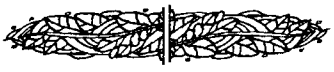

The Philippine Commitment to Primary Health Care: Policy Directions

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Abstract

Twenty five years after the Alma Ata Declaration for Primary Health Care, its principles and elements are revisited in the light of the pursuit for health sector reforms in a devolved health care system in the Philippines. Conceptual issues persist even as there is reaffirmation of the importance of PHC in attaining "health for all". The respective roles of the national government, local governments, civil society, academe and international health agencies are reviewed while policy issues that impact on integrated health development and health human resource development are identified. Finally, policy directions and recommendations are proposed based on consensus points.

Keywords: primary health care, Philippine health care system

Introduction

This policy paper on primary health care (PHC) presents a review of the Philippine commitment to the 1978 Alma Ata Declaration on Primary Health Care and identifies policy directions concerning primary health care for the consideration of government and other stakeholders.

In the Philippines, the 1992 implementation of the devolution of health care to the local governments and the 1999 health sector reform have brought about changes in the health care delivery system. The revitalization of primary health care is a policy issue to be addressed by national government, local government, civil society groups and even the private business sector, in the present set-up of a devolved health care system.

Background

The Alma Ata Declaration on Primary Health Care marked its 25th anniversary in 2003. The declaration was ratified by the global community at the International Conference on Primary Health Care, held on September 6-12, 1978 at Alma Ata, Russia, in the former Union of Soviet Socialist Republics (USSR), under the auspices of the World Health Organization (WHO) and the UNICEF.

At global and national levels in various parts of the world, the 2003 anniversary celebration was observed with the leadership of the WHO and participation of different stakeholders - governments, health professional organizations, and non-government organizations.

In the Philippines, the 25th anniversary was marked with the First Forum on Global Health Issues–Assessment of the Philippine Commitment to the Alma Ata Declaration (Primary Health Care) and Millennium Development Goals, held in July 2003, sponsored by the World Health Organization and the Department of Health-Bureau of International Health Cooperation, and organized by the Foundation for Integrative and Development Studies. The objectives of this initiative were to: (1) review the provisions of the Alma Ata Declaration, the Millennium Development Goals for Health (MDGs), and the progress of Philippine commitments; (2) examine the effects and status of implementation of primary health care in the Philippines, taking into consideration the country's health status, the governance framework, the health sector reform agenda, and the actions taken by stakeholders - government, non-government organizations (NGOs), community based and people's organizations (POs); (3) identify the directions that could be undertaken with respect to PHC and the goal of "health for all", considering the

present characteristics of the population, as well as economic, social, and political developments.

As a follow-up, the Second Forum on Global Health Issues—Alma Ata Declaration on Primary Health Care was organized in September 2005 to: (1) assess the status of the Philippine commitment to the Alma Ata Declaration on primary health care; (2) identify the policy options considering the stakeholders' commitments for primary health care; and (3) determine the elements of the planned policy paper on primary health care. The Forum examined the current perspectives on primary health care, the existence of divergence or convergence among stakeholders (DOH, WHO, academe, civil society, communities); and, the roles, commitments, mechanisms and undertakings of these stakeholders pertinent to primary health care.

Papers presented and the discussions that followed during the aforementioned forums provided the vital materials for this policy paper.

Policy Issues

The Philippine government, civil society, and academe are currently confronted with the issue of pursuing primary health care given the terms of the 1978 Alma Ata Declaration and the current Philippine health scenario. Some basic questions need to be answered to set the policy directions. Should primary health care be re-affirmed; should it be re-formulated? How should the Philippines engage in primary health care—is it an approach or a strategy embedded in health programs? Or is it by itself a program of action? With an ongoing health sector reform agenda, what is the place of primary health care?

Indeed, it is necessary to clarify the very nature of primary health care and to examine the changing contexts in the Philippines for its implementation. The re-affirmation of primary health care will need policies and actions to locate it in the health sector reform agenda, for people's participation and empowerment processes, governance and decentralization.

Methodology

The review of primary health care in the Philippines used the framework on primary health care derived from the initial conceptualization of principles and methods stated in the 1978 Alma Ata Declaration to assess whether or not the Philippines has conformed to the principles as originally set out. A review of literature of primary health care in the Philippines was done to trace its development and implementation, and to be familiar with the problems and issues encountered. A questionnaire was developed and interviews of a limited number of key informants were conducted to establish the prevailing perspectives and perceptions about PHC in the Philippines and in the global setting. The forums provided the platform for paper presentations and discussions.

