Documentation of Specific Area Experiences in **Primary Health Care**

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DOCUMENTATION OF SPECIFIC AREA EXPERIENCES IN PRIMARY HEALTH CARE: PHASE II

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For the Ministry of Health

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PART ONE: DESCRIPTION OF THE DOCUMENTATION PROJECT

I. *INTRODUCTION*

A. The Primary Health Care Approach

An effective health care strategy for the Philippines has never been more badly needed than during this decade. Limited resources in the face of a rapidly growing population and spiralling inflation have made the task of providing public health services increasingly more difficult. Through the years, the Philippine government has taken measures to cope with this growing demand for health services. It has expanded its conventional and structured health care system to serve a bigger percentage of the population. It has also implemented various innovative schemes to augment health manpower and to promote health among the people. While these measures have yielded positive results, they have fallen short of attaining the government's objective of "health for all Filipinos" (PCF, 1983).

Given this situation, the Philippines, along with other countries represented at the 1978 Alma Ata Conference in the Soviet Union, adopted the primary health care (PHC) approach to public health services.

Primary health care is a practicel approach to the effective provision of essential health services. These services are community-based, accessible and acceptable to and sustainable by the majority at a cost which the community and government can afford. PHC

involves the active participation of the community and recognizes that health is a necessary factor in the country's socioeconomic development.

The objectives of primary health care are three-fold:

1. To mobilize community participation for the identification and solution of basic health needs through self-reliant means;
2. To promote good health by encouraging correct patterns of living; and,
3. To integrate community-based health services with those for other social development goals, thereby serving as the channel for the total delivery of basic social services.

The PHC approach was officially implemented by the Philippine government in 1980. As a social development strategy, it hinges on four fundamental elements which may be considered the "pillars of PHC."

These elements are:

1. Active community participation and involvement in the identification and solution of the people's health needs and problems;
2. Intersectoral collaboration between various public and private agencies engaged in health services delivery and related concerns;
3. Development and use of appropriate technology to meet local health needs; and,
4. Development of support mechanisms to sustain PHC implementation (PCF, 1983).

B. Documentation of Primary Health Care: Objectives and Significance

The nationwide implementation of the PHC approach was a radical step taken by the Ministry of Health (MOH). It involves a shift in orientation for health care and delivery from one of a donor - recipient relationship to that of a partnership between the government, the private sector and the community.

To implement PHC, considerable time, manpower and logistics have been expended for pilot-testing its elements, for orienting health and other social service professionals to an integrated approach for community-based health care, for training barangay health workers, and for introducing PHC to community members at-large.

The lessons of the first years in implementing PHC will be important in mapping out the strategies for the coming years. To assist in this awesome task, a two-phased documentation project on the PHC was proposed. This project has two general objectives:

First, to document the operationalization of PHC as a strategy for providing community-based health and health-related activities; and

Second, to produce a slide-and-tape presentation on the progress and accomplishments of PHC.

B. PHC Documentation: Phases I and II

As envisioned, the documentation process was undertaken in two stages. In Phase I, existing documents[1] of the PHC unit in the Manila Office of the Ministry of Health (MOH) were reviewed and analyzed. This study was undertaken for the following purposes:

1. To provide indicators on the progress of PHC implementation based on monitoring reports from the field;
2. To identify problems reportedly encountered in PHC implementation; and,
3. To identify the areas of strength, weakness and gaps in the implementation of PHC.

Phase I of the Documentation Project was completed in December 1983. The documentary analysis revealed the following major trends in the nationwide implementation of the PHC (PCF, 1983):

1. By mid-1983, 77% of all barangays had been initiated to PHC, with about 150,000 barangay health workers trained for health care services.
2. In 1983 six major government agencies collaborated with the Ministry of Health to implement PHC by way of providing technical assistance and monitoring activities and relevant information to concerned MOH personnel.

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[1] These documents include Progress/Status Reports of provinces, reports of the PHC Technical Working Group, field visit reports, workplans, and minutes of the PHC-TWG meetings.

3. The eight elements of primary health care were provided within barangays with functional PHC committees.
4. While extensive efforts have been expended for social preparation of the staff, the collaborating agencies and the communities, improvements could be made for a more effective PHC implementation.
5. Improvements could also be made in the training of barangay health station midwives (BHSMs) and barangay health workers (BHWs) for health and community services.

Inasmuch as the first phase of the project relied on transmitted field reports available in the PHC office of the MOH Central Office, it was felt that a validation of these initial findings would be necessary. Thus, Phase II of the PHC Documentation Project was designed to corroborate the initial documentary findings by observing actual implementation processes in selected regions, provinces, municipalities and barangays.

The specific objectives of Phase II are the following:

1. To document actual experiences in PHC implementation - from regional to barangay levels of operation;
2. To describe the configuration of program factors and community variables that may affect PHC performance and accomplishments;

3. To determine the perceptions and assessments of a cross-section of program managers, workers and community residents on PHC as a health care approach; and,
4. Based on the above, to formulate recommendations for improving the implementation of the PHC program.

D. The Conceptual Framework for Phase II

The information collected for the second phase of the Documentation Project was organized on the basis of a conceptual framework which attempts to visualize the interrelationships between different sets of variables related to PHC.

The primary health care approach, by definition, is a strategy for providing health care to the grassroots through a partnership between the community the private sector and government. The specific activities and concerns implemented through this approach are ideally selected on the basis of two antecedent influences:

1. The community's readiness to participate in a health care program which it needs and wants;
2. The health professionals' preparedness to train the community to manage its social problems, particularly those related to health.

Eventually, the social impacts of PHC are expected to be those which define an improved health status among the grassroots, thereby enabling them to participate more meaningfully in the national life.

The goals of PHC, therefore, are attainable only through a gradual and tedious process of re-education and re-orientation of both the professionals and the community residents. It requires the development of skills, values, and technological capabilities that facilitate the implementation of health activities and health services through the collaborative efforts of government and laymen.

1. Indicators of PHC Accomplishments

As of this writing, the PHC strategy has been mandated for only three years. In the Phase I report, it was signified that much of the efforts for PHC implementation have progressed to the stage of social preparation only, or to the stage of initial implementation of community health care services. Given this set of events, the accomplishments of the PHC would be largely confined to the effects of social preparation activities. The set of indicators used to define PHC accomplishments would thus include the following:[2]

a. Perceived/identified community needs for health and social development;

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[2] More detailed definitions of these variables will be provided in chapters devoted to their documentation.

b. Community participation in PHC-related operations and services; and,

c. Knowledge, attitudes, and opinions on PHC.

2. Indicators of Antecedent Variables

The accomplishments of PHC can be realized only if certain activities are undertaken within the communities initiated into the approach. Broadly speaking, these PHC-related activities should include the following:

a. social preparation processes among program implementors;

b. social preparation processes within the communities;

c. intrasectoral linkages within the MOH structures;

d. intersectoral linkages between involved agencies; and,

e. provision of community-based health services.

In addition, inasmuch as the essential approach requires a partnership effort between program professionals and residents, the quality of program support and the characteristics of the community are expected to influence the nature of activities undertaken within PHC. The indicators corresponding to these variables would include the following:

a. Program support indicators

   1. program-level plans and targets

   2. technical assistance

   3. personnel/manpower

4. incentives and sanctions
5. communication network
6. monitoring mechanisms
7. integration and complementation structures

b. Community characteristics

1. municipal/provincial/regional characteristics
2. available health facilities
3. health, nutrition, family planning and sanitation practices

The paradigm which is used to interpret the relationships between the different variables is drawn from an input-output model. Roughly, program support and community characteristics are conceived to be the input variables. Together, they influence the different PHC activities undertaken, which are the process variables. When these social preparation activities are implemented, they are expected to result in certain behavioral and attitudinal changes among both the laymen and the program professionals. These are the program outputs of PHC.

The predicted relationships are depicted in Figure I.

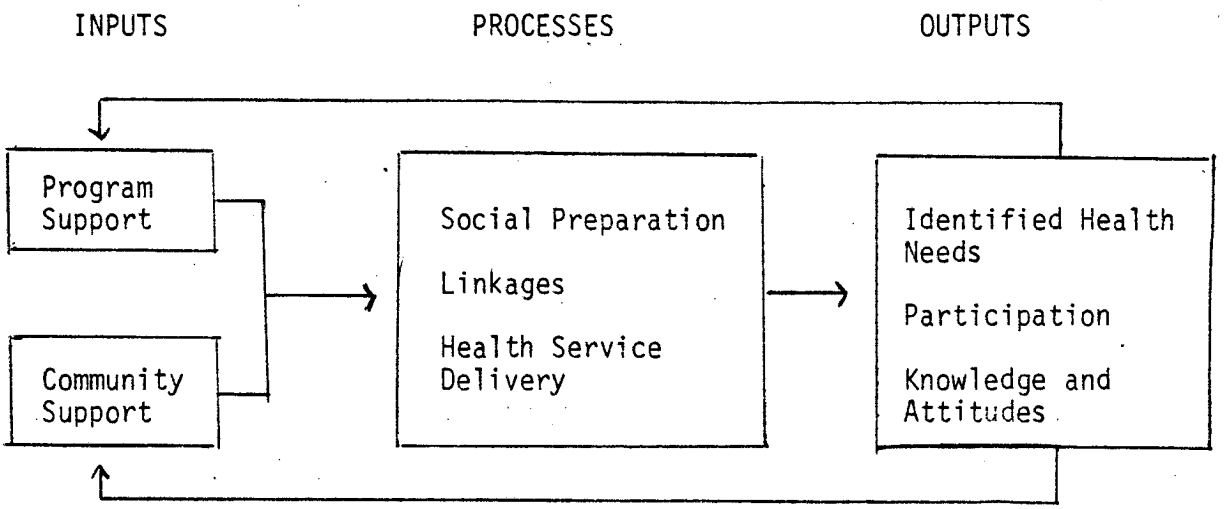


Figure I: Conceptual Relationships between PHC-related Inputs, Process and Output Variables

The succeeding discussion will be organized to coincide with the abovementioned paradigm. However, since the purpose of this investigation is to document the progress of PHC implementation, evaluative statements will not be made regarding the obtained information. Rather, the results of the documentation are intended to generate hypotheses for future evaluation/researches.

2. RESEARCH STRATEGIES

To facilitate the collection of information concerning the elements included in the framework, it was decided that a three-pronged study be undertaken. Foci of these separate documentations include the following:

1. A Community Survey in barangays initiated to PHC
2. A Survey of PHC Health Workers in the selected barangays, including the PHC Committees
3. Case Studies of Primary Health Care Committees (PHCCs) in selected regions, provinces, and municipalities

A. Sampling Plan

1. Site selection

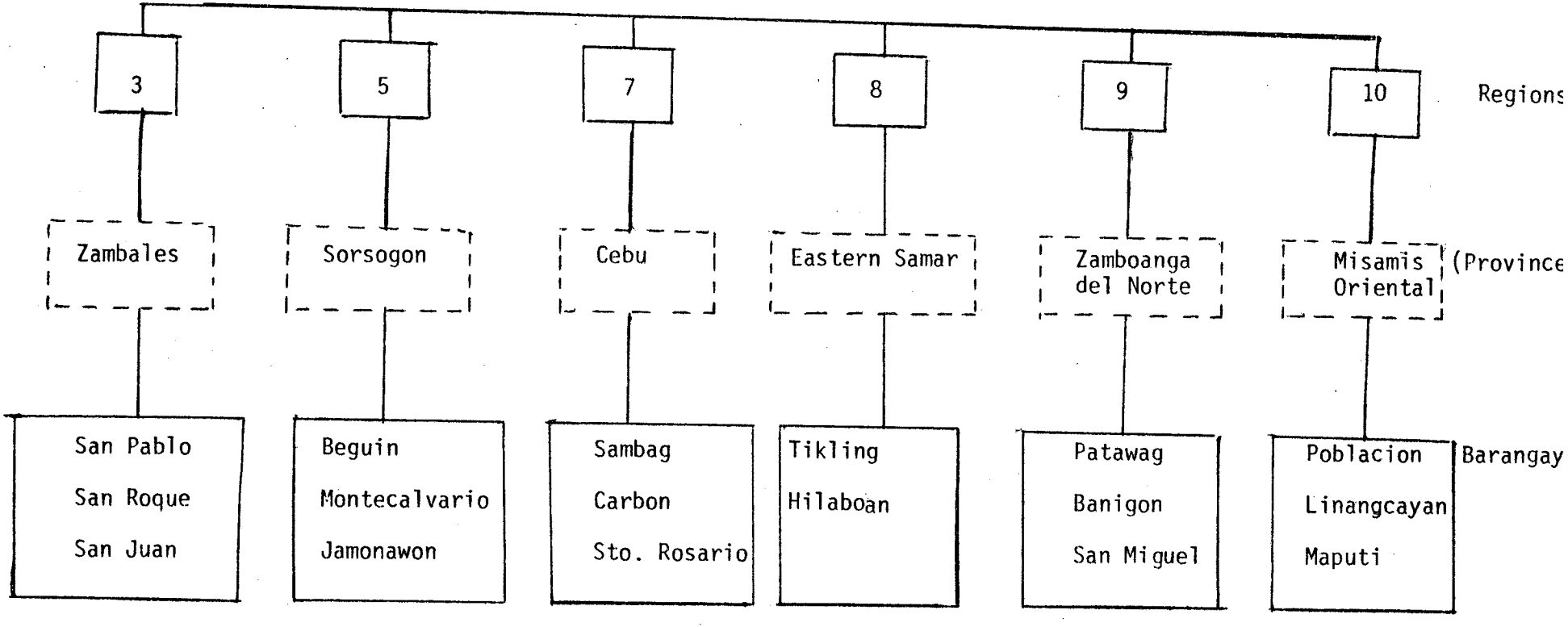
The sites included for study in Phase II were drawn from six geopolitical regions of the Philippines, with each of the three major island groups being represented by two regions.

These six regions were purposively selected. Following this procedure, barangays within these areas were identified from the Phase I reports and listed per region. Six barangays (one from each region) were randomly sampled, with two replacements per sampling unit. Then, MOH records were examined to identify the catchment areas within which these communities were located and to identify the BHS midwives assigned to these areas.

Two other barangays in the catchment areas, contiguous to the originally sampled units, were then selected. Using these procedures, a total of 17 barangays were included for the documentation. Respondent groups - housewives, BHWs and PHCC members - were sampled from these areas. The midwives (seven of them) responsible for each of the catchment areas were all included for interviews.

The final sites included in the study are diagrammed in Figure II and listed in Table I. Of these sites, the following were included in systematic sampling procedures: San Pablo (Region 3), Beguin (Region 5) and Sambag (Region 7). In the last three regions, the selected sites were changed due to peace and order problems. The regional offices of MOH determined the final choices of the barangays in Dolores, Eastern Samar, Lilay, Zamboanga del Norte, and Naawan, Misamis Oriental.

Figure II. Regions (Provinces) and Barangays included in Sample



2. The community survey

The elementary sampling units for the community survey were households. Fifty households were chosen from each barangay, using interval sampling. The interval (K) was determined by dividing the qualified number of households per barangay by 50. Following a random start, every Kth household in each barangay was sampled. A total of 900 households were interviewed, 150 from each of the six regions.[3] The survey respondents were housewives. In households with extended families, the respondent was the principal housewife or the one most actively involved in running the household.

3. Survey of community health workers

The community health workers included for interview were the BHS midwives, the Barangay Health Workers (BHWs) and the members of the Primary Health Care Committees (PHCC) in the barangays surveyed for the community study. The original plan was to interview one BHSM (servicing the catchment area) two BHWs, and ten PHCC members in every barangay. In the actual survey, however, a total of seven BHSMs and 57 BHWs were interviewed across all barangays. Instead of 180 PHCC members, only 127 were included, depending on the size of the committees

[3] In Region 8, only two barangays were in the BHSM's catchment area. One hundred interviews were conducted in one of these areas to fulfill the sampling quota.

themselves. The sampling distribution of the respondents in the various Regions and municipalities may be seen in Table 2.

3. Case studies of PHCCs

Members of the Primary Health Care Committees (PHCCs) at higher echelons of the service organization (in this case), the MOH and other line agencies of government) were likewise interviewed. These PHCCs include those in: 1) regional centers, 2) provinces, and 3) municipalities. The original intention was to interview the respective chairpersons of the various committees and at least five of their members from partner agencies for the case study reports. The final set of key informants is comprised of the following: (See also Table 3)

a) one regional PHCC chairperson
   three provincial PHCC chairpersons
   three municipal PHCC chairpersons
b) 35 regional PHCC members
   28 provincial PHCC members
   31 municipal PHCC members

B. Instrumentation

Four research instruments were devised for this documentation. Three were interview schedules and one was a case study guide. The interview schedules were used for the community survey, the study of barangay health workers or PHCC members, and for BHS midwives. The case study guide was utilized for the study of other higher-level

PHC committees.

All the instruments were pretested prior to finalization. The prototype English schedules for the interviews were translated into Tagalog, Cebuano, Bicolano and Waray by language experts. The back-translation technique was then used to insure questionnaire equivalence between the prototype and the translated versions.

These instruments are attached in the Appendix.

C. Data Collection Strategies

Two field research teams undertook data collection for the documentation. One team was assigned to do the barangay surveys—both for households and for the PHCC workers. Aside from actual interviews, they were asked to study pertinent PHCC information in the Barangay Health Stations, to cross-check verbal reports and to obtain details on the BHS services.

