IMPLEMENTING PROJECTS AND ACTIVITIES FOR COMMUNITY HEALTH DEVELOPMENT

PCHD Experiences, 1991-93

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Acronyms and Abbreviations

BHW	Barangay Health Worker
BHS	Barangay Health Station
CASAFI	Caceres Social Action Foundation, Inc.
CDA	Cooperative Development Authority
CHPC	Community Health Policy Committee
CHS	Community Health Service
CHS-PC	CHS Provincial Coordinator
CHW	Community Health Worker
CO	Community Organizer
DA	Department of Agriculture
DILG	Department of Interior and Local Government
DOH	Department of Health
DPWH	Department of Public Works and Highways
DSWD	Department of Social Welfare and Development
DTI	Department of Trade and Industry
FACE	Our Lady of Fatima Center for Human Development, Inc.
GO	Government Organization
HPO	Health Program Officer
IPC	Institute of Philippine Culture
IPHO	Integrated Provincial Health Office
IPHO-PC	IPHO PCHD Coordinator
LGU	Local Government Unit
LISAFI	Libmanan Social Action Foundation, Inc.
MHO	Municipal Health Officer
MNAO	Municipal Nutrition and Action Office/Officer

MOA	Memorandum of Agreement
MPDO	Municipal Planning and Development Office/Officer
NGO	Nongovernment Organization
PAGBICOL	Pag-asang Bicolnon Foundation, Inc.
PCHD	Partnership for Community Health Development
PCU	PHDP Project Coordinating Unit
PDO	Project Development Officer
PHDP	Philippine Health Development Project
PHN	Public Health Nurse
PHO	Provincial Health Officer
PO	People's Organization
POMR	Process-Oriented Management Report
PRRM	Philippine Rural Reconstruction Movement
RHM	Rural Health Midwife
RHO	Regional Health Office
RHU	Rural Health Unit
RSI	Rural Sanitary Inspector
SEC	Securities and Exchange Commission
SIO	Social Integration Office
TADs	Targeted Areas for Development
TALINGKAS	Tawong Lingkod Para sa Katalingkasan kan Bikol Foundation, Inc.

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Cynthia C. Veneracion

Chapter One

PCHD Implementation Scheme

In late 1989, the Department of Health (DOH) began implementation of the Philippine Health Development Project (PHDP), an investment package aimed at developing the country's health system. PHDP provides a further recognition to the need for DOH to upgrade its programs and facilities and to engage in more participatory strategies in delivering health services to local groups and communities. It has four components—improvement of the impact programs (control of tuberculosis, malaria, and schistosomiasis; and comprehensive maternal and child care), enhancement of DOH's organizational and managerial capabilities, establishment of partnerships for health development at the community level, and formulation of health and nutrition policies. It is expected that through each of these components significant attention could hence be provided to "high risk individuals, households, and communities" (Department of Health 1989b).

PHDP's third component, referred to as the "Partnership for Community Health Development" or PCHD, is specifically focused on the health care needs of the population in rural areas which had been underserved or unserved by DOH field offices as well as other groups. It is designed to involve the active participation of DOH offices, local government units (LGUs), nongovernment organizations (NGOs), and other government agencies (GOs) in addressing the immediate health care needs of local groups and communities while, at the same time, pursuing the development of community-based health management capabilities. The initial phase of PCHD implementation centered on the development of local DOH-LGU-NGO partnerships which, in turn, would be responsible for generating community-based plans and strategies for projects and activities in pursuit of community health. With financial support from PCHD, these partnerships were likewise to be involved in

assisting the groups and communities concerned in the implementation of the identified projects and activities.

This report presents selected initial experiences in implementing PCHD-funded community projects and activities. It discusses the results of a process monitoring research conducted in selected sites in Camarines Sur, one of the first four PCHD target provinces. Covering the period from late 1991 to late 1993, the report focuses on the first 12 months of the implementation of PCHD-supported projects and activities in seven barangays. It also describes other development initiatives which took place in these communities during the study period.

Framework and Strategies

A vision of a dynamic involvement of organized local groups and communities in managing their own health care needs directs the implementation of PCHD. Its initial concern is the development of partnerships among DOH field health units, LGUs, NGOs, and other organizations which would assist the local groups and communities in gaining health management capabilities. Its major task is to make financial and technical support available to the participating groups.

Objectives

The 1978 Declaration of Alma-Ata has been providing a major push toward an active role for local groups and communities in health care management. A participatory approach to health development derives, on the one hand, from the inadequacy of the public resources that had been made available (and in some instances, could be made available) for health services. On the other hand, it acknowledges that a key to a holistic, sustainable, and equitable development could be found in community-based approaches and strategies.[1]

Through PCHD, DOH is extensively involved in initiating and developing community-based health care systems and linking these systems with the larger health system. Learnings from initial experiences are looked upon as guides toward an efficient and expanded application of the community health development approach and strategies.

PCHD pursues its goals by providing technical and financial assistance in the development of local partnerships among the DOH field units, NGOs, and LGUs; and supporting the use of health-focused activities as an entry point to community health development. PCHD provides grants for partnership building and capability building for the participating organizations. It also extends grants to these groups for the pursuit of health-focused activities at the community level. These activities are

expected to provide immediate technical interventions with regard to health risks and, at the same time, serve as mechanisms for community organizing.

Partnership building is envisioned to begin at the provincial level, where initial planning also takes place. In broad terms, the planning process involves the identification of the potential NGO partners of the integrated provincial health office (IPHO) and the provincial government, selection of target barangays, and generation of community-based proposals which would access the PCHD project grants. PCHD supports the provincial planning activities through a grant released to an organization identified from among the participating groups. The planning process is likewise expected to initiate partnership formation at the municipal and barangay levels.

Target Areas

With a five-year schedule, PCHD was planned to be undertaken in 16 of the country's 75 provinces. Four of these provinces would be covered during the first year; the next four, in Year 2; and the remaining eight, in Year 3.

The first four PCHD provinces are found in four regions: one in Luzon, two in the Visayas, and one in Mindanao (see Figure 1). These provinces, along with the rest of the target provinces, were selected on the basis of the health risks obtaining in a province (through an analysis of such data as infant mortality rates, crude birth rates, crude death rates, and prevalence rates of major diseases) and the opportunities available for a DOH-LGU-NGO collaboration (among other things, presence of potential NGO partners and the openness of the provincial health office and the provincial government to working with NGOs), and assessment of the reach of public health services.[2] Moreover, the selection of target provinces considered the provincial income categories and the inclusion of pilot provinces under the government decentralization program. The list of the 16 PCHD target provinces was firmed up in late 1989 before field implementation started in early 1990.[3]

In each of the target provinces, potential barangay project sites were identified initially on the basis of the lists of targeted areas for development (or TADs) which were prepared in 1989. This project site selection was among the first activities of the PCHD provincial partnerships (see "Provincial planning experience," below). PCHD subsequently provided funds for implementing health-focused projects and activities in the selected sites.

Management

The Community Health Service (CHS) serves as the key DOH central-office-based unit in PCHD management. Created under the 1987 DOH reorganization

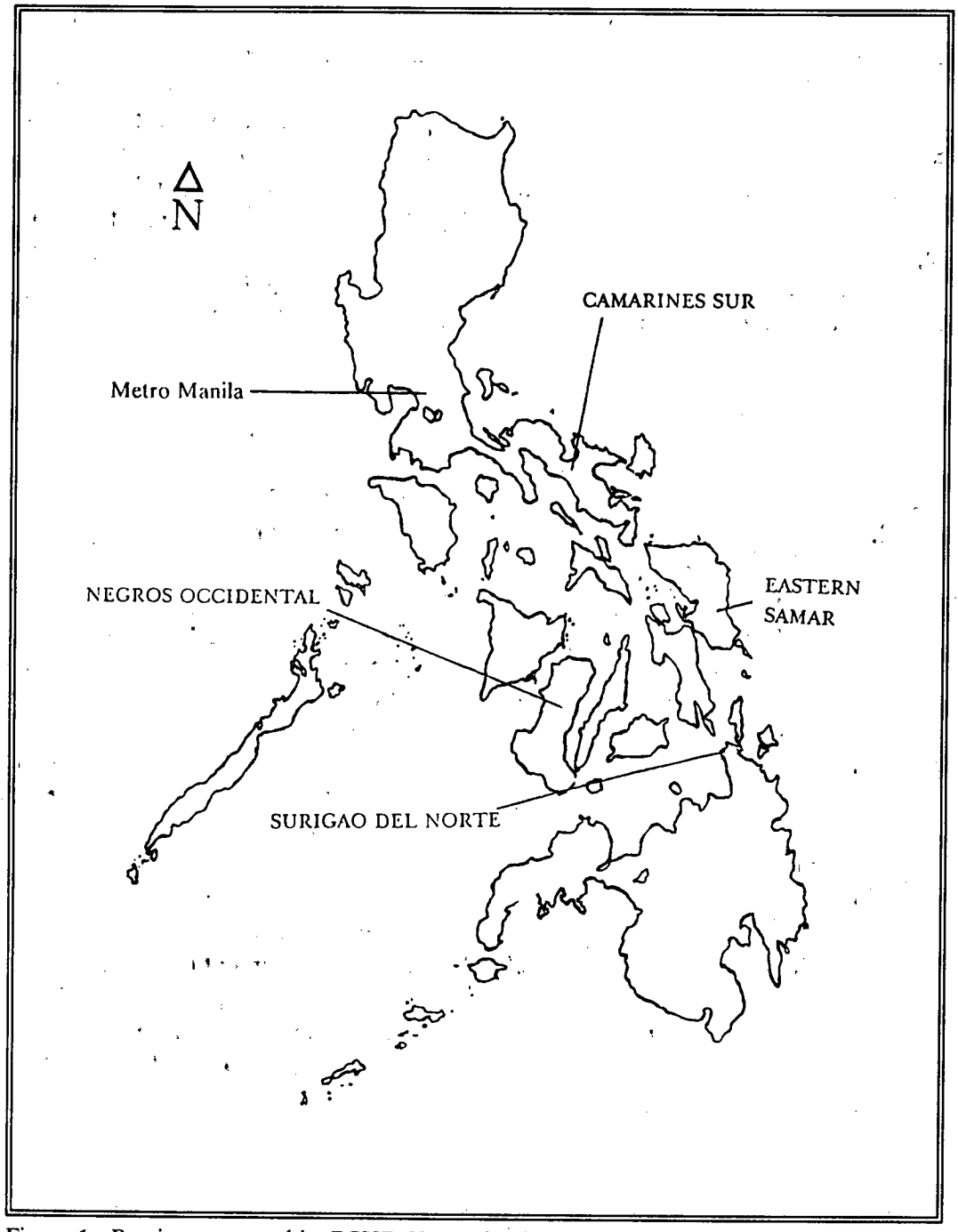

Figure 1. Provinces covered by PCHD Year 1 implementation

(Executive Order 119), CHS is under the Office of the Undersecretary of Health and Chief of Staff. It is mandated to pursue plans, programs, and services related to collaborative work with NGOs and LGUs relevant to community health development. PCHD is the first nationwide undertaking of CHS related to DOH-LGU-NGO collaboration and community participation.

In addition to CHS, the regular DOH organizational structure has been tapped for PCHD implementation. This includes central-office-based units which are involved in PHDP management and implementation, and the field units from the regional offices to the rural health units (see Figure 2). During the planning phase, a critical role is played by IPHO, which participates as a member of the provincial-level PCHD partnership and serves as a local-based partner of CHS. (It should be noted that this report covers the period prior to the implementation of the Local Government Code of 1991, which, among other things, provides for the devolution of health facilities and services at the provincial and municipal levels to the respective LGUs. Some of the implications of this development on PCHD implementation are discussed in Chapter Five.)

As the unit responsible for PCHD implementation, CHS provides the link among the other central-office-based units concerned, between the central office and the field, and among the DOH field units and other participating groups, including NGOs and LGUs. It likewise initiates general planning, budget preparation, and fund allocation, as well as undertakes field monitoring activities.

Two special bodies at the DOH central office, namely, the PHDP project coordinating unit (PCU) and the community health policy committee (CHPC), provide direct assistance to CHS. PCU is tasked with the financial and logistics management of PHDP, including PCHD; CHPC is responsible for proposal review and approval, in addition to policy formulation.[4] CHS also actively interacts with other central-office-based units, namely, the Office for Legal Affairs, Office for Financial Operations and Frontline Services Audit, and Finance Service in connection with the processing of grant papers and release of funds.

Together with the CHS director, the CHS staff involved in PCHD implementation are regular members who had been designated provincial coordinators. One of these coordinators also serves as PCHD national coordinator.[5] In addition to the support rendered by other regular CHS technical and administrative staffs, the provincial coordinators receive assistance from two technical assistants and a financial analyst hired specifically for PCHD.

The provincial coordinators are responsible for all field-level activities, namely, initiating the provincial partnership, facilitating coordination among the partnership members, and providing technical assistance to the participating organizations. They

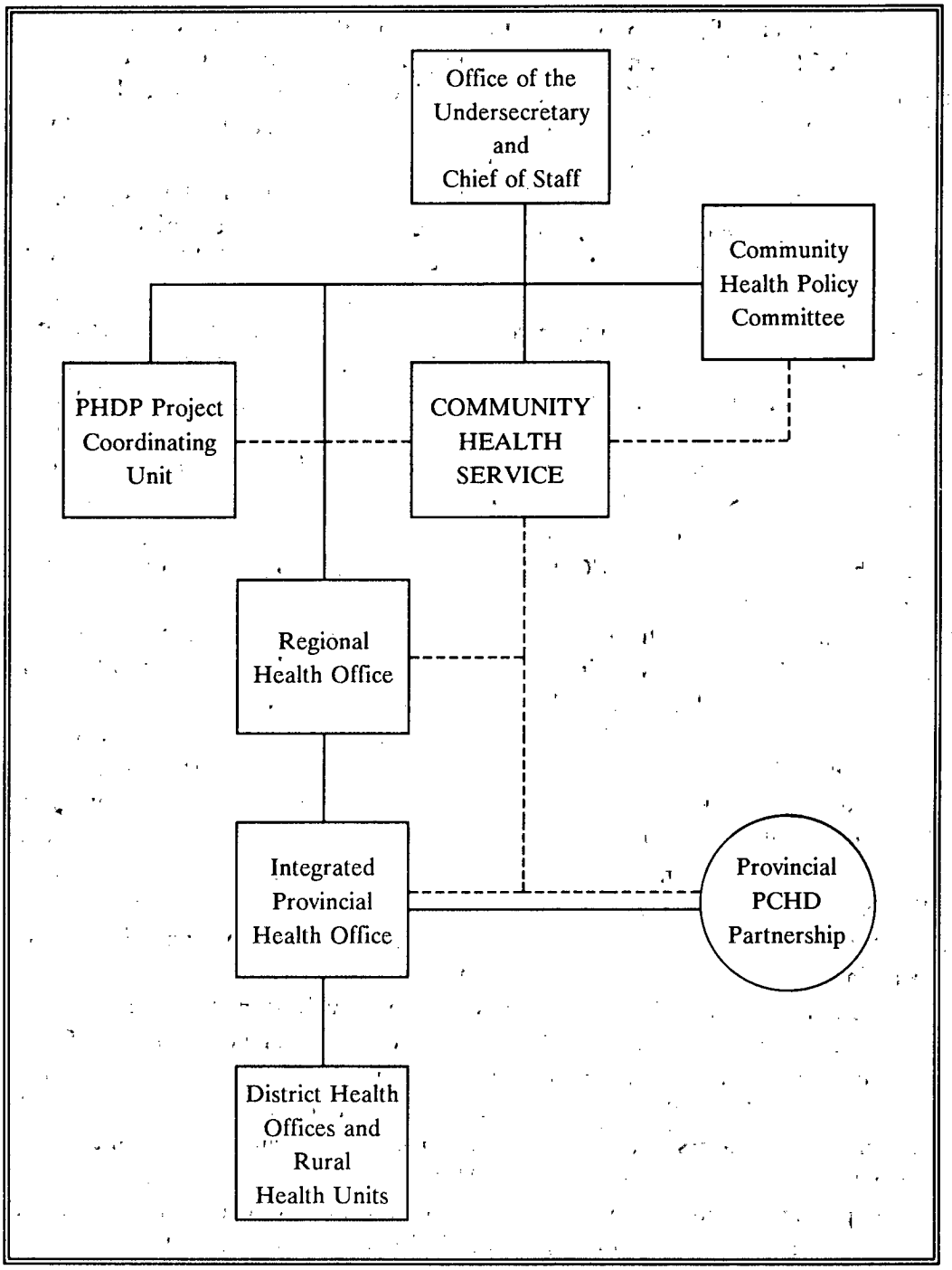

Figure 2. DOH organizational setup for PCHD implementation, 1990-92

also serve as the link between the field and the central office. (For Year 1 provinces, the provincial coordinators received assistance from an "understudy," that is, the person designated to take over the position of provincial coordinator when the original coordinator moved on to initiate implementation in a Year 2 province within the region.)

The financial analyst serves the financial management and audit requirements of PCHD. The latter pertains particularly to the review of financial statements, together with supporting documents, of grant recipients. The financial analyst likewise reviews PCHD fund allocations to and disbursements of IPHOs.

At the regional health office (RHO), a staff member is designated as PCHD coordinator for the region. The assignment is in addition to existing positions and tasks. In the case of IPHO, a regular staff member is likewise assigned to serve as PCHD coordinator for the province. Other members of RHO and IPHO staffs are invited to assist as a need arises. In addition, two persons were hired in Year 1 provinces to serve the needs of PCHD (a project development officer or PDO, and a health program officer or HPO); in Year 2 provinces, only one person was hired (a PDO). These persons were to work closely with CHS and other organizations concerned in implementing PCHD.

Process Monitoring Research

To support its need to undertake regular and systematic assessment of PCHD field experiences and, thus, be able to identify and institute appropriate implementation policies, guidelines, and strategies, DOH through CHS commissioned the Institute of Philippine Culture (IPC) of the Ateneo de Manila University to undertake a process monitoring research on selected PCHD sites.[6] The research provided qualitative information on field implementation processes, activities, and issues. (Details of the research methodology, including fieldwork procedure, are presented in Appendix B.)

Research Sites

The process monitoring research was first conducted in Camarines Sur, a PCHD Year 1 province. The research study began from the initial activity of the provincial planning phase, and extended to the implementation of PCHD-funded community projects and activities.[7]

The research in Camarines Sur was initially focused on the provincial planning activities. When activities shifted to the target barangays, IPC selected seven barangays as community research settings. The number represented a site each of

the proponent organizations in the province. (A proponent in the province covers one to four barangay project sites, for a total of 19 sites.) In addition to proponent organizations, the selection of the seven study sites took into consideration the variations in physical access and location in relation to their respective town centers, as well as the dominant economic resources and land use patterns.(see Figure 3).

Coverage

The provincial planning phase in Camarines Sur began in February 1990. On various periods between September 1990 and July 1991, the community profiling activities in connection with project proposal preparation were undertaken in the different target barangays. By June 1991 (or 16 months after PCHD was initiated in the province), one community project proposal had been approved; by December 1993, all 19 proposals expected from the province had been processed.

One of the seven study sites was the first Camarines Sur target barangay to have an approved proposal. Project implementation in this site began in July 1991. For the remaining six study sites, proposal approval came in different periods between late June 1991 and December 1991; project launching took place between September 1991 and October 1992. (The time lag between the approval of project proposals and the first release of grant funds took between 4 and 10 months, which brought the gap between community profiling and project launching to as much as 6 to 24 months; see Table A1 in Appendix A).

The research study on the seven sites started from the community profiling activities in connection with project proposal preparation. The study was maintained even as PCHD-related activities in the target barangays were suspended while the proposals and release of grant funds were being processed. It was conducted further for at least a year after the formal project launching. Thus, the end of the research period varied for each site (between December 1992 and August 1993); but all sites were covered during the implementation of the PCHD-approved project proposals, which all had 12-month timetables.

Present Report

This volume summarizes the activities and issues related to the implementation of the PCHD-funded community projects and activities.[8] To provide a background to these activities, Chapter Two presents profiles of the barangays studied and the proponent organizations. It also contains a summary of the planned projects and activities in these sites. Chapter Three and Chapter Four focus on the processes involved in implementing the planned activities; these chapters also describe the

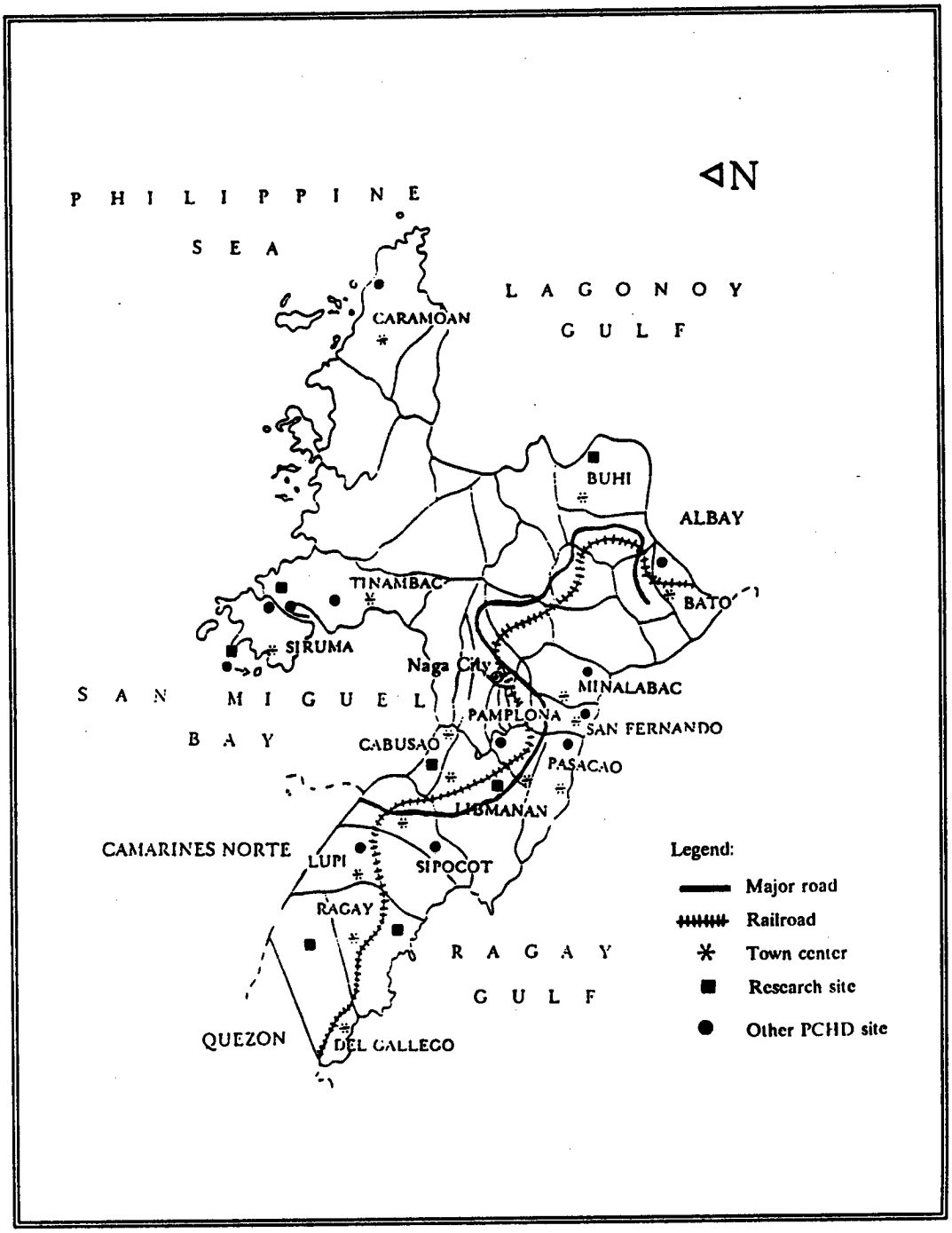

Figure 3. PCHD barangay project sites in Camarines Sur, 1991-93

other development activities which took place in the project sites during PCHD's implementation. The final chapter, Chapter Five, synthesizes the issues and problems which emerged and their implications on PCHD implementation, in particular, and on community health development, in general. Before proceeding to the discussions on barangay-specific PCHD experiences, a background summary on the provincial planning phase in Camarines Sur is in order.[9]

Provincial Planning Experience

As designed, PCHD field implementation would involve several key sequential activities, namely: (1) orientation-consultation meetings with potential participating organizations, (2) preparation of a provincial planning proposal, (3) provincial planning activities, including the holding of a multisectoral planning workshop, (4) preparation of community project proposals, (5) review and approval of project proposals, and (6) implementation of community projects. The details on the manner in which each of these activities would be carried out in a particular province were expected to be identified on the basis of existing local conditions. The first four activities, which constituted the provincial planning phase, were planned to be accomplished within a year. This meant that the project grants would have been released at the end of the first year (or within the first 12 months) so that community project implementation could commence during the first quarter of the second year. Through the conduct of the planning activities, it was expected that local DOH-LGU-NGO partnerships could be formed and health-focused project plans for selected barangay sites could be formulated.

Processes and Activities

PCHD implementation in Camarines Sur officially began on 5-8 February 1990 when the CHS coordinator for the province (CHS-PC) made a visit to prepare for an orientation-consultation meeting with potential participating organizations. This groundwork activity was conducted in coordination with IPHO, specifically PHO and the designated IPHO's PCHD coordinator (IPHO-PC), as well as the regional health office (RHO), which sent a representative. These RHO and IPHO members joined CHS-PC in calling on the provincial governor and some NGOs operating in the province to explain PCHD and invite them to the orientation meeting.[10]

Orientation meetings

Some three weeks after CHS-PC's visit, the Camarines Sur PCHD orientation seminar was held in Naga City. It was attended by key members of the seven NGOs

visited during the groundwork round, a representative of the governor's office, and personnel of IPHO, RHO, and CHS. Facilitated by CHS, the seminar discussions focused on PCHD, its goals, and implementation scheme, particularly as regards the DOH-LGU-NGO partnerships it was advocating. It likewise involved a getting-to-know-each-other session among the seminar participants. Finally, it brought about an agreement to hold a second meeting which would take up the formation of the provincial PCHD partnership, selection of a convenor, formulation of the group's vision and basic principles, and outline of the provincial planning proposal.[11]

The follow-up meeting, convened two weeks after the orientation seminar, was attended by representatives of all the seminar's organization-participants, which were then considered as comprising the Camarines Sur PCHD partnership. The meeting also resulted in the selection of one of the participating NGOs as the partnership convenor and fund trustee, and in the formation of a working committee which would draft the planning proposal. Moreover, the group formulated its working principles and agreed on a seven-point "credo" that emphasized primary health care in the context of a holistic community development to be pursued through a partnership among GOs, NGOs, and people's organizations (POs).

Planning proposal

The Camarines Sur planning proposal was submitted on 27 April (or two months after the orientation seminar); it was approved in June, after revisions were made on the basis of discussions between CHS and the partnership. Following the release of the planning grant in August, the partnership began a series of activities which included a vision-sharing workshop, an orientation session for DOH field units, and planning for the initial community work. Preparation for the community work focused on the designs of the community profiling for project proposal generation and training of community organizers (COs) to be involved in the work.

The partnership also firmed up the list of initial target barangays and the corresponding NGO proponents. Of the seven NGO-participants, four agreed to become proponents; one NGO would cover four barangays while the remaining three would have two each, for a total of 10 initial target barangays. As decided upon during the planning proposal preparation, the target barangays would be selected from the province's Congressional District 1, which had the most number of TADs. It was also pointed out that initially concentrating the PCHD work on a contiguous area would bring about a greater impact.

The list of 10 initial target sites was finalized shortly before the community profiling work began in mid-September. In addition to the respective NGO proponents, IPHO and the DOH field units concerned (district health offices and rural

health units or RHUs) assisted in identifying the final sites, using such criteria as the health-service underserved or unserved condition of a barangay (as reflected in the area's difficult access from the town center and the absence of regular visits from the rural health midwife or RHM concerned) and the plans of the NGO proponents as regards their areas of operations.

Project proposal preparation

The NGO proponents began the initial community work in their respective target areas by fielding at least a CO in each site. Using a common timetable (17 days beginning in mid-September) and data-gathering tool, the COs were tasked to collect data for a community profile and preliminary project plans, and identify potential leaders who would be involved in project planning and implementation.

In late October, the partnership convened a workshop to discuss the results of the initial community work in the 10 target barangays. Present in the three-day workshop were the COs and other key members of the proponent NGOs, two community leaders from each site, representatives of two municipal governments, selected staff of the DOH field units concerned, and members of the nonproponent participating NGOs, provincial government, IPHO, RHO, and CHS. The community leaders, with the help of the COs concerned, presented the profiles of their barangays, emphasizing the health problems and needs, as well as the corresponding projects and activities for potential PCHD funding. The planning workshop ended in agreements concerning the writing up of project proposals with the involvement of the community leaders as well as the other workshop participants.

The preparation of the community proposals took about a month. A consolidated proposal was prepared for the province, integrating the identified projects and activities into programs to be uniformly implemented in all 10 target sites. The proposal also included the creation of an organizational structure within the provincial partnership which would manage the projects, including a common fund. This proposal was disapproved by DOH with the suggestion that individual proposals be prepared for the target barangays so that specific community conditions and the corresponding planned activities and strategies could be highlighted.

The disapproval of the consolidated proposal brought several changes to the partnership and to general plans for PCHD implementation. Two NGOs, which initially committed to handle a total of six sites, decided to change their target sites to areas outside District 1. Two other proponent NGOs offered to take three of the abandoned sites, leaving another three without proponents. CHS and IPHO decided to look outside the partnership for other potential proponents for these three sites so that the community members' expectations would not be frustrated. For one site,

the mayor's office covering the barangay offered to take over as proponent; for two sites, a newly organized NGO decided to join the partnership and serve as proponent. Meanwhile, the two NGOs which decided to change their PCHD sites selected three barangays each in District 3 and District 4.

In addition to the new NGO which took over two abandoned sites, the disapproval of the consolidated proposal resulted in the entry of another NGO in the provincial partnership. This second additional NGO selected three barangays in a municipality in District 3. Thus, six NGOs and one mayor's office became PCHD project proponents for 19 barangays in the province.

For the preparation of barangay-specific project proposals, community profiling activities were conducted in the additional sites, while validation of the September 1990 data was carried out in the original sites, particularly by the new or substitute proponents. These activities were conducted by the NGOs concerned and their RHU counterparts, and involved different periods until July 1991 (see Table A1). An abbreviated form of the September community work in the original sites was used in the additional sites.

Proposal review and fund release

The project proposals were initially reviewed in the province. PCHD's IPHO-based PDO discussed the proposal drafts with the proponent organizations concerned. PDO was also responsible for discussing the drafts with members of the IPHO technical staff and CHS-PC. In turn, the latter presented the proposals to CHPC, PCHD's proposal review body.

After CHPC's approval of a project proposal, a memorandum of agreement (MOA) between DOH and the proponent organization was prepared. This signalled the processing of papers for the initial release of grant funds which, in most cases, also marked the start of community project implementation. First grant fund payments came on staggered basis beginning in October 1991. Thus, the first year of community project implementation in Camarines Sur spanned the period from mid-1991 to late 1993.[12]

Outcomes and Outputs

The Camarines Sur provincial planning phase covered almost two years. At the end of this period, 19 barangays in 11 municipalities had approved proposals with about P200,000 grant funds each. These proposals covered the conduct of small health-focused infrastructure projects and community activities which were aimed at addressing health-service needs and developing organized local groups which

would pursue community health care management. These proposals also specified the municipal-level DOH-LGU-NGO partnerships which would assist the communities concerned in implementing the planned projects and activities.

The planning phase involved a provincial partnership composed of IPHO, the provincial governor's office, and nine NGOs, six of which became PCHD project proponents. (Three NGOs declined to become proponents: two lacked experience in community organizing, while one, though engaged in organizing work, had a target-beneficiary mandate which did not match that of PCHD. Nonetheless, the three groups agreed to assist in other capacities which could be determined as PCHD implementation progressed.) The municipal governments and RHUs covering the target barangays likewise participated in the barangay-focused planning activities. As pointed out above, one mayor's office eventually became a project proponent. As envisioned, CHS served as facilitator in major activities of the provincial partnership as well as rendered technical assistance in proposal preparation.

Notes

1. The literature on community participation in the development process is rich in experiences and cases of initiatives in various development settings, that is, resource areas and cultures. Many of these cases are acknowledged as "success stories" in participatory development. Among the key issues raised in some of these cases concern the importance of local institution building and the need for development agencies to enhance their organizational competence so that they could meet the demands of participatory development. See, for instance, Lele 1975; Cernea 1985; Garcia-Zamor 1985; Uphoff 1986; Korten 1987; Carroll 1992; and Kiggundu 1992.

   Experiences in community participation specific to health development are discussed in Morley, Rohde, and Williams 1983; World Health Organization 1983; Oakley 1989; Osteria and others 1988; Streefland and Chabot 1990; and Coreil and Mull 1990, among others. Some of the key issues and concerns highlighted in the literature on community health development pertain to the nature of community participation in different phases of program development and implementation, and how this participation could bring about local resource management capability.

2. In 1989, the DOH's Community Health Service collected from all provincial health offices a list of the barangays in their respective areas which were considered to be at-risk on health, highly inaccessible or had critical peace and order condition, and thus, were unserved or underserved by government health personnel. The lists were used not only in assessing a candidate province, but also in determining PCHD's targeted areas for development. Moreover, selected members of the CHS staff visited potential target

provinces to conduct an assessment of the opportunity factors present in the area and generate an initial listing of NGOs operating in the province.

3. Sorsogon, Antique, Northern Samar, and Agusan del Norte comprised PCHD Year 2 provinces. In early 1992, shortly before implementation was begun for the remaining eight provinces, four of the original target provinces (Batanes, Tarlac, Laguna, and Davao del Norte) were dropped in favor of four provinces (Benguet, Mountain Province, Zambales, and Camarines Norte) which served as settings of the 1988-91 collaboration project between DOH and the Jaime V. Ongpin Foundation, Inc. (JVOFI). The collaboration, which was funded by JVOFI, focused on the enhancement of IPHO's capability for community health development. With the end of funding, CHS deemed it important to continue the work in the JVOFI areas and decided to use PCHD funds for the purpose. Moreover, CHS saw a need to respond to problems related to natural calamities (Mount Pinatubo eruption, the 1990 earthquakes, and a series of typhoons).

   In late 1992, DOH, under a new administration, decided to expand PCHD implementation in all provinces. For 1993, the target was to reach 35 of the country's 75 provinces. Among these 35 provinces were those (except Laguna) which were excluded in 1992.