INTERNATIONAL CONTEXT FOR PRIMARY HEALTH CARE

1978 Alma Ata Declaration on Primary Health Care

The International Conference on Primary Health Care, held at Alma Ata, Russia (then under the Union of Soviet Socialist Republics), from September 6-12, 1978, resulted in the signing of the document now known as the Alma Ata Declaration.[1] This document asserts: (1) the people's right and duty to participate individually and collectively in the planning and implementation of their health care; and, (2) the government's responsibility for the health of its people through the provision of adequate health and social measures. The document stresses that "health is a fundamental human right" and that the attainment of the highest possible level of health requires the action of many sectors.

Primary health care, commonly referred to as PHC, was viewed as the key to attaining the target of a level of health "that permits the people to lead socially and economically productive life" by 2000.

In Alma Ata, the conference participants reaffirmed the definition of

health as "a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity." Primary health care, commonly referred to as PHC, was viewed as the key to attaining the target of a level of health "that permits the people to lead socially and economically productive life" by 2000. PHC integrates political, social and economic development in the spirit of social justice. Thus, the important characteristics of primary health care were identified to include:

- essential health care based on practical, scientifically sound and socially acceptable methods and technology;
- accessibility of such essential health care to individuals and families in the community;
- full participation of the community;
- affordable cost that can be maintained at every stage of community and country development; and
- spirit of self reliance and self determination.

These essential elements of primary health care provide the analytic framework for any assessment, planning and implementation. Overall, one needs to look into the requisites for primary health care which are - maximum participation of the community and individuals; self-reliance; full use of local, national and other available resources; and development of the communities' abilities to participate. These must be complemented by other factors, such as: emphasis on people's education about health, particularly disease prevention and control, and health promotion. In turn, the essential elements of health promotion and disease prevention are: proper nutrition, sanitation, immunization, family planning, maternal and child care, and provision of essential drugs. Primary health care also includes other aspects of development (e.g., agriculture, housing, education, etc). Embedded in primary health care is a supportive referral system from the primary level to the tertiary level of health care that prioritizes those in need, the poor and marginalized population groups. It is assumed that health teams are well-trained to respond to the communities' health needs.

2001 Antwerp Declaration on "Health Care for All"

In 2001, the Antwerp Declaration on "Health Care for All" provided an update to the 1978 Alma Ata Declaration[2]. The government of Belgium initiated the ministerial meeting attended by high level representatives of the European Union and its member states; also by non-government organizations, scientists and experts, and the pharmaceutical industry. This document contains the observation that the Alma Ata's objective of "health for all" in 2000 has not yet been reached. Hence, the Antwerp Declaration re-stated that access to health care is a fundamental human right and rallied all stakeholders to work at "Health Care for All". It pointed to the complementary factors for health, namely: infrastructures, multisectoral approaches, specific disease control programs, health systems responsive to people's needs, partnerships for low-income countries, market mechanisms for essential drugs and health promoting commodities, development and management of human resources in the health sector.

Affirmation of the PHC

Despite setbacks in the past 25 years, different sectors in many parts of the world have affirmed the positive effects and importance of PHC. There have been calls to review the past and the present PHC, in the light of the Alma Ata principles and current trends, and to revitalize PHC. Observers have called attention to the replacement of comprehensive health programs by selective vertical programs (examples: expanded program of immunization; programs for safe motherhood, AIDS, TB, malaria and others). The First Global People's Health Assembly in December 2000 re-affirmed the Alma Ata Declaration and stressed the use of its principles when examining the present situation and new health initiatives; the vision, roles and leadership of international agencies such as WHO, UNICEF, World Bank; the current trends of neo-liberal economic policies, globalization and privatization; even the performance of civil society in the past 25 years.[3]

For instance, the People's Health Movement (composed of networks covering the regions of North and South America, Europe, South and Southeast Asia, East

Asia, except China and Africa) noted the "challenge to revitalize Primary Health Care by drawing together the best of the PHC experience".[4] The calls for new directions in PHC emphasized the need to examine the present contexts of decentralized health systems, health care reforms; globalization, privatization, cost-effectiveness; emerging health problems, capacity building of human resources; partnerships of civil society with many sectors, and roles of international agencies. Recent innovations such as quality assurance, essential drugs listing and social health insurance should also be analyzed for its implications to revitalizing PHC.

