Status Report on Primary Health Care (1987-1993)

VICTORIA A. BAUTISTA*

Everybody has a right to health care. More importantly, it is enshrined in the 1987 Philippine Constitution that the State shall safeguard the health of the people. The full realization of the primary health care policy of the Department of Health is a big stride towards the direction of providing basic health services to the masses.

Background

The implementation of primary health care (PHC) as a strategy of the government in 1987-1993 is significantly influenced by two legal mandates which have set the tone and the key perspective in the execution of organizational policies and thrusts of the Department of Health (DOH). First of all, the passage of the Philippine Constitution in 1987 stressed the importance of health as a basic right of the people. Article II, Section 16 argues that "(t)he State shall protect and promote the right of health of the people and instill health consciousness among them." Furthermore, while PHC is not directly advanced in the constitution as a strategy, the passage of Article II, Section 23 recognizes the basic principle of a "community based" approach which is the essence of the PHC strategy.

The second important mandate which carries substantial implication in the organization and management of PHC is the passage of the Local Government Code of 1991. This transfers power and authority in the management of PHC to local government units (LGUs). This was previously the chief responsibility of the national government through the DOH. Thus, for a total of twelve years, the responsibility for PHC was initially lodged in the national government commencing in 1979 with Letter of Instruction 949 issued by President Ferdinand Marcos.

*Professor and Director, Center for Policy and Administrative Development, College of Public Administration, University of the Philippines.

This is to acknowledge the assistance of Ms. Ma. Clarisa Sia, Development Management Officer III of the Center for Policy and Administrative Development of the U.P. College of Public Administration in gathering data in the preparation of this report.

However, the manner of fleshing out PHC shifted over the period 1987 to 1993 as the two key executives of the Department of Health assumed different postures for PHC. Under Secretary Alfredo Bengzon (1986-1991), experimentations were made to forge partnerships with nongovernment organizations (NGOs), coined as "Community Health Development." This meant going through a "holding pattern" for PHC as DOH "distanced itself from" using the term and campaigning vigorously for the strategy (DOH n.d.[e]: 5).

On the other hand, under the tutelage of Secretary Juan Flavier who served in 1992 to March 1995, PHC has once again been given primary attention as it is considered as the approach which should permeate all programs and projects in health. Furthermore, challenges are in store to make PHC operational under the local government units because of the devolution of PHC to local chief executives.

The following sections will therefore point out the accomplishments and performance for the two dispensations (Bengzon and Flavier) before recommendations or policy issues are raised in the implementation of PHC.

PHC to Community Health Development (1987-1991)

Less Emphasis on PHC. Under the leadership of Secretary Bengzon, PHC was not given as much attention as it used to be executed in the previous dispensation. This is indicated by the fact that the status of PHC implementation was not monitored religiously. The latest available data with complete information on PHC was in 1988. The succeeding year showed incomplete information with only ten out of 14 regions providing the necessary data. Thereafter, no data were presented on the status of PHC implementation nationwide in the Annual Reports.

The 1988 data indicated a decline in the total number of barangays initiated to PHC with only 96.6% in this category out of 39,629 barangays as against 98.3% out of 38,364 barangays in 1984 (DOH Statistical Data). (See Table 1.)

Table 1. Total Number of PHC Barangays

Status of Barangays	*1984*		*1988*	
	Number	*Percentage*	*Number*	*Percentage*
Initiated to PHC	37,705	98.3	38,316	96.6
Not initiated	1,345	1.7	1,313	3.4
Total Barangays	38,364		39,629	

Source: Statistical Data Community Health Service, DOH, 1988 and 1984.

The decrease in the number of Barangay Health Workers (BHWs) is even more remarkable since it dipped from 380,609 in 1984, to 371,762 in 1986 and 355,990 in 1988. (See Table 2.)