The other team was assigned to do the case studies of the PHCCs in the municipalities, the provinces and regions. They pored over written monitoring and summary reports on PHC within the various regions/provinces/municipalities. In addition to key informant interviews on PHC, they collected data on the areas themselves, including socioeconomic and health statistics.

While the documentation proceeded at various levels using two different data collection approaches, the amassed information will be integrated. The conceptual framework will serve as the guideline for organizing and synthesizing information.

The report contained in the succeeding chapters, therefore, represents findings obtained from the various data sources. Much of community-level (barangay) data were obtained from the household survey. Findings related to PHC activities and accomplishments, as reported by the BHSMs, BHWs and barangay PHCCs, were derived from the interviews with these individuals. Information pertinent to the activities, program support and accomplishments of program-level PHCCs was culled from key informant interviews and reports documentation.

PART TWO: PROCESSES IN IMPLEMENTING PRIMARY HEALTH CARE

Documentation of the achievements of PHC begins in Part II with a narrative account of its social preparation activities and other operations in the various areas - from the regional program level to the community base. Part III will describe the accomplishments (outputs) of the PHC approach with emphasis on its apparent achievements in the barangays.

Part IV will unfold the features of the communities which may influence PHC processes and results, as well as the descriptions of the underlying ministerial (program) support structures and processes.

The implementation process for PHC will be described in Part II in relation to three broad activities:

a. social preparation
b. intersectoral and intrasectoral collaboration/linkages
c. health service delivery

3. SOCIAL PREPARATION PROCESSES

Social preparation for PHC involves a set of interrelated activities intended to introduce its concept and to assist both program implementors and communities to know its goals and processes. Three activities are associated with social preparation:

a. Facilitative activities, including 1) intra- and inter-sectoral meetings at various levels of the program structures to prepare agency personnel for the full scale implementation of PHC, 2) dialogues and community assemblies to elicit support for PHC.

b. Training of involved personnel:

   1) training of midwives to develop PHC skills and positive attitudes

   2) selection and training of barangay health workers

c. Initial implementation of PHC projects

SOCIAL PREPARATION OF PROGRAM IMPLEMENTORS

A. Facilitative Activities at Various Levels

In 1980 PHC was introduced within Regions 3, 7 and 8 and in 1981 within Regions 5, 9 and 10.

At the regional levels, the MOH, as represented by the Regional Health Officer, was responsible for introducing the PHC concept. Among the agencies that helped launch PHC were the Ministry of Agriculture (MA), Commission on Population (POPCOM), Ministry of Social Services and Development (MSSD), Ministry of Human Settlements (MHS), Ministry of Local Government (MLG), National Nutrition Council (NNC), National Economic and Development Authority (NEDA), Office of Media Affairs (OMA), Regional Nutrition Council (RNC) and the Ministry of Public Works and Highways (MPWH).

At the provincial level, PHC was introduced by the same agencies, with the MOH as the lead agency. In Zambales (Region 3), the MOH was assisted by the provincial development officer, the provincial government, Catholic Relief Services (CRS), the Bureau of Fisheries and Aquatic Resources (BFAR), the Bureau of Agricultural Extension, and the United Way, Inc. Other organizations like the Jaycees, as well as the military (represented by the PC/INP), also helped. The military also lent a hand in introducing PHC in Eastern Samar (Region 8) together with the religious and private

sectors and the provincial treasurer. In Zamboanga del Norte (Region 9) and Misamis Oriental (Region 10) the provincial health officer was responsible for introducing the PHC concept.

The same agencies and persons were involved at the municipal level. In Castillejos, Zambales (Region 3), the Kabataang Barangay (KB), the Bureau of Plant Industry (BPI) and the private sector were active in introducing PHC. The primary agencies involved in Bulan (Region 5) were the MOH, MSSD and MLG. In Bogo I (Region 7) the provincial health officer, the municipal health officers and the rural health unit (RHU) staff launched PHC with the assistance of the provincial government, the municipal mayor and the barangay officials. The municipal health officer and the RHU staff were also responsible for introducing the concept to the municipality of Dolores (Region 8) with the help of the hilot and barangay council. The mayor in Liloy (Region 9) together with the MOH personnel in the municipality called a meeting to explain PHC. The meeting was attended by the Sangguniang Bayan members and Barangay officials. The RHU in Naawan (Region 10) was responsible for explaining the concept to the community.

B. Orientation Approaches

Seminar/workshops, inter-agency orientations, and training were conducted at the regional level to explain the PHC concept, rationale, objectives, and mechanics. Representatives of participating agencies were given the orientation. Resource

persons included MOH staff and speakers from different agencies. A three-day orientation was held in Region 5, during which PHC objectives and agency roles were discussed. The expectations of the participants were also discussed. An inter-agency PHC conference was also held for five-days to discuss the PHC concept, major issues on health, plans and the planning process. In Region 7, a seminar workshop was held as well as training in planning and organizing. The Regional Development Council (RDC) in Region 8 was utilized to introduce PHC. The concept and management of PHC were discussed in orientation meetings/seminars held in Regions 9 and 10.

At the provincial level, similar facilitative activities were conducted to orient the participating agency members to the PHC concept. The trainors and speakers also came from the MOH staff and different government agencies. In the province of Sorsogon (Region 5), MOH called an assembly of the different heads of agencies and the agencies echoed the subjects discussed in the assembly to their respective agencies - down to the barangay level. The Provincial Development Council (PDC) through one of its meetings was instrumental in explaining the PHC concept. A clarification of agency roles was included in the orientation activity held within the province of Misamis Oriental (Region 10).

Community assemblies were held to introduce PHC to the town residents. The RHU personnel, the Barangay Health Station Midwives (BHSMs) together with agency volunteer workers were actively involved in the launching of PHC at the municipal level in Region 3. In Region 8, dialogues with the residents and seminars/ workshops were conducted. The midwife, with the help of the BHS staff, introduced PHC to the local residents. This was also true for Region 10. In Region 9, the Barangay Captains assisted the MOH in introducing PHC within the communities.

C. Informational Materials

Among the information materials on PHC that were distributed to the residents and participating agencies were brochures, pamphlets, comics, primers, leaflets, books and handbooks. In addition, posters and stickers about PHC were put up in strategic places. Most of these IEC materials were written in English and Pilipino. Sometimes, through the initiative of the local health workers, these were translated into the vernacular. The MOH produced the PHC materials.

In Region 3, the reading materials were translated into Pampango. Video tapes were used in Region 7, at the provincial level, to familiarize residents with the PHC concept. The PHC materials were translated from English and Pilipino into Cebuano. At the provincial level in Eastern Visayas, the BHSMs were given midwife guides and teaching manuals. The reading materials were also translated into the vernacular from the original English

version. Soundslides and documentation films were used in Region 9. In Northern Mindanao, the informational materials from MOH were also translated from English into the vernacular.

Radio and the newspapers were utilized in some regions to disseminate information regarding PHC. In Regions 3, 5, 7 and 10 radio programs spread news concerning PHC using such formats as dramas, interviews and lectures, commercials and jingles. The television medium was also used in Regions 3 and 5. The mass media, however, were not tapped in the other regions due to lack of the necessary facilities.

D. Summary

Generally, therefore, PHC was initiated in the different localities, and at different levels of program management, by the MOH staff. For this purpose, seminars and orientation workshops were held. The concepts of PHC, health issues and planning processes were the usual topics at these seminars.

The seminars were attended by representatives of line agencies. Some of them became resource persons at lower level meetings. At the municipal level the mayors and their councils were involved in launching PHC. They also assisted the health staff in conducting community assemblies during which the PHC was introduced to the local residents.

Initially, brochures and other pamphlets from the national office of PHC were used as training materials during the orientation meetings/seminars. In some regions, these informational materials were eventually translated into the vernacular to facilitate community work in social preparation. Whenever possible, the mass media were employed to disseminate information.

SOCIAL PREPARATION IN THE COMMUNITIES

A. Facilitative Activities in the Barangays

As was evident in higher levels of program implementation, the PHC was introduced to communities in most areas as early as 1981. The BHSMs were responsible for introducing PHC within the communities in 4 areas. In three other areas, it was the barangay captain, the MHO or another BHSM who took the lead in initiating the barangay clusters to PHC.

As of mid-1984, more than 4,000 BHSMs and 80,000 Barangay Health Workers had been trained for PHC in the six regions. Table 4.a. describes this distribution across the different localities. In addition, about 4,000 Botika sa Barangay had been established by mid-1984. The distribution by region of functional BSBs is described in Table 4.b.

B. Personnel Recruitment and Training

1. Midwives

Half of the midwives in charge of the visited barangays have been in service for eight years in the RHUs. Two have been employed for about 28 years and the rest for at least three years. All of them had previously rendered health services within the provinces of their current assignments. Six of them had worked within the same barangay clusters for at least three years. Two others had been assigned to their areas for about a year. By and large, therefore, the BHSMs may be considered as experienced community workers, the majority of whom have had previous interactions with the members of the barangays.

All the BHSMs interviewed had participated in various types of training related to PHC. Table 5 describes the topics which were introduced to most of the midwives in training seminars. All of them had completed courses/ workshops on nutrition, immunization, disease control and environmental sanitation. All but one were trained in herbal medicine, use of drugs, maternal and child care/ family planning and beautification. Only three completed seminars on planting, and two were trained in project development and management. These data indicate that all the BHSMs have received training in subject matters directly related to PHC's objectives. To a lesser extent, some of

had completed seminars on topics related to livelihood concerns.

Despite their extensive training in a variety of health services, however, it is still family planning and childbirth the BHSMs often attend to (Table 6). Health education and other health care services are not considered as duties by three of the seven midwives. Even fewer BHSMs report organizational activities for PHC as part of their functions.

2. Primary Health Care Committees

As envisioned, the Primary Health Care Committees (PHCC) in the barangays are the formal conduits for PHC implementation. They operationalize the concept of intersectoral collaboration for the delivery of health services at the grassroots.

For this documentation, 184 members of the PHCCs were interviewed in the various barangays. Thirty-one percent (31%) were barangay health workers, 12% ordinary members (usually community leaders), 15% were barangay officials, and the rest were PHCC officers (chairpersons, presidents, etc.).

An examination by region, showed that many of those interviewed in Regions 7 and 8 were BHWs. Other PHCC members and agencies were better represented in Regions 3, 5, 9 and 10. The least number of BHWs interviewed was in Region 3 (Table 7).

A majority of the PHCC members have had no previous experience in formal community work (80%). Those who reportedly had experience were mostly workers of other government line agencies. Despite this fact, however, more than half of the respondents in Regions 3, 5, 9 and 10 have reportedly served as leaders or officers of various community organizations. Sixty percent and 70% of the PHCC members in barangays of Regions7 and 5 respectively, however, had never held positions of leadership in organizations.

The associations within which the respondents have served as officers include the PTA (15%), the barangay council (12%), the Rural Improvement Club (7%), church groups (7%) and other diverse interest groups.

Thirty-five percent have been involved as officials or members of the PHCC for a year or longer, particularly in Regions 3, 5 and 9.

Among the BHWs, 33% of the 57 had been functioning for only a month at the time of the interviews. Thirty percent had been BHWs for at most a year, and 20% for about two years. It appears, therefore, that while most of the PHCCs have been organized for longer than a year, the designation and training of BHWs is a fairly recent phenomenon.

How did these persons become members and/or officers of the barangay PHCCs? Eighty-seven percent (87%) had been recruited, mostly by the BHSMs (48%), the barangay captains (11%) or the BHWs (10%). Eighteen percent, however, had been elected by residents of the barangay (at-large) or of the purok.

Election of PHCC members by barangay residents occurred most frequently in Regions 5 (32%), 10 (20%) and 3 (20%). None of the respondents from Region 8, however, had been elected by the community (Table 8).

In the recruitment of PHCC members, the considerations most often cited for their selection were attendance at meetings on PHC (20%) or holding of relevant positions in the barangays (6%). A few had volunteered to be BHWs (4%) or were already volunteer workers in the health stations (3%). Nonetheless, some 6% could not cite any factor that led to their selection.

The barangay PHCC members are well-trained in various aspects of primary health care (Table 9). A majority had completed training in toilet construction methods, planting techniques, environmental sanitation, beautification, herbal medicines and MCH/FP concepts. The PHCC members most often trained in toilet construction, planting, beautification and

sanitation hailed from Regions 5, 9 and 10. About 80% of them had been trained in these subject matters. Those most frequently trained in the use of herbal medicines and MCH/FP concepts were PHCCs in Mindanao (Regions 9 and 10) and Eastern Samar (Region 8).

Slightly more than half of the PHCC respondents had undergone training in community development, nutrition, treatment of common diseases, disease control, use of essential drugs and community organization. Regions 9 and 10 again led the group in terms of the number of PHCC members trained in these topics.

When the training profile of BHWs is compared with that of BHSMs, it is seen that the former have been more adequately prepared for both health and non-health activities. While BHSMs have principally been trained for health service delivery, BHWs have also been given courses on community development and production activities for the barangays.

C. Initial Implementation of Activities

Against this backdrop of qualifications and the selection process, what tasks (or duties) are expected of the PHCCs?... Fifteen categories of responses were elicited from the respondents (See Table 10). Predominant among their various duties were the following:

Rank	Task
1	- Initiation and implementation of PHC activities
2	- Assistance to sick and/or needy people
3	- Distribution of medicne to the sick
4	- Information dissemination on health/nutrition
5	- Assistance to BHSMs; referrals for illnesses

The PHC-related activities which the PHCC members had been involved included beautification campaigns, herbal gardening and use of herbal medicine, toilet construction, and green revolution. Thus, it appears that the training seminars most often completed by the barangay PHCCs have been useful and relevant to the activities they actually carry out.

The emerging image of work complementation in the barangays is in the desired direction. From their training profile and duties, positive grassroots involvement in PHC is apparent. The BHW and others in the PHCCs have worked for the identification of community health needs. They manage beautification and cleanliness campaigns as well as herbal medicine production and dissemination. Health problems requiring skilled management are then referred to the mid-wives. The BHSMs have their hands full with medical consultation efforts, maternal and child care, family planning and home visits,

while the PHCCs continue their health monitoring and education activities.

The attached matrix summarizes the various ways in which social preparation is undertaken--in the program level and within the barangays.

MATRIX I. COMPARISON OF SOCIAL PREPARATION ACTIVITIES

ACTIVITIES	Region 3	Region 5	Region 7	Region 8	Region 9	Region 10
1. Facilitative activities						
a. Regional, Provincial, Municipal levels	1. Interagency orientation seminar 2. Dissemination of informational materials on PHC 3. Utilization of mass media	1. Interagency PHC conference, lecture discussion to explain PHC concept, mechanics and other related matters 2. Dissemination of PHC informational materials 3. Utilization of mass media	1. Interagency orientation seminar, discussion, workshop 2. Distribution of PHC informational materials through levels	1. RDC, SDC and MDC meetings, seminar/workshop conference to introduce PHC 2. Distribution of PHC informational materials through levels	1. Interagency meeting,briefing, orientation seminar, conference on PHC 3. Utilization of mass media	1. Orient minar, meetin logues PHC to ent pa agenci 2. PHC in materi distri 3. Utiliz mass m
b. Barangay level	1. RHU and MPHCC introduced PHC 2. IEC materials on PHC were distributed	1. Health personnel and MPHCC, introduced PHC through community assemblies	1. Community assemblies	1. Barangay meetings,dialogues 2. Translated PHC primers were distributed	1. Local officials Brgy. PHCC, BHSMs, nurses, RHU, introduced PHC concept through seminars,meetings 2. Audio-visuals were used during the meetings	1. Staff BHSMs, duced commun bly 2. PHC re terial tribut ing ce
1. Training of involved personnel						
a. Program level PHCC & health personnel	1. Leadership training	1. Training in PHC activities	1. Training in matters concerning PHC including CO and planning	1. Training in PHC activities, including CO, leadership and coordination	1. Training in PHC activities	1. PHC ma semina 2. CO sem
b. BHSMs, BHWs, PHCCs	1. Training in different PHC matters	1. Training in health services/	1. Training in different PHC topics	1. Training in PHC activities	1. Training to organize PHCC and on	1. Traini differ

4. *PROCESSES FOR COLLABORATION AND LINKAGES*

The processes of collaboration and linkages for PHC are ideally viewed as proceeding on two fronts - within the structures of the Ministry of Health and between the MOH and other social development agencies. Intrasectoral collaboration refers to the procedures instituted within MOH to:

1. link up planning and implementation activities at various levels;
2. develop a system of communication and feedback across program levels; and
3. develop a system of referrals and health service delivery between communities, clinics and hospitals.

Intersectoral linkages, in turn, involve:

1. developing schemes to engage the support of other social development agencies in PHC program planning and implementation; and
2. providing manpower and technical assistance to facilitate the total approach to community health care.

LINKAGES AT PROGRAM LEVELS OF THE IMPLEMENTING AGENCIES

A. Intrasectoral Linkages

At the regional, provincial and municipal levels, the implementation of PHC is channeled through the PHCCs, which are intersectoral bodies. Nonetheless, there are PHC coordinators

in the Ministry of Health at these various structural levels. They function primarily as the anchor persons at each of these levels - to disseminate directives, organize training programs, and to collate feedback information from lower implementing committees for transmittal to the next structure in the hierarchy.