Critics have questioned the failure to operationalize PHC essentially as an approach.[5] It was noted that the jargon of progressive words such as *"people's participation," "decision-making by the people,"* and *"empowerment"*, had not been fully translated into practice. For example, the PHC was situated within the old centralized top-down medical system where community health workers are engaged in the bureaucracy's curative health care system rather than in the community-based health system.[6] Furthermore, the health workers' training, technology and services could not adequately handle health problems nor could they render quality of health care.[7]

PHILIPPINE COMMITMENT TO PRIMARY HEALTH CARE: A SITUATIONAL ANALYSIS

Pioneering Initiatives of NGOs

In 1973, the Rural Missionaries of the Philippines (RMP) pioneered the approach of organizing and empowering the people in adherence to their mission of "serving the poor, deprived and oppressed" independently of government even before the 1978 Alma Ata Conference. Other non-government organizations (NGOs) and community organizations/people's organizations (COs/POs) have engaged in what can be recognized as a primary health care approach using community organizing and empowerment. The strategy was aimed at shifting the people's orientation from "self interest to communitarian interest; from the paralyzing myths and beliefs towards critical, scientific thinking; from powerlessness to

empowerment; from community-based to community-managed health care".[8] The Community Based Health Program (CBHP) was established 30 years ago and by now has an organized network of 60 programs in different parts of the country, and is continually adapting to changing conditions.[9]

Government: Policy Directions and Program Implementation

The Philippine commitment to the Alma Ata Declaration-Primary Health Care is demonstrated by policy formulation and program implementation that can be delineated historically, with the following timeline: (1) pilot program implementation from 1978 to 1981, during the Marcos regime; (2) pre-devolution, from 1981 through the 1986 People Power Revolution as Corazon Aquino assumed the Philippine presidency upon the ouster of President Marcos, until the enactment of the 1991 Local Government Code; (3) devolution, upon the implementation of the Local Government Code in 1992 until 1999 with changes in the national and local health systems; and (4) post-devolution, starting 1999 which was marked by health sector reform.[10]

First Stage- The Pilot Years. The 1978 Alma Ata Declaration definitely spurred changes in the Philippine health sector through primary health care approach. The public health system experienced innovative and pioneering changes when the Marcos administration adopted the national plan and strategy for PHC implementation. Pilot provinces in each of twelve (12) regions in the country were selected according to certain criteria, namely: health needs of the population, lack of people's access to health services at the regional center, poor peace and order condition. Two other major criteria were the willingness of the local government unit to participate and the presence of functional organizations that could participate at provincial and municipal levels. The Ministry of Health pushed for the District Health System model with the referral system for patients from the primary level of health care at the rural health clinic (RHU) of the municipality/city to the secondary and tertiary level of health care in hospitals in the area. In this stage, PHC committees were organized at national, regional, provincial, municipal/city and barangay levels. The national government ensured the training and deployment of volunteer barangay

health workers (BHW) for community participation and inter-agency collaboration in planning and implementation for the PHC. On the other hand, various non-government organizations who were already engaged in primary health care independent of government continued their respective missions. .

Second Stage- Pre-Devolution: Institutionalization of PHC. The second stage began in 1981 when the government moved the PHC from pilot stage to institutionalization nationwide, until the ouster of President Ferdinand Marcos in 1986. Initially under Pres. Marcos, the Ministry of Health marshaled local government involvement and community participation. This stage was sustained by the new government of President Corazon Aquino in 1986 as the Department of Health pursued the policy of engaging non-government organizations and volunteer community/barangay health workers in innovative health programs. Village drugstores (Botika ng Barangay) were set up to make medicines affordable and accessible to the poor and low income population. The provisions of the 1987 Philippine Constitution rendered legitimacy and significance to the participation of non-government organizations and people's organizations. Through the years prior to devolution, government allocated financial resources and supported the training and deployment of human resources for the PHC, specifically batches of BHWs, local government officials and health workers.

Third Stage-Devolution. In 1991, Congress passed the Local Government Code and the government began the process of devolution in 1992 that changed the system of health service delivery, the role and functions of national government (Department of Health), and the responsibilities of local government units.

The process of transition to the devolved set up that started in 1992 created some difficulties for the Department of Health. The responsibilities over health service delivery were transferred from national government to local government. The hospitals came under the jurisdiction and management of the provincial government, the rural health clinics under the charge of the municipality/city government, and the barangay health stations by the respective barangays within the municipality/city. Health personnel were also devolved from the national level to the local government units in different parts of the country.

At this point, the national government, through the Department of Health, took the view that PHC is an approach, a strategy for application in health programs; that it is not a program to be implemented by specific offices/units as it was in the pre-devolution years. In 1996, the DOH affirmed its policy of Primary Health Care for Community Health Development, within the framework of devolution. It asserted the principle of "health in the hands of the people" that can be done through various community processes.[11] In different parts of the country, the NGOs played a crucial role in the Department of Health's Partnership for Community Health Development (PCHD) by using their expertise in community organizing, empowerment and mobilization for primary health care.

Fourth Stage-Post Devolution. In 1999, the Department of Health embarked on the process of health sector reform. Specifically, the Health Sector Reform Agenda (HSRA) aimed to address the problem of fragmentation of the public health system during the period of transition when health care services had just been devolved from national to local government; as well as to improve the system for health care services. The Department of Health began with initial pilot sites and later expanded the implementation of the Health Sector Reform Agenda (HSRA).

