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BACKGROUND DOCUMENTS* RECEIVED
FROM NON-GOVERNMENTAL ORGANIZATIONS
(Rule 62 of the provisional rules of procedure for the United Nations International Conference on Population)

The Japanese Organization for International Cooperation in Family Planning.**

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**The designations employed, the presentation of material, and the views expressed in this paper are those of conference participants and do not necessarily reflect the practices and views of the Secretariat of the United Nations in any of these respects.

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Humanistic Family Planning Approaches: The Integration of Family Planning and Health

The Japanese Organization for International
Cooperation in Family Planning**

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Introduction

The Japanese Organization for International Cooperation in Family Planning (JOICFP) is the only non-governmental organization in Japan providing international assistance in the field of population and family planning. JOICFP's major activity has been the promotion of the Integrated Family Planning and Parasite Control Project in twelve developing countries * of Asia and Latin America, in cooperation with IPPF, UNFPA and Japanese governmental and non-governmental organizations.

Over the past ten years, we have been receiving reports from project countries not only of solid achievements in raising family planning acceptance, but also of community action in a wide variety of health and development efforts. These community activities, we found, had to a great extent been stimulated by the visible and immediate effects of parasite control work.

We hope to share through this paper our ideas on why family planning services should be integrated with the seemingly unrelated activity of parasite control, as well as experiences in how the Integrated Projects have been carried out and what they have accomplished. The first part will introduce the concept and implementation strategy of the project including JOICFP's role in a general way. The second part will provide a concrete illustration from the case of the project in the Philippines.

I. Concept and Strategy of the Integrated Family Planning and Parasite Control Project

1. Concept

1) Proposal for More Humanistic Family Planning

Majority of the government of developing countries today have national population policy and family planning programmes to limit the rapid population growth and solve the population problems. There are also many NGOs which are implementing family planning programmes in many countries.

There are two aspects to the population problems: One is the quantitative aspect (birth rate, population growth rate, etc.) which is concerned with the socioeconomic development of a country. The other is qualitative aspect which is closely related with the quality of an individual's life.

It seems that, today, population and family planning programmes on the whole have been implemented in the context of quantitative aspect, more precisely, population control. However, there is a reality in many areas, rural or urban, in developing countries that it is rather difficult for the poor, uneducated grass-roots people to understand the meaning of and voluntarily accept family planning for the purpose of population control.

JOICFP does not believe that family planning exists for the purpose of population control alone. Family planning means, first and foremost, the freedom and basic human right to choose the number and spacing of children so that the family as a whole may lead a healthy and happy life.

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* Bangladesh, Brazil, Colombia, China, Indonesia, Korea, Malaysia, Mexico, Nepal, the Philippines, Sri Lanka, and Thailand

Human beings are usually concerned with two basic desires: to have better income and to have their family members lead a healthy life without sickness. Therefore, family planning must place more emphasis on the human elements and must ground themselves on the concept which will enable people to have healthier and happier life. In other worlds, family planning should be promoted in consideration of felt needs of the community people.

2) Integration of Family Planning with Health (Parasite Control)

The idea that family planning programmes will be better accepted if combined with related services which the community people readily perceive as beneficial and useful, has recently come to be widely accepted among international population and family planning community. In this regard, family planning has been promoted in integration with maternal and child health and other health programmes in many countries. However, these health programmes are often too broad to be effectively integrated with family planning. Developing countries usually lack sufficient number of medical and paramedical personnel and medical facilities to effectively deliver these health services. Therefore, it needs a careful consideration to choose what kind of programme be effectively integrated with family planning. We might list four criteria for an appropriate programme to be integrated with family planning:

a) It should not obscure the objective of family planning.

b) It should be simple and closely related with the daily life of community people.

c) Its effects should be visible, immediate and easy to replicate.

d) It should not require highly sophisticated technology and equipment and much funds.

After having carefully examined the Japanese experience in the postwar family planning and health movement, we have chosen as a programme to be integrated with family planning, parasite control, more specifically, the mass examination and treatment of soil-transmitted parasites among many other health programmes.

3) Why Parasite Control?

There are many reasons for selection of parasite control. The leading one is the visibility and immediacy of the results of parasite examination and treatment.

There is no better way than having people infected by parasites look through the microscope to see the parasite eggs in his stool, to explain to him what is wrong with him as well as to make him to see that treatment is necessary. The effect of treatment with deworming drugs is quick and dramatic. The morning after the patient takes the medicine, he can see the living and still moving parasites come out of his body.

The Japanese experience in community health programmes during the immediate post-World War II years showed that parasite control work had succeeded in stimulating popular interest in broader health and sanitation activities. From this experience, we thought that by involving family planning workers in the stool collection, examination and treatment processes, the recipient

of those services would be more easily convinced that these workers were trying to -- and that they in fact could -- help them. In particular, parents of children who have been treated would be more readily persuaded that the family planning worker is encouraging contraception in order to help protect the health of the mother and child.

Our hypothesis was confirmed by the experiences of family planning workers in the pilot project areas who found that parasite control work made it easier for them to talk to community people. Even areas where people had traditionally been hostile to family planning reported favourable changes in atmosphere.

4) Parasite Control as an Effective Health/Sanitation Education Tool

The tangible effects of parasite examination and treatment are also excellent tools for health and sanitation education. At the most elementary level, it makes people realize that there is in fact health problems in their life that must be dealt with. In this connection, it is important that parasite infestations are endemic in most communities, rural or urban, of developing countries. The fact that the problem is widely shared by family and community members makes it easier to organize people to work together to solve it. Thus, if the examination and treatment are carried out in mass to make full use of this advantage, parasite control can become an effective catalyst for community action.

5) Community Participation and People-Building

We have in fact been witnessing in our projects many cases of active community participation in such activities as the construction of latrines, cleaning of environment and securing of clean drinking water supplies. Action by the people in these areas has in turn helped to encourage their branching out into new sphere of life improvement such as the betterment of nutrition through home gardening and increased use of locally available nutritious foods, and income generation through cottage industries and co-operative ventures.

Through these activities, the Integrated Project is helping people understand that family planning is a way of helping themselves and not something they must practise because the government says they must. We see that our Integrated Project, which has stimulated the awakening of community people to self-help from one sphere of life to others, is a way of opening the door to the possibility of unlimited development by the people themselves. Thus, we can say that the Integrated Project is a people-building programme.

6) Integrated Project and Primary Health Care

We would like to emphasize that our Integrated Project shares much in common with the idea of Primary Health Care, which, since the Alma-Ata Declaration, has come to be widely advocated as the approach necessary for bringing health for all by the year 2000.

Like Primary Health Care, the Integrated Project seeks to stimulate communities to strive for health and development as much as possible through their own efforts; the project attempts to nurture non-specialist, frontline personnel to help the community in this effort. But even more important than its identity of purpose with Primary Health Care is the fact that the Integrated Project offers in parasite control a concrete and practical strategy

for attaining that purpose. The Integrated Project is a Primary Health Care project in idea as well as in practice.