4. In early PCHD project papers, CHPC was referred to as the Committee on Community Health Policy (CCHP). It began meeting in December 1990 but was officially created, under a Department Order, in January 1992 and renamed Community Health Policy Committee or CHPC. It is chaired by the undersecretary of health and chief of staff and composed of the PHDP project coordinator; assistant secretary for public health services; the chiefs of the Management Advisory Service, Office for Financial Operations and Frontline Services Audit, and Community Health Service; a representative of the regional health offices; and two representatives from nongovernment organizations. CHS serves CHPC's secretariat needs.

   Until 1993, no representative of the regional health offices had attended a CHPC meeting. However, representatives of the Finance Service, Office for Legal Affairs, and PCU were invited to, and attended, CHPC meetings. Finance Service was subsequently made a regular member through an amendment to the Department Order creating CHPC.

5. The first PCHD national coordinator was the provincial coordinator for Camarines Sur. Soon after the start of Year 2 implementation, the chief of the CHS implementation support division and Negros Occidental provincial coordinator took over the national coordinator position. The Camarines Sur coordinator also became coordinator for Sorsogon, a Year 2 province. The Negros Occidental position was turned over to another CHS staff.

6. IPC also conducted a training program on process-oriented research for selected CHS and DOH field staff. The training resulted in the formulation of a process-oriented management reporting (POMR) system for all PCHD provinces (see Department of Health 1991). It also brought about the formation of POMR teams in each province which would be responsible for preparing narrative reports for PCHD management.

7. For PCHD's Year 2 implementation, IPC conducted the process monitoring research in Agusan del Norte. This additional coverage was adopted so that expansion issues could be given attention. Agusan del Norte was selected from among the Year 2 provinces because of its potentials in providing a wide expanse of field implementation issues. It is part of a region where diverse ethnolinguistic groupings and historical experiences are found. Its location and physical features could provide a good understanding of accessibility issues in health service delivery. Moreover, its health problems include schistosomiasis and malaria, two of the priority disease control concerns of PHDP.

   The research in Agusan del Norte covered only the provincial planning phase; its results are included in the report *Partnership Building and Planning for Community Health Development: PCHD Experiences, 1990-93* (Veneracion 1993a), which also contains the Camarines Sur experience.

8. Individual accounts of the experiences of the seven barangays covered by the process monitoring research, beginning from the PCHD entry for community profiling to the end of at least the first 12 months of the implementation of PCHD-supported projects and activities, are presented in the volume entitled *PCHD Community Project Implementation, 1991-93: Experiences from Camarines Sur* (Veneracion 1993b).

9. The summary of the Camarines Sur planning experience presented in this report was taken from the volume entitled *Partnership Building and Planning for Community Health Development: PCHD Experiences, 1990-93*. The volume also discusses the provincial planning experience in Agusan del Norte as well as other PCHD Year 1 and Year 2 provinces.

10. For simplicity in presentation, this report uses the term "NGO" to refer to PCHD participating groups which are neither LGU, DOH unit, nor other GO. This does not imply an expansion of the definition of NGOs as contained in mainstream development literature (see, for example, Brodhead 1987, Drabek 1987, Korten 1987, and other articles in *World Development*, Vol. 15, Supplement; Uphoff 1986; Korten 1990; and Carroll 1992). This research study shares the basic definition which delineates NGOs, in the context of development, as groups working directly with the grassroots for "specific developmental purposes and main activities" (Carroll 1992:9). The definition refers to organizations which serve as intermediary between the poor and the disadvantaged, and government and other resource-providing organizations. It also stresses the facilitator role and institution-building competence of NGOs.

11. The agenda of the follow-up meeting was essentially a response to the concerns raised by CHS as regards the provincial planning activities and how these could be funded by PCHD through a planning proposal to be submitted by the partnership through its designated convenor.

12. As programmed, PCHD would support two years of community project implementation in each site. A proposal would be required each year.

Chapter Two

Settings, Plans, and Proponents

One of six provinces in the Bicol Region (or Region 5), Camarines Sur has a total land area of 5267 sq km of lowland irrigated areas, rainfed and upland areas, and coastal plains. Two mountain peaks—Isarog and Iriga—are located in the mountainous eastern portion of the province. The central part of the province is generally plain, becoming rugged toward the northeastern and western parts which are bounded by Lagonoy Gulf and Ragay Gulf, respectively. On the north are San Miguel Bay and Philippine Sea.

Camarines Sur is located over 400 km from Metro Manila. The pan-Philippines highway traverses the central part of the province and connects it to the provinces of Camarines Norte on the northwest and Albay on the southeast. Naga City, the province's major center of transportation, commerce, business, and education, lies along this highway. The provincial capital, Pili, is about 20 km from Naga City and is the site of a domestic airport.

Most Camarines Sur municipalities are linked to Naga City by a network of roads, which generally becomes of poorer quality toward the upland areas. A few municipalities, however, may be reached only through railroad or water routes. While town centers are generally accessible through the use of public transportation facilities, many barangays can only be reached from their respective town centers partly by using hired boats or hiking. A number of barangays, which also required hiking, are served by improvised vehicles running on railroad tracks.

Covering 35 municipalities and 2 cities, Camarines Sur has a total of 1065 barangays. In 1990, its total population reached 1,305,919 in 230,515 households. The two cities (Naga and Iriga) accounted for some 14 percent of the population. About 24 percent of the barangays outside the two cities had been classified as TADs.

The 1990 Camarines Sur health statistics generally reflected a poorer picture compared with the country's overall figures. The province's leading causes of morbidity were influenza, bronchitis, and diarrhea, with rates far exceeding the national figures. Pneumonia and tuberculosis, two leading causes of mortality, also overshot the country's overall rates (see Table 1).

In 1990, public health facilities in the province consisted of 9 hospitals with a total of 605 beds, 44 health centers, and 263 barangay health stations. These facilities were found in centrally-located areas in the province and were being augmented by 31 subsidized beds in 8 private hospitals and clinics. Health manpower-population ratios were below national standards. Moreover, considerable disparities were found between health districts (see Table 2).

Features of Selected Target Sites

The seven barangays covered by the process monitoring research are located in seven municipalities in three congressional districts. These municipalities are of some distance from Naga City; the nearest (Tinambac) is about 25 km away and the farthest (del Gallego), about 100 km. Travel using public transportation from Naga City to the centers of two municipalities (del Gallego and Ragay) is generally through the railroad tracks, either by train or *skates* (improvised motor-driven vehicles on railroad tracks), and to one municipality (Siruma), by jeepneys and then motorboat. The rest (Cabusao, Tinambac, Buhi, and Libmanan) are served by jeepneys and minibuses.

The following sections describe the selected barangays in terms of their general physical features, socioeconomic characteristics, and health conditions at the start of PCHD implementation. Also presented are the barangays' experiences in development initiatives.

Physical and Socioeconomic Characteristics

PCHD's aim to reach barangays with difficult access from town centers is satisfied by the seven study sites. Only one (Pandan) lies along a major highway, but this is also not served by regular public transportation. Reaching all seven sites entails some hiking. Two barangays (Cabinitan and Bagadion) may be reached partly by using skates, while four (Ibayugan, Mansalaya, Pantat, and Penitan) require boat rides (see Table A2). Travel time through public transportation to the seven barangays from their respective town centers comes to about 15 min (Pandan) to over 5 hr (Pantat). The additional hiking required takes from about 5 min (Cabinitan) to 45 min (Pantat).

Table 1. Ten leading causes of morbidity and mortality (rate per 100,000) in Camarines Sur, 1990

Morbidity Cause	Rate[a]	Mortality Cause	Rate[a]
Influenza	2483.7 (878.0)	Pneumonia	84.7 (66.5)
Bronchitis	1992.3 (1580.3)	Diseases of the heart	67.0 (74.6)
Diarrhea	1725.6 (1520.7)	Tuberculosis - all forms	61.1 (39.2)
Pneumonia	532.1 (380.3)	Malignant neoplasms	22.1 (35.7)
Tuberculosis - all forms	216.3 (246.1)	Accidents	16.4 (19.3)
Diseases of the heart	108.5 (160.7)	Diarrheal diseases	13.3 (10.3)
Malaria	97.9 (118.7)	Measles	6.8 (5.6)
Measles	94.0 (69.2)	Infectious hepatitis	2.7 --[c]
Chickenpox/varicella	74.8 --[b]	Bronchitis	2.1 --[c]
Accidents	40.9 (215.5)	Tetanus	2.0 --[c]

[a]The figures in parentheses indicate rate (per 100,000) for Philippines.
[b]The disease is not among the country's 10 leading causes of morbidity.
[c]The disease is not among the country's 10 leading causes of mortality.

Source: DOH 1990.

Table 2. Camarines Sur health manpower-population ratio, 1990

District	MHO[a]	PHN	RHM	RSI
IPHO Catchment	1:21,780	1:16,940	1:4,574	1:17,591
Libmanan	1:32,761	1:24,571	1:3,931	1:24,571
Sipocot	1:41,284	1:16,513	1:5,504	1:16,513
Ragay	1:30,437	1:15,219	1:4,348	1:12,175
Caramoan	1:28,790	1:11,517	1:1,429	1:14,396
National standard[b]	1:10,000	1:10,000	1:3,000	1:15,000

[a]The abbreviations used are: MHO, municipal health officer or rural health physician; PHN, public health nurse; RHM, rural health midwife; and RSI, rural sanitary inspector.
[b]Figures represent those set for mountainous areas (DOH 1989a).

Source: Camarines Sur IPHO.

The different types of resource areas found in Camarines Sur are generally reflected in the seven study sites. Three barangays (Penitan, Pantat, and Pandan) are along San Miguel Bay's coastline; Penitan and Pantat also cover upland areas while Pandan has extensive irrigated lowlands. The fourth barangay (Ibayugan) is found beside Lake Buhi and extends to a forested upland. The remaining two (Mansalaya and Bagadion) are both inland barangays; Mansalaya is a rainfed upland while Bagadion is in the plains.

Pantat has the biggest land area, reaching about 1000 ha. Penitan, Ibayugan, and Pandan come close, with 870, 868 ha, and 750 ha, respectively; while Cabinitan, Mansalaya, and Bagadion cover 300 ha, 240 ha, and 222 ha, respectively. The greater portions of cultivated lands in Bagadion, Cabinitan, Mansalaya, and Pandan are planted to rice, while those in Ibayugan, Pantat, and Penitan are coconut farms.

In 1990, the total population in the seven barangays ranged from 589 (in 105 households, Cabinitan) to 1753 (in 267 households, Pandan). The average household size reached about six in all sites.

The major source of income in all sites was farming, either rice growing or coconut cultivation or a combination of these. Except in Ibayugan where most farmers considered themselves as owners of the public lands they tilled, the majority of the cultivators in the study sites were tenants. In Cabinitan, Ibayugan, Pandan, Pantat, and Penitan fishing also constituted a major income source of residents. In many cases, fishing was combined with farming or farm wage work.

The facilities found in the seven sites were limited to public schools (complete elementary grades in six sites and a high school in Cabinitan), chapels (at least one in each barangay), multipurpose concrete pavements (in all sites), and *sari-sari* (small, variety) stores ranging from 4 (Penitan and Cabinitan) to 21 (Pandan). Three barangays (Bagadion, Cabinitan, and Pandan) received electric service although this was limited to households within centrally-located areas or along the main road. Some rice farms in two barangays (Bagadion and Pandan) were served by irrigation systems (see Table A3).

Health Condition

As shown in available records (see Table A4), malnutrition among children under six appeared as a common problem in all seven sites. Figures on severely and moderately underweight children covered by weight surveys (*Operation Timbang*) ranged from 6 (Penitan) to 68 percent (Pandan) while those on mildly underweight ranged from 24 (Pandan) to 41 percent (Mansalaya).

Immunization coverage of children was quite high, reaching over 100 percent of the target in three barangays (Ibayugan, Mansalaya, and Pandan). One barangay

(Pantat) posted 100 percent of the target while two barangays reached 97 and 88 percent (Bagadion and Cabinitan, respectively). The lowest child immunization figure was 64 percent of the target (Penitan).

Sanitary toilets were uncommon in the seven sites. The highest figure was 37 percent of households (in Pandan) and the lowest was 6 percent (Penitan). Even pit privies were not popular in the seven barangays, except to a certain extent in Cabinitan (28 percent).

The common domestic water sources of households in the seven barangays were pumps on shallow or deep wells, open wells, springs, rivers, and creeks. One site (Mansalaya) had a Level II system with five faucets connected to a concrete tank on a spring. Most households in the seven sites exerted extra efforts to secure their drinking water from sources they perceived as safe (such as pumps and springs). They resorted, however, to drawing drinking water from any available supply (including from rivers and creeks) when their usual sources dried up or became flooded.

Health services within the selected barangays were provided by traditional healers and the RHM assigned to these areas (see Table A5). The services of traditional healers were most commonly sought when home remedies failed. These healers, some of whom were also RHU-trained *hilot* (traditional birth attendants), numbered from 2 (Mansalaya) to 10 (Ibayugan and Pantat) and provided services for a variety of health problems.

Active RHU-identified barangay health workers (BHWs) were present in four sites (Cabinitan, Ibayugan, Mansalaya, and Pandan). These volunteer workers' tasks generally focused on providing assistance to RHM during the latter's visits. Three barangays (Ibayugan, Pantat, and Mansalaya) had PHDP-assigned RHMs.[1] Only the Mansalaya RHM, however, resided in the barangay. The Ibayugan RHM lived in an adjacent barangay but reported to her assigned site almost daily. The RHM assigned to Pantat, like her counterparts in the other study sites, resided in neighboring areas where barangay health stations (BHSs) were located. Visits of RHMs to the other study sites without resident RHMs varied from once a week to once a month.

The relatively accessible public health facilities available to the residents of the seven barangays were the main health centers located in their respective town centers and staffed with a physician, nurses, and midwives, among others. Bagadion and Cabinitan residents also had district hospitals situated in their town centers, while residents of the other sites had to travel to neighboring municipalities or to Naga City where a regional training hospital was found. Residents of Ibayugan also availed themselves of services in private hospitals and clinics in nearby Iriga City

while those in Penitan found it easier to cross San Miguel Bay for services of the provincial hospital in neighboring Camarines Norte.

Experience in Development Initiatives

The seven barangays had been recipients of external assistance, mostly from government agencies (see Table A6). The relatively more accessible barangays appeared to have been targeted more by government programs. Pandan and Bagadion received assistance from 10 and 8 government agencies, respectively; while Pantat and Mansalaya were provided assistance by 3 agencies. Except Ibayugan which appeared as a favored site of relief and welfare programs, the study barangays were hardly reached by programs of NGOs and other private groups. Two barangays (Bagadion and Penitan) had not experienced any major assistance from NGOs.

The most popular assistance rendered to the seven barangays was the construction of facilities—school buildings, domestic water sources, barangay halls, and concrete pavements for use as sun-drying areas of rice and other produce, sports and dancing areas, and venue for barangay meetings and other group activities. The provision of agricultural production loans, as well as crop and livestock production enhancement training seminars, was also a common form of external assistance.

A usual pattern of assistance, whether from government or nongovernment agencies, began with the formation of community organizations. These groups would subsequently be used as conduit for or implementor of the externally assisted projects. In some cases, the formation of community associations served as the assistance rendered to the barangay. Community organizations formed through the initiatives of external groups numbered from four (Mansalaya) to eight (Pandan and Ibayugan), with an average of six in all sites (see Table A7). Most of these were organized shortly before PCHD implementation (that is, late 1980s to 1990) and produced an average of four active externally assisted community associations.

The community residents also initiated projects and activities to improve their barangays. Similar to externally initiated assistance, locally initiated projects were generally carried out through community organizations. The barangay councils also sponsored a number of projects, including some involving external funding.

Associations formed by the community residents themselves numbered from one (Cabinitan and Penitan) to 13 (Pantat). No locally initiated group was found in one site (Mansalaya). Most locally initiated groups existed longer than their externally initiated counterparts and a greater proportion also had remained active.

The usual projects undertaken by locally initiated community organizations likewise involved infrastructure development, such as construction of chapels and domestic water sources. Most of these associations also spearheaded barangay

dances, sports tournaments, and cleanliness campaigns. There appeared to be no differences in the types of projects and group activities initiated by organizations which had become inactive compared with the active ones, but as pointed out above, many of the associations had only been in existence for a a few years or were just in the organization formation stage. There were also no considerable differences in the types of activities carried out by locally organized groups and by externally initiated organizations, although the latter were involved in projects with more substantial funding.

Proposed Community Projects

As pointed out in Chapter One, PCHD-supported projects and activities were expected to address immediate health needs or critical health problems in the target barangays. Moreover, these projects were looked upon as mechanisms through which community capability for basic health care and local resource management could be enhanced or developed. Thus, a community organizing process constituted a desired component in the design of proposed PCHD-funded projects.

Activities

As contained in PCHD-approved project proposals, the nature of planned activities did not differ much (see Table 3). Common to all seven study sites were the provision of sanitary toilets and sources of domestic water supply, establishment of vegetable and herbal gardens, and conduct of health education seminars for selected household members. Three barangays (Cabinitan, Pandan, and Penitan) included the identification and training of volunteer community health workers; two barangays (Pandan and Penitan), the construction of health centers; and one site (Mansalaya), the provision of food supplements for malnourished children.

While the planned activities were drawn up on the basis of barangay health profiles, efforts were also made to respond to community-specified needs. This could best be seen in domestic water source provision for which the general expressed intent was easy access to water sources. It is also interesting to note that while RHU records indicated that malnutrition of children under six appeared as a disturbing problem in the target sites, only one proponent planned for a direct intervention, that is, a supplemental feeding program (Mansalaya).[2] The rest of the proponent organizations regarded the planned vegetable gardening activities as the main component of a nutrition education program.

In preparing their PCHD proposals, proponent organizations appeared to have given significant consideration to the one-year time frame of initial grants as well as

Table 3. Summary of planned PCHD-funded activities in selected Camarines Sur sites, 1991-92[a]

Barangay (NGO proponent)	Activities[b]						
	1	2	3	4	5	6	7
Bagadion (TALINGKAS)	x[c]	x		x		x	
Cabinitan (LISAFI)	x	x		x		x	x
Ibayugan (FACE)	x	x		x		x	
Mansalaya (MAYOR'S OFFICE)	x	x		x	x	x	
Pandan (PRRM)	x	x	x	x		x	x
Pantat (PAGBICOL)	x	x		x		x	
Penitan (CASAFI)	x	x	x	x		x	x

[a]The activities are contained in PCHD-approved project proposals.

[b]The numbers indicate the following: 1, construction of sanitary toilets whether communal or for individual households; 2, provision or improvement of domestic water sources; 3, construction of health/multipurpose center; 4, establishment of herbal and/or vegetable gardens; 5, provision of food supplements for malnourished children; 6, household health education seminars; and 7, training of community health workers.

Except that for Mansalaya, all project proposals included the fielding of a full-time CO who would assist the community in project implementation, particularly in forming community organizations. In Mansalaya, staff members of municipal-based national agencies would be tapped for the task. In the six sites, plans for community organizing also included leadership and other specialized training seminars for organization development.

[c]With deferred funding (see Chapter Four).

the need to involve community participation in activities with visible or physical results. Except the Mansalaya proposal, which had an approved budget of P105,534, all project proposals had budgets close to the PCHD P200,000-allocation. The Cabinitan proposal had the biggest budget, totalling P249,850.[3]

Strategies

The presence of a CO who would facilitate project implementation was a part of all project proposals, except that for Mansalaya. In this barangay, personnel of municipal government and municipal-based national agencies were designated for the task. In the other barangays, COs would be fielded full-time to the project sites

and would receive assistance from other members of the proponent organizations as well as staff members of the RHUs concerned.

COs' major concern was the identification or formation of community health-focused organizations which would be actively involved in the implementation of the PCHD-supported projects and activities. These organizations would be prepared to eventually manage the barangays' health and related activities (see Table A8). Toward this end, the planned activities also included leadership and organizational management skills training, membership value formation sessions, and skills upgrading for income-generating projects of both the organization and its members.

RHU and LGU Participation

While the bulk of PCHD barangay-level implementation tasks rested on the proponent NGOs and barangay residents, the participation of the RHUs and municipal governments concerned were also incorporated in the approved proposals. The major tasks assigned to RHUs involved the conduct of health education seminars as well as enhanced health service delivery. Through the rural sanitary inspectors (RSIs), the RHUs' technical assistance was also expected in the construction of domestic water sources and sanitary toilet facilities. (As RHU supervisor and PCHD implementor in the province, IPHO was also expected to provide technical support in the health-focused activities. IPHO and CHS assistance was also expected in the NGOs' capability building for health-focused work.) On the part of municipal governments, a major, but generally unspecified, expectation pertained to support in terms of financial or material resources, particularly in the infrastructure projects.

Profiles of Proponent Organizations

As already mentioned, one of the seven PCHD proponents in Camarines Sur was an LGU, that is, a mayor's office (del Gallego). The rest were NGOs: five were province-based groups and one was the local branch of an NGO operating in different parts of the country. The following sections describe these NGOs in terms of their history, programs, and organizational structure. Also presented is a summary of the participation of these NGOs' staffs in PCHD barangay-level implementation, including profiles of COs assigned to the study sites.

With regard to Mansalaya in del Gallego, the key person in PCHD implementation was the municipal mayor. He negotiated with IPHO and CHS for the continuance of the work abandoned by an NGO and personally supervised the implementation of the PCHD-approved proposal. He directed the active involvement of personnel of the municipal government and members of national agencies based

in his municipality, as well as Mansalaya's barangay council. Born in del Gallego, the mayor was 72 years old and first assumed the position in 1952. After a term, he served in various elected and appointed positions in the province and the region. He was elected anew as del Gallego mayor in 1988 and reelected in 1992.

History and Organization

The six proponent NGOs (Caceres Social Action Foundation, Inc. or CASAFI, Our Lady of Fatima Center for Human Development, Inc. or FACE, Libmanan Social Action Foundation, Inc. or LISAFI, Pag-Asang Bicolnon Foundation, Inc. or PAGBICOL, Philippine Rural Reconstruction Movement or PRRM, and Tawong Lingkod Para sa Katalingkasan kan Bikol Foundation, Inc. or TALINGKAS) were organized specifically for development work (see Table A9). Five had been involved in community organizing, while one (LISAFI) included this among its planned programs. This NGO which had no experience in community organizing was a newly organized group—a social action center of the Catholic Church. (This group was formed when a prelature was carved out of the province's archdiocese. Its initial staff was tapped from among the personnel of the existing social action center [CASAFI], which remained with the archdiocese.)

Five of the NGOs were organized to serve the province, while one was a two-year-old local office of a national NGO (PRRM). As of 1990, the oldest group had been operating in the province for about 20 years (CASAFI). One NGO (PAGBICOL) was organized the year before PCHD was begun in Camarines Sur while another (LISAFI) was formed during PCHD's first year in the province. All were registered with the Securities and Exchange Commission (SEC) as nonprofit, nonstock corporations or foundations.[4] Two of the five province-based groups were local social action centers (CASAFI and LISAFI) of the Catholic Church, one (FACE) was organized and managed by Catholic sisters, and two (TALINGKAS and PAGBICOL) were organized as part of, or as a result of, the social action activities of a local Catholic school.

All six NGOs covered extensive areas in the province, as viewed either in their mandates or with regard to programs they had undertaken. Five could point to existing cooperatives and people's organizations among their achievements. Three NGOs were involved in health-focused activities.

Staff in PCHD Implementation

All six NGOs had full-time staff, including COs. Three groups (FACE, PRRM and CASAFI) had between 20 and 30 full-time and part-time members in their

administrative and technical staffs in 1990; the rest (TALINGKAS, LISAFI, and PAGBICOL) had less than 10 full-time members.

In addition to the COs and persons designated as PCHD project coordinator or supervisor, most key members of the six NGOs were involved in PCHD implementation (see Table A10). These members included the organization heads, program managers, and CO supervisors and other technical staff. (For specific activities or needs, these NGOs also invited resource persons from other NGOs as well as from government agencies.)

The COs assigned to the PCHD sites were mostly females (see Table A11). In the six sites with NGOs as proponents, a total of 11 COs were fielded, with three NGOs (LISAFI, FACE, and CASAFI) retaining the same CO for the duration of the planned year-long PCHD-supported projects and activities. In two barangays, the NGOs (TALINGKAS and PRRM) each fielded a total of three COs each; in one site, the NGO (PAGBICOL) employed two COs. Of the 11 COs, two participated in the community profiling activities in connection with the PCHD proposal preparation; one of the two completed the one-year PCHD community project implementation.

Of the 11 COs, 8 were females and 3 were males. Only two (both females) were married. The oldest was 45 years old (female, married) and the youngest were 20 years old (one male and one female, both unmarried). Five were in their early 20s, with 27 as the average age.

The COs had varied college degrees, but social work graduates comprised almost half (5 of the 11). The rest had degrees in biology (2), business management (1), economics (1), and mathematics (1); while one reached a year in college. Except two, all were recruited by the NGOs for the PCHD work, including one new college graduate. The rest had some experiences in research or CO work, ranging from 1 to 10 years.

As specified in the approved project proposals, one CO would be designated full-time to the PCHD sites of the six NGO proponents. This CO would reside in the barangay project site and would receive occasional assistance from other staff members of the NGO concerned. Outside of job supervision, this assistance involved serving as facilitators and resource persons in seminars and other group sessions as well as technical aid in infrastructure projects.

The COs established residence in the PCHD sites, generally boarding with barangay officials or other key members of the community. They spent between one and nine days each visit to the barangay, averaging a total of about a week each month (see Table A10). In the case of the PRRM CO, the visits were done mostly in the company of COs of other PRRM project sites as well as other staff members,

in consonance with the organization's team approach in project implementation. In the other sites, the COs were accompanied by other members of their NGOs generally when group activities were scheduled in the barangay.

Notes

1. As part of PHDP, DOH contracted RHMs for deployment in hard-to-reach areas. While this arrangement appeared as a temporary augmentation of health manpower in selected RHUs, it was considered as a component of DOH's organizational improvement.

2. The municipal mayor of del Gallego, the proponent for the Mansalaya PCHD project, had had extensive involvement in nutrition programs, having once served as regional coordinator of the National Nutrition Council.

3. Except that for Mansalaya, the PCHD-provided budgets covered the salaries of COs; honoraria fo resource persons; field travel expenses; meals, materials, and related expenses for trainings; and costs of major materials and skilled labor for construction projects. The Mansalaya proposal did not include the services of a CO.

4. One proponent NGO (TALINGKAS) was registered with SEC shortly before its PCHD proposal was approved in 1991. This group emerged from a program of the 10-year-old Social Integration Office (SIO) of the Ateneo de Naga, a local Catholic school. SIO was an original member of the PCHD provincial partnership; its PCHD work was continued by TALINGKAS, whose key staff members were also SIO members. Unless otherwise specified, SIO's profile is used in this report.

Chapter Three

Forming Community Organizations

One aspect of the twofold objective of PCHD community-level implementation is the development of organized community health groups. As envisioned, these organizations would be identified or formed as PCHD-supported projects and activities were carried out, and would be developed to subsequently be responsible for addressing the community's health problems and needs.

This chapter begins the presentation of the conduct of PCHD-funded projects and activities in the seven study sites by describing the manner in which community health-focused organizations were formed.[1] It presents the process of identifying potential leaders who would constitute the core of the community organizations and describes the strategies and activities undertaken to enhance the leadership and management skills of these residents. It then discusses the formation and initial roles of the organized community health groups and also the participation of non-health-focused community organizations in PCHD implementation. Finally, it discusses the selection and training of volunteer community health workers, who were likewise regarded as potential community leaders in health, as well as the follow-up supervision given to these workers.

Identifying and Training Leaders

A major task carried out by COs upon their entry in their assigned barangays was the identification of residents who had the potentials for active involvement as leaders in PCHD implementation. These potential leaders were expected to be the COs' initial allies in the communities, particularly in the project planning phase. They were also looked upon as core members of the community health-focused organizations to be developed in the area.

Strategies for Selection

The potential leaders in the seven barangays were identified through various means (see Table A12). The most common process of selecting leaders were the following: (1) identified by COs and/or other staff members of the proponent organizations and later given tacit acceptance by residents, (2) volunteered participation by the potential leaders themselves, (3) nominated or suggested by the community residents, and (4) selected or elected by a group or assembly of residents. In many cases, potential leaders identified through any of the above processes were subsequently elected to formal positions in community organizations created for or as a result of PCHD activities.

The majority of potential leaders were generally identified during the initial stage of PCHD implementation, some as early as the community profiling activities. Additions or replacements came as PCHD implementation progressed. (See Box 1 and Box 2 for leadership selection process in two barangays.)

In the case of Bagadion, although the formation of a community organization was part of the plans, PCHD projects and activities were initiated through the leadership of the barangay council. Most of the activities were nearing completion when a new CO convened a meeting of active PCHD participants so that a community association could be organized. The barangay council members became automatic members of the association but were disqualified from becoming officers. The association officers supervised the completion of ongoing and other planned PCHD activities. In Mansalaya, the implementation of PCHD-supported activities was likewise managed by the barangay council. Unlike in Bagadion, however, no new organization was subsequently formed because at the outset the barangay council was considered as the organized community group which would implement the PCHD work. As planned, the council would be supported by existing area groupings as well as working committees which would be created. Election of officers for the area groupings was conducted.

In all cases, the identification of leaders took into account population size and settlement patterns. Community residents invariably suggested that leaders be selected to represent specific geographical groupings. They likewise urged the selection of more leaders for areas with larger populations or more dispersed settlements. But in Pandan, in accordance with the NGO proponent's community organizing strategy, sectoral leaders were selected (from among the fishers, farmers, women, and youth). However, the farmers and fishers' groups also took geographic area distinctions as the majority of the members of each group were in separate residential area clusters.

Box 1. Selection of leaders in Barangay Pantat

As part of its community-building strategy, PAGBICOL sought the identification of a core group of leaders that would take on major responsibilities and tasks for PCHD implementation. These leaders, aside from coordinating project activities, would be involved in problem identification, strategy formulation, and organizing.

Eight core leaders were initially identified in a general assembly on 7 March 1992 (five from Poblacion and three from Laming), and another four, in a health seminar on 6 May (three from Turo and one from Nagpatong). The core leaders agreed to meet every first Saturday of the month. Moreover, they agreed to meet regularly with residents of their respective sitio for consultation as well as for problems and needs identification in their area.

During their meetings, the core leaders identified their specific tasks: information dissemination; mobilization of residents for project participation; planning, implementation, and evaluation of PCHD activities; linkage-building with other agencies; and monitoring of the DOH immunization program. PAGBICOL provided a form which would be used in the leaders' monitoring activities. In June, the core leaders conducted a dialogue with RHM to determine ways of improving and maximizing RHU's services in Pantat.

Five additional core leaders in Poblacion and one in Turo were selected by CO herself in connection with the leadership training seminar from 31 July to 2 August. CO supervisor, however, said that attendance in the leadership training seminar did not necessarily mean becoming a core leader; however, residents perceived that one's attendance made him/her a core leader. CO supervisor tolerated this perception, claiming that this motivated the residents to become active in PCHD work. Another pair of core leaders for Turo was identified in August, and another person was chosen in December (the latter was observed to be very active at the start of the toilet and water system projects; he was also eventually chosen as the community's "para-engineer"), bringing the total number of core leaders in the sitio to seven.

In the case of Laming, the residents themselves decided to add another core leader even before the leadership training seminar owing to the sitio's large population and to the fact that one of its core leaders made frequent trips to Manila, spending at most two weeks away from the barangay. The new core leader was a more active PCHD participant than the core leaders earlier identified.

By December 1992, the rounds of selection and identification had resulted in a list of 22 core leaders in the barangay, with almost half of the number coming from Poblacion (10), and the rest from Turo (7), Laming (4), and Nagpatong (1). Of this number, 14 were still actively involved in project implementation; 8 leaders had dropped out of participation because of birth deliveries, family concerns, or employment in Manila.

The core group of leaders was involved in a leadership training-seminar conducted from 31 July to 2 August. Some leaders also participated in a vision-setting seminar held on 14 August at the residence of a core leader in Poblacion. Nine leaders (three from Turo and six from Poblacion; Laming core leaders were occupied with other obligations) formulated a vision of their organization and the community. They envisioned a strong organization with full participation and cooperation of each member.

Box 2. Selection of leaders in Barangay Penitan

During the home visits she conducted in July 1992 and subsequent months, CO sought residents whom she believed were interested in PCHD activities and were perceived to be honest, disciplined, and responsible. In October, she called a meeting of the persons she had identified. The group, numbering 14, was considered as the core group of leaders who would assist CO in PCHD implementation. The leaders then decided to select from among themselves an ad hoc president, who would be responsible for assisting CO in disseminating information on PCHD. They considered selecting a public information officer, but shelved the idea until a bigger group was formed. They also agreed that barangay council members could become members of the core group but could not be elected as officers so that dual leadership positions could be avoided.

In the same October meeting, the core leaders decided on a name for their group. Among several suggestions, the name *Kapit-Bisig sa Kaunlaran at Kalusugan ng Penitan* (KBKKP; literally, hand-in-hand for the progress and health of Penitan) was adopted. On 26 November, the core group met to select its officers and discuss the recruitment of members. Upon CO's suggestion, six individuals were chosen as the core officers. Each of the six was tasked to recruit 10 members. No area of coverage was assigned to the leaders in the recruitment of members.

In February, CO and the core leaders decided that each officer would recruit only 7 instead of 10 members. The leaders were also asked to submit a list of the residents they had recruited. The submitted lists came up with a total of 45 members. On 23 March, KBKKP was formally organized with the election of officers. This meeting was attended by 23 residents. Through raising of hands, the attendees elected a set of officers composed of a president, two vice-presidents (one for the barangay proper and one for Sitio Punta), secretary, treasurer, auditor, public information officer, two business managers, two sergeants-at-arms, and a muse and escort. The barangay captain and his wife were chosen as the organization's muse and escort. The ad hoc president was elected president of KBKKP.

The organization met on 4 April for a vision-setting activity. The group articulated that its vision was to create a group which had faith in God and trust in others. It would cooperate in the implementation of projects and activities for community development. During the activity, the participants also reviewed the list of members and declared that 37 individuals, who were actively participating in project activities, comprised the organization's members. Moreover, CO informed the group that the vice-president and secretary had exchanged position. This was decided on in the leadership training seminar held from 31 March to 2 April, during which the vice-president realized that her position would require her to be present everytime visitors came, an expectation which she would have difficulties fulfilling because of the distance of her residence from the barangay center. She then approached the association secretary, who readily agreed to swap positions with her after he himself realized that his position involved being able to write fast during meetings, which he admitted he was not capable of because of his age.

The number of leaders chosen in each site ranged from a total of 10 (Pandan) to 46 (Ibayugan). These gave the residents of the selected barangays with a leader for every 6 (Cabinitan and Ibayugan) to 26 (Pandan) households. The figures, however, could not entirely be taken as leader-member ratios as the leaders often served as the only participants in most PCHD-related work, including those planned as barangay-wide activities. (The 10 leaders from Pandan were the elected officers of a consolidated association of sectoral groups. Thus, the total number of Pandan leaders would be much higher and would yield a higher leader-member ratio.)

