welfare of specific population groups such as soldiers, military veterans and their dependents. Still others undertake missions as part of their larger social-upliftment mandate or as part of the evangelical call. However, others are involved in missions only peripherally, their central mandate being education, research and extension and professional development, business and finance or some other rea-

sons. This indicates that almost any organized group can mount a mission, provided it has the wherewithal to do so.

Most missions are conducted "to alleviate the health problems of the poor" or "to reach out to the poor". However, these objectives are often combined with other reasons, such as "to promote the goodwill of the sponsoring institution or "to execute a program with a nongovernmental organization in an outreach community". A small but disturbing number of sponsors were not able to articulate the ultimate purpose of their mission. None of the respondents, however, admitted conducting missions for extraneous purposes such as promoting a product or political objectives.

Multipurpose missions such as medical/dental/surgical (37.1%) and medical/dental (35.0%) appear to be more frequently held, compared to single-purpose ones such as medical (5.6%), surgical (4.2%) and dental (2.1%) missions. However, in terms of patients' perception, single-purpose missions seem to be more important than multipurpose ones.

Box A summarizes the key steps in planning, implementing and monitoring missions in the Philippines.

Box A – Key Steps in Planning, Implementation and Monitoring of Missions

A medical/surgical mission involves a complex set of activities that must be organized well to achieve its intended purpose. Ideally, the mission must be planned way in advance. Planning involves, among others: (a) Obtaining a formal request from the local government unit (LGU). (b) Inquiry from the DOH, the Professional Regulations Commission and local medical and related professional societies on rules and regulations governing missions. This is important if foreign doctors are involved. (c) Coordination with co-sponsors and other groups on their committed resources, e.g., personnel, drugs and other inputs. (d) Finalization of the mission date and announcement of the date to the local community. (e) Orientation of mission staff and volunteers.

The implementation of the mission itself involves: (a) Courtesy call to LGU or NGO hosts. (b) Physical exploration and assessment of the community and venue. (c) Organized registration and listing of patients. (d) Preassessment and identification of medical cases, patient screening and patient "clearance" for treatment. (e) Providers' consultation and treatment of patients, including prescription and all necessary medical information that patients must do after the mission. (f) Referral to local doctors of surgical cases or patients who otherwise cannot be dealt with during the mission. (g) Medical and pharmacy recording and encoding of patients seen. (h) Provision of amenities (snacks) to patients seen.

Post-mission work usually involves: (a) Submission of patient lists and reports to government or NGO offices. (b) Financial liquidation of advances received or reimbursement of expenses incurred. (c) Post-assessment and follow-up of post-operative cases through feedback from district hospitals or local doctors on the referred cases. (d) General monitoring and evaluation.

B. Location, Duration and Frequency of Missions

Mission location is determined largely through consensus among mission sponsors (35.0%) or as an executive decision by the president, the executive committee, the social action director or the community extension service officer (25.9%). Although the sponsoring group invariably makes the final decision, the mayor/municipal council, the barangay chief/council or the rural health unit in the locality are usually consulted, although this is not a universal practice.

A mission sponsor may have a regular focus area to conduct missions, but this does not appear to be the rule. Rather, most mission sponsors (55.2%) reported conducting missions in different areas, depending on such key criteria as the needs of the beneficiaries and the request of the LGU. Among 143 respondents, 42.2% said they took into account the needs of beneficiaries, 24.5% said they responded to a specific LGU request and 12.4% mentioned area accessibility as an important consideration. These criteria are confirmed by barangay respondents who reported that the large population, the number of poor residents and inadequate medical

care in the barangay as the key factors in mission sponsors' choice of their locality. However, the barangay respondents also cited "LGU mandate" and "political considerations" as important determining factors.

Most missions are conducted on an annual basis (21.7%) or semi-annual basis (19.6%). Some sponsors do so as frequently as quarterly, monthly or 2-3 times a month, although not always in the same location. Others mount missions on a non-regular basis or as the need arises. Contrary to conventional wisdom, most missions do not occur during specific anniversaries, Christmas breaks or semestral breaks. Sponsors showed no preferred months or days to conduct a mission; timing is usually a function of the request of the LGU or the availability of resources, especially personnel. In most cases, however, missions occur at the height of the dry season, from March to June, with April and May being the busiest months. Missions are usually held on weekends and may involve the Friday before or the Monday after.

...large population, the number of poor residents and inadequate medical care in the barangay (are) the key factors in mission sponsors' choice of their locality.

Most missions are of short duration. A simple outreach to a sponsor's immediate vicinity or own locality may take half-a-day or one day at most, as for instance an urban hospital doing outreach work to a slum area. A major medical/surgical mission usually takes 2-3 days for a relatively accessible site. A remote site may take a week of mission work, with a significant amount of the time taken up by travel. In terms of venue, missions are usually held in the barangay or multipurpose hall, the health center, the school, the hospital, a covered court or the plaza.

II. EVALUATION STUDY OF MEDICAL AND SURGICAL MISSIONS

A. Objectives of the Study

In April 2001, the DOH's Essential National Health Research Program commissioned the Center for Economic Policy and Research (CEPR) to conduct a rapid assessment of medical and surgical missions in the Philippines. The increas-

ing frequency in the deployment of these missions as a health service delivery mechanism especially in underserved areas calls for objective information on whether missions are appropriate to the health needs of poor Filipinos, whether they are effective and whether they use resources well. Thus, the objectives of the study are: to describe the sponsors of missions and to build a typology of them; to analyze how such missions are operated by identifying their objectives, describing their mechanics and procedures, and establishing information on the costs they incur and the benefits they generate; and to assess their effectiveness by quantitative (resource use and costs) and qualitative means.

B. Methodology of the Study

The study involved desk research and primary data gathering. Desk research involved the analysis of the results of the survey of Ugnayan ng Pahinungod and DOH Regional Health Offices (RHO) on the occurrence of medical/surgical missions. The results of this analysis informed the subsequent surveys undertaken for this study, including the typology of mission sponsors and thus the sampling frame and the site selection. Individual names of institutions were downloaded from the mission sponsors' Internet websites or taken from the Commission on Higher Education or from specialty societies.

Subsequently, primary data were gathered through three surveys. On the basis of two criteria – number of missions conducted and the conduct of all three types of missions, i.e., medical, dental and surgical mission – four provinces were selected as survey sites: Cagayan and Zambales (in Luzon), Negros Occidental (in the Visayas) and Davao del Sur (in Mindanao). A random sample of barangays was selected from these provinces. The site visits were made from June to July, 2001. Table 2 provides a summary of the location and number of respondents of the three CEPR surveys.

Three inter-related surveys were undertaken. The CEPR survey of patient-beneficiaries generated information on the household profile mission beneficiaries, including socio-economic and demographic characteristics; the household's medical mission experience, including knowledge and actual use of mission services;

illness reported to these missions; patient compliance with mission provider's instructions; perceived improvement in health status after the mission; and problems encountered with the mission.

TABLE 2: Number of Respondents for the CEPR Surveys, 2001

Province	*Focus Barangays and Cities/Municipalities*	*Mission Sponsors' Institutional Survey* (N=no. of institutions)	*Patient-Beneficiary Survey* (N=no. of households)	*Barangay Survey* (N=no. of officials and other key informants)
Cagayan	Carig Norte, Tuguegarao	6	12	1
	Carig Sur, Tuguegarao		13	1
	Pussian, Alcala		21	2
Zambales	San Isidro, Castillejos	1	27	2
	Baloganon, Masinloc		27	2
Negros Occidental	Tabao Proper, Valladolid	1	20	2
	Isio, Cauayan		20	2
Davao del Sur	Mintal, Tugbok District, Davao City	2	20	2
	Sirawan, Toril District, Davao City		20	2
Others	Manila-based MSM Institutions, etc.	148	—	—
Total	8 barangays in 7 cities and municipalities	158	180	16

Source: This study.

The CEPR survey of sponsors of missions generated information on their institutional profile including name, contact address, institutional type, year of incorporation, mandate and institutional affiliation; mission activities including the type of

missions conducted; frequency of missions; rationale of these missions; institutional coordination and collaboration; location, timing and duration of the missions; mission operational policies and procedures; mission beneficiaries; the resources used in the conduct of these missions; and the problems faced by the institution in the conduct of missions.

The CEPR survey of municipal and barangay officials and medical practitioners generated information on the officials' knowledge of the operations of missions in their locality; their level of involvement in the choice of location, timing and venue of the missions; existence of local policies and procedures governing the conduct of these missions; general collaboration and participation before, during and after these missions; their perception on the beneficiaries of these missions; the resources used by the barangay in these missions; and the immediate benefits as well as long-term ripple effects of these missions on the locality.

C. Limitations of the Study

Respondents provided generally scanty data. Although the CEPR institutional survey generally received a good response rate from mission sponsors, data provided were not always complete. Only a few bothered to answer the sections on resource use and costs and on mission processes and procedures. The incompleteness of responses may be a reflection of poor record-keeping which, in turn, may be due to the lack of a systematic and regular reporting of mission work to a regulating or clearinghouse body. These institutions' poor process documentation may also reflect the absence of work standards that they are mandated to follow. Although the DOH has issued a department order on key aspects of mission work, the extent to which the order is being heeded is not known since enforcement capacity is weak, especially after health services were devolved to local government units.

III. KEY FINDINGS OF THE STUDY

The study's findings revolved around four key areas: (1) the immediate health benefits of missions, especially among the poor; (2) operational issues in the planning, implementation and monitoring of missions and the generally poor regulation

of these activities; (3) the large and often under-appreciated opportunity costs of missions; and (4) the potential negative ripple effects on the health system as a consequence of missions.

A. Health Benefits Among the Poor

Household Knowledge and Availment of Mission Services. True to their intention, missions mostly cater to the poor. The typical head of a household availing of mission services is a male, between 31-50 years old, who has at least finished high school. He is usually a laborer, a tricycle or jeepney driver or a farmer. Some household heads are so poor that they are completely dependent on other relatives. The typical household has an annual income of only P20,000 to P40,000, but the household is usually large with as many as 6-10 members. The crowding may explain the average household's proneness to contracting diseases, especially communicable ones. Around 15.6% of the household respondents said they had a household member who got sick during the last six months, usually from fever, flu, coughs and colds, asthma or a combination of symptoms.