Monitoring the BHWs was different for the previous dispensation vis-a-vis the Bengzon Period. The former categorized trained BHWs vis-a-vis those to be trained. An improvement in the succeeding leadership is the distinction made between active and inactive BHWs since being trained does not necessarily imply being active. However, subsequent to 1988, monitoring was no longer pursued religiously. Furthermore, the dwindling enthusiasm for PHC is further indicated by the decreasing ratio of active/trained BHWs to PHC barangays from 7:1 in 1984 and 1986 to 5:1 in 1988.

Table 2. Number of Barangay Health Workers

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

Source: Statistical Data Community Health Service, DOH, 1988, 1986 and 1984.

In addition, monitoring of the level of PHC implementation of every barangay was no longer carried out after 1988. Four levels of PHC were previously adopted as modes in classifying barangays. These were:

First Level — Social Preparation/Awareness Level
Second Level—Leadership Organization Design (LOD)
Third Level —Program Planning and Management
Fourth Level—Institutionalization of PHC

A set of indicators was formulated for each level with the Rural Health Unit or the Barangay Health Station personnel taking charge of classifying the

barangays under their jurisdiction. While the set of indicators was difficult to translate in operational terms (see Appendix), earlier assessment of the utilization of these indicators showed the initiative of local implementors to come up with more measurable criteria (Bautista 1988: 53). The problem, though, in allowing local implementors to define their own criteria leaves them much discretion, thus preventing standardization in the process.

The issue of sustaining the interest in PHC is indicated by the decrease in the percentage of barangays in the highest level of PHC implementation in the earlier years of the Bengzon Period. In 1986, the percentage of barangays in the fourth level of PHC was close to a third of the total. This decreased to a fourth in two years time. (See Table 3.)

Table 3. Level of PHC Implementation of Barangays

Level of PHC	*1986*		*1988*	
	No.	*%*	*No.*	*%*
I	3,424	9.5	4,762	12.0
II	7,927	22.0	9,220	24.0
III	13,101	36.4	14,597	38.0
IV	11,564	32.1	9,737	25.0
Total	36,016		38,316	

Source: Statistical Data Community Health Service, DOH, 1988 and 1986.

Another indicator of waning interest in PHC implementation is the decline in the total number of *Botika sa Barangay* (BSB), a community cooperative drugstore taking care of selling drugs in the locality. In 1983, 14,777 BSBs had been set up nationwide covering 37.8% of all barangays (Pesigan *et al.* 1992: 15). By 1988, DOH statistical data revealed an increase to 17,150 BSBs although only 43% (numbering 7,367) of this total was considered functional. These served only 19% of PHC barangays.

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

The decrease in the support provided to PHC during this phase may be attributed to the leadership's assessment that PHC carried "many wrong connotations" since it was a "thwarted advocacy" for being implemented under a "dictatorship" (DOH n.d.[e]: 5). Furthermore, the new leadership wanted to correct the misconception that PHC was implemented as a means to reduce the budget for health.

Partnership in Community Health Development. In lieu of the term PHC, "Partnership for Community Health Development (PCHD)" was the approach that was elucidated, advocated and implemented since 1989. Community Health Development was conceived as a "people-centered development process where people who, initially, are beneficiaries of health programs become partners in health care until finally they are empowered to become managers of their own health programs and able to attain self-reliance and self-determination" (DOH n.d.[c]). The basic strategy applied is through "partnership" with organized groups in the locality among LGUs, NGOs, field health units (i.e., provincial health office, district health office, and rural health unit) and people's organizations which share the vision of community health development. This is forged on the assumption that the partnership is able to decentralize decisionmaking and use the participatory approach in different phases of the management cycle of planning, implementing and monitoring and evaluating local development programs and projects. It is particularly aimed at "depressed, underserved, hard-to-reach and critical communities" (DOH n.d.[c]). Furthermore, this partnership is made possible through the technical and financial support of the Community Health Service of DOH extended to the community identified with the assistance of local groups or organizations.