Planning and monitoring duties, however, are expected to be discharged by the PHC committees rather than by the MOH-based coordinator.

B. Intersectoral Linkages

Collaborative efforts of implementing agencies for PHC start with the formation of Primary Health Care Committees (PHCCs), whose task is to accomplish various functions at the different levels of implementation. The following functions are expected of these committees: incorporation of PHC in regional/provincial/municipal workplans, social preparation, development and maintenance of linkages with other agencies in the locale; monitoring and evaluation of PHC activities; and provision of technical/consultative services.

To facilitate the organization of PHCCs at the various program levels, the PHC implementing guidelines suggest the utilization of existing intersectoral committees at the regional, provincial, and municipal levels. These existing bodies may be

the regional development committees, the health and nutrition committees of Provincial Development Councils, or the equivalent committees attached to the Municipal Development Councils.

1. Institution of PHCCs

The PHCCs at the regional level were formally organized in 1980 in Regions 3 and 7 and in 1981 in Regions 5, 8, 9, and 10.

The PHCC was formalized in 1981 in all six provinces in the different regions included in the documentation. For the municipalities of Castillejos (Region 3), Bulan (Region 5), Bogo 1 (Region 7) Liloy (Region 9) and Naawan (Region 10), the PHCCs were organized in 1981; while in the municipality of Dolores (Region 8) the PHCC was formalized in 1982. Except for Region 8, therefore, intersectoral linkages were formalized, in the various program levels for primary health care, in the months of 1981. The organization of barangay-level PHCCs would have been accomplished soon after this period, except for Region 8, where organization of barangay for PHC may have started only in 1982 or 1983.

2. Organizational Character of the PHCCs

In the different regions, existing organizations or committees were tapped to function as the Regional Primary Health Care Committees (RPHCC). Among these regional

organizations were the Regional Development Council (RDC), the Social Development Council (SDC), and the Regional Task Force of the National Nutrition Council (NNC).

In Regions 3 and 7, it was the health and nutrition Committee of the RDC which was mobilized to be the RPHCC. In Region 5, the role was assumed by the Bicol Integrated Health, Nutrition and Population Program (BIHNPP), in Region 10 by the Regional Task Force of NNC and in Region 8 by the RDC in coordination with the Social Development Council (SDC). Only in Region 9 was the RPHCC organized independently of any existing committee. Inter-organizational collaboration for PHC was therefore facilitated through the involvement of existing inter-agency bodies in its implementation at the regional level. This move is in accordance with the implementing guidelines.

Similarly, at the provincial level, the counterpart of the RDC often functioned as the Provincial Primary Health Care Committee (PPHCC). In Regions 3, 7 and 8, the Health and Nutrition Committee of the Provincial Development Council (PDC) served as the PPHCC. In Misamis Oriental (Region 10), the Provincial Task Force on Health (an inter-agency body) is also the the PPHCC, while the Provincial Nutrition Committee serves as the PPHCC in Zamboanga del Norte (Region 9). In Sorsogon (Region 5), the PPHCCs were organized as separate committees.

At the municipal level, the Municipal Development Council (MDC) was the usual organization mobilized to serve as the Municipal PHCC (MPHCC). In Castillejos, (Region 3), Bogo I (Region 7), and Dolores (Region 8), the Health and Nutrition Committees of the respective MDCs simultaneously serve as the MPHCCs. The Nutrition Committee of the NNC functions as the MPHCC in Naawan (Region 10), while in Bulan (Region 5) and Liloy (Region 9), no existing organization was tapped to handle PHC affairs. Instead, the MPHCC was formed as a new committee.

The original functions of the organizations which assumed the role of PHCCs are more or less similar to the desired PHCC tasks. At the regional level, these organizations initiate, implement, and monitor nutrition and other health programs. They plan activities, coordinate the various activities of regional agencies, and develop regional workplans, among other tasks. In Central Luzon, these organizations undertake nutrition education, supplementary feeding, food assistance and food production. In Region 8, the RDC coordinates all activities and programs in the region into regional workplans.

At the provincial level, the identified organizations undertake health-related activities and plan and make recommendations concerning health and nutrition matters. This also holds true for the municipal organizations. In Castillejos, Zambales, for instance, the particular activities of the Health and Nutrition Committee include helping undernourished children, providing technical assistance, and

community planning. LIkewise, in Dolores, Samar, coordination of health-related projects and different agency activities was among the functions of the MDC.

3. Perceived Functions of the PHCCs

The PHCC informants were asked to state what they considered to be the appropriate functions of the PHCCs. Generally, they envision the role of the PHC committees to be focused on planning, implementation, coordination, monitoring and evaluation of PHC programs and activities. More specifically, these tasks were seen to be directed towards lower-level program implementors.

The regional and provincial PHCCs tended to view their roles more in terms of setting policies and guidelines for undertaking PHC in the barangays. In some provinces, moreover, it was reported that some operational plans stem from them directly, rather than from regional or national offices.

In turn, the municipal PHCCs see themselves, appropriately so, as implementation arms, with administrative, advisory and fund-generating functions.

4. Communication System

Essentially, the mechanism for feedback between the various levels of program implementation makes use of monitoring forms which emanate from the barangays. The pertinent information is collated at each rung of the PHC implementation hierarchy, and responses to problems are expected to be made at these various levels, whenever appropriate. These reports, however, take time

to accomplish and collate. Hence, problems may not be transmitted early enough for immediate decisions to be made.

The reported dynamics in the use of these mechanisms by actual implementors will be discussed in Chapter 9.

LINKAGES AT THE GRASSROOTS

A. Intrasectoral Linkages

The intrasectoral linkages at the level of the barangays are best described by the functional relationships existing between the PHCCs, including the BHWs and the BHSMs. Another area of intrasectoral linkage is the relationship of this set of implementors to the municipal health workers and city/district hospitals.

In the previous chapter, it was noted that the PHCCs and the BHSMs apparently carry out complementary functions for PHC. A more detailed description of this collaboration is provided by an examination of the routinary tasks of the BHWs and the BHSMs.

1. Complementation of functions

As noted in Table 6, the midwives perceive their duties in PHC to be focused on health service delivery. This perception is borne out by the reports given concerning their routinary tasks. Maternal care, home visits, and medical consultations take up most of their time. To a lesser extent, the midwives reportedly train/supervise new batches of BHWs, provide health education, and implement environmental sanitation and herbal gardening projects. Four of the seven midwives stated that they

did PHC work for six or seven days a week. Only two worked for half a week (three to four days) while another remained in the barangays for five and a half days.

When the midwives were asked to identify other parties involved in implementing PHC tasks, the following were most frequently mentioned: the PHCC members, community residents, BHWs and other RHU personnel (Table 11). Often, the activities initiated had been planned with the BHWs and/or the residents. To a lesser extent, some midwives simply tell the BHWs what need to be done, or the PHCC and the BHSMs plan their activities together.

From the standpoint of the midwives, it appears that intrasectoral collaborative functions have successfully been carried out in the barangays.

In general, the duties reportedly undertaken by BHWs parallel those of the PHCCs. Unlike the BHSMs, however, these volunteer health workers spend less time on PHC. Sixty-seven per cent spend only one to two days a week on PHC, 7% devote three to six days and 5% work for seven days. Surprisingly, 21% of the BHWs said they did not devote any day to PHC work. These workers were probably inactive at the time of the interviews, or tended to view their PHC duties as occupying less than a day for any activity (Table 12).

What do the BHWs do on the days devoted to PHC? The most dominant task reported was mobilization of the community for PHC involvement (20%). This was followed by the health survey and monitoring function (16%), herbal gardening (14%) and health service delivery (10%) (See Table 13). In going about their work for PHC, the BHWs were assisted by the midwives (42%), other BHWs (35%), community members (19%), and PHCC members (10%). Only 12% stated that no one helped them. The identification and implementation of PHC activities were reportedly coordinated with the residents (37%), planned by the midwives and the BHWs (37%), directed by the midwives (33%) or planned by the BHWs, PHCCs and the BHSMs. These were the same strategies reported by the midwives, validating the information obtained from that small sample.

The profile of routinary tasks as reported by the BHWs supports the earlier observation that intrasectoral efforts between the BHSMs, the BHWs and the PHCCs transpire along desired directions. As interpreted in the preceding chapter, the present set of results confirms the contention that community mobilization and participation are catalyzed by the community health workers themselves, while the midwives step in to respond to identified health, fertility and nutrition needs.

The initial link maintained between the barangays and the program structures is accomplished through monitoring forms. This intrasectoral channel provides vital information on the PHC to higher-level program implementors, and should serve as a guide for further plans and actions.

2. Monitoring and feedback

The following monitoring forms are most often maintained by the midwives: referral forms, nutrition forms, community census, and the Barangay Monitoring Form of the Ministry. Only one response each was obtained concerning the use in community planning of the memo of agreement, minutes of meetings, immunization and FP records by the midwives.

For their part, the BHWs kept the following records most frequently: the BHW diary (21%), community census (18%), and referral forms (16%). Unfortunately, 40% (23 BHWs) stated that they kept no records whatsoever of their PHC activities.

The documentation reveals, therefore, that the intrasectoral linkages between the community and the program structure can be improved. The midwives have been more efficient record-keepers than the BHWs. However, the forms maintained by the BHSMs fail to catalog the non-health activities of PHC, which take up a considerable amount of the BHWs' time. The processes implemented for successful community participation may provide valuable insights concerning the institutionalization of PHC.

The BHWs need to be motivated and trained further to improve the documentation of their efforts in community organization and development.

B. Intersectoral Collaboration

Intersectoral linkages in the communities are best indicated by the extent to which the other public and private groups become involved in PHC activities.

From the viewpoint of the BHSMs, the Ministry of Education and Culture (MECS) has been most often involved with them in PHC implementation, principally by providing help in educational activities. The next two agencies most frequently reported by the midwives are the Ministry of Agriculture (MA) through the Bureau of Agricultural Extension (BAEx) and the Commission on Population (Popcom). The BAEx participation takes the form of food/cooking classes and lectures on animal dispersal. Popcom has helped through its IEC efforts. Many of the BHSMs also mentioned the Ministry of Social Services and Development (MSSD) whose collaborative efforts have been in terms of giving food and medical assistance within the barangays. Apart from these ministries, other PHC-linked agencies are the Ministry of Local Government, religious organizations, the Kabataang Barangay and other private groups.

The ranking made by the BHWs of the agencies involved with them in PHC implementation differs somewhat from that made by the midwives (See Table 14). As far as the BHWs are concerned, the most intense collaboration has come from the MSSD through its food

assistance schemes. Following this agency is Popcom, which has extended medical and FP assistance to the communities. Third in rank is BAEx for its medical, financial and community organizing efforts rather than its food-related tasks. The barangay council is next, particularly with regard to cleanliness campaigns. The BHW reports rank the MECS and the MLG equally, followed by the parish and the Kabataang Barangay.

The differences in reported intersectoral linkages obtained from midwives and volunteer workers point to two possibilities. First, these groups have interacted separately with either the BHSMs or the BHWs on different activities. Thus, either of the latter set perceives its participation in different ways. Second, the channels of communication between the midwives and the BHWs are incomplete, such that neither one is completely oriented on the activities of the partner agencies within the communities. Whichever has precipitated the differences, the documentation indicates a need for the PHC implementors to discuss more adequately the avenues taken by other agencies for PHC collaboration, so that their involvement may be put in correct perspective and maximized for the goals of PHC.

5. *PRIMARY HEALTH CARE SERVICES: INITIAL IMPLEMENTATION*

Social preparation and collaborative efforts pave the way for the provision of essential health services in the barangays. These services comprise the eight elements of PHC, namely:

a. Promotion of proper nutrition and adequate supply of safe water
b. Basic sanitation
c. Maternal and child care, including family planning
d. Immunization
e. Prevention and control of locally endemic diseases
f. Education on prevailing health problems and the methods of preventing and controlling them
g. Appropriate treatment for common diseases
h. Provision of essential drugs

The initial documentation of PHC indicated the uneven quality of the achievements made by the different regions in terms of health service delivery. More specific information on this matter was obtained in the present documentation -- from interviews with both community households and community health workers.

SURVEY OF COMMUNITY HEALTH NEEDS

A. BHW Efforts

A prerequisite to the implementation of any of the PHC elements is a survey of the community to determine the pressing health needs of its constituents. As indicated in the previous chapter, this task principally belongs to the BHWs (Table 13), although they report their findings to the BHSMs.

On the average, the BHWs perceived that there were 20 to 30 families under their supervision (46%). Seven percent (7%), stated that the ratio of BHWs to households were 1:10, and 1:50. Four percent (4%) said it was greater than 1:50. (Thirty-seven percent did not know). Despite these targets, 54% of the BHWs had visited only 20 families, at most, before the interviews. Twenty-eight percent (28%) had not visited any household; this group probably represents the newly trained BHWs. Generally, therefore, the BHWs have been able to visit less than half of their targetted households.

When the BHW efforts are examined against program expectations, it becomes apparent that many have fallen short of their respective municipal targets. It is only in Naawan and Liloy where the expected BHW-to-household ratio is low -- 1:11 and 1:25, respectively. In Dolores, the expected BHW outreach is one per 89 households. In Bogo and Bulan, it is 1 BHW for every 35/36 families.

The results indicate that BHWs need to intensify their efforts to be able to service more of the households under their jurisdiction.

B. Achievements of the BHSMs

The households for which the seven midwives were responsible varied widely from 97 to 720. When this information is matched with the number of actual visits, it can be seen that the BHSMs have managed to reach out to about half of the targetted groups.

Generally, the results indicate that the BHSMs have been more successful than the BHWs in reaching their targetted families or households. Considering that the BHSMs work almost every day and extend special health services, the differences in performance are not surprising.

PROCESSES OF IMPLEMENTATION: SUCCESSFUL ACTIVITIES

As a strategy for doing a process documentation of PHC implementation, both the midwives and the volunteer workers were asked to re-enact the chain of events which transpired in implementing a PHC activity which they considered "successful". These processes include the following:

1. Who were involved in planning the activity?
2. How was the activity introduced in the barangay?
3. Who participated/benefited from the activity?

BHSMs and BHWs had slightly different perceptions about which PHC efforts were successful. Three types of project -- cleanliness campaign, toilet construction, and herbal gardening or compounding -- were mentioned by two midwives each. One referred to the nutrition campaign and another to hog-raising. Still another considered no activity successful in her catchment area. For their part, the BHWs mentioned mostly the nutrition campaign (19%), followed by toilet construction (12%) and herbal gardening (10%). Almost half (42%) could not cite any successful activity.

A. Who Helped Them Plan the Activity?

The answers of the health workers confirm their reports on intrasectoral linkages for PHC. The midwives unanimously mentioned the PHCCs, the BHWs, the residents and themselves as having been party to PHC planning. BHWs, in turn referred to the midwives (6%), the PHCCs (60%), the residents (42%) and themselves (44%). Also mentioned by the BHWs were the Barangay Brigades (44%).

Thus, it appears that as reported, most of those projects deemed "successful" had the advantage of community representation in PHC planning.

B. How Was the Activity Introduced?

The two sets of community health workers agree that the following procedures were often followed in implementing successful activities:

a. house-to-house campaign

b. meetings between the community and PHCCs

c. leaders of existing organizations informed of planned projects

To a lesser extent, the following approaches were employed: through local organizations, BHWs and BNSs, barangay officials, and lectures.

In the interpretation of these procedures, it may be concluded that the successful PHC activities were launched through the use of community development principles -- that is, by directly linking up with the residents and the community gatekeepers. (In this case, the PHCC members who have held community leadership positions even prior to PHC implementation).

C. Who Benefited from the Activity?

The midwives and the volunteer workers agree that the principal beneficiaries of the PHC activities were either infants, children, or expectant/lactating mothers. The next set of beneficiaries was

composed of healthy men and women. The BHSMs consider PHC to benefit the youth and the elderly as much as the mothers; BHWs rank the youth lower, with the elderly on the same level as morbidity cases.

Despite the PHC workers' comprehensive training in health care, it appears that their activities favor certain sectors of the community. These include the infants and their mothers, more than the aging, the sick and healthy individuals. Apparently, it is the former groups which most often require health care in the various localities.

REPORTED OUTREACH OF PHC: THE COMMUNITY VIEWPOINT

Apart from the community health workers themselves, information regarding the initial implementation of PHC was gathered from the households. The measures of implementation focused on:

1. activities known by residents to have been implemented in their barangay within the past year, regardless of whether or not they associate these with PHC;
2. home visits from health workers experienced by households during the month prior to the interviews.