In the post-devolution stage, the continuing adherence to PHC can be gleaned from the following structures, policies and activities:[12]

- Formal inclusion of barangay health workers as a category in the classification of health workers in the public health system and formulation of policies on their rights and privileges.
- Continuing cooperation and support from NGOs in government programs and projects, as recognized pioneers in primary health care and experts in community processes.
- Existence of models and best practices in PHC experiences, including the legacies of trained primary health care-oriented health professionals and community workers and of processes in organizing and mobilizing for community based and community managed health interventions.

- Enactment of relevant laws, i.e., National Health Insurance Act, the Generics Act, and the National Drug Act.

The DOH continued to use PHC as an approach, a strategy, to be integrated into the components of the Health Sector Reform Agenda (HSRA).

Although some NGOs continued to work in the health sector and to use PHC in their health programs, some observers noted a decline in the participation of NGOs in government programs and felt a slack in PHC. They pointed to a lack of clarity on the use of PHC as an approach within the framework and implementation of the HSRA. Another criticism is the lack of a structural or institutional locus of responsibility within the Department of Health for monitoring PHC, unlike the presence of PHC committees and the Partnership for Community Health Development program in the previous years.

Current Challenges to Primary Health Care

The practice of primary health care in the new millennium is confronted by several challenges. These include the location of PHC in the Health Sector Reform Agenda, the devolved set-up and insufficienct capacities of local government, the sustainability of civil society engagement - NGO and community participation, the diminishing support of international development agencies, and the inattention to continuing training and education of community health workers and professionals in PHC. Furthermore, in 2000, the Philippines participated in the United Nations Millenium Summit that framed the Millenium Development Goals and the Millenium Declaration. These documents included the goals on health for all. The Philippines also expressed commitment by formulating the Philippine Millenium Development Goals.

THE HEALTH SECTOR REFORM AGENDA AND PHC

Convergence and Integration

From the DOH perspective, primary health care has been incorporated as an approach in current health policies and programs.[14] Hence, there is no need for a specific program nor an office for PHC as it had been in the early stages. Since 1999, the DOH assumed that PHC had been integrated into the components of the Health Sector Reform Agenda (HSRA), which consists of the following components, or pillars: (1) health financing (social health insurance), (2) hospital reform, (3) public health, (4) health regulation, and the (5) local health system. In 2005, health sector reform was revitalized and given the catchy term, "FOURmula One (F1)", referring to four key areas, namely (1) financing, (2) regulation, (3) service delivery and (4) governance.

According to DOH sources, PHC has been infused and located in the FOURmula One components under a devolved public health system, as shown in the matrix below (Table 1).[15] FOURmula One is asserted as a new opportunity to affirm and advocate PHC. It ensures that PHC principles and strategies are embodied in the National Objectives for Health (NoH) and in the Health Sector Reform Agenda. In this DOH policy perspective, FOURmula One incorporates the PHC principles of accessibility, availability, affordability and acceptability in health services, while fostering participation, self-reliance, and empowerment of the people. Supportive of primary health care are the Sentrong Sigla quality seal for health facilities, the engagement of community volunteers—the barangay health worker, the community programs of Botika ng Barangay, and other health programs at the primary level of health care in the rural health center of the municipal/city. These constitute a comprehensive set of reforms intended to be implemented as a single package through a convergence strategy in specific sites.

As the lead agency, the DOH acknowledges the need to align the directions of various sectors toward the desired health outcomes in the country. DOH would like to see the integration of various perspectives and experiences of key stakeholders, as well as the clear definition of their roles in revitalizing PHC. The reformulation of DOH strategies and activities to bring PHC into the current efforts for health sector reform constitutes a challenge.

Table 1: Locating the Elements of Primary Health Care in the Health Sector Reform Agenda (FOURMula One)

Primary Health Care Elements	FOURmula One (Health Sector Reform) Areas			
	Financing	Service Delivery	Governance	Regulation
Essential Health Care	• Accreditation of providers based on quality standards	• Clinical practice guidelines for hospitals • Inter-local Health Zone networks	• Sentrong Sigla quality seal	• Quality seal for providers, drugs, and devices
Accessibility	• Improving financial access through (a) social *health insurance* (b) rationalizing budget allocation to cost effective services	• Upgrading PHC and primary medical services at the *Rural Health Center* for accessibility to the power	• Information technology improvement • *Web access for* information and services	• Harmonization One stop shop Botika ng Barangay
Participation	• Rationalizing financing sources (*decrease out* of pocket) • National and local government sharing	• Public-private sector partnerships	• Multisectoral participation in *national objectives* for health (NOH) formulation	Decentralizing regulatory *functions to* Centers for Health Development and local government units; and self-regulation
Affordability	• Positioning social health insurance as a major payer of health services • Full government subsidy for priority programs • Increase in patient and out patient benefit packages		•Financing and procurement reforms	•Parallel drug imports
Self-reliance /self-determination	• Empowering client with funds to choose quality provider	• Increasing health promotion and healthy lifestyle	• National objectives for health dissemination to guide all stakeholders in the health sector	Quality seals to inform client's choice on quality products