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* This was confirmed in the Manila Statement, issued at the Eighth Asian Parasite Control/Family Planning Conference, held in Manila, Philippines, in 1980, a meeting of government officials, experts and representatives of private family planning associations involved in the implementation of the Integrated Projects in the 12 project countries.

II. The Strategy: Some Keys to Implementation and Development

In the launching of Integratetd Projects in each of the 12 countries, JOICFP, while providing the overall conceptual framework of the project and basic guidelines for organization and design, has left the details of implementation for the most part up to the countries themselves. We have taken this approach in the belief that freedom of experimentation and room for trial and error are crucial for meeting community needs precisely and flexibly.

We therefore do not want to provide in this section a comprehensive 'how-to' guide to implementation, but only to share those measures which we feel are essential for project sustenance and growth, and which we request all project countries to take. They are:

1) Starting on a Pilot Basis

The project should first be launched on a trial basis for a limited target population in a limited area in order to test and demonstrate its feasibility, and in order to enable modifications in design and strategy toward the adoption of the project or certain aspects of it as a larger programme.

We have normally asked countries to set up two or more pilot areas of differing social and economic characteristics in order to allow for development of different approaches to suit communities living in different situations. We also believe that healthy competition and exchange of ideas and experiences between pilot areas will accelerate project development. The pilot term is six years.

2) The Formation of a National Steering Committee

In all the project countries, a national steering committee serves as the highest policy-making body for the Integrated Projects. The committee always consists of representatives from three sectors: government agencies concerned with family planning and health, experts in parasitology and a voluntary family planning association.

The purpose of establishing a national steering committee is to combine the funds, material resources and authority of the government, the expertise of the parasitologists and the flexibility of the private family planning association toward maximum support of the projects. The idea for this

tripartite alliance of government, experts, and private sector is based on the Japanese experience in parasite control in which the cooperation of the three sectors contributed greatly to the near eradication of parasite infections in a very short period of time.

The fact that parasite infections are largely neglected in government health programmes (not being considered as serious as many other health problems) works as an advantage in overcoming bureaucratic barriers to inter-sectoral cooperation. This is because, since parasite control is a low priority, no one institution has claimed it as its 'sacred territory,' nor has any organizational structure of firm line of command been set up for the activity.

The involvement of the government in the steering committee becomes especially important when the time comes to consider expanding the pilot project into a larger programme. Government adoption has either already occurred or is underway in some of the older projects. In Indonesia, for example, the project in Sawahlunto, West Sumatra Province was taken over by the provincial government while in Korea the provincial government adopted the projects in Kyunggi.

3) Baseline Survey

Before the implementation of the Project, a baseline survey on family planning, parasite infection, and environmental sanitation must be conducted in each project area to determine the size of population, number of eligible couples, crude birth rate, crude death rate, infant mortality rate, morbidity rate, family planning acceptance/continuation rates by method, parasite infection rates, latrine use, drinking water sources, degree of community participation, etc.

The baseline survey data will become an important means to assess the progress and effectiveness of the project by comparing it with periodic progress reports and evaluation at the end of the project term.

4) Encouragement of Bottom-Up Planning and Community Participation

As one way of enabling bottom-up planning and community participation, we have encouraged the formation of local steering committee in each project area. These committees consist of the project manager appointed by the national steering committee and formal and informal local leaders, such as the mayor, village headman, school principal and teachers, religious leaders, local government officers such as the health officer, and leaders of local community organizations.

The local steering committee would be responsible for planning and supervising the day-to-day activities of the project as well as for reporting on these activities and the community response to the national committee.

The local committee should also encourage the existing community organizations to take part in project activities such as by helping to collect stool specimens, distributing contraceptives and spreading health, sanitation and family planning messages.

5) Maximum Use of Parasite Control

The special advantages of parasite control work for community motivation and education have already been explained in the previous section.

Here, we wish to add the caution that these advantages will only demonstrate a fraction of their potential unless the examination and treatment processes are used every step of the way. In other words, just passing out deworming medicines to everyone is not enough.

We encourage projects to: explain to the community why you want to collect their stools; ask everyone to come and look at stools being examined; in administering treatment, gather everyone in one place and do it in mass if possible so that people will see for themselves that parasite infection is a problem shared in common by the community, to be tackled together by the community; and explain to the community how worms get inside their bodies, what kind of harm they do, and how to prevent infection.

Certainly, educational materials such as films, slides and posters are useful and should be utilized to the greatest extent possible, but we would like to emphasize here that parasite control work is in itself one of the best tools for education. And the mass approach -- working with people openly, in groups -- we believe is essential for maximizing the educational effect of parasite control and its capacity to motivate people to act together.

6) People-Building

In the previous section, we mentioned people-building in the sense of awakening the community people themselves to the possibility of improving their lives with their own hands. Here, we would like to touch on the building of helpers of the community in its effort at self-development.

In the Integrated Project, these helpers would range from people like family planning workers, health educators and laboratory technicians (although one worker might cover more than one of these functions) at the grass-roots level to important government officials and university professors at the highest level.

Whether the community level workers are liked and respected by the community and whether they have received the proper kind and amount of training are of the most immediate consequence to the day-to-day operation ofa project. But the question of whether the project has been able to seek out people at higher levels of authority who can provide continuous supervision and support is critical to its long-term development and expansion.

Toward people-building at all levels, we have encouraged not only frequent training and refresher courses for field-level workers and community volunteers, but also the convening of annual national conferences on the Integrated Project. So far four countries, the Philippines, Nepal, Thailand and Bangladesh, have carried out national conferences with the active participation of people at various levels involved in or interested in the Integrated Project. These conferences have provided valuable forums of information exchange, and served both to boost the morale of project personnel and to create excellent publicity.

7) Evaluation

We encourage periodic reviews of project accomplishments and evaluations both by the project implementors themselves and by third parties. Regarding evaluation, project countries and JOICFP agree that it should not be limited merely to the assessment of how much family planning practice

rates have gone up and how much parasite infection rates have gone down. A fair evaluation should attempt to grasp the total impact of the project on a given community. It should try to look at how the project affectetd and changed people's attitudes, life styles, and living conditions in a broad and imaginative way. Attached to this paper is a list of indicators of project effects -- quantitative qualitative, direct and indirect -- which JOICFP has compiled as a guide to such an undertaking.

As for the overall strategy of the Integrated Project itself, a review/ assessment has been conducted on the pilot projects that terminated the six year pilot terms by IPPF on request by JOICFP. The IPPF Review has identified important lessons to support JOICFP's hypotheses on the value of bottom-up planning, effectiveness of parasite control as an entry point to stimulate health, sanitation and family planning activities, involving active community participation, etc.

8) JOICFP's Role

JOICFP's role so far in the development of the Integrated Projects can be summed up as follows: funding, material assistance, technical assistance, and the sponsorship of international meetings of concerned personnel from project countries and representatives of international organizations.