Household respondents appeared to be knowledgeable about missions. Around 55.0% of them said the barangay health worker informed them of the mission, while 36.1% said it was the mayor or the barangay captain or other officials. Radio spots were also sources of mission information. Almost all (96.1%) beneficiaries reported availing of mission services in the last 2.5 years. Only 3.9% reported not availing, mainly because the respondent was not at home during the mission, or did not hear about the mission or did not have an illness.

Household knowledge about a mission and actual attendance varies by the type of mission sponsor or group. For instance, those knowing about a mission sponsored by a government official, politician or public figure are much more (4.4% of the respondents) than those actually using the services of such a mission (only 1.1%). (See Table 3). It may be that a politically-motivated mission only attracts persons who subscribe to the sponsoring political party, even if people knew that such a politician-sponsored mission is meant for all. On the other hand, actual

attendance at missions sponsored by specialty societies, religious groups and socio-civic groups is higher, even if these are not usually known as sponsors.

TABLE 3: Household Knowledge of and Actual Attendance in a Mission, 2001

Mission Sponsor or Group	Percent of Households Who Know Group as Usual Mission Sponsor (N=180)	Percent of Households Who Know Group as Regularly Conducting a Mission (N=180)	Percent of Respondents Who Actually Used Services of Mission Sponsor (N=180)
DOH	43.3%	28.3%	34.4%
Local Governments	25.0%	21.1%	26.1%
Dept. of National Defense	7.8%	6.7%	6.1%
Public figure/Gov't official	4.4%	3.9%	1.1%
Medical specialty societies	6.1%	4.4%	8.3%
NGOs (religious and socio-civic groups, and voluntary organizations)	2.9%	6.7%	12.2%
Don't know/ no response	10.5%	28.9%	11.9%

Missions vary in the health services they offer. Among household respondents, 61.1% received free medicines and vitamins; 28.3% had surgery; 7.8% received free medical check-up or consultation; and 2.2% were given prescriptions for medicines to be bought elsewhere. None reported being referred to a hospital or another health facility. The typical illnesses for which mission services were provided were dental; circumcision; cough, cold or fever; cataract or other eye problems; hypertension; asthma; wound dressing; pneumonia; and immunization (see Table 4). Less frequently mentioned medical conditions are allergies, arthritis, rheumatism, breast cancer, diarrhea, goiter, harelip, hearing problems, kidney problems, migraine, sinusitis and tuberculosis.

TABLE 4: Usual Cases Seen as Reported by Households and as Perceived by Barangays and Mission Sponsors, 2001

Usual Cases Seen	According to Households (N=180)	According to Barangays (N=16)	According to Mission Sponsors (N=143)
Dental	26.7%	20.0%	5.7%
Circumcision	11.7%	12.0%	1.4%
Cough, cold, fever/URTI	10.6%	20.0%	14.9%
Cataract/ other eye problems	5.0%	4.0%	2.8%
Asthma	4.4%	0.0%	12.8%
Hypertension	2.8%	4.0%	4.6%
Wound dressing	2.8%	0.0%	0.0%
Immunization	2.2%	0.0%	0.4%
Others	33.8%	40.0%	57.4%

Quality of Care. Although no specific assessment of quality of care was made, results of the survey can provide indications of how well missions cater to patients' needs. Three indicators were examined: unserved patients, volume of patients per provider and patient compliance and continuity of care.

1. Unserved Patients. Results of both the institutional survey and barangay survey confirm that in some cases, demand for mission health services exceeds supply. Table 5 shows a sample of mission sponsors by the volume of patients seen (with cutoffs for "small", "medium" and "large" missions), and whether or not they were able to cater to all their patients. Of the 42 respondents that provided complete information on their patient load, 26 (or 61.9%) were able to accommodate all their patients. However, 16 of the sponsors (or 38.1%) admitted that not all of their visitors were served. Unserved patients appear to occur whether or not the mission is small, medium or large. These findings on unserved patients were confirmed by both sponsors and barangay officials. Among mission sponsors, 30.3% said they were not able to serve all patients while 8.2% had no response or did not know. Among the 16 barangay respondents, six (or 37.5%) reported a significant number of unserved patients, ranging from 20 to 620 per mission.

TABLE 5: Number of Unserved Patients as Perceived by Mission Sponsors, 2001

Mission Sponsor Respondents by Volume of Patient Visitors and Ability to Serve All Patients (N=42)	How Many Patient Visitors Go to Your Mission? (A)	How Many Patient Beneficiaries are Served in Your Mission? (B)	Estimated Number of Unserved Patients (A-B)
I. Missions that are able to serve all patients (n=26)			
Small missions (n=10)	30 to 150	30 to 150	-
Medium missions (n=7)	200 to 480	200 to 480	-
Large missions (n=9)	501 to 1,000	501 to 1,000	-
II. Missions that are not able to serve all patients (n=16)			
Small missions (n=3)	200 to 250	100 to 150	Around 100
Medium missions (n=10)	280 to 550	40 to 360	50 to 510
Large missions (n=3)	800 to 4,000	700 to 3,000	100 to 1,000

Note: Under I, small missions are defined as those with patient visitors from 1 to 150; medium, from 151 to 500; and large, from 501 and more. Under II, small missions are defined as those with patient visitors from 1 to 250; medium, from 251 to 600; and large, from 601 and more. Source: This study.

Mission sponsors who are not able to accommodate patients refer them to other medical institutions (37.8%), give them cash to purchase medicines or provide other forms of financial or assistance (7.7%). A few sponsors, however, simply instruct the patient to wait for the next mission (17.5%) or have no response at all, leaving the patient uncared for (27.3%).

2. *Volume of Patients Per Provider.* Based on available data of 10 mission sponsors, Table 6 shows the number of patients served per physician and nursing personnel per day of the mission. Each doctor or surgeon sees an average of 47 patients per day, ranging from 16 to 100. On the other hand, each nurse or medical aide sees an average of 40 patients per day, ranging from 13 to 75. The large vari-

ances in output per health personnel can be accounted for by factors such as patient caseload, type of patient seen (medical or dental or surgical), severity of illness treated, orderliness of the mission, bottlenecks (inadequacy of instruments) and distance of the mission site. The provision of an honorarium is also an important factor in personnel productivity. Some external factors, such as the devotion of the mission sponsor, or perceived politicization of the mission can also affect the performance of the health provider.

The large number of patients seen by each provider (especially those exceeding 50 a day) raises issues about quality of care of mission services, especially those providers seeing 50 or more patients a day. The limited number of providers and time during a mission tends to make providers work in a hurry, resulting in "depersonalized" consultation and treatment. There are currently no set standards with respect to this aspect of mission work, and could be developed through a more detailed time and motion study.

TABLE 6: Number of Patients Served Per Physician and Nursing Personnel Per Day, by MSM Institution, 2001

Mission Sponsor	No. of Patients Served Per Doctor and Surgeon Per Day	No. of Patients Served Per Nurse and Medical Aide Per Day
Code # 4	41	20
Code # 23	100	57
Code # 24	40	13
Code # 42	60	51
Code # 51	16	-
Code # 82	16	19
Code # 83	36	25
Code # 84	25	40
Code # 89	59	59
Code # 97	75	75
Average	47 (n=10)	40 (n=9)

3. Patient Compliance and Continuity of Care. A key issue in medical/surgical missions is whether patients follow doctor's instructions and whether they receive continuity of care after the mission ends. Most patient respondents (93.3%) said they followed the mission doctor's instructions; only 2.8% said they did not do so, due to financial constraints (*"walang pera"*) or lack of follow up by the mission doctors. In fact, among all respondents who availed of mission services, 63.3% said they were not given post-mission care. The seriousness of the issue of continuity of care needs to be underscored since majority of poor households (53.9%) reported having a regular (*"suki"*) doctor, with almost all of them being able to name and locate such a doctor. If this is the case, then a mission has a tendency to disrupt the care provided by the household's *"suki"* doctor.

Analysis of the usual caseload of missions can provide indications of whether MSMs can appropriately handle these health conditions or not. For instance, while dental extraction, cataract removal, wound dressing, circumcision and elective surgeries are "once-off" cases and can be properly dealt with in missions, many of the reported cases are chronic in nature – allergies, asthma, diabetes, hypertension, etc. – and require continuing care. The provision of immunization and other preventive health services could also turn problematic, especially if these mission services are not properly coordinated with local health or DOH programs mandated to do this. Spurts of tuberculosis care provided by missions through TB drugs may engender drug resistance, if the patient fails to complete the therapy and falls sick again after the mission has left. Finally, the generally poor referral reported in the survey could result in animosities with patients as well as with local providers.

In most cases, patients did not encounter problems in availing of the services of missions. However, a significant percentage of patient-respondents (28.3%) encountered problems, including the inadequacy of drugs, too many patients that led to long queues, disorderly service (*"hindi maayos na serbisyo"*) probably due to the lack of a structured mission program and protocol, non-uniform services (*"hindi parehas na serbisyo"*), prescribing medicines for a fee and inadequate medical equipment and instruments.

Impact of Missions on Individual and on Public Health. Individually, some 63.3% of the patient-respondents noted the general improvement in their health status (*"bumuti ang kalusugan"*) after receiving services from a mission. An additional 8.9% of the respondents also recognized the positive contribution of missions, although they were less specific (*"nakatulong sa amin"*). Some 6.1% of the interviewees responded positively to the preventive/promotive health aspects of missions and now recognize the value of health (*"pinahahalagahan ang kalusugan"*). However, a disturbing 17.8% had no response to the impact of missions in their lives, possibly because they did not utilize, or did not get well from, mission services.

From a public-health point of view, health workers noted four specific social benefits. First, the immediate health intervention provided by missions, especially in calamity situations, can prevent the outbreak of an epidemic. This was cited by as many as seven mission sponsors. Second, missions provide medical specialists who otherwise are not available in the area. Third, the identification of early symptoms and risk factors during a mission can avert the development of more serious (and more expensive to treat) medical conditions later. Finally, missions can engender transfer of technology through the interaction of mission providers with their local counterparts. It covers not only the technical aspects of the provision of care (proper medical procedures, types of medicines prescribed and up-to-date professional practices), but the general exchange of ideas, problem-solving techniques, communication and ways of relating with clients. Close to half (43.8%) of the barangay respondents value this enhancement of the knowledge and skills of local medical practitioners brought about by missions.