A. Activities Undertaken Within Barangays

The respondents in the community were shown a list of various health-related activities, and these were explained to them. They were then asked to indicate which of those in the list they knew to have been undertaken in their barangays over the past year (1984). The distribution of responses to this question may be seen in Table 15. The following interpretations may be derived:

First, the following PHC activities have been undertaken most frequently in the different barangays:

Rank	Activity	% - Age Report
1	Cleanliness Campaign	82%
	Nutrition Campaign	82%
2	Toilet Construction	75%
	Family Planning Campaign	75%
3	Immunization Campaign	73%
4	Cultivation of Herbal Gardens	59%
5	BHW Training	50%

Secondly, regional differences surface in the extent of community awareness on the implementation of these various activities. These differences with regard to the first five activities are as follows:

a. The cleanliness campaign was reported by almost all the households in Regions 9 and 10. About 85% of those in Regions 5 and 7 were aware of this project, while less than 70 % in Region 3 and 5 mentioned it.

b. The nutrition campaign was mentioned by 96% of households in Regions 10 and 5, 93% in Region 9, and 81% in Region 7. Only a little more than half of the residents in Regions 3 and 8 were aware of such a campaign in their localities.

c. The ranking of regions which reportedly had a toilet construction project was as follows:

Region 9 :	100%	Region 5 :	77%
Region 10 :	97%	Region 8 :	62%
Region 7 :	80%	Region 3 :	34%

d. FP campaigns were undertaken most frequently in Region 10 (97%) and least often in Region 8 (39%). Regions 9, 5, 7 and 3 are in between (by rank order).

e. Regions 9 and 10 led in undertaking immunization campaigns (about 93%). They are followed by Regions 5 and 7 (87%), Region 3 (46%) and Region 8 (34%).

On the basis of these results, the various regions may be *ranked in terms of the extent of the sampled community's awareness* of PHC activities, as follows:

1. Regions 9 and 10
2. Regions 5 and 7
3. Regions 3 and 8

The types of PHC activities which housewives knew to have been undertaken in the different barangays are depicted in Matrix 2.

B. Home Visits of PHC Workers

The second measure of community efforts taken for PHC related to the household outreach of PHC workers. The respondents were asked the following:

1. Have any health workers visited your household this past month? Who made the visit(s)?
2. Why did they come to your home?
3. Who among them are residents of this barangay?

1. Who made any visit?

In response to this question, it was determined that 106 of the households (12%) had been visited by any of the health personnel in the month prior to the interviews. Among the different community (or PHC) health workers, the following reportedly made most of the visits: the BHSM (25%), the BHWs (23%), the barangay captain or councilman (21%) and the sanitary inspectors (13%). (Table 16).

When the information is examined by region, it is noted that most of the recent home visits occurred in Regions 9 and 10 (37% and 19% of total visits respectively). Nine visits each were reported by households in Regions 7 and 8, and only two or three in Regions 5 and 3, respectively.

These results support previous findings. For one, they confirm the observation that more BHSMs than BHWs have been able to do home visits.

Secondly, they reiterated the finding that PHCC members participate in community mobilization efforts. Thirdly, they shed light on the observation that there are many more ongoing PHC activities in Regions 9 and 10 than in the other three areas.

2. Reasons for visits

The most common purpose for the household visits in the past month was to conduct a health survey. These surveys were undertaken most frequently by the barangay officials (86%), the sanitary inspector (64%), and the BHSMs (56%). (See

Table 17). This finding partially explains the earlier observation that few home visits were made by BHWs to assess health needs.

Following the conduct of health surveys, home visits were also made to motivate the residents to participate in PHC projects. Again, the barangay officials and the sanitary inspectors led in this effort (45%). Instead of the midwives, however, more BHWs undertook this task (38%).

The BHWs were also involved in teaching the households about herbal medicine and promoting nutrition (10%), besides a variety of other tasks (15%). The BHSMs, on their part, were involved in promoting herbal medicine (9%) and providing child care services (7%).

The nature of the PHC activities which prompted household visits indicates that most of the barangays are in the initial stage of PHC implementation. Since the completion of the Phase I study, therefore, many have moved forward from the stage of social preparation. The health services being delivered have mostly been information-seeking (the survey) and educational (herbal medicine) in nature. Apart from health services, mobilization efforts for PHC participation have engaged the attention of PHCC members. This explains why many visits were made by the councilmen and barangay captains. As noted in Chapter 3, these PHCC members are apparently the informal

leaders of their barangays. Thus, they work more effectively than the health workers in assessing community needs and undertaking mobilization activities.

3. Residence of health workers

It is an axiom of community development that effective mobilization is best achieved when the intervenor (or organizer) is immersed in the community itself. One way of becoming "part of" the community is by residing within it. The other precondition to community development is that the community organizer should enjoy the goodwill of the residents. Acknowledged community gatekeepers -- such as popular local officials, educated individuals, experienced elders, and the like -- are thus more influential in mobilizing community efforts than persons who are relatively unknown to others in the barangay.

The respondents mostly reported that the PHC workers who visited them lived within their barangays. Of the various health workers, 90% of the BHWs, 86% of the barangay officials, and 73% of the sanitary inspectors were known by the interviewees to be residents of the barangays. Only 35% of the midwives reportedly resided in the barangays. In all, 13% of the respondents perceived the PHC home visitors to have been non-residents of their own barangays.

The significance of this observation is that, since most of the PHCC workers are known by the households to be residents of their respective barangays, they would have had previous inter-

action with them. If the barangay officials, sanitary inspectors and BHWs have enjoyed prestige, respect and good interpersonal relationships in the communities, then PHC implementation through them becomes an easy task. Otherwise, they may retard its acceptance as a health care strategy. The usefulness of involving local officials in PHC will be discussed in Chapter 6.

Summary

This examination of the initial activities implemented for PHC, and the manner of their implementation, indicate the following:

First, of the eight PHC elements, the following have been implemented in most areas: cleanliness and sanitation campaigns, including toilet construction; nutrition campaigns; FP campaign and immunizations and herbal gardening; BHW training; and disease control and prevention campaigns. Health education activities have been implemented in fewer instances.

Second, the successful implementation of PHC activities, which includes the full participation of the community, is facilitated by the involvement of the residents and their PHCC representatives in the planning and implementation phases of these projects.

Third, the community health workers in active barangays who participated in mobilization and needs assessment efforts include local officials and sanitary inspectors, in addition to the BHWs and BHSMs. By and large, these individuals are known by their neighbors in the various barangays.

PART THREE: PHC ACCOMPLISHMENTS: RESPONSIVENESS TO NEEDS AND INCULCATED VALUES

The next set of chapters delineates the accomplishments attained through the PHC approach. These achievements are viewed in terms of the extent to which various PHC activities facilitate the attainment of the following goals:

First, community involvement in identifying and solving its health needs;

Second, the promotion of good health for as many people as possible; and,

Third, the use of PHC as the entry point for total social development delivery systems.

In examining the levels of goals attainment, information from all sectors will be utilized ~~in the examination of levels of goals attainment.~~ However, the focal point of PHC goals remains the barangay. Ideally, all other parties participate in the implementation of the strategy for the welfare of the grassroots.

6. *THE ADEQUACY OF NEEDS ASSESSMENT*

In the previous chapter, it was seen from the documentation that the following activities were implemented in many of the barangays: cleanliness and sanitation campaigns, nutrition campaigns, toilet construction, FP, immunization projects, herbal gardening and BHW training. The question posed in this section is: "How well do these projects respond to the pressing needs of the barangays?" Another way to put it is: "Are these PHC activities relevant to the perceived needs of the people?" To provide answers to these issues, the following information will be delineated in the succeeding discussions:

1. Identification of the pressing problems in the barangays from the standpoint of both the community and the health workers;
2. Perceived solutions to these problems;
3. Initial remedies taken to solve problems;
4. Persons perceived to ideally participate in solving problems; and
5. Resources in barangays that may be utilized to remedy problems.

IDENTIFIED COMMUNITY PROBLEMS

A. Perceptions of the Laymen

The question "What is the most pressing problem in this barangay?" was answered by only 49% of the interviewees. The rest "did not know" (10%), or perceived no serious problems in their communities (41%). Thus, the reported problems represent the opinions of only half of the households in the sample. When their answers are categorized and ranked, the problems emerge as (See Table 18):

a. Economic problems - including the high price of prime commodities, food shortages, poverty and unemployment (18%)

b. Health and sanitation problems - such as the lack of potable water, insufficient supply of medicines, lack of toilets, malnutrition, unsanitary surroundings, and the lack of doctors (14%).

c. Infrastructure and facilities - the absence of electricity, health centers and school buildings in the barangays; poor road conditions and no bridges (10%).

d. Social problems - including robbery, drug addiction and gambling (6%).

Economic problems were most often mentioned by the respondents from Regions 10 (59%) and 7 (28%) and least often by those in Region 5. The economic problems in these areas were predominantly high prices and inadequate food supplies. Regions 3 and 7, however, were also plagued with an unemployment problem.

Health-related problems were considered pressing almost equally in the various regions, although twice as many households in Region 7 than in the others mentioned these needs. Highest ranking among the health problems were the lack of potable water sources and toilets and inadequate medical supplies.

Infrastructure problems and the lack of facilities were considered most pressing by respondents in Region 3 (21%). They were followed in mentioning these issues by residents of Regions 9, 5 and 8, in that order. Only 2% of the households in Region 7 were bothered by infrastructure needs and none of those in Region 10

deemed this a problem area. Flooding and the absence of electricity were mentioned in Region 3. In the other localities, poor roads and the absence of health centers and schools were mentioned.

Social problems bothered many of those from Regions 3 and 8, while only 1% of those in Region 9 mentioned these irritants. The pressing social issues usually included drunkenness and robberies.

In summary, the perceived barangay problems indicate the following:

a. The high prices of commodities and inadequate supplies of food are common problems in the various communities.

b. Common health needs focus on the absence of potable water sources and sanitary toilets, and on insufficient supply of medicines.

c. Infrastructure-related needs and social problems are uneven in the various regions and are of different types.

B. The Perceptions of the BHWs and BHSMs

The problems of the community are similarly perceived by the BHWs and BHSMs. These groups ranked the community problems as follows (See also Table 19):

Matrix 3. Community Problems Perceived by Health Workers

Ranking of Problems	Problems Perceived by BHWs	Problems Perceived by BHSMs
1	Lack of drugs	Lack of drugs
		Financial difficulties
2	Financial difficulties	Lack of project funds
		Lack of food
		Lack of toilets
3	Absence of health personnel	
4	Lack of toilets and water sources	

From experience, therefore, PHC workers see that health and economic problems beset various communities. Like the residents themselves, the midwives and volunteer workers realize the need for improved finances among the rural families, as well as for medicine, toilets and water supply.

PERCEIVED SOLUTIONS AND INITIAL REMEDIES: THE COMMUNITY VIEW

A. Economic Solutions

In the face of unaffordable prime commodities, inadequate food supplies and unemployment, what do the common people see as ways to remedy their needs?

The interviewees in Regions 3 and 7, who considered unemployment as their most severe economic problem, believed that the remedy to their situation lay in the creation of new jobs. In Region 10, however, where food shortage and high prices were mentioned, the perceived solutions were the planting of vegetables, hard work by all family members, and Sariling Sikap projects.

In this regard, about 9% of the households who considered the existence of community problems, had started to plant vegetables, rice and other crops. Other food-generating activities have also been stepped up, such as animal-raising and fishing (6%). Another 4% have tried to look for jobs. Unfortunately, 5% are not aware of immediate remedial measures which they could take and 12% have not attempted any solutions.

B. Health Solutions

Solutions to the commonly recognized health problems were easily linked to the community needs. Thirty-nine percent stated the need to construct sources of water supply and 15% believed that toilets and clean surroundings were needed to maintain environmental sanitation. Sadly, few solutions had been attempted at the time of the interviews. Water pumps or wells had been constructed only in the barangays visited within Regions 9, 5 and 7. Medicine was reportedly distributed in only three instances and toilet construction was completely unreported. In fact, 18% stated outright that nothing had been done as yet to remedy their pressing health problems.

C. Solutions to Problems of Facilities

The infrastructure problems commonly mentioned concerned the absence of roads and the unavailability of electric power. Thus, perceived solutions were road construction and community action toward the installation of street lights, and the construction of bridges, schools, chapels or health centers.

Unfortunately, 19% were aware that none of these recommended measures had been attended to. The repair of roads was mentioned only in Barangay San Miguel (Region 9). Lights and public buildings had not been provided yet.

D. Solutions to Social Problems

The usual social problems experienced in the barangays were drunkenness and robberies. The perceived solution to these problems was to ask the Barangay Captain to discipline the troublemakers (7%) and to have burglars arrested (4%). In Regions 3 and 8, community meetings had reportedly been held to identify solutions to drunk and disorderly conduct. Nothing had been accomplished in the other places. Robbers had been arrested in three regions--3, 5, and 10 -- but only 5 report this as a remedial measure.

This review of the communities' solutions to known problems reveals that many of the difficulties encountered remain. Generally, the percentage of responses that stated "nothing had yet been done" often exceeded the percentage of responses which mentioned specific solutions.

The revelation that few of the health problems have been solved identifies areas for PHC projects. In fact, the community health workers themselves already recognize these problems. The documentation of initial PHC activities also reveals (Chapter 5) that cleanliness, nutrition and sanitation campaigns have received top priority in most of the barangays. Remedies to health needs are, thus, apparently in the offing. Problems of unemployment and food resources, however, are still unattended to in these initial projects.

E. Perceived Resources for Problem-Solving

This section will describe the households' opinions concerning the resources which they perceived to be available for solving their different problems. These findings will be important insofar as they provide insights concerning the acknowledged leaders in the communities and the known natural or physical resources to remedy hunger, unemployment, sanitation, flooding and other problems.

1. Human resources

The individuals on whom most households obviously depend in the face of difficulties are local barangay officials (81%) and the town mayor (14%). Among the former, they depend mostly on the barangay captain (49%) and the councilmen (20%)to identify appropriate remedies. These were the attitudes of the households, particularly in Region 5 (84%). About 60% of those in Regions 3, 8 and 9 were similarly disposed. However, only 39% and 18% of respondents in Region 7 and 9,

respectively, depended on the barangay captains. Apparently, there are area differences in terms of how well the local officials are appreciated.

In addition to local officials, some respondents (23%) believed that the residents themselves should work out solutions to the problems of the community. This was most often expressed in Region 8 (31%), followed by Regions 7, 9 and 10 (about 25% in each). Less than 20% of residents in Regions 3 and 5, however, were inclined to work out their own solutions.

2. Environmental resources

The various assets of the community which may be utilized in remedying economic and social ills may be classified as natural, material/financial and human.

The most abundant resources known to the residents are natural assets (13%) including herbal plants, vacant or idle lots, fish, plants, and other geological elements. These resources may be exploited to alleviate medicinal and food crises. Material and financial resources are less commonly available (7%). These include: toilet bowls, tools, building materials and barangay funds. The equipments/materials mentioned would suffice to provide toilets for the community, but they provide no avenues for employment, production activities or infrastructure development. Human resources in the communities are even less appreciated (5%). Those

mentioned include the residents, the tanodbayan, and the policemen or soldiers. Obviously, men are viewed as resources only for the solution of peace-and-order problems. Health workers are never mentioned as human resources in the barangays.

SUMMARY

The findings delineated in this chapter provide the following insights:

First, that primary health care is a valid strategy for social development insofar as health-related needs constantly surface as community problems. It was previously seen that most of the activities which were completed in 1984, and were still being undertaken during the time of the interviews, were preparatory steps towards alleviating health needs -- including sanitation and cleanliness campaigns, nutrition projects and herbal gardening. These activities will eventually diminish the problems fomented by unsanitary conditions and shortages of medicine. The nutrition campaign, in turn, may lead to more active interventions aimed at improving the food supply and intake of children, lactating mothers and others in the communities.

Second, that local officials in most localities are respected and recognized leaders, capable of identifying solutions to felt needs. The strategy in many barangays, whereby initial health surveys and community mobilizations are undertaken by councilmen and health workers living within the communities, is apparently a correct move. The needs assessment process described in the present chapter identifies these individuals as acknowledged leaders in problem-solving tasks. Their participation in the PHCCs and in all stages of PHC implementation, should thus be encouraged.

Third, that the people in the barangays fail to perceive themselves as important resources for making decisions on problems. They tend to depend on community officials more than on themselves in seeking remedies to existing problems. Initial steps to solve economic problems, for example, tend to be uncreative and traditional (planting more rice and vegetables). Greater effort could perhaps, also be made by the residents in terms of tapping potable sources of water in the barangays. Besides, while the presence of "toilet bowls" was mentioned as an available resource in a few barangays, toilet construction projects remain largely unreported. Self-reliance for social development is a value which still needs to be cultivated among the rural people.

Fourth, that the initial years of PHC implementation have so far not been directed towards making PHC the entry point for total community development. Health workers in the community are rarely identified as persons capable of solving the people's problems. They are not even mentioned as human resources in the localities under study. More importantly, however, the activities which have been completed and are ongoing fail to link-up with economic solutions. Yet, the community health workers are well aware that economic difficulties are equally pressing as health needs in the communities. Future plans should give this aspect of social development more serious consideration.

7. *COMMUNITY PARTICIPATION*

The participation of the barangay residents in PHC is examined in two ways. First, in terms of the nature of their involvement in the process of PHC implementation -- from planning to monitoring and evaluation of the activities. Second, in terms of how the households avail themselves of the health services provided through PHC -- from medical consultation to medical supplies.

PARTICIPATION IN IMPLEMENTATION PROCESSES

The manner of implementing PHC projects was discussed earlier (Chapter 5) in order to identify the processes used by health workers to reach out to the community. To recapitulate: it was documented that the planning and mobilization processes for PHC often involved the BHWs, the BHSMs and the PHCCs. In fewer instances, the residents themselves were involved in laying out plans. The monitoring system for PHC, however, was primarily the responsibility of the BHWs and the midwives. Community assessments on the gains of PHC have so far not been reported.