In essence, PCHD is an approach which subscribes to the basic concepts of PHC for intersectoral collaboration, concern for the depressed sectors of the locality and participatory thrust in decisionmaking. The difference lies in the manner of execution since the responsibility is lodged in an NGO instead of the field health office personnel of the Department of Health. Furthermore, financial support is extended to the partnership for various activities such as:

(1) collective multisectoral planning by the NGOs, provincial health office/rural health units and the local government unit;

(2) community project implementation for those formulated to be tailor-fitted to community needs—a cumulative total of 76 proposals covering 99 barangays were reportedly approved by 1992; and,

(3) institution-building activities of partner agencies—this is aimed to enable DOH to actually experience and appreciate community organizing; for LGUs to become socially oriented and take the responsibility for the management and promotion of preventive health

programs; and for NGOs to become better implementors of health programs (PCHD n.d.: 10).

PCHD started to become operational in 1990 targeting four provinces (i.e., Camarines Sur, Eastern Samar, Negros Occidental and Surigao del Norte) and another four provinces in the second year (i.e., Sorsogon, Northern Samar, Antique and Agusan del Norte).

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

Some initial problems encountered in the partnership as reported in PCHD's Accomplishment Report for 1992 is the lack of clarity on the role of the LGU in managing the partnership. Another is the ambivalence of NGOs to work with LGUs for fear of political interference. Some NGOs were reportedly not accepted by local executives as they had their own preferences to work with some NGOs inexperienced in community organizing. Another stumbling block is the delay in the releases of funds resulting to slow-paced implementation. Another point pertains to sustainability of the projects after the NGOs' role as facilitators is completed. There is also the issue on the capability of interested parties to prepare project proposals which become the substantive basis for the partnership.

In spite of these problems, some improvements in the approaches of DOH had been made in support of PCHD which may be considered as landmarks in forging PHC. These are:

(1) Implementation of an information system in order to detect the areas which can be targetted for social development. This is the institution of TADS or Targetted Areas for Development which is a collection of barangay health-related data as the basis not only for "health improvement but also for total development of the community" with the end in view of redressing inequalities. TADS are barangays which are considered as "hard to reach, underserved, depressed and/or critical areas where the inhabitants are most vulnerable to and health systems research is most difficult" to pursue (DOH n.d.[d]).

TADS Forms were formulated as baseline indicators and information guide on the status of the barangays. The general information include: region, province, district, municipality, population, name of midwife, number of households, regular mode of transportation, distance from town proper, geographical description, number of active BHWs, number of trained birth attendants, presence of Barangay Primary Health Care Committee, name of NGOs present, number of households with potable water and number of households with sanitary water.

(2) Conduct of the First National Convention of NGOs for Health in November 1989 to formally open the DOH to all private sectors involved in health. A listing of NGOs in health was formulated as a result of this undertaking.

(3) Encouraging collaborative activities with NGOs notably the Jaime V. Ongpin Foundation (JVOFInc.) which signed an agreement with the DOH to finance projects for the provinces of Zambales and the Cordilleras particularly Benguet, Mt. Province, Ifugao, and Nueva Vizcaya (Development Partners 1993: 4). JVOFInc. serves as the social arm of the Benguet Corporation and is the trustee of the donation for the Philippine government to develop the mining areas of the corporation.

A total amount of ₱55 million was available for a six-year period. The projects involved primary health care, health-related community development and general development including livelihood. This agreement commenced in 1986 and facilitated the evolution of the DOH/Community Health Service GO-NGO-community partnership program (Development Partners Inc. 1993: 26). This collaboration was also tapped by DOH to bridge the slack period for PHC projects (Development Partners Inc. 1993: 30).

The framework for implementation of the collaboration signifies its affinity with PHC since it has capitalized on community organizing as the basic process in undertaking social development efforts focusing on "disadvantaged communities within the target areas through the provision of financial and technical assistance which could encourage community participation in health promotion and livelihood development" (Development Partners Inc. 1993: 8). The ultimate goal was to develop and mobilize community structures capable of managing and sustaining projects initiated by the collaboration (Development Partners Inc. 1993: 8).

The collaboration implemented a total of 522 projects from 1987 to 1992 with 61% being devoted to PHC. The others were mostly in local development, social development and institutional development.