Barangay and municipal officials generally approve of the conduct of missions in their locality. Fourteen of the 16 respondents (or 87.5%) think that missions positively affect health status and health practices through curative care (free consultations, medicines and operations), preventive and promotive care (the importance of personal hygiene and cleanliness of their houses and surroundings), general health information and education on how to avoid specific diseases and the need to seek medical care as soon as symptoms were felt. Support of missions by barangay respondents, however, was not universal. A few of them did not view

missions in a positive light principally because these only had limited beneficiaries and services and are only held seasonally or irregularly.

Mission Effectiveness. Table 7 shows the effectiveness ratings of missions from the points of view of mission sponsors and client barangays. Institutional self-rating of effectiveness is generally high: 23.1% of institutions surveyed rated missions in general as "excellent" in providing community benefits, while 35.0% rated them as "very good". Most of the missions sponsors that rated themselves "very good" (20.3%) in providing community benefits are from the government, the 13.3% that rated themselves as "excellent" are also from the government.

less-than-compelling rating of missions may be due to these missions' inability to address the full spectrum of health care or the total needs of their clients.

TABLE 7: Effectiveness Rating of Missions by Mission Sponsors and by Barangays, 2001

Rating	Mission Sponsor Self-Rating of Effectiveness in Providing Community Benefits (N=143)	Barangay Rating of Mission Sponsor in Treating Illness (N=16)	Barangay Rating of Mission Sponsor in Improving Health Care (N=16)	Barangay Rating of Mission Sponsor in Improving Quality of Life (N=16)
Excellent	23.1%	0.0%	0.0%	0.0%
Very Good	35.0%	50.0%	18.8%	12.5%
Good	18.9%	43.8%	62.5%	56.3%
Fair	4.9%	6.3%	18.8%	18.8%
Bad	0.0%	0.0%	0.0%	12.5%
No response	18.2%	0.0%	0.0%	0.0%

Barangays, however, are less convinced about the effectiveness of missions. Only 50.0% of the barangay respondents think missions are "very good" at treating

illness, while a much smaller 18.8% of them think they are "very good" at improving health care. None of the barangay respondents rated these missions as "excellent". The majority think they are either "good" or just "fair" in these endeavors. The less-than-compelling rating of missions among barangay respondents may be due to these missions' inability to address the full spectrum of health care or the total needs of their clients.

B. Operational and Regulatory Issues

Existence of Mission Operational Guidelines. Only 58.7% of the sponsors reported having mission guidelines and a smaller percentage (37.1%) reported having mission policies. (Most of the mission sponsors with operational guidelines and policies were established and began sponsoring missions in the 1990s.) Of those who do have operational guidelines, the high variability in their responses indicates the high variability of these procedures. These are disturbing indicators considering the increasing visibility of missions in the Philippines.

It is not known what form these guidelines and policies take. As a matter of good practice, these should be in written form and disseminated by the mission sponsor to mission partners and providers. Of those who reported having guidelines, the steps summarized in Box A were deemed important as to be written in an operational manual.

Awareness of Relevant Laws and Regulations. Only 18.9% of mission sponsors are aware of specific government laws and administrative orders on the conduct of missions. In fact, as much as 63.6% of the institutional respondents claimed ignorance of these legal and regulatory instruments. Clearly, the regulation of medical and surgical missions in the Philippines leaves much to be desired.

Among the institutions that claimed knowledge of applicable laws, orders and circulars, the following were mentioned:

- Republic Act. No. 7846; Republic Act. No. 8172;
- Laws on physician licensing, medical specialties, patient safety and ethical practices in medicine;

- DOH Administrative Order 16-A s. 1998, Administrative Order 13-A, s. 1999 and Administrative Order 41-B, s. 1999 all of which defined the standard operating procedures with respect to request and approval of the holding of missions;
- Policy on foreign-sponsored missions requiring permit from the DOH and the Professional Regulation Commission;
- Philippine Medical Association administrative procedure from the Committee on Disaster and Relief Operations;
- Generic Drugs Law, Pharmacy Law (drug dispensing), Bureau of Food and Drug Administration policies; and
- the Local Government Act.

Level of Local Participation. From the point of view of barangay officials, the participation of local leaders and practitioners in missions is very active or moderately active; none of them admitted being inactive. Barangay perception of helpfulness varies highly from site to site, and from one partner to another. Among the barangay sites, Baloganon (in Masinloc, Zambales) and Mintal (in Davao City) appear to provide examples of good practices in the area of partner helpfulness. Their experiences need to be documented for wider-scale sharing with other mission sponsors and participants. It appears from Table 8, however, that helpfulness is highly correlated with the level of organization of the partners, i.e., the better organized the partners, the more helpful they are. Conversely, poorly organized partners also tend to be less helpful. The level of helpfulness and organization does not appear to be a function of the number of partners involved in the missions. There are sites with few mission partners but are not very organized; on the other hand, there are sites with quite a number of partners but are highly organized.

Mission sponsors generally provided lukewarm response with respect to their level of collaboration and coordination. Less than half (47.6%) admitted coordinating their mission work with other agencies or partners, while more than half (55.9%) admitted having collaborative relations with others. Curiously, these same institutions invoked the importance of coordination and collaboration in mission work. It is not clear, however, where the responsibility and locus of coordination or

collaboration should be. Many mission sponsors take the view that other agencies (DOH, local governments) should coordinate or collaborate with them, rather than the sponsors themselves taking a proactive stance in actively seeking the inputs of these partners. This is a contentious issue that needs further clarification.

Table 8: Barangay Perception of the Level of Helpfulness of Various Mission Sponsors in Missions, 2001

Organization	Isio	Tabao	Pussian	Carig	San Pablo	Baloganon	Mintal	Sirawan
Politicians					8		10	7
LGUs	4		8	8.5		10	8.5	8
Military	8.5	7	8			10	10	
Local private health providers	8	7						
Local gov't health providers	10							
DOH, DECS						10	10	
NGOs		8			8	10	9.5	6.5
Religious leaders						10	9	

Note: 1=least helpful; 10=most helpful. Source: This study.

C. Opportunity Cost of Missions

Missions entail a variety of inputs, incurred by both the sponsor itself as well as those by partners or co-organizers, e.g., drugs and supplies donated by other parties and volunteers' time. Analysis of available data from 15 mission sponsors indicates the large opportunity costs of these activities.

Personnel Costs. A medical mission usually consists of a team of doctors, nurses, medical aides and field guides. A surgical mission also includes surgeons.

In addition, there may be other trained providers such as pharmacists, interns, social workers and barangay health workers. The size of the mission is determined principally by the number of doctors in the mission team. Small missions usually involve 1-5 doctors; medium missions, 4-10 doctors; and large missions, 8-15 doctors. Mission personnel usually work as volunteers. However, many mission sponsors do provide an honorarium, the average per day being P930 for doctors, P930 for surgeons, P430 for nurses and P365 for medical aides.

Cost of Drugs and Other Supplies. In many cases, medicines, surgical and other medical supplies are donated by other parties, e.g., health care companies, the DOH, other government agencies and philanthropic organizations. For the most part, mission sponsors do not keep accurate and reliable records of the value of these donated inputs. However, based on incomplete information, the cost of medicines, surgical and other supplies could vary from P7,300 to as high as P100,000 per mission, depending on the volume of patients and the type of health services dispensed.

Other recurrent costs include medical instruments and apparata, food and lodging for mission members, gasoline and other vehicle expenses, and food for selected patients. In general, mission sponsors keep poor track of these expenses but from three informants who provided data, the following can be gleaned: (1) Food for mission members is mostly donated by the local government unit (municipal or barangay council) or the hospital or health center where the mission is being held. Only three mission sponsors reported spending on food, with food allowance varying from P100 to P400 per person per day. (2) Board and lodging is, for the most part, the responsibility of the local government. In one case where the mission sponsor had to pay for this, an allowance of P150 per person per day was provided. (3) A gasoline allowance of P2,000 to P3,000 is usually provided for by the sponsoring institution, though sometimes, the local government unit shoulders this cost. Special arrangements may be resorted to where the local government unit vehicles are borrowed, with their own gasoline allowance. (4) Medical instruments and apparata (weighing scales, sphygmomanometers, medical kits, thermometers) are usually solicited from mission partners. Foreign missions almost always bring their own equipment and apparata.

Cost Per Patient. Cost data were generated for personnel and supplies (see Table 9). Personnel cost averaged P35 per patient, varying from P16 to P395 (the extreme high value due to the high honorarium provided by a Manila-based socio-civic organization to its participating surgeons). Supplies cost averaged P118 per patient, varying from P70 to P379. Overall, total cost per patient averaged P153, ranging from P70 to P379.

TABLE 9: Cost of Personnel and Medical Supplies Per Patient Served, by Type of Cost and by Mission Sponsor, 2001

MSM Institution	Personnel Cost Per Patient, in Pesos	Supplies Cost Per Patient, in Pesos	Total
Code # 4	P 43	n.a.	n.a.
Code # 23	P 16	P 58	P 74
Code # 24	P 54	P 73	P 127
Code # 26	n.a.	P 691	n.a.
Code # 42	P 23	P 81	P 104
Code # 51	P 19	n.a.	n.a.
Code # 82	P 395	n.a.	n.a.
Code # 83	P 48	P 116	P 164
Code # 84	P 46	P 333	P 379
Code # 89	P 23	P 47	P 70
Code # 97	P 18	n.a.	n.a.
Average (n=6)	P 35	P 118	P 153

Note: In this table, personnel refers only to doctors, surgeons, nurses and medical aides and excludes all other support staff (field guides, interns, social workers, etc.) Supplies refer only to medical and surgical supplies and reported cost for medical instruments and apparata. Supplies exclude food, lodging, gasoline, vehicle costs, etc. for which information was mostly unavailable. The average was derived only from mission sponsors that provided complete information for both types of costs (n=6). Source: This study.

These cost data are not definitive but point the direction for more intensive work in this area. Cost data are important for more accurate budgeting and planning of resources and for providing information on alternative uses of resources.