Generally, therefore, the residents-at-large take part in PHC activities as beneficiaries rather than implementors of projects. Their representatives -- meaning, the BHWs and the PHCC members -- are more often the participants in the planning and mobilization processes.

The households themselves were asked to indicate which health activities they had participated in. Participation, in this case, meant being beneficiaries or recipients of health services. The reports' ranking of the involvement of the households in PHC activities closely parallels the extent of implementation of any of these activities (Table 20).

The five activities in which most of the residents were involved include the following:

1. Cleanliness campaign (69%)
2. Toilet construction (55%)

   Nutrition (feeding or weighing campaign) (55%)
3. Immunization campaign (47%)
4. Cultivation of herbal gardens (40%)

Regional distribution related to involvement in any of these projects parallels the extent of respondent awareness of these activities. Thus, households in Regions 9 and 10 were most often involved in these various campaigns/projects, followed by those residing in Regions 5 and 7. The lowest participation reports were usually obtained from respondents belonging to Regions 3 and 8.

The close correspondence in the response distributions, depicting awareness of PHC projects and involvement in them, signifies that more often than not people learn about (or become aware of) activities when they become direct beneficiaries.

AVAILMENT OF HEALTH SERVICES

The health services from which households may benefit as separate social units are classified in this report as follows:

A. Medical consultations and treatments

B. Immunizations, and

C. The Botika sa Barangay and other medical supply sources

A. Quality of Medical Consultations and Treatments

The nature of consultations and treatments is described in this report in terms of the following measures:

1. Persons in the communities perceived by the households as capable of giving health advice;
2. Persons usually consulted about health problems;
3. Persons who decide on or are consulted for illness;
4. Nature of symptoms referred to various persons; and
5. Hospitalization profiles.

1. Sources of advice and consultation

Generally, the following individuals are considered to be capable of extending advice on health-related problems: health personnel in RHU or BNS (69%), the *hilot* or *herbolario* (40%), private physicians (34%) and BHWs (23%). To a lesser extent, nurses in hospitals, government physicians, neighbors and even the barangay captains are acknowledged as health advisors (Table 21).

When the households actually seek consultation about health problems, however, the ranking of persons shifts slightly. The persons most frequently consulted include BHS/RHU personnel (47%), private physicians (20%), the *hilot/herbolario* (16%) and the BHWs (6%). Thus, although the *hilot* are accepted as health-wise individuals, slightly more of the households would seek health advice from physicians rather than from them. Moreover, most of those who consult the BHWs come from Regions 10, 9 and 7.

2. Persons consulted for treatment of ailments

Health problems may vary from nutrition to FP to illness. The previous section identified the types of individuals associated broadly with health knowhow. The next topic to be discussed is concerned specifically with consultation about illnesses, in the case of both children (below 3 years) and other persons.

The persons who usually decide on treatments for specific complaints include the housewife, the household head, health personnel in RHUs or private clinics, and the hilot or herbolario. When the sick household member is older (more than 3 years of age), the housewife (72%), the household head (58%), and the hilot (3%) are the parties who usually determine the course of treatment (Table 22.a). Among infants and younger children, however, the health personnel in private clinics (16%) and in the BHS (13%) are consulted more often than the hilot (11%). The mother (or housewife) and the head of the family are also consulted less frequently when the sick parties are young children (See Table 22.b.).

These findings indicate that relative self reliance in attending to health problems is achieved by households when the ailing family member is older than 3 years. Household heads and their spouses are less confident of themselves, however, in attending to sick infants and very young children.

3. Nature of complaints consulted about

The most frequent medical complaints reported by the households include fever (48%), cough (36%), colds (19%), stomach pains (18%), headaches (17%) and LBM (10%). Does the nature of symptoms determine which parties are consulted for treatment?

Professional health workers are the ones usually depended on for advice in case of fever, cough and colds. The BHW is consulted about headaches, cough, colds and stomachaches. The hilot or herbolario, in turn, is sought for the treatment of coughs, stomachaches and headaches (Table 23).

These results indicate that the community residents usually refer to professional health workers ailments which may require more intensive treatment. The BHW is consulted about symptoms for which he may have primary-level remedies available. The hilot or herbolario, however, remains a mainstay for the treatment of most complaints.

4. Hospitalization of sick household members

According to the housewives, only about 9% of their family members had required hospitalization in the six months prior to the interviews. The complaints which required hospital care included fever (17%), loose bowel movement (13%), kidney trouble (9%), and vomiting (8%). The regions from which most of the reports of hospitalization came were 3, 7 and 10. The lowest incidence was in Region 5 (Table 24).

In the majority of cases, it was the head of the family or the household who decided that the individual needed hospitalization. In most instances, the sick person was admitted to a government hospital in the municipality or province (60%). Ironically, the respondents also stated that in 46% of the cases, ill children who needed hospitalization were not brought to any hospital for treatment.

The incidence of voluntary treatment in hospitals, therefore, is rather low.

B. Immunization Profile

Immunization campaigns were reportedly waged in all the barangays observed in this study (Chapter 5). The following discussion will describe the extent to which the households who have young children and infants availed themselves of the immunizations.

There were a total of 463 children below the age of three in the 18 barangays. According to the mothers interviewed, about 55% of these children had received immunization, usually including DPT injections (36.3%), oral polio vaccine (36%) and BCG (35%). In addition, the mothers claimed that 14% had been immunized against smallpox (Table 24).

The highest incidence of immunizations occurred in Region 9 (75%). About half of the children in Regions 3 and 10 were similarly inoculated. In Region 7, 40% were protected; in Region 5, only 17% were immunized. None of the children in Region 8 had received BCG or DPT injections, and only 2% had been given the oral polio vaccine.

In most cases, the health personnel who administered the immunization were the BHSMs (77%). This seems to indicate that the inoculations had been provided during the immunization campaigns for PHC. Other health personnel, taken together, had provided only 9% of the immunizations.

Since most of the immunizations were administered by the BHSM, her records were examined to validate the claims of the mothers. Table 24 indicates that the mothers' reports were fairly accurate. In addition, it becomes apparent that smallpox and cholera vaccines were administered by health workers other than the midwives.

It was earlier stated that about half of the younger children and infants had not yet been immunized. When asked about this situation, the mothers stated the following reasons: that the child was still too young or that she did not know the immunization schedule (19% in both cases); that the baby was ill during the scheduled date or that no campaign had yet been conducted in her barangay (16%). A few others also said they were too busy to have their babies immunized (7%), or that the child was healthy anyway (3%). By and large, these responses indicate that most mothers appreciate the value of immunizations for their children. Only a small percentage still require proper education and motivation with regard to immunizations. These positive orientations on immunization, if developed through the PHCC's efforts, may be considered an achievement of the strategy.

C. Sources of Medical Supplies

An effective health care strategy carries with it the provision of essential drugs or medicinal sources for the treatment of health complaints. This is in fact the eighth element of PHC.

The structure which was devised to provide barangays with medicinal supplies is the Botika sa Barangay. These facilities are supposed to be opened in barangays which are more than 3 kilometers from the nearest drugstore. A Botika sa Barangay Aide (BSB Aide) is selected to man this supply point, in coordination with the BHWs and the PHCCs.

To determine whether the households availed themselves of BSB supplies, the respondents were first asked where they usually obtained their medicinal requisites. Follow-up questions slowly focused on the respondents' awareness and patronage of the BSBs.

1. Usual source of medicinal supplies

The places where households ordinarily obtain medical supplies include the following (Table 25):

a. commercial drug stores (52%)
b. Barangay Health Station (23%)
c. Rural Health Units (7%)
d. Botika sa Barangay (10%)
e. Sari-sari stores (6%)

One percent each went to the herbolario, the BHW and even the barangay captain. Others relied on their herbal gardens.

What factors determined the choice of particular supply sources? The various answers may be classified in the following manner:

a. availability/completeness of medical supplies (42%);

b. accessibility of supply point (35%);

c. financial reasons: cheaper or free medicine (25%);

d. quality of service: always open, worker always present (5%); and

e. quality of medicine: good quality, effective (2%).

On the one hand, the commercial drug stores are patronized primarily because they are considered to have medicinal supplies readily available for any and all complaints (62%). On the other hand, the BHS and RHU are perceived to be sources of free medicine (56%) and 67% respectively). They are patronized mainly for financial reasons. In turn, the BSB and the sari-sari stores are appreciated because of their accessibility to the households (74% and 69% respectively). In places where free medicines are not given away at the BHS or RHUs, residents go to the commercial drugstores.

2. The Botica sa Barangay

Are there operational Botika sa Barangay in the different communities sampled? In Regions 3, 5, 8 and 10, residents in only one barangay per catchment area were aware of the presence of BSBs in their village. Two barangays had BSBs in Region 9, but in Region 7, none of the visited areas had any BSB (See Table 26).

The BSBs in the 6 barangays previously referred to were usually attached to a sari-sari store in the community (Regions 5, 9 and 10). In Region 3, the BSB was in the house of the BHW; in Region 8, it was located in the house of the barangay captain. The usual service providers in the BSBs were the sari-sari store owners themselves (64%, probably trained as Botika Aides). Other individuals who tended BSBs were the BHWs (22%), PHCC workers (6%), Botika Aides (4%) or barangay officials (2%).

Three-fourths of the households who knew of the BSB in their communities patronized it. Analgesics and antipyretics were the most marketable medicines (62% of purchases). This was followed by cough syrups (31%), anti-diarrheal drugs (27%), antacids (16%), other household remedies (14%) and multivitamins (2%).

This rank-order parallels the nature of usual medical complaints among the residents (Table 23), and indicates that the operational BSBs are useful facilities for responding to health needs.

The reasons given by those who did not patronize the BSB include: the BSB supplies are usually clinical samples and should not be sold (38%); needed medicines are not always available (8%); the BHS and other family members supply medicine to the households (6%); or the households do not have the money to purchase drugs (4%).

SUMMARY

The findings on community participation provide the following insights:

First, participation in the implementation processes among the households is usually in terms of being beneficiaries of the various projects. Residents may at times be consulted concerning which health activities they desire, but it is the PHCC and the health workers who plan most of the PHC activities.

Second, health professionals (such as RHU physicians, nurses and midwives) are looked upon as sources of health advice, especially in the treatment of illnesses. The BHW is not as frequently perceived to be knowledgeable on health matters. In fact, hilot are consulted more often than the BHWs.

Third, less than 10% of the household members had been hospitalized in the 6 months prior to the field surveys. Children who may need institutionalized care are not always brought in for hospitalization.

Fourth, the PHC efforts for massive immunizations of children have been relatively successful. Essential immunizations for DPT, BCG and oral polio have been administered to many of the children and infants. Mothers, for their part, generally have positive orientations on immunizations.

Fifth, the BSBs have not been operational in many areas. Thus, commercial drugstores and health centers are still the usual sources of medicinal supplies. In places where BSBs have opened, they have been patronized for their ready accessibility. However, commercial outlets are preferred by some households because of the wide choice of drugs

they offer. RHUs and BHSs, on the other hand, are convenient sources of free medicine.

These results point to the massive involvement of the barangays in community wide sanitation and beautification campaigns. However, mobilizations may be improved for their greater participation in immunization programs, and for utilizing BHWs as health advisors. The BSBs may also be improved in terms of their outreach and medicinal stock.

9. *KNOWLEDGE OF AND ATTITUDES CONCERNING PRIMARY HEALTH CARE*

While PHC is ultimately interested in providing grassroots-level health care for both urban and rural populations, the process of re-orienting services to one of a "partnership" effort between government and the communities is in fact an educational experience. It introduces new approaches to solving old problems, and provides broader avenues for the direct involvement of paraprofessionals and ordinary citizens in day-to-day health services.

The accomplishments of PHC, therefore, are not completely delineated without portraying its effects on the cognitions and attitudes of the various participating sectors. This is the concern of the present chapter.

KNOWLEDGE OF PHC CONCEPTS AND GOALS

The cognitive inroads of PHC will be examined among the program implementors in terms of the following indices:

1. Knowledge of PHC objectives
2. Knowledge of activities/elements subsumed under PHC
3. Perceived similarities and differences between clinic-based health service delivery and community-based health service delivery

Among the households, indicators of knowledge pertaining to PHC include:

1. Awareness of community health activities undertaken in barangays (discussed in Chapter 5, under Reported Outreach of PHC: The Community Viewpoint)
2. Familiarity with primary health care and its meaning.

A. Stated Objectives of PHC

1. Program-level PHCCs

The perceived objectives of PHC at the regional level can be roughly divided into five (5) categories, as follows:

a. To promote/maitain health, prevent diseases and deliver health services;

b. To mobilize the community to identify their needs and problems and to find solutions with the use of locally available resources;

c. To promote self-reliance;

d. To develop a partnership between the people and the different agencies, as well as inter-agency coordination; and

e. To develop the community and improve the quality of life of the people.

The informants in the regional PHCCs state these objectives in various specific ways. In Central Luzon, for instance, nutrition and health education are cited as health objectives, while the formulation of a development program is a community-related goal. In the Bicol region, health education and improved attitudes to health practices and health services are considered important. In Region 7, the integration of hospital services with rural health services is a health objective, while inter-agency collaboration for health service delivery is a goal in Eastern Visayas.

On the provincial level, the cited objectives of PHC can be categorized into health-related objectives, inter-agency coordination and self-reliance. Specifically, they are:

1. Promotion of good health and delivery of basic health services;
2. Development of the capability of the people to identify and solve their own needs and problems with the use of their own resources and with limited support from agencies;
3. Development of a better quality of life; and
4. Development of self-reliance.

Aside from the stated general objective of "health for all by the year 2000," the specific health objectives mentioned in Region 3 include the promotion of maternal health, health education and the delivery of health services to depressed areas. Education in appropriate technology is also a PHC goal in the region. In Cebu, the PHCC aims to promote preventive medicine and to intensify the information drive on health-related matters. Meanwhile, the achievement of better health and community development through the partnership approach is emphasized as a PHC goal in Eastern Samar (Region 8). To update the people in modern ways of health care is one of the concerns in Zamboanga del Norte (Region 9), while the specific health objectives in Misamis Oriental (Region 10) include the prevention of malnutrition, lowering of the death rate and improvement of personal hygiene.

As in the higher levels, the PHCC goals at the municipal level are the promotion of health and the delivery of health services, promotion of self-reliance, development of community participation, improvement of the quality of life, organization of the barangays

and establishment of intersectoral linkages. The construction of toilets and water systems and development of the motivation of people to plant medicinal herbs are among the health objectives in Bulan (Region 5). In Dolores, Eastern Samar, among the PHC goals are community organization and development of leadership qualities among the residents.

Common to these various objectives of PHC, in the eyes of the program-level PHCCs, are the goals of improving health among the people, intersectoral efforts, and the development of community self-reliance. By and large, these perceptions dovetail with the desired objectives of PHC and speak well of the extent to which the PHCCs understand PHC goals.

To determine further how much the informants appreciate the PHC approach, they were asked to describe the activities encouraged under the strategy.

About eight of the key informants "did not know" what these activities were. Among the rest, enumerated activities may be subsumed under the PHC elements, e.g., environmental sanitation, immunization, nutrition, health education, herbal gardening and the provision of potable water. Apart from these health-centered activities, however, the PHCC informants also mention the following as encouraged by PHC: fund-raising, income-generation, food production, training and manpower development, inter-agency involvement, and community seminars on health and livelihood matters. Thus, the informants' awareness regarding the specific operational approaches of PHC are rather adequate since the

activities they mention are those which are programmed within the strategy. However, the interviews indicate that PHCC representatives tend to remember more those activities undertaken by their respective agencies but fail to have a total grasp of the inter-agency efforts.

As a final measure of the PHCC's cognitions on PHC, they were asked to indicate what aspects of the PHC approach are similar or dissimilar to the clinic-based health service delivery.

To begin with, only about 35% of the informants could articulate the similarities or differences between the two approaches. The similarities which they often mentioned include the following:

1. both PHC and clinic services concern health service delivery;
2. both involve inter-agency collaboration;
3. both focus on treatment of diseases;
4. both deal with nutrition, immunization, FP, etc.

The noted differences, on the other hand, were as follows:

1. Health service delivery and responsibility for health maintenance are better appreciated by the people through PHC;
2. Health workers are given more opportunities in PHC to realize the health problems of the people, because of their more frequent interactions;
3. Indigenous leaders are trained in PHC for health service delivery;
4. PHC involves non-health activities in its strategies; and

5. PHC focuses on the prevention rather than the treatment of diseases.

In analyzing the knowledge/perceptions of the PHCC informants, it may be noted that the role of intersectoral linkages and the development of community self-reliance are well-appreciated. Corollary to these, the importance of non-health activities, like food production and livelihood projects, are perceived to be part of the PHC strategy.

2. Community-level health workers

Among the BHSMs, the identified objectives of PHC may be grouped into three main categories:

a. the initiation of health-related activities, including herbal gardening, toilet construction, nutrition and green revolution projects (71%);

b. education in self-reliance, disease prevention, health improvement and child care (86%);

c. improvement or maintenance of health until the year 2000 (57%).

In addition, two of the seven BHSMs mentioned the promotion of unity or cooperation among the people as a PHC objective.

The midwives' concepts of the objectives of PHC focus on the aspect of health promotion more than on community mobilization and the provision of integrated services. However, these service providers highlight the educative process in PHC, an objective which is built into the goal of developing community self-reliance for health.