In addition to the previous innovations, support was extended to BHWs in spite of the fact that DOH tried to distance itself from the use of the term PHC. The following were initiated in Bengzon's period such as:

(1) Issuance of BHW identification card

This served as a reference for program managers and a convenient tool for monitoring and evaluation. This also provided security to the workers especially if they move about in areas with peace and order problems. A total of 159,442 ID cards were issued during the period (DOH n.d.[e]).

(2) Provision of incentives to BHWs

Incentives offered include free medical and dental check-up with blood typing and the establishment of a separate file of the BHWs in the family health folder in the Municipal Health Center and the Barangay Health Station.

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

The services extended by the DOH program were to be delivered as well to all immediate family members of the BHW. Thus, their files are included in the family health folder.

(3) Provision of income generating projects (IGP)

Extending financial grants to BHWs to undertake livelihood projects is one important step to prevent turnover. The amount of ₱100,000 seed fund per province and ₱30,000 for each city was made available to start or augment a collective livelihood endeavor to be administered and managed by the BHWs themselves. This was aimed at supplementing their finances for health and health-related needs and to ensure sustainability of efforts. This was to be implemented provided that BHWs are federated per province. The Provincial BHW Federation was to organize a review committee for the purpose of studying all proposed IGPs in the province and approving for endorsement to Regional Health Office.

(4) Conduct of a survey by the Community Health Service in January and February 1991 to determine the needs and problems of BHWs

(5) Formulation of a directory of BHWs

The preparation of a BHW directory was started and was to contain all information of trained, active and functional BHWs. This covered such information as ID number with codes for province, municipality and BHW number, and other information such as age, sex, civil status, blood type, address, catchment area, BHW Kit, date of entrance to duty and other information. This provided baseline information on BHWs.

Impact. The impact of PHC as a strategy was evaluated during this phase by a team from the academic community (Bautista 1988). The data for the survey of twelve barangays for three regions were collected between 15 April and 15 July 1987. A rate of 154 persons per 1000 got sick among those who were not exposed to PHC as against 139 to 1000 among those familiar with PHC thus signifying the positive impact of the strategy (Bautista 1989: 153). Mortality patterns among the

twelve barangays also improved over two time periods for six out of eleven barangays with available data. This may be attributed to the fact that surveyed household decisionmakers on health familiar with PHC had significantly higher level of health practices than the unfamiliar ones (Bautista 1989: 152).

Post-evaluation studies conducted by Development Partners Inc. of the collaboration of JVOFInc. and DOH which implemented PHC activities indicated the impact of this approach. As many as 63 percent of the 106 surveyed respondents expressed their view that there were "major improvements" in their health and nutritional standing (Development Partners Inc. 1993: 100).

PHC as the Core Strategy (1991-Present)

Background. The appointment of Secretary Juan Flavier at the Department of Health brought about major revisions in the approach regarding PHC. The term PHC was once again put into the limelight and even mandated to permeate all programs and projects implemented by the DOH. Administrative Order No. 11 of 1993 was passed to install PHC as the "core strategy in program thrusts of government at national, local and community levels in order to enable people's active participation and involvement for better health and self-reliance." The Philippine Policy Paper on PHC expressly provided that it is an approach to bring "Health in the Hands of the People." The major agenda is to make the people "manage their own health;" to be less "doctor-centered" but "people-centered."

It is also during this phase when the 1991 Local Government Code was put in force and therefore devolving the implementation of PHC in the hands of local chief executives. Thus, the role of the national government for PHC implementation has become coordinative, recommendatory and regulatory and not of direct control.

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

Upon the assumption into office of the new set of leadership at the DOH, two major groups were created to define the framework of PHC (Sia 1992: 10). One was the Task Force on PHC whose aim was to evaluate the status and implementation of this approach and its implications on the National Development Plan. The second was composed of DOH-NGO Cluster Groups to thresh out the

roles and working relationships between the government and the private sector. Subcommittees were formulated to dwell on traditional medicines, NGO accreditation, accreditation of training programs for voluntary health workers, protection of health workers, exchange programs and social mobilization.

