



STATE OF THE NATION REPORTS

ASSESSMENTS OF PRIMARY HEALTH CARE IN THE PHILIPPINES

Arturo M. Pesigan
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**University of the Philippines Press
and the
Center for Integrative and
Development Studies**

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PREFACE

This publication puts together two articles – the paper featured in the 1992 State of the Nation Report which assesses the implementation of primary health care (PHC) during the Marcos administration and a recent assessment of PHC in the post-Marcos years (1987-1993). Both papers provide the reader with an overview of an important program which rest on the principles of democratization and empowerment.

In response to the requests of health practitioners and students, the University of the Philippines-Center for Integrative and Development Studies (UP-CIDS) is reprinting its State of the Nation Report No. 2 and the article of Dr. Victoria A. Bautista, Professor of Public Administration, University of the Philippines which first appeared in the *Philippine Journal of Public Administration* (No. 2, Vol. 33 of April 1995). The Center wishes to acknowledge the Editors of the Journal of Public Administration for permission to reprint the Bautista article and Ms. Bella Lucas and Joy Aparis for seeing this Report through its publication with the help of Ellen Cometa.

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and Marilyn Lorenzo

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FOREWORD

The *State of the Nation Reports* are condensed and popular versions of studies produced under the UP Assessments on the State of the Nation: A Multi-Disciplinary Research and Outreach Program. By making these scholarly studies accessible to the public, the University of the Philippines–Center for Integrative and Development Studies (UP-CIDS) hopes to contribute to the continuing debate on the nation's future and the alternatives for shaping it.

This *State of the Nation Report* assesses the implementation of primary health care in the Philippines. Primary health care, with its emphasis on community participation over dependence on doctors and hospitals, promises not only improved health care for the public but also popular empowerment. It is important, therefore, that more people are made aware of its history, implementation and possibilities. This is precisely what Arturo M. Pesigan, MD, Ruben N. Caragay, MD, MPH, PhD and Marilyn Lorenzo, BSN, MPH, Assistant Professors of Public Health at UP Manila provide the readers. The authors are uniquely qualified to undertake this study given their experience as health professionals and academics. Aside from teaching and research, they have been extensively involved in community-based health programs.

This report was produced with the assistance of Mr. Charlson Ong of the Department of English and Comparative Literature, UP Diliman.

A grant from the Ford Foundation to the University of the Philippines enabled the UP Center for Integrative and Development Studies to publish the *State of the Nation Reports*.

Finally, the assessments and recommendations published in this series are solely those of the authors whose academic freedom is held sacred in the University and guaranteed by the Constitution.

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General Editor

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PRIMARY HEALTH CARE IN THE PHILIPPINES

Introduction

An important innovation in the health care delivery system in the Philippines was the introduction of the concept of Primary Health Care (PHC). Primary health care, as defined by the World Health Organization (WHO), is "essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost that the community and country can afford. It forms an integral part both of the country's health system of which it is the nucleus and of the overall social and economic development of the community."

Essential health care includes: (1) information and education on health; (2) proper nutrition; (3) water and sanitation; (4) maternal and child health; (5) immunization; (6) prevention and control of endemic diseases; (7) treatment of common diseases; and (8) provision of essential drugs. Thus, PHC is not only concerned with the curative or medical aspects (as emphasized in many countries) but also the promotive, preventive and rehabilitation aspects.

PHC's features, as will be discussed later, consist of community participation (**versus overdependence on medical doctors**), appropriate technology (**versus high-cost and sophisticated technology**), and intersectoral linkages (**versus reliance on the government sector or the medical sector**).

There had been numerous small scale-projects using the primary health care strategy in the Philippines before its nationwide introduction in 1979. Some of these efforts were coordinated by government, while others were initiated by nongovernment organizations (NGOs). However, such projects have largely remained fragmented and isolated from the health care priorities of the government.

The early efforts toward PHC concentrated mainly on the training and development of health volunteers or paramedics who can provide health care to the underserved population in remote and depressed rural areas and selected urban poor communities. Among these early efforts were those initiated by the Development of People's Foundation in Davao (the *Katiwala* Program) and the *Makapawa* Program in Samar both of which were initiated by NGOs. The Ministry of Health on the other hand, initiated the *Sarikaya* Program, (a Maternal and Child Health or MCH-based program) and the pilot program for the training and employment of *barangay* health workers which was made part of the International Development Agency and the International Bank for Reconstruction and Development (IBRD)-assisted Population Project.

The Philippine Health Situation Before PHC

In the late 1960s and early 1970s the health picture in the country was far from encouraging. Population grew rapidly: the base population of 32.3 million in 1965 was projected to increase to 69.9 million by the year 2000. While the health status of the Filipino has been described as "slowly but steadily improving over the years," the major health problems have remained the same and are anticipated to remain the same with some minor changes.

In the late 1970s and early 1980s the Philippine health situation was characterized by a preponderance of respiratory infections, namely, pneumonia and tuberculosis, as the leading causes of mortality. Together with gastroenteric diseases and nutritional deficiencies, they remain to be prominent public health problems. Dr. Jesus C. Azurin, former Minister of Health during the Marcos administration, offers an explanation for this unfortunate situation.

The persistence of communicable diseases, notably respiratory and gastroenteric disease, is reflective of the poor socioeconomic condition of a substantial number of Filipinos. It is also to a certain extent, reflective of the limited outreach of essential public health services, particularly in those areas of the country that have been described as underserved.

While the Department of Health (DOH) anticipated the persistence of these communicable diseases, it has also been cognizant of the increasing incidence of cardiovascular diseases and malignant neoplasms. There is likewise a noticeable shift in proportion between the incidence of communicable diseases and chronic degenerative diseases among the ten leading causes of mortality. Furthermore, in some endemic areas in the country, malaria and schistosomiasis continue to be major health problems. The advent of these chronic degenerative diseases on top of the persistent diseases has made the task of health workers more complex and seem formidable.

The upsurge of the cases of chronic degenerative diseases, particularly cardiovascular diseases and malignant neoplasms, is reflective of the increased environmental and occupational stresses affecting Filipinos. They also indicate changes in lifestyle and habits which increase a person's vulnerability to particular disease conditions. Among these changes are the increasing pollution of the environment with noxious gases and industrial waste, the rising incidence of smoking and drug abuse among the youth and working people, the low levels of environmental and food sanitation and unsatisfactory methods of refuse and excreta disposal.

In response to these problems, the DOH launched a restructuring of the health care delivery system in 1975. This move was aimed at decentralizing the organization of DOH. However, it was discovered that even as late as 1980, there were still many rural folk who could not be serviced due to a number of factors.

First, financial resources for health services, especially for field health services, remained scarce. Instead of keeping pace with population increase, the allocation for health care in relation to total national government expenditures decreased over the years. In 1979, only 1.37 billion pesos, representing a mere four percent of the total national budget, was appropriated for health care as compared to 4.4 percent, or 90.6 million pesos appropriated in 1964. It has been observed

that since 1975, appropriations for hospital services have been consistently larger than that for field health services. In 1979, only 38 percent of the total DOH budget was appropriated for field services.

Second, there is an inequitable distribution of health care manpower in the country, with a disproportionate number concentrated in the urban areas. It is estimated that about 15 percent of the total population have no access to the public health care system.

Third, health infrastructure has not kept pace with the growing population. In 1980, there was one rural health unit for every 24,772 people. Likewise, the 1980 ratio for *barangay* health stations was 1:6571. In terms of hospital beds which are still needed for efficient referral of primary health care, the national average was one bed per 577 people in 1980. While this figure may seem adequate, a closer look at regional differences will show the gross inequity. In Region 8, the bed to population ratio for the same year was 1:1004; in Region 9, 1:912; in Region 12, 1:845; in Region 4, 1:346; and in Regions 1 and 2, 1:632 and 1:629, respectively.