In terms of materials, we have been providing equipment for parasite examination, deworming drugs, vehicles for field work and information, education and communication (IEC) materials. IEC materials have included educational slides, documentary films on Integrated Projects and other Primary Heralth Care activities as well as other innovative verbal and audiovisual aids such as the recently developed "Worm Kit" which consists of paper clay models of worms and leaflets explaining the infection routes of each type of parasites.

Technical assistance is provided mainly in the areas of parasite examination and treatment technology and their utilization for communbity education and motivation. JOICFP has undertaken this through: the enlistment and dispatch of Japanese parasitologists as advisors to the parasitologists of project countries; the sending of service terms to project areas made up of JOICFP staff and, at times, experts from other project countries; and the sponsorship of an annual training course for trainers of laboratory technicians at Mahidol University in Bangkok.

Until this year, JOICFP has been annually sponsoring four international meetings: 1) the Asian Parasite Control/Family Planning Conference for the project directors and national steering committee representatives of the 12 project countries: 2) the parasitologists' meeting; 3) the Workshop for More Effective Management and Promotion of Integrated Projects for field-level personnel; and 4) the American Conference on Integrated Programmes for the three Latin American countries implementing the Integrated Projects.

These meetings have provided forums for the active exchange of ideas and experiences, and mutual help in the solution of problems and in the exploration of future directions. Through the invitation of new individuals and organizations to participate, these meetings have also served to spread information about, and interest in the Integrated Projects beyond the 12 project countries.

JOICFP wishes that many more governments and NGOs will adopt the Integrated Family Planning and Parasite Control Project to improve health and sanitation standards of the people and enhance their voluntary acceptance of family planning.

JOICFP would be pleased to provide further information and technical assistance, if necessary, to any governments and NGOs on the basis of rich experiences accumulated by the 12 project countries.

Appendix

INDICATORS OF INTEGRATED PROJECT EFFECTS

Direct/Quantitative

1. Increase in family planning acceptance rates.
2. Increase in family planning continuation rates.
3. Decline in intestinal parasite infection rates.
4. Increased number of nutrition education activities, such as nutrition classes, demonstration of home gardening, fish ponds and animal husbandry, and promotion of breast feeding.
5. Increase in counterpart contributions to the project from government, private agencies and the community.
6. Increase in number of volunteers working actively for the project.

Direct/Qualitative

1. Increase in the formal and informal community leaders' awareness of and interest in the project.
2. Increase in the people's awareness of and interest in the project.
3. Increase in the people's demand for project services.
4. Increase of the family planning worker's acceptability by the people.
5. Increase in the family planning worker's credibility among the people.
6. Increase in community participation in project activities.
7. Increase in local agencies' involvement in the project.
8. Increase in the national governments' and bi- and multilateral agencies' support for the project.
9. Adoption of the integrated project approach in national policy

Indirect Quantitative

1. Increased practice of breast feeding.
2. Increased construction and usage of sanitary latrines.
3. Increased construction and usage of safe water systems.
4. Increased usage of regular health facilities.
5. Reduced malnutrition levels.
6. Increased height and weight of children.
7. Reduced absenteeism in schools and enterprises.
8. Increased labor productivity rates.
9. Reduced maternal and child morbidity and mortality rates.
10. Increased/number of volunteers active in community health and welfare activities.
11. Increased financial and other inputs by the community into community health and welfare activities.

Indirect Qualitative

1. Increased community interest and involvement in nutrition, such as changes in family eating habits and increased home gardening and domestic animal husbandry activities.
2. Increased community interest and involvement in personal and environmental hygiene and sanitation activities.
3. Increased activities relating to environmental beautification.
4. Increased community interest and involvement in other community health and welfare activities.
5. Increased demand from neighboring communities for project and related services.
6. Development of community income generating activities.
7. Strengthened community organizations/concerned with community welfare, such as mothers' clubs and youth groups.
8. Increased skills of community people in taking care of their own health and welfare by themselve
9. Development of additional skills by project field workers and laboratory technicians.
10. Increased cooperation or better relationships between government personnel and the community.
11. Increased cooperation between government and private sectors in promoting community welfare.
12. Institutionalization of primary health care.

II. CASE STUDY

THE INTEGRATED PROJECT ON FAMILY PLANNING, PARASITE CONTROL AND NUTRITION IN THE PHILIPPINES

I. BACKGROUND INFORMATION

The Filipino-Japanese cooperation in the implementation of the integrated project started in 1976 when the Japanese Organization for International Cooperation in Family Planning (JOICFP), a private, non-profit and non-religious organization based in Tokyo, Japan, assisted four pilot areas of Caramoan, Camarines Sur; Kawit, Cavite; San Pedro, Laguna; and Davao City in the implementation of family planning using the integrated approach with parasite control as an entry point to increase family planning acceptance rate and promote health consciousness among the rather curative-conscious Filipinos.

This approach draws from the 30 years of Japanese experience in successfully promoting family planning through improved health of the people and with particular focus on the health of the mothers and children.

Through this integreted concept, it seeks to enhance or establish the credibility of family planning workers among the community people by promoting family planning alongside a related public health service that can deliver immediate and visible effects. The ultimate goal, however, is to inculcate self-reliance through active community participation so that, eventually after six years, even without foreign/outside assistance, family planning and other related efforts will be sustained by the community on its own.

II. CONCEPTUAL FRAMEWORK DEVELOPED AFTER SIX YEARS OF THE PROJECT IMPLEMENTATION

The Philippine experience after six years of the project implementation in the pilot areas has concretized and operationalized the concept of the integrated approach based on local conditions and needs.

The six years of experience has shown that the strategy of using parasite control as an IEC strategy/entry point for family planning and health is indeed proven to be highly practical,

economical and effective for increasing family planning acceptance rate and for the people to appreciate the importance of health.

As experience shows, family planning and family welfare are difficult for an average person to understand and appreciate if explained from the "population explosion" and "contraceptive point of view". This is particularly pronounced in rural Philippines where family planning is misconstrued to be synonymous with birth control, and where poverty and lack for health concerns and facilities caused many deaths among the infants and the children. This is perhaps the reason why more children are sought as insurance for an eventuality, and why family planning lagged behind knowledge.

The Integrated Project on Family Planning, Parasite Control and Nutrition does not emphasize the traditional view of family planning as merely "child spacing" and "limiting the number of children". Rather, under the integrated strategy, family planning is promoted in its broader perspective - that family planning is planning the family and that "birth spacing" and "limiting the number of children" are only two of the several components in planning one's family.

Against this background, the strategy therefore is to advocate an element of welfare that is closest and most easily perceptible to the families - their health, particularly, the health of children. Family planning therefore will use health as the starting concern of welfare and parasite control as simple economical health service as a rallying point for family planning and primary health services.

The introduction of parasite control provides the parents with a dramatic demonstration of the quick effects of deworming on the health of children. The effects of treating the children of parasite infection is easily appreciated by the parents and the community since the results are immediate and visible. These are effects that will increase the credibility of the family planning workers. Once their credibility is established or increased, they can promote family planning and other related services more easily and more effectively.