As a result of the dialogues of these task forces, modifications were made in the organization and strategies for implementing PHC.

At the organizational level, Administrative Orders were issued on 31 March and 21 May 1993 setting up structures at the national and area levels for the management of PHC. These are the National Advisory Committee which is tasked to provide technical advice to the Secretary of Health and the National Technical Working Group on PHC and to raise policy agenda for legislation. Of significance is the involvement of NGOs and the private sector with expertise on PHC, other than representatives from the DOH.

The key structure to oversee PHC at the DOH is the National Technical Working Group. This facilitates and ensures the implementation of the plan and the monitoring of PHC activities. It also serves as a forum for consultations with LGUs, NGOs and local organizations. It also provides the necessary resources and facilities to support PHC requirements.

Area-based Technical Working Groups are to be formulated to oversee the implementation of the strategy in their respective areas.

To provide administrative, financial, secretariat and technical support is the Secretariat/Operations Center based at the Community Health Service.

Accomplishments. Innovations in the implementation of PHC at the grassroots level include the following:

(1) Recognition of volunteer health workers other than the Barangay Health Workers as potential source of support for PHC

Thus, the nomenclature for voluntary workers for PHC has been changed to Community Volunteer Health Workers (CVHWs) to take into consideration other existing health workers such as Community Health Workers of community-based health programs often initiated by NGOs, Volunteer Family Health Care Workers (VFHCWs) or the DOH-trained health workers per family, Barangay Nutrition Scholars of the nutrition program, and volunteer workers of the family planning program (DOH 1993c).

In line with this thrust, a more synchronized package of incentives and management procedures have been formulated to ensure standardized treatment of voluntary workers. The following moves have been made to indicate

convergence of efforts to consider the welfare and harness the potential of all volunteer workers. These are:

(a) Computerized masterlisting of all active CVHWs instead of mere listing of BHWs.

A total of 445,589 CVHWs are listed with Community Health Service as of 15 January 1994.

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

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

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

(c) Inclusion of other volunteer workers who are certified by the DOH to benefit from the incentive scheme recognized for DOH-trained BHWs.

(d) Move to expand incentives for BHWs to include:

- preferential access to loans provided by government agencies;
- system of national and local awards for outstanding health workers;
- discount for transportation fare in land, sea and air travel;
- one-child educational benefit per BHW, e.g., scholarship in college studies;
- preferential treatment of other benefits given by non-health agencies like Department of Agrarian Reform, Department of Education, Culture and Sports, Department of Welfare and Social Development and Department of Environment and Natural Resources; and
- regular funding for maintenance of logistical support and assistance for accredited health volunteer health workers like kits, supplies, medicines, equipment and materials (DOH n.d.[b]).

(e) Move to have a CVHW represented in assistance unit/desk per province and municipality to ensure the protection of health workers.

(2) Highlighting community organizing as a basic approach for empowerment

Policy guidelines for community organizing have been formulated by the DOH in cooperation with five NGOs and is now in force. The principal responsibility for organizing has been entrusted to NGOs as they are given the role of "designing, planning, implementation, monitoring and evaluation of the community organizing process for health" (DOH Community Organizing Policy Guidelines 1993: 2).

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

(3) Expansion of PCHD started during Bengzon's term

The current dispensation expanded the Partnership in Community Health Development (PCHD) started by the previous leadership. In addition to the eight provinces prioritized for this approach, the addition of 26 expansion provinces has been considered in 1993. To learn from the lessons gained by the eight provinces, a National Project Implementation Review of those involved in PCHD was conducted in Surigao City on 22-25 November 1993. A summary of the lessons learned from this workshop is being prepared. Nevertheless, PCHD is now being reviewed as one of the approaches to implement PHC and possibly, no distinctions will be made between the two subsequently (Interview with Program Officer, 11 January 1994).

(4) Plan to identify model PHC barangays

There is also a plan to identify five model barangays per province in order to serve as a showcase and laboratory for training participants. This is a laudable move to inspire other barangays to pattern their development after them.