The PHCC members echo these perspective in their own responses. The following PHC objectives were mentioned by these respondents:

a. initiation/maintenance/implementation of health-related activities such as herbal gardens, toilet construction, nutrition, MCH/FP and disease control (39%);
b. education of people in health-related activities, including the areas of health care within which projects have been launched (19%);
c. improvement and promotion of health (23%);
d. assistance to the sick and the young (24%);
e. disease prevention and control (8%).

Like the midwives, what the committee members perceive best are the health activities and goals of PHC. The concept of "helping" rather than "working with" the residents is highligted in their perceptions. Moreover, the linkage between health and other concerns fails to surface.

Among the barangay PHCC respondents from various regions, those who conceived PHC's objectives to be concerned with project implementation belonged mostly to Regions 8 (54%), 9 (43%) and 10 (48%). Members from regions 10 and 3 cited its educational goals more frequently (31% and 18%, respectively), and those from Regions 9 and 10 mentioned its promotional objective (45% and 4%, respectively). (See Table 28)

When the BHSMs were asked about the activities they considered to be part of the PHC, five of seven interviewees cited environmental sanitation activities; four mentioned MCH/FP and health education efforts; three mentioned nutrition, immunization, herbal gardening and compounding; and others referred to disease control and livelihood projects. For their part, PHCC members referred most frequently to health education and health care training (21%), followed by cleanliness campaigns (20%), herbal gardening (14%), nutrition (14%), disease prevention and control, MCH/FP (8%) and immunization (8%).

If these listed activities are classified in relation to the categories of PHC elements, it is seen that the community health workers most frequently refer to the following elements: sanitation, MCH/FP, provision of (herbal) drugs, MCH/FP disease control, nutrition and health education. Interestingly, the BHSMs and BHWs have parallel cognitions regarding the activities which fall within the PHC approach.

The health service providers were also asked to indicate whether or not they perceived any similarities or differences between PHC and the clinic-based approach. Only 30% could give any response.

All the midwives interviewed said there were similarities between the two approaches, and only three mentioned differences. The similarities were in terms of common types of services provided by either health approach, such as a pre and post natal care, sanitation, immunization and nutrition campaigns,

use of essential drugs and referrals. Among the perceived differences were the following: the PHC implements herbal gardening projects; and PHC seeks the assistance of herbolarios for service delivery.

Just like the midwives, the PHC members perceived the following differences:

a. that PHC enables more people to avail themselves of health services;

b. that PHC is interested in maintaining cleanliness; and

c. that PHC is meant for everybody while clinics service mostly pregnant women only.

The similarities seen by the community health providers pertain to services which are basic to the health needs of the public. Their differences are roughly perceived in terms of the methods used by either strategy to deliver services. What is left out in these perceptions, however, is a conscious appreciation of the partnership approach and of community involvement in the process of providing these services.

B. Households' Familiarity with PHC

In a previous chapter, the households' awareness of PHC-related efforts was solicited indirectly, by asking whether they had experienced (or knew about) various health projects. PHC was not mentioned in that particular question. More than half of the households were aware of the major PHC activities in the various communities.

In another part of the interview, the respondents were pointedly asked: "Are you familiar with primary health care?" To this question, only 23% replied in the affirmative; the rest were unfamiliar with the term.

Among the few respondents who had heard of PHC, a majority (54%) had learned of it through the RHU personnel. In less than 10% of the instances the information was obtained from the media, the neighbors, or the BHWs. The respondents who were most familiar with PHC hailed from the barangays of Lilog, Region 9 (57%), and those in Naawan, Region 10 (37%). Households in Bulan (Region 5) were least familiar with PHC as a concept.

The respondents were further asked what their understanding of PHC was: "What is it all about?" Sixty-one percent stated that it had to with health and disease prevention and control. Others referred to its efforts for maintaining environmental sanitation (26%), cultivating herbal gardens (19%), maternal and child care (8%) and promoting the green revolution (10%). (See Table 28).

These results indicate that PHC as a concept was not introduced to the households, or that ff it was, then the phrase and its meaning could not be recollected. Nevertheless, it is heartening to note that, among the few who do know the term "primary health care," it is correctly associated with the health concerns which it wishes to propagate.

C. Summary of Knowledge on PHC

This documentation of what the various PHCCs know of PHC reveals that, while the essential nature of the approach is appreciated by all parties -- program implementors, community health workers and barangay residents -- its finer points are perceived differently on various fronts.

The different sectors know that PHC is interested in the promotion and improvement of health, through community-based service delivery and health education. On the program level (i.e., among regional, provincial and municipal committee members), the role of intersectoral collaboration, the total social service delivery approach, and community self-reliance are realized. Among the community workers and residents, however, the partnership approach for PHC is not highlighted. Neither do they mention the linkages between health and other welfare concerns. Instead, health services and campaigns are best appreciated.

It would seem, therefore, that while the intersectoral collaboration and community participation strategies of PHC are consciously known on the program level, these aspects are not disseminated on the operational level -- that is, in the communities themselves. This finding is consistent with the earlier observation (Chapter 4) that the nature of intersectoral linkages in the barangays is not generally known, even among the health workers.

ATTITUDES CONCERNING PRIMARY HEALTH CARE

The attitudinal concerns which were elicited from different PHC respondents, key informants and BHS midwives dealt with the following topics:

1. the implementation of the primary health care appraoch, including its prospects, problems and directions; and
2. work-related feelings and opinions of community implementors.

Aside from these factors, members of the community were separately asked to assess the Botika sa Barangay as a supply point for their medicinal requirements.

A. Attitudes and Suggestions on PHC Implementation: The BHWs' Viewpoint

The Barangay Health Workers, being the initial links of the progr implementors with the participating communities, were asked two things regarding PHC implementation:

1. their views about the residents' attitudes concerning PHC and its attendant activities;
2. their suggestions for the improvement of PHC.

About half of the 57 BHWs gave positive/favorable comments vis-a-vis the communities' reactions towards PHC. These included the following observations:

1. that the residents usually follow the PHC workers' advice on health matters (21%);
2. that the residents appreciate PHC because it is able to help them; thus, they tend to be cooperative on projects (14%);
3. that the residents like the free services obtained from PHC and are receptive to its concept (9%).

4. that the residents have learned methods of disease prevention (5%); and
5. that they have learned to clean their surroundings (3%).

Among the few unfavorable comments (28%), the following were mentioned:

1. that the residents do not participate in PHC activities (14%); and
2. that residents fail to follow the BHW's instruction (6%).

"What aspects of PHC implementation need improvement?"

The answers of the BHWs center on the need to increase the supply of medicine (72%). There seems to be tremendous anxiety to back up health motivational drives with supplies for treatments and remedies.

Fewer opinions were expressed on the need to improve the following matters: financial support for projects (33%), educational materials (23%), maintenance of health status (17%), the number of BHWs in the barangays (14%), community mobilization (12%), and social preparation of the communities (10%).

In evaluating these comments, it is apparent that BHWs consider the barangay households to be generally receptive to community-based care. The sources of satisfaction to them in this respect include seeing the residents participate in planned activities and learning to look after their health and sanitation needs. On the other side of the coin, what dissatisfy the BHWs are the residents' failure to cooperate in health activities and to learn methods properly.

Suggestions for PHC improvement single out the need for increased medicinal supplies and other support mechanisms emanating from the program. Community preparation and mobilization are not perceived to be as problematic as obtaining program support for PHC efforts.

B. The Midwives' Opinions

The BHSMs were also asked which areas of PHC implementation they thought needed improvements. Like the BHWs, they feel a strong need to improve medicinal supplies. The following were explicitly suggested concerning the Botika sa Barangay:

1. training of more BSB aides
2. capital for regular purchase of medical supplies
3. change of expired medicine
4. quarterly resupply and reporting of medicinal needs

Other felt needs of the midwives were related to the training and recruitment of BHWs. They felt that the midwives and communities should have a longer time to recruit BHWs. The time spent training the latter should also be extended, and they should be given monetary allowances during this period. No apprehensions were expressed relative to community receptiveness to PHC approaches.

C. The PHCCs at Program Levels

More extensive opinions on PHC were elicited from the key informants. Their views on the matter will be discussed in terms of the following concerns:

1. their opinion on what the PHCC role should be, including suggestions for restructuring and changes in personnel;
2. opinions on and attitudes to the pressing problems faced in PHC implementation, and suggestions for solutions;
3. attitudes to the negative and positive aspects of PHC, and
4. agency views about their potential contributions to PHC.

1. Views on the appropriate role of the PHCCs

Generally, the PHCC members at the regional, provincial and municipal levels perceived the PHCC as an administrative/ managerial and advisory body. They cited such roles as coordination, planning, policy-making, decision-making, implementation, supervision, evaluation/assessment and advising as among the appropriate roles of the PHCC.

Most of the informants also agreed that structural changes were not necessary within their respective agencies to facilitate the enactment of the PHCC's roles and functions. Instead, they opened that more field personnel were needed to work within the barangays, and that these persons required more extensive training in the various elements of PHC. In this respect, the opinions of the program implementors and the midwives concur.

2. Problems in PHC implementation

The following were problematic aspects in the implementation PHC: personnel, coordination within and between agencies, community mobilization, supplies and technical support.

The foremost problem cited by PHCC informants concerning personnel (or manpower) has to do with its number: at all levels, the PHCC informants campaign that more BHWs, BHSMs and other health professionals are needed to implement PHC. In addition, they noted that not all the community health workers are qualified and trained, or exhibit good leadership qualities. The members of the Regional PHCCs also mentioned that these personnel do not always have the "spirit of volunteerism" needed in their work.

In terms of intra-sectoral problems, those which were cited at all levels were: lack of funds, poor monitoring systems, lack of incentives/allowances for doing community work, and poor supervision. Between the agencies involved in PHC, the dominant problem was poor coordination which results in overlapping schedules/activities. In addition, it was seen that irregular meetings and ad hoc representation at PHCC meetings (different persons per agency attending different meetings) contribute to uncoordinated efforts in the communities.

Within the barangay themselves, the peace and order (or disorderly) situation in some of these areas was thought by the committee informants to be the prime obstacle to PHC implementation. Poverty was next cited as a factor which may prevent community participation in health programs, because the households tend to concentrate on livelihood activities. Other conditions existing in the barangays which hinder PHC implementation include: the people's negative attitudes toward PHC, lack of informational material, and the presence of too many simultaneous activities in pursuit of the social development goals of various ministries.

Like the community PHC workers, the informants were unanimous in pinpointing implementation problems related to logistics and technical support. They agreed that medicinal supplies were sorely lacking, and that more training and technical assistance to PHC areas were badly needed.

3. Solutions to problems

What has been done to solve these blocks to the implementation of PHC? What else could be done?

Problems related to manpower shortage have generally remained unresolved. Only in Sorsogon were seminars/training programs reportedly stepped up to increase personnel competency. However, the issues associated with funding support have been responded to in some areas. In Region 5, increases in allowances were given. In Zambales, trainees were given allowances for attending seminars. In Regions 3 and 10, funds were rechanneled to PHC activities.

To enhance inter-agency collaboration, regular PHCC meetings have been conducted in Region 3 (on both the regional and municipal levels). In Region 8, the PHCC members were encouraged to attend the committee meetings regularly.

In Dolores, Eastern Samar PHC activities have been integrated with military operations as a response to peace-and-order problems. The disadvantage of this approach, however, was that the people were made to comply rather than volunteer their participation. In addition to this strategy, IGPs and Functional Education programs for out-of-school youth have been undertaken in Eastern Samar. In Region 9, religious leaders have been mobilized for PHC, while in Region 10 the residents were motivated to participate more actively in projects.

Solutions to the problem of inadequate supplies of medicine have been reported only in Zambales. In this area, the governor was requested to put up counterpart funds for the PHC operations of the province.

As such, key informants fail to note any systematic approach from the program to respond to identified problems in PHC. Most obvious is the failure of the agencies/PHCCs to upgrade the quality of their PHC workers.

Given this situation, what else do the PHCC informants propose as solutions?

Across all the regions a consistent proposition is to "increase funds" -- either by adding support from the national agency (MOH) or by rechannelling funds from other projects or sources. With more material support, more personnel can be recruited and trained, and more medical supplies can be procured.

In addition, the following steps were suggested:

a. revitalization of PHCCs -- through regular meetings, permanent representation, greater inter-agency commitments through memos of agreement, and increased involvement in actual activities;

b. improved mobilization of communities -- to survey health needs, to relate PHC to existing reality, to change attitudes and values.

Together, the implementation of these proposals may diminish the problems of manpower, coordination and logistical support.

4. Positive and negative aspects of PHC

Knowing the nature, scope and limitations of PHC, the informants were asked to express their feelings as to which aspects of PHC they consider to be positive and which negative.

The various members of the PHCCs generally considered the following as accomplishments of PHC:

a. health promotion
b. community participation in health activities
c. community education on disease prevention and control and other health matters
d. improved opportunities for inter-agency coordination in social service delivery
e. socioeconomic development for the community by way of lowered costs for health care, preventive measures, population education and the like

On the other hand, it was also observed that PHC implementation suffers in some respects as in:

a. poor coordination of agency functions
b. inadequate monitoring
c. selling of sample drugs in some BSBs
d. inability to overcome community resistance
e. diverting the time of volunteers for livelihood efforts into PHC activities.

It may seem that the positive and negative attitudes regarding PHC represent polarities of the same attributes, such as health care, coordination, community involvement and socioeconomic development. Presumably, in localities where PHC has been successfully implemented, its positive aspects are highlighted. In areas where implementation is bad, the opposite becomes apparent.

These results indicate that there are generally favorable view on PHC as a strategy for health service delivery. Problems cited refer to limitations in implementation rather than criticisms of its framework. Similarly, perceived negative aspects of PHC are based on its inadequacies in operationalization, not on its conceptualization. Thus, while the PHC concept is acceptable to most, limitations in its actual implementation are also very apparent to its implementors.

5. Potential agency roles in PHC

The informants suggested several ways by which each participating agency could fully assist in PHC implementation. These suggestions may be categorized as: a) ways to improve agency participation and b) ways to improve PHCC functions.

Participating agencies said they could improve their participation in the following manner: through active involvement, proper coordination, integration of PHC activities in their own programs, and cooperation with one another.

In the PHCCs themselves, the following were suggested: delineation of functions to avoid duplication of work, organization of the participating agencies, increased training/orientation seminars on the PHC concept for participating agencies, regular meetings of the committees for planning activities, and improved monitoring of implementation efforts.

D. Community Ratings of the Botika sa Barangay

The provision of sufficient medical supplies has emerged as an aspect of PHC services which requires improvement. To complete the profile of opinions on the BSB, the households were asked to express their opinions about this service.

A total of 113 households reportedly patronize the BSBs in the various barangays. Most of them were residents of Regions 9 (89%) and 5 (81%). In this group, 72% gave favorable comments about the BSBs. Among the factors mentioned were the following:

1. accessibility of the BSBs (60%)
2. cheap prices of its medical supplies (14%)

3. availability of drugs (11%)

4. good quality of medicines (9%)

5. good quality of services (7%)

The unfavorable comments were the opposite of the above -- incomplete stocks (11%) and ineffective medicines (10%).

To further concretize the residents' opinions on the BSB, they were asked to rate the following aspects of the facility: price of medicine, supply of medicine, quality of supplies, service availability, location and service workers. A five point scale was used in these ratings, generally scaled as: 1 - "very positive" to 5 - "very negative."

The price of medicine was rated mostly as "just right" (38%) and "somewhat cheap" (34%). However, the quantity of drugs was adjudged as "somewhat inadequate" (39%) and "just enough" (25%). Good ratings of their quality were obtained, however: 26% said "very good" and 60% said "good."

The location of the BSBs was rated very positively, and 92% said they were "accessible" to the residents. Similarly, the schedule of its services was widely appreciated, and 62% rated it as "always available." The workers who manned the BSBs were seen to be generally knowledgeable about medical supplies and the symptoms they treated (88%).

The community households who have patronized the BSB appear quite satisfied with its operations. If these comments are coupled with those of the other service providers, it appears that logistical support of the BSBs should indeed be encouraged, so that medical supplies can more satisfactorily reach the majority of the rural households.

E. Work Attitudes of Health Personnel

The work attitudes of service providers have consistently been implicated in the quality of their services. These work attitudes were determined in the present documentation for two reasons:

1. to determine their influence on service delivery; and
2. to determine how health professionals (BHMs) and para-professionals (BHWs) integrate and complement their functions.

1. BHWs attitudes on interpersonal relations with BHSMs

Eighty-one percent of the BHWs had only favorable remarks about the BHSMs, and 16% had both positive and negative comments. The aspects of their relationships that were positively viewed were expressed in the following ways:

a. The midwife is friendly and knows how to deal with people (26%).
b. The midwife is always willing to give advice (19%).
c. The midwife is helpful; she and the BHW help each other in their duties (16%).
d. The midwife gives medicine/medical supplies whenever needed (10%).

The unfavorable aspect of the relationship between the midwife and the BHW centered on their concern with the midwives' services to the needy. The BHWs were anxious when the midwives were always absent and failed to give medicine to sick people.

The BHWs' assessment of the BHSMs, therefore, does not focus on the relationship between the two of them. Rather, the relationship was perceived positively when the latter worked assiduously and intensively with community members.