Sources: Maylene Beltran, "Primary Health Care Within the Context of Health Reforms" and Maylene Beltran, "Comments on the Policy Paper on Philippine Commitment to PHC: Directions in 2005".

Table 1 illustrates how the PHC elements and principles are integrated in the elements and components of FOURmula One (Health Sector Reform) areas.

For instance, Table 1 shows that essential health care is operationalized in the financing component by the accreditation of qualified health service providers and in the service delivery component by clinical practice guidelines. In governance, the Inter-local Health Zone, a cooperative venture of two or more local government units, represent structures providing for representation of various local stakeholders for health care planning, policy formulation and implementation. On accessibility, the DOH considers this operationalized by social insurance, the upgrading of rural health clinics, information services, and the village drugstores. Participation as an indispensable PHC element is served, according to the DOH perspective, by multisectoral participation in setting objectives, public private partnership, The ways by which self-reliance is achieved can be seen in the entries for each HSRA component, consisting in the informed choice or decision of an individual over matters concerning his or her personal health.

On accessibility, the DOH considers this operationalized by social insurance, the upgrading of rural health clinics, information services, and the village drugstores.

THE LOCAL HEALTH DEVELOPMENT

In line with devolution, the DOH-Bureau of Local Health Development (BLHD) has been assigned to matters involving local health systems development, civil society participation, and HSRA implementation in convergence sites (A.O. 37 s. 2001).[16] With this mandate, recent activities include the program for Geographically Isolated and Disadvantaged Areas (GIDA). The program is geared at the development of the local health system, with community organizing and community participation, multisectoral participation in planning, the inter-relationship between health and development, and the fostering of self reliance. The BLHD has conducted the training of barangay health workers and people's organizations. The DOH launched the Botika sa Barangay Project and advocated the organizing of people's organizations for social health insurance.

In the BLHD perspective, the plan for National Objectives for Health incorporates primary health care strategies. Through the BLHD, the DOH monitors the local health boards and local health system development. It coordinates with the National Economic and Development Authority (NEDA) Multisectoral Committee on International Human Development Commitments and Social Development Committee in monitoring the Millenium Development Goals on health targets. Recently, the BLHD organized a Technical Working Group on primary health care and began collaboration with a non-government organization - Plan International, in revitalizing the primary health care approach in the local health system's health programs.

SUPPORT OF INTERNATIONAL DEVELOPMENT AGENCIES

The World Health Organization/Philippines operationalizes its strategic thrusts through close consultation with its regional office and the country's national health department. It has provided support for national health priorities; and technical and financial inputs to combat communicable diseases, build health communities, and achieve health sector development (WHO/Phil CCS 2005-2010). WHO advocacy work emphasizes the primary health care approach integrated into the components and implementation processes of health programs. Efforts have been exerted to ensure the interface of national government with local government, even with respective communities for their participation in health projects and for consultative decision making processes among community leaders and the people involved in health projects.

Other international organizations such as the USAID, UNICEF, UNFPA were cited by key informants as stakeholders currently implementing primary health care or related approaches. The European Commission is engaged in women's health projects in three regions.

CIVIL SOCIETY ENGAGEMENT IN PRIMARY HEALTH CARE

Growth of CBHPs. Pioneered by the Rural Missionaries of the Philippines (RMP) in 1973, the Community Based Health Program (CBHP) has now grown to a network of sixty (60) CBHPs all over the country.[17] These programs have maintained a health care approach that is holistic and people-oriented. In contributing to the attainment of "Health for All", the CBHPs implement PHC by using processes and methodologies appropriate to the capacities and resources of the people themselves. It is recognized that PHC is a response to the basic needs of the poor majority in the population. In using the approach, the CBHPs follow the principles and processes of interaction (1) among people in the community, in organizing themselves and in acquiring knowledge and skills to pursue their basic right to participate in the planning and implementation of health care; (2) with the NGO facilitators—particularly the program members, in providing guidance and serving as catalysts for change; (3) with government in ensuring the "basic right" to health care, in the provision of healthy living conditions through decent employment, housing, education, food, and other resources, and in the promotion of social justice.