Profile of Leaders

In the seven study barangays, a total of 136 residents were identified as potential leaders of PCHD-supported activities (see Table A12). The majority of the leaders were males: 85 (62 percent) versus 51 (38 percent). Only in one barangay (Penitan) did the female leaders outnumber their male counterparts (8 versus 5). The leaders were mostly married, with ages ranging from 21 to 73 years. The majority (53 percent) were between the ages 30 and 49.

The PCHD leaders were also current leaders or had occupied leadership positions in other community organizations as well as in their barangay councils. In sites where barangay council members were not barred from leadership positions in the PCHD-initiated group, many of the PCHD leaders were also incumbent barangay council members. In Bagadion and Pandan, the barangay council members were deliberately excluded from organization leadership positions.[2] They were, nonetheless, encouraged to become association members.

The leaders belonged to households which were engaged in the major livelihood activities in their respective barangays. Most completed at least the elementary grades; not one finished a college degree although a handful reached a few years in college.

In the selection of potential leaders, COs made it known to community residents that those to be chosen should be individuals with recognizable skills, commitment, and interest to lead group activities. COs likewise emphasized the need for leaders to have available time, a quality also widely endorsed by community residents. As PCHD implementation progressed, the demand for the leaders' time became apparent and produced dropouts.

Leadership Enhancement Activities

The training of potential leaders was an activity incorporated in all PCHD-approved proposals, except that for Mansalaya. In four cases (Bagadion, Ibayugan,

Pantat, and Penitan), formal training sessions outside the barangay constituted the core of the leadership training activities (see Table A13 and Box 3). In one instance (Pandan), the leaders' training was held in the barangay and included other residents (see Box 4); while in another (Cabinitan), the planned training had yet to be undertaken.

The off-site leadership training sessions took at least two days. In two barangays (Bagadion and Pantat), a three-day seminar was given; while in one barangay (Ibayugan), two two-day sessions; and in another (Penitan), two three-day sessions. The training sessions also included leaders of other PCHD target sites of the proponent NGOs, except in the case of Bagadion. (The latter's proponent NGO had yet to begin its work in its other PCHD sites when the Bagadion leadership training seminar was held.)

Residents of the study sites who attended the training sessions held outside their barangays numbered from 5 (Penitan) to 28 (Ibayugan). In all cases, the number of leader-attendees was much smaller than the total number of leaders (less than half). While the leadership training sessions were organized for the identified leaders, other residents were encouraged to participate. This took place particularly when the identified leaders were unavailable for the activities and, thus, provided slots to interested residents. In Pandan in which an onsite leadership training was held and made open to all residents, the number of participants reached 61.

Staff members of the NGO proponents concerned conducted the leadership training seminars. These included the COs assigned to the study barangays as well as COs of other PCHD sites. COs, who generally served as overall facilitators, usually stayed for the duration of the seminars, while other staff members came to act as discussant-facilitators of specific sessions. In the training seminar for one site (Pantat), IPHO members (PDO and the chief of the technical division) and officials of selected cooperatives in the province were invited as resource persons.

The training seminars involved lecture-discussion and small group dynamics sessions, with a liberal dose of "energizers" and "unfreezers." The topics taken up included types, qualities, roles, and functions of leaders; and skills required in mobilizing community participation, and organizing and conducting meetings. The seminars were also occasions for the leaders to formulate their visions and goals for their organizations and their communities. As part of the Pantat seminar, the participants visited offices of two cooperatives in the province and engaged the leaders of these groups in experience-sharing sessions.

In addition to their participation in formal training sessions, the leaders were assisted in honing their leadership and management skills through their involvement

Box 3. Leadership training seminar in Barangay Penitan

The seminar took place on 14-15 November 1992 at the FACE session hall. FACE's PCHD project manager, Ibayugan CO, and COs of two other FACE sites served as the facilitators and resource persons. In addition to the Ibayugan participants, who numbered 28, there were 12 participants from Del Rosario in Bato.

The first day of the seminar formally started at 10:30 a.m. with the introduction of the FACE staff and participants. This was followed by CO's overview of the seminar, expectation setting, and review of the basic leadership training seminar held on 8-9 August. Lunch followed at 12:10 p.m.

A small planning workshop took place at 1:30 p.m. The participants were grouped into three (one group for Del Rosario and two for Ibayugan). FACE instructed the groups to illustrate their visions/dreams for their barangay for the next five years. The workshop output reports showed the Ibayugan groups listing such visions as having a public toilet, office for its organization, barangay hall, potable water system, fish cages, school, social hall, chapel, handicraft office, roads, and barangay health station.

The workshop was followed by CO's discussion of the ideal qualities and characteristics of an organization and its members. CO then gave the participants from Del Rosario the remaining part of the day to rest. (They hiked from their barangay to the town center, where passenger jeepneys were available.)

While the Del Rosario participants were resting, the Ibayugan residents met with their CO for a planning session. The activities agreed upon included (1) the establishment of a potable water system by November; (2) formulation of the organized group's constitution and bylaws and the finalization of members' profiles; (3) coordination with RHU for the toilet construction project; (4) monthly conduct of activities for a zonal vegetable gardening project; and (5) construction of the organized group's office. The group also decided that in addition to FACE, the residents, barangay council, and RHU would be tapped as resources in the implementation of the water system and toilet construction projects.

The second day of the seminar began at 8:10 a.m. with a liturgical session led by the FACE novices. This was immediately followed by CO's summary of the previous day's activities. FACE associate director gave a short message on the importance of an organization and cooperation among people, emphasizing that the PCHD project was a joint undertaking of NGOs, government agencies, and the people. She added that spirituality in the organization and community would lead to a holistic approach to project implementation. Before ending her talk, she commended the participants for having been chosen as barangay leaders.

Two more topics (organization management and importance of project monitoring) were subsequently discussed. With regard to an organization, the facilitators expounded on its definition, elements, values, functions, and constraints. They likewise discussed the responsibilities of officers and members of an organization.

At the end of the seminar, an evaluation of the topics, facilitators, and participants took place. Certificates of attendance were awarded to all participants before the activity ended at 3:20 p.m.

Box 4. Leadership and management training in Barangay Pandan

A two-day training on basic leadership organization and management was conducted by PRRM for Pandan Sectoral Association (PSA) officers and members on 19-20 August. It was held at Sabang chapel and attended by 61 officers and members on Day 1 and 59 on Day 2. The facilitators from PRRM included the area coordinator (AC), three COs, and a community health nurse (CHN).

The training began at 10:00 a.m. with an invocation led by a PSA member. This was followed by AC who gave a brief account of completed projects and explained that the training was being held as part of the training of new members. Expectation setting and introduction of PRRM staff followed at 11:00 a.m. After an energizer, CO presented the objectives and outline of the training. The participants then copied the objectives and topic outline in the notebooks provided by PRRM. Lunch was served at 12:15 p.m.

The session resumed at 1:23 p.m. with CHN as facilitator. The participants were grouped into two. Each group chose a member who would be adorned with materials representing the qualities of a good leader. The participants used an assortment of materials, including a bicycle to represent mobility and speed, and notebook and pen to symbolize intelligence. CHN facilitated the interpretation of the participants' outputs, which was followed by a discussion of the definition and characteristics or qualities of a leader. After another energizer, the topic "proper leadership" was tackled. The election of new PSA officers which was planned for Day 1 was postponed for the next day because of the lack of a quorum. Day 1 ended at 5:45 p.m.

Day 2 began at 8:45 a.m. with the election of PSA officers. Before the elections, a PSA member suggested that the new officers' term be extended to two years. AC said that the suggestion would be discussed by the new executive committee. The election of new PSA officers took place. The president, vice-president, and treasurer were reelected, while two more positions were filled (auditor and public information officer).

The training resumed at 10:00 a.m. A discussion on managing an organization took place. CO explained the processes involved in handling a meeting, such as facilitating, planning, and agenda setting. A role playing on how to conduct a meeting was done by seven volunteers. AC then asked the other participants to give their observations. A discussion on how to conduct a meeting and convene an assembly followed. Lunch break at 12:00 p.m. ended the morning session.

In the afternoon, the importance of communication was given focus. The rest of the topics in the course outline: organizing (definition, importance, and functions of an organization), role of organizations under the local government code, and elements of an organization (orientation, members, leaders, committees, and resources) were also discussed. AC emphasized that people's organizations, as members of the barangay development council, could take part in the planning, decision-making, and implementation process. After an evaluation of the training and a short break, the graduation of participants was held. The newly-elected PSA officers gave their messages. AC and the barangay captain then handed the certificates of attendance. A prayer from one of the officers and AC's closing remarks ended the activity at 5:00 p.m.

in PCHD work. With COs' guidance, the leaders met to plan or assess activities, some were asked to preside over barangay meetings, and others were made to organize and facilitate echo seminars of the training sessions they had attended. (In the case of Mansalaya, the leaders held regular onsite monitoring and evaluation sessions with the municipal mayor and other municipal-based officials.)

Organizing Community Health and Other Groups

The selection of potential leaders was closely connected to the formation of community organizations whose major initial focus was the implementation of PCHD-supported projects and activities. Except in the case of Pandan, the leaders served as the core of the groups which would mobilize other residents in the PCHD work. In Pandan, the NGO proponent's organizing strategy emphasized the formation of sectoral groups. Moreover, the proponent's work in the barangay went beyond PCHD and health concerns, with a number of activities preceding the start of the PCHD-funded projects.[3] The implementation of the PCHD-supported projects thus became one of the initial activities of the consolidated association of organized Pandan sectoral groups which had for some time been engaged in non-health-focused work.

In four sites (Bagadion, Ibayugan, Pantat, and Penitan), the community groups engaged in PCHD implementation were formalized into barangay-wide or broad-based organizations. In one case (Cabinitan), the initial core group of leaders had expanded to include more barangay residents but it had yet to be formally organized into an association. In another barangay (Mansalaya), PCHD implementation was undertaken through the barangay council which, in turn, organized and mobilized area *rabus* (voluntary work) groupings.

The formation of the organizations did not take long after the COs' entry or the PCHD launching (see Table A14). In Pandan, basic sectoral groups were organized about four months following the COs' entry in the barangay; the consolidated association was organized seven months after all the sectoral groups had been formed. The Ibayugan association was organized three months after the CO began PCHD work in the barangay. The Penitan and Pantat groups were formally organized seven and eight months, respectively, after the PCHD formal launching in the barangay. The Bagadion group likewise was created eight months after PCHD's start. But it took only about a month for a newly deployed CO to initiate the formation of the Bagadion organization which subsequently took over the PCHD work from the barangay council.

(As already mentioned, the Mansalaya experience in the formation of community organizations for PCHD implementation took a different process. Under the

supervision of the mayor's office, which was the PCHD project proponent, the barangay council served as the barangay-level implementor. The council, in turn, divided the barangay residential clusters into zones. A council member was designated supervisor of each zone, with a teacher from the barangay elementary school assigned as zone adviser. The zones elected their own set of officers who would take charge of mobilizing the residents for participation in zone-specific PCHD-related activities. Thus, all barangay residents were considered as members of their respective zone associations. The barangay council members and zone officers constituted the committees formed for non-zone-specific activities, such as the domestic water system construction.)

Objectives and Areas Covered

The community organizations formed in five sites were considered as barangay-wide groups, that is, all residents were qualified to become members. In one of these sites (Pandan), membership in the organization was through the sectoral groups; while in the other sites, the recognized residential clusters guided membership recruitment. The COs' active areas of operation, generally the barangay center or main built-up area and nearby residential clusters, thus provided the leaders and members of the organized groups.

The organized groups took broad, multi-issue development goals and objectives. The names given to the organized groups, except the one in Ibayugan, carried names which reflected the residents' concerns which went beyond community health problems and needs. The names of the associations in Bagadion and Penitan carried local words for "progress" or "development" while that in Pandan had a generalized name, "Pandan Sectoral Association." In one meeting, leaders and members of the yet-to-be named Pantat association agreed that they would try to come up with an association name which would have the word "Promesa" (promise) for an acronym. The Ibayugan group, in spite of its limiting name (*Samahang Pangkalusugan ng Ibayugan* or Health Association of Ibayugan), had nonetheless drawn up a vision which included non-health development concerns.

Leaders and Members

While it was easy to identify leaders of the organized groups, it was not so with regard to the members. Membership lists had not been either prepared or updated. Active participation in PCHD-supported activities was generally used by the leaders and COs in considering whether or not a resident was an organization member. There had been efforts, however, to solicit the residents' volunteered preference to

become organization members as well as to review the residents' membership status. In Penitan, the core leaders were tasked to recruit 10 members each. They later reviewed the submitted lists to come up with a list of active organization members. In Ibayugan, the association distributed membership registration forms to residents; it planned to make the issuance of membership certificates dependent on the submission of completed forms.

As seen from Table 4, the core group of leaders comprised the bulk of the organization members. In all cases, the number of members of the organized groups did not exceed a third of the households in the selected barangays. Except in the case of Pandan where sectoral organizing was employed, most of the organization members were residents of barangay centers and nearby areas and were active participants in PCHD-supported activities.

PCHD Participation and Other Activities

As earlier pointed out, the identified potential leaders and the organizations which were subsequently formed were regarded as the core group which would manage the implementation of PCHD-supported projects and activities. This was realized except in the case of Bagadion in which initial PCHD-supported activities were undertaken through the barangay council. Nonetheless, the association which was created later was composed of those active in the PCHD work, including the barangay council members. (As explained above, in Mansalaya the barangay council was looked upon as the community organization which would implement PCHD in coordination with rabus groups; the creation of a new community organization was not part of the plans.)

Except the Pandan association, the NGO-organized groups immediately focused their attention on the PCHD-supported activities. This may be attributed to the fact that the major funding for the proponent NGOs' presence in the selected sites was from PCHD. Association leaders were thus the recipients of leadership and organization-management training seminars. They were also active in mobilizing the participation of residents in community-building seminars, health education sessions, and other group meetings. Moreover, the leaders were involved in selecting sites for such projects as construction of domestic water sources and health centers; establishment of herbal and vegetable gardens; and installation of communal toilets. In the case of toilet bowl provision to individual households, leaders were likewise tapped to identify the household-recipients (see Chapter Four for a discussion of these health-focused activities).

Organization members were mobilized to render voluntary labor in construction activities as well as to provide locally available materials (such as bamboo poles,

Table 4. Leaders and members of PCHD-organized community groups in selected Camarines Sur sites, 1991-93

Barangay	Leaders[a]			Members	
	Total	Male	Female	Number	HH Percent[b]
Bagadion	11	8	3	25	11%
Cabinitan	17	12	5	36[c]	34
Ibayugan	46[d]	33	13	membership recruitment was still ongoing at end of study period	
Mansalaya	17	13	4	no barangay-wide organization was formed; all residents were considered as members of their respective rabus groups which assisted the barangay council in PCHD implementation	
Pandan	10[e]	7	3	100[e]	31
Pantat	22	7	15	31	16
Penitan	13	5	8	37	22

[a]The figures indicate the total number of leaders identified as of the end of the study period, including those who were becoming inactive or had dropped out of active PCHD participation.

[b]The percent is based on the number of households before the PCHD launching (that is, 1990 or 1991) and assumes a one-person membership per household. Leaders are also included in the membership total.

[c]The membership size pertains to the members of the core group which had yet to be formalized as an organization. These members held positions in committees organized for the implementation of PCHD-supported activities. Another group, composed of 17 female residents, was formed following a series of livelihood training seminars for women initiated by the proponent NGO in coordination with the local mayor's office. The group was named *Samahang Pangkalusugan at Pangkabuhayan ng mga Kababaihan ng Barangay Cabinitan* or SAPPKA (Association for Health and Livelihood of the Women of Cabinitan). The group's initial activity was capital build up for a planned conversion of the association into a cooperative.

[d]The number includes the selected leaders from residential zone groupings which, in turn, elected a four-person set of officers for the barangay-wide association.

[e]The number of leaders indicates the officers of the umbrella organization of the basic sectoral units; the membership size, the total number of members of the sectoral groups.

lumber, sand, or gravel) for the construction needs. Members and leaders likewise contributed cash or food items for meals or snacks during meetings, seminars, construction work, and other group activities. They were also invariably requested to be on hand to welcome PCHD-connected visitors.

The participation of organization leaders and members as well as other barangay residents in some PCHD-funded construction activities, however, also resulted in cash income for a number of them. Some residents with special skills (e.g., carpentry or masonry) received small cash compensations for their work in construction projects. (Outsiders were hired in case the needed skills were not available in the barangays concerned.)

Other Community Organizations

In three (Pandan, Cabinitan, and Bagadion) of the seven sites, community groups in addition to those specifically formed for PCHD participation were organized as a result of the work of the proponent NGOs (see Table A15). Moreover, during PCHD's implementation period, other groups (GOs and NGOs) were undertaking activities which also resulted in the formation of community organizations. In addition to the PCHD-related organizations, groups were formed in the selected sites except in Pantat (see Table A19). A total of 13 organizations were formed: four (Cabinitan and Pandan) through the assistance of government agencies and six (Bagadion, Ibayugan, Mansalaya, and Penitan) through the work of other NGOs. In addition, three groups were formed through the initiatives of the residents themselves (Ibayugan and Cabinitan). None of these groups became involved in PCHD activities.[4]

The organizations formed as a result of the work of the proponent NGOs in the selected PCHD sites included the Pandan basic sectoral units and their corresponding consolidated groups. During the more than three-year period covered by this study in Pandan, five fishers' units and a united fishers' group, a women's organization constituted from two groups, a farmers' organization, and a barangay-wide association composed of the sectoral groups were organized. (A youth organization was also in the process of consolidation.) The fishers' groups undertook livelihood-improvement projects, using loans provided by the NGO. Selected organization leaders and members received various training activities. Moreover, the sectoral groups were involved in the formation and activities of municipality- or region-based federations, which were also being assisted by the NGO.

In Cabinitan, a women's group was formed through the assistance of CO. Linking up with the local municipal mayor's office, CO was able to arrange for livelihood (handicrafts) training of selected female residents. The trainees subsequently

organized themselves into an association. With 17 initial members, the association started savings and capital build up activities as part of a planned transformation into a cooperative.

In Bagadion, the 21 attendees in a PCHD-planned primary health care seminar decided to form a "mothers' group" upon the suggestion of the RHU personnel who served as lecturer-discussants in the seminar. The group went as far as holding a graduation ceremony and induction of association officers. However, it had not engaged in any other activity nor planned for one. Also in Bagadion, COs worked with an existing youth group in an effort to revitalize and mobilize it for PCHD participation. Leaders and members of the youth association assisted in the domestic water project and attended PCHD-convened barangay meetings. They refused, however, the CO's invitation for the group to take over a bio-intensive gardening project for fear of offending their elders.

In the rest of the selected barangays (Ibayugan, Mansalaya, Pantat, and Penitan), no efforts were made to involve in the PCHD work any of the community organizations existing prior to PCHD implementation. As discussed in Chapter Two, at least four active community organizations were found in each of these sites when PCHD implementation was begun. Many of these organizations, which were formed either through external assistance or local initiatives, were barangay-wide or broad-based groups.

Training Community Health Workers

In three barangays (Cabinitan, Pandan, and Penitan), the identification and training of community volunteer health workers was a component of the approved PCHD-supported activities. As planned, health workers were selected in these sites and received training.

The project proposal of another site (Bagadion) indicated that the core group of leaders were to "function as barangay health workers or indigenous organizers in the barangay." The identified leaders, however, were not given specific training for tasks required of community health workers. Neither was it underscored to these leaders that they would be expected to play the roles of health workers. But most of them, along with other residents, attended a two-day primary health care seminar. In this seminar, the Bagadion RHM encouraged one of the female participants to volunteer as a barangay health worker. The resident was later asked to attend an orientation and training seminar for barangay health workers at the district health office. Since then, the resident had been assisting RHM in her work in the barangay, particularly during the latter's almost weekly visits for immunization, consultation, and treatment.

It should be noted that before PCHD's entry to the seven sites, five barangays (Cabinitan, Ibayugan, Mansalaya, Pandan, and Penitan) had active government-trained barangay health workers. Three barangays (Cabinitan, Pandan, and Penitan) had two workers each; Mansalaya had one while Ibayugan had eight. Only the Cabinitan barangay health workers were integrated in the PCHD-supported health workers' training in three of these sites.

Selection of Health Workers

COs played key roles in the identification and selection of residents who would be trained as community health workers (see Table A16). As in the selection of potential leaders, COs emphasized not only a willingness to serve the community but the need for available time from the chosen health workers. Thus, residents were encouraged to volunteer their services or to assist in recruiting volunteers. A total of 21 residents were selected as health workers in the three sites: 5 in Cabinitan, 11 in Pandan, and 5 in Penitan. These figures translated to a ratio of one health worker for about 21, 24, and 34 households, respectively.

In Cabinitan, selected residents were invited to a three-day *hilot* (birth attendant) training-seminar conducted in the barangay. Attended by 19 female residents, the seminar was understood to be used as an occasion for identifying the barangay's health workers whose major tasks concerned care of pregnant women and child delivery. (Hilot kits—containing two pairs of scissors, a thermometer, a pair of surgical gloves, a stethoscope, and a sphygmomanometer—were later distributed by the NGO proponent to the selected health workers.) The Cabinitan RHM, who served as the main training facilitator, selected five individuals from among the participants after giving an examination on the last day of the seminar. The selected health workers were composed of a traditional healer, two wives of barangay council members, and two barangay health workers who had been working with RHM prior to PCHD implementation. All five selected health workers were married, with ages ranging from 27 to 52 years. All finished at least the elementary grades, with one completing a year in college.

In Pandan, 11 individuals (eight females and three males) were identified from resident-volunteers as well as from recruits of initial volunteers. At least one health worker resided in each of the barangay's household clusters; six were residents of the most dispersed residential area. The health workers' ages ranged from 18 to 59 years. Eight were married, while three were single and still in school. One was a practicing traditional healer and two professed to have some knowledge of traditional healing. One of those still studying was a female midwifery student. All were active members of community groups formed by the proponent organizations.

In Penitan, three of the five community health workers (four females and one male) were selected by CO from among the initial core leaders of the PCHD work; two were chosen by the residents through election. Four of the health workers were subsequently elected association officers when the core group was formalized into a community organization. All five were married, with ages between 31 and 57 years. The male health worker had attained the highest education, reaching a year in college. Two were elementary graduates, while two finished high school.

Formal Training Sessions

The volunteer community health workers received a three-day basic training seminar. Staff members of the RHUs concerned conducted the seminars for the Cabinitan and Penitan health workers. For the Pandan health workers, the health team of the proponent NGO provided the training, which was also attended by selected health workers from its other PCHD target barangays as well as other program sites.

In addition to attending the initial three-day hilot seminar, the Cabinitan health workers were given three half-day sessions by RHM. These were focused on growth monitoring, oral rehydration, breastfeeding, immunization, and herbal medicine (GOBIH training). Like the three-day seminar, the sessions were conducted in the barangay, with CO's assistance.

The Pandan health workers' group participated in two three-day training seminars held outside the barangay and attended also by selected health workers from other project sites of the proponent NGO. The first seminar was a basic health skills training (see Box 5), while the second focused on first aid and home nursing care. After the second seminar, the Pandan health workers conducted a medical clinic in the barangay as a practicum. They were supervised by the proponent NGO's health and other staff members who also brought medical and related supplies.

For their part, the Penitan health workers went through four three-day training seminars which were conducted at the town center and also attended by volunteer health workers from two other PCHD sites in the municipality. The NGO proponent's staff members assisted RHU personnel in facilitating the seminars.

Common to the training seminars conducted for the health workers of the three barangays were lecture-discussion sessions on common diseases, maternal and child health, nutrition, first aid, and herbal medicine. Also taken up in these seminars were the roles and tasks of community health workers. The seminars also included demonstration or hands-on sessions as well as small-group workshop sessions. In the case of Pandan, the seminar also incorporated discussion sessions on the national health situation and concepts of health and illness.

Box 5. Community health workers' basic training in Barangay Pandan

On 19-21 April, PRRM conducted the first health skills training of volunteer community health workers. Eleven residents (nine females and two males) from Pandan attended the training seminar. In addition to the Pandan health workers, there were also participants from other PRRM-PCHD sites (nine from Sipocot and six from Pamplona) as well as other PRRM project sites (three from San Fernando). Present throughout the training were PRRM staff members composed of a doctor, two community health nurses, Pandan-CO, and Pamplona-CO.

The seminar's schedule was announced to some of the residents during the basic health orientation in Pandan in March. PRRM also asked the residents to tune in to a radio station during its 9:30-10:00 a.m. broadcast for announcements. (A participant heard the announcement on Sunday, 18 April.)

The training officially began on 19 April, though some participants, including the Pandan group, arrived in the afternoon of 18 April. A getting-to-know-each-other session took place in the evening as well as a discussion of expectations.

Day 1, 19 April, started at 8:30 a.m. with a review of the past night's activities and the introduction of newcomer-participants. This was followed by the presentation of expectations and assignment of tasks. An outline of the training was also given. (PRRM provided a pen and notebook to all participants.) The first session was a review of the topics discussed during the basic health orientation. It also included an overview of the national health situation and a discussion of the functions of community health workers. The participants then discussed modern and traditional concepts of health and diseases.

A forum on traditional practices of disease management followed. The participants then undertook a role-play of traditional healing practices (*pagbuga* or to chew and apply betel nut and *santigwar* [ritual healing] for *nausog* and *naibanan* or affliction perceived to be caused by supernatural and unseen spirits). In the evening, a plenary discussion and workshop on health maintenance and disease prevention took place. Participants were provided with old magazines and art materials with instructions to use cutouts or to draw their definition of good health. After the reporting of the results of the workshop, a lecture on personal hygiene (definition, importance, ways and practices of personal hygiene maintenance, and importance of personal habits) was given by one of the nurses. A brief discussion on mental hygiene, environmental sanitation, and dental hygiene followed. Day 1 ended at 10:00 p.m.

Day 2 began at 8:50 a.m. The other nurse gave a lecture on the use of herbal or medicinal plants and rational drug use. Another small group activity followed. The participants were asked to go out of the room and gather medicinal plants within the training center's compound. Some participants returned with leaves of sampaloc (*Tamarindus indica*), cogon (*Imperata cylindrica*), atis (*Anona squamosa*), and takip-kohol (*Centella asiatica*). The participants shared their knowledge on the medicinal use of each plant. The activity was followed by another lecture by the nurse. It involved a presentation of the national situation, including the government's expenditure for the purchase of pharmaceutical drugs. The lecture also emphasized the use of herbal medicines as an

Box 5 (cont.)

economical and effective alternative to drugs, and thus, the need to maximize the use of herbal plants available in the community. The rest of the morning was spent discussing the proper ways of preparing herbal medicines, including the collection of plants and storage.

In the afternoon, the doctor led a demonstration on preparing herbal medicines. The participants were divided into three groups. Using leaves of sampalok, luya (ginger, *Zingiber officinale*), and kalamansi (*Citrus microcarpa*), Group 1 prepared SLK (sampalok-luya-kalamansi), a medicine for cough and colds. Group 2 prepared BLS or bawang (garlic, *Allium sativum*)-luya-sili (chili, *Capsicum frutescens*) for rheumatism and painful joints. Group 3 prepared kanda ointment out of kanda leaves for skin diseases and fungal infection. Luya powder or "instant salabat" was also made by the participants for treating sore throat, cough, and colds. Each group gave a report on their respective herbal preparations.

In the evening at 7:00, a workshop was handled by the nurse. The participants were asked to define malnutrition using the drawing materials which were provided by PRRM. The workshop was followed by a discussion of malnutrition (including its definition), emphasizing the susceptibility of malnourished persons to various diseases.

A lecture on nutrition (definition and importance to health) followed. The nurse also introduced the three food groups (protein, carbohydrates and fats, and minerals and vitamins), and discussed the functions and sources of each group. Tips on food selection and preparation were also given.

Immunization was discussed briefly. The nurse enumerated the vaccines against preventable diseases (BCG for tuberculosis, DPT for diphtheria and pertussis, OPV for polio, and vaccines for measles, tetanus toxoid, and hepatitis B). The discussion ended the day at 10:00 p.m.

Day 3 began at 9:00 a.m. with the doctor's lecture on family planning, which covered reproductive organs and birth control methods. The doctor pointed out that a woman could have the temporary method of contraception using IUD, condom, pills, diaphragm, and injection. He also mentioned the permanent methods of contraception, that is, ligation and vasectomy.

At 2:45 p.m., planning for the activities of each group (that is, barangay) took place. The Pandan group (facilitated by the female nurse) planned on (1) forming a barangay health committee, (2) conducting an echo seminar of the basic health skills training, and (3) holding a barangay medical consultation session.

In the evening, a program was held for the "graduation" of participants. PRRM's assistant branch manager was present to award the participants' certificates of attendance. A celebration, which lasted until 11:00 p.m., followed the ceremony. PRRM also announced that another health skills training would be conducted, although no date had yet been set.

In the morning of 22 April, after CO had reimbursed the transportation of one participant, the Pandan group returned home.

Followup and Supervision

No substantial data on the follow-up training and regular supervision of the community health workers were available as the workers' selection and basic training sessions came toward the end of the study period. What was evident, however, was the role of RHU personnel, particularly the RHMs concerned, in the training of community health workers in Cabinitan and Penitan. In these sites, the staffs of the RHUs concerned, including MHOs, PHNs, and RSIs, served as lecturer-discussants or resource persons in the health workers' training seminars. Moreover, the RHMs concerned subsequently sought the assistance of the newly trained health workers in delivering health services in the workers' respective barangays, an activity which could be considered as partly serving the need for follow-up supervision. (This relationship between the RHMs and the health workers was found in Mansalaya and Ibayugan in which active barangay health workers were present prior to PCHD implementation, as well as in Bagadion where a new barangay health worker was identified and trained during the PCHD work.)

In Cabinitan, the newly trained volunteer health workers were affiliated with a municipality-wide association of barangay health workers. This organization met monthly with the RHU staff, during which discussions on the health workers' activities as well as review lectures took place.

In Pandan, the linkage of the newly trained community health workers with the RHU and the existing barangay health workers was quite unclear. This could be gleaned partly from the absence of RHU participation in the training of the health workers and their subsequent activities. Moreover, in the initial stage of PCHD implementation, IPHO suggested the merging of the existing RHU-trained barangay health workers and the community health workers to be identified and trained under the PCHD project. The NGO proponent, however, rejected the suggestion, explaining that the health workers it would identify and train would be involved not only in health-focused activities but in other community concerns as well, including livelihood-improvement projects.

The trained Pandan health workers were eventually organized into a group with a chairperson and assistant chairperson. They were subsequently supported by the NGO proponents' health team in conducting a one-day barangay medical clinic (which also served as their training practicum). During the clinic, the residents, particularly the family planning acceptors, were informed that they could obtain their supplies as well as other medical and related supplies from the health workers who would, in turn, request token contributions for their group's fund. At the end of the study period, the health workers' group was planning a livelihood project. (Meanwhile, the RHU concerned also recruited additional barangay health workers. These

workers, numbering seven including two original barangay health workers, were subsequently given training by the RHU staff. They later assisted the Pandan RHM in conducting activities for the national immunization day.)

Notes

1. The reference to health-focused community organizations is aimed at emphasizing the direct and immediate link to health concerns of the groups formed through the initiatives of PCHD proponents or in connection with PCHD-supported projects and activities. It does not disregard the long-term expectations that these organizations must eventually become multifaceted or integrated resource managers in order to be able to effectively address community health needs and problems (see Chapter 5).

2. As explained elsewhere in this Chapter, the exclusion of Bagadion barangay council members from leadership positions in PCHD work came during the election of officers of a community organization which a new CO initiated eight months after PCHD's launching. Before that, the barangay council was managing PCHD implementation.

3. Pandan was part of the area covered by PRRM's sustainable district program. Undertaken in inaccessible barangays in four contiguous municipalities, the program involved sectoral community organizing, integrated economic development activities, and delivery of social services. The PCHD-supported projects and activities in selected sites were considered as augmentation of the ongoing health-focused work.

4. Some of the non-PCHD-related groups formed in the study sites also became engaged in group projects or activities (see Chapter Four).

Chapter Four

Pursuing Health-Focused and Other Projects

Common to the PCHD-supported plans for the seven barangays were the conduct of health education seminars for households, provision of sanitary toilets, installation or improvement of domestic water sources, and establishment of vegetable and herbal gardens. In two sites, the construction of health centers was included among the funded activities; while in one site, the provision of food supplements for malnourished children was also incorporated in the PCHD plans. (As discussed in Chapter Three, the training of community health workers was likewise part of the health-focused plans in four barangays.)

This chapter describes the manner in which PCHD-supported health-focused projects and activities were undertaken. Given particular attention in the discussion is the participation or contribution of community members in the conduct of these activities as well as the role of the proponent organizations and other participating groups in mobilizing this participation. Also discussed are health-related and other activities which were added to the PCHD-funded projects for the study barangays, as well as other development work initiated in the barangay by other groups during PCHD's implementation period.

Providing Health Education and Services

The conduct of health education seminars for household members was similarly included in the PCHD-approved proposals for the seven study sites (see Table 3 and Table A8). The seminar plans varied in their intensity and coverage in terms of topics on basic health and nutrition as well as the number of target households. These plans, however, constituted the least completed among the proposed activities (see Table A17 and Table A18).

As contained in the proposals, the health education seminars would involve from at least a total of 6 days (Bagadion) to 15 days (Cabinitan and Pantat). A total of 10 days of seminars would be conducted in another barangay (Penitan) while once- and twice-a-month sessions during the year-long PCHD implementation were planned for two sites (Ibayugan and Mansalaya, respectively).

The Pandan proposal did not specify the number of days to be taken up by the health education sessions but indicated four key topics to be covered: environmental sanitation, value formation, nutrition education, and family welfare. For Bagadion, the planned seminar topics included primary health care orientation, nutrition education, maternal and child care, and family welfare; for Cabinitan, Pantat, and Penitan, the planned sessions would cover nutrition, maternal and child care, common illnesses, first aid, environmental sanitation, herbal gardening and medicine, and responsible parenthood. Except in Pandan, at least half-day sessions were planned for each of the topics.

Seminar Venue and Schedule

The health education seminars were held in the barangay, in a centrally located area such as the elementary school or barangay chapel. These venues were mostly rooms or structures which hardly afforded the participants with comfortable accommodations for a "classroom" learning situation, and the facilitators, with supportive facilities. The rooms also allowed participants to freely go in and out. In cases of big attendance, these venues also required sound systems, which either were not available or there was no electricity in the barangay. During such big gatherings, some participants were observed listening to the proceedings outside the venue or engaging in their own discussions.

The seminars were organized as barangay-wide activities, that is, all households in the barangay were welcome to send their representatives. As it turned out, the location of the seminar's venue as well as the COs' specific areas of operation in the barangay readily became the places from which most attendees came. (As pointed out earlier, not all residential clusters in the target barangays were covered by the PCHD work. At best, the main built up area and clusters close to it were reached by the COs' activities.)