Similarly, deworming which leads to the improvement of health and nutritional status provides a highly visible manifestation of welfare. Improved health as a result of parasite treatment and improved environmental sanitation and other peripheral health effects is a concrete example of welfare that an average rural folk can easily understand and appreciate.

The dynamics of the integrated approach as it influences the population growth rate is illustrated as follows:

1. Improved health will lead to dramatic decrease of mortality rate among infants and children, including decrease in morbidity rate. Once the parents are assured of the survival of their children, their desire for more children is similarly decreased, thus necessitating decrease in births.

2. Improved health also means that parents have more stamina and vigor to accelerate economic production in order to increase their capability to provide for the welfare needs of their children. Satisfaction of the basic needs of the family is a major concern of the family planning and welfare thrust.

3. Awareness of the parents for the future of their children should include education for their broods. These children are future parents and study shows that the more educated the parents are the lesser number of children they have.

4. Once the parents are highly conscious about the futute of their children, they will start to equate their existing resources with the desired number of their children. Thus, the parents will decide for themselves the size of their family as dictated by their capability to provide for the welfare needs of their children in terms of improved health and education.

The main focus of concern of the integrated approach is the children. The future of any society depends on how that society develops its children. The child is the center of love and aspiration in the family. His health and education as the starting development of his future must be the primordial concerns of the parents. Having a very high emotional appeal, any activity that concerns the child will win the support and interest of the parents.

With the child as the main focus of concern, indeed, every child has the right to be healthy and educated and every child should be a wanted child. Parents should therefore plan his future even before they plan to have a child.

III. GOALS/OBJECTIVES OF THE INTEGRATED PROJECT

The broad goal of the Integrated Project on Family Planning, Parasite Control and Nutrition is the welfare advancement of the people through improved health and education of the children.

The general objective is to institutionalize family planning and other related services in the community through self-reliance and community involvement/participation.

Specific Objectives are the following:

1. to decrease to the barest minimum parasitic infestation in the pilot areas with the children as the priority targets.

2. to decrease the incidence of malnutrition among the pre-schoolers, in-school and out-of-school children, and pregnant mothers.

3. to construct sanitary toilets and condemn those which do not conform with the prescribed standard guidelines.

4. to register pregnant mothers for purposes of regular check-up and follow-up.

5. to immunize all infants and children against polio, tuberclosis and other diseases.

6. to increase the prevalence rate of family planning acceptance, particularly the more effective methods, among the married couples of reproductive age (MCRAs).

IV. ORGANIZATION/STRATEGIES/POLICIES

A. ORGANIZATION/STRUCTURING

1. POLICY UNITS:
   - o National Steering Committee
   - o Regional Population Committee
   - o City/Provincial, Municipal and Barangay Development Councils

These units provide the policies at various levels based on the general policies and guidelines set by the National Steering Committee. The regional, city/provincial, municipal and barangay development councils will work the scheme for the gradual absorption of the integrated project by local governments with active support of the private sector.

2. COORDINATING/ MINOTORING UNITS

- o National Project Director
- o Regional Project Coordinator
- o City/Provincial Project Officer
- o Municipal Project Officer

These units will coordinate, monitor and render technical assistance to the implementing units.

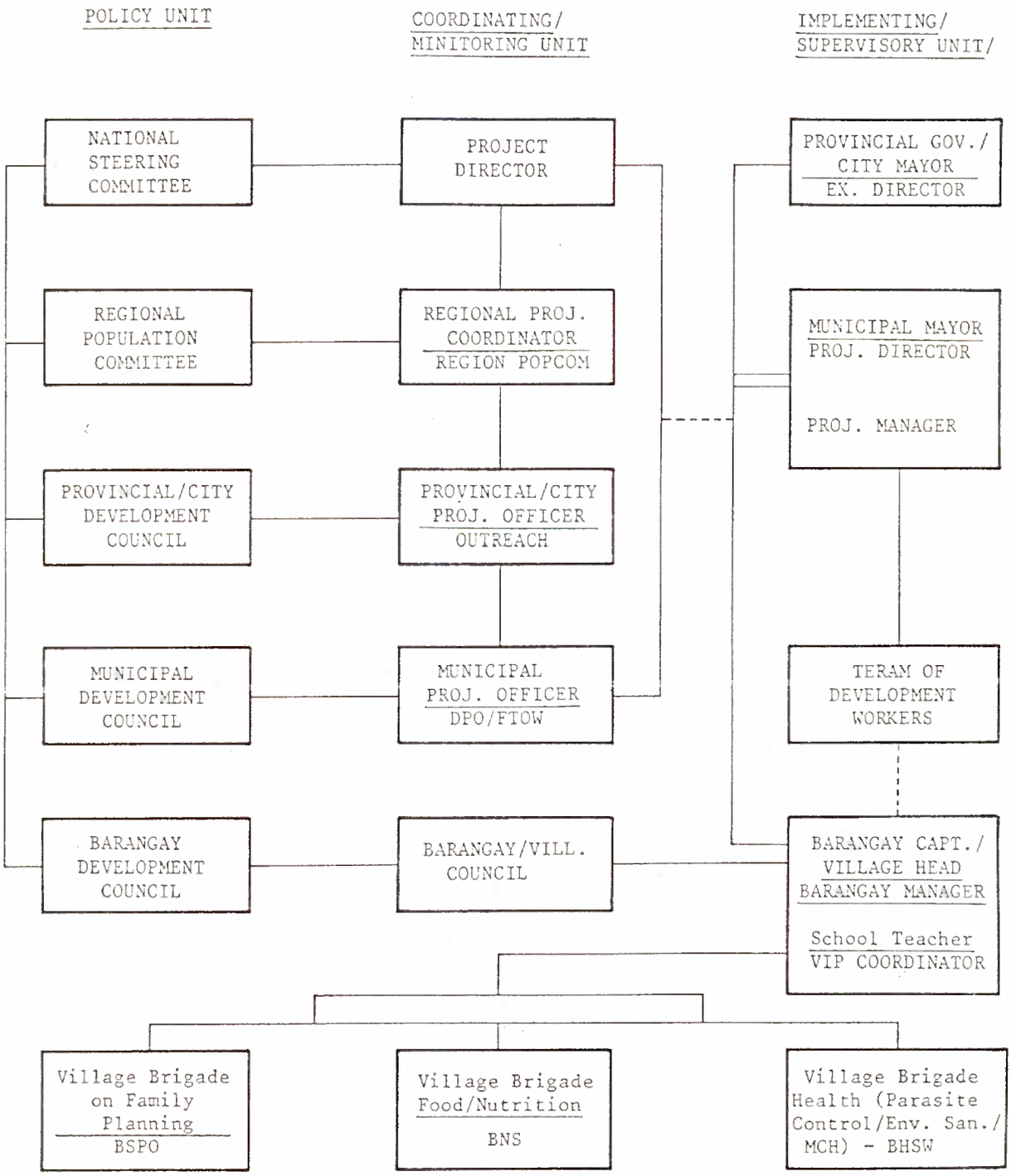
All the staff are from the Commission on Population and the Outreach structures from the national down to the minicipal levels. These units will also conduct trainings/orientation for the Project staff in order to upgrade their managerial skills and operational strategies.