NGOs and PHC in Health Programs. Non-government organizations continue to carry the paradigm of primary health care, to initiate community organizing and community empowerment for health in CBHPs, to develop community managed health systems. One example of an NGO is the Council for Health Development (CHD), set up in 1989 as a national organization of non-government community based health programs. Some health NGOs maintained independence from government in doing the primary health care approach, while others engaged in collaborative projects with government. Their activities use community organizing and community empowerment focused on various concerns such as disaster management, reproductive health, herbal medicine, nutrition, and health promotion. They also conduct medical and dental missions, case referrals to the public health system (LGUs), etc. Among the NGOs which work with government are: Likas, the National Pharmaceutical Foundation Inc with provincial NGO partners for the Botika ng Barangay projects (360 barangay outlets in 24

provinces); the Botika Binhi (807 barangay outlets in 43 provinces); Women's Group (nationwide), the Community Medicine Foundation, the Health Alert Information Network and the Plan International (518 barangays in 11 provinces) engaged in child centered programs and projects, now venturing into PHC. On other hand, Plan International works in integrated child centered program and projects.

The NGO experiences emphasize the organized action of the poor for access to resources, as well as for comprehensive health care – preventive, curative, rehabilitative. Hence, in the course of their activities, their community health workers faced harassment and were even tagged as rebels and left leaning, for example, the CHD experiences. Despite these, the CHD and other health NGOs continue to pursue PHC, while others have shifted to other strategies for health development in the Philippines.

Thus, NGOs and PHC advocates continue to push for and to stress community organizing and capacity building for community-oriented and community-based health services, and to ultimately bring about a truly community managed health care. It is, however, posited that as of now, there are gaps in the community empowerment processes and there is less attention to PHC practice and capability building. "Primary health care" is differentiated from individualized health care service to patients at the "level of primary health care" in the rural health clinics. There are tensions between the NGOs' liberational and emancipatory perspective of primary health care for the poor and deprived sectors of the population

The practice of primary health care requires an orientation towards community health and not necessarily toward hospital services. With the exodus of health professionals to foreign countries for work opportunities, there is a serious need to develop new health professionals who can address the need for health services of the poor and marginalized sectors of the population and those living in remote areas in the Philippines.

vis-à-vis the government's neo-liberal economic, cost effective, demand driven perspective in health care services.

There is also a general lack of documentation on NGO processes, programs and projects, and site-specific best practices. There is a need to document the state-of-knowledge about primary health care as practiced by the civil society sector, for lessons that can be applied in the replication and revitalization of PHC.

THE ACADEME: SERVICE AND DEVELOPMENT OF HEALTH HUMAN RESOURCES

Among the academic institutions involved in PHC, the University of the Philippines Manila College of Medicine integrates the medical curriculum and the practice of community oriented health and medicine. Also in UP Manila, the College of Public Health has been involved in community health and primary health care. Other educational institutions in different parts of the country are the Davao Medical School Foundation, Zamboanga Medical School Foundation, Davao Medical Center, St. Louis University, Baliuag University College of Nursing, and Ateneo de Manila University.[18]

The practice of primary health care requires an orientation towards community health and not necessarily toward hospital services. With the exodus of health professionals to foreign countries for work opportunities, there is a serious need to develop new health professionals who can address the need for health services of the poor and marginalized sectors of the population and those living in remote areas in the Philippines.

To cite an example, the UP Manila College of Medicine has a track record of community health experiences, way back in 1965 in the towns of Laguna. The most recent are the community based health programs located in Pasay City and in Sto. Tomas, Batangas.[19] The programs are geared at training primary care providers and community leaders who are accessible to the people (barangay health workers (BHW, midwives), even the municipal and city health personnel; community organizing of community local leaders and BHWs; health information systems and governance by assistance in planning and policy formulation for the local health boards. The college has given exposure and opportunities for medical students to participate in

the CBHP, to render medical services to numerous patients at the local health center, and to assist in community managed projects.

The collaboration of UP, DOH, and the communities demonstrate the capacities and potential of involving the academe in primary health care. The many educational institutions offering degree programs in health and medicine can be tapped to bring PHC into their curriculum and teaching-learning modalities.

POLICY ISSUES

Clarification of the PHC Concept. The clarification of the "primary health care" concept among stakeholders—government and civil society – is necessary to assess the current scenario and to plot the directions to be undertaken. The prevailing views are as follows:

- PHC is an approach not a program.
- PHC is a basic strategy that permeates the different health programs.
- PHC is implemented in health programs and projects by the national. government, LGUs, NGOs and communities.
- PHC is different from primary level of health care even if PHC is the suitable approach at the primary level of health care.