Objectives of PHC in the Philippines

Faced with these multifarious health problems, the DOH in 1979 commenced the implementation of Primary Health Care (PHC) with the following objectives.

General objectives:

1. Mobilize communities and make them participate effectively in planning for their health and development.
2. Maintain health by promoting optimum standards of living and good health practices,
3. Democratize access to essential health services by providing a channel for broadening the base of citizen and community participation in basic health care.

Specific objectives:

1. Sensitize and organize communities into functional entities that are aware of their problems and are able to participate effectively in planning for their health and development.
2. Provide the needed technical, institutional and logistical support to sustain community interest and commitment to health and health-related activities at the *barangay* and municipal levels.
3. Intensify health education efforts, particularly among the poorest 40 percent of the population.
4. Train *barangay* health workers (volunteers) who will serve as vital links between communities and the health care delivery system.
5. Provide susceptible households and communities with a ready supply of low-cost but effective remedies for diarrheal diseases, respiratory infections and other endemic diseases.
6. Strengthen and upgrade the capabilities of rural health units and district hospitals to provide technical, managerial and referral support for health activities at the community and *barangay* levels.
7. Organize and revitalize interagency committees at all levels for purposes of facilitating intersectoral collaboration, synchronizing activities, and optimizing resource utilization.

In 1981, the DOH also identified the following health targets for 1987:

1. Reduce the infant mortality rate from 63.2 in 1980 to less than 50 per 1,000 live births.
2. Reduce the crude birth rate from 8.3 in 1980 to 6.0 per 1,000 population.

3. Reduce the crude birth from 33.24 in 1980 to 28.66 per 1,000 population.
4. Reduce the prevalence of severe and moderate undernutrition among preschoolers from 20 percent in 1980 to 12 percent.
5. Increase the proportion of the population with access to safe drinking water to 80 percent.
6. Increase the proportion of households with sanitary toilets to 86 percent.

Initially, the key strategies for the operationalization of the PHC approach as specified in the Philippine Policy Program included the following:

1. Increasing opportunities for community participation in local level planning within the context of regional and national objectives.
2. Developing interdisciplinary, intrasectoral and intersectoral linkages with other government and private agencies so that programs of the health sector will be closely linked with those of other socioeconomic sectors at the national, intermediate and community levels.
3. Emphasizing partnership so that those in the health systems and the community view each other as partners rather than merely providers and receivers of health care, respectively.

Organization and Management of the National PHC Program

Primary Health Care (PHC) became an official policy when Letter of Instruction (LOI) No. 949 was issued by President Ferdinand E. Marcos in October 1979. The LOI specified that the Department of Health (DOH) shall "provide the leadership in the promotion of Primary Health Care in the country as well as promote close coordination with the appropriate ministries through the National Primary Care Committee." This national committee, composed of senior officials from the DOH and other

departments, educational institutions and private sector representatives, was tasked with designing the national PHC program focusing on health development at the community level. Specifically, the committee chaired by the DOH, was expected to develop or strengthen relationships with the existing health and health-related agencies. Basic health programs were envisioned to be reoriented and linked up with the health-related programs of the government and the private sector. The aim was to forge strong program linkages among government and nongovernment groups involved in PHC at the *barangay*, municipal, provincial, regional and national levels.

There are also regional, provincial, municipal and *barangay* PHC Committees composed of the health officers, who serve as the PHC coordinators, as well as other representatives from concerned government and private agencies. The PHC chairman is elected from among the committee members.

The PHC committees at different levels are responsible for coordinating, monitoring and reviewing various projects. The regional, provincial and municipal development councils provide technical support to the PHC committees to help ensure effective PHC implementation. The focal point of PHC activities is at the *barangay* level where all implementation occurs.

Within the DOH, organizational changes have been initiated to support the operationalization of PHC. On December 3, 1982, President Marcos issued Executive Order No. 851 entitled "Reorganizing the Ministry of Health, Integrating the Components of Health Care Delivery into its Field Operations and for Other Purposes." This mandate decentralized the field services of the Ministry, making it more responsive to the field situation within which PHC is being implemented.

In the beginning, the PHC coordinator within the DOH acted concurrently as chairman of the Technical Working Group. The coordinator was responsible for reviewing, coordinating, and monitoring program activities. After 1986, when PHC was presumed to be integrated into the entire DOH program, this position was dissolved.

However, in addition to the national PHC committee, existing coordinating mechanisms were utilized to insure the "full commitment and cooperation" of both government and private sectors. The Social Development Committee (SDC) of the National Economic and Development Authority (NEDA) became the central coordinating body. It was tasked with the approval of policies and strategies in support of PHC. At the lower levels, the regional development council (RDC) and the local development councils served as the coordinating bodies at their corresponding levels. They were charged with the additional responsibilities of monitoring and evaluating the PHC program in their areas.

Resources Mobilized for the National PHC Program

While the country realized then that effective national health services could be developed through Primary Health Care (PHC), the Philippines strengthened its commitment to PHC by making it an integral component of the "Population II" loan agreement with the World Bank in 1979, with the goal of "setting the pace for a coordinated and unified PHC in the country."

In 1980, PHC was piloted in 12 provinces – one in each region. A total of 100 municipal health officers of selected municipalities were trained in managing community health programs. Even while the pilot project was still ongoing, the Department of Health (DOH) launched PHC nationwide on September 11, 1981 as part of a birthday present to then President Marcos. As an initial activity, 9,000 rural midwives were oriented to the PHC concept and trained in community organization. After three years, about 99 percent or 38,000 of the 39,364 *barangays* had been initiated into PHC.

As the lead agency, the DOH mobilized "all its available resources" to promote the internationalization of the concept of self-reliance through family and community responsibility for health care.

With the realization that the success of PHC implementation is dependent on the mutual support and coordination among various agencies, the DOH led the establishment of intersectoral PHC Committees at all levels. Five government agencies extended strong support to PHC through provision of technical assistance, monitoring of PHC activities and sharing of information with concerned DOH personnel. These agencies include the National Economic and Development Authority (NEDA), the Department of Human Settlements (DHS), the Department of Local Government (DLG), the Department of Education, Culture and Sports (DECS) and the Department of Social Services and Development (DSSD). There were varying degrees of success in obtaining concrete and sustained support for PHC from these partner agencies. In some cases, there was more support at the local level. For instance, the DOH was unsuccessful in convincing DECS to restore health education as a basic subject in the elementary curriculum at the national level, but collaboration with DECS teachers at the local level was more fruitful. Local DECS workers had been active partners in the implementation of projects such as nutrition, immunization, deworming, and health education.

While PHC was considered a low cost and affordable alternative to existing health care system models, concerned personnel needed reorientation and retraining. In the absence of allocated funds, initial financing was sourced from funds previously allotted to "moribund" health programs, vacant positions, and "unnecessary purchases." The World Bank was also prevailed upon to allot \$3 million from Loan II for PHC. The budget office provided a small amount but subsequently increased funding for PHC in succeeding years, while an unspent portion of an International Development Agency loan was also channeled to PHC.