3. IMPLEMENTING/ SUPERVISORY UNITS

- o Governor/City Mayor as Executive Director
- o Municipal Mayor as Project Director
- o Present Project Manager of Family Planning, Parasite Control and Nutrition (FAPPCAN)
- o Team of Development Workers
- o Barangay Captain as Barangay Manager
- o Village Teacher as VIP Coordinator

The strategy of putting the ownership, management and implementation of the integrated project on the local and barangay governments is a preparation for the eventual absorption of the project by the local governments and the institutionalization of family planning and other related services in the community.

ORGANIZATIONAL STRUCTURE
POPCOM-JOICFP ASSISTED PROJECT



BSPO - BARANGAY SERVICE POINT OFFICER
BNS - BARANGAY NUTRITION SCHOLAR
BHSW - BARANGAY (VILLAGE) HEALTH STATION WORKER

B. STRATEGIES

1. MANAGEMENT STRATEGY

1.1 Local governments manage, supervise, control and monitor the various phases of activities of the integrated project with the aim in view of fully funding the financial requirements of the integrated project.

1.2 FAPPCAN Project Manager assists the municipal mayor in the implementation of the integrated project until such time that the municipal government shall have fully absorbed the integrated project.

1.3 Fieldworkers of both the government and the private agencies operating within the municipality are organized into a Team of Development Workers (TDWs) to effect synchronized and well-coordinated delivery of vital services to the barangays (villages). Placed under the functional supervision of the municipal mayor, the Team of Development Workers (TDWs) assists the Project Director and the Project Manager in the management, supervision, monitoring and implementation of the integrated project. The TDWs is involved in the delivery of services and in IEC drives to support the barangay implementors.

2. PRE-IMPLEMENTATION STRATEGY

2.1 Orientation/briefing for local and barangay officials and leaders from the community and private sector on the concept/philosophy, objectives and organizational structure and strategies of the Integrated Project on Family Planning, Parasite Control and Nutrition. These officials and staff are also members of the regional, city/provincial, municipal and barangay development councils and population committees, including members of the local councils. During the briefing, local officials and community leaders are briefed on the functions, responsibilities and accountabilities of the local governments and the implementors.

2.2 Signing of the Memorandum of Agreement between the Provincial Governor/City Mayor and the Chairman of the FAPPCAN National Steering Committee on one hand, and the Provincial Governor and the Municipal Mayor, on

the other hand, regarding the implementation of the Integrated Project on Family Planning, Parasite Control and Nutrition.

2.3 Organization of workers from the various agencies of government and private agencies operating within a municipality into a Team of Development Workers (TDWs) after a thorough orientation.

2.4 Basic Training Course for the Project Implementors composed of the Municipal Mayor, as Project Director, the Project Manager, Team of Development Workers, Barangay Captains and the VIP Coordinators. Objectives of the training are to build teamship and commitment among the managers and implementors. Topics discussed include the concepts/philosophy, organizational structure, strategies, thrust of the Philippine Population Program, JOICFP's role in Human Resource Development under international cooperation, and the rationale and operationalization of the concept of integration. Participants are also given backgrounder on family planning, parasite control, environmental sanitation, maternal and child health, and nutrition.

2.5 Development of action plans on the last day of the training at the following levels:

2.5.1 Lead Agency Action Plan

Lead agency is required to present its action plan based on the barangay action plan.

2.5.2 TDWs Action Plan

As a team, the Team of Development Workers develops its plan of action in support of the Lead Agency Action Plan. Action Plans of both the Lead Agency and the TDWs are supporting the Barangay Action Plans.

2.5.3 Barangay Action Plans

Each barangay captain (village head) with the help of the VIP Coordinators make his action plan based on the felt and priority needs of his community.

2.5.4 Provincial/City, Municipal Development Plan and Regional Integrated Development Plan

Once the barangay action plan is indorsed by the Barangay Development Council and approved by the Barangay Council, it is forwarded to the Municipal Mayor who will in turn consolidate all barangay action plans. Once indorsed by th Municipal Development Council and approved by the Sangguniang Bayan (Municipal Council), the consolidated action plans become an integral part of the Municipal Development Plan. The Municipal Development Plan is then forwarded to the Provincial Governor for indorsement by the Provincial Development Council; and approval by the Sangguniang Panlalawingan (Provincial Council) to become a part and parcel of the Provincial Development Plan.

The Provincial Development Plan is submitted to the Regional Population Committee for sanction and for its reference and information. The Provincial Development Plans are consolidated into a Regional Integrated Development Plan and forwarded to the National Steering Committee also for its sanction, reference, information and monitoring purposes.

3. OPERATIONS STRATEGIES

3.1 Barangay (village) Council, the lowest government unit, implements the integrated project with the Barangay Captain as the Barangay Manager.

3.2 Village Teachers as Volunteers for the Integrated Project (VIP) Coordinator and assist the Barangay Captain.

3.3 Barangay (village) brigades, existing volunteer structures under the Barangay Captain, bring the services of the integrated project to the community, with the assistance of the Team of Development Workers.

3.4 Existing volunteer workers of the various agencies in the community help the barangay brigades in the implementation of the integrated approach. These are the Barangay Service Point Officers (BSPOs), for family planning; Barangay Nutrition Scholars (BNS), Day Care

Center workers, for food and nutrition; and Barangay Health Station Workers (BHSWs), for health services on parasite control, environmental sanitation, maternal and child health, and other related services under the primary health care.

3.5 Existing community organizations such as the Mothers' Club, Homemakers' Club, Parent-Teacher Association (PTA), Rural Improvement Club (RIC), Kabataang Barangay (KB) Youth Association, Satisfied Users/ Acceptors Club (SAC/SUC), Day Care Centers and other community organizations and leaders assist the barangay implementors in the delivery of services and in the information/education/communication and motivation campaign, including the recruitment of new acceptors.

3.6 The village is divided into zones, with each zone having a Zone Coordinator who is a member of the Barangay Council. Each zone is subdivided into several puroks (areas) headed by a Purok Leader. Each purok has 25 married couples of reproductive age.

3.7 Strategies in the implementation of the Project Components are summarized as follows:

3.7.1 Preparation for the intensified implementation of the integrated project

a. Preparing the Community

- o Barangay Captains with the assistance of the TDWs conduct community surveys to establish/ identify community resources, priorities and come up with a comprehensive community resources and profile data.

- o Based on the surveys and community resources and profile, the community leaders with the assistance of the TDWs prepare their action plans.