For instance, what would be the total cost of a mission if all the volunteer personnel and donated supplies were paid? Although the cost of mission personnel are, in general, not incurred by the sponsoring institution, these still need to be reckoned as they entail opportunity costs. A DOH doctor participating in a mission as a volunteer may be reckoned as free by the mission sponsor, but s/he is being taken away from other tasks for which s/he is being paid by the government, and for which DOH patients are being denied care because the doctor is not there. The same is true with other health personnel.

volunteers, therefore, entail societal or opportunity costs when they perform mission duties

These volunteers, therefore, entail societal or opportunity costs when they perform mission duties, i.e., they are not free to "society" although they may be registered as such in the books of the mission sponsor. The principle of opportunity cost is not well-understood by mission sponsors, as gleaned from their responses. The DOH and other regulatory bodies need to inculcate this principle among them.

D. Potential Negative Ripple Effects of Missions on the Health System

Despite the immediate as well as medium-term benefits of missions, many mission sponsors and barangay respondents think that missions can, in the long term, undermine the development of a fully functioning and sustainable health delivery system. The critical negative consequences of missions cited by survey respondents were:

(1) Dependency of patients – The results of the beneficiary survey indicates that as many as 25.6% of the respondents deemed missions necessary simply because they are free. An additional 7.2% noted passively that missions came along (*"yun ang dumating sa amin"*), while the rest cited no specific reason for preferring missions. Thus, close to a third (33.9%) could be considered "passive" in their attitude about medical/surgical missions. Encouraging the culture of dependency (cited by 15 mission sponsors) and discouraging patient self-reliance (cited by five mission sponsors) was seen

as a major problem with the increasing pervasiveness of missions in the Philippine health care system.

(2) Weak targeting and "leakage" of free care - Operationally, dependency could worsen if patients are not properly screened in terms of indigency, which is the main thrust of missions. Although the mission sites appear to be geographically-targeted well, there were a considerable number of non-poor households in these areas, e.g., 8.3% of household heads attended or completed college. Interestingly, none of the mission sponsors cited specific individual or household targeting protocols to ensure that only the poor are provided free mission services or that the non-poor patients are excluded from free care. A few mission sponsors also cited undue wastage from free care, as when persons try to obtain free medicines even if they are not sick. The undue politicization of medical/surgical missions may also result in people with real health concerns being unable to obtain care, simply because they might think only those who will vote for the political sponsor are entitled to get care or they might be actively screened out by political functionaries.

missions can undermine the development of a fully functioning and sustainable health delivery system.

(3) Worsening relationship with local medical practitioners – Missions that are not properly coordinated with local medical practitioners tend to cause animosity. If the patient has capacity to pay, then the mission is seen as "stealing" patients from local practitioners. Moreover, if no proper referral is done, then the patient tends to get "dumped" on the clinics of local practitioners.

(4) Drug resistance – Inadequate treatment in terms of duration and/or amount can lead to the development of bacteria that are resistant to the inadequate antibiotic. In the case of missions, the potential for this is great due to their sporadic and non-continuing nature. Giving free starter doses with no certainty of compliance with the treatment after these doses are consumed can lead to antibiotic resistance. This is particularly true in the treatment of TB.

(5) Undue politicization of medical/surgical missions – Politicians often use these missions to gather support and "score points" in the communities,

both during and after an election season. The mission sponsor may also be misrepresented by the politician for his/her own ends. As one medical specialty group noted, mission "care-giving" could end up in "care-grabbing."

(6) Dependency of local government units – Missions may undermine the capacity of local government units to address key public health concerns in their locality on a sustainable basis. LGU expectations of the periodic visits of missions may make them less responsible to their constituents' health needs as more and more of their mandated functions are usurped by these missions. Ideally, missions should complement LGU and DOH health services which could be achieved if these missions focus on the provision of medical skills and services that the LGU cannot provide. The danger, however, is when these missions substitute for LGU health services or begin to evolve as a parallel health service delivery system.

IV. CONCLUSIONS AND RECOMMENDATIONS

(a) Overall policy context: The increasing proliferation of medical/surgical missions calls for a proper review of the role of missions in the context of overall health service delivery to the poor. This study has shown that missions do have a role to play in the provision of care especially to disadvantaged Filipinos. However, they involve significant resources and considerable opportunity costs. They also engender significant negative ripple effects that, in the long-term, may damage efforts by the DOH and local government units to achieve sustainable health services. Thus, there is a need to strategically focus the work of missions so that they can complement the work of the DOH and local government units, and do not substitute for them instead, or worse, become a parallel health delivery system.

(b) Lack guidelines and knowledge of relevant laws: A mission is a complex undertaking, involving quite a number of stakeholders and beneficiaries. Not all mission sponsors currently have a structured program with established rules, policies and procedures to mount these activities. Knowledge of existing laws, administrative orders and circulars pertaining to missions is generally weak among sponsors. (The laws, administrative orders and

circulars pertaining to mission work are, themselves, not contained in a single publication, making it difficult for existing and would-be mission sponsors to familiarize themselves with their contents.) Their level of collaboration and cooperation with other agencies is also very weak, although there are shining exceptions to good collaboration and cooperation. At present, almost any person or institution can mount a mission.

(c) Opportunity cost of missions: Most mission sponsors are not aware of the opportunity cost of mounting a mission since most mission personnel go as volunteers or are paid modest honoraria, and most supplies are donated or solicited from partners. However, so-called free resources have alternative uses, e.g., a vacated DOH health facility whose personnel have gone on a mission are unable to cater to clinic patients who go there that day. While missions do provide health services to usually underserved areas, it remains to be shown whether these are the most cost-effective means of addressing the health needs of the poor.

(d) Continuity of care: Discontinuity of health services and disruption were cited as frequent problems arising from missions, especially with respect to chronic cases or cases for which the mission has no wherewithal to offer. Referral and coordination with local health providers is usually done by missions, but not universally so. In not a few cases, some patients were simply left behind for a local practitioner or the patient's "*suki*" doctor to care for. Finally, there are concerns raised with respect to missions' tendency to engender drug resistance.

(e) Sustainability of missions: The missions' tendency to encourage dependency of patients and stunt the development of sustainable local health systems were recognized as major weak points of missions. Conceptual notions of integrating mission work into the existing health delivery system were broached by key informants but so far, there are as yet no concrete proposals to operationalize this approach.

(f) Focus on measurable impact: Given the above concerns about missions' actual as well as opportunity costs, disruptive effects on local health service delivery and sustainability, it is important to focus the work of missions on those for which they can show measurable impact. Provision of care to "once-

off" cases (harelip, circumcision, tooth extraction and other dental procedures, cataract removal and other ophthalmic cases, and elective surgeries) appear to be the areas where mission services are called for since these services are not usually available in the localities, and for which mission sponsors have comparative advantage. Most medical cases and diseases for which the DOH and the LGU have existing health programs, however, are difficult to justify as the purview of mission work, since little measurable impact can be shown and since beneficiaries, though poor, appear to have "*suki*" doctors and mission "poaching" of patients can create animosity in the local health environment.

(g) Politics: Majority of the missions are sponsored by well-meaning institutions and individuals, both in the government and the private sector. However, there are quite a few that are often used by politicians for reasons that are less-than-philanthropic. Adding political color to these missions tends to make them counter-productive because it distracts health professionals' focus on providing care. It may also discourage patients from utilizing their services, especially if these patients see themselves as subscribing to a party different from the political sponsor. Mission sponsors unanimously endorse the need to de-politicize health care for the poor.

(h) Excess demand for mission services: Although the majority of missions are able to cater to all their clients, a significant number have unserved patients. To avoid this, it is necessary for mission sponsors to undertake better planning and needs identification, better dispensing of medicines and better targeting of the truly sick and needy. So far, aside from the demographic and location targeting, no mission has reported a thorough mechanism of targeting (individual) indigents, which has been suggested as one approach of solving the occurrence of excess demand.

(i) Reporting, monitoring and evaluation: Data-gathering on all fronts, but especially on inputs (resources use and costs), the effect of interventions (number and profile of patients served) and impact (longer term benefits on the household) is poorly developed in most mission sponsors. There is virtually no post-mission evaluation that is undertaken. Most of these weaknesses are simply a function of the absence of a body or agency (DOH or

local government unit) or clearinghouse of "industry or trade organization" to which missions are mandated to report their activities. Thus, there has not emerged a systematic and regular monitoring of missions work.

(j) Development of good practices and enforcement of standards: Despite their rather long history and pervasiveness, mission sponsors have not documented – much less shared with others – good practices on the conduct of missions. There are individual cases of documented institutional practices and processes, but there is no "industry-wide" set of standards. DOH itself has issued a department order on the proper conduct of missions but enforcement appears to be weak.

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An Assessment of the DOH Procurement System [1]

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I. CONSTITUTIONAL FRAMEWORK AND GENERAL RISK ASSESSMENT

The 1987 Constitution explicitly directs the government to ensure the availability and accessibility of quality drugs and medicines at affordable costs. Section 12, Art. XIII thereof states that "[t]he State shall establish and maintain an effective food and drug regulatory system and undertake appropriate health manpower development and research responsive to the country's health needs and problems." The availability and accessibility of quality drugs and medicines is declared by the Constitution as a vital goal in the national health strategy. Section 11, Article XIII in the 1987 Constitution provides that "[t]he State shall adopt an integrated and comprehensive approach to health development which shall endeavor to make essential goods, health and other social services available to all the people at affordable costs." These constitutional mandates provide the basis for the current law and policy pertaining to the production, manufacture, import, sale, use and disposition of drugs and medicines. The present Constitution is replete with proclama-

tions and declarations that safeguard against graft, corruption and wastage in the use of scarce government resources. It also underscores the need to institute and preserve an honest, transparent and effective system of governance.

Various studies on the procurement system of the Department of Health (DOH) had been conducted over the last eight years. While most of the administrations at the helm of the Department during this same period sought to introduce meaningful reforms in procurement, major weaknesses that result in hidden costs still exist.

Virtually each step in the procurement process exposes one to graft and corruption.

Virtually each step in the procurement process, from setting the specifications to the release of payment, exposes one to graft and corruption. Procurement work is perceived as fraught with risks. Hence, managers involved in procurement prefer to be given assignments other than procurement.