However, misconceptions continue as there are those who look at primary health care as a program, which should be a unit in the government bureaucracy, with fund allocation and personnel to do community health development, reminiscent of the pre-devolution stages of PHC implementation.

Awareness of PHC. The decline in people's awareness of PHC during the post-devolution period has been attributed to the emphasis on health service facilities upgrading, health programs geared at individual and household needs, social health insurance membership and health cards. Another reason is the DOH reorganization such that programs, structures, and funding directly intended for PHC implementation were abolished. There is no focal unit at the DOH to oversee the continuity of using the PHC as an approach in the formulation of health policies, and in the implementation of programs and projects. Recently, the Bureau of Local

Health Development has been designated to resume the tasks relevant to the elements of PHC.

Different Perceptions on PHC in Health Policies and Programs. There are two opposite perceptions about the current re-affirmation of PHC. On one hand, primary health care is considered to be embedded in the DOH policies and programs (2005 Health Sector Reform Agenda/FOURMula One, 2005 National Objectives for Health, Millennium Development Goals). On the other hand, there are those who perceive that primary health care is not clearly articulated in current policies and programs; and, community participation and related community processes are not evaluated in depth.

Structural Locus for PHC Management. Since the onset of devolution and re-engineering, there has been no clear identification of the structural responsibility within DOH for civil society linkages, monitoring community participation, and other related matters concerning PHC. Recently, the Bureau of Local Health Development organized the Task Force for Primary Health Care and linkages with civil society groups. Additionally, the BLHD and Plan International organized a civil society summit on PHC in the first quarter of 2006; the results should be examined for lessons learned, best practices, and for policy and planning.

It is expected that the BLHD shall take charge of monitoring, coordination, information management, capacity building pertinent to stakeholders and initiatives on PHC. DOH should keep an updated list of stakeholders and document their initiatives, including best practices of PHC implementation, community organizing and empowerment processes, outcomes, effects and impact.

Indicators, Measurement and PHC Goal Attainment. The undertakings of NGOs and of the national government have not been clearly assessed in terms of attaining the goals of PHC. Essentially, the final goal of a community-managed health system has not materialized. The principles of Alma Ata should be the starting point for assessment. However, indicators have to be properly established. Examples are:

- functioning local health boards in local government units;
- awareness, knowledge, preparation, training of local government officials on primary health care;

- access of the poor to social health insurance;
- community processes, community health system management;
- health outcomes; mix of outputs and outcomes;
- trained community health workers;
- competent and committed health professionals.

The basic question is: what constitutes primary health care, what are its essential features that should be stated as indicators for measurement. Evaluation should also include indicators for processes and outcomes.

Integrated Health Development. In a more holistic perspective, social and economic development are considered to be determinants of health. How these are related to PHC will have to be examined, as well as the negative impact of globalization and structural adjustments on health.

Furthermore, there is perceived lack of support in the formulation of a national population policy related to the goal of sustainable development, poverty alleviation, and "health for all". And, the indicators of the millennium development goals given the Philippine contexts and its assessment have not been given much attention.

Health Human Resources Development. Health professionals have not been inclined toward community medicine, health promotion, disease prevention and control; instead they continue to be curative rather than preventive in orientation. Community medicine is not attractive to medical students. Those who stay in the community are traditional health workers.

It is important that health professionals acquire competencies and be committed to community health, using the primary health care approach, as well as understand the social, economic and political contexts of the poor and marginalized sectors in the population. The current situation in the Philippines shows inadequately trained barangay health workers; low ratio of health personnel to population that contribute to poor quality health care; general lack of health human resources, particularly due to overseas employment of Filipino doctors and nurses, and other health professionals.

The academe is a vital force in the development of health human resources and can provide the numbers in the process of curriculum implementation. On the other hand, there is need for alternative modes of training and education of

community health workers and health professionals with adequate exposure and opportunities to work in marginalized and remote communities. However, getting funding for developing health human resources has become difficult. Hence there is need for resource generation and commitment for budget allocation.

Commitment and Action of Stakeholders in PHC. The sustainability of community-based health programs and projects handled by NGOs and POs are not altogether ensured. These civil society organizations need to examine their commitment and to evaluate their programs and projects on the utilization of the PHC approach. Fund support from external or foreign sources and from national and local governments, have increased the budget of NGOs. But recently, the funds have become limited.

Partnerships between and among national government, local government, civil society NGOs and communities, academe, international fund and development organizations have to be examined. Twenty five years after Alma Ata, multisectoral and other collaborative endeavors need new innovative approaches to pursue PHC. Expressions of commitment at this point in time should be obtained.