- o Meanwhile the barangay captain after the basic training course, orients the members of the Barangay Council and the Barangay Development Council about the integrated project.

- o Barangay captain with the assistance of the VIP Coordinator, the Barangay Council and the Barangay Development Council, calls a community assembly to orient the community residents regarding the implementation of the integrated project to get their unqualified support and active participation.

- o Barangay Captain, supported by the VIP Coordinator and the members of the Barangay Council and the Barangay Development Council, and the TDWs conducts basic training course for the members of the brigades and other volunteers and groups in the community.

- o Conduct special assemblies for the organized groups in the community such as the Mothers' Club, Kabataang Barangay (Youth Association), Rural Improvement Club, Homemakers' Club, Satisfied Users/Acceptors' Club (SUCs/SACs) Parent-Teacher Association (PTA) and other community organizations.

b. Implementing the Project Components

The policy of the integrated project is aimed at strengthening the existing activities of the primary health care, family planning and nutrition and other related activities. Thus, the Integrated Project is a strategy to promote/create health consciousness and increase family planning acceptance rate. It does not introduce new activities but provides merely a system to organize the delivery of integrated services in the community.

1. Parasite Control

1.1 The TDWs distributes stool containers to and collect them from the barangay captains.

1.2 The barangay captain distributes the stool containers to the teachers and collect from them the containers with the stool specimens of the school children.

1.3 The Lead Agency, with the assistance of the TDWs and the barangay implementors, conducts mass stool examination in the school compound. Children are asked to see for themselves the infected stools through the microscope.

1.4 At this stage, TDWs conducts lectures on the life cycle and types of parasites, ill-effects of parasite infection and on the economy, and preventive measures like use of sanitary toilets, drinking safe water, personal hygiene, eating the right kinds of food, proper food preparations and handling and other sanitation practices.

1.5 The TDWs also conducts film showing on the integrated project components.

1.6 During the mass stool examination and mass treatment, the parents through the teachers, the Parent-Teacher Association, the barangay captain and barangay leaders are invited to witness the event.

1.7 Mass treatment is usually conducted after the morning flag ceremony where the pupils are asked to bring a drinking glass and provided with anthelmintics to be taken together under the supervision of the Lead Agency and assisted by the TDWs.

1.8 In some instances, the TDWs, in cooperation/ coordination with the barangay implementors, conduct house-to-house and office-to-office deworming after the mass stool examination among the family members.

1.9 Still in some instances where stool examination cannot be conducted in the schools, specimens are submitted to the Lead Agency by the barangay captain through the TDWs.

2. Evnironmental Sanitation

After making people aware about the ill-effects of parasite infestation they can now relate the importance of sanitary toilets, potable drinking

water, personal hygiene, nutritious food and other environmental practices, to their health. The promotion of environmental sanitation, particularly, construction and use of sanitary toilets, can now be implemented effectively.

In some pilot areas, in Kawit, Cavite, the Project Manager was able to secure the assistance of local governments to purchase toilet bowls at a discounted rate at the Philippine Standard, the biggest manufacturer of porcelain watersealed bowls. These bowls are sold to the homeowners on installment basis. However, bowls will only be delivered after the homeowner has constructed the deposit tank and the structure in accordance with the specifications.

The Kawit strategy also includes the construction or improving the toilet facilities in public schools where the sanitary toilets serve as demonstration area for the school children and the community. In other pilot areas, manufacture of toilet bowls is done right in the community using the design made by the Ministry of Health. The people help in the manufacture of these bowls with their labor and gravel and sand while the local government and other private sector contribute the cement.

Still in some areas, the municipal government are helping the project by constructing a model barangay sanitary toilet in every barangay to serve as a demo toilet on what is a sanitary toilet and its proper use and maintenance.

Under the new strategy, the mayors in the pilot areas are encouraged to improve or expand sanitary toilet facilities in all public places like the public market, government buildings, schools and public toilets to serve as models for the people to see the importance and proper use and maintenance of sanitary toilets.

Some Project Managers were successful in asking the assistance of UNICEF in providing them water pumps and pipes to improve the source of water supply. In some areas, they were able to get

garbage truck from the National Environmental Protection Agency, an agency under the Ministry of Human Settlements.

3. Nutrition

3.1 The Lead Agency(ies) conducts Operations Timbang (babies weighting) among the target audience with the assistance of the TDWs and the active support of the barangay implementors under the leadership of the barangay captain and coordinated by the VIP Coordinator.

3.2 TDWs through the barangay captain makes separate list of those found malnourished according to age, group classification and degree of malnutrition.

3.3 List of malnourished preschoolers is submitted to the Day Care Center and the in-school and out-of-school and pregnant mothers to the Ministry of Education and Culture, Ministry of Agriculture, and Ministry of Health. Each agency has its own feeding program.

4. Family Planning

4.1 The Lead Agency sees to it that the implementation of family planning is built-in into the different components of the integrated project.

4.2 TDWs and the barangay implementors assist the Lead Agency in the IEC, motivation and recruitment of new acceptors and maintenance of continuing acceptors.

4.3 The success of the integrated project is measured by the number of new acceptors increased and maintenance of continuing users.

V. ACCOMPLISHMENTS AND ANALYSIS AFTER SIX YEARS OF IMPLEMENTATION

1. PARASITE CONTROL

At the start of the Integrated Project in the pilot areas, parasite infection rate was 84.6% and by the end of 1982, it was down to 28.09% or a decrease of 44.77% after six years of operation. Prevalent among the three types of parasite was trichuris which registered an infection rate of 77.13% in 1977 and followed by ascaris with 73.94% in the same year. After six years or at the end of 1982, ascaris has a dramatic decrease of 46.98% and trichuris, 40.27%. Trichuris is still prevalent in Kawit, Cavite than in the two pilot areas of Caramoan and San Pedro.

TABLE I - PARASITE INFECTION RATE BY TYPE

	1977	1978	1979	1980	1981	1982	1983
ASCARIS							
Caramoan	80%	43%	34.3%	21.8%	16.3%	9.6%	10%
Kawit	88.2%	67.9%	62.7%	58.8%	57.7%	54%	53%
San Pedro	53.6%	34.7%	22.3%	29.1%	34.7%	17.4%	29.8%
HOOKWORM							
Caramoan	10%	0.5%	16.5%	15.1%	8.9%	5.3%	2%
Kawit	58.6%	8.3%	7.5%	4.3%	1.6%	0.6%	0.4%
San Pedro	11.4%	2.7%	4.8%	3.7%	1.4%	1.9%	1.45%
TRICHURIS							
Caramoan	84%	54%	63%	67%	72.4%	31.6%	8.9%
Kawit	86.9%	87%	68%	7.18%	61%	53%	37%
San Pedro	69.9%	39%	33.6%	28.1%	49%	27.4%	30.3%