II. VOLUME OF TRANSACTIONS

This article focuses on the procurement of drugs and medicine by the DOH, although it will take a cursory look at the procurement system at the local government level.

The DOH has large procurements of drugs and medicines annually. Procurement of pharmaceuticals is shared by the Central Office and the regional health offices for public health programs. The regional hospitals and/or retained medical centers have their own budget allocation for drugs/medicines for their own operations. Based on the Government Appropriations Act (GAA) of 2002, the DOH annual budget for drugs and medicines (limited to those that are itemized) sums up to more than Php 565.9 M. These include only the budget for EPI vaccines, oral contraceptives, Vitamin A supplements and drugs/medicines for other DOH programs and services. The amount for drugs and medicines for the operations of the

regional hospitals and/or medical centers are allocated separately but classified under the general category of "supplies and materials". The procurement of TB drugs has been decentralized to the regional health offices and classified with the general supplies and materials budget of each region. The overall annual budget of DOH for drugs and medicines is thus definitely larger than is reflected below. It must also be noted that the budget for drugs and medicines, at least for the items below, has been increasing over the past three years.

TABLE 1: DOH Budget for Drugs and Medicines Year 2000-2002

Year	2000 (PhP)	2001 (PhP)	2002 (PhP)
Total DOH Appropriations	10,728,905,000.	9,456,263,000.	11,278,237,000.
Itemized Budget	398,960,000.	491,960,000.	565,960,000.
EPI vaccines	316,960,000.	316,960,000.	376,960,000.
Vitamin A	19,000,000.	39,000,000.	39,000,000.
Oral Contraceptives	63,000,000.	86,000,000.	100,000,000.
Other Drugs/ Medicines for other programs		50,000,000.	.....50,000,000.

The amount allocated for drugs and medicines through foreign-assisted projects comprises a small portion of the DOH annual procurement. The Year 2001 Annual Procurement Plan of DOH only programmed PhP 13.0 M, mainly for ferrous sulfate drops and syrups through the Early Child Development Project (ECDP). A higher budget was allocated for medical equipment and supplies. Drugs and medicines represented almost 80% of the total procurement amount of DOH.

TABLE 2: Amount of Drugs and Medicines in the Annual Procurement Plan, Year 2001

Items	Amount	Per Cent
Drugs/Medicines	PhP 518,047,297.00	78.1
Medical Equipment/supplies	PhP 23,347,662.00	3.5
Other items (administrative, financial supplies, IEC, training, computer/supplies, janitorial, office supplies, etc.)	PhP 122,472,262.46	18.4
Total	**PhP 663,867,221.46**	**100.0**

III. STRENGTHS AND WEAKNESSES OF THE DOH PROCUREMENT SYSTEM

There is not much difference in the lead or turn-around time of the procurement process over a 7- year period; the lead time observed in 1994 holds true up to the present.

In a 1994 study by Alano et. al[2], the procurement process from the preparation of the Requisition and Issue Voucher (RIV) to delivery of goods summed up to 4.75 months or 143 days. The time lag between the opening of the bid to delivery of goods takes about 85 days. Comparing this cycle with the procurement flow prepared by the DOH-United Project Management Office (UPMO) in Year 2001, the estimated time from opening of bid to delivery takes about 2.25 to 3.25 months or 67 to 97 days, which becomes even longer if the package requires NEDA's approval. (Please refer to Annex 1.)

Based on sample records that were reviewed by the team, the actual procurement cycle took much longer than expected. Using the International Competitive Bidding (ICB) as the mode of procurement for a drug/medicine under the Early Childhood Development Project (ECDP), the procurement was completed in a period of 364 days. This did not include the payment period, since at the time of this study, no payment has been made. The same can be observed in the procurement of medical equipment under another foreign-funded project – the Women's

Health and Safe Motherhood Project through national shopping, which took 531 days or 17.7 months from RIV preparation to the actual delivery of the item. Using the government-funded procurement through public bidding, the procurement cycle took 192 days or 6.4 months from RIV preparation to payment. Analysis of these transactions reveals major bottlenecks (Please Refer to Annex 2) especially at the following points in the procurement processes:

- preparation of specifications
- contract perfection
- issuance of the Notice to Proceed
- payment

Further assessment made on other procurement transactions showed that the targeted schedules and deadlines set by the DOH procurement units for each procurement milestone were not followed. Deviations were noted to be from 8 months to more than 1 year. One transaction was even delayed for more than 2 years. (Please refer to Annex 3.)

A. PROCEDURES AND PRACTICES

The following is a brief assessment of each major procurement milestone in the DOH procurement system.

1. Pre-bidding

(a) Supplier Accreditation and Product Registration

The list of accredited suppliers, both large and small, has expanded over the past three years, which could be a reflection of the improved credibility of the DOH procurement process. There are now efforts to give more stress to eligibility checks with the fail-pass test criteria that leave no room for accommodation.

However, the old bottlenecks that were the cause of recurring informal and formal complaints from interested bidders such as the lengthy and cumbersome accreditation process, remain in place. The issuance of a Certificate of Product Registration (CPR) from the Bureau of Food and Drug Administration (BFAD)

takes 20-60 days. Initial registration could take as long as six months. A report in one of the Procurement Committee meetings was that there are pending contracts between DOH and suppliers due to the absence of the CPRs. While supplier failures are also reasons for this bottleneck (e.g., incomplete documentary requirement, erroneous document submissions, insufficient physical samples for testing, etc.), insufficient staff and equipment support for BFAD remain the main culprits.

BFAD is overwhelmed by numerous applications for registration and accreditation. There are about 15,000 applications still pending from past years, with new applications numbering to 30,000. With only 10 evaluators in BFAD, the processing and evaluation of these applications cannot possibly be completed within the year. This weakness, however, is acknowledged fully by the DOH and has been identified as a priority area for improvement, with funding support from WB thru the SEMP II Project.

BFAD has established a fast track lane to register/accredit suppliers who have been selected winners in the bidding. With complete and accurate documentation by the suppliers, the CPR can be issued within 20 days.

The Alano Report in 1994 mentioned 2 recommendations to facilitate registration and accreditation, namely: (1) increase the human resource complement in BFAD; and (2) accredit private laboratories to undertake the testing and evaluation. Although BFAD has been given additional evaluators, these are still inadequate to meet the demand. To date, there has been no move to accredit private laboratories.

Another issue is the widespread perception among suppliers that the purposes and functions of accreditation and registration overlap since most of the accreditation and licensing requirements are the same. This is reinforced by the fact that most of the members of the Accreditation Committee are mainly BFAD staff and personnel who are also in-charge of registration.

Moreover, there are instances when even staff and officials involved in the procurement process do not have the same understanding of when the CPR should be required from the suppliers. The rules/guidelines only state that this is not a requirement before the suppliers could participate in the bidding but do not specify exactly when this is required.

(b) Procurement Planning

The DOH has issued Administrative Order No. 14-A dated August 1, 1997, specifying reasonable schedules for preparing the Annual Procurement Plan (APP) and submitting it to the concerned units at the DOH and the Department of Budget and Management (DBM). This makes the general procedure for preparing the Annual Procurement Plan clear enough. At present, the APP for foreign-funded projects is prepared by the Unified Project Management Office (UPMO) while procurement funded by the government is prepared by the Procurement and Logistics Service (PLS). The PLS consolidates these two procurement plans then packages and schedules the procurement. The submission of a supplemental APP is allowed but requires the approval of the Secretary of Health before procurement is initiated.

While the mechanics are clear, the inputs and outputs of the planning exercise are still wanting in terms of guiding the procurement process to ensure timely delivery and to prevent wastage of resources. Aside from technical issues that impinge on sound forecasting of drug requirements (i.e., different programs and offices use varying population data bases and sometimes inaccurate assumptions), there is also a problem in stock keeping which has remained inaccurate, especially at the local government level. This has proved to be a major constraint in monitoring the status of inventory, in estimating future needs and in controlling leakage and wastage of stock.

Based on records review, the formulation and submission of the APP are not done within the timeframe or schedule provided for in the AO, thus effectively delaying the whole process. For example, procurement plans of individual services were submitted to the PLS as late as February or March 2001, instead of September or October of the previous year. As a result, scheduling of procurements tends to be unevenly distributed throughout the year. This drags out the evaluation periods, resulting in adjustments in bidding schedules.

A related observation, shared by one DOH official, is that since a supplemental APP is allowed, program or service managers tend to take this route rather than the regular submission, not realizing that the supplemental APP would require another loop for the DOH Secretary's approval. Moreover, the AO is also unclear in terms of the threshold of amount of supplemental APP that would require the approval of head of the agency.

There is also an observation that while an APP must be submitted for local procurement, it was never used as a procurement tool since it is the RIV that initiates the procurement process. A question is posed as to whether it is necessary for the PLS to wait for the end user to prepare the RIV, or if the PLS can prepare the RIV based on the APP, to be concurred with by the end user. One lesson learned by the UPMO in handling foreign-funded projects is that the procurement process is facilitated if the UPMO prepares the RIV based on the APP submitted by the end users, instead of waiting for the end-users to prepare them.

Another significant development related to procurement planning is the automation of the process. The DOH-Information and Management Service or IMS (formerly Management Advisory Service-MAS) has developed the software for the automation of the preparation of the APP. The software enables the categorization of the items by types of goods, products and commodities to be procured and the computation of the total amounts involved. The APP has been formatted as well to include the quarterly requirements programmed by all DOH offices and services. However, at the time of this study, the DOH-wide network for the APP was not yet in operation, although the program has already been installed in the IMS and PLS.

(c) Preparation of Specifications and the RIV

Numerous complaints from end-users and requests for modification from winning bidders seem to point to poor research (e.g., on what should be delivered to the end-user) and inability to mobilize experts during the preparation of specifications of the items to be procured. There were also occasions when items in the RIV, or efforts to modify the specifications of the item to be procured, were not in agreement with the Philippine National Drug Formulary (PNDF)[3]. The weakness in setting specifications is also revealed in cases where higher level DOH officials, who are recognized experts but are not party to the procurement process, would recommend the purchase of equipment different from that presented by the winning bidder who met the given specifications.