(5) Monitoring by levels of PHC implementation

There is also a revival of interest to monitor PHC by level of its implementation. However, the indicators for assessment have yet to be formulated.

(6) Preparation of a BHW Operational Manual

Plans are underway towards the preparation of a BHW Operational Manual. The proposed content of the Manual gives substantial attention to basic programs in health such as nutrition, maternal and child care, personal hygiene, dental care, environmental sanitation, rational use of drugs and herbal medication. The proposed manual also provides instructions on how to detect and manage common illnesses (i.e., diarrhea, pneumonia, intestinal worms, chest pains, etc.). This also imparts information on how to render first aid for fever and convulsion, shock, loss of consciousness, wounds, bleeding, etc. Other special topics are also covered like AIDS, hepatitis, malaria and sexually transmitted diseases.

Another part is devoted to work management such as keeping records, referring a patient, conducting community health teachings, and how to mobilize the community.

Policy Issues and Recommendations

Considering the context and accomplishments of PHC implementation by the government in the recent past, the following are some issues which can be raised and the corresponding recommendations offered:

Role of Local Chief Executives

The implementation of the 1991 Local Government Code necessitates that relationships between the local chief executives (LCEs) with the field offices of the national government, NGOs and people's organizations be properly spelled out. It has been mandated by the Code that LCEs be chiefly responsible in "implementing programs and projects on primary health care, maternal and child care, and communicable and non-communicable disease control services" (Rule V, Art. 27, c-1). Thus, clarification on the specific duties of LCEs in various policy guidelines on PHC should also be incorporated.

For example, the policy guidelines on partnership with NGOs in community organizing defines the role of DOH in pursuing such partnership (DOH 1993b: 2). In turn, NGOs are the ones viewed to assume the major responsibility in implementing the process. The Guidelines should incorporate as well the task of the LCE in the process. In fact, it may be important to mobilize the LCEs first to make them a part of making decisions in identifying key persons/institutions who will be tasked to implement the process. This way, the LCEs will have a feeling of "ownership" and therefore endorse activities which will be evolved from the CO process and be incorporated in the local development plan. This may avoid lack of rapport or even suspicion that may develop between the two parties.

Partnership in Community Health Development or PHC?

Bengzon's leadership led to the evolution of the term PCHD to veer away from the use of the word PHC. Furthermore, PCHD also paved the way in harnessing NGOs to implement community organizing as a basic process since NGOs are noted for this expertise. The difficulty though in juxtaposing PCHD with PHC is to make it appear that the two strategies are different from each other. In essence however, both subscribe to the same mission—of empowerment, equity and accessibility of services. The only difference lies in the mode of applying the strategy of CO. PCHD relies on NGOs while PHC depends on the governmental apparatus and resources, principally the BHWs.

What must be clarified is the current role of LCEs in these two strategies. It is recommended that one terminology be adopted to avoid confusion since PHC is the term recognized in the Alma Ata Conference and the one used in the Local Government Code.

Nevertheless, the approaches which may be implemented to flesh out PHC can also encompass the methodology subscribed to by PCHD. Thus, the PCHD approach may be considered as one alternative which can be offered to LCEs to implement PHC. Three tracks may in fact be considered as options to implement CO. Track 1 is to harness the LGUs' capacity for CO if this capability is available. Track 2 is to harness the PCHD approach which taps NGOs to take the lead in the process. Track 3 can encourage the convergence of efforts of LGU implementors for CO in tandem with NGOs.

Whichever track is finally decided upon by the LGU, intersectoral effort or partnership must be made through the leadership of the LCE. The venue for threshing out the tracks to pursue is the local development council (LDC) which is expected to operate in an integrated manner. The LCE can constitute the LDC with the combined efforts of LGU implementors, field unit implementors of national government, NGOs and POs. The expansion of the total membership of NGOs to not less than one-fourth of the total membership of the LDC institutionalizes the opportunity for LCEs to harness their expertise and potential.