The schedules of the health education seminars were largely determined by the COs and the core group of leaders. In many instances, the schedules also depended on the availability of facilitators and resource persons from the RHUs concerned. There were no apparent efforts to time these seminars in relation to ongoing work nor planned activities (e.g., environmental sanitation sessions and toilet construction). Moreover, the activity calendars of the study barangays appeared not to have

been consulted in scheduling the seminars. Thus, an often cited reason for the poor attendance in the seminars was the busy farm-work schedule or regular income pursuits of residents.

Contents and Design

In the five barangays (Bagadion, Cabinitan, Ibayugan, Pantat, and Penitan) where health education seminars were handled by the RHUs concerned, the seminar contents and design were decided upon by members of the RHU staff. A DOH-distributed manual was used as a lecture-discussion guide. Copies of the manual were also distributed to a few residents with instructions to share these with friends and neighbors.[1] One NGO proponent (for Pantat) attempted to sit down with its RHU counterpart in coming up with site-specific seminar designs. This was met, however, by the assurance from RHU that it already had the design and materials for the sessions.

The seminars in the five barangays were conducted mostly as lecture sessions. The question-and-answer portions at the end of the lectures veered toward medical consultation sessions. The COs assigned to the study barangays and other NGO staff members attempted to provide a more nonconventional style to the seminars by introducing role playing and other group dynamics activities. (Box 6 and Box 7 describe the conduct of health education seminars in two barangays).

In Mansalaya, the seminars focused on nutrition and family planning. Held in the barangay, the participants were mothers of recipients of a supplemental feeding activity for malnourished children. These were conducted by the municipal nutrition action officer and the teacher-in-charge of the elementary school in the barangay.

The Pandan seminar was conducted by the NGO proponent's staff. The occasion served as a basic orientation course on health as well as a part of the community health analysis being undertaken by the NGO for its project planning activity.

Seminar Participants

As pointed out above, the health education seminars were open to all residents of the barangays concerned. However, in sites where the proponent NGOs' work focused on selected areas, the residents of these areas naturally were the first to be informed of the sessions and, hence, became the attendees.

In most cases, attendance in the health education sessions reached less than a third of the households, and failed to meet the targets (between 50 and 85 percent of households; see Table 5). The highest coverage was a first-aid seminar in Penitan which gathered representatives from about 51 percent of households and the

Table 5. Selected information on health education sessions conducted in selected Camarines Sur PCHD sites, 1991-93

Barangay[a]	Seminar Conducted (Duration)[b]	Attendance	
		Number[c]	Percent[d]
Bagadion (6)	Primary health care (2 days)	23 (22F, 1M)	11 (85)
Cabinitan (15)	Basic health orientation (1 day)	41 (35F, 6M)	39 (50)
	Maternal and child care (3 half days)	30 (27F, 3M)	28
	First aid (half day)	28 (23F, 5M)	27
	Environmental sanitation (half day)	20 (17F, 3M)	19
	Herbal medicine (1 day)	38 (no data)	36
	Responsible parenthood (half day)	45 (43F, 2M)	43
Ibayugan (12)	Basic health and sanitation (1 day)	46 (no data)	17 (75)
Mansalaya (12)	Nutrition/family planning (3 half days)	20 (all F)	16 (85)
Pandan	Basic health orientation (2 days)[e]	15 (13F, 2M)	6 (75)
Pantat (15)	Primary health care (1 day)	22 (19F, 3M)	11 (25)
	Environmental sanitation (1 day)	16 (14F, 2M)	8
	Prevention of common illnesses (1 day)	30 (25F, 5M)	15
Penitan (10)	Primary health care (2 days)	32 (no data)	19 (60)
	First aid (3 days)	87 (no data)	51
	Environmental sanitation (3 days)	70 (no data)	41

[a]The figures in parentheses indicate the planned total number of days of seminars.

[b]Sessions held for less than 4 hr were rounded off to half a day; those over 4 hr, to a day.

[c]The figures indicate the highest total number of attendees. In most cases, attendance dropped after the first few hours of a session. Male (M) participants were usually members of the core group of leaders.

[d]The percent is based on the total number of households and assumes a one-member participation per household; the figures in parentheses indicate the target percent of households as indicated in the project proposals.

[e]From 1990, a yearly basic health orientation seminar was held in the barangay. The attendance pertains to the 1993 seminar. The 1990-92 attendance also did not exceed 20.

Box 6. Basic health and sanitation seminar in Barangay Ibayugan

Held at Ibayugan's elementary school, the health seminar was attended by 29 residents in the morning and 46 in the afternoon. CO and another FACE staff (CO of another PCHD site) served as facilitators. RHU staff members (PHN, RSI, and three RHMs) as well as a veterinarian invited by MHO from the Department of Agriculture served as resource speakers.

The participants began to arrive at 8:20 a.m. An hour after, registration of participants took place and name tags were distributed. The participants were asked to take part in group singing before the seminar formally started at 10:30 a.m. CO first gave an overview of the seminar. He also apologized for the delay in the start of activities and asked the participants to share the results of the seminar with residents who were unable to attend the day's session.

RHM discussed maternal and child health, emphasizing that mothers should undergo pre- and postnatal checkup to ensure good health of their babies. She added that unhealthy babies were susceptible to more diseases. RHM pointed out that DOH had assigned a PHDP midwife in Ibayugan to assist in the community's health needs. She also discussed the merits of breastfeeding, citing that there was a "law" which required all mothers to breastfeed their babies. During the discussion, RHM referred to a book and also consulted PHN for more topics.

During her turn, PHN also talked on maternal and child care. She explained that a woman's best years to have babies were between the ages 23 and 33 years, with two years between each child. She then enumerated the various methods of contraception, from condom and pills to vasectomy and tubal ligation. She adviced the participants to limit their number of children to enable them to take proper care of their families.

After maternal and child care, PHN discussed the national tuberculosis program. Using an illustration, she cited the symptoms of tuberculosis and the ways of preventing the disease. She ended the morning's discussion with a note that immunization was the most effective way of preventing tuberculosis.

After lunch, PHN discussed the nutrition program and under-six clinic. She explained that RHU regularly conducted Operation Timbang to determine if a baby was healthy or not. She also explained the three basic food groups, stating that deficiencies in certain nutrients led to illnesses, such as night blindness (deficiency in vitamin A), goiter or thyroid gland condition (iodine), or anemia (iron). RHM encouraged the residents to establish their own vegetable and herbal gardens.

RSI gave a brief lecture on sanitary practices with regard to toilet facilities, water disinfection, and food and garbage collection. This was followed by the veterinarian's discussion on animal rabies. He enjoined the residents to avail themselves of DOH's free immunization against rabies. Another RHM tackled the symptoms, prevention, and control of common childhood diseases such as measles, poliomyelitis, diphtheria, tetanus, mumps, chicken pox, and diarrhea. She likewise briefly discussed dental care.

The seminar ended after a planning session on the formation of an organization in the barangay. Each participant was given a certificate of participation.

Box 7. Environmental sanitation seminar in Barangay Pantat

Attended by 13 residents (2 males and 11 females), the seminar was held at the barangay chapel with RSI and RHM as resource persons. Also present were CO supervisor and the Daligan and Bani COs. Daligan CO discussed the participants' expectations for the seminar, while Bani CO introduced RSI and the topics he would discuss, which included water sources, toilets, and garbage disposal.

In his discussion, RSI pointed out the significance of maintaining adequate sanitary toilet facilities as these prevent intestinal diseases. He also stressed the necessity of keeping a water-sealed toilet facility, with a ventilation pipe, made of bamboo or polyvinyl, for proper flushing. He advised the use of bamboo because polyvinyl pipe was expensive. He explained further that a toilet facility should be built at least 25 m from a water source in order to avoid water contamination; the pump could be brought closer to the toilet by using a T-pipe.

In the open forum which followed, a participant asked RSI about the proper installation of the ventilation pipe. Another pointed out the presence of dirty water sources in the barangay and suggested the conduct of a water examination. RSI agreed to conduct the water sampling in his next visit to the barangay. RHM promised to procure the water sampling bottles from the Bicol Regional Training Hospital in Naga City. She asked RSI if the residents could still use the water sources even if these were found not potable as these were the only water sources available. RSI responded that the water sources could be used provided these were chlorinated.

After the morning break, RSI began his lecture on proper garbage disposal. Enumerating the diseases caused by improper disposal methods, he stressed the importance of maintaining a compost pit, covering leftover food, burning combustible garbage, and burying noncombustible materials. He also explained the necessity of washing hands before and after eating, as well as the need to store a constant supply of chlorinated water to disinfect kitchen utensils.

In the afternoon session, RSI continued with the discussion on water sanitation. He emphasized the importance of having a cover on open wells, or building an intake box so that ground water would not reach the water source during the rainy season. He explained the procedure for preparing a solution for water disinfection which could be done at home. RSI explained that the solution was good only for a week's use and that it should be stored properly. He used a bottle of softdrinks to show the quantity of water needed to dissolve a teaspoon of chlorine.

RSI reiterated his promise to bring water sampling bottles and chlorine on his next visit. He also explained that the stock solution must be kept properly because it easily dried up, reducing its efficacy. He emphasized that one must know the amount of chlorine to be used in preparing the stock solution. CO suggested that because chlorine was not yet available, the participants should not forget to boil their drinking water. RHM added that she would ask for chlorine from RSI for a household chlorination process on her next visit. Before the seminar ended at 3:30 p.m., CO supervisor inquired about the status of the water system and toilet construction projects in Poblacion.

lowest was the basic health education seminar in Pandan which had about 6 percent of household representative-attendees. The majority of the attendees were women. The handful of men who came to the sessions were usually the members of the core group of leaders. In inviting residents to the seminars, there was, however, no explicit instructions as to who in the household should attend.

Health Service Delivery

The RHU staff members' presence during health education seminars also served as occasions to provide medical consultation-treatment services. In three barangays (Bagadion, Cabinitan, and Pantat), the municipal health officer joined the RHU team in at least one health seminar; in two sites (Penitan and Ibayugan), the team was led by a public health nurse. In addition to the open forum sessions which were used by residents to explain or ask solutions for their health problems, the seminars, generally ended with formal consultation-treatment sessions with the RHU staff. Moreover, the RHU staff took the occasion to invite residents to avail themselves of health facilities and services available at the main health center and district hospital covering the barangay.

Of the seven barangays, three (Ibayugan, Mansalaya, and Pantat) had been provided with PHDP midwives. In one of these barangays (Mansalaya), the RHM resided in the barangay although she also covered three neighboring barangays. In another barangay (Ibayugan), the PHDP-RHM resided in a neighboring barangay and reported almost daily to her assigned site. The other four barangays (Bagadion, Cabinitan, Pandan, and Penitan) were covered by regular RHMs assigned to health stations in neighboring barangays.

The presence of the PCHD work in the study sites appeared to have brought about more efforts on the part of the RHU staff to provide health services to these communities. In Mansalaya where the PCHD proponent was the mayor's office, the RHM concerned was aware that she was under the guarded observation of the municipal mayor, who occasionally visited the barangay to check on the ongoing PCHD work. In the other barangays, RHMs were also under the explicit instructions of their superiors to improve their performance as RHU was a major partner in the PCHD implementation in the barangay. In the case of Bagadion, for instance, the RHM was deloaded of one barangay service area so that she could devote more time to the PCHD site. In this site, as well as in Cabinitan, the RHMs explained that the COs' presence in the barangay had been helpful in mobilizing the residents' presence during their health service delivery visits. In the case of Pantat, through the mediation of the NGO proponent, the residents were able to demand more regular presence from the RHM. In Penitan, RHU personnel (including the municipal

health officer and a public health nurse) visited the barangays specifically to render health services on two occasions during the study period.

Improving Domestic Water Supply

In all study sites, the need for domestic water sources was cited by residents as a priority concern during the initial PCHD planning sessions. This appeared, however, to be borne out of a need for more accessible water supply. As indicated in the community profiles, domestic water sources were generally available to the households except, to a certain extent, those in Pantat. In all cases, nonetheless, a number of sources might have questionable potability as these included open wells and unimproved springs.

Domestic water supply projects were provided in all seven sites (see Table 6). These projects sought to improve the supply of drinking water as well as provide more accessible sources. Pumps were installed in two barangays (15 in Bagadion and 3 in Cabinitan), concrete intake boxes with a network of faucets were constructed in two barangays (Mansalaya and Pantat), a spring source was developed in one site (Ibayugan), five open wells were lined and provided with covers in another barangay (Penitan), and extension pipes were connected to a municipal water system in one site (Pandan). Except the Pandan water source which had a problem with regard to the municipal system (it broke down before the PCHD project was begun), the PCHD-assisted water sources were functional at the end of the study period.

The major costs involved in the water system projects were provided for by the PCHD grants. These included hardware materials and payments for skilled labor. For their counterparts, the residents were expected to contribute such materials as gravel and sand, if these were available in the locality, as well as render labor during construction, particularly in hauling materials. They were also expected to provide some of the meals or snacks during group work.

Site Selection

The responsibility for choosing the places where the water sources would be installed or improved was generally given to the PCHD core group of leaders, with COs initiating the decision-making process. Moreover, in this activity, members of the barangay council, whether or not they were part of the PCHD core group, were consulted, if not given the tasks of making the final decisions. In the case of spring development, RSIs of the RHUs concerned and technicians hired by the proponent NGOs (in Pantat and Ibayugan) also assisted in assessing the technical feasibility of the selected sites or water sources.

In addition to the availability of ample water supply, the convenience of residents was an important consideration in site selection. (In Bagadion, the PCHD-approved plan was for the construction of a deep well; it was changed to pitcher pumps when the barangay captain expressed preference for pitcher pumps. The official explained that a number of these pumps could be installed in areas where more households would have better access and that this type of water source was easier to construct and maintain.) Particularly in the installation of pumps, locating them in areas where there were a number of potential household-users played a major part in the decisions. Nonetheless, some of the final choices were not spared of comments that these were in places most convenient to some core group members.

Construction Activities

Among the PCHD-supported activities, it was the construction of domestic water sources which drew considerable participation from the barangay residents. In fact, it constituted the single most attended group activity. In Ibayugan and Pantat, for example, the construction activities involved young and old men and women. (Box 8 and Box 9 describe the activities related to the construction of domestic water systems in two barangays.)

Construction work in all seven barangays involved voluntary labor of residents, particularly those from potential household-beneficiaries of the water sources. In four barangays (Bagadion, Cabinitan, Ibayugan, and Pantat), nonresidents were also hired for some of the technical work. In one barangay (Mansalaya), a number of residents also received cash payments for their work. Supervision of the work rested on the core leaders, or the committees created by the core leaders, as well as on COs. In the case of Pandan, the NGO proponent also had on its staff an engineer who also assisted in supervising the construction activities.

In two sites (Cabinitan and Pantat), right-of-way problems were encountered by the residents as regards the construction of intake box in a spring. In both cases, securing rights of way was initiated during the construction period.

In Pantat, the landowner of one site initially rejected the residents' request for permission to undertake the construction for fear that it might damage her ricefields. She also believed that the construction might disturb the "enchanted beings" guarding the water source and result in its drying up. She finally gave in after the barangay council's intercession was sought by the residents, and after being assured that should the intake box affect her ricefields, she could immediately have it destroyed even without informing the residents or the NGO proponent. Moreover, the construction was started with a food offering to the spirits. The landowner in another water project site in Pantat readily gave permission for the construction.

Table 6. Construction of domestic water sources in selected Camarines Sur PCHD sites, 1991-93

Barangay	Water Source Installed	Construction Procedure
Bagadion	15 pitcher pumps *(Original plan was for a deep well, but barangay captain suggested the change so that more households could be benefitted and because of the facility in installing and maintaining pitcher pumps.)*	The pumps, pipes, and cement were purchased from the PCHD fund, while sand and gravel were provided by residents. A plumber (nonresident) was hired to install the pumps. Households which would benefit from the pumps assisted the plumber and provided food for the workers.
Cabinitan	3 jetmatic pumps *(Three more were set to be installed, but plan for an intake box in a spring was abandoned although materials had been bought because a right-of-way agreement could not be obtained from the affected landowner. Instead, a plan was made to swap the materials for more pumps.)*	A plumber (nonresident) was hired and paid from the PCHD fund. Pumps, pipes, and cement were also paid from the grant funds, while sand and gravel were contributed by residents.
Ibayugan	Spring development: area around spring was cemented, pipes were laid, and 9 faucets were installed	From the PCHD fund, a plumber (nonresident) was hired and materials (pipes, fittings, faucet, and cement) were purchased. The residents contributed sand, gravel, and labor. A total of about 120 residents participated in the construction which took 7 days.
Mansalaya	Concrete intake box with a network of 5 faucets was installed	A total of 24 residents worked intermittently for 18 days and each received P50 daily. Materials were provided from the PCHD grant. A barangay leader served as construction supervisor.
Pandan	Extension of the pipes connected to a municipal water system	Installation of the pipes was begun in anticipation of the repair of the water system which broke down in early 1992.

Table 6 (cont.)

Barangay	Water Source Installed	Construction Procedure
Pantat	- Concrete intake box with a pump - Concrete intake box with pipes and faucet - *(A jetmatic pump was set for installation in another household cluster)*	Proponent NGO hired an engineer to supervise construction which was undertaken through voluntary labor of residents. When the engineer left, two residents were trained and given honorarium for supervising the construction. Sand, gravel, and boulder were contributed by the residents while the rest of the materials were purchased from the PCHD fund.
Penitan	5 open wells improved: lined with concrete and provided with cover and pulley *(2 more to be improved)*	Using cement bought with PCHD fund, laborers prepared hollow blocks. Households which would benefit from the wells contributed for the laborers' payment and rendered free labor for the construction.

Box 8. Water system construction in Barangay Mansalaya

As stated in the PCHD-approved proposal, the Mansalaya water system project would involve the repair of two rundown reservoirs and three nonfunctioning deep wells, and the installation of four additional jetmatic pumps. This plan was modified by the executive committee with the consent of the barangay council. The barangay residents, however, were not consulted in changing the plan.

The revised plan involved building an intake box in Zone 3 and installing pipes and faucets at strategic areas. Construction of the box began with the delivery of construction materials on 15 February 1992. The materials were brought to the barangay using a truck owned by the barangay captain. These were kept at the barangay captain's storeroom.

Five days after the materials had been delivered, the municipal planning and development officer (MPDO) and a staff from the mayor's office came to the barangay. They discussed the planned intake box construction with two barangay council members. They also visited the water source. Moreover, MPDO informed the leaders to begin construction and authorized them to choose three laborers who would work for P50 a day. She also appointed the female barangay council member as the workers' timekeeper.

The two barangay council members then discussed recruitment of the workers, concerned that funds had not been released yet. (They were not informed that funds had already been received by the mayor's office.) They agreed to do the work themselves;

Box 8 (cont.)

they likewise chose another barangay council member as the third member of their team. The leaders believed that it was their duty to pursue any projects given to the barangay and, thus, it did not matter if they were not paid.

MPDO returned to the barangay on 7 March to further discuss the intake box construction with the barangay residents. She informed them about the P6,000 budget allotted for labor. She also stressed the immediate need to construct the water facility as elections were fast approaching and, with it, the attendant rumors. Residents agreed with her suggestion. Barangay council members later went around their respective areas to look for laborers who might want to work for P50 a day. They also decided to do the work in case no residents were willing to accept the rate. Some interested residents did not wait for their visits, but approached the council members to offer their services.

Following an earlier meeting with MPDO, three workers (two council members and the husband of a council member) started clearing the site on 21 February, from 7:00 a.m. to 5:00 p.m. The next day, they burned the grasses. They had begun digging the well when they realized that the area was a water path during rainy days. The barangay captain, who visited the site, suggested another site 25 m from the original site. Clearing of grasses, and digging at the alternative site commenced. After working for two days, they discovered that the site was also inappropriate. They agreed that digging must be made where the spring was located, which was about 10 to 15 m from the second selected site.

The three had been working for about a week when they received their initial payments. Upon learning of the release of the money, other residents joined the three. A total of 24 residents were involved in the construction. The number of workers varied each workday (between 3 and 19), which was held intermittently for a total of 18 days. The female barangay council member served as the timekeeper and paymaster. Each worker, including the paymaster, received P50 a day, irrespective of the task. The workers provided their own food as well as the tools needed for the construction. MPDO released a total of P6,000 as payment for labor.

By 10 April, the intake box was completed, pipes had been laid, and five faucets had been installed in selected sites within the residential clusters. In late June, however, only the first three faucets were functioning as the dry months had limited the water supply.

In addition to the repair and rehabilitation of existing water facilities in the barangay, the formation of the Barangay Waterworks and Sanitation Association (BWSA) was also considered as part of the project activities. In an assembly on 7 October attended by 30 residents, including members of the barangay council and the barangay tanod, as well as RSI, MPDO, and the municipal waterworks engineer, a set of officers who would be responsible for the repair and maintenance of the jetmatic pump near the school site in Zone 3 and the water system was elected. The six BSWA officers elected were the president, vice-president, secretary, assistant secretary, treasurer, and bookkeeper.

Four BSWA officers later attended a one-day waterworks system seminar at the town center sponsored by the mayor's office and RHU. The manner of drawing water and chlorination were discussed in the seminar.

Box 9. Water system construction in Barangay Ibayugan

A major need expressed in almost every community meetings initiated by FACE was the construction of a water system which could provide ample supply of potable water in places convenient to the residents. Barangay leaders and residents indicated their willingness to contribute labor and materials. Plans for the water system construction were drawn up during the preproject launching meeting between CO and the barangay council as well as during the launching activity. Among the suggestions made was the construction of an intake box at the water source and additional intake boxes and faucets in each zone. The barangay captain rejected the suggestion, stating that it would be very expensive to implement it.

In November, CO informed the residents that RSI and a plumber hired by FACE would visit the water source located in Zone 5. He encouraged the residents to assist these persons in accomplishing their tasks. In preparation for the visit, the residents of Zone 5 held a rabus to clear a path to the spring. The plumber arrived in late November accompanied by COs of other FACE sites. (RSI was unable to join the group.) With 14 residents as guides, the plumber and COs hiked to the spring. Finding the spring to have a good quantity of clear water, the plumber expressed his willingness to build a system which would bring the water down near the elementary school. He also solicited the residents' assurance of assistance in gathering gravel and sand as well as in undertaking other construction tasks. He promised that he would immediately prepare the program of works and budget so that project implementation could begin in January. On the way back to the center of the barangay, the plumber measured the path of the pipes to be laid from the source.

In a meeting on 10 January 1993 attended by 15 residents, CO announced that the limited budget of the water system project could provide only 10 bags of cement, 200 pieces of pipes, 10 faucets, fittings, and rubber tapes. The materials could bring the water only as far as the elementary school area and not to all zones as expected. CO also informed the residents that the materials would be delivered on 27 January. A truck from Iriga City would transport the materials to Barangay Tambo. Residents should come with their motorboats to bring the materials to Ibayugan. On the said date, a number of residents went to Tambo but the delivery truck did not arrive. A new schedule was set, but this was postponed anew. Finally, the materials were delivered on 16 February. From the motorboats, the materials were taken to the chapel in Ibalete.

The construction began on 18 February, with a 7:00 a.m. to 5:00 p.m. schedule. The work included clearing the area around the water source, making a well near the spring, hauling gravel from the creek and sand from the lakeside, and cementing the well. Laying the pipes, connecting the faucets, and cementing the area around the faucets started the following day. On 22 February, nine faucets had been installed: seven in Zone 5 and two in Zone 3. The locations of the faucets were identified by the zone leaders in consultation with the zone residents and CO.

About 120 residents (young and old, male and female) participated in the work. Most were involved in the hauling of materials. The residents were served snacks; they went

Box 9 (cont.)

home for lunch. The plumber and his two helpers were provided free meals and snacks by FACE. A female resident took charge of preparing all the meals and snacks throughout the construction period. She was given a P500-honorarium by FACE.

The project had consumed all the materials delivered to the barangay except a piece of faucet. Two additional bags of cement were donated by the Zone 5 chairperson and were taken from the supplies he was keeping for the repair of his house. The excess faucet was returned by CO to the FACE office.

The plumber hired by FACE was an unlicensed engineer. The two helpers were his sons. His work was under a *pakyaw* (piece rate) agreement, involving 25 percent of the total project cost. During the week-long construction, the plumber and his sons stayed in the house of the Zone 5 chairperson.

When the plumber and his sons left the barangay on 23 February, he asked the residents to cover the pipes with soil and bamboo so that these would not be destroyed easily. However, a rabus to cover the pipes with soil took place only on 24 May, from 7:00 a.m. to 12:00 noon. The work was discontinued because of the lack of bamboo.

After the construction, two meetings were conducted to elicit the residents' evaluation of the water system project. The first was held on 6 March when CO met with the residents of Zone 5; the second took place during the health association's regular meeting on 7 March. The residents expressed their gratitude for the project and suggested measures for the proper use of the system. They pointed out that the users should be reminded that the faucets should be used only to fetch drinking water. Washing and bathing at the faucet areas should be prohibited.

In May, the Zone 3 chairperson built a structure to cover the faucet area near the elementary school. The structure was made of light materials, including ipil-ipil branches and coconut leaves. In the same month, one resident complained to the zone chairperson that there was no water at the faucet near his house. The chairperson responded by putting up a sign indicating schedules in the use of the faucets in the area: 5:00-8:00 a.m. and 2:00-4:00 p.m. for the downstream areas, and 8:00-10:00 a.m. and 4:00 p.m. onwards for the upstream group.

In a meeting in May among Zone 3 and Zone 5 leaders and residents, it was also decided that a fee would be collected from the water users. Each household-user would contribute a fee of P10 and monthly dues of P5. The collections would go to a system maintenance fund. (By June 1993, six households had paid their P10-fee; no monthly dues had been collected.)

It was also later proposed that the water system be turned over to the barangay council for maintenance. The council, in turn, could pass an ordinance imposing a P20-fine to those found misusing the system. One zone chairperson disagreed with the suggestion, claiming that the zones should take care of the portion of the system within their respective areas. The issue had not been resolved as the association officers appeared firm on their decision to turn over the system to the barangay council. They also planned to attend a regular session of the council to discuss their proposal.

However, the wife of the caretaker of the land opposed the construction. The issue reached a local police detachment when the woman was brought in after she disturbed the ongoing construction; the woman was eventually pacified.

In the case of Cabinitan, a landowner adamantly refused to give rights of way, partly because of a standing land dispute with some residents. The construction of an intake box near a spring had to be abandoned in spite of the earlier purchase of materials. (At the end of the study period, the NGO proponent and core leaders were planning to trade the materials for pumps.)

Constructing Toilets

As indicated in the barangay profiles prior to PCHD implementation, sanitary toilet facilities constituted a most obvious health-related need in all seven sites. The barangay with the highest number of toilets had only about one-third of its households owning sanitary toilets, while the rest of the sites had less than 20 percent of their households with sanitary toilets. Plans for providing toilets in the selected sites varied. In two sites (Mansalaya and Penitan), the objective was to have a 100-percent presence of sanitary toilets, while the others had plans for the construction of "model" toilets. Of the seven barangays, five (Bagadion, Ibayugan, Mansalaya, Pantat, and Penitan) still had ongoing toilet construction activities; two (Cabinitan and Pandan) had yet to finalize their plans at the end of the first 12 months of PCHD implementation (see Table 7).[2]

Preparatory Activities

The construction of toilet bowls was the initial major activity undertaken with regard to toilet construction. In Bagadion and Mansalaya, the production of concrete toilet bowls was done in the barangay by residents trained by the RSI from the RHUs concerned. These residents received small cash amounts for their work. In Pantat and Penitan, residents also received training in bowl making, but the task was eventually carried out by nonresidents who were hired for the job. (In Pantat, the bowl maker was the Bagadion resident who also produced the bowls for his barangay.)

The hardware materials used in toilet bowl making were provided from the PCHD funds, while sand and gravel were contributed by the residents. In Bagadion, a truckload of sand and gravel was donated by the mayor's office upon the barangay captain and CO's representation. Moreover, to complete the needed number of bowls, the NGO proponent bought additional sand, and collected ₱7 from residents who were unable to contribute sand for their bowls.

Table 7. Toilet construction in selected Camarines Sur PCHD sites, 1991-93

Barangay	Sanitary Toilets Needed	PCHD-Provided
Bagadion	166	166 toilet bowls were produced; 149 were claimed, of which 44 were installed
Cabinitan	97	still being planned; but RHU provided 21 bowls, 18 of which were installed
Ibayugan	235	construction of 20 communal toilets ongoing
Mansalaya	130	33 bowls were produced; 22 of 27 distributed were installed
Pandan	100 (estimate)	still being planned
Pantat	182	construction of 7 communal toilets ongoing
Penitan	158	147 bowls were distributed, of which 112 were installed

Construction

The lists of bowl recipients were generally prepared by the core group of leaders, with the assistance of COs or the RHM concerned (in the case of Mansalaya). The responsibility for constructing the toilets rested on the recipient-households, whether for individual or communal toilets. These households would also provide the construction materials for installing the bowls and building the housing. In Bagadion and Mansalaya, households were asked to pay for the bowls (P20 and P50, respectively). The amount was for the labor cost. But in Mansalaya, the municipal mayor eventually ordered that the bowls be given free after the residents complained that they had no money to pay for the bowls. In Penitan, the bowls were given free plus a bag of cement courtesy of the municipal government. (The cement was donated upon the representation of a municipal councilor, who was also one of the proponent NGO's COs in the PCHD sites.)

In Pantat, where communal toilets were being installed, the plan was for the households which would use the toilets to work as a group. As it turned out, only the households on whose lots the toilets were located performed most of the work; the constructed toilets were being used only by these households. Others refused to use the toilets either because of embarassment as they did not help in the construction

or because the location of the toilets would put them on display as they entered these facilities.

In Ibayugan, the construction of communal toilets was still in the site selection and pit preparation stage. Moreover, the residents were lobbying for the provision of more toilet units as they believed that the planned two units per zone would pose inconvenience to the user-residents. To augment the available fund, they also began soliciting contributions from local officials.

Toilet construction spanned a long time, particularly when the households needed cash to accomplish the activity. In Bagadion, for example, nine months after toilet bowls started to be made available, only about one-fourth of potential recipient-households had installed their respective facilities; in Mansalaya, the figures reached 17 percent of the target after nine months, but the majority were installed after the mayor decided to shoulder the labor cost of the bowls. In Penitan, where a bag of cement came with the free bowls, the number of installed toilets reached about 71 percent within four months. Nonetheless, the toilet construction activities in the three barangays had already more than doubled the number of sanitary toilets. (See Box 10 and Box 11 for descriptions of toilet construction activities in two barangays.)

Box 10. Toilet construction in Barangay Bagadion

Although toilet construction was not included in the approved proposal, TALINGKAS and the barangay leaders decided during the July 1991 planning sessions that the project be pursued. They agreed that funds saved from the other project components would be used. Thus, one of the committees formed was the latrine committee and its chairperson was elected. (The position was initially offered to the barangay captain who declined and instead recommended a carpenter-resident. Hence, of the four committees, only the latrine committee was headed by a non-council member.) The committee had two other members–both carpenters–chosen by the chairperson himself.

The committee and CO convened one meeting in September 1991. The meeting took place at the committee chairperson's house during which plans were made for the sponsorship of four batches of training-seminar on bowl making. The committee expected the participation of some 50 residents in each batch of training.

The committee's next meeting took place on 21 March 1992. (Earlier that month, KAIBA (the PCHD-formed group) conducted a census of households to determine those without sanitary toilets. The census revealed that 166 households [75 percent] of a total of 222 households in 1992 did not have sanitary toilets. A list of the households which would need toilet bowls was given to the committee.) The committee discussed the details of the

Box 10 (cont.)

construction of toilet bowls in the barangay. The members agreed that TALINGKAS would provide the major materials, including cement and wire; for their counterpart, the residents would provide the sand. They also decided that every zone would contribute one can of sand for use during the 30 March demonstration on bowl making.

On the afternoon of 26 March, the construction of molders was started by the chairperson and a committee member. In the morning of that day, the two, accompanied by CO and two RSIs, visited a resource person in Libmanan town center. The resource person gave pointers on bowl making and sold them two molders.

The first demonstration session took place on 30 March at the barangay hall. It was managed by two RSIs. About 25 persons from the different zones, including the chairperson and a commitee member, were present.

It was expected that after the demonstration, residents in need of toilet bowls would make their own bowls. They only needed to inform the resident who was in charge of the materials before they proceeded with their bowl making. (This resident was not a committee member but lived conveniently near the barangay hall.) It was also agreed that households which could not construct their own bowls would pay P20 for a bowl to be made by the committee members. The amount would be considered as payment for labor. Thus, the committee members also began producing bowls.

By July, quite a number of bowls had been produced and kept at the barangay hall. CO talked with leaders and visited households to find out why the bowls had not been obtained. She was told that most residents did not have the cash to pay for the bowls as it was then the planting season. At that time, payment for a bowl had risen to P27. In addition to the P20 for the labor, P7 was being charged for the sand which was paid for in advance by TALINGKAS.

The plan to have sand as the residents' counterpart was not realized. On the first and second batch of bowl construction, the workers used the sand donated by the municipal mayor. CO and the barangay captain made the request with the mayor, who immediately sent a truckload before the May elections. After that, TALINGKAS bought more sand to complete the number of bowls needed.

In August, CO asked the KAIBA president to find out the number of households which had installed their toilets bowls, and those which had yet to secure their toilet bowls. CO also asked him to oversee the distribution of the bowls left in the barangay hall (37 as of 19 August), as well as collect the P7-payment for the sand.

By December 1992, a total of 166 toilet bowls had been produced. Of this number, 149 had been claimed, of which 44 had been installed. In addition to households included in the list of 166 in need of sanitary toilets, 19 households also availed themselves of the toilet bowls, to construct either a new or additional toilet facility; 1 bowl was allotted for the barangay hall. For their part, CO and the committee did their share in informing the residents of the availability of the completed toilet bowls. They also told the residents to go to the bowl makers (the committee members and the resident in charge of the materials), who would give the bowl after collecting the P20-payment.

Box 11. Toilet construction in Barangay Pantat

On 10 July, Poblacion residents (five males and five females) met with CO to plan for the construction of the toilet facilities. Dismissing CO's suggestion to construct three communal toilets, the residents decided that one toilet be installed at the barangay hall and the rest be given to selected households. The barangay captain suggested giving three months to the household-beneficiary to build the toilet; if the facility had not been built by then, the materials would be given to other households. The plans, however, were disapproved by PAGBICOL which proposed the building of the "cluster" type. On 25 August, during the seminar on environmental sanitation, residents finally agreed with CO supervisor's suggestion to construct toilet facilities by clusters. Three clusters composed of six households each were formed.