Two of the suppliers interviewed for the study complained that there were occasions when they felt the specifications were slanted towards a specific brand which only 1-2 suppliers were capable of delivering. DOH officials also reported

that most of the complaints from the suppliers regarded "specifications" of DOH which seemed to favor a certain brand.

As to the Advice of Allotment (AA) which should accompany the RIV, studies have pointed out that waiting for the AA greatly lengthens the requisitions phase of the process since the budgetary cycle allows the earliest release of the AA late in the first quarter or even in the second quarter of the year.

A positive development in this procurement milestone is the mobilization of a "clearing house" composed of end-users to assist in drawing up the specifications of item(s) to be procured.

(d) Preparation of Bid documents

There are standard bid documents for pharmaceuticals procurement. The weakness seems to be in ensuring confidentiality of the bid documents. There have been reports, albeit undocumented, that some suppliers are informed in advance about the procurement package to be undertaken, giving these suppliers undue advantage over the others.

(e) Pre-Bid Conference

The DOH generally complies with the rules and regulations in conducting the pre-bid. The meetings are properly documented and the bid bulletin is immediately issued after the conference. Based on sample transactions reviewed, the bid bulletin is issued on the same day or 3 days after the conference at the latest.

The DOH may also be described as duly complying with the requirements regarding advertising. Advertising the bid is adequately done now, including through internet.

However, while pre-bid conferences and standard procedures are strictly adhered to, there is concern as to how exhaustive the conferences are. Clarifications sought after the pre-bid conference indicate that the conduct of the conference can be improved. But according to the DOH, some suppliers do not maximize the conferences to clarify issues or concerns regarding the procurement package at hand. Then they complain after the pre-bid has been conducted. There is also an observation that there is not enough time for the preparation of bids after the holding of the

pre-bid conference. The DOH-UPMO has declared that for foreign-funded procurement, the pre-bid conference should be held not later than two weeks prior to the submission of the bids. However, an interview with selected suppliers revealed that this time allotted is inadequate for them to comply with all the requirements.

2. Bidding Proper

(a) Opening of Bids

Opening of bids is described to be transparent. The Bids and Awards Committee (BAC) is experienced in conducting this, with the members on jury duty when going through this process.

(b) Technical Evaluation

Given the exacting work of technical evaluation, improvements had been introduced in recent years to better dispense this task. For example, there are now templates and matrices for the evaluation of bids. As a step towards an exhaustive evaluation of bids for foreign-assisted projects, the Technical Evaluation Committee (TEC) report is clarified with each member of the Committee (e.g., each member is given the opportunity to explain or clarify his/her finding/observation). This process is also properly documented.

However, there are still cases indicating that documents are not meticulously reviewed, thus resulting in delays. This problem is traced to two factors: a) Technical evaluation is not a full-time function, that is, it is treated as an additional function over and above the official duties and responsibilities of the persons designated to the Committee; and b) Procurement proficiency is not normally the main requirement for appointment to procurement committees.

(c) Financial Evaluation

In the absence of written guidelines on what deviations or "errors" in the financial proposal can be tolerated by the Committee, there have been instances when – out of fairness – bidders with faulty computations were given a chance to re-submit or correct their bid documents. The corrections are then properly docu-

mented. Though driven by good intentions, this has caused other bidders to complain that the Committee is unfair and overly accommodating.

Another and, perhaps, the more major issue, is the lack of access to comparative price data. The Committee operates in an information vacuum, with insufficient information on prices or on the performance record of international suppliers. This problem remains as no system or mechanism for the price monitoring of drugs and medicines has been set up. While the DBM has its price catalogue for common supplies, there is none that exists for pharmaceuticals. An Administrative Order (No. 14-A, August 1, 1997) issued by the Health Secretary in August 1997 spoke of the need for a Drug Price Monitoring Committee. However, the issuance did not go as far as appointing committee members and stating the terms of reference. At present, the PLS has assigned one staff to keep track of drug prices. But this has been limited to simply summarizing the prices resulting from the biddings conducted by the different regional hospitals and DOH medical centers. Its use has been limited to providing a rough list of comparative prices of drugs to regional health offices requesting the information. On the other hand, the IMS has developed an automated drug price monitoring system which has not been put to use, awaiting the training of the PLS staff on the software.

(d) Notice of Award

This seems to be a bottleneck as complaints and cases of graft and corruption filed against members of the Bids and Awards Committee in the past have made committee members over-cautious in making decisions as to choice of bidder. It was also mentioned as a reason for the lack of quorum during BAC meetings.

(e) Notice to Proceed

There is also lack of common understanding among officials and personnel concerned of the application of the Notice to Proceed which, at present, is applied to all procurements entailing International Competitive Bidding (ICB) and public bidding as well as requests for quotations. The DOH has raised the issue of whether this should be required for the Request for Quotations (RFQs) which elicited different responses from the members of the Procurement Committee. Furthermore, the re-

cently passed EO 40 states that procurement, other than public bidding, should be approved by the head of the agency. This EO is also silent on the amounts involved.

(f) Contract Preparation and Signing

The preparation of contracts has been identified as a major bottleneck in the procurement process. In the original arrangement, the PLS was responsible for preparing the contracts after the BAC has decided on the winning bidder. The contract is then reviewed by the DOH Legal Service Division (LSD). This process proved to be rather lengthy. However, even after the responsibility for contract preparation was transferred to the LSD, the process has not improved. This is attributed to LSD's being swamped by many legal cases and lack of adequate staff. The delay in the finalization of the contract is also caused by the inability of the supplier to submit the necessary requirements (e.g. performance bond, CPR, etc.). At the time of the study, there were 13 contracts pending at the DOH-Legal Service for review.[4] Most of these incompletely processed contracts need the submission of either the performance bond from the suppliers concerned or the CPR before the contracts are finalized.

(g) Grievance or Appeal Mechanism

The DOH units involved in procurement seem to know the process of addressing any complaint or grievance from a participating supplier. However, this route and procedure for reporting and addressing grievances or appeals are not documented nor disseminated to the suppliers. Hence there are complaints that are submitted to the PLS, others to the BAC and, in the case of foreign-funded projects, to the donor agencies. Moreover, proper documentation and recording of these grievances or appeals are also wanting.

3. Delivery

(a) Trade Practices (Pre-Shipment Inspection)

Pre-inspection of pharmaceuticals and equipment from other countries is not a standard practice even though it is important in ensuring the correct specification

and good quality of the goods that will be delivered. In instances when there is a need for pre-inspection, the cost of pre-inspection is shouldered by the procuring agency, resulting in higher prices of commodities and equipment. Another instance is when an international donor agency delivers commodities that are later on found to be defective. In this instance, the DOH (not the donor agency) is made to deal directly with the supplier of the defective commodities. This weakness has led to incidences of commodities being delivered that do not meet specifications. There was one case when the supplier delivered hydralazine powder instead of solution, and a case wherein the winning bidder delivered Oral Polio Vaccines in the wrong dosage form.

(b) Payment

While it is a widely acknowledged fact that sustained low prices are possible only when a procurement system is able to guarantee prompt payment in full according to the terms of contract, payments have been delayed for long periods of time. A case in the recent past: a supplier to both the DOH and Philippine General Hospital charged a much higher price for the same item procured by DOH in even greater quantity and justified the higher price quoted for DOH by citing the long waiting time for payment by DOH, which takes up to 1 year, compared with PGH's two weeks to a month. Another supplier observed that there is no system in the DOH finance office for alternate cashiers or clerks to handle payment/transactions. More often than not, suppliers are told to come back since the person in charge is absent or is attending a meeting. The delay in payment is also compounded by the limitations of the overall financial management system of the government. Cases when payments have been obligated, but the cash needed to back these obligations are not available, sometimes happen.

4. Record-Keeping

Bid documents and tenders are safely secured. Proper filing and archiving of pertinent documents is observed, although this can be improved significantly by computerization. The DOH is yet to have a centralized filing and systematic codi-

fying of pertinent records. Some complaints or cases in the recent past about lack of transparency were reinforced partly by records that were not made easily available or, if made available, were not in order.

While foreign-funded projects have difficulties accessing relevant records especially for those transactions that were processed two years ago, a certain level of efficiency seems to have been established by individual units in the PLS in filing and maintaining procurement-related documents.

5. Monitoring Transactions and Processes

Monitoring of procurement activities is now done at two levels. At the top management level is the Central Procurement Committee (formerly the Procurement Reform Advisory Committee under the previous leadership) that meets weekly with an NGO observer present. The Committee tackles developments in the procurement activities of the agency. At the program or service level, a monitoring form that serves as an audit trail form – an innovation introduced by the WHSMP - has been adopted by the PLS. This tracking form, though, is quite limited as it starts with the opening of bids as the initial milestone to be tracked. But substantial delays occur during the pre-bidding phase, especially in the preparation of the RIV (indicating specifications and clearing it with designated units in the DOH).

Except for the deliberations of procurement issues by the Procurement Committee, monitoring of procurement is not pro-actively undertaken. There are certain issues and concerns that can already be acted upon or resolved even outside the Procurement Committee meetings.

There is no clear entity in the DOH designated to monitor procurement transactions, whether foreign-funded or locally funded. The issue on whether the PLS and UPMO should take on this task has been raised since they are themselves key players in the procurement process. Options being considered include tapping the Internal Auditing Staff for the "oversight committee" being planned to replace the Accreditation Committee.

6. E-procurement

The DOH has made the initial step towards e-procurement thru its website (www.doh.gov.ph) which has a portal for procurement related information that includes requests for quotations and invitations to bid. The portal also includes the lists of accredited suppliers for all categories of items, the lists of requirements for accreditation and product registration and an application form for accreditation that can be downloaded from the website. However, like most agencies, the DOH needs to strengthen its technical capacity before it can reasonably harness e-procurement and reap its benefits.

There is also a plan to post the results of DOH bidding on the DBM website.

B. ORGANIZATION AND RESOURCES

1. Organizational Structures on Procurement

Units and committees handling procurement are in place and officially established through the issuance of Department Orders 5-As, 2001 and 36s, 2001. The top level Procurement Committee mandated to monitor procurement activities and reform the procurement system of the DOH was first created during the term of Sec. Alberto Romualdez, Jr. It initially started as the Procurement Reform Advisory Team (PRAT) which met weekly to address procurement-related issues and concerns. At present, the Committee, which is chaired by an Undersecretary, continues to meet to monitor progress in the procurement of both GOP and foreign-funded items. The Procurement Watch, an NGO monitoring office, is a member of the Procurement Committee.