It was only in 1983, the third year of PHC implementation, that the Office of the Budget Department appropriated 40 million pesos for PHC. The greater part of this went to the organization of PHC Committees in 39,000 *barangays* and to the selection and training of 350,000 *barangay* health workers (BHWs). External funding assistance was provided by the

International Bank for Reconstruction and Development (IBRD), United States Agency for International Development (USAID), World Health Organization (WHO), United Nations Children's Fund (UNICEF), and Asian Development Bank (ADB). In some cases, external donor agencies were convinced to reprogram some of their resources for PHC. These were mostly used for massive training of provincial, municipal and *barangay* health workers; the intensified information, education, and communication campaign for PHC; the supply of kits for trained BHWs and the initial stock of pharmaceuticals for village drug stores (*Botika sa Barangay* or BSB) that were set up in support of PHC. External funds were also used to support technical assistance that led to the development of appropriate technology such as oral rehydration, acupuncture and herbal medicine.

Strategies Used in PHC

The government initiated the delivery of health services using the Primary Health Care Concept by utilizing the "partnership approach." Various sectors are encouraged to collaborate in bringing primary health care to the communities. In the early 1980s, joint efforts between the government and the private sector were pushed. Lately, however, NGO initiatives are more widely acknowledged and encouraged.

The "partnership approach" has four fundamental elements which are referred to as the pillars of PHC:

1. **Active community participation and involvement** – People are ready and willing to involve themselves in identifying their health needs and problems and in planning and carrying out solutions to these problems.
2. **Intersectoral collaboration** – There are harmonious and coordinated working relationships between government and private agencies on one hand, and among various types of health workers and other community workers, on the other.

3. **Development and use of appropriate technology to meet local health needs** – Health workers together with the people utilize scientific methods, techniques and equipment that are acceptable to those who apply it and to those for whom it is used. Moreover, this implies that the technology used can contribute significantly to solving a health problem, keep with the local culture, and be adapted and further developed if necessary.
- 4.. **Development of support mechanisms to sustain PHC implementation** – This initially involved development of human resources, logistic support and intersectoral collaboration. Lately, however, there has been more interest in Research and Development efforts in support of PHC.

PHC Accomplishment During the Marcos Administration: 1979-1985

In 1979, implementation started on a pilot basis in 12 provinces representing each region. A total of 100 municipal health officers from selected municipalities were trained in managing community health programs. An initial 9,000 rural midwives were oriented to the primary health care (PHC) concept and trained in community organization. In 1981, the Department of Health (DOH) launched PHC nationwide.

The following were accomplished in the six-year period:

1. Establishment of organizational and structural setup, including the : National Technical Group on PHC National PHC Coordinator and Office, Regional PHC Action Group and Provincial PHC Committee, District and PHC Group, Municipal PHC Action Group and Municipal PHC Committee, and *Barangay* PHC Committee.
2. Agreement on the need for coordinators to facilitate cooperation among various agencies.

3. Laying of the groundwork for the District Health System (catchment area).
4. Initiation of PHC training and orientation with accompanying manuals and pamphlets.
5. Training of 147,511 BHWs as of 1993, achieving a ratio of 1:43/households (target ratio is 1:20/households).
6. Setting up of the *Botika sa Barangay* (BSB) and BSB aides – As of 1983 a total of 14,777 BSBs have been set up nationwide (covering 37.8 percent of all *barangays*).
7. Establishment of a Medical Herbal Garden Concoction, pamphlets, tablet factory and seed bank.
8. Collaboration with other government offices (GOs), especially with the Department of Education, Culture and Sports (DECS).
9. Collaboration with Women's Federation.
10. Launching of "AKO" campaign on Health and "*Nagkakaisa Kami sa PHC*" slogan.
11. Initiation of Household Training including its manuals and books.
12. Establishment of the Health Referral System.
13. Establishment of early linkages with nongovernment organizations (NGOs).
14. Sourcing of PHC financing and PHC funds.
15. Setting up of income generating projects – through the *Kilusang Kabuhayan at Kaunlaran* (KKK); community-based profit-oriented projects that were of the following types: agro-livestock, aquamarine and cottage industries.
16. Institutionalization of a "cooperation system" in the health care of the communities.
17. Organization of the Integrated Provincial Health Office (IPHO).

PHC Accomplishment During the Aquino Administration: 1986-1989

Initiatives started under the previous regime finally came to fruition under the Aquino administration. The efficacy of the primary health care (PHC) approach was established and government support firmed up. By 1989, PHC funding finally approximated the WHO-suggested figure of five percent of gross national product (GNP). The other accomplishments during the first half of the Aquino government are as follows:

1. Dismantling of organizations and structures at the national and regional levels. The municipal and *barangay* structures were kept intact and reviewed. The *Botika sa Barangays* (BSBs) and *barangay* health workers BHWs were retained and their status reviewed.
2. Inclusion of the concept of PHC in the 1986 Philippine Constitution, although PHC is not explicitly mentioned in the document.
3. Formalization of the community-based health program (CBHP) policy.
4. Propagation of the decentralized approach. Reorganization of the Department of Health (DOH) under Executive Order (EO) No. 119. Stratification of communities (cities and provinces) to be served.
5. Increasing recognition that health concerns cannot be tackled by government alone.
6. Attainment of sectoral recognition and support.
7. Advocacy and upholding of consultative programs.
8. Advocacy of the goal of community empowerment.
9. Integration of the clinical and public health components of health service delivery, especially Maternal and Child Health (MCH).
10. Appropriate strategies initiated to effect delivery of minimum elements of PHC:

- * Establishment of a "simplified and realistic" health information system (EHIS)
 - * Establishment of hospital catchment area system
 - * Funding of community health actions and projects
 - * Use of appropriate strategies (e.g. area/program-based health planning, community health analysis)
 - * Putting up of floating clinics
11. Formulation of the National Drug Policy and the passing of the Generics Law.
 12. Operationalization of the belief in the capabilities of non-government organizations (NGOs), field health office personnel, and the community; creation of the NGO desk in DOH.
 13. Strengthening of the District Health Office.
 14. Congressional liaising which resulted in a proposed congressional bill regarding PHC.
 15. Coordination of national and regional programs/projects.
 16. Involvement in multiagency and trisectoral efforts, forging a memorandum of agreement and forging relationships among various government agencies and NGOs.
 17. Provision of support to active BHWs – 45,000 BHW kits were given to identified active BHWs
 18. Establishment of Community Health Service to strengthen the planning and implementation of the service delivery mechanisms of the National Health Network.

Problems Identified in National PHC Implementation

Although field reports indicate the increasing efficacy of the primary health care (PHC) approach, certain operational problems have also been identified. While the health care targets for 1987 were largely met, the percentage of malnourished children increased from 20 percent of the population in 1980 to 33.33 percent in 1987 – well above the target of 12 percent. This setback may not be entirely attributed to the PHC

approach. Still, implementors have noted areas where PHC may be enhanced.

Among the problems encountered in the nationwide implementation of the PHC are:

1. Community-based activities have not filtered down to the depressed sectors of the population. The more affluent were the ones who derived more benefits from these efforts – the government bureaucratic system had difficulty in extending government resources down to the local level.
2. Community participation, the use of appropriate technology, *barangay* health workers (BHWs), *barangay* PHC Committee (BPHCC), and *Botika sa Barangays* (BSBs) have been difficult to sustain.
3. The level of motivation and interest of health workers in carrying out their responsibilities have been low. This may be due to their failure to internalize the true concept of PHC, their low salaries and insufficient logistical support.
4. The technical skills of health workers in community organizing and communication have been inadequate.
5. Interagency linkages have been weak. Collaboration among agencies have mostly been geared toward nonhealth government offices.
6. Some health workers and communities have attitudinal problems, e.g., attempts to integrate Western medicine with traditional medicare have been met with skepticism. People in communities have also exhibited a high dependence on medical intervention and a tendency to establish a provider-recipient relationship.
7. The level of trust between nongovernment organizations (NGOs) and Department of Health (DOH) personnel has been low because of past unresolved conflicts.