TABLE II - TOTAL PARASITE INFECTION RATE

YEAR	TOTAL INFECTION RATE IN THE PILOT AREAS	CARAMOAN	KAWIT	SAN PEDRO
1977	84.6%	77.9%	94.9%	81%
1978	57.2%	32.5%	85.3%	53.7%
1979	53.4%	37.7%	69.3%	53.2%
1980	55.3%	34.6%	80.9%	50.3%
1981	55.3%	32.5%	76.5%	57%
1982	41%	15.5%	72.2%	35.2%
1983*	38.8%	13%	62.7%	40.8%

* 1983 Midyear Report

TABLE III - ENVIRONMENTAL SANITATION

YEAR	TOTAL NUMBER OF TOILETS CONSTRUCTED PER YEAR
1977	57
1978	351
1979	468
1980	585
1981	679
1982	885
CUMULATIVE TOTAL	3,025

TABLE IV - FAMILY PLANNING

METHODS	1977	1978	1979	1980	1981	1982	TOTAL
Tubal Ligation	81	122	268	463	1,182	1,010	3,226
Vasectomy	4	13	15	13	35	16	96
IUD	75	118	523	156	211	108	1,191
Pill	440	543	1,240	948	938	1,057	5,165
Condom	147	251	664	498	616	580	2,756
Rhythm/ Others	290	324	575	623	623	590	2,751
GRAND TOTAL	1,037	1,371	3,159	2,653	3,605	3,361	15,185

2. COMPARATIVE ANALYSIS OF PARASITE CONTROL AND FAMILY PLANNING

1. KAWIT, CAVITE: A CASE STUDY

The Municipality of Kawit is a coastal town in the Province of Cavite about 23 kilometers southwest of Manila. It is classified as a cross-section of rural and urban type of community with a total population of 41,470 as of 1980 Censal Year.

The Integrated Project on Family Planning, Parasite Control and Nutrition started in Kawit last April, 1977, or exactly six years last April, 1983. The town has 10 elementary schools (9 are public schools and 1 a private institution); one main Rural Health Center and 9 Barangay (village) Health Stations; and several private clinics.

Before the start of the Integrated Project, there were 697 acceptors and 4,514 married couples of reproductive age (MCRAs). Parasite infection in 1977 was recorded at 94.9%, with ascaris as the most prevalent among those examined, followed by trichuris, and then by hookworm.

One village, Barangay Tochlong, was found out by the Project staff to have a zero family planning acceptance rate.

Early this year, a survey was conducted in the nine villages of Kawit, including the village of Toclong, with a total population of 5,642. Questionnaires were sent through the school children. Out of the total 5,642 respondents, 3,114 or 55.19% sent back the answered questionnaires. Based on these results, family planning acceptance rose from 697 to 2,191 over a period of six years in the surveyed villages. This represents 70.38% of the total respondents who answered the questionnaires.

One interesting development as a result of the Integrated Project is the village of Toclong where family planning acceptance rate was zero percent in 1977. Out of the nine barangays sampled, Barangay Toclong registered 79.31 family planning prevalence rate, the highest rate in the surveyed areas.

On the various family planning methods, tubal ligation recorded the highest of 29.62% among the acceptors; pill, 26.52%; and rhythm, 18.94%. Barangay Aguinaldo takes the lead in tubal ligation with 30.65% out of 509 surveyed acceptors.

On the other hand, parasite control has not yet gained headway in the surveyed areas. Or it is also probable that reinfection rate is high in those areas. Of the total 1,325 examined in 1981, 1,069 were found to be positive with either ascaris, hookworm, trichuris or mix family, having an infection rate of 80.60%. While this indicates a decline from the overall parasite infection rate of 94.9% in the pilot area in 1977, the gain however is negated with increased parasite infection rate in late 1982. Of the total 405 stools examined, 355 were found to be positive or a 87.90% infection rate, upped by 7.3% in less than a year. There are of course several factors to consider in the increased infection rate. One is lack of anthelmintics, lack of the Project staff personnel, lack of facilities and poor observance of personal hygiene and poor environmental sanitation like sanitary toilets due to poverty.

VI. EXPANSION OF AREA COVERAGE

As a result of the six-year experience in the pilot areas, the three original areas have now expanded to neighboring municipalities. The expansion is with the full support of the local governments and private sectors in the respective areas.

1. CAMARINES SUR, BICOL REGION

The Caramoan experience is now introduced in 16 municipalities of Camarines Sur Province and 3 barangays in Naga City situated in the same province in Bicol Region (Region V).

The new areas covered have a total population of 555,426 with a total of 76,231 married couples of reproductive age (MCRAs). There are 91,017 households with 17,155 malnourished children in the 1st degree, 9,003 in the 2nd degree and 5,912 in the 3rd degree, bringing the total of malnourished children to 32,070.

At the start of the project, schoolchildren examined were 7,321 and total infected were 7,162 or 97.83%, a very high infection rate indeed.

Trichuris registered the highest with 95.53%, followed by ascaris, 95.18%; and hookworm, 92.83%.

A total of 42,705 households were found to have sanitary toilets, representing 46.92% of the total households in the new expanded areas.

2. LAGUNA PROVINCE, REGION IV

Similarly, the San Pedro experience is now introduced to adjoining three barangays of the Resettlement Area of the said municipality.

The total population of the newly covered three barangays is 25,023, bringing the total population coverage in San Pedro, Languna to 53,078. Total households are 7,056 with 73.33% of those with toilets are water sealed; 66.66% are pit privy; while 20% have no toilets.

Parasite infestation registered 82.66% among the 2,453 stools examined with trichuris having the highest infection rate

of 65.51%; followed by ascaris, 40.31%; and hookworm, 37.63% with approximately 3,000 married couples of reproductive age (MCRAs).

3. CAVITE PROVINCE, REGION IV

The Kawit experience for the past six years is also brought to the neighboring town of Bacoor in the same province of Cavite. The new town covered has a total population of 90,386, bringing the total population covered in the two municipalities of Kawit and Bacoor to 131,856.

Total Married Couples of Reproductive Age (MCRAs) is approximately 10,846 or a total of 15,822 including Kawit Municipality, with total households of 16,091. Parasite infection rate in new pilot area is 65.58% among the 247 examined stools.

4. QUEZON CITY

Barangay Apolonio Samson in Quezon City is the new area under Phase II of the JOICFP-assisted Integrated Project on Family Planning, Parasite Control and Nutrition. The choice of an urban village is to experiment the viability of the integrated project in populous and highly urbanized community like Quezon City.

Barangay Apolonio Samson as of 1980 Censal Year has a total population of 18,948, with 3,706 households and a land area of 212,357 hectares. The village is considered as a depressed area and the cluster of houses is a typical scene in a crowded city. MCRAs is estimated to be 2,374.

Survey results conducted late last year show that Barangay Apolonio Samson has 88.1% of parasite infection rate with ascaris registered the highest infection rate of 40.8% and hookworm as the second prevalent worm among the sampled stools.

The Integrated Project is managed and supervised by the Philippine Medical Women Association, Quezon City Chapter and implemented through the Quezon City Health Office, a public health office, under the Ministry of Health. The Integrated Project started January, 1983.