As to the Bids and Awards Committee (BAC), its chairmanship was initially on a rotation basis among the Undersecretaries. At present, the BAC is chaired by an Assistant Secretary who is assisted by various chairpersons with alternates for each category of items to be procured: (1) drugs and medicines, (2) medical supplies and materials, (3) infrastructure services, (4) hospital and laboratory equipment and (5) non-medical goods and general services. The Technical and Financial

Evaluation Committees are in place. While these are permanent committees, the composition changes depending on the items for procurement.

The establishment of the Unified PMO in October, 2000 streamlined the procurement of foreign-funded items for different projects. This de-loaded the programs or technical units of the task of coordinating procurement.

Clearing houses have been identified to review and ensure that goods procured are consistent with DOH policies and follow set standards. Specifications of drugs and medicines are reviewed by the PNDP, while medical equipment and supplies are reviewed by the Hospital and Maintenance Service before RIV's are approved.

2. Human Resource

The strong support of top DOH management, especially during the term of Dr. Romualdez, for procurement reforms has strengthened the procurement system. In terms of human resource, trainings on procurement management were given to at least 55 personnel from the PLS and the UPMO and to selected program coordinators and regional representatives. Orientations were also conducted among BAC, TEC and FEC members, PLS and PMO staff on the overall flow and requirements of foreign-funded procurement.

The UPMO has 10 organic staff as well as the technology and expertise in procurement -acquired through foreign-funded projects – that can be institutionalized through these staff.

On the other hand, the DOH has to tackle some serious constraints with regard to human resource. Among these is the reduction in the number of PLS staff from 75 to 35, five of whom were assigned to other units of the DOH. Another concern is that members of the Technical Evaluation Committees lack the capability to undertake thorough analyses of bids, especially in determining the financial capability of the bidders. Program coordinators or end-users have limitations in coming up with appropriate specifications for the items to be procured. There is also a need to upgrade the capacity of concerned staff to document and prepare reports.

The two most senior managers at PLS appreciate the pivotal role that procurement plays in the life of the Department and are aware of the problems that need to be addressed. They also recognize the need to instill a sense of mission and excitement about procurement work, at least within the PLS.

3. Financial Resources

The limited resources of the DOH hamper its need to increase the needed human resource and equipment (e.g., those needed by BFAD) to improve the procurement process.

Aside from the limited budget, there is also the case of lack of cash availability from the national government. In 2001, this problem prevented the regions from doing their own procurement. The lack of cash availability for GOP-funded procurement results in at least two major delays: delays in the processing of the RIV (thus lengthening the entire process), and delay in payments. The latter has also been a major source of corruption as some suppliers vie to influence the paying office into prioritizing their payment from the monthly releases of DBM.

delay in payments has also been a major source of corruption

IV. POLICY IMPLICATIONS

Based on the foregoing discussion, a strategic approach in effectively pursuing procurement reforms will include the following key actions that involve the DOH and other agencies:

A. Strengthening the Mechanisms for Oversight

While the needed changes are not yet in place, and even after they have been instituted, there should be robust mechanisms to ensure that oversight functions are performed. The existence of a DOH Procurement Committee is laudable. However, its processes for oversight or review of major procurement transactions should be continuously strengthened. "Integrity circles", once formed, can also

take on procurement oversight functions, with their findings or observations routed to the Procurement Committee.

B. Getting Out of the Information Vacuum

The formation and operationalization of a National Drug Price Monitoring body that will guide procurement should be considered a priority action. It is proposed that this body be lodged with an independent institution or the academe where the systems and technology for research are already developed and functioning. A modest grant could very well start off the establishment of this body.

C. Professionalizing the Procurement System

Aside from capacity-building that tackles the technical demands of procurement work, a human resource development program for procurement-related personnel should include culture-building (vision/mission/goals), values formation and clarification. This is to ensure that the values of people engaged in procurement resonate with the desired norms and conduct in the procurement profession.

The formulation of a Code of Ethics for Procurement Personnel/Professionals, the formation of "integrity circles" and the granting of a more appropriate and decent salary or benefits would be helpful in building a culture of integrity, a sense of mission and pride among procurement personnel.

D. Achieving a Common Understanding of Procurement Policies

As another requisite to culture-building and a guide to instituting procurement reforms, there is a need to review and codify all laws, policies and issuances (including Department Orders and Administrative Orders) relevant to procurement. To "laymanize" this compendium, a procurement manual explaining the various steps in the procurement process and the time-frame involved in each step should accompany it. These documents should also harmonize the seemingly conflicting procurement guidelines of foreign donors and the government that resulted in a major administrative case in the recent past.

As soon as these documents are ready, an internal marketing of these materials to all concerned personnel (including those that are only "indirectly" and "occasionally" involved in procurement) should be done.

E. Streamlining the Cash Allocation Process

The existing cash allocation process that results in delayed initiation of the procurement process and in delayed payment (with the latter resulting in a much higher cost of drugs and medicines), should now be given the needed focus by the Department of Budget and Management and related agencies. All other reforms would appear superficial if this single biggest constraint in the procurement system is not addressed.

F. Strengthening the Bureau of Food and Drugs

Strengthening the BFAD should be a priority if it is to meet the high demand for product registration. Concomitantly, the possibility of tapping private laboratories for product testing without sacrificing quality assurance should be explored.

G. Bringing Best Practices to Light

There are pockets of procurement innovations that until now go unnoticed, thus hindering our ability to learn. It is time to bring best practices to light by documenting and disseminating them in both technical and non-technical media and by bestowing awards to organizations or agencies which have exemplified the highest consideration and standards for procurement reforms. This can be done within and across agencies.

H. Reckoning With and Harnessing the Bigger Policy Environment

There is a need to clarify/develop a framework for procurement reform consistent with the larger policy environment (e.g., decentralization, generics law). The issue of the extent to which procurement should be devolved to the local govern-

ment units, how it should be devolved and when should be resolved to guide investment decisions, especially for systems and capability-building.

From the standpoint of social equity, the parallel drug importation initiative (Plan 50) should be studied for its consistency with the Generics Law.

ANNEX 1: Assessment of DOH Procurement of Drugs and Medicines

Procurement Milestone	Alano Report, 1994	UPMO, 2001
1. RIV Preparation to Approval	4.0	No estimate
2. Bid Document Preparation to Opening of Bids	63.0	No estimate
3. Opening of Bids to Selection of Winner	43.0	23.0 – 28.0
4. Preparation of PO to delivery	33.0	46.0 – 74.0
Total No. of Days (Step 3 to Step 4)	76.0	69.0 – 102.0
Total No. of Months	2.53	2.25 – 3.25

Source: Flowcharts A and B, Clark, Alano et. al., 1994
Flowchart on Foreign-Funded Procurement, UPMO, 2001

ANNEX 2 : Procurement Cycle of Sample Transactions

A. Foreign-Funded Procurement

Project	:	Early Childhood Development Project	
Funding Source	:	World Bank	
Package	:	Ferrous Sulfate Drops	411,237 bottles
		Ferrous Sulfate Syrup	241,516 bottles
Total Amount	:	U$ 259,494.80	
Procurement Mode	:	International Competitive Bidding	

Procurement Milestone	Dates	Elapse Time (Calendar Days)
1. Preparation of RIV	January 18, 2000	-
2. PLS received RIV	February 14, 2000	34.0
3. Preparation of Bid Documents		
3.1 By the DOH-PMO to ECDP	January 31, 2000	
3.2 ECDP-PMO to WB	February 13, 2000	
4. WB concurrence to Bid	February 23, 2000	9.0
5. Advertisement	March 17, 18, 25, 2000	32.0
6. Pre-Bid Conference	May 2, 2000	38.0
7. Bid Bulletin Issued	May 11, 2000	9.0
8. Opening of Bid	May 16, 2000	5.0
9. Bid Evaluation Report	June 20, 2000	24.0
10. Concurrence of WB to BER	June 27, 2000	37.0
11. Notice of Award		
11.1 by COBAC	July 10, 2000	13.0
11.2 received by PLS	July 25, 2000	15.0
11.3 conformed by Supplier	July 31, 2000	6.0
12. Approval of CPR	August 17, 2000	17.0
13. CPR received by PLS	August 24, 2000	7.0
14. Performance Bond		
14.1 posted by supplier	August 8, 2000	-
14.2. PLS received PB	August 24, 2000	-
15. Contract perfected	October 31, 2000	67.0
16. Notice to Proceed	November 22, 2000	21.0
17. Delivery	no delivery yet	> 30.0
Total Days		> 364.0
Equivalent Months		> 12.0

B. Foreign-Funded Procurement

Project	:	Women's Health Safe Motherhood Project	
Funding Source	:	World Bank	
Package	:	Examining Tables	230 units
		Examining Stool	230 units
		Examining Lamps	230 units
Total Amount	:	Php 5,313,000.00	
Procurement Mode	:	National Shopping	

Procurement Milestone	Dates	Elapse Time
1. Preparation of RIV	July 26, 2000	-
2. RIV cleared by HOMS	August 21, 2000	25.0
3. PLS received RIV	August 23, 2000	2.0
4. Advertisement	December 16, 17, 23, 2000	120.0
5. Pre-Bid Conference	January 12, 2001	19.0
6. Opening of Bids	January 16, 2001	4.0
7. Bid Evaluation Report	January 27, 2001	11.0
8. COBAC Resolution	February 26, 2001	30.0
9. Notice of Awards	June 4, 2001	112.0
10. Performance Bond	July 5, 2001	30.0
11. Contract Perfected	September 6, 2001	61.0
12. Delivery Date	September 9, 2001	3.0
13. Request for Inspection	September 20, 2001	0.0
14. Inspection Report	November 13, 2001	53.0
15. Payment Completed	January 14, 2002	61
Total No. of Days		531.0
Equivalent Months		17.7

C. GOP-Funded Procurement

Package : Aluminum Hydroxide
Total Amount : Php 1.4 M
Procurement Mode : Public Bidding