It is an opportune occasion that an integrated model of development is subscribed to by the 1991 Local Government Code as this is the structural arrangement that is appropriate for PHC as it argues the importance of "integrating health in the socioeconomic development of the locality." The role of DOH can be in the conduct of social mobilization initiatives for LCEs who are now the chief actors in implementing PHC to capitalize on this opportunity.

BHW as Multipurpose Worker or Health Worker?

The expectations of BHWs as key persons in PHC are very high. The combined roles of community organizer, health care provider, facilitator and data gatherer/reporter are expected to be performed by the BHW. Although in reality, performing the CO role is one of the weakest areas which they were able to perform (Bautista 1988). This is because the training or preparation provided for BHWs focuses on promotive, preventive and curative aspects of health. In fact, the training guidelines highlight the role of BHWs in delivering the impact programs of DOH. Thus, BHWs are labelled as "adjuncts" in the DOH service delivery channel rather than effective mobilizers of the community for group decisions and actions.

It can therefore be asked if BHWs should still be depended upon to perform the CO function if the training provided to them does not adequately prepare them for this role. Considering the experts who may be tapped by LCEs for CO work in an area-based development process under devolution, the role of CO may be entrusted to the experts while the performance of technical functions of health care may be a specialized role of the BHW. On the part of the LGU, devolved personnel from the Department of Social Welfare and Development may be mobilized for the role of CO worker. Their personnel have been purposely fielded to perform this function. NGO-CO workers and others with this capacity may also be tapped to augment or supplement the LGUs' resources. BHWs can then phase in to perform technical health support functions after the community has been mobilized to identify and formulate program priorities in health.

Unilateral Efforts vis-a-vis Convergence of Efforts

It is important to emphasize that local implementors need not operate single-handedly. The essence of devolution is to implement an area-based approach in local development management. Thus, many processes and approaches which used to be implemented in support of PHC need not be solely applied by the local health implementors if they are already undertaken by others. For example, the implementation of Targetted Areas for Development or TADs can be jointly undertaken with Social Welfare Officers who usually implement focused targetting of depressed, deprived and underserved communities. Hence, the areas for collaboration may be threshed out by the LCEs through the LDCs to avoid duplication of efforts of sectoral implementors both from LGUs, NGOs and other groups.

Monitoring Levels of PHC

Monitoring PHC level is one of the activities implemented in the Marcos Regime. While difficulties were encountered in applying the set of criteria,

nevertheless it has been very useful in identifying the level of progress of every barangay as far as PHC is concerned. This defines the level of mobilization to be executed. However, it is important to formulate simple indicators in order to facilitate the implementation of the criteria.

Some possible indicators include the following:

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

The presence of BHW as an indicator for Level I suggests the potential in mobilization for PHC activities. The argument for the indicator in Level II is to demonstrate that there are functioning health activities which have been initiated/facilitated by the BHW. The Level III indicator demonstrates that it is not enough to implement community health activities but that these activities are forged by organized groups in the community. This then shows the level of community mobilization for the community. Level IV indicators suggest the potential for institutionalization and sustainability. The fact that community activities are embodied in the local development plan depicts the commitment of the local political leadership to health activities. Another possible indicator is the existence of community-based financing schemes which will show the potential of a barangay to support local health activities.

Part of the mobilization process of the community should also highlight the importance of setting up community-based information system to provide the community up-to-date information of its progress pertinent to their health. This information will be useful for community-based planning. Data boards may be adopted similar to those applied in Davao City initiated by the Institute for Primary Health Care. Volunteer mothers may be harnessed to take care of monitoring a group of families similar to the ones started by the National Statistical Coordination Board through its Community Based Child Monitoring System.

Process Documentation

It is important to pay particular attention to the manner of implementing PHC—who are the persons able to effectively harness CO, what institutions do they represent, and what factors facilitate or impede community mobilization. Learning from the experiences of these types of persons can only be captured if

there is concern for documenting the processes involved. This may be facilitated if the LGUs tie up with local schools and research institutions who can assist in training local implementors in process documentation and data analysis.