2. Perceived work satisfiers and dissatisfiers

Both the BHWs and BHSMs were asked to identify the aspects of their work which they deemed "satisfying" or "dissatisfying". The information obtained elicits attitudes which lay bare the "helping" motive among these community workers.

The BHWs considered the following as enjoyable in their work:

a. participating in health activities (26%)
b. making home visits (14%)
c. helping people in the neighborhood (12%)
d. assisting the ill, helping in the Center, and learning new skills (9%)

Midwives, in turn, mentioned the following: meeting people, giving health advice, answering delivery calls and helping people.

As such, these community workers seem primarily concerned with helping others. None mentioned self-development or improved status in the communities as work satisfiers for themselves. The apprehension earlier expressed by program implementors that some community workers lack volunteerism is also unsupported by these self-supports.

Corollary to these concerns, the BHWs and BHSMs are unhappy or "dissatisfied" when they are unable to render service (5% of BHWs) or when health problems arise (4% of BHWs). Associated with these factors is the question of finances. Midwives are dissatisfied when they fail to receive salaries or bonuses. They feel that their salaries are too small, and that travel allowances are insufficient. A few BHWs are also unhappy that they do not receive any salary for their work (4%).

These dissatisfiers point to an important factor in service delivery: that material incentives for satisfying individual needs still have to be allocated to enhance positive attitudes. Besides, mobility in communities cannot be facilitated when there is no money for the workers' transportation. The "helping" attitude towards the community, therefore, will always be there. However, the basic needs of the workers also require "help."

F. SUMMARY

The various opinions and feelings on PHC expressed by the involved sectors are generally favorable to the concept. However, unfavorable remarks have been made concerning its implementation in the various localities.

Both program-level PHCCs and barangay PHCCs consider primary health care to be a meritorious approach to health service delivery. The program implementors emphasize its role in developing self-reliance in health while community workers single out its widespread effects in the provision of health care.

However, the intersectoral nature of PHC is recognized by implementors more than by the community workers. The latter even fail to express a grasp of the partnership approach in PHC. So long as health services are delivered, the community workers view PHC as beneficial.

The most dominant problems in implementing PHC zero are the shortage of manpower and logistics. Program implementors and the BHSMs propose recruitment of more and better trained BHWs who will be given sufficient logistics for transportation and fieldwork.

Besides this, all sectors recommend improvement in providing medicinal supplies -- for BSBs and RHUs. More BSBs are also required to be functional since their main advantage lies in their accessibility to the residents.

Definitely, this documentation reveals that more of the obstacles to the favorable implementation of PHC rest with program support factors. Community workers, on the average, perceive few hindrances emanating from the community, although higher-level implementors consider peace-and-order problems to be deterrents in some areas.

The nature of program and community support variables for PHC will be discussed in Part Four, to further elucidate on these opinions and operations.

PART FOUR: THE QUALITY OF SUPPORT FACTORS FOR PRIMARY HEALTH CARE

Thus far, this documentation has focused on a discussion of PHC-related process and output variables. While the portrayals which have emerged are complete insofar as describing the extent and nature of PHC activities and levels of goal attainment is concerned, the portraits fail to provide background images against which to view these events.

The purpose of this part of the report will be to describe the nature of two sets of variables which are assumed to lay the basis for PHC operations and achievements. These include factors related to program support from the implementing agencies, and community support from the participating barangays.

The discussion of these factors rounds off the documentation of PHC implementation according to the framework adopted for Phase II.

9. PROGRAM SUPPORT FOR PRIMARY HEALTH CARE

In earlier discussions, it was pointed out that essential elements in PHC implementation include the quality and quantity of efforts of the health workers in the community, and the volume and quality of basic medical supplies. The presence of an adequate number of well-trained BHSMs and BHWs in the barangays does not happen by accident. It is a planned move. Similarly, the availability of medical supplies for BSBs and other public health units is a planned logistic decision.

While PHC thrives in the barangays, its success is partly the result of prior moves taken by implementing agencies. These decisions which affect the realization of PHC include:

1. the provision of PHC guidelines, directives and operational policies
2. technical assistance for field operations
3. incentives for community service delivery
4. supervision monitoring and feedback mechanisms
5. intersectoral collaborations

Most of these variables have been discussed in terms of how the barangay PHCCs and the community workers fulfill their duties. In this chapter, the documentation will focus on program-level mechanisms. Discussions which deal with barangay support factors, and which have not previously been touched on, will likewise be included.

PHC INTEGRATION IN WORKPLANS OR OPERATING GUIDELINES

From the key informants' interviews, it appears that PHCC members generally do not know the extent to which PHC workplans and guidelines have been devised.

On the regional level, some respondents in Regions 3, 5, and 8 were aware of PHC integration with their workplans. However, many more Provincial PHCC members were aware that primary health care had been integrated with the Provincial Development Plans. These included informants form Regions 3, 5, 9 and 10.

The municipal PHCCs, being the committees closest to the operational PHC communities, are mandated to draw up implementing guidelines for PHC.. Unfortunately, PHCC informants at this level were unfamiliar with such documents having emanated from them. Instead, they stated that most of their functions in the municipalities tie up with older programs of their separate agencies, which they implement according to each of their separate (agency) guidelines. Fortunately, in many cases, these social development tasks are related to PHC objectives and elements.

The findings indicate that intersectoral workplans covering PHC are largely absent at program levels. Instead, previous efforts already being undertaken by the different agencies for health, nutrition and community development are categorized as PHC activities. Thus, new guidelines are not perceived to be necessary.

TECHNICAL ASSISTANCE FOR PRIMARY HEALTH CARE: STRUCTURES AND RESOURCES

Technical assistance for the PHC comes in the form of advisory consultations and training for health activities, as well as resource assistance for food production, livelihood and other community projects.

For a description of the nature of these forms of assistance extended to the communities, the following matters were documented:

1. the nature and functions of personnel assigned to PHC implementation
2. the specific resources extended by these individuals or structures for PHC
3. the qualifications of the implementing staff.

A. Intra-agency Assitance

Practically all the health professionals in the line structures of the Ministry of Health are mobilized for PHC. Within the regional offices, the following sectors are expected to assist in PHC implementation: the technical division staff, the health education committee, budget and finance division staff, and training. Aside from these units, the district hospitals are also involved in PHC, and referrals from lowerline service points are given to them for action.

Equivalent sectors work for PHC in the provincial offices, from the provincial health officer, the provincial task force on health, the provincial health staff, to the provincial pharmacist. Within the Rural Health Units, all medical and paramedical employees are expected to lend assistance to PHC. Thus, the mobilization of MOH service providers and program sectors for PHC is, to say the least, formidable.

Health Ministry staff at all levels, particularly those in the technical division, are expected to assist in monitoring activities for PHC. In addition, the technical staff are expected to recommend policies to the regional health officers, and to render direct services to communities, such as in training programs and seminars. The health education committee, in turn, plans, formulates and supervises information programs for PHC. The budget and finance division allocates and releases funds for these different endeavors.

On the provincial level, the provincial health staff gives orientation seminars to program implementors and assists in direct services. The provincial task force supervises, coordinates and monitors PHC activities, while the health education committee sees to information dissemination. In the RHUs, personnel are assigned to supervise and monitor community activities. They also act on referrals brought in by the BHWs and BHSMs, and render direct services in health campaigns. The RHU nurse and midwife are responsible for training BHWs and hilot for PHC, while the pharmacy aides are in charge of replenishing supplies of the BSBs.

Functionally, therefore, line structures of the MOH are ready to render logistics and technical assistance for PHC. Note, however, that these support functions center on health activities.

B. Inter-Agency Assistance

Specific structures and personnel of the various participating agencies are mandated to assist in PHC implementation. These structures include (on the regional level):

1. From the Ministry of Agriculture: the Rural Improvement Clubs (RIC), Samahang Nayon, Anak Bukid, farm management technicians, the home management technicians, and rural youth development workers.
2. From NEDA: social service specialist, economic development specialist
3. From the Ministry of Public Works and Highways (MPWH): The construction and maintenance division.
4. From the Office of Media Affairs (OMA): The general information division, photographers, and a mobile delivery service unit.
5. From the Ministry of Education, Culture, and Sports (MECS): school health and nutrition working committee, school health guardian, drug abuse prevention and control programs and projects council, school and community health council, school health personnel associate, health supervisor, medical senior supervisor, dental supervisor, nutrition supervisor and vocational education supervisor.
6. From the National Nutrition Council (NNC): The Regional Nutrition Program Coordinator, the Regional Training Assistant, Home Management Technicians and Barangay Nutrition Scholars.
7. From the National Manpower and Youth Council (NMYC): The manpower guidance officer.

1. Experiences from the case studies

As examples of the types of assistance extended by these agencies for PHC, the following experiences are described:

In Region 3, the RIC is in charge of matters concerning food, nutrition, income-generating projects (IGP), feeding, child care and development. Food production activities are among the tasks of the Samahang Nayon and the Anak Bukid. The FMT provides technical assistance to farmers, the HMT provides technical assistance to women, while the rural youth development workers (composed of out-of-school youth) are involved in food production and nutrition. Coordination of planning and implementation in social services (including health and other related efforts) is the task of the social services specialist of the NEDA. The construction and maintenance division of MPWH is responsible for the construction and maintenance of barangay roads and bridges, hospitals and rural health centers, while the information drive on PHC is the task of the general information division, public assistance and training staff of the Central Luzon Office of Media Affairs.

Several personnel and structures in MECS are directly involved in PHC activities in the Bicol region. The school health guardian deals with nutrition education, utilization of medicinal plants and delivery of health services. The school health and nutrition working committee looks into the programs of the school health guardian in the Alay Tanim Program which includes food production, Green Revolution and Sariling Sikap. Prevention and control of drug abuse are the main tasks of the Regional and Division Drug Abuse Prevention and Control Programs and Projects Council. The school and community health council takes care of all health activities in schools and communities while the school health

personnel associate is involved in medical and health education activities. The regional nutrition program coordinator (RNPC) of the NNC coordinates and implements the nutrition program in the region with the assistance of the regional technical technician (HMT) while the manpower guidance officer of NMYC takes care of everything related to training. In Region 5, the economic development specialist is in charge of the education matters while the other personnel are involved in health, nutrition, social services and population activities.

In the OMA of Region 7, a photographer and a mobile service delivery system work on PHC activities while the technical team of the MLG supports the training and organizational aspects of PHC. Popcom personnel perform such jobs as service delivery, training, research and IEC production. The MSSD extension workers and volunteers are also involved in PHC.

The MLG in Region 8 is involved in strengthening local government potential and organizing barangay brigades. The training needs of PHC are handled by the NMYC in the region while the MA fieldmen coordinate with other agencies at the local levels on training and demonstrations.

In Region 10, the BNS of the NNC also works as BHW while the MA fieldmen are also involved in PHC implementation.

At the provincial level, the participating agencies assign personnel/structures to work on some aspects of PHC. The MA personnel involved in PHC are the HMT, the rural youth development officer, the municipal development officer and the FMT. The health sector

of the provincial development staff also performs functions related to PHC. MSSD assigns the special services sector to work for PHC, together with the day care workers, social workers, sub-station officers, supervisors and fieldworkers. Popcom has FTOWs and Barangay Service Point Officers (BSPOs) together with other personnel supporting PHC activities. The home nursing class and paramedic workers of the Philippine National Red Cross (PNRC) help to implement PHC. Among the structures within the MPWH involved in PHC are the construction section, the planning and design section, and the maintenance section. The provincial MECS personnel and structures directly involved in PHC affairs include the health supervisor, the home economics supervisor, the dental and medical team and the school and community health council. In MLG, the local government officers and the senior staff also work for PHC. The Catholic Relief Service (CRS) has nutritionists involved in PHC, while the Bureau of Agricultural Extension (BAEX) has fieldworkers, and the Provincial Nutrition Office has the BNS.

2. Municipal assistance

At the municipal level the personnel/structures involved in PHC include the following: volunteers of the CRS, the FTOWs, and BSPOs of Popcom, teachers in MECS, the barangay development officer, the municipal development office of MLG, the youth development worker of MSSD and the barangay MA workers and HMT of MA. For instance, the CRS volunteer workers assist the CRS head in his work within the barangays of Castillejos. The FTOWs and BSPOs distribute supplies, motivate FP acceptors, make referrals and encourage residents

to participate more in PHC activities. The teachers in the municipality teach health, physical education, nutrition education, dental care, involved in the herbary and school clinics, and at the same time make referrals to the RHU.

In the municipality of Bulan, the barangay development officer is involved in planning and funding of projects. The BSPOs integrate PHC concepts during motivational activities and barangay assemblies.

In Bogo I, the teachers disseminate the PHC concept, while a youth development worker of MSSD is responsible for implementing programs catering to the youth, specially those out of school.

The MSSD personnel's functions in Dolores include providing food and social and moral assistance; while the HMT assists mothers in barangays, and MECS designates teachers to disseminate the latest information on PHC development.

In Liloy, the municipal health officer and other MLG personnel are involved in PHC implementation in the municipality. Giving technical assistance is the support given by the MA-BAEX to PHC implementation.

The mayor's office through the Municipal Development Council is involved in the information campaign for PHC in Naawan while the public school teachers act as purok coordinators for PHC in the municipality.

These experiences illustrate that provision for agency participation in PHC are well-laid out. What need to be improved, perhaps would be the synchronization and complementation of these activities

in the specific communities to avoid duplication of functions and activity saturation in the barangays.

C. Qualifications of Program Implementors

In the six regional areas which were visited for the study, the PHCCs at various levels were composed of a chairperson (usually the chief executive for the region, province or municipality) and from three to eight members representing the different participating agencies, both public and civic.

As noted in Table 3, only seven of the 101 key informants were PHCC chairpersons. In some regions, the vice-chairman was interviewed in lieu of these officials. This was because the chairmanship in most cases is usually a titular position; it is the vice chairman who is more fully involved in PHC meetings and other activities. Nevertheless, in the various localities, the 101 key informants represent a cross-section of MOH line executives, and members of the assorted agencies involved in implementation. The line-up of key informants by agency is seen in Table 29.

On all levels, the members of the PHCCs who served as key informants are also the directors, assistant directors and chiefs of the offices they represent. Included were regional and assistant regional directors of MOH, a superintendent in agriculture, population officers, coordinator of the nutrition program, provincial development officers, division superintendent of schools, social welfare officers, local government officers, municipal health officers, public health nurses, a president of the association of barangay councils, an industry development specialist, and mayors or vice mayors, among

others. As such, they list their duties to include supervision, program coordination, program implementation and administration. On the basis of this profile, it may be assumed that these committee members are experienced social development implementors, with long years of experience to bolster their abilities to plan, supervise and implement service delivery programs.

In terms of educational attainment, one key informant was a non-college graduate who reached only the second year of high school. The baccalaureate degrees earned by the informants include: BSEducation, BSNursing, BSSocial Work, BSElementary Education, and BS Agriculture. Post-baccalaureate degrees included, Doctor of Medicine, Master of Arts, Master in Public Administration, Master of Education, MA Public Administration, Bachelor of Laws, and Master of Social Work. One respondent also had a Doctor of Philosophy.

In terms of education background, therefore, the PHCC informants are generally well-qualified for their tasks in the agencies. This, coupled with their official functions, may be utilized to redirect their expertise towards a more efficient implementation of the PHC approach.

INCENTIVES FOR COMMUNITY HEALTH SERVICE DELIVERY

Both the BHWs and the BHSMs were asked to state why they accepted their respective jobs. Among the BHWs, the deciding factor in accepting their work was that it "gives me an opportunity to help other people" (72%). Apart from this, the volunteers said that work in the PHC gave them new ideas and skills (49%) and gave them the opportunity to meet different people (30%). As was noted in Chapter 8, an overriding motive for the BHWs is the desire "to help" others in their community. This resurfaces as a key factor in their efforts.

Among the midwives, the helping motive was also the primary consideration in accepting their jobs. Like the BHWs, they consider the opportunities in PHC to meet different people as an incentive to work. Thus, the implicit incentives in community service delivery for both parties have a helping orientation.

What fringe benefits do the community health workers receive from the program? Only 54% of the BHWs could mention any benefits accruing to them; the rest said there were none. Among the benefits mentioned, the availment of free medicine and medical consultations tops the list (40%). No new benefits accrue to the midwives as PHC workers. Only one mentioned having travel allowances and monetary incentives for generating FP acceptors. Thus, monetary rewards for PHC efforts are generally absent. However, the psychic rewards appear ample enough, if personal motives and incentives are analyzed. The spirit of volunteerism is apparently very strong in most of the BHWs and BHSMs.

COMMUNICATION SYSTEMS FOR SUPERVISION AND MONITORING

The various participating agencies are expected to be updated on developments in PHC implementation through the meetings of the PHCCs. To supplement the discussions at these meetings, monitoring forms have been devised for use at various levels.

A. Meetings of the PHCCs

Ideally, the PHCCs are expected to convene quarterly. The actual number of meetings varies, however, across regions, provinces and municipalities. The RPHCC in Regions 3, 5 and 10 did meet quarterly. In Region 7, it met only once in the past year, while the RPHHC in Region 8 met monthly.

On the provincial level, quarterly meetings were reportedly convened in Cebu and Zamboanga del Norte. The PHCC in Misamis Oriental met five times in the past year; the Zambales PHCC, thrice. The most active PHCC was the one in Eastern Samar, which met monthly over a period of one year. Least active was the Sorsogon PHCC, which met only once.