8. There has been lack of sustained political will that may have had negative effects on decisions on health and health-related matters.
9. Poor economic conditions have inhibited community participation.
10. Peace and order problems in some areas have limited the mobility and participation of communities.
11. The management skills of middle line managers and program implementors have been inadequate.
12. High inflation rate has resulted in high cost of medicines and medical equipment as well as of hospitalization.
13. Reporting systems have not been adequate and the monitoring of programs and activities at the peripheral levels has been ineffective.
14. The weak referral system among government and private institutions has hampered the exchange of expertise, technology and resources.
15. The distribution of doctors, nurses and midwives has been inequitable, resulting in the lack of trained personnel in far-flung areas.

RECOMMENDATIONS

Given the experience of the last decade, the following recommendations on how to enhance project implementation are advanced:

1. A truly decentralized rural-oriented health system should be established. The attempts of the Department of Health (DOH) toward decentralization should not be geared only to administrative concerns but also to more substantive ones. For instance, the district level should be given more decision making function in resource allocation. There should also be

decentralization within the community by establishing community managed health programs. The health service providers, government offices (GO) and nongovernment organizations (NGOs), and the University of the Philippines (UP) could set up pilot areas as health service models for training purposes.

2. The DOH and NGOs must define their respective roles and strengths in addressing the health and health-related problems in the country. Successful GO-NGO collaboration should revolve around a common policy framework from which programs, goals, and specific activities shall be identified.
3. Levels of decision-making and accountability should be identified and decentralized, e.g., NGOs are accountable to the people they work with while GOs have a bureaucratic structures where decisions in terms of use of funds and project commitments rest on higher authorities. A rigid system of accountability will continue to stifle creativity and effectiveness.
4. Sectoral and intersectoral communication must be strengthened, e.g., more health information can be incorporated into the school curriculum.
5. A holistic approach to community development where health is merely a component and not the focus must be adopted. Intersectoral mechanisms, such as the PHC committees, could be reactivated to develop not only the health aspects but also the education and housing dimensions of community development.
6. The monitoring capability of the health system needs to be strengthened. Because UP does not directly provide health services, it is in a position to initiate the development of standards for the health operations of GOs and NGOs, as well as to monitor and evaluate health activities. The potential involvement of the University in monitoring and evaluation can,

in turn, enlighten the process of realigning its academic programs to the wider needs of society and the broad goals of national development.

7. Studies on PHC activities and their outcomes must be undertaken. In particular, research is needed in the following areas: community health financing, resource allocation, the degree of equity of health resources, community involvement, organizational framework and management process. This can be spearheaded by the academe. Moreover, the evolution of processes used should be described and health targets evaluated.
8. Policies and guidelines for the use of funds and resources allocated to PHC must be clearly defined to facilitate realistic and expedient project commitments at the local level.

TABLE 1.1

Primary Health Care Funds

Annual support for program implementation compared to total Department of Health (DOH) budget and gross national product (GNP), 1979-1990

YEAR	ALL REGIONS (in million pesos)	CENTRAL OFFICE BUDGET (in million pesos)	TOTAL DOH BUDGET (in billion pesos)	% of DOH budget
1979	402 M	1.28 B		31.3%
1980	515 M	1.27 B		40.4%
1981	615 M	1.58 B		38.8%
1982	701 M	2.05 B		34.0%
1983	930 M	48 M	2.54 B	36.6%
1984	143 M	25 M	2.18 B	6.5%
1985	151 M	20 M	2.34 B	6.5%
1986	1,363 M	20 M	3.27 B	41.6%
1987	20 M	221 M	4.14 B	.5%
1988	3,568 M	150 M	4.99 B	71.4%
1989	4,139 M	160 M	6.71 B	61.6%
1990	97,455 M	34 M	7.42 B	1.3%

Source: General Appropriations Act, Department of Health.

Table 1.1 shows the breakdown of the allocated funds for primary health care (PHC) support from 1979 to 1990. The table shows that separate funding for PHC at the national level had been incorporated into the budget only since 1983. Funding support has varied from a low of .5 percent (in 1987) to a high of 71.4 percent (in 1988) of the total DOH budget. This represents an average allocation of 30 percent of the total DOH budget for PHC during the period.

TABLE 1.2
Primary Health Care Funds
Annual support for program implementation as percentage of
gross national product (GNP), 1979-1989

YEAR	ALL REGIONS (in million pesos)	CENTRAL OFFICE (in million pesos)			% of GNP allocated to PHC (in billion pesos)
1979	402 M	402 M	88.1 B		.45%
1980	515 M	515 M	92.5 B		.55%
1981	615 M	615 M	95.7 B		.64%
1982	701 M	701 M	97.5 B		.71%
1983	930 M	48 M	978 M	98.6 B	.99%
1984	143 M	25 M	168 M	91.6 B	.18%
1985	151 M	20 M	171 M	88.7 B	.19%
1986	1,363 M	20 M	1,383 M	89.6 B	1.50%
1987	20 M	221 M	241 M	94.7 B	.25%
1988	3,568 M	150 M	3,718 M	101.0 B	3.60%
1989	4,139 M	150 M	4,299 M	106.8 B	4.00%

Source: General Appropriations Act, Department of Health; Center for Research and Communications (for GNP figures).

Table 2 gives the yearly allocations for primary health care (PHC) funds from 1979 to 1989 as a percentage of annual GNP. The table shows that support for PHC approximated a level of adequacy only in 1989 when it reached 4.0 percent of GNP. The World Health Organization suggests that PHC funding should be at least 5.0 percent of the GNP.

PRIMARY HEALTH CARE: 1987-1993*

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PRIMARY HEALTH CARE : 1987-1993

Background

The implementation of primary health care (PHC) as a strategy of the government in the 1987-1993 period is significantly influenced by two legal mandates that set the tone for and the perspective on the execution of the Department of Health's organizational policies and thrusts. First, the passage of the Philippine Constitution in 1987 enshrined health as a basic right of the people. Article II, Section 16 states that "The State shall protect and promote the right of health of the people and instill health consciousness among them." Furthermore, while the Constitution does not directly advance PHC as a strategy, the passage of Article II, Section 23 recognizes the basic principle of a "community-based" approach, which is the essence of the PHC strategy.

Second, an important mandate which carries substantial implications for the organization and management of PHC from 1987 to 1993 is the passage of the 1991 Local Government Code. The Code transfers power and authority in the management of PHC to local government units (LGUs). Until the promulgation of the Code, this had been the chief responsibility of the national government through the former Ministry of Health, later renamed the Department of Health. For twelve years beginning with the Letter of Instruction No. 949 issued by former President Ferdinand E. Marcos in 1979, the responsibility for PHC has been lodged in the national government.

However, the relative importance of PHC shifted from 1987 to 1993 as the two key health department executives assumed different postures toward it. Under Secretary Alfredo Bengzon (1986-1991), experimentations falling under the umbrella of "Community Health Development" were made to forge partnerships with nongovernment organizations (NGOs). This meant putting the PHC on hold as the health department, "distanced itself from" using the term and campaigning vigorously for the strategy (DOH Update on PHC Policy and Implementation, no date: 5).

On the other hand, under the leadership of Secretary Juan Flavio, PHC regained its primacy as the approach which should permeate all health programs and projects. During this time, government was also concerned with the devolution of PHC to local government units.