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

Sustainability of PHC Activities

Sustaining PHC activities is one of the issues that should be dealt with. Plans are not meaningful unless they are pursued continuously to reap beneficial effects. Thus, efforts to generate resources on the part of the LGUs to finance health care must be tapped to ensure that health projects are perpetuated. LCEs may be assisted to determine ways to generate local resources instead of depending merely on internal revenue allotments. LCEs' awareness may be enhanced through capability building programs for resource generation. Measures of improving resources include utilizing LCEs' taxing powers; seeking grants from donor institutions, the national government and other LGUs; and exacting user charges for services from those who can afford. On the part of the community, motivating the development of community-based financing schemes may be undertaken to make the locality self-reliant in pursuing activities they have initiated.

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

Improving the Management of Health Facilities in the Locality

Mechanisms to improve the management of health in the locality can be installed to prevent wastage of resources. One way to maximize the contribution of CVHWs is to serve as the first stage of screening the users of public health facilities by providing referral forms for higher level facilities. This mode is adopted in some countries like Thailand. This therefore prevents unnecessary burden on higher level facilities as those in the first line of defense are able to resolve them. Exceptional provisions may be made for emergency cases.

References

Bautista, Victoria A.

1989 How effective is the PHC Study: Highlights of the Results of a Survey. *Philippine Journal of Public Administration.* 33(2) (April): 142-169.

1988 Assessing PHC as a Strategy in Health Service Delivery. Volume 1. For Training and Development Issues Project of the National Economic and Development Authority. Quezon City: College of Public Administration, University of the Philippines.

Department of Health (DOH)

1993a *Accreditation of Government and Non-government Organizations Training Program for Barangay Health Workers and Community Health Workers.* Manila: DOH and Community Management Institute.

1993b *Community Organizing Policy Guidelines.* Manila: DOH and Community Management Institute.

1993c *Community Volunteer Health Workers* (CVHWs) *Support Package.* Manila: DOH.

1993d *Protection of Health Workers.* Manila: DOH and Community Management Institute.

1992 *Health in the Hands of the People: Positioning for Performance, Department of Health Strategy Paper on the National Health Plan.* Manila: DOH.

1988 *Statistical Data Community Health Service.*

1986 *Statistical Data Community Health Service.*

1984 *Statistical Data Community Health Service.*

n.d.[a] *Community Health Volunteer Health Workers Support Package.* Manila: CHS-DOH.

n.d.[b] Position Paper in Connection with Senate Bills 433, 491 and 833 Regarding Barangay Health Workers. Manila: DOH.

n.d.[c] *Primer on Partnership for Community Health Development.* Manila: CHS-DOH.

n.d.[d] *Project Description Summary of Targetted Areas for Development* (TADS). Manila: CHS-DOH.

n.d.[e] *Update on Primary Health Care Policy and Implementation.* Manila: Community Health Service, Department of Health (CHS-DOH).

n.d.[f] *What is the Partnership for Community Health Development?* Manila: CHS-DOH.

Development Partners Inc.

1993 Ex-Post Evaluation of the DOH-JVOFInc. Integrated Primary Health Care and Livelihood Program. Manila: Development Partners Inc.

Partnership for Community Health Development (PCHD)

1992 *Accomplishment Report.*

Pesigan, Arturo M. *et al.*

1992 *Primary Health Care in the Philippines.* Quezon City: U.P. Center for Integrative Studies.

Republic of the Philippines
1991 Republic Act No. 7160. *The Local Government Code of the Philippines.*

1991 *Rules and Regulations Implementing the Local Government Code of 1991.*

Sia, Clarisa
1992 Gearing for Community-Based Health at the DOH. *Public Administration Bulletin.* 1(1) (December): 10-11.

Interviews

Cerveza, Diane. Program Health Officer, Community Health Service, 11 January 1994.

Nicanor, Renato. Coordinator for BHW, Community Health Service, 17 January 1994.

San Agustin, Leni. Community Health Service, National Technical Working Group on Primary Health Care. 11 January 1994.