Revitalizing PHC and Paradigm Shift. Updating, strengthening, revitalizing the primary health care approach and framework would strengthen its relevance and application, considering current health problems and recent directions in the health sector. The DOH asserts that a paradigm shift is now needed, involving PHC integration into the current decentralized health system and levels of the health referral system—from primary level of health care to secondary and tertiary level. Community participation can be integrated in the different levels of the health care and referral system. The PHC paradigm shift entails balancing people's demand vs presumed people's needs; and the provider orientation vs value for money orientation. The PHC can be revitalized as it is included in the health sector reform activities with goals and values for efficiency, cost effectiveness, equity, and people empowerment.

POLICY DIRECTIONS AND RECOMMENDATIONS

Consensus Points. There appears to be a consensus on the affirmation and revitalization of the Philippine commitment to the 1978 Alma Ata Declaration, given the responses of key stakeholders from government, academe, and civil society. The government and other sectors—NGOs, LGUs can prioritize collaboration on areas of common concern. The tensions in perspectives (neo-liberal, economic and public choice approaches *vis a vis* people empowerment approaches) can be the subject of continuing dialogue, sharing of experiences, and demonstration of positive results.

Policy Issuances from National Government. The DOH can assume the lead by policy issuances to:

- Articulate the DOH commitment to PHC.
- Set indicators and measures to guide the use of and evaluation of PHC in health program and project implementation.
- Evaluate the implementation of the health sector reform agenda/formula one and other related policies, including PHC implementation.
- Set up collaboration of the national government with NGOs and LGUs.
- Identify the focal DOH unit for monitoring PHC, assisting LGUs, and linking with civil society groups, academe, and the private sector.

As initial activities, it is suggested that the national government conduct consultative mechanisms with stakeholders to determine the operational plan and evaluative framework for PHC. Specific indicators and measurement of PHC implementation must be laid down at the start. Entry points in the FOURmula One and the health system for civil society's PHC community managed health programs need to be identified. Furthermore, the national government can be more vigorous in assisting the LGUs in using PHC in local health development. Government resources can be judiciously expended to support or collaborate with stakeholders on PHC.

Local Government Units. LGUs not only have the responsibilities, but the power as well, to formulate local policies and activities for primary health care to:

- Ensure participation of civil society groups in the Local Health Boards.
- Make LHBs functional.
- Evaluate community participation.
- Contribute counterpart funds.
- Intensify public health programs with PHC.
- Integrate socio-economic plans for poverty alleviation
- Dialogue with groups, document and replicate positive cases of PHC implementation.
- Collaborate for human resources development in PHC implementation.
- Undertake activities involving PHC (Botika sa Barangay, social health insurance membership, etc).

Civil Society. For the NGOs and communities, the recommendations for them to contribute to sustaining PHC are:

- Identify areas of strengths and weaknesses in respective health programs *vis a vis* the Alma Ata principles and essential element.
- Document the PHC cases with positive results and best practices.
- Determine complementation of efforts for PHC and civil society entry points in the national and LGU programs.
- Contribute health care providers in essential health services in localities.
- Infuse community oriented, community based or community managed interventions where feasible in the Health Sector Reform Agenda/FORMula One – such as in social health insurance, health service delivery, infrastructure, drug regulation and procurement.
- Participate in determining and evaluating health centers for Sentrong Sigla.
- Provide funding for PHC activities.
- Set up accountability measures for civil society involvement in PHC.

Academe. The educational institutions with resources in terms of their curricular offerings, training, research and extension can help sustain PHC by the following activities:

- Develop training and education programs for human resources development for PHC.
- Document and replicate best practices.

- Establish linkages with communities, LGUs, DOH and other entities for community based and community managed health programs.
- Develop indicators and measures for evaluation of PHC endeavors.
- Evaluate PHC endeavors for learning and replication.
- Conduct researchers for policy and program improvements identified by stakeholders.

CONCLUSION

In conclusion, the leadership of national government, the Department of Health particularly, in revitalizing PHC in its current policies and program implementation can provide the "enabling environment" for the involvement of different stakeholders. Civil society groups, communities, academic institutions, even LGUs that have gained experiences over the years can show best practices and lessons on PHC to guide new groups and replicate in other sites. As a signatory to the 1978 Alma Ata Declaration, the Philippines can join other nations and collaborate with international development organizations in their attempts to revitalize PHC.

Notes

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3 Ravi Narayan and Unnikrishnan PV, editor, Revive Alma Ata. People's Health Movement, www.phmovement.org and www.iphcglobal.org, pp. 1-13.

4 Ravi Narayan and Unnikrishnan PV, pp. 6, 14-15.

5 David Werner, Questioning the Solution:The Politics of Primary Health Care and Child Survival, Chapter 3, www.healthwrights.org/books/qts/qts

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9 Caguiat, p. 1

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