This paper focuses on the accomplishments and performance of the Department of Health under two Secretaries. It also raises policy issues and concludes with several recommendations.

PHC to Community Health Development: 1987-1991

Less emphasis on PHC. Under Secretary Alfredo Bengzon's leadership, PHC was not given as much attention as it had been during the Marcos administration. This is indicated by the fact that the status of PHC implementation was not monitored religiously. The latest available data with complete information on PHC were for 1988. The succeeding year showed incomplete information, with only 10 of 14 regions providing the necessary data. Thereafter, no data were presented on the status of PHC nationwide in the Annual Reports.

The 1988 data indicated a decline in the total number of *barangays* initiated to PHC, with only 96.6 percent in this category out of 39,629 *barangays*, as against 98.3 percent out of 38,364 *barangays* in 1984 (DOH Statistical Data, Table 2.1).

TABLE 2.1
Total Number of PHC *Barangays*

Status of <i>Barangays</i>	1984		1988	
	Number	%	Number	%
Initiated to PHC	37,705	98.3	38,316	96.6
Not initiated	1,345	1.7	1,313	3.4
Total <i>Barangays</i>	38,364	100.0	39,629	100.0

Source: DOH Statistical Data, Community Health Service.

The decrease in the number of *barangay* health workers (BHWs) is even more remarkable since it dipped from 380,609 in 1984 to 371,762 in 1986 and 355,990 in 1988 (Table 2.2).

TABLE 2.2
Number of *Barangay* Health Workers

Status	1984		1986		1988	
	No.	%	No.	%	No.	%
Trained	262,553	69.0				
To be trained	118,055	31.0				
Active			244,668	65.8	193,374	54.0
Inactive			127,094	34.2	162,616	46.0
Total no. of BHWs	380,609		371,762		355,990	
Total no. of PHC bgys.	37,705		36,016		38,316	
Ratio of trained/ active BHW to bgy.	7:1		7:1		5:1	

Source: DOH Statistical Data, Community Health Service.

The Bengzon administration differed from the previous dispensation in the way it monitored BHWs. The latter categorized BHWs into those who are trained and those who need training. The former on the other hand, made a distinction between active and inactive BHWs since training does not ensure active involvement. Although the Bengzon administration improved the way BHWs are categorized, monitoring after 1988 had not been pursued regularly. The dwindling enthusiasm for PHC in the Bengzon years is further indicated by the decreasing ratio of active/trained BHWs to PHC *barangays* from 7:1 in 1984 and 1986, to 5:1 in 1988.

Moreover, monitoring of the level of PHC implementation in every *barangay* was no longer carried out after 1988. Previous to this, four levels of PHC were considered as basis for classifying *barangays*. These were: first level, Social Preparation/Awareness; second level, Leadership Organization Design (LOD); third level, Program Planning and Management; and fourth level, Institutionalization of PHC.

A set of indicators was formulated to ascertain each level with the Rural Health Unit or the Barangay Health Station personnel taking charge of classifying the *barangay* under its jurisdiction. While the set of indicators was difficult to translate in operational terms, an earlier assessment of the utilization of these indicators showed the initiative of local implementors in providing more measurable criteria (Bautista, 1988: 53). However, the problem with allowing local implementors to define their own criteria is that it leaves them much discretion, thus preventing standardization in the process.

The waning interest in PHC in the earlier years of the Bengzon administration is further indicated by the decrease in the percentage of *barangays* in the highest level of PHC implementation. In 1986, the percentage of *barangays* in the fourth level of PHC was close to a third of the total. This decreased to one-fourth in two years (Table 2.3).

TABLE 2.3
Level of PHC Implementation of *Barangays*

Level of PHC	1986		1988	
	No.	%	No.	%
I- Social Preparation/ Awareness	3,424	9.5	4,762	12.0
II- Leadership Organization Design	7,927	22.0	9,220	24.0
III- Program Planning and Management	13,101	36.4	14,597	38.0
IV- Institutionalization of PHC	11,564	32.1	9,737	25.0
Total	38,316	100.0	36,016	100.0

Source: DOH Statistical Data, Community Health Service.

Another indicator of the lack of interest in PHC implementation is the decline in the total number of *Botika sa Barangay* (BSB), a community cooperative drugstore selling drugs in the locality. In 1983, 4,777 BSBs had been set up nationwide, covering 37.8 percent of all *barangays*

(Pesigan *et al.*, 1992: 15). By 1988, DOH statistical data revealed an increase to 17,150 BSBs, although only 43 percent (or 7,367 BSBs) of this total was considered functional. These served only 19 percent of PHC *barangays*.

While financial resources for PHC had reportedly increased by as much as four percent of gross national product (GNP) in 1989 – or close to the ideal of five percent, based on World Health Organization standards – the average allotment for PHC from 1979 to 1986 constituted only 0.65 percent of GNP (Pesigan *et al.*, 1992: 12-13). Interviews on the usage of PHC funds in 1989 nevertheless indicated that these were not solely channeled to PHC (Interview with a member of the National Technical Working Group, 11 January 1994).

The decrease in the support given PHC during this phase may be attributed to the leadership's assessment that the term carried "many wrong connotations" since it was a "thwarted advocacy, having been carried out under a "dictatorship." (DOH Update on PHC Policy and Implementation, no date: 5). Furthermore, the new leadership wanted to correct the misconception that PHC was implemented as a means to reduce the health budget.

Partnership for Community Health Development. In lieu of the term PHC, "Partnership for Community Health Development (PCHD)" was the approach proposed although that was not fully developed and carried out. Community Health Development was conceived as a "people-centered development process where initial beneficiaries of health programs become partners in health care until they are finally empowered to become managers of their own health programs, able to attain self-reliance and self-determination" (DOH Primer on PCHD). The basic strategy is "partnership" with organized groups in the locality – local government units (LGUs), nongovernment organizations (NGOs), field health units (*i.e.*, provincial health office, district health office, and rural health unit) and people's organizations which share the vision of community health development.

The strategy is based on the assumption that such a partnership decentralizes decision making and that the participatory approach is used in the different phases of the management cycle of planning, implementing, monitoring and evaluating local development programs

and projects. It is particularly aimed at "depressed, underserved, hard-to-reach and critical communities" (DOH Primer on PCHD). This partnership is made possible through the financial support of the health department's Community Health Service, with the assistance of local groups or organizations.

In essence, PCHD is an approach which subscribes to the basic ideas of PHC on intersectoral collaboration, concern for the locality's depressed sectors and participatory decision making. The difference lies in the manner of execution since the responsibility is lodged in an NGO instead of the health department's field health office. Furthermore, financial support is extended to the partnership for various activities such as:

- collective multisectoral planning by the NGOs, provincial health office/rural health units and the LGU;
- community project implementation for those formulated according to community needs – a cumulative total of 76 proposals covering 99 barangays were reportedly approved by 1992; and
- institution-building activities of partner agencies, aimed at making the health department have an actual experience and appreciation of community organizing; at infusing in LGUs a social orientation and service of responsibility for the management of preventive and promotive health programs; and at making NGOs better implementors of health programs (PCHD 1992 Accomplishment Report: 10).

PCHD became operational in 1990 in four provinces (Camarines Sur, Eastern Samar, Negros Occidental and Surigao del Norte). Another four provinces were included in 1991 (Sorsogon, Northern Samar, Antique and Agusan del Norte).

Since 1990, 151 NGOs have attended the PCHD orientation and partnership meetings. However, as of 1992, only 81 remained active, with 84 percent being project proponents (PCHD 1992 Accomplishment Report).