Construction of a two-unit toilet facility in Cluster 3 began on 29 October and was completed on 4 December. The facility was situated between the houses of two cluster members. Two toilet bowls were installed on a single deposit box, a concrete bowl earlier given by DOH and a porcelain bowl purchased by the other household.

On 29-30 October, from 7:00 to 11:00 a.m., two persons helped in making 166 hollow blocks. One of the workers was a member of Cluster 1, whose residence was identified as the site of the toilet facility in that cluster. Work on the toilet facility was undertaken on 1-8 November and 2-4 December. Four individuals, three of them belonging to one family, dug and put up the foundation on 1 November, working from 7:00 to 11:00 a.m. and 1:00 to 6:00 p.m.

On 2 November the floor where the toilet bowl would be installed was cemented from 7:00 to 11:00 a.m. and from 1:00 to 6:00 p.m. Drying the floor took two days. On 5 November, three workers prepared the floor of the deposit box, using *sawali* (woven bamboo strips) and cable wires. A layer of concrete was poured on 6 November, then allowed to dry for one day. The final layer of concrete was placed on 8 November by a cluster member. It was allowed to dry before construction of the walls began. On 2 December, the wooden slabs which were used to form the deposit box were removed, revealing some defects. The remaining cement was used to cover the defect. Polishing the deposit box was completed by 4 December.

Construction of the partition of the twin toilet facility was begun on the last week of November, just before the completion of the deposit box. Excess materials from the school building construction in 1986 and PCHD water system construction were used by one household to build a portion of the wall. These materials included three and a half pieces of plywood measuring 4 ft x 8 ft, coconut lumber, assorted nails, and five 3 ft x 6 ft galvanized iron sheets.

The participation of cluster members in the construction of the toilet facility was significantly low. Of seven members, only two were enthusiastic about getting on with the construction. Worried that the cement would harden, the two members proceeded with the construction. As a result, only their families used the facility, with one latrine for each family. Families of other cluster members appeared embarrassed to make use of the facilities because they did not participate in the work.

Establishing Gardens

All seven selected sites had plans for the establishment of vegetable and/or herbal gardens. Food production through the vegetable gardens was looked upon as a component of a nutrition program as well as a part of efforts to help improve the income of residents; the herbal gardens were expected to provide some of the herbal medicine needs of the community.

Gardens were established in five sites (Bagadion, Cabinitan, Mansalaya, Pantat, and Penitan). These were considered as demonstration or model plots which could encourage the residents to establish gardens in their homelots or nearby vacant spaces. Training seminars on bio-intensive gardening—a multiple cropping system which sought to integrate pest management and soil conservation—were also provided in these barangays.

A major consideration suggested by COs in selecting sites for the model gardens was easy access to those who would take responsibility for maintaining these as well as to those who needed to be motivated to establish their own gardens. While members of the core group of leaders agreed with the suggestion, they also expressed the need to locate the gardens in areas close to the caretakers to discourage unauthorized harvesting. This view was also shared by other residents.

Seedlings were provided by the proponent organizations; some were solicited from local DA offices. Preparing plots and planting were generally performed through group work. It was also expected that the care of the garden would become a group task, at least by an assigned committee. But this was the most difficult task to follow. Gardens easily became overrun by weeds (see Box 12).

The Mansalaya gardens reached the harvest period; the Bagadion and Pantat gardens were overrun by weeds while those in Cabinitan and Penitan had just been established at the end of the study period.

In Mansalaya, the gardens were located within small parks put up in each of the barangay's four zones. Rabus groups in these zones took responsibility for the parks which were also fenced and included ornamental plants, small huts, and benches in areas for group gatherings. A contest was conducted among the zones, for which cash prizes were provided by the municipal mayor. A round of harvesting and replanting had already been undertaken by residents.

Providing Food Supplements

While malnutrition was a common problem in the seven sites, it was only in Mansalaya in which specific activities were carried out to immediately address this problem as part of the PCHD work. The activities, which included center-based

Box 12. Bio-intensive gardening in Barangay Bagadion

As agreed upon during the community planning activity, the establishment of a bio-intensive garden would be the first major activity in the barangay. The chairperson of the committee was subsequently selected; eight residents, all of whom lived in Zone 5 like the chairperson, were asked by the latter to become members of the committee.

As scheduled by CO, a seminar was held on 20 August, with two Department of Agriculture (DA) staff members as resource persons. Conducted from 9:30 a.m. to 4:45 p.m., it was attended by five members of the barangay council, including the barangay captain, and 27 barangay residents (25 males and 2 females).

The DA technicians explained the different types of bio-intensive gardens and the techniques for their establishment and management. They also distributed reading materials to the participants. During the seminar, the residents decided to establish a garden beside the barangay hall. This garden, to be managed by the gardening committee, would serve as a "model garden" for households which would eventually put up their own gardens. The participants also scheduled a second session with the DA technicians, during which they would be shown how to prepare the seedlings. The committee was also asked to begin preparation of the plots.

In the morning of 5 September, the DA technicians returned to the barangay for the demonstration on seedling preparation. CO also arrived with vegetable seedlings (bell pepper, eggplant, baguio beans, and sponge gourd) solicited from the DA regional office. The members of the gardening committee were already assembled at the barangay hall, with the seed boxes they had prepared and the materials for the soil mixture.

Even before the seed boxes were planted, the committee had begun preparing the garden plots. For the initial plowing of the 200-sq m plot, the committee hired a farmer and his carabao. (The payment of P150 came from the PCHD grant funds.) On 30 October, three committee members, assisted by the barangay captain and some children, transplanted the seedlings.

Concerned about the management of the garden and the apparent inability of the committee members to regularly perform their tasks, CO approached the Bagadion Youth Organization to take over the management of the garden. Leaders of the youth group declined the offer, explaining that they did not want to be criticized for "grabbing" their elders' project. Moreover, the group had organizational problems which it wanted to resolve first before going into new endeavors.

During a meeting with the barangay council in November, CO explained that the chairperson of the gardening committee had acknowledged his inability to continue his tasks because of his farmwork and the remoteness of the garden from his residence. With the council's encouragement, CO approached for assistance the rabus groups in each of the six zones. Leaders of four groups responded favorably. By the end of November, fences had been erected through rabus of 10 residents and 2 committee members.

In February 1992, CO again discussed the project with the barangay council, which promised to take charge of the garden as well as build additional plots for the seeds. By then, however, the dry months had begun, making gardening a difficult task.

feeding, distribution of food supplements, and mothers' classes, were implemented through the local office of DSWD.

Feeding sessions were carried out thrice a week for about four months. This was held at the residence of the barangay health worker and involved from 12 to 15 children. Mothers of these children took turns in preparing and serving the food, and also contributed ingredients such as sugar and cocoa. They were also asked to participate in the mothers' classes conducted by the municipal nutrition and action officer.

Moreover, 39 children were given about a kilo each of powdered corn-soya blend, powdered milk, green peas, or bulgur, at least once every quarter. Pregnant women and lactating mothers were also given shares whenever there were extra supplies. The food supplements were supplied by the DSWD, DOH, and the parish-based "Targeted maternal and child health program." The plan was to provide the food supplies for two years, but the distribution was suspended after nine months because of the unavailability of supplies.

The distribution of food supplements was managed by the barangay health worker and RHM, who also identified the recipients. The beneficiary-households were asked to contribute for the transportation costs incurred in bringing the food supplies from the town center to the barangay.

Other Activities and Projects

Except in one site (Mansalaya), activities were added to the list contained in the approved PCHD proposals (see Table A8). These activities were not too numerous and were generally non-health-focused and concerned the need for the residents, particularly the project participants to have improved sources of income. Among these activities were livelihood training seminars (Cabinitan and Pandan), and participation in local governance seminars (Bagadion and Pandan).

Added activities related to health needs and concerns included a multipurpose center (Ibayugan) and toilet facilities (Bagadion). Additional health education sessions, through echo seminars provided by trained community health workers, were also conducted in one site (Penitan). The added activities were generally funded by savings from the PCHD grant.

Meanwhile, the activities and projects supported by PCHD were not the only development-oriented efforts which took place in the seven barangays.[3] Among these were infrastructure development projects and livelihood enhancement enterprises; a number likewise were part of community organizing activities. Moreover, many of these activities also sought the participation of or benefitted many of the households being targeted by PCHD. These included those which were initiated by

the residents themselves as well as those assisted by external agencies, that is, government agencies and NGOs.

Local Initiatives

The most common effort made by the local community groups toward improving their respective barangays was the provision or improvement of facilities or structures (see Table A19). The barangay councils generally took the lead in these activities, either by using barangay funds or by soliciting assistance from political leaders or the government agency concerned. In some instances, community organizations undertook some of the small infrastrucuture projects.

The popular locally initiated projects were the construction or improvement of barangay chapels (Cabinitan, Mansalaya, Pandan, and Pantat) and installation of domestic water sources (Cabinitan and Ibayugan). Funds for these projects were solicited by residents, particularly from political candidates.

External Assistance

All seven sites received development assistance from external agencies. Five barangays (Bagadion, Mansalaya, Pandan, Pantat, and Penitan) were recipients of assistance from both government and nongovernment organizations; one (Cabinitan) was reached by government agencies only, while another (Ibayugan) received assistance only from an NGO.[4] Government agencies provided infrastructure projects, assisted in forming community organizations, and provided livelihood improvement projects; while NGOs were involved mostly in the formation of community organizations and income-generating projects.

The most common assistance rendered to the selected sites was the construction of barangay facilities—barangay hall, multipurpose pavement, school building, and domestic water source. In all seven sites, this type of assistance came from national government agencies, congressmen (using their development funds), or municipal mayor's office.

Infrastructure projects were undertaken either by outside contractors or by residents, who received compensation for their labor. In some cases, voluntary labor of residents also formed their counterpart to the projects.

The provision of loans for crop or livestock production was a common strategy in efforts to help the residents improve their cash incomes. In Cabinitan, a pig-dispersal project was implemented by the municipal mayor's office. Penitan residents likewise received a pig-dispersal project from the mayor's office as well as the local DA office.

In Ibayugan, assistance for an income-generating project was provided by the NGO to the community organization it helped to organize. Members of the organization received loans for fish cages and fingerlings. The NGO subsequently bought the produce for distribution in its disaster relief work.

In Pandan, agricultural loans were made available to individual rice farmers by an NGO. The barangay captain served as coordinator, with the assistance of a farm technician from the NGO. Some 68 farmers received loans but only 20 were able to repay their loans. (Negotiations to restructure the loans were underway at the end of the study period.) Another NGO also provided loans to members of an organization it had organized in the barangay. About 20 members availed themselves of livelihood assistance loans.

Notes

1. The topics included in the planned health education seminars were also those included in the DOH's health education program for households as contained in the manual *The Family Health Guide* used by RHUs.

2. The construction of toilets was part of the original proposal for Bagadion. This was disapproved by CHPC, with the comment that the plan was not only expensive but also appeared as a dole out (all materials would be provided to the recipient-households at a cost of P2,940 per household). CHPC suggested that the activity be deferred for the second year of PCHD implementation so that the NGO proponent and the community could study cheaper options. The NGO proponent and the community leaders nonetheless decided to pursue the activity using funds saved from other project components. They also decided that instead of providing all materials needed for constructing the toilets, only toilet bowls, to be produced in the barangay, would be provided to households at a subsidized cost.

3. It should be noted that 1992 was an election year, for national and local positions.

4. The development assistance discussed in this chapter exclude regular or routine services of government, whether national agencies or local government units.

Chapter Five

Emerging Issues and Their Implications

The launching of PCHD in late 1989 was looked upon as an important component of the DOH's investments toward an improved health system. PCHD involved an innovative approach. While seeking to provide immediate health-focused interventions to areas previously unreached or underserved by public health services, its major concern was the development of community capabilities for basic health care management. At the same time, it sought the systematic and active involvement of NGOs and LGUs in initiating and sustaining community health development.

PCHD was both a resource-provision and a capability-building endeavor. It made available grant funds for the development of provincial-level partnerships among LGUs, NGOs, and the field health offices, as well as for the enhancement of the respective distinguishing competencies of the participating groups. But its major interest was to provide grants to NGOs for planning and implementing health-focused projects and activities which would serve as entry points in the formation or development of organized community groups with the capability for managing local basic health care needs.

As initially envisioned, PCHD would be implemented in selected barangays in 16 provinces over a five-year period. Midway into field implementation and under a new administration, DOH substantially expanded PCHD's implementation coverage. During its fourth year (1993), PCHD was targeting to reach 35 of the country's 75 provinces. The goal was to cover all provinces by Year 2000.

As part of the efforts to systematically assess and immediately extract learnings from PCHD field experiences, a process monitoring research was initially conducted in Camarines Sur, one of the first four PCHD target provinces. The start of the research study in Camarines Sur coincided with the first stage of PCHD field

implementation, specifically, the provincial NGO-LGU-DOH partnership building and planning. When PCHD activities shifted to community-level work, the study focused on 7 of the 19 initial target barangays in the province. Begun from the community profiling activities, the study was maintained until at least the end of the 12-month coverage of the first community project grants given to these barangays. (In four sites, the study was extended for some one to six months after the 12-month initial PCHD grant period.)

This volume focuses on the PCHD and related experiences of seven barangays and seven organizations (six NGOs and one mayor's office, which constituted the entire group of PCHD proponent organizations in the province). These barangays are located in 7 of Camarines Sur's 35 municipalities. On the one hand, the barangays illustrate variations in physical characteristics and accessibility, natural resources, and resource access and use; on the other hand, they share basic livelihood problems, physical infrastructure needs, and deprivation in many essential services, including health.

Described above, in Chapter 2 to Chapter 4, are details of the activities and processes involved in the barangay-level implementation of PCHD. This chapter provides a summary of these experiences. It then discusses the issues highlighted by these experiences and their implications on sustaining and expanding action, particularly in the light of the devolution of health facilities and services from DOH to LGUs, which had overtaken PCHD implementation.

PCHD's Initial Years: A Summing Up

Full-scale barangay-level implementation began more than a year after PCHD was introduced in Camarines Sur. The time lag between the community profiling work for proposal preparation and the start of the implementation of planned projects and activities reached from 6 to 24 months. The gap in five of the seven study sites was over a year, a delay attributed partly to the extended proposal preparation period spent by the proponent organizations and to the slow fund release process of DOH.

The projects and activities planned for the selected target barangays did not differ much. Targeting the participation of the residents as a group as well as individual households, these could broadly be categorized as construction-related or group work activities and education or training sessions. In all seven study sites, the improvement of domestic water sources, construction of sanitary toilets, conduct of household health education seminars, and cultivation of vegetable and herbal gardens were incorporated in the planned projects and activities. In three sites, the planned work also included the training of community health workers; in two sites,

the construction of a health center; and in one site, the provision of food supplements to malnourished children.

In six barangays with NGOs as proponents, the fielding of a full-time CO was a shared key strategy. This worker was tasked to identify residents who would constitute the initial group of leaders that would assist in PCHD implementation, particularly in project planning and mobilizing the participation of other residents. In the course of implementation, it was expected that these leaders would form the core of the community organization which would be developed to eventually manage local health needs. Hence, planned activities included community-building seminars and leadership training sessions. In the barangay which had the mayor's office as proponent, personnel of national government agencies with offices in the municipality as well as members of the barangay council were identified as supervisors and leaders of PCHD implementation. Their involvement was viewed as part of a more dynamic operation of their regular functions.

The PCHD-provided budget for the 12-month work in six barangays reached about P200,000 each, the amount allotted by DOH and requested by the NGO proponents. Included in the requested budget as direct costs were the salaries of the CO; honoraria of resource persons; field travel expenses; meals, materials, and related expenses for training seminars; and costs of major materials and skilled labor for construction projects. Only about P100,000 was requested and approved for the barangay which had the mayor's office as proponent and where the strategies did not incorporate the services of a CO.

In all cases, community residents were expected to render free labor for some of the construction work, contribute materials available locally, such as gravel and sand, or provide meals and snacks for group activities. As the proponent organization's major partner in PCHD implementation, the RHU concerned was given the responsibility for managing health education seminars, providing technical assistance in such projects as water system and toilet construction, and improving the delivery of health services. The municipal government concerned, as the other major partner, was likewise expected to assist in PCHD implementation, but the nature of assistance was not made specific.

Planned Versus Completed Activities

In all cases, the planned projects and activities were not completed within the requested and approved 12-month schedule. At the end of this period, a number of activities were still ongoing while others had yet to begin or be calendared. Moreover, the sequencing of implementation schedules, as contained in project proposals or program plans of action, became modified. Changes in the details or

specifications were likewise made in some of the planned projects or activities. A few additional projects were also undertaken.

Priorities for completion

There seemed to be no particular types of projects and activities which received priority in scheduling or completion. In all sites, there were completed and ongoing construction work as well as conducted and yet-to-be scheduled training sessions. The availability of funds, however, appeared to have guided decisions on immediate plans. Hence, in sites where COs were fielded before the release of the first grant payment, onsite training sessions were undertaken ahead.

The construction or improvement of domestic water sources became a major preoccupation when funds became available. So did toilet construction in sites for which mass distribution of toilet bowls was a planned project, as well as multi-purpose center construction in two barangays. Because of the often substantial budgets for construction activities and the residents' articulated interest in their concrete results, these activities were given major attention, overshadowing others, when the 12-month schedule was nearing its end or had lapsed.

Schedules of participants

Aside from funding problems, the availability of key participants, particularly for the conduct of training seminars which involved resource persons who were not members of the proponent NGOs or directly involved in PCHD, was a major reason for the revision of schedules. While the absence of a resource person resulted in the postponement of a session, the poor attendance of residents generally did not merit such a decision. It was different, however, in the case of construction activities. Scheduled group work was sometimes rescheduled or canceled because the expected participants were not on hand. In one barangay, work on a health center was suspended for two months because of the residents' inability to comply with agreed-upon arrangements on voluntary labor and other contributions.

The competition between the regular livelihood pursuits of residents and the schedule of PCHD activities was certainly a key issue in accomplishing planned projects and activities. Poor attendance in group activities was often attributed to the residents' busy schedule for farm or other livelihood activities. This was particularly so during certain periods such as rice planting, harvesting, or copra-making season. The problem might not have negative repercussions on the goals of PCHD if it merely resulted in the postponement of an activity or in a protracted work schedule. But if a planned activity, such as a training session, was carried out in spite of a poor turnout of participants, questions on PCHD reach became highlighted. As indicated by data on health education sessions, for instance, attendance in these activities

hardly reached a third of the households in the selected sites.[1] (Targets were between 60 and 85 percent of household totals.) Activities which called for barangay-wide participation gathered representatives from an average of 10 to 30 percent of the households. Higher figures (reaching almost half of households) were registered in built-up areas to which COs devoted more time or attention, such as in the main residential cluster and its neighboring areas.

Sequencing of activities

The general schedule of activities was made long before the start of field implementation; in some cases, as early as almost two years back, when the proposals were being prepared. These schedules assumed a Month 1 which ignored the specific activity calendar of the sites. When PCHD was launched in the barangays, there was also no attempt to revise the schedule to fit the prevailing activity patterns or seasons. Schedules of specific activities were drawn up as implementation progressed and, as already mentioned, were generally made in response to fund availability. One exception was the water source project for which the need to undertake construction during the dry months was raised both by NGO workers and the residents because of concerns to expedite the work and be assured of a year-long water supply. But in the case of the vegetable and herbal gardening projects, which did not appear to be a major interest of residents, improper timing became a reason for delayed conduct of activities or unsuccessful results. And as pointed out above, a common reason for the poor attendance in PCHD group sessions was the residents' livelihood activities.

A review of the planned projects and activities as well as their planned pace and sequence reflected a logic in the community organizing strategy. Orientation sessions and basic community-building seminars constituted the activities during the COs' initial community integration period. These were to be followed by leadership and organizational management seminars, as well as health education sessions. Construction and related group work was set somewhere at the midpoint of the year-long schedule. As it turned out, the pacing and sequencing of activities which were conducted differed substantially from the original, and were often made in response to short-term concerns to complete the activity list.

Changes in plans

The sequencing of activities was not the only change made in the PCHD plans. During implementation, there were also revisions in the details of some of the planned projects and activities, either upon the residents' request or owing to unforeseen conditions. In three barangays, the planned domestic water source projects were revised—pitcher pumps instead of a deep well in one site so that more households would have easier access to the water source, pumps in place of a spring

development project in another barangay because of an unresolved right-of-way problem, and a new concrete intake box with a network of faucets instead of the repair of existing reservoirs and deep wells in the third barangay. In one barangay, the planned provision of sanitary toilets to all households without such facilities was changed to the construction of communal toilets. In building the health center in another barangay, more concrete materials instead of the planned semipermanent ones were used so that, according to the proponent NGO, residents could gain skills in carpentry and masonry.

Additions were also made on the list of PCHD-approved and funded projects and activities. The added activities, nonetheless, were not too numerous nor diverging considerably from the planned work. These were generally funded from savings or realignments of PCHD grants. Most of these additions were seminars on non-health-focused concerns, including training on income-generating activities and orientation sessions on the then newly enacted Local Government Code. In one barangay, the provision of sanitary toilets was pursued in spite of the deletion of its budget from the approved proposal. In another barangay, a health center was constructed in response to the residents' clamor.

In sum, the projects and activities which were undertaken by the proponent organizations in the study sites were essentially those planned for and funded by PCHD. Likewise, the proponent organizations' presence in the selected barangays was in keeping with their selection as PCHD target sites, and generally matched the grant periods. (One exception was one proponent NGO whose PCHD sites were also the sites of its other programs. This NGO maintained its presence in the sites even before the PCHD grants were released, undertaking activities related to its sustainable rural district program. Nonetheless, it concentrated its work on the planned PCHD work when DOH released the first grant payment.)

Assurance of completion

Because the approved budget for the COs' presence was pegged at 12 months, the completion of planned projects and activities might have to be foregone or undertaken after the COs had pulled out of the sites, unless the proponent NGOs found supplementary funds to be able to retain these COs. In two barangays, the completion of some activities took place without the COs' full-time presence. This occurred because of the delayed release of the first grant payment. Upon being advised by DOH of the certainty of PCHD funding, the proponent NGOs in these barangays decided to begin the work and to underwrite the COs' salary and incidental expenses. These NGOs, however, did not also advance the funds needed for the major activities planned for the initial implementation period. Thus, there came a rush to undertake the planned activities, particularly the construction work,

when funds became available; but some projects remained incomplete when the 12-month grant period ended.

The completion of the unfinished construction work appeared more assured even after the end of the grant period because the materials were already in the sites. Only the residents' labor contribution and procurement of some locally available materials were needed to get these done. Difficulties might be encountered though in the construction of some individual household toilets, as indicated by the low accomplishment figures in barangays where residents were citing the lack of cash to purchase hardware materials, and given the experiences in the DOH's toilet bowl distribution projects.

The training seminars which had not been conducted, including organizational management and health education sessions, however, might eventually be given up unless the proponent organizations provided additional resources to ensure their completion. As experienced, these activities required the COs' presence in the selection and mobilization of participants, and in such preparatory activities as designing the sessions, getting together resource persons, and making arrangements for venues and participants' meals and accommodations. The COs likewise served as key facilitators during the sessions. The nonconduct of some of the planned training seminars would create substantial gaps in the capability-building inputs in the selected sites. For instance, in two barangays only the first basic leadership seminar was conducted; the followup seminar focusing on organizational management had yet to be conducted. In three barangays, only the basic health orientation session took place; planned sessions focusing on such specific topics as nutrition education, maternal and child health, and family welfare had remained unscheduled. In one barangay, the planned year-long semimonthly health education sessions had not gone beyond three half-day sessions on nutrition and family planning.

The noncompletion of the work programmed for the first 12-month grant period appeared to have jeopardized the implementation of the intended second year of PCHD support. By the end of the study period, no proposal had been submitted for a second year of funding; only two of the sites had conducted preliminary discussions concerning a Year 2 PCHD implementation. This meant either a discontinuance of the PCHD work after a year or a big gap between the first and second year of implementation.

Busy Days for Some Community Residents

The implementation of PCHD-supported projects and activities became major events in the target sites. This was particularly so because these were hard-to-reach areas where the entry of outsiders could not pass unnoticed and could easily turn

into a community occasion. Moreover, most PCHD-related activities called for voluntary group work or big group sessions, some of which occurred simultaneously or with only brief intervals.

That PCHD implementation demanded a lot of time from the residents was quite obvious. Its participatory strategy meant the involvement of residents in all phases of work, from the planning to the execution of specific activities; and its community capability-building goal required the participation of groups with differing skills, interests, and needs. From the PCHD's barangay launching or the COs' formal community entry until the end of the grant period, there was hardly any month without a PCHD-related activity in the target sites. In some months, activities took place for several consecutive days or on weekly intervals, mostly weekends. (It needs likewise to be noted that the community profiling activities in connection with the preparation of proposals for PCHD funding involved about two weeks of intensive interaction between the NGO workers and community residents who served as key informants and guides. The residents were also invited to assemblies which discussed data on their barangay's condition, problems, and needs, along with potential actions and strategies which could address these problems and needs.)

PCHD implementation took place amid the usual day-to-day pursuits of residents, which generally included their own collective efforts to improve their community and the occurrence of externally initiated events, some of which also entailed development assistance. Added to the days devoted to scheduled PCHD activities were visits of members of participating organizations, including those involved with other PCHD target barangays.

Core group of leaders

During PCHD's implementation period, the busiest barangay residents were those selected to constitute the core group of leaders. In addition to their presence in the conduct of group activities, they sat in numerous sessions with COs to plan and assess the results of these activities. They also had to be on hand for discussion sessions with outsiders interested in the progress of PCHD implementation.[2] Furthermore, it was from their ranks that participants in PCHD-initiated activities held outside their barangays were selected.

A very active PCHD leader, that is, one who was involved in almost all PCHD-related activities, would have given no less than about 30 days during the 12-month implementation period in the study sites. These included days spent with COs on formal and informal planning sessions as well as on welcoming PCHD-connected visitors. Training activities held outside the selected barangays, which completely blocked off the participants' time, took place on one to three occasions and covered one to seven days, excluding travel time to and from the training venue. (On at least

three occasions during the proposal preparation period, some of the leaders also traveled outside their barangays for planning sessions, including a three-day workshop, with the proponent organizations and other PCHD participating groups.)

The leaders tried to be present in the group activities. Thus, for instance, the few male participants in the women-dominated health education sessions were usually members of the core group of leaders. Often the leaders also felt compelled to undertake the planned construction work themselves, particularly when mobilizing the residents to participate became difficult. They were also the first to be requested for donations or to volunteer contributions, either cash or goods, when the need for such arose.

Between 10 and 46 persons were identified as potential leaders in the selected sites, representing some 4 to 17 percent of households. The majority were males, most of whom were between the ages 30 and 49 years and engaged in the major livelihood activities in their communities. Many were also incumbent leaders or had served leadership positions in various community organizations, as well as in their respective barangay councils. Thus, in addition to participating in PCHD activities, a number of them were attending to other externally assisted or locally initiated activities, many of which were also construction-related work or involved meetings and training seminars.

Other residents

For the rest of the community residents, participation in PCHD implementation entailed attending meetings or seminars, rendering voluntary labor for construction work, and contributing materials or money. General meetings and seminars did not exceed a total of 15 days in each of the selected sites, including health education sessions which took one to eight days. Construction work which involved voluntary labor covered a maximum total of about 20 days, but work was done either by rotation or only by the specific beneficiary groups. In five barangays, the construction work also gave small cash incomes to a few residents who rendered skilled labor or performed special tasks.

The single most-attended PCHD activity (the launching or orientation session) brought together representatives of about two-thirds of households in one barangay and less than a third in the other sites. In all cases, group activities involved less than a third of households (numbering about 30 to less than 100 households, including those of leaders), turning PCHD into a set of activities which the majority of residents had heard about or seen taking place but in which they had no direct participation. An exception would be the sanitary toilet construction in three sites which attempted to reach all households concerned, covering 79 to almost 100 percent of households. (It could also be assumed that every household in the

selected sites was reached at least once by the NGO workers, either during the community profiling activities or the COs' community integration period.)

New Features of the Barangays

The first year of the PCHD barangay-level implementation period brought about new features of the target sites in spite of some unfinished projects and activities. Immediately visible were the physical results of these activities, some of which were already serving their purposes. Other outcomes were not as discernible but were more indicative of the efforts toward PCHD's community health development goals.

Physical results

The most prominent tangible results of the PCHD work were the domestic water sources, which either became more numerous (in the case of installed pumps or springs with concrete intake boxes and a network of pipes and faucets) or improved (in the case of open wells which were provided with concrete lining and covers). All seven study sites acquired this added feature, although in one site the new facility was still unused because its water source, which was not under the control of the community, was in need of repair.

Another concrete result was the increase in the number of sanitary toilets. In three barangays where mass distribution of toilet bowls was carried out, the number of sanitary toilets more than doubled. In one site (in which a bag of cement came with the free toilet bowl), the figure already reached 71 percent of the target households, while in the other two (in which a small amount was required to receive a bowl), 17 and 26 percent, respectively. In these three barangays, there were still more bowls for installation and bowl construction was continuing. The rest of the sites were either building communal toilets or planning the construction of individual household toilets. When finally accomplished, the plans could substantially increase the number of households with access to sanitary toilets.

In one barangay, PCHD implementation gave a facelift to the area. The residential clusters developed distinctive appearances, supplied by new homelot fences and hedges, tidy open spaces, and small parks with vegetable and herbal gardens built as part of the beautification and cleanliness campaign as well as the food production components of the PCHD work. In some sites, however, the gardens became testimonies to flaws in planning or implementation as these were either being overrun by weeds or had just been established owing to the difficulties encountered in mobilizing the residents' participation. The planned number of gardens had also not been met. (Work on the planned gardens in two barangays had yet to be started.)

In three barangays, multipurpose centers were added to the landscape. The main function of these structures would be to house the RHM during her visits to the barangay. In at least one case, the PCHD-organized community health group also planned to use the structure as its office.

Without doubt, the year-long PCHD implementation in the selected barangays had physical results to show off. These reflected both the external assistance given and the voluntary group work that the residents rendered. Constructing domestic water systems and sanitary toilets, building multipurpose centers, and establishing vegetable and herbal gardens were employed as strategies in attaining collective action and, at the same time, regarded as health-focused interventions. Hence, PCHD had already put in place some of the facilities which could help improve the communities' health condition.

Other outcomes

Though not readily discernible, the conditions for, even the beginnings of, personal and community transformations were gained. Planning the PCHD work in the selected sites granted the residents a process by which they could look inward into their individual and community situations and the resources they could harness to address their problems and needs. By participating in PCHD projects and activities, residents were exposed to occasions in which they could cultivate their group-directed values, enhance their leadership and organizational capabilities, improve their health knowledge and practices, and learn skills in income-generating enterprises.

Construction work gave opportunities to some residents to gain skills in carpentry and masonry. In four barangays, a number of residents learned how to make concrete sanitary toilet bowls (which also could have long-term positive implications on the presence of sanitary toilets in these areas). One of these residents was subsequently invited to demonstrate bowl making to the residents of other PCHD target barangays. Moreover, formal training on handicrafts production was given to residents of two barangays.[3]

At the community level, PCHD implementation resulted in the formation of new community organizations or the reactivation of old groups, and the training of volunteer community health workers. It also allowed the communities to establish linkage with groups from other areas.

In six sites, at least one new organization was formed, whose membership was open to all residents. Four of these groups were formally organized, with a name, set of elected officers, and constitution and bylaws. The others were still in the ad hoc stage but had apparent plans of becoming formal groups. In one site, no barangay-wide organization was formed as the barangay council was considered as

the group responsible for PCHD implementation. However, groups by residential clusters were formed, each with a set of officers. The first task of the organized groups in the selected sites concerned the implementation of PCHD-supported projects and activities.

Trained community health workers were added in four barangays. In two other sites, existing barangay health workers received a boost in their stature, if not their skills, through their active participation in PCHD activities. Thus, trained community health workers were now found in six of the seven sites, forming worker to households ratios between 1:21 and 1:125. (In addition, at least one RHU-trained traditional birth attendant resided in these areas.)

The communities' work with the proponent NGOs was certainly the first external linkage which PCHD helped to forge. This linkage expanded as PCHD implementation progressed, and gave the communities specific reasons to come in closer contact with the DOH's RHU and IPHO, the municipal government, local offices of other national government agencies, and other NGOs. Equally important, residents of the selected sites were involved in sharing sessions with their counterparts from other barangays which were also pursuing development goals, including PCHD. This took place either in training seminars or in study visits, in which the participants bared their problems, their needs, and their visions for their respective communities. In two cases, the participation of the newly organized community groups in municipality-based associations with similar interests or goals was initiated.

Issues and Implications

The barangay-level phase of PCHD implementation yielded issues, problems, and areas of concern which could provide lessons related to forming and sustaining community health development partnerships, strengthening the individual competence of partner-organizations, and building community capabilities for health care management—with the effectivity of the Local Government Code serving as backdrop. While the issues were highlighted by the year-long community work, some needed also to be viewed in the context of the almost two years of provincial partnership building and planning which initiated the PCHD's community health development process.

Developing Partnerships for Health

PCHD implementation could be viewed as involved in the development of two levels of partnership for health—provincial and municipal. The first to be initiated was the DOH-NGO-LGU partnership at the provincial level. In addition to its

capability-building tasks, this partnership would assist in forming municipal-level partnerships. The latter would pursue barangay-level PCHD implementation and subsequently support community-level basic health care management. PCHD gave funds and technical assistance to the provincial partnership. It supported the municipal-level partnerships through the grants given to individual barangay-level work. As recipients of these grants, NGOs became entrusted with the responsibility for overseeing PCHD community implementation and keeping the municipal-level partnership active.[4]

All groups expected to be key partners in barangay-level PCHD implementation need to perform their roles and tasks actively and in consideration of attaining an integrated and effective field action.

In keeping with PCHD's design, most approved PCHD proposals specified the roles and tasks of the proponent organizations, and indicated the participation of the other major partners, that is, the RHU and municipal government concerned.[5] In general, RHU was tasked to perform its usual service delivery functions, particularly the conduct of health education seminars and assistance in the provision of sanitary toilets and safe water sources. The municipal government was expected to augment the resources made available by PCHD, a role which was also envisioned for other national government agencies.

The partners' roles tended, however, to become parallel pursuits, if not altogether inoperative. As revealed by the selected Camarines Sur experiences, PCHD implementation could have gone on, and did go on in many instances, without the active participation of the other partners. In tandem with community residents, the proponent NGO carried out the completion of the proposed PCHD work, so it could meet its obligations as grant signatory-recipient. This was not difficult to pursue as any of the planned projects and activities could indeed meet their physical or quantitative targets without the involvement of either RHU or LGU. For instance, one proponent NGO which included a health team in its staff conducted sessions on health education and community health workers' training, as well as held a barangay medical clinic, without the presence of an RHU member. In sites where RHU provided the health education, the sessions' designs and conduct rested almost solely on the RHU staff. Two proponent NGOs hired engineers to supervise the water system projects, which were completed without a visit from an RSI. In the case of LGUs, participation in PCHD implementation was limited to the provision of asked-for construction materials and the occasional presence of officials to address PCHD-initiated community assemblies. In one site, the LGU concerned did not enter into

the implementation picture nor was this sought by any of the participating groups. Interestingly, in three barangays the LGUs were also undertaking projects similar to those being implemented through PCHD.