Procurement Milestone	Dates	Elapse Time (Calendar Days)
1. Preparation of RIV	May 29, 2000	-
2. Verified against APP by PLS	May 30, 200	1.0
3. RIV cleared	June 4, 2000	5.0
4. Advertisement	June 20, 23, 2000	19
5. Issuance of Bid Documents	June 6 – July 27, 2000	-
6. Pre-Bid Conference	July 16, 2000	26.0
7. Bid Bulletin Issued	July 20, 2000	4. 0
8. Opening of Bid	July 31, 2000	7.0
9. BAC Resolution	August 21, 2000	20.0
10. Notice of Award		
10.1 COBAC	August 27, 2000	6.0
10.2 Received by Supplier	September 7, 2000	10.0
11. Performance Bond	September 10, 2000	3.0
12. Purchase Order		
12.1 PO Approved	October 12, 2000	32.0
12.2 PLS issued final PO	October 19, 2000	7.0
13. Notice to Proceed	October 19, 2000	-
14. Delivery	November 27, 2000	38.0
15. Inspection	November 28, 2000	1.0
16. BFAD Resolution	December 5, 2000	7.0
17. Voucher Prepared	December 14, 2000	9.0
18. Payment	December 17, 200-	3.0
Total Days		192.0
Equivalent Months		6.4

Annex 3: Assessment of Procurement

A. Drugs and Medicines

A.1 Ferrous Sulfate under ECDP-WB - ICB

Procurement Milestones	Target	Actual	Deviation (calendar days)
Opening of Bids	May 9, 2001	May 16, 2001	7.0
Notice of Award	June 9, 2001	July 25, 2001	46.0
Performance Bond	July 6, 2001	July 25, 2001	49.0
Contract Perfected	August 24, 2001	Oct. 31, 2001	67.0
Notice to Proceed	August 24, 2001	Nov. 22, 2001	88.0
Delivery date	Oct 24, 2001	Not yet delivered	> 75.0
Payment Completed	Nov 24, 2001	Not yet done	
Duration (Months)	6.5 months	> 8 months	4.0 months
Equivalent Days	195.0 days		> 120.0 days

A.2 Ferrous Sulfate under ECDP – ADB – Shopping

Procurement Milestones	Target	Actual	Deviation (calendar days)
Opening of Bids	Feb. 16, 2001	Feb. 16, 2001	-
Notice of Awards	March 9, 2001	May 31, 2001	82.0
Performance Bond	Apr. 6, 2001	July 9, 2001	93.0
Contract Perfected	Aug. 24, 2001	Oct. 31, 2001	67.0
Notice to Proceed	Aug. 24, 2001	Nov. 21, 2001	87.0
Delivery Date	Oct. 24, 2001	Dec. 27, 2001	63.0
Payment Completed	Nov. 24, 2001	No payment	>45.0
Duration (Months)	9.25 months	11.0 months	1.75 months
Equivalent Days	278.0 days	>330.0 days	>52.0 days

A.3 Hydralazine Under WHSMP – ICB

Procurement Milestones	Target	Actual	Deviation (calendar days)
Opening of Bids	July 11, 2000	July 11, 2000	-
Notice of Awards	Aug. 18, 2000	Jan 23, 2001	158.0
Performance Bond	Sept. 15, 2000	Feb 20, 2001	155.0
Contract Perfected	Oct. 30, 2000	Nov. 21, 2001	416.0
Notice to Proceed	Nov. 2, 2000	Nov. 22, 2001	415.0
Delivery Date	Jan. 2, 2001	No deliveries yet	>365.0
Payment Completed	March 2, 2001	-	>313.0
Duration (Months)	8.0 months	18.0 months	>12 months
Equivalent Days	229.0	558.0 days	>329.0

B. Medical Equipment

B.1 Ice-Lined Refrigerator

Procurement Milestones	Target	Actual	Deviation (calendar days)
Opening of Bids	Jan. 22, 2001	Jan 22, 2001	-
Notice of Awards	Feb 22, 2001	Feb 14, 2001	0
Performance Bond	Mar 21, 2001	Mar 2, 2001	346.0
Contract Perfected	Aug 16, 2001	Oct 10, 2001	54.0
Notice to Proceed	Aug 17, 2001	Oct. 17, 2001	
Delivery Date	Oct 17, 2001	Not yet	>12 weeks
Payment Completed	Nov. 17, 2001		
Duration (Months)	9.79 months or	>12 months or	>2.20 months
Equivalent Days	299 days	365 days	>66 days

B.2 Toilet Bowl, Portable Water Test Kit, et al

Procurement Milestones	Target	Actual	Deviation (calendar days)
Opening of Bids	Aug 16, 1999	Aug 16, 1999	-
Notice of Awards	Sept 22, 1999	July 12, 2001	680
Performance Bond	Oct 20, 1999	Aug 15, 2001	655
Contract Perfected	Aug 23, 1999	Oct 20 2001	777
Notice to Proceed	Aug 24, 1999	Oct 29, 2001	785
Delivery Date	Oct 24, 1999	No delivery yet	>795
Payment Completed	Nov 24, 1999	No payment yet	>765
Duration (Months)	3.33 months	>27.23 months	>23.98 months
Equivalent Days	100 days	>827days	

Notes

1 This article is based on the Country Procurement Assessment Report on the Department of Health undertaken by Health Futures Foundation, Inc. (Dr. Jaime Z. Galvez Tan, Ms. Eireen B. Villa, Mr. Pedrito B. dela Cruz and Atty. Carlo Taparan) from January to March 2002 under the auspices of the World Bank.

2 Clark, Malcolm; Alano, Bienvenido et.al., PHILIPPINES: Women's Health and Safe Motherhood Project, Logistics Report, Cranfield University, U.K., 1994.

3 The Philippine National Drug Formulary (PNDF) is a major strategy in promoting rational drug use and is a component of the Philippine National Drug Policy. The PNDF is composed of two lists, the Core Lists and the Complementary List. The drugs in the Core List include drugs that are needed by the majority of the population and should therefore be available at all times. The drugs in the Complementary List are those needed for treating rare disorders, drugs with special pharmaceutical properties and alternative drugs to be used where there is no response to the Core List drugs or when the Core List Drugs cannot be administered for one reason or another. Executive Order No. 49 operationalized this mandate and made mandatory the use of generic names by requiring the use of the PNDF which is considered as the "Essential Drug List" required by the Generics Act, as a basis for the procurement of drug products by the government. Thus, by virtue of E.O. No. 49, only drugs listed in the PNDF can be subject to procurement by the government. In instances that the drugs to be acquired by a government agency are not found in the PNDF, the executive order requires the prior approval of the National Drug Policy Office. In support of the said policy, the Philippine Health Insurance Corporation (PhilHealth) upholds the use of the PNDF as basis for the reimbursement of claims for drugs by its members under the National Health Insurance Program. Drugs and medicines not found in the PNDF are generally not subject to reimbursement. The PhilHealth maintains a Positive List that is based on the highest level of scientific or medical evidence which is submitted to the National Formulary Committee for evaluation for inclusion in the formulary. The positive list may be considered for possible reimbursement by the PhilHealth.

4 Based on the Minutes of Meeting of the Procurement Meeting dated January 17, 2002.

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PUBLIC POLICY

Effective Screening for Diseases Among Apparently Healthy Filipinos: A Need for Philippine Guidelines on Periodic Health Examinations (PHEX)

DANTE D MORALES, ANTONIO MIGUEL L DANS, FELIX EDUARDO R PUNZALAN and MARIO R FESTIN

The Annual Physical Examination (APE) or Executive Check-Up (ECU) is a common practice (which) refers to the routine yearly performance of history and physical examination plus predetermined/preset tests and procedures to detect the presence or absence of disease. (But) questions have since arisen as to the appropriateness of this widespread practice.... The inappropriate application or interpretation of screening tests can rob people of their perceived health, initiate harmful diagnostic testing and squander health care resources. It is envisioned that the Project on Philippine Guidelines on Periodic Health Examinations (PHEX) via the guideline development cycle will demonstrate that screening can, in fact, improve health.

The Mandatory Death Penalty for Perpetrators of Incestuous Rape: The Point of View of Child-Survivors

BERNADETTE J MADRID and MARIELLA SUGUE-CASTILLO

Public and professional opinion on the effectivity of the death penalty in deterring crime has been divided. Because of the existence of the mandatory death penalty for familial child rape in the Philippines and the increasing numbers of victims of child sexual abuse... the prescription of the mandatory death penalty for familial child rape using standards applied in clinical decision making such as ethical principles, best interest of the child and evidence-based medicine will be examined.... The methodologies for assessing the evidence consist of the critical review of legal literature as well as case studies of patients seen in the PGH Child Protection Unit. The outcomes of interest are the following: change in crime rate, recidivism rate of sex offenders and effects on the quality of life of the child-victim. Finally, recommendations for public policy and research are offered.

Assessment of the Effectiveness of Medical and Surgical Missions in the Philippines

JUAN PABLO NANAGAS, OSCAR PICAZO, BIENVENIDO ALANO and EMELINA ALMARIO

Medical/surgical missions are temporary health care services, of short duration, usually given free to under-served communities by ... a government unit or agency, a government official, a private philanthropic individual or group, a private non-governmental and non-profit institution or even a for-profit institution that uses its resources for a philanthropic purpose.... No official document has been found formally endorsing these missions. The earliest reference appears in Department of Health (DOH) Order No. 184-A, s.1988 on the National Medical/Surgical Outreach Program which aimed to enhance health care services in the countryside through a series of medical/surgical outreach nationwide...The impact of such policy, however, was never evaluated and despite an absence of policy evaluation, missions have become more frequent through the years.

An Assessment of the DOH Procurement System

JAIME Z GALVEZ TAN, EIREEN B VILLA, PEDRITO B DELA CRUZ and CARLO TAPARAN

Constitutional mandates provide the basis for the current law and policy pertaining to the production, manufacture, import, sale, use and disposition of drugs and medicines. The present Constitution is replete with proclamations and declarations that safeguard against graft, corruption and wastage in the use of scarce government resources. It also underscores the need to institute and preserve an honest, transparent and effective system of governance....(But) while most administrations at the helm of DOH ... sought to introduce meaningful reforms in procurement, major weaknesses that result in hidden costs still exist.