Among the initial problems encountered in the partnership as reported in PCHD's Accomplishment Report for 1992 is the lack of clarity with regard to the role of the LGU in managing the partnership. Another is the reluctance of NGOs to work with LGUs for fear of political conflicts. Some NGOs were reportedly turned down by local executives who had preferred to work with other NGOs who have little experience in community organizing.

Another stumbling block is the delay in the releases of funds, which caused a slow-paced implementation. Another problem has to do with the projects' sustainability after the NGOs' role as facilitators is completed. There is also the issue of the interested parties' capability to prepare project proposals on which the partnership is substantially based.

In spite of these problems, some landmark improvements in the approaches of the health department have been made in support of PCHD. These are:

- Institution of an information system in order to detect the areas that can be tapped for social development. The system entailed identifying Targetted Areas for Development (TADS). The idea is to collect *barangay* health-related data that will be the basis not only of "health improvement but also of the total development of the community," with a view to redressing inequalities. TADS are *barangays* that are "hard to reach, underserved, depressed and/or in critical areas where the inhabitants are most vulnerable and health systems research is most difficult" to pursue (TADS Project Summary).

TADS Forms were formulated to obtain baseline information and to serve as a guide on the status of the *barangays*. The general information in the Form includes region, province, district, municipality, population, name of midwife, number of households, regular mode of transportation, distance from the town proper, geographical description, number of active *barangay* health workers (BHWs), number of trained birth attendants, presence of Barangay Primary Health Care Committee, names of NGOs present, number of households with potable water and number of households with sanitary water.

- Conduct of the First National Convention of NGOs for Health in November 1989 to formally open the health department to all private sectors involved in health. A listing of health NGOs was drawn as a result of this undertaking.
- Encouragement of collaborative activities with NGOs, notably the Jaime V. Ongpin Foundation Inc. (JVOFI) which signed an agreement with the health department to finance projects for the provinces of Zambales and the Cordilleras, particularly Benguet, Mountain Province, Ifugao, and Nueva Vizcaya (Development Partners Inc., 1993: 4). JVOFI serves as the social arm of the Benguet Corporation and is the trustee of the donation to the Philippine government for the development of the corporation's mining areas.

Some 55 million pesos had been made available for a six-year period. The projects involved primary health care, health-related community development and livelihood. This agreement commenced in 1986 and facilitated the evolution of the DOH/CHS GO-NGO-community partnership program (Development Partners Inc. 1993: 26). The health department was also tapped in this collaboration to bridge the slack period for PHC projects (Development Partners Inc., 1993: 30).

The collaboration's framework for implementation signifies its affinity with PHC since it capitalized on community organizing as the basic process underlying social development efforts in disadvantaged communities within the target areas. (Development Partners Inc., 1993: 8). The ultimate goal was to develop and mobilize community structures capable of managing and sustaining projects initiated by the collaboration (Development Partners Inc., 1993: 8).

The collaboration carried out 522 projects from 1987 to 1992 with 61 devoted to PHC. The others were mostly in local development, social development and institutional development.

In addition to previous innovations, support was extended to BHWs in spite of the distance of the health department from the term PHC. The following were initiated in Bengzon's administration:

- Issuance of BHW identification (ID) card

This served as a reference for program managers and a convenient tool for monitoring and evaluation. This also provided security to the workers especially in areas with peace and order problems. A total of 159,442 ID cards were issued during the period (DOH Update on PHC Policy and Implementation).

- Provision of incentives to BHWs

Incentives included free medical and dental checkup, with blood typing and the establishment of a separate file for the BHWs in the family health folder in the Municipal Health Center and the Barangay Health Station.

The BHWs were to be provided free drugs and medicines if available, laboratory examinations (*i.e.*, sputum examination and/or fluoroscopy), blood smear for malaria, dental services and tetanus toxoid injection.

The services extended by the health department program were to be extended as well to the BHW's immediate family members. Their files were thus included in the family health folder.

- Provision of income generating projects (IGP)

Extending financial grants to BHWs to undertake livelihood projects is one important step to prevent turnover. A 100,000 peso seed fund per province and 30,000 pesos for each city was made available to start or augment a collective livelihood endeavor to be administered and managed by the BHWs themselves. This was aimed at supplementing their finances for health and health-related needs and to ensure the sustainability of their efforts. This would be carried out provided that BHWs are federated per province. The Provincial BHW Federation was to organize a review committee for the purpose

of studying all proposed IGPs in the province and endorsing the deserving ones to the Regional Health Office.

- Conduct of a survey by the Community Health Service in January and February 1991 to determine the needs and problems of BHWs
- Compilation of a BHW directory

Preparations for the BHW directory began. The directory was to contain all information on trained, active and functional BHWs, including ID number with codes for province, municipality and BHW number; the age, sex, civil status, blood type and address of BHW.

Impact. The impact of primary health care (PHC) as a strategy was evaluated during this phase by a team from the academic community (Bautista, 1988). Survey data from 12 *barangays* located in three regions were collected between April 15 and July 15, 1987. The rate of sickness among those who were not exposed to PHC was 154 persons per 1,000 as against 139 per 1,000 among those familiar with PHC, thus proving the strategy's positive impact (Bautista, 1989: 153). Mortality patterns in the 12 *barangays* also improved over two periods for six out of 11 *barangays* with available data. This may be attributed to the fact that the surveyed respondents who were familiar with PHC held a significantly higher level of health practices than the unfamiliar (Bautista, 1989: 152).

Post-evaluation studies conducted by Development Partners Inc. of the Collaboration of the Jaime V. Ongpin Foundation, Inc. (JVOFI) and the health department which implemented the PHC activities noted the following: "Major improvements" in their health and nutritional status were indicated by 63 percent of the 106 respondents. The rest claimed minor improvements (Development Partners Inc., 1993: 100).

The Core Strategy : 1991-1993

Background. The appointment of Juan Flavio as Secretary of the Department of Health brought on major revisions in the approach to primary health care (PHC). Once more, PHC was thrust into the limelight and even mandated to permeate all programs and projects of the health department. Administrative Order No. 11 of 1993 was passed, which defined PHC as the "core strategy in the program thrusts of government

at national, local and community levels in order to enable people's active participation and involvement for better health and self-reliance." The Philippine Policy Paper on PHC expressly provides that it is an approach to bring "Health in the Hands of the People." The major agenda is to make the people "manage their own health," to be less "doctor-centered" and more "people-centered."

With the 1991 Local Government Code in place, the implementation of PHC has therefore been devolved and is now in the hands of local chief executives. The national government's role for PHC is thus coordinative, recommendatory and regulatory in nature.

While previous dispensations had recognized the importance of the participatory strategy as a key process in PHC, this was not fully carried out in the implementation phase. Under Flavio's stewardship, however, the agenda of Health in the Hands of the People is the application of "community organizing as well as other empowering approaches as crucial to developing grassroots capabilities for decision making in response to community health needs, institutionalizing health leadership among the people and creating a true democratic milieu for full expression of health as a social goal" (DOH, 1992: 12).

The new leadership in the health department created two major groups to define the framework of PHC (Sia, 1993: 10). One was the Task Force on PHC, in charge of evaluating the status and implementation of this approach in health delivery and its implications for the National Development Plan. The second, the DOH-NGO Cluster Groups, threshed out the corresponding roles and working relationship between the government and the private sector. Subcommittees were formed to take care of traditional medicine, NGO accreditation, accreditation of training programs for voluntary health workers, protection of health workers, exchange programs and social mobilization.

Following the dialogues among these task forces, modifications were made in the organization and strategies for implementing PHC.