In 1982, crude birth rate was placed at 17 births for every 1,000 population; crude death rate at 1 for every 1,000; infant mortality rate at 17 for every 1,000; and foetal death rate registered zero rate from 12 for every 1,000 in 1980 to 10 for every 1,000 in 1981.

5. POPCOM-JICA INTEGRATED FAMILY PLANNING AND MATERNAL/CHILD HEALTH PROJECT

The experiences gained from the JOICFP assisted pilot areas, the integrated strategy was adopted by the Commission on Population, a government entity mandated by law to coordinate the population and family planning activities in the Philippines, on a pilot basis as a means to institutionalize family planning in the community and increase acceptance rate.

The Integrated Family Planning and Maternal/Child Health Project, assisted by the Japan International Cooperation Agency (JICA), launched the JOICFP integrated concept on July 3, 1981 when the two governments of Japan and the Philippines signed the New Record of Discussions outlining the details of each country's responsibilities and participation. Under this agreement, the Commission on Population shall coordinate and monitor the implementation of the integrated project and render technical assistance while the Japan International Cooperation Agency shall provide equipment and supplies necessary for project implementation, training of Filipino counterparts locally and in Japan.

In June, 1982, the integrated project started in the two model areas of Tuba and La Trinidad in Benguet Province under the management and supervision of the local governments; and implemented by the Barangay governments with the assistance by the government and private fieldworkers organized into a Team of Development Workers (TDWs).

After less than a year of implementation, the model area experience is introduced beginning 1983 to seven municipalities and two cities, all situated in Luzon Island.

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INTECRAGED PROJECT
ON
FAMILY PLANNING/PARASITE CONTROL/NUTRITION
(Family Planning Survey)

School Survey	Total POP.	Total RESPONSE	FP Users	Non-Users	METHOD BREAKDOWN: VSS	PILL	IUD	CON	RHTM	NS	DEPO	OTHERS	W/ TOILETS	W/OUT TOILETS	
1. EINAKAYAN Elem. Sch.	2,309	1,268	916	216	525	194	114	57	185	12	12	77	822	349	
(Percentage)			(72.2)	(17)									(64.0)	(27.5)	Percentage Rate
2. GAHAK Elem. Sch.	800	290	212	66	54	76	25	13	35	2	1	12	226	58	
			(73.1)	(22.75)									(77.9)	(20.)	(%) Rate
3. AGUINALDO Elem. Sch.	1,063	733	509	169	180	156	45	30	86	9	9	29	483	117	
			(69.44)	(23.5)											(%)
4. PUTOL/STA. ISABEL E.S.	650	327	242	57	58	63	12	13	47	1	5	10	258	31	
			(74.)	(74.0)									(78.8)	(9.4)	(%)
5. WAKAS Elem. Sch.	395	203	115	40	40	27	4	6	39	5	0	4	136	46	
			(56.65)	(19.7)									(66.99)	(22.97)	(%)
6. PANAMITAN Elem. Sch.	294	111	71	33	33	17	5	2	15	2	0	5	78	6	
			(63.06)	(29.72)									(70.27)	(5.45)	(%)
7. KAINGEN Elem. Sch.	206	82	50	16	76	18	4	2	0	0	2	1	49	27	
			(60.9)	(19.5)									(59.7)	(19.5)	(%)
8. BATONG-DATIG Elem. Sch.	128	71	53	11	7	18	4	0	6	1	0	5	57	14	
			(74.64)	(15.5)									(80.2)	(19.7)	(%)
9. TOCLONG Elem. Sch.	67	29	23	6	6	12	1	3	2	0	2	0	17	12	
			(79.31)	(20.56)									(58.56)	(41.37)	(%)
Total - - -	5,642	3,114	2,191	674	649	581	214	126	415	32	31	143	2,326	660	
Percentage - - - - - -	55.19		70.35	29.65	29.62	26.52	9.77	5.75	18.94	1.46	1.41	6.53	(74.69)		

PARASITE CONTROL/ENVIRONMENTAL SANITATION
(ACCOMPLISHMENT REPORT)

AREAS COVERED SCHOOL/COMMUNITY	PERIOD	TOTAL NO. EXAMINED	TOTAL NO. POSITIVE	POSITIVE (+) Percentage	TREATMENT CASES	ENVIRONMENTAL SANITATION CERVICE: Toilet Bowls	Water Supply	Garbage Cans	TARGET POPULATION
1. BATONG-DALIG E.S.	June '80:	78	76	97.4%	82				131 S.C.
	Feb. '81:	81	64	79.0%	81				
" " Community	June '81:	-	-	-	116				
" " School	May '82:	11	9		78				
	Nov. '82:	23	16		73				
2. PANAMITAN									
. School	Sep. '80:	126	106	82.8%	139				297 S.C.
	Feb. '81:	41	21	51.0%	125				
	Jan. '82:	46	33	71.0%	87				
	Jun. '82:	27	17	63 %	134				
3. AGUINALDO/TABON									
. School	Sep. '80:	470	422	89 %	625				997 S.C.
	Mar. '81:	345	202	58.6%	481				
	Oct. '82:	287	198	69 %	419				
4. TOCLONG									
. School	Nov. '80:	32	27	84.4%	43				62 S.C.
	Mar. '82:	18	7	38.9%	189				200 Adults
	Aug. '82:	9	5	55.0%	39				
5. BINAKAYAN									
. School	Jan. -								
. Community	Dec. '79:	3,672	2,546	69.3%	10,463				1,848 S.C.
. School	Jan. '81:	564	527	93.0%	545				
. Community	Apr. '81:	300	-	-	304				
. School	Jan. '82:	297	860	87.0%	1,029				2,038 S.C.
	Jul. '82:	130	100	76.0%	1,035				
6. WAKAS									
. School	Dec. '80:	152	145	95.4%	221				340 S.C.
	Jul. '81:								
	Mar. '82:	87	75	81.0%	147				391 S.C.
	Nov. '82:	27	22	86.2%	179				
7. KAINGEN									
. School	Feb. '81:	83	80	96.3%	133				221 S.C.
	Jan. '82:	66	54	81.0%	109				
	Jul. '82:	34	30						206

PARASITE CONTROL/ENVIRONMENTAL SANITATION
(ACCOMPLISHMENT REPORT)

AREAS COVERED SCHOOL/COMMUNITTY	PERIOD	TOTAL NO. EXAMINED	TOTAL NO. POSITIVE	POSITIVE (+) Percentage	TREATMENT CASES	ENVIRONMENTAL SANITATION SERVICE			TARGET POPULATION
						Toilet Bowls	Water Supply	Garbage Cans	
8. GAHAK									
. School	Mar. '81:	193	167	86.0%	335				
	Sep. '82:	153	95	62.0%	390				811
9. PUTOL/STA ISABEL									
	Jan. '82:	118	41	65 %	299				633
	Dec. '82:	29	11	37.9%	129				