(Thus, when viewed from a physical accomplishment-oriented perspective, PCHD implementation in one barangay in which the proponent was the LGU did not considerably differ from that in other sites. The infrastructure projects undertaken in this barangay were similar to those in the other sites, and these brought about even more dramatic positive physical results. The planned education and training activities in this barangay were not as numerous and elaborate as those planned for the other sites, but because of the unfinished work in the latter, the difference might not matter much.)

PCHD is not a result-driven endeavor, at least not on the short term and with regard to physical accomplishments. The active involvement of various groups in its implementation is in itself a goal, ensuring consequently the intersectoral nature and sustainability of action at the community level. Averting independent work has to be embedded in the initially defined roles of the partner-organizations. More important, one of the partners has to take on a facilitator role to ensure that all involved become actively engaged in the planned work.

At the provincial and municipal levels, mechanisms which will allow regular interactions for enhancing the learning process among the partner-organizations need to be established.

Barangay-level PCHD implementation in Camarines Sur took place after the provincial partnership ceased functioning as an active group.[6] Unfortunately there was no other venue or mechanism in which field experience sharing and assessment at the provincial level, and thus across sites, could regularly be conducted among the participating groups.[7] PCHD's a priori concerns and the issues emerging from field implementation, however, called for systematic action-reflection sessions among the participating groups.

At the outset, it was evident that the participating groups had diverse backgrounds and skills, and generally needed a balanced social and technical perspective of community health. For one, proponent NGOs which had no extensive health-focused experience could hasten the improvement of their knowledge of the technical aspects of PCHD work through experience-analysis sessions with IPHO and other NGOs with long-time experience in health-focused activities. Some NGOs likewise needed assistance in developing their community organizing strategies. On the part of IPHO and the provincial government, their regular sessions with the

proponent NGOs could help them gain better understanding and appreciation of the community organizing process. Regular interactions could also bring about more effective or timely resource sharing (see next section).

Moreover, regular sessions of the provincial partnership could address questions pertaining to its role after the PCHD provincial planning and barangay-level implementation phases, that is, beyond PCHD as a DOH grant-providing activity. Does the PCHD-initiated provincial partnership have a long-term place in community health development? What are its roles as a group? What type of group should the partnership be? What are the IPHO's redefined roles in the partnership and in community health development as an LGU unit under the Local Government Code? What are the other roles of the LGU and its other offices? the NGOs? the DOH and its field office?

At the municipal level, regular interaction among the participating organizations was likewise absent. In addition to bringing about a more systematic group learning process, such sessions could result in timely decisions as regards site-specific actions. (Initial PCHD implementation in Camarines Sur involved 15 of the province's 35 municipalities. Only two municipalities had more than one PCHD target sites but each of these municipalities had only one NGO proponent.) At the same time, the sessions could cover more general concerns such as refining roles and tasks not only for the ongoing PCHD implementation but, more important, for expanding the coverage of, and sustaining community health development efforts beyond, the PCHD grant period.

- *Resource sharing in the partnership is important not only for an improved community-level PCHD implementation but for eventual intersectoral action for health.*

When PCHD brought together the partner-organizations, one expectation was that each group's capabilities and resources could openly be made available in pursuit of more effective field implementation. This was reflected in the limited PCHD-allocated budget for each site, which was earmarked only for health-focused work, as well as in the DOH's candid urging to proponents to tap other sources of assistance, including other national government agencies.

Resource sharing among the PCHD participating groups took place. This was particularly evident in the provincial planning phase but was clearly in need of being systematized or formalized during the barangay-level implementation period, particularly because this was taking place mostly only among the fieldworkers. For instance, a CO in one site invited members of another proponent NGO (her friends

and former co-workers) as resource persons in seminars she was organizing for the PCHD work. Members of one NGO invited to their PCHD leadership training seminar some officers of cooperatives organized earlier by another proponent NGO. Another NGO requested a resident of another PCHD site who was trained in toilet bowl making to share his skills with selected residents of the NGO's PCHD sites. (But for the same activity, another NGO invited a resident of a non-PCHD site.) The instances of sharing among the participating NGOs took place largely because many of the proponent NGOs' workers were personally known to each other, with quite a number having previously worked together for another PCHD proponent NGO. Thus, there could have been more occasions for sharing had this been systematized. This could have been more effectively done, too. In the case of the CO who invited her friends to serve as resource persons, for example, scheduling the visits to the PCHD site became quite difficult because the invitations were not officially known to the NGO.

(In relation to resource sharing, it is worth noting that three original member-NGOs of the provincial partnership offered their assistance in barangay-level implementation when they declined to become proponent organizations. These NGOs had well-known experiences in mobilizing resources for development projects. As seen in the study sites, however, their offers had not been taken up.)

Local offices of other national government agencies were also tapped to assist in PCHD implementation. But these were discrete actions and did not involve a look into how a more intersectoral action could take place. For instance, while the Department of Agriculture provided trainors and materials for some of the vegetable gardening projects, its regular agricultural extension and other work in the PCHD sites were not drawn into the ongoing PCHD work. The Department of Social Welfare and Development was asked to support through its food-for-work program a PCHD construction work, but assistance from its nutrition program was not solicited in spite of the nutrition component of the planned PCHD activities.

As already pointed out, some LGUs also implemented projects in the PCHD sites which were similar to the planned PCHD work; this, despite their being PCHD partner-organizations. The Department of Public Works and Highways undertook infrastructure projects, including domestic water system construction, in some of the PCHD sites, but there was no attempt to relate these to the ongoing PCHD work.

The importance to PCHD implementation of resource sharing among the participating organizations is easily recognized. Equally necessary, but particularly for the sustainability of community health development, is intersectoral action.[8] But how can intersectoral action occur? Who brings together the various actors, with each having its specific mandate or target groups? To what extent beyond resource

sharing can intersectoral action be carried out at the community level? As initial PCHD experience revealed, intersectoral action might not logically take place without more directed efforts. But without the participation of the various sectors, development work would remain limited. DOH, specifically, CHS and RHO, is thus challenged to actively seek intersectoral action for health.

Strengthening Competence of Assisting Agencies

As an innovative development approach, PCHD embraces an assumption that the participating organizations do not have all the capabilities needed to become an effective partner to each other. Its implementation hence is envisioned as also a process by which the required structures, procedures, skills, and tools are identified and eventually absorbed as routine parts of the health system. PCHD challenges DOH to incorporate community health development in its work mode, particularly in its new roles vis-a-vis LGUs and the local health systems. NGOs, for their part, are placed in that critical role of serving the needs of government, on the one hand, and of communities, on the other.

DOH has to have more dynamic enabling roles, beyond providing grants and technical assistance, which should actively involve not only CHS but other central-office-based units and particularly RHO.

The most prominent role of DOH in PCHD implementation was that of a grant provider. Through CHS and IPHO, DOH was very active in providing assistance in activities related to the formation of provincial partnerships and generation of community project proposals, which were requirements for accessing PCHD grant funds. Its presence, however, was hardly felt in barangay-level implementation, except through RHU's involvement as a PCHD co-implementor, which in many instances was also wanting.

As already mentioned, the Camarines Sur partnership, which was expected to be a venue for CHS's direct participation, became inactive. Taking its place was the occasional one-on-one interaction between CHS or its provincial counterpart, IPHO, and the proponent groups, which certainly was a staff-engaging and time-consuming task. Moreover, this type of interaction tended to be confined to specific problem solving and gave less opportunity for surfacing and understanding broader-based issues and concerns.

In the selected barangays, personnel of CHS, RHO, and IPHO occasionally conducted "monitoring and supervisory" visits. That is, the personnel concerned came to the sites, looked at some of the physical results of PCHD implementation,

asked some residents and other PCHD participants a few questions, and gave suggestions to the proponent organization as well as to other participating groups. Such visits will become valuable when learnings are used in micropolicy formulation; otherwise, they turn out to be extractive, remaining only as part of the visitors' individual learning endeavor.

It is not being suggested, however, that DOH improve its physical presence in the PCHD barangay sites. DOH's involvement has to be evident through policies, guidelines, procedures, and structures supportive of the community health development processes taking place at various levels. The effort of CHS to come up with PCHD implementation manuals on the basis of initial field experience was a step toward this direction. A continuing need concerns the regular review and revision of these manuals as more experiences are gained and more areas are reached. Other notable CHS-initiated activities were the holding of provincial implementation review sessions, regional conferences, and cross-site visits which could bring together PCHD implementors from different areas. All these can allow the participating organizations, as well as individual participants, additional opportunities for reflection and learning, and hence are in need of systematic adoption.

Under the devolution, DOH lost both IPHOs and RHUs as its field units. Only RHO remained its direct link to local groups and communities. As PCHD coverage expands, the tasks which CHS and IPHOs have been performing will have to be turned over to RHO. These include partnership building and technical support to barangay-level implementation, as well as meeting the administrative requirements for releasing grant funds. In the PCHD Year 1 sites, to which the study barangays belonged, RHO's participation in barangay-level implementation was limited to occasional barangay visits and meetings with some of the participating groups. The efforts made in succeeding sites to get RHO more involved in PCHD implementation need hence to be directed toward improving its capability to take over most of CHS's administrative and facilitator tasks. The latter needs to be given emphasis as this is critical for maintaining PCHD's DOH-LGU-NGO partnership element, and for ensuring that the required technical support is accessible.

Even as it makes itself available for assisting RHO in developing its capability for PCHD work, CHS can then be released to concentrate on its policymaking and advocacy roles. In the central office, CHS is challenged to actively share its learnings on PCHD with other service units, particularly with program managers, so these could also be used in developing community-based perspectives for disease-focused or area-specific programs (e.g., tropical disease control or urban health). At the national level, CHS can also begin to address issues related to the integration of health-focused work into intersectoral action. In addition to these advocacy activities,

CHS has to look into policies which may need to be formulated in support of community health development.

While community organizing is a task that has been delegated to NGOs, in many cases the capability to undertake this may need to be improved or enhanced and has to be coupled with some amount of technical competence in health-focused work.

An assumption of PCHD was that the capability for community organizing was to be found among NGOs. There was nonetheless an acknowledgment that many NGOs might not have the needed experience in health-focused work. In PCHD's active search for NGOs which could serve as main proponents of barangay-level projects, the potential proponent's community organizing skill was thus given more attention. This could not strictly be applied, however, owing to the limited number of NGOs operating in or willing to work in the target areas.

PCHD experience in the study sites raised a number of questions on the community organizing strategies employed. In all sites, the PCHD work tended to focus on the major residential clusters and neighboring areas. An overlay of the areas and households directly benefitted by PCHD against the barangay layout would show this tendency. Moreover, the membership composition (e.g., who among the members of a household, male or female residents) of the PCHD-organized groups did not become a subject of intensive community discussions. What are the implications of these on the nature of the newly organized community health groups and the concern to have a community-based basic health care system? Are the households and individuals most in need of services already being reached? If not yet, when? Who will ensure that the marginalized households and groups are eventually covered?

The NGOs' capability for health-focused work may be viewed through the plans for the selected sites. Similar projects and activities were proposed in spite of the varying specific health conditions in these barangays. While the participatory nature of the planning process could account for the commonalities, still questions may be raised as regards the need for the planning process facilitators to assist the communities in recognizing critical health problems or more urgent needs. For instance, why were demonstration vegetable gardens the only intervention planned in sites where malnutrition was at alarming levels? (In one barangay, the figure for severely and moderately underweight children reached 45 percent on the basis of a 100-percent weight survey coverage.) Why was the training of community health workers not included in the plans for a highly inaccessible barangay with no such

health provider? Why was a limited number of communal toilets planned for a barangay where about 85 percent of households had no sanitary toilets and many domestic water sources were open? And why was there no forceful effort to link health-related infrastructure work with health education sessions?

Weaknesses in the community organizing process as well as in the technical aspects of the PCHD work could again be traced to the absence of mechanisms by which the proponents could systematically share and assess their experiences. These could likewise be attributed to the hardly-felt facilitator role of DOH. As the initial assumptions of PCHD with regard to the NGOs' community organizing skills and technical competence in health development work become clarified during implementation, more efforts need to be given toward the training of NGO workers. While improving their community organizing skills is the responsibility of NGOs themselves, DOH has to actively assist them in gaining technical knowledge. This can largely be accomplished through formal training and experience assessment sessions. Moreover, DOH needs to train IPHO and RHU field personnel in health service delivery within a community organizing process so that their work with NGO members could also redound to the latter's technical competence building.

Together with giving attention to improving their skills in facilitating a community-directed implementation of health-focused projects and activities, NGOs need to render assistance in developing the competence of DOH and LGUs in pursuing participatory development.

In the efforts to reorient DOH and LGUs on the participatory strategies advocated by PCHD, much also depend on the NGOs' capability to analyze and translate their field experiences into lessons for improving the organizational and managerial capability of government agencies. The NGO participants in the PCHD work in the initial target sites indisputably faced constraints in field implementation attributable to DOH organizational or managerial structures and procedures, as well as to the absence of active LGU participation. In the study barangays, for instance, the DOH's grant release procedure contributed significantly to the big gap between the community profiling and planning process and the implementation period, as well as to the ill-timed start of projects in relation to the communities' usual activities. While a number of problems were outside the DOH's control (such as Commission on Audit rules), many could have been handled more effectively by proponents had these been presented to them at the outset in more definite terms (such as the DOH's usual lack of funds in the first quarter of the fiscal year and thus the need to release grant commitments before the yearend, and the requirement for

a Bureau of Internal Revenue-registered receipt in receiving DOH payments). Unfortunately, aside from individual criticisms and complaints, there had been no collective suggestion or action from NGO proponents which could propel DOH to improve its procedures. Likewise, there had been no clear nor unified NGO stance on how LGUs could effectively participate in PCHD field implementation.

The provincial partnership provides an available forum for systematically analyzing PCHD implementation issues and the implications of these on improving the DOH system, as well as on enhancing LGU participation. As PCHD facilitators, CHS and RHO need to ensure that such assessments regularly take place and that results from various sites are collated and analyzed at the central-office level. The Community Health Policy Committee was considered as the body which could provide this analysis, but its initial task became confined to proposal review and approval. With the decentralization of this task as a result of the devolution, CHPC could hence focus on its policymaking assignment. CHS, CHPC's secretariat, should ensure that there are appropriate NGO and LGU representations and that there are collective or systematic NGO and LGU inputs in the agenda and discussions.

The devolution of health facilities and services from DOH to LGUs challenges the latter to render more significant attention to the use of the community health development approach.

The 1991 Local Government Code provides for conditions in which local resource development and management could best take place. In health, the devolution was a challenge to improve both the reach and quality of health services. PCHD pursued the same goals, highlighting the roles of organized community groups in identifying the appropriate or site-specific activities and strategies in basic health care management, and the involvement of NGOs in organizing communities and developing their management capabilities. Thus, when RHU became an LGU office and was thrust into the forefront of almost all major activities related to health development, PCHD offered strategies which RHU could adopt. In areas in which PCHD was implemented, RHU-NGO partnerships had been forged and community health development had been initiated in selected sites. Here, there is a need for mechanisms for maintaining these partnerships and using the learnings from the initial experience to expand community health development efforts. In non-PCHD sites, the need focuses on popularizing PCHD experiences, specifically, strategies and processes. Both needs require DOH, particularly CHS and RHO, to take an active advocacy role coupled with making technical assistance readily available to RHUs.

Building Community Management Capability

Enhancing and sustaining the gains made by PCHD toward community health development depend considerably on the capabilities developed among the organized local groups. Thus, the pursuit of active community participation from project identification and planning to implementation has to incorporate organizational capability building. This includes raising questions on the major roles and relationships of various community groups in health care management, within a community-based local resource management perspective.

A reassessment of the processes, methods, and tools used in generating data for community planning appears in order.

PCHD required that proposals for community project grants be generated through a process of participatory community diagnosis and planning. To achieve this, PCHD provided a grant to proponent organizations, through the provincial partnership. Moreover, CHS and IPHO assisted the partnership in developing health-focused community profiling and planning methods and tools, and in training fieldworkers of proponent organizations in using these tools.

Community diagnosis and planning begins the process of raising the awareness of residents as regards their collective conditions, needs, problems, and potentials. It produces appropriate plans and is the foundation of community-based action. As it turned out, the process appeared to have become less systematic but more focused on its output, the project proposal. This could partly explain, as earlier pointed out, the similarities of the planned projects in the study sites in spite of varying health and other local conditions, as well as the absence of a fit between the PCHD implementation schedule and the community activity calendar.[9] Moreover, additions or revisions in the approved plans, such as installing pitcher pumps in different places instead of one deep well or abandoning a water system project because of an unresolved right-of-way problem, reflected some weaknesses in the planning process.

The big gap between community profiling and project implementation owing to funding and other constraints likewise frustrated a smooth transition from planning to implementation. The subsequent drive to complete the approved projects and activities did not include another community diagnosis and planning process, blunting the efforts to develop among the community residents a systematic view of the link between local conditions and collective action. (A parallel weakness may be found among the NGO workers. Of the six study sites with NGO proponents, only one had a CO who was present from the community profiling activities to project implementation.) Unfortunately, the noncompletion of the planned projects at the

end of the 12-month grant period apparently also prevented the conduct of a community diagnosis and planning process for a second year of PCHD assistance.

Several issues surface from the community diagnosis and planning process in the study sites and demand attention from DOH (that is, CHS and RHO), LGUs (particularly the health offices), and NGOs in the effort to assist communities in pursuing health development. One pertains to the methods and tools developed in initial PCHD sites and the need for DOH to maintain its assistance not only in popularizing their use but also in refining these as more experiences are gained. Another issue concerns COs and other fieldworkers and may be phrased, thus: To what extent can community members be assisted in identifying project activities and strategies which appropriately interface social and technical data without violating the participatory perspective? Related to this are the issues regarding the need to enhance the COs' skills in the data gathering and analysis methods of community profiling, and their technical competence in health-focused work.

Finally, community diagnosis and planning has to become an iterative process or a routine part of community action. In their community capability-building activities, COs and other fieldworkers have to systematically include developing the community residents' skills in this process.

The role of the barangay council in community health development has to be given attention.

PCHD implementation in the study sites saw variations in the role of, or expectations from, the barangay council. In two sites, the barangay councils served as PCHD community implementor, but in one of these sites a new CO subsequently organized the active PCHD participants into an organization. The members of the barangay council were disqualified to become officials of this group, which took over PCHD implementation three months before the end of the 12-month grant period. In two other sites, the barangay council was deliberately left out, while in the other sites, no position on the barangay council's role was apparent. In these sites, barangay council members were included among the potential leaders though their selection was not clearly a result of their official positions.

The barangay council is a given, undeniably important, part of a community and its resource management activities. Residents of one site highlighted this when they brought up the need to turn over a PCHD-completed water system to the barangay council for management, citing that this was the logical thing to do. Other sites turned to the barangay council in mobilizing labor and materials for construction work which would benefit residents outside the membership of the PCHD-organized

community health groups. Moreover, in one site the barangay council was prevailed upon to pass an ordinance imposing fines on residents who would not cooperate in the PCHD-supported toilet construction project.

At the outset of the community organizing process for health development, there is a critical need to raise the issue on the barangay council's role. With its broad concerns and multipurpose mandate, the barangay council may indeed not be expected to become the lead community organization in managing health-focused concerns. Involving the barangay council in PCHD implementation, however, could help surface some of its tasks relevant to supporting and sustaining community health care management. The barangay council's participation could also bring about the intersectoral action required by community health development. The challenge to COs and other key participants is to ensure that the barangay council does not dominate the development process and result in the planning and implementation of PCHD-supported projects and activities in the conventional manner usually employed by the barangay council. More important, such participation should not draw away the potentials for organizing and strengthening a group which would focus on the community's health problems and needs.

In addition to their health service provider roles, volunteer community health workers need to be regarded and supported as leaders and organizers for health.

The training given to the community health workers highly suggests that their roles would focus on being health service providers, especially in the absence of the RHM. The relationship initiated between the health workers and the RHU staff likewise emphasized this role, preserving the traditional outlook that community health workers were aides of the RHM and other RHU personnel. While a link between the health workers and the health personnel was established, the relationship between the workers and the organized community groups was not very clear. The workers' place in the organization nor the organization's responsibility toward the workers was not raised. (An exception was one site, in which the health workers were organized and considered as the health group within a barangay-wide organization. Unfortunately, the recruitment and training of these new workers ignored the existing barangay health workers who had linkage with RHU.)

The devolution provides an auspicious condition for helping shift the community health workers' sense of accountability, from DOH to the community. Continuing assistance to the health workers, as well as to the community health group, hence needs to focus on how they could become an integral part of this group, not only as health service providers but as mobilizers and catalysts for community health

development. Attention has also to be given to how the workers can directly be supported by the community health group.

Further Needs and Concerns

A year of health-focused projects and activities could not immediately bring about a changed health status in a community. Neither could it develop a community organization which could already sustain health care management. These were realized even before PCHD went on to its barangay-level implementation stage. Thus, a second year of funding support to communities was part of the programmed assistance from PCHD. The end of the first 12-month grant period, however, did not become the appropriate time to raise the issue as many planned projects and activities were still ongoing or had yet to be undertaken. Hence a fast, uninterrupted transition to a second grant could not be achieved. Neither could the outcomes of the first grant be completely assessed.

An assessment of the processes involved in PCHD implementation is significant in keeping track of its participatory nature. On the long term, it may likewise be important to quantify the qualitative changes taking place among individual community residents, their households, and the community itself, as well as to look into health status impact. As in other aspects of PCHD implementation, the formulation of indicators needs also to become participatory.

The first year of PCHD's barangay-level implementation centered on basic health needs and general concerns, and the formation of community health groups. Succeeding years will have to focus on sustaining these groups and how these groups could manage not only basic health needs but address more specific or specialized community concerns. Among these are the disadvantaged groups owing to extreme poverty, women and children, the aged, special cases such as those with debilitating or degenerative diseases, and those with exceptional physical or emotional needs. Indeed, there is yet a lot to be done to finally put in place a community health care system.

Notes

1. In assessing attendance in group activities, this study assumes a one-person attendee from each household. Figures on PCHD reach may actually be slightly lower because, in the case of the households of leaders and other active PCHD participants, there were occasions in which the couples or a number of adult members were present.

2. Certainly researchers are included among the outsiders vying for the residents' time and energy for experience sharing.

3. In one barangay, more intensive livelihood enhancement activities, including the provision of loans, were undertaken, but these were components of the proponent NGO's other programs and were clearly outside the PCHD-supported work.

4. While one of the proponents in the selected sites was an LGU, the study's discussion on implementation issues focuses on NGOs as proponents, which was PCHD's original intention. In one of the study sites, the LGU became a proponent only because an NGO abandoned the site after the planning phase. Nonetheless, the implications of involving an LGU as a PCHD proponent are also discussed in pertinent sections of the report.

5. Letters of endorsement from the RHU and LGU concerned were also required in the PCHD proposal approval process.

6. Among other reasons, the Camarines Sur PCHD provincial partnership became inactive when its NGO convenor considered its role as accomplished when an integrated project proposal was submitted to, and subsequently disapproved by, DOH (see Veneracion 1993a).

7. As part of the PCHD's capability-building strategies, a grant was given to the province for the conduct of training activities among selected members of the proponent organizations. This, however, came at the tail end of the first year of barangay-level implementation.

8. The call for intersectoral cooperation for a sustainable health development is contained in numerous materials, from policy and program papers to studies of experiences in community health initiatives (see, among others, World Health Organization 1978; Morley, Rohde, and Williams 1983; World Health Organization 1986; and Oakley 1989).

9. The similarity of the planned PCHD work in the study sites is likewise found in other Camarines Sur PCHD sites as well as in other PCHD provinces. This raises the issue on whether or not the projects and activities are indeed the logical initial interventions toward community health development. The growing PCHD experience can eventually provide enlightenment on this.

   Moreover, there is a need to understand the extent to which the grant fund allocated by DOH for each target site has influenced the type and number of proposed projects and activities. In the majority of cases, the exact full amount of the allowable grant, or with small additions which could not be rounded off, was requested.

Appendix A

Tables to Accompany Text

Table A1. Selected information on the project proposals for selected Camarines Sur PCHD sites, 1991-93

Barangay/ Proponent	Community Profiling Conducted[a]	Proposal Submitted to CHS	Date Approved	Approved Grant	Fund Releases[b]	Start of Project[c]	End of Study Period[d]
Bagadion TALINGKAS	Sep-Oct 90	May 91	Jun 91	P 211,028	Dec 91 Jun 92	Jul 91	Dec 92
Cabinitan LISAFI	Sep-Oct 90	Sep 91	Oct 91	P 249,850	Apr 92 Dec 92	Sep 91	Dec 92
Ibayugan FACE	Apr-May 91	Jun 91	Jul 91	P 200,000	Apr 92 Dec 92	Jul 92	Jun 93
Mansalaya MAYOR'S OFFICE	Sep-Oct 90	Jun 91	Jun 91	P 105,534	Oct 91 Jul 92	Sep 91	Dec 92
Pandan PRRM	Sep-Oct 90	Nov 91	Dec 91	P 210,500	Oct 92 --[e]	Oct 92	Aug 93
Pantat PAGBICOL	Apr-May 91	Jun 91	Jun 91	P 699,220[f]	Oct 91 Aug 92	Nov 91	Dec 92
Penitan CASAFI	Jul 91	Sep 91	Oct 91	P 613,350[f]	Apr 92 Dec 92	Aug 92	Jul 93

[a]In Bagadion, Cabinitan, Mansalaya, and Pandan, the profiling activities were conducted in the same period using an agreed-upon design and timetable (about two weeks). When the Mayor's Office took over proposal preparation for Mansalaya, it used the data gathered by the NGO concerned and validated these in a meeting with barangay leaders. In Ibayugan, Pantat, and Penitan, the profiling activities took about a week.

[b]The PCHD grant was given in 50-50 percent releases; the dates indicate the periods the first and second checks were prepared by the DOH cashier's office. In general, checks were received by the proponents concerned soon after these became available.

[c]The dates indicate the formal PCHD launching in the barangay, except in Pandan, in which the date marks the receipt of PCHD funds.

[d]The process monitoring research was begun from the community profiling activity, and lasted until at least 12 months after launching.

[e]The second payment had not been released as of August 1993.

[f]The requested and approved amount covered three PCHD target sites of the proponent; no breakdown per barangay was presented.

Table A2. Selected characteristics of selected Camarines Sur PCHD sites, 1990-91[a]

Barangay/ Municipality	Modes of Access from Town Center and Distance (in km or Travel Time)	Population (HHs)	Land Area: Major Land Types	Major Sources of Income
Bagadion LIBMANAN	- skates (11 km away), then hiking - jeepneys (but rare) via Barangay Mambulo Nuevo, then hiking	1195 (211)	222 ha: Rainfed ricelands (about 140 ha), irrigated ricelands (30 ha), open spaces and homelots	Rice farming (about 80 percent of households), wage farmwork, small business enterprises
Cabinitan RAGAY	- skates through 7-km railroad tracks, then hiking	589 (105)	300 ha: Rainfed ricelands (about 100 ha), coconut lands (70 ha), areas planted to coffee and fruit-bearing trees (65 ha), open spaces and homelots	Rice farming (24 percent), coconut farming (15 percent), wage farmwork (27 percent), carpentry, operating skates, rootcrop and vegetable cultivation, small business enterprises, fishing
Ibayugan BUHI	- motorboat (30-40 min)	1600 (272)	868 ha: Coconut lands (about 250 ha), lands planted to abaca, rootcrops, and vegetables (350 ha), rainfed ricelands (15 ha), fishponds (12 ha), homelots and forested areas	Vegetable and rootcrop cultivation (40 percent), fishing (20 percent), coconut and rice farming, abaca production, hired labor
Mansalaya DEL GALLEGO	- motorboat (45 min) then hiking through 1.5-km dirt road - private trucks during dry months (30-45 min)	740 (125)	240 ha: Rainfed ricelands (about 120 ha), coconut lands (70 ha), lands planted to sugarcane, rootcrops, and vegetables, and homelots	Rice and coconut farming, hired labor, small business enterprises

Table A2 (cont.)

Barangay/ Municipality	Modes of Access from Town Center and Distance (in km or Travel Time)	Population (HHs)	Land Area: Major Land Types	Major Sources of Income
Pandan CABUSAO	- tricycles (15 min)	1753 (267)	750 ha: Irrigated ricelands (about 300 ha), rainfed ricelands (150 ha), pasture lands, homelots, shoreline	Rice farming (70 percent), fishing (20 percent), fish trading, carpentry, small businesses
Pantat TINAMBAC	- motorboat (3-4 hr; once-a-day trip) until Sitio Nagpatong, then banca to Sitio Turo (over 1 hr), then hiking (30-45 min)	1129 (199)	994 ha: Coconut lands (about 900 ha), rainfed ricelands (3 ha), lands planted to rootcrops, and homelots	Coconut farming (90 percent); rice farming, charcoal making, fishing, gathering shells, copra making, and carpentry
Penitan SIRUMA	- motorboat (about 30-40 min) - banca (about 1 hr) - hiking (2.5 hr)	868 (172)	870 ha: Coconut lands (about 270 ha), areas planted to rootcrops, swamplands, forested areas, and homelots	Fishing (66 percent), coconut cultivation and copra making (11 percent), rootcrop cultivation (6 percent); rice farming, carpentry, hired labor, farmworkers, and small businesses

[a]For Bagadion, Cabinitan, Mansalaya, Pandan, and Pantat, data were as of 1990; for Ibayugan and Penitan, as of 1991.

Table A3. Major facilities found in selected Camarines Sur PCHD sites, 1990-91

Barangay	Facilities Present[a]
Bagadion	Elementary school (Grades I-VI); Chapel; Irrigation system; Multipurpose pavement[b]; Partly concrete main barangay road; Rice mills (2)[c]; Palay buying stations (4); Sari-sari stores (12); Electricity
Cabinitan	High school; Barangay/multipurpose hall; Multipurpose pavement; Sari-sari stores (4); Electricity (only in one sitio)
Ibayugan	Elementary school (Grades I-VI); Chapels (2); Health center; Multipurpose pavement; Sari-sari stores (13)
Mansalaya	Elementary school (Grades I-VI); Chapel; Barangay hall; Multipurpose pavement with stage; Partly concrete main barangay road; Sari-sari stores (12)
Pandan	Elementary school (Grades I-VI); Chapels (4); Barangay hall; Day care center; Barangay tanod outpost; Multipurpose pavement; Partly concrete main barangay road; Ricemills (3, but not operating); Sari-sari stores (21); Electricity; Irrigation system
Pantat	Elementary school (Grades I-VI); Chapels (3); Barangay hall; Multipurpose pavements (3); Sari-sari stores (15)
Penitan	Elementary school (Grades II-VI); Chapels (2); Multipurpose pavement with stage; Sari-sari stores (4)

[a]The lists do not include domestic water sources (see Table A4).

[b]Concrete pavements are generally used as basketball courts, areas for sun-drying of rice and other produce, and areas for community dance and other gatherings.

[c]Figures in parentheses indicate the number of the facility found in the barangay.

Table A4. Selected health-related data on selected Camarines Sur PCHD sites, 1990-91[a]

Barangay	Malnutrition (in %)[b]			Immunization[c]		HHs with Toilets (in %)[d]		Sources of Domestic Water
				Child	TT	ST	PP	
Bagadion	14%	38%	(n.d.)	35 (36)	39 (42)	14%	n.d.	Pumps (about 50); Open wells; Rivers/creeks
Cabinitan	30	36	(85%)	16 (18)	13 (21)	8	28%	Pumps (22); Open wells; Rivers/creeks
Ibayugan	12	31	(100%)	40 (37)	60 (43)	8	2	Pumps (10); Springs; Open wells
Mansalaya	27	41	(100%)	31 (21)	12 (n.d.)	16	5	Level II system with 5 faucets; Springs; Pumps (3)
Pandan	68	24	(n.d.)	61 (37)	25 (34)	37	n.d.	Level II system with 1 faucet; Pumps (10); Open wells; System in nearby town for drinking water
Pantat	46	38	(100%)	34 (34)	21 (47)	12	<1	Pumps (3); Springs; Open wells
Penitan	6	0	(100%)	16 (25)	8 (30)	6	n.d.	Pumps (10); Springs; Open wells

[a]Data on malnutrition and immunization were provided by the RHUs concerned.

[b]The three columns indicate, respectively, the percent of severely and moderately underweight children, mildly underweight children, and coverage of the weight survey (*Operation Timbang*) among children under six years old; "n.d." means no data available.

[c]Figures on child immunization indicate the number of fully immunized children; those under TT (tetanus toxoid), the number of pregnant women who received at least TT1. The figures in parentheses represent the target number.

[d]"ST" stands for sanitary toilet; "PP," for pit privy.

Table A5. Access to health services and facilities of selected Camarines Sur PCHD sites, 1990-91

Barangay	Within Barangay	Outside Barangay[a]
Bagadion	- 7 traditional healers, including 2 *hilot* (traditional birth attendants); 1 of the hilot received training from RHU - RHM who visited once a week; residing in a nearby barangay (4 km away) where her assigned BHS was located	- Main health center and district hospital, both located in town center (11 km)
Cabinitan	- 4 traditional healers - 2 BHWs - RHM who visited twice a month; assigned to and residing near a BHS in a neighboring barangay	- A traditional healer (who was also a trained hilot) residing in a nearby barangay - Main health center and district hospital, both located in town center (8 km)
Ibayugan	- 10 traditional healers, 3 of whom were also hilot - 8 BHWs - RHM (under PHDP) residing in a neighboring area and who reported to the barangay almost daily	- Health center located in town center - Three private hospitals in a nearby city (17 km away)
Mansalaya	- 2 hilot, 1 of whom was RHU-trained - 1 BHW - RHM (under PHDP) residing in the barangay and covering three other neighboring barangays	- Health center in town center
Pandan	- 3 traditional healers, 1 of whom was also a hilot - 2 BHWs - RHM assigned to a nearby BHS and who visited once a week	- Health center in the town center - District hospital in a neighboring town (8 km away)

Table A5 (cont.)

Barangay	Within Barangay	Outside Barangay
Pantat	- 10 traditional healers, 6 of whom were hilot (2 trained by RHU) - RHM (under PHDP) based in another barangay and who visited once a week	- RHU II center located in another barangay and main health center in the town center
Penitan	- 5 traditional healers, 3 of whom were also hilot (1 RHU-trained) - RHM assigned to a five-barangay coverage and who visited at least once a month	- BHS in a neighboring barangay - Health center in town center - Provincial hospital in Camarines Norte - Two traditional healers residing in neighboring barangays

[a]These pertain to the nearest health service providers and facilities frequented by residents. In addition, a regional hospital and several private hospitals and clinics were available in Naga City.