At the organizational level, Administrative Orders were issued on March 31 and May 21, 1993, to set up structures at the national and area levels for the management of PHC. Among these structures are the National Advisory Committee which is mandated to provide technical

advice to the Health Secretary and the National Technical Working Group on PHC which is tasked with preparing the agenda for legislation. Worth noting is the involvement of NGOs and the members of the private sector with expertise on PHC.

The designated overseer of the PHC at the health department is the National Technical Working Group, which facilitates and ensures the implementation of the plan and the monitoring of PHC activities. It also serves as a forum for consultations with local government units (LGUs), nongovernment organizations (NGOs) and local organizations. Moreover, it also provides the necessary resources and facilities for all PHC requirements.

Area-based Technical Working Groups will be organized to oversee the implementation of the strategy in their respective localities.

The administrative, financial, and technical support will be provided by the Secretariat/Operations Center based at the Community Health Service.

Accomplishments. The innovations in the implementation of primary health care (PHC) at the grassroots level include the following:

1. *Recognition of volunteer health workers other than the barangay health workers as potential source of support for PHC*

To include other workers such as those in community-based health programs initiated by nongovernment organizations (NGOs); Volunteer Family Health Care Workers (VFHCWs) or the health department-trained health workers per family; *Barangay* Nutrition Scholars of the nutrition program; and volunteer workers of the family-planning program (CVHW Support Package, 1993), the term Community Volunteer Health Workers (CVHWs) was coined to replace BHW.

As a further encouragement to volunteer health workers a more synchronized package of incentives and management procedures has been formulated to ensure the standardized treatment of these volunteers. The following measures have been taken in an effort to consider the welfare and harness the potential of all volunteer workers:

- a. The preparation of a computerized masterlist of all active CHVWs instead of a mere list of *barangay* health workers (BHWs).

Some 445,589 CVHWs have been listed with the Community Health Service as of January 15, 1994.

A total of 174,195 or 39 percent of the BHWs, constitute the 445,589 CVHWs. This number is a big drop, however, from 1988's 193,374 BHWs.

- b. Accreditation of training programs of NGOs and government offices (GOs) for voluntary workers to ensure that the preparation of the volunteers comply with standards to effectively perform their functions as community health workers.

The program document on accreditation proposes the creation of accreditation committees at the national and regional levels to be composed of representatives from the health department, NGOs and the academe. The program content for training has also been specified to ensure a standard scope of training for accreditation.

- c. Inclusion of other volunteer workers who are certified by the health department to benefit from the incentive scheme recognized for DOH-trained BHWs.
- d. Expansion of incentives for BHWs to include preferential access to loans provided by government agencies; system of national and local awards for outstanding health workers; discount for land, sea and air transport; one-child educational benefit per BHW, e.g., scholarship in college studies; preferential treatment of other benefits given by nonhealth agencies like the Departments of Agrarian Reform, Education, Culture and Sports, Welfare and Social Development; and Environment and Natural Resources and regular funding for the maintenance of logistical support and assistance to accredited volunteer health workers like kits, supplies, medicines, equipment and materials (Position Paper in connection with

Senate Bill Nos. 433, 491 and 833 Regarding Barangay Health Workers).

- e. More for representation of CVHW in Assistance Unit/Desks per province and municipality.

2. Highlighting community organizing as a basic approach for empowerment

The health department's Policy Guidelines for Community Organizing, which was formulated in cooperation with five nongovernment organizations (NGOs), is now in force. The principal responsibility for organizing has been entrusted to NGOs since they are given the role of "designing, planning, implementation, monitoring and evaluation of the community organizing process for health" (DOH Community Organizing Policy Guidelines, 1993: 2).

Based on these guidelines, the role of health department personnel and field units should be to assess and analyze community health needs as well as to determine preventive and curative interventions.

3. Expansion of PCHD begun in Bengzon's term

The Flavio administration expanded the Partnership in Community Health Development (PCHD) begun by the previous leadership. In addition to the eight provinces prioritized for this approach, there were 26 provinces considered for expansion in 1993. To learn from the lessons gained by the eight provinces, a National Project Implementation Review of those involved in PCHD was conducted in Surigao City on November 22 to 25, 1993. While the findings from this assessment are not yet available, PCHD is nevertheless being reviewed as one of the approaches for carrying out PHC. It is possible that no subsequent distinctions will be made between the two (Interview with the Program Officer, January 11, 1994).

4. Plan to identify model PHC barangays

There is also a plan to identify five model *barangays* in a province that will serve as a laboratory for training participants. This is a praiseworthy move to inspire other *barangays* to pattern their development after these models.

5. *Monitoring by levels of PHC implementation*

There is also a revival of interest in monitoring PHC at different levels of its implementation. The indicators for assessment, however, have yet to be formulated.

6. *Preparation of a BHW Operational Manual*

Plans are underway for the preparation of a BHW Operational Manual. The Manual's proposed content gives substantial attention to basic programs in health such as nutrition, maternal and child care, personal hygiene, dental care, environmental sanitation, rational use of drugs and herbal medication. The proposed manual also aims to provide instructions on how to detect and manage common illnesses (*i.e.*, diarrhea, pneumonia, intestinal worms, chest pains, etc.). It also hopes to impart information on first aid for fever and convulsion, shock, loss of consciousness, wounds and bleeding. Other special topics intended to be covered include AIDS (acquired immune deficiency syndrome), hepatitis, malaria and sexually transmittable diseases.

Another part of the Manual will be devoted to work management such as keeping records, referring a patient, conducting community health teaching sessions and mobilizing communities.

Policy Issues and Recommendations

Considering the context and accomplishments of PHC implementation in the recent past, the following are some of the issues and recommendations:

1. *Role of local chief executives*

The 1991 Local Government Code underscores the need to define the relationship of the local chief executives (LCEs) with the field offices of the national government, nongovernment organizations (NGOs) and people's organizations. The Code mandates that LCEs be chiefly responsible for "implementing programs and projects on primary health care, maternal and child care, and communicable and noncommunicable disease control services" (Rule V, Art. 27, c-1). As such, the specific duties of LCEs in connection with PHC must be incorporated in PHC guidelines.

To illustrate, the current policy guidelines on partnership with NGOs in community organizing defines the role of the health department in pursuing such an alliance (DOH Community Organizing Policy Guidelines, 1993: 2). NGOs are looked upon as having the major responsibility of carrying out the process. The guidelines however are quiet on the role of the LCE in the process. This role has to be specified and incorporated into the guidelines. It may in fact be important to mobilize the LCEs to help identify key persons/institutions that will be tasked to carry out the process. Involving the LCEs will give them a feeling of "ownership" and encourage them to endorse activities that will evolve from community organizing.

*2. Partnership in Community Health Development (PCHD)
or Primary Health Care (PHC)*

Alfredo Bengzon's leadership produced the term PCHD which paved the way for harnessing NGOs to carry out community organizing (CO). However, in juxtaposing PCHD and PHC one risks the impression that the two strategies are different from each other. In essence, however, both subscribe to the same goals – on people empowerment, equity and democratization of access to health services. The only difference lies in the mode of applying the CO strategy. PCHD relies on NGOs while PHC depends on government resources, principally on the BHWs.

What deserves a closer look is the current role of local chief executives (LCEs) in these two strategies. As an initial step, it is recommended that only one term be adopted to avoid confusion. Since PHC is recognized in the Alma Ata Conference and is used in the Local Government Code, it may as well be adopted.