Table A6. Major external assistance received by selected Camarines Sur PCHD sites as of 1990-91[a]

Barangay/Agencies[b]	Year	Assistance
Bagadion	1970s	Repair of barangay chapel; Construction of additional elementary school building
	1983	Training seminar on livestock production
GO = 8	1984	Distribution of housing materials to typhoon victims; Donation of trophies and cash for barangay sports competition; Donation of bags of cement for construction of barangay road (the cement was used instead to build an irrigation diversion works)
Others = 0	1985	Installation of domestic water sources
	1986	Installation of domestic water sources
	1989	Distribution of food items to typhoon victims; Sale of fertilizer at subsidized prices; Construction of a multipurpose pavement; Repair of a bridge; Installation of domestic water sources
	1990	Sale of rice at subsidized prices
Cabinitan	1984	Construction of high school building
	1988	Installation of a domestic water source
GO = 6	1989	Construction of multipurpose pavement (initial fund release); Installation of domestic water sources; Donation of land for a barangay hall; Donation of materials for barangay hall
Others = 2	1990	Construction of multipurpose pavement (second fund release); Donation of land for a barangay hall; Donation of materials for barangay hall; Issuance of certificates of land transfer

Table A6 (cont.)

Barangay/Agencies	Year	Assistance
Ibayugan GO = 7 Others = 6	1966	Construction of elementary school building
	1970s	Provision of agricultural production loans
	1980s	Donation of materials for chapel construction
	1986	Installation of domestic water source; Improvement of elementary school; Provision of relief goods (food and clothing) to typhoon victims
	1987	Conduct of spiritual education sessions
	1980-89	Provision of fertilizer at subsidized prices
	1988	Construction of elementary school building; Provision of relief goods (food and clothing) to typhoon victims
	1988-89	Provision of medical supplies to civilian victims of military-insurgent encounter
	1990	Construction of elementary school building; Dispersal of tilapia fingerlings; Improvement of chapel; Installation of domestic water sources
Mansalaya GO = 3 Others = 1	1960s	Construction of elementary school building
	1968	Construction of elementary school building
	1970s	Donation of lot for school site
	1971	Construction of high school building (high school operated only for a few years)
	1974	Donation of additional land for school site
	1989	Donation of cement for construction of a stage
	1990	Construction of a barangay hall

Table A6 (cont.)

Barangay/Agencies	Year	Assistance
Pandan GO = 10 Others = 3	1960-90	Establishment of day care centers; Supplementary feeding of malnourished children
	1970s	Construction of elementary school building
	1972	Issuance of certificates of land transfer
	1973	Construction of a bridge
	1982	Installation of a domestic water source
	1987	Installation of domestic water sources; Supplementary feeding of malnourished children
	1988	Provision of agricultural loans; Installation of domestic water sources; Dispersal of piglets and seminar on pig raising; Construction of elementary school building; Construction of a basketball court
	1989	Construction of an irrigation system; Construction of a multipurpose pavement; Installation of domestic water sources; Provision of agricultural production loans
	1990	Installation of a domestic water source; Construction of barangay hall; Improvement of a barangay road; Distribution of fertilizer; Provision of agricultural loans; Sale of rice at subsidized prices; Conduct of farm-improvement seminars; Training on food processing and handicrafts
Pantat GO = 3 Others = 1	1950s	Donation of land for school site and barangay hall; Construction of elementary school buildings
	1960s	Construction of school buildings; Construction of barangay social hall
	1967	Donation of a basketball ball
	1976	Donation of a concrete bust of Jose Rizal for elementary school
	1987	Construction of school building
	1989	Construction of multipurpose pavement
	1990	Construction of school building; Extension of multipurpose pavement; Installation of a domestic water source;
	1991	Donation of land for barangay facilities; Improvement of a chapel; Construction of a multipurpose pavement

Table A6 (cont.)

Barangay/Agencies	Year	Assistance
Penitan	1968	Construction of school building
	1980s	Construction of school building
GO = 6	1988	Construction of barangay road
Others = 0	1989	Construction of multipurpose pavement
	1990	Provision of food supplements for malnourished children
	1991	Provision of medical and dental services; Distribution of piglets for a pig-dispersal project

[a]The lists do not include assistance in the formation of community organizations (see Table A7), which became conduits of some of the external assistance. Also excluded are regular services of government agencies, such as the delivery of health services and agricultural extension work.

[b]The number indicated in the GOs (government agencies) which provided assistance included national government agencies, local government units (municipal or provincial), and congressmen using their development fund or other appropriations; "Others," included NGOs, educational institutions and other organized groups, and individuals or families.

Table A7. Experiences in community organizations of selected Camarines Sur PCHD sites as of 1990-91

Barangay	Total Formed[a]			Total Active			Activities Undertaken	
	GO	NGO	Com	GO	NGO	Com	Inactive	Active
Bagadion	7	0	3	2	0	3	Engaged in capital build up and savings program; Attended cooperative education seminar; Collected contributions from members; Assisted in the distribution of land boundary markers; Undertook management of domestic water sources	Organized benefit dances and sports tournaments; Conducted clean-up drives; Attended to repair and beautification of elementary school; Managed electric service distribution in barangay; Constructed and managed communal irrigation system; Contributed to chapel improvement
Cabinitan	5	0	1	2	0	1	Undertook caroling to raise funds for social activities; Planned for a pig-dispersal project (not carried out)	Engaged in a pig-dispersal project; Requested sprayers from the Department of Agriculture (no response)
Ibayugan	3	5	5	2	4	3	Sponsored benefit dances; Undertook cleanliness, beautification, and gardening activities; Sponsored adult education seminars and mothers' classes; Collected contributions from members	Sponsored adult education classes; Contributed facilities to the elementary school; Conducted prayer meetings; Attended to the maintenance of and activities in the chapel; Attended livelihood training seminars

Table A7 (cont.)

Barangay	Total Formed			Total Active			Activities Undertaken	
	GO	NGO	Com	GO	NGO	Com	Inactive	Active
Mansalaya	4	0	0	4	0	0	(All considered as active in 1991)	Attended to construction and improvement of elementary school facilities; Sponsored benefit dances and basketball games; Took charge of chapel improvement
Pandan	6	2	9	3	2	7	Engaged in capital build up and savings program; Initiated dialogue between landowners and tenants	Organized fiesta and benefit dances; Attended to the construction and improvement of chapels; Engaged in pig-dispersal project and loan program
Pantat	5	1	13	1	1	10	Attended to cleanliness and beautification projects, distribution of toilet bowls, and construction of health center	Attended to the construction and improvement of chapel, basketball court, and waiting shed; Engaged in cleanliness and beautification campaigns; Requested a deep well
Penitan	7	0	1	7	0	1	(All considered as active in 1991)	Constructed a footbridge, fish sanctuary, and stage; Engaged in pig-dispersal project; Managed a domestic water source; Checked on teachers' attendance

[a]The formation of community organizations was initiated by government agencies (GO), nongovernment organizations (NGO), or the community residents themselves (Com).

Table A8. Planned and accomplished PCHD-supported activities in selected Camarines Sur sites, 1992-93

Barangay	Planned Project Components[a]	Status at End of Study Period
Bagadion	- health core group formation with 12 residents	- formed 25-member organization with 11 residents as officers and board members
	- three-day orientation seminar	- conducted two-day orientation seminar on 17-18 Jul 91 for 65 residents
	- establishment of 200-sq m herbal and vegetable garden	- cleared and planted a 200-sq m garden near barangay hall
	- three-day primary health care seminar	- conducted two-day primary health care seminar on 20-21 May 92 for 23 residents
	- installation of one deep well	- installed 15 pitcher pump units
	- three days of onsite leadership training	- conducted three-day leadership training on 28-30 May 92 in Pili, Camarines Sur for nine KAIBA officers
	- three-day nutrition education/maternal and child care seminar	- [b]
	- construction and installation of 67 toilet bowls	- constructed 166 toilet bowls, of which 44 had been installed
	- three days of off-site leadership training	- [b]
	- three-day family welfare seminar	- [b]
		Additional activities:
		- organized 21-member mother's class in May
		- reactivated Bagadion Youth Organization
		- sponsored the participation of one resident to a four-day electoral organizing seminar on 16-19 Jan 92
		- conducted one-day electoral education seminar on 5 Apr 92 for 20 residents

Table A8 (cont.)

Barangay	Planned Project Components	Status at End of Study Period
Cabinitan	- three-day maternal and child care training for 50 residents (onsite) - three-day first aid training for 50 residents (onsite) - three-day environmental sanitation training for 50 residents (onsite) - three-day herbal medicine training for 50 residents (onsite) and trainors' bio-intensive gardening - three-day training on responsible parenthood and value formation for 50 residents (onsite) - seven days of hilot training for five hilot (off-site) - eight days of training on leadership and project management for 10 residents (BHW and leaders; off-site) - eight days of GOBIH training for 15 residents (BHW and leaders; off-site) - installation of six jetmatic pumps - construction of intake box - construction and installation of toilet bowls for 71 HHs	- conducted three-day maternal and child care training for 42 residents on 21 May and 16-17 Jul 92 - conducted half-day first aid training for 20 residents on 3 Aug 92 - conducted two half-day sessions on environmental sanitation for 48 residents on 23 Jul and 3 Aug 92 - conducted three half-day seminar on bio-intensive gardening on 26 Nov 92 for 38 residents and 30-31 Jul 92 for 32 residents - conducted one-day responsible parenthood seminar for 45 residents on 9 Apr 92 - conducted three-day hilot training for 19 residents on 20-22 Aug 92 - [b] - conducted three half-day sessions on GOBIH for 12 residents on 18-20 Nov 92 - installed two jetmatic pumps - [b] - [b] *Additional activities:* - conducted one-day seminar on communicable diseases on 25 Jul 92 with 23 residents

Table A8 (cont.)

Barangay	Planned Project Components	Status at End of Study Period
Cabinitan (cont.)		- conducted two half-day sessions on sloping agricultural land technology on 30-31 Jul with 32 residents - conducted premembership seminar on cooperatives on 8 Aug 92 with 6 residents - established 8-sq m demonstration garden on 21 Nov 92 - conducted nine-day integrated farming seminar from 30 Nov to 8 Dec 92 with 2 residents - conducted one-day training on farm plan and budgeting on 17 Dec 92
Ibayugan	- monthly meetings of 25 residents from eight clusters for one year - leadership training for 25 residents - health training I and II for 25 residents - specialized training for 25 residents - organization training I and II for 25 residents - cooperative premembership training for 25 residents - Christian education I and II for 25 residents - construction of intake box and installation of pipelines (spring development) - construction of toilets	- [b] - conducted leadership training for 12 residents on 8-9 Aug 92 - conducted health training I on 6 Sep 92 for 46 residents - [b] - conducted organization training I for 28 residents on 14-15 Nov 92 and training II for 35 residents on 3-4 Apr 93 - [b] - [b] - constructed an intake box and installed nine faucets from Jan to Feb 93 - began construction of four public toilets *Additional activities:* - constructed multipurpose center from May to Jun 93

Table A8 (cont.)

Barangay	Planned Project Components	Status at End of Study Period
Mansalaya	- monthly executive committee meetings for one year - organization of barangay subcommittees - repair of three deep wells and two reservoirs; construction of four jetmatic pumps - organization of barangay water association - organization of rabus for information-education campaign - conduct of seminars and trainings - environmental sanitation training of skilled laborers - construction of 120 toilet bowls - center-based feeding - establishment of demonstration farm - establishment of 127 backyard gardens - establishment of six communal gardens	- conducted three monthly executive meetings in Jul, Sep, and Dec 92 - organized barangay subcommittees in Feb 92 - constructed a new intake box with a network of 5 faucets - organized water association in Oct 92 - organized four rabus groups in Jul 91 - conducted seminars and trainings in Oct 91 - conducted three-day training on toilet bowl making for 3 residents on 17-19 Feb 92 - constructed 33 toilet bowls, of which 22 had been installed - conducted center-based feeding from Sep to Dec 91 - established a demonstration farm in Jul 92 - [b] - established four communal gardens
Pandan	- identification and formation of community health workers' (CHWs) group - leadership training for CHWs - project management training for CHWs - basic health orientation for CHWs - advance health skills training for CHWs - special health skills training for CHWs - conduct of health services and campaigns - information and education campaign on environmental sanitation for residents	- formed 11-person CHW group in March 93 - (refer to *Additional activities*) - [b] - basic health skills training on 19-21 April 93 - second health skills training on 1-3 June 93 - [b] - conducted health services and campaign in April 93 - two days of basic health orientation on 27-28 Mar 93 for 15 residents

Table A8 (cont.)

Barangay	Planned Project Components	Status at End of Study Period
Pandan (cont.)	- information and education campaign on value formation for residents	- [b]
	- information and education campaign on nutrition education for residents	- [b]
	- information and education campaign on family welfare	- [b]
	- construction of multipurpose health center	- began construction of multipurpose health center in May 93
	- provision and installation of water pipes in three sitio	- installed water pipes in one sitio
	- construction of toilet models	- conducted a toilet bowl making demonstration in August 93
	- food production	- [b]
		Additional activities: - organized basic sectoral units (BSUs) of fishers, farmers, and women from Oct 90 to Nov 91 - consolidated BSUs as Pandan sectoral association in Feb 92 - conducted participatory resource inventory and environmental scanning seminar on 27-28 Feb 92 - conducted orientation on Bureau of Rural Workers on 23 June 92 - conducted orientation on the Local Government Code on 24 and 29 Sep 92 - conducted basic leadership organization and management training on 19-20 Aug 93

Table A8 (cont.)

Barangay	Planned Project Components	Status at End of Study Period
Pantat	- community-building seminar	- conducted community-building seminar for 44 residents on 12-14 Feb 92
	- identification of core group of leaders	- identified 14 residents as core group of leaders
	- vision and objective setting	- conducted one-day vision and objective-setting seminar for nine core leaders on 14 Aug 92
	- one-day seminar on primary health care	- conducted primary health care seminar for 22 residents on 10 Apr 92
	- two-day seminar on nutrition and sanitation	- conducted seminar on environmental sanitation for 16 residents on 25 Aug 92
	- two-day seminar on bio-intensive gardening	- conducted bio-intensive gardening seminar for 30 residents on 6 May
	- two-day seminar on common illnesses and prevention	- conducted seminar on expanded program of immunization and national tuberculosis program for 30 residents on 6 May 92
	- two-day seminar on medicinal plants	- [b]
	- two-day seminar on maternal and child health	- [b]
	- two-day seminar on immunization	- [b]
	- two-day seminar on first aid	- [b]
	- three-day leadership training for core leaders	- three-day leadership training for 10 core leaders and 4 residents on 31 Jul - 2 Aug 92
	- three-day training workshop on program and project planning, monitoring, and evaluation	- [b]
	- food production	- began a vegetable garden in Dec 92
	- herbal gardening	- established one herbal garden in Dec 92
	- construction of community health center	- [b]
	- construction of toilets	- constructed three public toilets by Dec 92
	- construction of water system	- constructed intake box with jetmatic pump and intake box with faucet; began work on one jetmatic pump

Table A8 (cont.)

Barangay	Planned Project Components	Status at End of Study Period
Pantat (cont.)		*Additional activities:* - conducted premembership education seminar on cooperatives for 14 residents on 12-13 Dec 92 - conducted half-day seminar on soil analysis for five residents on 4 Nov 92
Penitan	- community-building seminar for 50 residents (onsite) - primary health care overview for 50 residents (onsite) - first aid seminar for 50 residents (onsite) - nutrition and environmental sanitation seminar for 50 residents (onsite) - maternal and child health program seminar for 15 residents (town center) - common childhood diseases, common illnesses, immunization, malaria control, herbal medicine for 15 residents (town center) - seminar on hilot training for 15 residents (town center) - leadership training for 15 residents (town center) - responsible parenthood, Filipino values formation for 15 residents (Naga City) - project planning and management seminar for 15 residents (Naga City) - improvement of seven wells - construction of 100 toilet bowls	- conducted community-building seminar for 51 residents on 4-6 Oct in Penitan - conducted primary health care seminar for 32 residents 27-28 Oct 92 in Penitan - conducted first aid seminar for 87 residents on 23-25 Nov 92 - conducted nutrition and environmental sanitation seminar on 11-13 Jan 93 - conducted maternal and child health program seminar for 5 residents on 28-30 Jan 93 at town center - conducted common childhood diseases seminar for 5 residents on 18-20 Feb at town center - conducted hilot training for 5 residents on 16-18 March at town center - conducted leadership training for 5 residents from 31 Mar to 2 Apr 93 at town center - conducted responsible parenthood seminar for 6 residents on 6-8 May 93 at Pili, Camarines Sur - conducted project planning and management seminar for 7 residents on 24-26 Jun 93 at Pili - improved five wells by Jul 93 - constructed 147 sanitary toilets by Jul 93

Table A8 (cont.)

Barangay	Planned Project Components	Status at End of Study Period
Penitan (cont.)	- establishment of backyard vegetable and herbal gardens - construction of self-help health center	- established a communal garden in Barao and three backyard gardens in Punta in Jan 93 - constructed self-help health/multipurpose center from Feb to Mar 93 *Additional activities:* - conducted medical consultation and treatment in Jul and Aug 92 - distributed relief assistance to disaster victims in Aug and Sep 92 - conducted echo seminar on maternal and child health in Sitio Punta for 30 residents on 4 Mar 93 and Sitio Barao for 28 residents on 5 Mar 93 - conducted echo seminar on common childhood diseases and leadership training for 13 residents on 19 May 93 - conducted echo seminar on responsible parenthood in Punta for 25 residents on 17 Jul 93

[a]Except in Mansalaya, activities in the sites included a year-long full-time presence of a community organizer.

[b]The activity had not been conducted.

Table A9. Selected information on PCHD proponent NGOs in Camarines Sur, 1990-91

NGO[a]	Years in the Province	Staff[b]	Areas of Operation/Coverage[c]	Projects/Programs/Activities[d]
CASAFI	20	20	Archdiocese of Caceres[e]	community organizing, cooperatives, nutrition, family welfare, medical assistance, relief and rehabilitation, demonstration farm, community potable water source
FACE	15	30	Iriga City and selected municipalities in Districts 1, 3, and 4	community organizing, cooperatives, social development, social welfare, livelihood, health and nutrition, nature conservation, social-special ministry
LISAFI[e]	less than 1	7	District 1 (Prelature of Libmanan)	relief/rehabilitation; Targeted Maternal and Child Health Program
PAGBICOL[f]	1	8	Naga City, municipalities of San Fernando and Presentacion	rural development and leadership training; seminars on value formation, development concepts and approaches, team building, project conceptualization and packaging; community forestry program (organizing communities for protection, management, and utilization of forest lands), cooperative organizing

Table A9 (cont.)

NGO[a]	Years in the Province	Staff[b]	Areas of Operation/Coverage[c]	Projects/Programs/Activities[d]
PRRM	less than 2[g]	25	Libmanan, Cabusao, Sipocot, Pamplona	sustainable rural district development; organizational and leadership development; social services; cooperation and advocacy; development policy research and planning
TALINGKAS[h]	10	4	Pili, Ocampo, Naga City, Libmanan, Milaor	organizing among farmers, urban women, labor; issue advocacy

[a]The abbreviations used for the NGOs are CASAFI for Caceres Social Action Foundation, Inc.; FACE, Our Lady of Fatima Center for Human Development, Inc.; LISAFI, Libmanan Social Action Foundation, Inc.; PAGBICOL, Pag-Asang Bicolnon Foundation, Inc.; PRRM, Philippine Rural Reconstruction Movement; and TALINGKAS, Tawong Lingkod Para sa Katalingkasan kan Bikol Foundation, Inc.

[b]This includes members of the administrative and technical staff who were employed either full-time or part-time as of the approval period of the PCHD proposal.

[c]This refers to areas where projects or community activities were undertaken or currently being undertaken.

[d]Most of the terms used or titles of programs and projects cited were lifted from those used by the organization concerned.

[e]Until early 1989, the entire province of Camarines Sur was under the Archdiocese of Caceres. The 10 municipalities comprising congressional district 1 were since placed under the Prelature of Libmanan. A separate social action center (LISAFI) was subsequently established under the prelature.

[f]This group joined the Camarines Sur PCHD provincial partnership a year after the provincial orientation session.

[g]This pertains to the establishment of the Camarines Sur branch; PRRM was organized in 1952.

[h]This group used to be a part of the Social Integration Office (SIO) of the Ateneo de Naga. SIO was among the original members of the Camarines Sur PCHD provincial partnership. TALINGKAS was formed and registered with the Securities and Exchange Commission shortly before the PCHD project proposal was submitted in 1991, and moved out of SIO's office soon after the start of its PCHD projects. Except the staff complement, the information presented pertains to SIO; some of TALINGKAS's key staff members were also employed by SIO.

Table A10. Participants from NGO proponents, DOH, LGUs, and other groups and their activities in PCHD implementation in selected Camarines Sur sites, 1991-93[a]

Barangay	COs/ Time Spent[b]	Other NGO Proponent's Staff-Participants: Activities Undertaken	Participants from DOH/LGU/Others: Activities Undertaken
Bagadion	3 COs 7 days 1-8 days	- Director: Attended project launching; Served as facilitator in PCHD orientation seminar - PCHD project supervisor: Assisted CO in major activities such as bio-intensive gardening seminar and meetings with leaders	- MHO, RHMs, PHNs, RSIs: Served as resource persons in PCHD orientation and primary health care seminar - RSIs: Served as resource persons in toilet bowl demonstration seminar; conducted water sampling from PCHD-installed water sources - Technicians from DA: Provided seminar on bio-intensive gardening - Municipal mayor: Donated a truckload of sand for toilet bowl construction
Cabinitan	1 CO 7 days 1-7 days	- CO of another PCHD site: Assisted CO in meetings and seminars - Director: Attended monitoring and evaluation activity	- MHO: Served as resource person in health education seminar - RHM: Served as resource person in seminars on health education, bio-intensive gardening, maternal and child health, communicable diseases, environmental sanitation; hilot training; Attended meetings of core group; Attended monitoring and evaluation activity - RSI: Served as resource person in health education seminar and seminars on bio-intensive gardening, maternal and child health, environmental sanitation and first aid, hilot training, GOBIH training; Attended monitoring and evaluation activity; Attended core group meetings

Table A10 (cont.)

Barangay	COs/ Time Spent	Other NGO Proponent's Staff-Participants: Activities Undertaken	Participants from DOH/LGU/Others: Activities Undertaken
Cabinitan (cont.)			- DA staff: Served as resource person in bio-intensive gardening seminar - Municipal councilor: Served as resource person in bio-intensive gardening seminar; Attended monitoring and evaluation activity - CASAFI staff: Served as resource person in bio-intensive gardening seminar
Ibayugan	1 CO 8 days 1-9 days	- COs of two other FACE PCHD sites: Assisted CO in seminars - PCHD project supervisor: Assisted in leadership training seminar	- RHM: Served as resource person in health and sanitation and leadership and organizational training-seminars; Attended community planning meetings - RSI and PHN: Served as resource persons in health and sanitation seminar - Veterinarian from DA: Served as resource person in health and sanitation seminar - Training officer from DTI: Served as resource person in livelihood (paper-making) seminar
Mansalaya	(No CO)	Mayor: Served as overall coordinator/program manager of implementation team; Facilitated executive committee meetings; Attended planning, monitoring, and evaluation activities DOH: Assisted in health-related activities including toilet construction (RSI) and feeding (RHM) DSWD: Served as lead agency of center-based feeding activities, food supplement distribution for malnourished children, and conduct of mother's classes DA: Provided seedlings for communal gardens; Conducted agriculture seminar	

Table A10 (cont.)

Barangay	COs/ Time Spent	Other NGO Proponent's Staff-Participants: Activities Undertaken	Participants from DOH/LGU/Others: Activities Undertaken
Pandan	3 COs[c] 3 days 1-5 days	- PCHD supervisor and area coordinator:[d] Assisted CO in meetings and seminars - Engineer: Prepared water system improvement plan and health center plan; managed construction of health center - Community health nurses: Provided training seminars on health; Assisted in providing health clinic services - Doctor: Served as resource speaker during training-seminars on health; Assisted in providing health clinic services	- RHU: Attended meeting wherein approved plan for Pandan was presented; Attended special barangay assembly and partnership workshop - Mayor, vice mayor and councilors (7): Donated cash and materials for health center construction; Attended special barangay assembly and partnership workshop - Municipal agriculture officer: Donated materials for health center construction; Attended partnership workshop - DSWD, DAR, DECS: Attended special barangay assembly and partnership workshop
Pantat	2 COs 9 days 1-9 days	- COs of two other PCHD sites: Assisted CO in seminars and activities; Facilitated sitio meetings - CO supervisor: Assisted in community-building seminar, leadership training, and evaluation activity - Director, and administrative officer: Assisted in community-building and leadership training seminars and evaluation activity	- MHO: Served as resource person in primary health care overview seminar - RSI and PHN: Served as resource persons in EPI/NTP and environmental sanitation seminars - RHM: Assisted in EPI/NTP seminar and environmental seminar; Attended seminar on primary health care overview; Attended a core group meeting

Table A10 (cont.)

Barangay	COs/ Time Spent	Other NGO Proponent's Staff-Participants: Activities Undertaken	Participants from DOH/LGU/Others: Activities Undertaken
Penitan	1 CO 5 days 1-4 days	- CO supervisor: Assisted CO in major activities such as community-building seminar and project planning and management seminar - PCHD project director: Assisted CO in meetings and major activities such as project launching, health seminars, hilot training, leadership training and monitoring activity - CASAFI director: Attended monitoring activity - COs of two other Penitan PCHD sites: Assisted CO in seminars and activities; Facilitated echo-seminars and trainings - TMCHP supervisor: Assisted CO and served as resource person in health seminars	- MHO and PHN: Served as resource person in health seminars including primary health care, nutrition and environmental sanitation, maternal and child health care, common childhood diseases, and hilot training seminars - RHM: Served as resource person in seminars including primary health care, nutrition and environmental sanitation, maternal and child health care, common childhood diseases, hilot training; attended soil analysis seminar - RSI and RHMs of other Siruma barangays: Served as resource speakers in health seminars - DA: Served as resource speaker in soil analysis seminar

[a]The activities included here pertained to those undertaken in the selected sites or participated in by residents of these sites.

[b]The number of COs cited pertained to those specifically assigned as COs of the particular PCHD site. The figures on "Time spent" indicate the average number of days spent in the barangay from the PCHD launching to the end of the study period, and the shortest and longest continuous stay in the barangay. A fraction of a day was counted as a day (e.g., arriving in the barangay in the morning and leaving in the afternoon of the same day).

[c]This pertained to the COs who were assigned in the site from the community profiling activity in September 1990 to the end of the study period. In accordance with the NGO proponent's strategy, most visits of the COs concerned were in the company of COs from other sites as well as other staff members.

[d]This PCHD supervisor was one of three COs (CO-2) assigned to Pandan (see Table A11). He continued to visit Pandan as PCHD supervisor after June 1992 and acted once more as its CO in May 1993 when CO-3 became unavailable.

Table A11. Background characteristics of community organizers assigned to selected Camarines Sur PCHD sites, 1990-93

Barangay	CO	Age/Sex/ Civil Status	Highest Education	Years in NGO Proponent (in PCHD Work)[a]	Other Work Experience
Bagadion	CO-1	21/M/Single	College (Accounting)	Recruited for PCHD (8 mo)	Volunteer worker of an NGO
	CO-2	22/F/Single	College (Biology)	Recruited for PCHD (4 mo)	CO (less than 1 yr), research assistant
	CO-3	22/F/Single	College (Biology)	Recruited for PCHD (6 mo)	CO (less than 1 yr), research assistant
Cabinitan	CO-1[b]	45/F/Married	College (Commerce, Education, Social Work)	Recruited for PCHD	Nutritionist, CO, and trainor in one NGO (10 yr)
Ibayugan	CO-1	20/M/Single	College (Social Work)	Recruited for PCHD	Volunteer worker of an NGO (less than 1 year)
Mansalaya	No CO was employed for the PCHD project; Under the supervision of the municipal mayor, staff members of the municipal government and municipal-based national agencies were assigned specific activities and tasks, as well as a day a week for PCHD-related work in the barangay.				
Pandan	CO-1[b]	30/F/Single	College (Social Work)	Recruited shortly before PCHD (9 mo)	Volunteer field worker in Sri Lanka (2 yr); social worker (4 yr);
	CO-2	27/M/Single	College (Economics)	Recruited for PCHD (12 mo)	Agricultural economics researcher (less than 1 yr)
	CO-3	31/F/Single	1st year College	Office-based secretary for 1 yr (9 mo)	Day care worker

Table A11 (cont.)

Barangay	CO	Age/Sex/ Civil Status	Highest Education	Years in NGO Proponent (in PCHD Work)[a]	Other Work Experience
Pantat[c]	CO-1 CO-2	29/F/Single 20/F/Single	College (Math) College (Social Work)	Recruited for PCHD (5 mo) Recruited for PCHD (4 mo)	CO for an irrigation project (New graduate)
Penitan	CO	28/F/Married	College (Social Work)	Recruited for PCHD	None

[a]Figures in parentheses indicate the period in which the CO was involved in PCHD work in the assigned barangay; otherwise, the CO concerned was involved in the entire PCHD implementation period covered by the study. In the case of Pandan, previous COs continued to participate in PCHD activities in other capacities, that is, as supervisor or CO of other sites.

[b]This CO also undertook the community profiling for proposal preparation.

[c]In the first four months of the PCHD work, six social work students who were on their practicum training joined the PAGBICOL COs in conducting community activities.

Table A12. Community leaders in PCHD activities and their selection process in selected Camarines Sur sites, 1991-93

Barangay	Leaders[a]	Profile	Selection Process
Bagadion	11	8 males and 3 females; ages from 21 to 73 years; education from Grade 3 to second year high school; all married; all from farming households; 5 were also leaders in other barangay organizations	Upon entry of a new CO 8 months after PCHD launching, CO prepared a list of residents actively participating in PCHD activities. She then convened a meeting of these residents (about 30) and initiated the formation of an organization and the subsequent election of officers. Before this election, PCHD activities were being managed by the barangay council.
Cabinitan	17	12 males and 5 females; ages from 25 to 50; education from elementary graduate to third year college; 16 married and 1 widow; all from farming households; 9 were members of the barangay council, while the rest were leaders of other community organizations	During PCHD launching, the assembly chose 7 leaders, representing the barangay's 6 sitio, plus a coordinator. Others were added later by consensus of original members or appointment by barangay captain to form committees for PCHD implementation, using criteria set by CO (ability, willingness to serve, interest, and time availability).
Ibayugan	46	33 males and 13 females; ages from 23 to 54 years; the majority were married; most completed at least the elementary grades, with 1 reaching second year college; engaged mostly in farming while others were involved in fishing, hired labor, carpentry; all involved in other community organizations, while 5 were barangay council members	The leaders were composed of 7 to 9 residents elected in each of the barangay's 5 zones. These leaders, in turn, elected 4 officers of the community health group.

Table 12 (cont.)

Barangay	Leaders[a]	Profile	Selection Process
Mansalaya	17	13 males and 4 females; ages from 35 to 60; all married; most completed the elementary grades; 7 were barangay council members, while the others were members/officers of other barangay organizations	The barangay council was considered as the main PCHD implementor in the community. Thus, the council members automatically became PCHD leaders. The rest of the leaders were composed of elected officers in each of the barangay's 4 zones and those selected to constitute PCHD committees.
Pandan	10[b]	7 males and 3 females; ages from 26 to 72 years; all married; education from less than elementary graduate to a vocational course; rice cultivators, landless farmworkers, fishers, and fish trader; all involved as leaders/members of other community organizations	Sectoral organizations in the barangay (farmers, fishers, women, and youth) elected their own leaders. These leaders, in turn, constituted a barangay-organization which elected a set of officers from among the sectoral leaders.
Pantat	22	7 males and 15 females; ages from 28 to 67 years; most were elementary school graduates, with one reaching some years in college; all were married; almost all were coconut cultivators, although some were also engaged in fishing and charcoal making; 2 were incumbent barangay council members, one was a former barangay captain, and the rest were members/leaders of other community organizations	First 12 were selected during initial PCHD community meetings; the rest were selected by COs or by the residents themselves to replace inactive core leaders. The leaders represented specific sitio.
Penitan	13	5 males and 8 females; ages from 26 to 57 years; mostly elementary graduates, with 1 reaching first year college; a majority were fishers; 3 were incumbent barangay council members, while others held positions in other community organizations	Initial group was selected by CO during her initial months in the barangay. This group recruited other residents to form an organization, which subsequently elected a set of officers.

[a]The number pertains to the total number of leaders selected; some had become inactive or had been changed by the end of the study period.

[b]This refers to the leaders of the consolidated sectoral groups.

Table A13. Training seminars and other leadership-enhancement activities conducted for PCHD-identified leaders in selected Camarines Sur sites, 1991-93

Barangay	Training Seminars[a]	Others
Bagadion	- Three-day leadership seminar held outside the barangay (6 of the 11 core leaders were present, plus 2 organization members and 1 officer of another barangay organization)	- Preparation of association constitution and bylaws
Cabinitan	None	- Evaluation and monitoring meetings with NGO proponent and RHU staff (four between January and August 1992)
Ibayugan	- Two-day basic leadership training seminar held outside the barangay (12 residents [7 males and 12 females] attended the seminar which was conducted before the formal selection of core leaders) - Two-day organization management seminar held outside the barangay (28 resident-participants)	- Two-day organizational development seminar held in the barangay prior to association formation
Mansalaya	None	- Monitoring and evaluation meetings with mayor and staff of municipality-based agencies
Pandan	- Two-day onsite leadership training seminar (61 resident-participants)	- Orientation on savings/credit policies, basic leadership and organizational management training, financial management training, and briefing on alternative trading and marketing for fishing sector leaders and members

Table A13 (cont.)

Barangay	Training Seminars[a]	Others
Pandan (cont.)		- Ecology seminar, regional fisherfolk consultation seminar, and fisherfolk congress for selected fisher-representatives - Sustainable agricultural orientation-seminar and participatory technology development training-seminar for farming sector leaders and members
Pantat	- Vision-setting sessions conducted in the barangay - Three-day leadership training seminar held outside the barangay and which included visits to 2 cooperatives (10 leaders plus 4 other residents attended)	- Two-day premembership education seminar on cooperatives held outside the barangay
Penitan	- Three-leadership training seminar held outside the barangay (5 resident-participants) - Three-day project planning and management training seminar held outside the barangay (7 resident-participants)	- Echo seminars in the barangay

[a]This pertains to formal training seminars conducted specifically for the core leaders. In some cases, other residents joined the seminar participants, either as volunteers or substitutes of leaders.