The approaches which may nonetheless be used to carry out PHC can also encompass the methodology subscribed to by PCHD. Thus, the PCHD approach may be considered an alternative open to LCEs in implementing PHC. At the moment, three tracks may be considered as options to implement CO as the strategy at the heart of PHC and PCHD. The first is to harness the capacity of local government units (LGUs) for CO if this capability exists. The second is to harness the PCHD approach which taps NGOs to take the lead in the process. The third can encourage the convergence of efforts of LGU implementors for CO in tandem with NGOs.

In the end, whichever track the LGU intersectoral partnership chooses must be made through the leadership of the LCE. The venue for threshing out the most desirable track is the local development council (LDC) which is expected to operate in an integrated manner. The LCE can constitute the LDC with the combined efforts of LGU implementors, field unit implementors of the national government, NGOs and people's organizations (POs). The expansion of the NGO membership to not less than one-fourth of the total membership of the LDC institutionalizes the opportunity for LCEs to harness their expertise and potential.

It is fortunate that the Local Government Code subscribes to an integrated model of development. This structural arrangement is most appropriate for PHC as it argues for the importance of "integrating health in the socioeconomic development of the locality." The health department can play a role in the conduct of social mobilization initiatives for LCEs who are now the chief actors in carrying out PHC.

3. *The BHW as multipurpose worker or health worker*

The expectations of *barangay* health workers (BHWs) as key persons in PHC are high. The BHWs are expected to combine the roles of community organizer, health care provider, facilitator and data gatherer/reporter. In reality, however, performing the community organizing (CO) role is one of the BHW's weaknesses because their training or preparation focuses on the promotive, preventive and curative aspects of health (Bautista, 1988). The training guidelines in fact highlight the role of BHWs in delivering the health department's impact programs. Small wonder then that the BHWs are labeled as "adjuncts" in the health department's service delivery channel rather than as effective mobilizers of the community for group decisions and actions.

It can therefore be asked if BHWs should still be depended upon to perform the CO function in spite of their inadequate training. Considering the experts the LCEs may tap for CO work in an area-based development process under devolution, the role of CO may be entrusted to experts while the BHWs could fill in technical health care functions. On the part of the local government units (LGU), devolved personnel from the Department of Social Welfare and Development may be mobilized to play the role of CO worker. Their department's personnel have, in the first place, been purposely fielded to perform this function. NGO-CO workers

and others with this capacity may also be tapped to augment or supplement the LGUs' resources. BHWs can then phase in to perform technical support functions after the community has been mobilized to identify and formulate health programs and priorities.

4. *Unilateral vis-à-vis convergence of efforts*

It is important to emphasize that local implementors need not operate single-handedly. The essence of devolution is to implement an area-based approach in local development management. Many processes and approaches which used to be implemented in support of primary health care need not therefore be solely applied by the local health implementors if these are already being done by others. For example, the implementation of Targetted Areas for Development (TADs) can be jointly undertaken with social welfare officers who usually carry out focused work in depressed, deprived and underserved communities. The areas for collaboration may thus be threshed out by the local chief executives (LCEs) through the local development councils (LDCs) to avoid duplicating the efforts of sectoral implementors from local government units (LGUs), nongovernment organizations (NGOs) and other groups.

5. *Monitoring levels of PHC*

Monitoring the level of primary health care (PHC) was one of the activities of the Marcos regime. While there were difficulties in applying the set of criteria, these were nevertheless useful in identifying the level of progress of every *barangay* as far as the required mobilization for PHC was concerned. However, it is important to formulate simple indicators in order to facilitate the implementation of the criteria.

Some possible indicators include the following:

- Level I - Presence of active *barangay* health workers (BHWs)
- Level II - Presence of community health activities
- Level III - Presence of community activities undertaken by people's organizations
- Level IV - Endorsement of community health activities in the local development plan and/or presence of community-based financing schemes

The presence of BHWs as an indicator of Level I suggests their potential contribution to mobilizations for PHC activities. The reason for choosing the indicator for Level II is to demonstrate that there are functioning health activities that have been initiated or facilitated by the BHWs. The Level III indicator, on the other hand, demonstrates that it is not enough to carry out community health activities. These activities should be forged by organized groups in the community. The Level IV indicator suggests the potential for institutionalization and sustainability. The fact that community activities are embodied in the local development plan depicts the commitment of the local political leadership to health activities. Another possible indicator is the existence of community-based financing schemes which will reflect the potential of a *barangay* to support local health activities.

Part of the community's mobilization should highlight the importance of setting up a community-based information system to keep the community abreast with its progress in health-related matters. This information will be useful for community-based planning. Data boards may be adopted, similar to those in Davao City which were initiated by the Institute for Primary Health Care. Volunteer mothers may be harnessed to take care of monitoring a group of families similar to the effort of the National Statistical Coordination Board through its Community-Based Child Monitoring System.

6. *Process documentation*

It is important to pay particular attention to the manner of carrying out primary health care (PHC): who can effectively harness community organizing (CO), what institutions they represent, and what factors facilitate or impede community mobilization. Experience shows that the appropriate types of persons can be trained if there is concern for documenting the processes involved. Toward this end, local government units (LGUs) may tie up with local schools and research institutions who can assist in training local implementors in process documentation and data analysis.

Process documentation is important since the essence of PHC is the application of the CO strategy and methodologies like focused targeting and area-based planning.

7. Sustainability of PHC activities

Sustaining primary health care (PHC) activities is one of the actual issues to be addressed. Plans are not meaningful unless they are diligently pursued to produce beneficial effects. In this connection, local government units (LGUs) must tap fund sources other than internal revenue allotments to ensure that health projects will continue. The capacity of LGUs to do this entails enhancing their awareness of this function through capability-building programs for resource generation. Measures to improve resources include utilizing LCEs' taxing powers; seeking grants from donor institutions, the national government and other LGUs; and exacting user charges for services from those who can afford. On the part of the community, the development of community-based financing schemes may be pursued to enable the locality to become self-reliant.

There should be a way of screening clients according to their ability to pay. Free service may be extended to depressed and deprived individuals and/or families on the basis of a set of criteria which are agreed upon consensually. Fees or charges may be prorated according to the client's socioeconomic standing.

8. Improving the management of health facilities in the locality

Mechanisms to improve the management of health in the locality can be set up to prevent the waste of resources. One way to maximize the contribution of Community Volunteer Health Workers (CVHWs) is to request them to screen the users of public health facilities by providing referral forms for higher level facilities. This mode is adopted in some countries like Thailand. Such a mechanism promises to ease the needless burden on higher level facilities since those in the first line of defense can resolve simple cases at their level.

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RESOURCE PERSONS

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2. Renato Nicanor, Coordinator for BHW, Community Health Service, January 17, 1994.
3. Leni San Agustin, Community Health Service, National Technical Working Group on Primary Health Care, January 11, 1994.

Field reports said community-based health projects have not filtered down to the more depressed sectors of the population. Doctors, nurses and midwives were lacking in many far-flung areas. Worst, nongovernment organizations (NGOs) and the Department of Health personnel did not trust one another, thus delaying delivery of health care services.

* * *

The group composed of Arturo Pesigan, Ruben Caragay and Marilyn Lorenzo — all assistant professors in Public Health — has published an analysis of the PHC program in the state-of-the-nation report of the UP Center for Integrative and Development Studies (UP-CIDS).

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"The efficacy of the PHC approach was established and government support firmed up," the analysis said, adding that by 1980, PHC funding approximated the WHO-suggested figure of five percent of the gross national product (GNP):

Manila Standard
28 September 1992



STATE OF THE NATION REPORTS

Handog sa BAYAN ng UNIBERSIDAD ng PILIPINAS