Table A14. Health-focused community organizations formed in selected Camarines Sur PCHD sites, 1991-93

Barangay	Date PCHD Launched (Organization Formed)	Organization Process	Participation in PCHD Activities	Registration Status of Organization
Bagadion	July 91 (March 92)	The barangay council served as the initial core group in project implementation, with the barangay captain serving as coordinator. Eight months after PCHD-supported activities were begun, the CO prepared a list of active PCHD participants and called these residents to a meeting. The meeting brought about the formation of an association and the election of officers. Members of the barangay council were disqualified from being elected officers. The group had 25 members.	Most of the PCHD-planned activities were carried out through the barangay council's leadership. The community organization, which was formed 8 months after PCHD's launching, took over the task of completing ongoing projects. The planned leadership training seminar was given to officers of this organization.	CO told members that registration with the Securities and Exchange Commission would be secured but this was not undertaken yet. The organization also sought, but failed, to obtain accreditation from the municipal council as a PO.
Cabinitan	September 91	Core group had not been formalized into an organization. A 17-person group, headed by a barangay council member, was identified during the project launching in September 1991. The barangay captain, secretary, treasurer, and five other council members were also part of the core group whose members either had specific geographic areas of responsibilities or project implementation tasks. By December 1991, the core group totalled 36, with additional members coming from committees formed for project implementation as well as regular participants in training seminars and meetings.		

Table A14 (cont.)

Barangay	Date PCHD Launched (Organization Formed)	Organization Process	Participation in PCHD Activities	Registration Status of Organization
Ibayugan	July 92 (September 92)	Seven to nine leaders were selected in each of the barangay's five zones following zone meetings and elections initiated by assigned barangay council members. A general meeting for the election of officers took place.	Most of the activities, including project planning, were initially implemented with the barangay council's assistance. After a community organization was organized, PCHD implementation was given to its leaders and members. Almost all the leaders and some members were able to attend the leadership and/or organizational development seminars.	Inquiry was made with the Cooperative Development Authority, but membership recruitment had yet to be completed.
Mansalaya	September 91	Each of the barangay's four zones was organized into a *rabus* (voluntary work) group with an elected set of officers. These officers became members of the barangay's core group of leaders for PCHD implementation, but no barangay-wide association had been formed.		

Table A14 (cont.)

Barangay	Date PCHD Launched (Organization Formed)	Organization Process	Participation in PCHD Activities	Registration Status of Organization
Pandan	July 90 (October 90-November 91 for sectoral groups; July 92 for consolidated group)	Organizing began at the sectoral level–farmers, fishers, women, and youth. Initial activities were channelled through these groups. When sectoral groups were formed among farmers, fishers, and women, a barangay-wide association was organized where leaders of the various sectors were elected as officers.	Planned activities were undertaken through the consolidated sectoral groups.	Formal registration had been brought up; organized groups were affiliated with municipal, provincial, and region-based groups.
Pantat	November 91 (July 92)	The formation of a core group of leaders began four months after project launching. The rounds of selection resulted in the identification of a 22-person group.	Members of the core group of leaders were the active participants in PCHD implementation.	The group had yet to give itself a name. Some of its members had attended a cooperative premembership seminar organized by the proponent NGO.

Table A14 (cont.)

Barangay	Date PCHD Launched (Organization Formed)	Organization Process	Participation in PCHD Activities	Registration Status of Organization
Penitan	August 92 (March 93)	At the start of project implementation, CO identified a 13-person core group of leaders who would assist in project implementation. The core group decided on the name KBKKP. From this core group, six were chosen as ad hoc officers and were tasked to recruit members. The list submitted by the leaders totalled 45 residents. An election of officers was subsequently held. The membership size was trimmed to 37 during the organization's vision-setting activity when a review of active and inactive members was made.	The organization undertook the implementation of PCHD activities and its members were active participants in training-seminars and major activities.	Not taken up yet.

Table A15. Other community organizations formed in connection with PCHD activities in selected Camarines Sur sites, 1991-93

Barangay	Nature of Group	PCHD Participation/Activities Undertaken
Bagadion	- Existing youth organization composed of about 50 active members, but claimed a membership of about 100 residents, 15-35 years old, was revitalized - Mothers' group composed of 21 attendees in a PCHD-organized primary health care seminar[a]	- The group was invited to take over the PCHD model bio-intensive garden, but refused because of concern that the elder residents involved in the project might feel offended. Some members assisted in the installation of water pumps and attended PCHD-convened barangay meetings. - The group held a graduation ceremony and induction of officers, but had not engaged in another activity since then.
Cabinitan	- Women's health and livelihood organization composed of 17 residents (plus CO, RHM, and RSI); core members were participants in a livelihood skills training (stuffed toy, bag, and flower making) given by the municipal government through the intercession of CO; a 5-person set of officers was elected[a]	- The association planned to become a cooperative. It collected P100-share of stocks from members, and P5-monthly voluntary contributions. The organization fund was being loaned to members with a P5-interest for every P100 loan.
Ibayugan	None	
Mansalaya	- Mothers of beneficiaries of a feeding program were organized into a mothers' class; about 20 mothers formed the group[a]	- The group assisted in food preparation and distribution during feeding days and also attended the mothers' classes conducted by the municipal nutrition action officer.

Table A15 (cont.)

Barangay	Nature of Group	PCHD Participation/Activities Undertaken
Pandan	- Fishers' groups: 5 groups composed of at least 6 members each	- PRRM gave loans from P25,000 to P30,000 to the 5 groups for improving the members' fishing equipment; 1 of the 5 decided to use its loan for a shrimp trading business.
	- United fishers' groups composed of the basic sectoral units	- Selected officers of the group attended a regional fisherfolk congress which resulted in the formation of a regional fishers' group; some officers also represented the group in a municipality-based fishers' group.
	- Women's groups: 2 groups which were eventually consolidated into a barangay-wide women's organization; the organization had an initial membership of 39, with a 9-person set of officers	- The group convened meetings and attended PRRM-initiated training activities. It also planned to engage in a savings program and livelihood training.
	- Farmers' group composed of 33 members (28 males and 5 females) with a 5-person set of officers	- The group convened monthly meetings and formulated plans for organizing into a cooperative. It also became a member of a federation of farmers' groups in the province organized by PRRM.
	- Consolidated barangay-wide organization composed of sectoral groups[a]	- The group prepared and ratified its constitution and bylaws, and elected a set of officers. This group became active in PCHD activities.
Pantat	None	
Penitan	None	

[a]This group also included health among its concerns.

Table A16. PCHD-identified community health workers in selected Camarines Sur sites, 1991-93

Barangay	Number and Profile	Selection Process	Training Received
Bagadion	None, although the selection and training of community health workers was part of the project design. During the primary health care seminar, however, RHM encouraged one participant to volunteer as a barangay health worker. This resident subsequently joined a BHW training seminar organized by RHU. The resident had since been assisting RHM during the latter's visit in the barangay.		
Cabinitan	5: all females; ages from 27 to 52 years; all married with children; education from elementary school graduate to first year college; 2 were BHWs prior to PCHD implementation, 1 was a traditional healer, and 2 were wives of barangay council members	A three-day hilot training was held in the barangay and attended by 19 residents invited by CO and RHM. It was understood that community health workers would be selected from among the participants through an examination to be given by RHM. Five were subsequently selected to become hilot.	In addition to the three-day hilot training, the selected health workers attended a seminar on GOBIH (growth monitoring, oral rehydration, breast-feeding, immunization, herbal medicine) and three half-day review sessions. Each received a hilot's kit from the proponent NGO. They also became members of a municipality-wide organization of BHWs initiated by RHU.
Ibayugan	None, the selection and training of community health workers was not part of the PCHD project plans.		
Mansalaya	None, the selection and training of community health workers was not part of the PCHD project plans.		
Pandan	11: 8 females and 3 males; ages from 18 to 59 years; 8 married and 3 single; at least 1 from each of the barangay's sitio; 1 was a practicing traditional healer while 2 professed to have knowledge in traditional healing	After one basic health orientation seminar, PRRM sought volunteers who would be trained as health workers. From among the 6 initial volunteers, a temporary chairperson and vice chairperson were selected. The 2 were tasked to recruit additional volunteer health workers.	The health workers attended two three-day training seminars conducted in the PRRM training center for health workers in different PRRM project sites. After the second seminar, the health workers held a medical clinic (as practicum) in the barangay with the assistance of PRRM health and other staff.

Table A16 (cont.)

Barangay	Number and Profile	Selection Process	Training Received
Pantat	None, the selection and training of community health workers was not part of the PCHD project plans.		
Penitan	5: 4 females and 1 male; ages from 31 to 57 years; all married; education from complete elementary grades to a year in college	Selected from among the core leaders plus resident-volunteers (4 of the 5 were officers of the PCHD-organized group)	The health workers attended four three-day training seminars held outside the barangay. After the seminars, they conducted echo seminars for other barangay residents.

Table A17. Health education seminars for households conducted in selected Camarines Sur sites, 1992-93

Barangay	Topic	Participants		Venue/Design
		Comm	Others	
Bagadion	- Primary health care	- 23 (22f, 1m)	- RHU (MHO, PHN, 2 RSIs, 6 RHMs), CO	- Two-day overview course held in the barangay, with RHU staff as lecturer-facilitators
Cabinitan	- Basic health orientation	- 41 (35f, 6m)	- RHU (MHO, 2 PHNs, 2 RHMs, RSI, Dental aide), CO	- One-day overview course held in the barangay, with RHU staff as lecturer-facilitators
	- Responsible parenthood	- 45 (43f, 2m)	- RSI, CO	- Half-day overview course held in the barangay, with RSI as lecturer-facilitators
	- Maternal and child care	- 30 (27f, 3m)	- RHU (2 RHMs, PHN, RSI, Medical technologist), CO	- Three half-day sessions held in the barangay with RHU staff as lecturer-facilitators
	- Environmental sanitation	- 28 (23f, 5m)	- RHU (RSI, Medical technologist), CO	- Half-day overview course held in the barangay, with RSI as lecturer-facilitators
	- First aid	- 20 (17f, 3m)	- RHU (RHM, PHN, RSI), CO	- Half-day overview course held in the barangay, with PHN and RSI as lecturer-facilitators
	- Herbal medicine	- 38 (n.d.)	- RHU (MHO, 2 PHNs, 2 RHMs), 2 COs, DA agricultural engineer, 2 municipal councilors, municipal secretary, 2 officers of municipal-based organizations	- One-day session held in the barangay

Table A17 (cont.)

Barangay	Topic	Participants		Venue/Design
		Comm	Others	
Ibayugan	- Basic health and sanitation	- 46 (n.d.)	- RHU (PHN, RSI, 3 RHMs), CO and another FACE staff, DA veterinarian	- A one-day overview course held in the barangay, with RHU staff as lecturer-facilitators; DA veterinarian discussed immunization against rabies
Mansalaya	- Nutrition and family planning	- About 20 women	- Municipal nutrition action officer, elementary school teacher-in-charge	- Three half-day sessions were conducted in the barangay for mothers of recipients of food supplements.
Pandan	- Basic health orientation	- 15 (12f, 3m)	- CO, PRRM doctor, PRRM nurse	- Two-day overview course held in the barangay, with PRRM staff as lecturer-facilitators
Pantat	- Primary health care	- 22 (19f, 3m)	- RHU (MHO, PHN, RHM), 3 COs, CO supervisor	- One-day overview course held in the barangay chapel with MHO as lecturer-discussant; MHO also held a consultation-treatment session
	- Environmental sanitation	- 16 (14f, 2m)	- RHU (RSI, RHM), CO, CO supervisor,	- One-day seminar with RSI and COs as lecturer-facilitators
	- Prevention of common illnesses	- 30 (25f, 5m)	- RHU (PHN, RSI, RHM), CO, CO supervisor	- One-day seminar with RHU staff as lecturer-facilitators

Table A17 (cont.)

Barangay	Topic	Participants		Venue/Design
		Comm	Others	
Penitan	- Primary health care	- 32 (n.d.)	- RHU (PHN, RHM, malaria canvasser), CO, PCHD supervisor	- The three sessions were held in the barangay with the RHU and CASAFI staff members as lecturer-facilitators. The first seminar took 2 days; the second, 3 days; and the third, 3 days. Lectures, role playing, and demonstration sessions were used.
	- First aid	- 87 (n.d.)	- CO, PCHD supervisor, CO of another PCHD site	
	- Environmental sanitation	- 70 (n.d.)	- RHU (PHN, RHM, RSI), CO, PCHD supervisor, COs of 2 other PCHD sites	

Table A18.1. Summary of proposed and actual implementation schedule of PCHD activities in Barangay Bagadion, July 1991 - December 1992[a]

Activities	Month 1 Jul	2 Aug	3 Sep	4 Oct	5 Nov	6 Dec	7 Jan	8 Feb	9 Mar	10 Apr	11 May	12 Jun
Orientation seminar	PPP AAA											
Herbal plant and vegetable gardening		PPP AAAAAAAAAAAA[b]										
Primary health care seminar			PPP						AAA			
Deep well installation (Pitcher pumps)				PPP			AAAAAAAAAAAA[c]					
Leadership training seminar-1				PPP					AAA			
Nutrition education/Maternal and child health seminar							PPP					
Toilet construction								PPP	AAA			AAA[d]
Leadership training seminar-2									PPP			
Family welfare seminar											PPP	

[a]The proposed schedule (PPP) is contained in the project proposal; the actual schedule (AAA) is based on the process monitoring research.

[b]The model bio-intensive garden had not been sustained; as of December 1992, plans for alternative strategies had been drawn up.

[c]This includes the installation of 15 pitcher pumps; as of December 1992, Bagadion residents and TALINGKAS had yet to meet for a discussion on whether or not more pumps would be installed using funds from the existing grant.

[d]The activity was still ongoing in December 1992.

Table A18.2. Summary of proposed and actual implementation schedule of PCHD activities in Barangay Cabinitan, September 1991 - December 1992[a]

Activities	Month	1 Sep	2 Oct	3 Nov	4 Dec	5 Jan	6 Feb	7 Mar	8 Apr	9 May	10 Jun	11 Jul	12 Aug
Maternal and child care seminar			PPPPPPPPPPPPPPPPPPPPPPPPPP							AAA		AAA	
First-aid seminar			PPPPPPPPPPPPPPPPPPPPPPPPPP										AAA
Environmental sanitation seminar			PPPPPPPPPPPPPPPPPPPPPPPPPP									AAAAAA	
Herbal medicine and bio-intensive gardening (for trainors)			PPPPPPPPPPPPPPPPPPPPPPPPPP									AAA[b]	
			AAA										
Responsible parenthood and value formation			PPPPPPPPPPPPPPPPPPPPPPPPPP										
									AAA				
Hilot training			PPPPPPPPPPPP										
												AAA[c]	
Leadership training/project management						PPPPPPPPPPPPPPPPPPPPPPPP							
GOBIH						PPPPPPPPPPPPPPPPPPPPPPPP							--[d]
Installation of six jetmatic pumps			PPPPPPPPPPPP										
												AAA	
Construction of intake box						PPPPPPPPPPPPPPP							
Construction of sanitary toilets						PPPPPPPPPPPPPPP							

[a]The proposed schedule (PPP) is contained in the project proposal; the actual schedule (AAA) is based on the process monitoring research.
[b]A communal garden had been established by December 1992.
[c]Another session was held in October.
[d]A session was held in November.

Table A18.3. Summary of proposed and actual implementation schedule of PCHD activities in Barangay Ibayugan, July 1992 - June 1993[a]

<table>
<tr><th rowspan="2">Activities</th><th rowspan="2">Month</th><th>1</th><th>2</th><th>3</th><th>4</th><th>5</th><th>6</th><th>7</th><th>8</th><th>9</th><th>10</th><th>11</th><th>12</th></tr>
<tr><th>Jul</th><th>Aug</th><th>Sep</th><th>Oct</th><th>Nov</th><th>Dec</th><th>Jan</th><th>Feb</th><th>Mar</th><th>Apr</th><th>May</th><th>Jun</th></tr>
<tr><td rowspan="2" colspan="2">Leadership training</td><td></td><td></td><td colspan="2">PPPPPPP</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td>AAA</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td rowspan="2" colspan="2">Health training I and II</td><td></td><td></td><td></td><td></td><td>PPP</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td>AAA[b]</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td rowspan="2" colspan="2">Specialized training</td><td></td><td></td><td></td><td></td><td></td><td colspan="2">PPPPPPP</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td rowspan="2" colspan="2">Organization training I and II</td><td></td><td></td><td></td><td></td><td></td><td></td><td colspan="2">PPPPPPP</td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td></td><td>AAA</td><td></td><td></td><td></td><td></td><td>AAA</td><td></td><td></td></tr>
<tr><td rowspan="2" colspan="2">Cooperative premembership training</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>PPP</td><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td rowspan="2" colspan="2">Christian education I and II</td><td colspan="12">PPPPPPPPPPPPPPPPPPPPPPPPPPPPPPPPPPPPPPPPPPPPPPPPPPPPP</td></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td rowspan="2" colspan="2">Spring development</td><td></td><td></td><td></td><td colspan="2">PPPPPPP</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td>AAA</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td rowspan="2" colspan="2">Construction of latrine</td><td></td><td></td><td></td><td></td><td>PPP</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>AAA</td><td></td><td>AAA[c]</td></tr>
<tr><td rowspan="2" colspan="2">Construction of multipurpose center[d]</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td colspan="2">AAAAAA[c]</td></tr>
</table>

[a]The proposed schedule (PPP) is based on the November 1991 program plan of action; the actual schedule (AAA), on the process monitoring research.

[b]Only Health training I had been conducted.

[c]Ongoing in June 1993.

[d]This was not included in the original plan.

Table A18.4. Summary of proposed and actual implementation schedule of PCHD activities in Barangay Mansalaya, September 1991 - December 1992[a]

<table>
<tr><th>Activities</th><th>Month</th><th>1
Sep</th><th>2
Oct</th><th>3
Nov</th><th>4
Dec</th><th>5
Jan</th><th>6
Feb</th><th>7
Mar</th><th>8
Apr</th><th>9
May</th><th>10
Jun</th><th>11
Jul</th><th>12
Aug</th></tr>
<tr><td rowspan="2" colspan="2">Organization of barangay subcommittees</td><td>PPP</td><td colspan="11"></td></tr>
<tr><td colspan="5"></td><td>AAA</td><td colspan="5"></td><td>--[b]</td></tr>
<tr><td rowspan="2" colspan="2">Repair of three deep wells and two reservoirs[c]</td><td colspan="3">PPPPPPPPPPP</td><td colspan="9"></td></tr>
<tr><td colspan="12"></td></tr>
<tr><td rowspan="2" colspan="2">Construction of four jetmatic pumps[c]</td><td colspan="2"></td><td colspan="2">PPPPPPP</td><td colspan="8"></td></tr>
<tr><td colspan="12"></td></tr>
<tr><td rowspan="2" colspan="2">Organization of the Barangay Waterworks Association</td><td></td><td colspan="3">PPPPPPPPPPP</td><td colspan="8"></td></tr>
<tr><td colspan="11"></td><td>--[d]</td></tr>
<tr><td rowspan="2" colspan="2">Seminars and trainings</td><td colspan="12">PPPPPPPPPPPPPPPPPPPPPPPPPPPPPPPPPPPPPPPPPPPPPPPPPP</td></tr>
<tr><td></td><td>AAA</td><td colspan="10"></td></tr>
<tr><td rowspan="2" colspan="2">Construction of sanitary toilets</td><td colspan="4"></td><td colspan="7">PPPPPPPPPPPPPPPPPPPPPPPPP</td><td></td></tr>
<tr><td colspan="5"></td><td colspan="7">AAAAAAAAAAAAAAAAAAAAAAA[e]</td></tr>
<tr><td rowspan="2" colspan="2">Center-based feeding</td><td colspan="8">PPPPPPPPPPPPPPPPPPPPPPPPPPPPPPPPP</td><td colspan="4"></td></tr>
<tr><td colspan="4">AAAAAAAAAAAAA</td><td colspan="8"></td></tr>
<tr><td rowspan="2" colspan="2">Demonstration farm</td><td colspan="12">PPPPPPPPPPPPPPPPPPPPPPPPPPPPPPPPPPPPPPPPPPPPPPPPPP</td></tr>
<tr><td colspan="10"></td><td colspan="2">AAAAAA</td></tr>
<tr><td rowspan="2" colspan="2">127 backyard gardens</td><td></td><td colspan="11">PPPPPPPPPPPPPPPPPPPPPPPPPPPPPPPPPPPPPPPPPPPPPP</td></tr>
<tr><td colspan="12"></td></tr>
<tr><td rowspan="2" colspan="2">Six communal gardens</td><td colspan="6"></td><td colspan="6">PPPPPPPPPPPPPPPPPPPPPPPPP</td></tr>
<tr><td colspan="10"></td><td colspan="2">AAAAAA[f]</td></tr>
</table>

[a]The proposed schedule (PPP) is based on the project proposal; the actual schedule (AAA), on the process monitoring research.

[b]Additional subcommittees were formed in October.

[c]These activities did not push through; instead, the construction of an intake box was undertaken from February to April.

[d]The committee was created in October.

[e]Training of toilet bowl maker was undertaken in February while bowl production was begun in March; toilet construction was ongoing in December.

[f]Ongoing in December.

Table A18.5. Summary of implementation schedule of PCHD activities in Barangay Pandan, October 1992 - August 1993[a]

Activities	Month	1 Oct	2 Nov	3 Dec	4 Jan	5 Feb	6 Mar	7 Apr	8 May	9 Jun	10 Jul	11 Aug
Organizing and training for health		AAA	AAA	AAA	AAA	AAA	AAA	AAA	AAA	AAA	AAA	AAA
Leadership training												AAA
Project management training												
Basic health orientation							AAA[b]					
Advance health skills								AAA				
Special health skills												
Health services and campaigns										AAA		
Environmental sanitation												
Value formation												
Nutrition education												
Family welfare												
Construction of multipurpose health center									AAA			AAA[c]
Construction of water system												AAA[d]
Toilet construction												
Food production												

[a]Except the number of days involved in an activity, no planned schedule of activities was incorporated in the project proposal. The actual (AAA) implementation schedule was based on the process monitoring research.

[b]This was the fourth session conducted since PRRM's entry in 1990.

[c]Work was suspended on 29 May and resumed in August.

[d]Ongoing in August.

Table A18.6. Summary of proposed and actual implementation schedule of PCHD activities in Barangay Pantat, November 1991 - December 1992[a]

Activities	Month	1 Nov	2 Dec	3 Jan	4 Feb	5 Mar	6 Apr	7 May	8 Jun	9 Jul	10 Aug	11 Sep	12 Oct
Socioeconomic survey, community integration and identification of participants		PPPPPPP AAA											
Data presentation, identification of community problems, and initial planning			PPP										
Community-building seminar				PPP	AAA								
Identification of core group of leaders				PPP		AAAAAAAAAAAAAAAAAAAAAAAAAA[b]							
Vision and objective setting					PPP						AAA[c]		
Primary health care seminar					PPP	AAA							
Nutrition and sanitation seminar (Environmental sanitation)						PPP					AAA		
Bio-intensive gardening seminar							PPP						--[d]
Common illnesses and prevention seminar (EPI and NTP)								PPP	AAA				
Medicinal plants seminar									PPP				
Maternal and child health seminar									PPP				
Immunization seminar											PPP		
First aid seminar												PPP	

Table A18.6 (cont.)

Activities	Month 1 Nov	2 Dec	3 Jan	4 Feb	5 Mar	6 Apr	7 May	8 Jun	9 Jul	10 Aug	11 Sep	12 Oct
Leadership training for core of leaders					PPP					AAA		
Training workshop on program and project planning, monitoring and evaluation							PPP					
Food production						PPPPPPPPPPPPPPPPPPPPPPP						--[b]
Herbal gardening								PPPPPPPPPPP				--[b]
Construction of community health center					PPPPPPP							
Toilet construction						PPPPPPPPPPPPPP						--[e]
Water system construction						PPPPPPPPPPPPPP						--[f]

[a]The proposed schedule (PPP) is based on the project proposal; the actual schedule (AAA), on the process monitoring research.
[b]Activity ongoing as of December 1992.
[c]Conducted in only two sitio.
[d]A garden was established in December.
[e]Began in October and ongoing in December.
[f]Began in November and ongoing in December.

Table 18.7. Summary of proposed and actual implementation schedule of PCHD activities in Barangay Penitan, July 1992 - July 1993[a]

Activities	Month	1 Jul	2 Aug	3 Sep	4 Oct	5 Nov	6 Dec	7 Jan	8 Feb	9 Mar	10 Apr	11 May	12 Jun
Community-building seminar				PPP									
					AAA								
Primary health care overview					PPP								
					AAA								
First aid						PPP							
						AAA							
Nutrition and environmental sanitation							PPP						
								AAA					
Maternal and child health program								PPP					
								AAA					
Common childhood diseases, immunization, malaria control, herbal medicine seminar									PPP				
									AAA				
Hilot training										PPP			
										AAA			
Leadership training											PPP		
											AAAAAA		
Responsible parenthood and Filipino values formation seminar												PPP	
												AAA	
Project planning and management seminar													PPP
													AAA
Improvements of wells								PPPPPPPPPP					
													AAAAAA[b]
Latrine construction								PPPPPPPPPP					
								AAAAAAAAAAAAAAAAAAA[b]					

Table 18.7 (cont.)

Activities	Month	1 Jul	2 Aug	3 Sep	4 Oct	5 Nov	6 Dec	7 Jan	8 Feb	9 Mar	10 Apr	11 May	12 Jun
Backyard vegetable and herbal garden		PPPPPPPPPPPP						AAA					
Self-help multipurpose/health center					PPPPPPPPPPPP				AAAAAA				

[a]The proposed schedule (PPP) is based on CASAFI's planned schedule of activities; the actual schedule (AAA), on the process monitoring research.

[b]The activity was still ongoing in July 1993.

Table A19. Other major development efforts, by types of assistance or initiatives, undertaken during PCHD implementation in selected Camarines Sur sites, 1991-93

Barangay	GO-assisted	NGO-assisted	Community Initiatives[a]
Bagadion	- Installation of a pump (DPWH) - Installation of electric lights in basketball court (Electric company) - Partial construction of barangay hall (Congressman) - Expansion of multipurpose pavement and construction of basketball court (Congressman) - Installation of two pumps (Mayor's Office) - Completion of barangay hall (Congressman)	- Formation of a farmers' organization - Formation of a community organization (pastoral council)	- Repair of the communal irrigation system - Partial construction of barangay hall
Cabinitan	- Pig-dispersal project (Mayor's Office) - Completion of multipurpose hall, and construction of barangay hall and basketball posts (Congressman) - Construction of waiting shed (Congressman) - Organization of agrarian reform beneficiaries (DA) - Organization of a multipurpose cooperative (DA) - Construction of two high school buildings (DECS) - Completion of a multipurpose pavement (DPWH)		- Formation of two community organizations - Construction of a barangay chapel - Construction of a communal nipa hut - Improvement of a domestic water source (open well) - Construction of a palay-drying pavement - Installation of five units of pitcher pumps (*)

Table A19 (cont.)

Barangay	GO-assisted	NGO-assisted	Community Initiatives[b]
Ibayugan		- Revival of a community organization; Provision of loan for a livelihood project of the group	- Construction of water intake box (*) - Formation of a community organization
Mansalaya	- Construction of a 150-m concrete road (DPWH)	- Formation of a youth organization	- Construction of a waiting shed - Fencing of area around barangay chapel
Pandan	- Formation of the Barangay Agricultural and Fisheries Council (DA) - Formation of the Barangay Waterworks Association (DILG) - Construction of a day care center building - Construction of an additional elementary school building (DECS)	- Provision of agricultural productivity loans - Provision of livelihood loans	- Improvement of chapels - Construction of a wooden bridge
Pantat	- Installation of a deepwell (DPWH)	- Establishment of a cooperative store	- Rebuilding of a sitio chapel - Construction of a basketball court - Construction of a sitio chapel - Improvement of a waiting shed

Table A19 (cont.)

Barangay	GO-assisted	NGO-assisted	Community Initiatives[b]
Penitan	- Construction of a Level II domestic water system (DPWH) - Construction of a three-room elementary school building (DPWH) - Pig-dispersal project (DA) - Pig-dispersal project (Mayor's Office) - Training on construction and management of artificial reefs (DA)	- Formation of a fishers' group (PCHD proponent NGO in coordination with DA)	

[b]Included here are projects and activities initiated by organized community groups and the barangay council, using barangay funds, as well as donations or solicitations from political candidates; the latter are indicated by asterisks (*)

Appendix B

Research Procedure

The research study conducted on the implementation of the Partnership for Community Health Development in Camarines Sur employed the methodology called "process monitoring research." A qualitative methodology, this is applied to an innovative set of development activities, such as PCHD, with expansion or programming goals. It focuses on the dynamics and contexts of the interactions among the participants or actors, generating data on the activities, interactions, and concerns of these participants. The data form a substantial set of detailed information necessary for understanding what takes place, under what circumstances, and with what results. An important component of the research, therefore, is the presence of a mechanism for using the data in regularly assessing field experiences and extracting from these experiences the lessons for improving implementation.

Process monitoring research entailed intensive and extended presence in the study sites. These sites are looked upon as settings in which field-level implementation experiences become systematically known and understood. Through the research study's regular reports, lessons from these experiences could immediately be extracted and form the basis for improving decisions or actions.

Setting and Focus

One of four provinces covered by the first year of PCHD implementation, Camarines Sur served as an initial setting of the process monitoring research. (The Institute of Philippine Culture also conducted a process monitoring research in Agusan del Norte, a PCHD Year 2 province; the study covered only the provincial planning phase.) The study began from the first visit of the Community Health Service provincial coordinator in preparation for the provincial partnership-building and planning phase; it ended after at least the first 12 months of community project implementation in seven sites selected as barangay research settings. Following the extended time spent for the provincial planning phase as well as in processing grant funds, the field research period spanned over three years, from February 1990 to

December 1993. The first half of this period focused mostly on the provincial-level activities. Research fieldwork in each barangay site began from the community profiling activities and continued until at least 12 months after the formal start of the implementation of the approved PCHD project proposals. In four sites, the research coverage was extended from one to six months after the end of the grant period. The research in each site hence reached from 20 months to 36 months.

The Camarines Sur barangay study sites were selected from among the 19 PCHD sites in the province. Each proponent organization had a site each among the study barangays. (The mayor's office, had only one PCHD site; one proponent nongovernment organization had two sites, another NGO had four, and four had three sites each.) Moreover, the selection of the seven sites took into account having a variety in terms of the barangay's physical accessibility to their respective town centers, types of resources present, and dominant resource use.

The research study covered all activities related to PCHD implementation and involving any of the participating groups and/or community members, whether conducted onsite or outside the barangay. Moreover, it also looked into other development projects or activities which were undertaken or initiated in the barangay study sites, either by external agencies or the residents themselves, during PCHD's implementation period.

Data Collection

The major data-gathering techniques used by the research study were participant-observation and semistructured interviewing. As far as possible, the researchers conducted participant-observation. In cases when activities were scheduled on the same dates, the researchers attended those types which they had not documented earlier. This ensured that every type of activity had been documented at least once, irrespective of participating groups or target sites. This strategy also helped develop the researchers' facility in reconstructing activities which were not documented. The researchers would thus have a clearer grasp of the key aspects of specific activities and be able to formulate appropriate guide questions.

For the reconstruction of events and activities missed, the researchers engaged some of the key participants in semistructured interviews, and collected such documents as minutes of meetings and attendance lists. They also inspected the physical results, if any, of the activities. The researchers also conducted interviews to clarify points or issues raised in documented activities. Moreover, data on the pre-PCHD conditions of the barangays were gathered using semistructured interviews, walkthroughs, and secondary data review.

Research Team

At the start of the research study, a pair of researchers was deployed in Camarines Sur to document the province's PCHD partnership-building and planning activities. This entailed attending meetings and other group sessions of the participating organizations and being present when members of these organizations made their initial visits to potential sites. As soon as target project sites were identified, another pair of researchers was sent to the province. A

third pair assisted in the final fieldwork period, which also focused on assessing the outcomes of the PCHD initial work. Thus, for the most part during the PCHD implementation phase, two pairs of researchers were in the province.

The researchers established a base in Naga City. With rotating pair assignments, the researchers visited the study barangays at least once in two months, staying in the area from a day to two weeks and spending, in turn, a day to a week in their Naga City base to write up their field notes. Each researcher, therefore, was able to conduct data collection in all sites. This strategy was adopted to ensure that a "fresh" outlook was introduced to the field visits. Continuity was achieved by assigning one researcher the responsibility of keeping track of the research progress in a particular site.

The researchers also reported to the IPC office in Metro Manila at least once every four months, staying at most two weeks. This period was used to finalize reports and plan for further field research activities, including the formulation of additional data-gathering tools.

The research teams received supervision from the research director (the author), who visited the province at least once every quarter. These visits extended from a week to a month. In addition to reviewing research notes and report drafts, the visits also included conducting interviews and other onsite data-gathering activities as well as attending PCHD activities. (In a few instances, attendance in PCHD provincial partnership activities involved serving as resource person or facilitator, a task which was part of the research director's participation as a resource person of CHS.)

In all, 10 researchers were involved in the research study. All were females, unmarried, and with ages ranging from 21 to 30 years. All were speakers of the dominant language in the research sites, with seven born and educated in the province. The researchers had undergraduate degrees in psychology, business management, mathematics, economics, and zoology. Of the 10, three were also involved in the Agusan del Norte process monitoring research study; six had also served as research assistants in earlier community health studies of IPC.

Research Reports

The results of the process monitoring research were initially presented in semiannual reports submitted to CHS. These reports contained detailed narrative accounts of activities and other developments in the research sites. While these accounts generally focused on the period covered by a report, some summing up were also done particularly in later reports. At the same time, emerging issues and problems were highlighted, particularly those with implications on ongoing or planned activities. (The reports also contained summaries of developments in other Year 1 provinces.)

The drafts of all semiannual reports were shown to key members of the participating organizations, particularly to the field staff. This review process was adopted not only to further validate the data presented in the reports but to assure the individuals concerned that the research was not a job performance evaluation. The latter was particularly important to the continued cooperative interaction between the IPC research staff and the PCHD key field implementors.

The semiannual reports also contained some discussions on emerging issues, initial lessons highlighted, and their implications on improving PCHD implementation. The assessment of initial PCHD experiences through these reports was complemented by formal and informal discussion sessions between CHS key staff and the research director. (In addition to serving as a member of the Community Health Policy Committee, the research director participated as a resource person in CHS-facilitated PCHD activities, including project implementation review sessions.)

A final summary report was prepared, focusing on the partnership building and planning phase (Veneracion 1993a). Individual writeups on the PCHD implementation in the seven selected barangays were also presented (Veneracion 1993b). Each of these profiles contained the experiences of the barangays in connection with the PCHD entry for community profiling for project proposal generation and the details of the 12 months of PCHD implementation which are synthesized in the present volume.

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