Among the municipal PHCCs, those in Liloy and Naawan met four times (or quarterly) in 1984. The MPHCC in Castillejos convened three times and the one in Bogo met once. No meeting reportedly was held in Bulan during the year.

The usual matters taken up at meetings of the PHCCs were: discussions of PHC concepts (orientation meetings), progress reports, evaluation of activities, problems encountered, coordination questions, and clarification of agency functions.

In Zambales, progress reports of the BHSMs were discussed in the meetings. Training proposals were included in the agenda of PPHCC meetings in Cebu, while matters pertaining to nutrition, logistics and self-reliance were some of the matters taken up in Eastern Samar. In Misamis Oriental, the PPHCC deliberated on the improvements that could be made in PHC implementation.

Accomplishment reports, problems and PHC orientation were the usual matters discussed in municipal PHCCs. In the municipality of Bogo 1, the identification of agency programs, problems, and services was included in the agenda. In Castillejos, the schedules of Barangay PHCC reorientation seminars were discussed. The election of officers was also held in one of its meetings.

The rate of attendance at such meetings was very satisfactory at the regional level (80-100%). Informants within Region 5 and 10 reported an attendance of 80-100% while attendance ranged rom 90-100% in Region 3.

Fifty per cent to 95% was the range of attendance reported by key informants in PHCC meetings at the provincial level. Region 3 reported an 85% - 90% attendance; Region 5 had a comparatively poor attendance (60%) while Region 10 had a 50% attendance rate. Region 7 had a slightly better rate of attendance at 50-80%, while Region 9 managed to have 90% attendance in PHCC meetings. The attendance rate in Region 8 was very satisfactory (95%), according to its members.

The attendance rate at the municipal level varied from 75% to 100%. Most meetings, however, were poorly attended. This was true of the MPHCC in Bogo I. Only Dolores, Eastern Samar reported a 90-100% attendance in its meetings. Naawan PHCC meetings managed to maintain a quorum, while the attendance rate in Castillejos ranged from 75-90%.

Solutions to problems, plans and proposals were the usual outputs of PHCC meetings at the regional level. At the provincial level, outputs of PHCC's meeting included plans, solutions to problems, and recommendations. In Zambales, the Provincial PHCC came up with a monitoring system, an improvised referral system and targets/goals to be accomplished. In Cebu, an action plan was formulated during one of the provincial PHCC meetings.

As in the higher levels, the outputs of the municipal PHCC meetings included plans, solutions to problems, and recommendations. New activities to be undertaken were taken up in the PHCC's meetings in Castillejos.

B. Supervision and Feedback Mechanisms

Directives and communications pertaining to PHC pass through the usual channels, from the highest level down to the lower levels. At the regional level, directives/communication on PHC usually come from the central offices of the participating agencies, including the MOH. Communications reaching the provincial agencies come from the various regional offices.

PHC communications coming to municipal offices of the different agencies are usually transmitted by the MOH through the provincial health officer (PHO) or the municipal health officer (MHO), and through the provincial offices of the participating agencies. Sometimes the mayor of the municipality issues communications on PHC, as in Bogo I and Dolores.

Within the PHC committees at different levels, communications and directives on PHC usually come from the MOH -- from the national office down to the municipal office -- through the PHCC chairman or the health officers.

Feedback communications on plans, activities or problems on PHC also pass through the hierarchy of each agency, from the lower-level offices to the national offices. Within the PHCC at different levels, any plan, activity or problem concerning PHC is communicated to the MOH -- through the regional director or chairman of the PHCC at the regional level, through the PHC coordinator or PHO at the provincial level, and through the MOH or MPHCC chairman at the municipal level.

C. Summary

The system for receiving and transmitting communications pertaining to PHC appears well laid-out. Nevertheless, the frequency of meetings could stand improvement in many areas for more efficient management of community operations. It is also sad to note that committee attendance is lowest in the municipalities in relation to program levels of implementation. The MPHCCs are the first links between actual operations and the program structure. Thus, the accuracy

and rate of feedback on PHC from this level is critical since higher level decisions are pegged on upward communications. Municipal implementors need to be better motivated to participate in these committee deliberations.

INTERSECTORAL COLLABORATIONS

So far, the information which has been presented represents a compendium of responses obtained from the various key informants. While they detail the different facets of program support, these discussions fail to reflect the extent to which any one person in the PHCCs has a clear grasp of all PHC operations.

The reality is that, as in the barangays themselves, most of the agency representatives remain unaware of the activities which have been completed or are ongoing in the communities. Each informant tends to be more aware of his/her own agency's contribution to the PHC effort, leading to complaints about the monitoring system (See Chapter 8). The poor links between agencies are also better understood in the light of how infrequently meetings transpire and who attend them. Even if the PHCCs meet regularly, the agency representatives may change with every session. The formal members of the committees (who served as the key informants) do not always attend these meetings and thus are not updated on developments in PHC.

Finally, the weak coordinative links between agencies may be attributed to the absence of separate workplans for PHC at the regional and provincial levels. Since the integrated functions of PHC are similar to what the different agencies have been doing in the past, the implementators fail to be reoriented to a collaborative perspective,

with health care as the entry point for services. An explicit workplan which specifies the interlinkages, supervisory and implementing roles of each participating unit, would help concretize the "total development" approach of PHC.

SUMMARY

This review of the program support factors for PHC reveals that, while the structural supports for implementation of a community health care approach are available, the processes undertaken to utilize these mechanisms may be further improved.

For one, PHC workplans and guidelines can be better explained so as to serve as anchor points for its implementors, who fail to perceive actual interlinkages occurring in PHC.

Secondly, the participation of agencies in terms of giving direct assistance to barangays tends to be uneven. While the problems of the communities were assessed to be similar on many counts (See Chapter 7), the nature of technical assistance in the different localities is disparate. More collaborative efforts also appear to be needed in response to the need for more medicinal supplies in the barangays and for more health workers.

Thirdly, both midwives and BHWs stated that their primary motive in working on community health matters was to help. Yet these same individuals (the BHSMs) report that their work is hampered by delayed allowances (Chapter 8). More logistical support for community field work is needed by the health workers.

Fourthly, while the communication systems are in order, there is need to make attendance more regular and meetings more frequent to discuss plans and evaluate reports, especially among the non-health personnel.

10. *COMMUNITY SUPPORT FOR PRIMARY HEALTH CARE*

The PHC approach strives to mobilize the communities to attend to their health needs through their own efforts. For this purpose, the social preparation stage of PHC implementation looks into the communities' health and other welfare needs, trains members of the barangays as volunteer health workers, and disseminates information on the PHC concept to community residents.

The acceptance and adoption of PHC as a health care strategy is influenced by factors pertaining to the communities themselves. These include:

a. the facilities existing in the barangays for health care services
b. health and nutrition status and practices of the residents
c. community resources for an improved quality of life

FACILITIES FOR HEALTH SERVICES

A. Health Infrastructure

Barangay health stations have been established in 12 of the 17 visited barangays (Table 30)[4]. Moreover, Rural Health Units are found in each of the six respective municipalities. Apart from these basic service points, puericulture centers are accessible to the barangays in Regions 5 and 8, and private clinics are found in Regions 3, 5, 8 and 9. Hospitals -- both private and government types -- are located in areas accessible to each of the barangays.

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[4] It may be, however, that Barangay health stations were located in other barangays within the 6 catchment areas included for study.

In addition to these facilities, the PHC implementation guidelines make provisions for district hospitals to accept referrals from PHC communities. No district hospitals are located in the municipalities within which the visited barangays are located. However, at least two or three such hospitals are located within the provinces themselves (Table 31). In all instances, these district hospitals are situated in nearby municipalities -- as in Regions 3 (San Marcelino District Hospital), 5 (Irosin District Hospital), 7 (Bogo District Hospital), 8 (Oas Emergency Hospital), 9 (Labason District Hospital) and 10 (Initao District Hospital).

B. Health Personnel

Except for the municipality of Naawan in Misamis Oriental, all the RHUs are regular units (i.e., with MHOs). Each one has at least one nurse on the staff and from five to ten midwives. Other personnel of the RHUs are dentists, dental aides, sanitary inspectors and medical technologists.

The barangay health stations are more sparsely staffed. Only Beguin (in Bulan, Sorsogon) has a nurse assigned to the BHS. BHSMs are found in all of the BHSs, however, and barangay nutrition scholars are assigned to the barangay health stations of San Roque, San Pablo, San Juan (Region 3), Beguin (Region 5) and Maputi (Region 10).

C. Nutrition, Sanitation Services

Apart from infrastructure and personnel resources for health services, health-related social service programs were examined in the provinces and municipalities.

Operation Timbang (OPT) is the most common nutrition activity in the various areas. All the six municipalities reportedly completed, or were undertaking, this weighing program. Aside from OPT, sanitation campaigns were reported by program implementors in four of the localities.

In Zambales, nutrition and sanitation programs have been actively pursued. Among the nutrition services which have been extended are:

1) mothercraft programs; 2) food assistance; 3) visitation and clinical examination of malnourished children; 4) treatment of nutritional deficiencies.

The sanitation projects appear equally impressive. These include:

1) examination and disinfection of water supplies; 2) toilet inspection; 3) construction of water supplies and toilets; 4) establishments inspection; and 5) supervision of garbage disposal.

In Bulan, Sorsogon, the OPT and food assistance programs have been implemented. Within Dolores (Region 8), OPT and mothercraft classes have been undertaken. In addition, a survey of water supply sources has been completed, and the types of existing toilets in the area have been ascertained.

Activities within Bogo (Region 7) have been more extensive. Aside from OPT and mothercraft classes, various sanitation studies have been conducted, like surveys of water supply sources, potable water examination, excreta disposal facilities, drainage and garbage disposal facilities. Food handlers are also inspected before they are granted sanitary permits.

In the municipalities of Naawan (Region 10) and Liloy (Region 9), only OPT has reportedly been undertaken. Other agencies report no other health-related projects.

D. Summary of Findings: Facilities Support for PHC

The preponderance of nutrition services which have been extended to the various municipalities may explain why "malnutrition" was not cited as a pressing problem by barangay respondents (See Chapter 6). OPT, mothercraft and food assistance programs have been completed (or are ongoing) in most areas.

In contrast, personnel shortage and the need for toilets were perceived to be problematic in most communities (Table 19). Although RHUs are usually complete in their staff complements, it was seen that BHSs are manned only by BHSMs. Dependency on professional health care is thus still uppermost in the minds of community members and workers. In turn, the perceived need for sanitation programs may be explained by the fact that such campaigns have not been widely implemented in at least two areas.

These findings indicate two directions for future efforts to provide resource support for PHC:

First, improved educational activities to emphasize the need for family self-reliance in health care at the primary level;

Second, increased efforts to conduct environmental sanitation surveys and programs.

HEALTH, NUTRITION AND FAMILY PLANNING PROFILES

Now that the existing resources for health and nutritional care are known, the next set of information will describe the status of health, nutrition and FP in the different localities.[5]

A. Morbidity and Mortality in 1984

Respiratory and gastrointestinal diseases were among the five leading causes of morbidity in the six regions within the past year. In addition, the incidence of tuberculosis ranked high in Regions 3, 5, 8 and 9 (Table 31), while urinary tract infections (UTI) were the foremost cause of morbidity in Region 3, and malaria ranked fifth in Region 10.

The same respiratory and gastrointestinal disorders were reported in the six provinces. Parasitism was the third cause of morbidity in Zambales. Ranking fifth were heart diseases (Region 5), dysentery (Region 7), whooping cough (Region 8), measles (Region 9) and dysentery (Region 10).

On the municipal level, leading diseases which were not reflected in the regional and provincial prevalence tables included the following: UTI (Bulan, Bogo I and Liloy), anemia (Bulan, Bogo and Liloy), avitaminosis (Bogo I), schistosomiasis and salmonella infections (Dolores).

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[5]The sources for these statistics include those in the Bibliography.

Pneumonia, TB and various diseases of the circulatory system (including CVA and cardiac disorders) were among the leading causes of death across the regions. In addition, cancer was among the five highest mortality causes in Regions 3 and 7 and death from gastrointestinal diseases was common in Regions 5, 8, 9 and 10. Accidents and violence were the third leading causes of death in Mindanao (Table 32).

Provincial causes of mortality were similar to the regional profiles. Aside from pneumonia, TB, and circulatory diseases and cancer, stab wounds was the fourth ranking cause of mortality in Eastern Samar. Measles ranked second in Zamboanga del Norte.

Within the municipalities: violent death was the fourth leading cause of mortality in Castillejos; liver cirrhosis ranked second in Bogo I; medico-legal cases were the primary cause of death in Dolores, followed by PTB, CVA, drowning and peptic ulcers.

Within the barangays, 42% of the respondents mentioned that one or more family members (three years and older) had been ill during the month immediately preceding the interviews. The majority had from one to four sick family members in the past month, although one respondent reported as many as 12 sick members in her household.

Cough (46%), fever (53%) and colds (42%) were the usual complaints of these sick family members, followed by headaches (40%), stomachaches (15%), and LBM (10%). The rest complained of asthma, chest pains, vomiting and nausea, skin rashes, and

allergies, tonsilitis, toothache, chills, measles and rheumatism, flu and bleeding, ulcer, expelled parasites and others.

A total of 224 respondents (59.8%) mentioned that one or more infants and young children in the household were sick in the past months. Majority or 52% had one sick child, 7% had two sick children and only two or 0.53% said they had three sick children in the past month.

The usual complaints of the sick children were cough (62%), fever (61%) and colds (60%). Fewer had LBM (22%), stomachaches (8%) and measles (6%). The rest complained of skin rashes or allergies, vomiting or nausea, asthma, expelled parasites, headaches, chills, and other ailments.

Except for death occurring from accidents, violence and medicological cases, therefore, most of the incidences which lead to morbidity or mortality may be prevented and controlled through the widespread observance of the eight PHC elements.

B. Nutrition Information

Over all the provinces, young children were found on the average to be mildly underweight (first degree malnourished). This was especially true of children in the four municipalities of Bulan, Bogo, Dolores and Naawan. The young children in Castillejos were reportedly of normal weight, while the average child in Liloy seems to be overweight. In contrast, severe malnutrition (4%) was reported in Naawan. (In Chapter 6 it was determined that food shortage is a problem in Region 10, where Naawan is located).

C. Family Planning Profile

The province with the highest number of acceptors and continuing users in 1984 was Misamis Oriental (25,117). It was followed by Cebu (19,473) and Zambales (14,365). Low levels of family planning practice were reported in Sorsogon (3,344), Eastern Samar (1,391) and Zamboanga del Norte (160). At the municipal level, however, the highest number of acceptors and continuing users was reported for Bulan (5,614) followed by Dolores (1,292), Liloy (775), Bogo I 272) and Castillejos (128). The most popular contraceptive methods were the pill and the condom.

Among the housewives interviewed, 65% were MWRAs. Of this group (584 women), only 46% were practising FP at the time of the interviews. The ranking of regions in terms of FP prevalence rates in the sample is as follows (See also Table 36):

Rank 1	-	Region 10 (56%)
2	-	Region 5 (53%)
3	-	Region 3 (52%)
4	-	Region 9 (50%)
5	-	Region 7 (44%)
6	-	Region 8 (18%)

Overall, rhythm is the most frequently practised method (36%), especially in Regions 7 (24%) and 9 (30%). Rhythm is also the second most popular method in barangays of Regions 3 (14%), 5 (12%) and 10 (17%).

The pill was the second ranking FP approach. It ranked highest in barangays of Region 5 (25%), 10 (21%), and 3 (18%), and second in Region 7 (11%). Only 5% of housewives in Region 9, and one in Region 8, used the pill.

The pill was followed by ligation and withdrawal (12% each). Most of the ligated women were from Region 3 (10%) and 10 (7%), while 11% of those practising withdrawal came from Region 8.

When these figures are compared with municipal data, differences in prevalence rates emerge. The municipal ranking was: Regions 5, 8, 10, 7 and 3, while the highest percentage of acceptors was actually reported in the barangays of Naawan, Misamis Oriental and Bulan, Sorsogon and the lowest in Dolores, Eastern Samar. The methods profile is also different. Rhythm and the pill were the most common methods rather than provincial reports of the pill and the condom.

SUMMARY

The need for improved practices in preventive health is well illustrated by the fact that most of the leading causes of morbidity and mortality in the six localities are respiratory and gastrointestinal in origin. PHC elements focused on educating communities in disease prevention and for improved sanitation appear highly warranted.

Malnutrition does not surface as a major problem in the various areas although most of the children are still underweight. Livelihood and food production projects should probably be increased, to assist those areas with scarse food sources to cope with their nutritional needs.

Improved IEC for FP is also needed, in order to increase acceptor and prevalence levels, especially in Regions 7 and 8.

HEALTH, NUTRITION AND SANITATION PRACTICES

A. Environmental Sanitation

The sanitation practices of the households were documented in terms of the following measures:

1. sources of potable water
2. whether or not households have their own toilets
3. garbage disposal practices
4. fencing-in of yards
5. care of animals
6. visibility of garbage in yard

The households' usual source of drinking water is either an artesian well (bomba) (36%) or an open well or poso (27%). Some (18%) rely on private pumps for their supply of potable water, while others (8%) get their potable water from the public faucet. About the same number of respondents obtain theirs from rivers or natural springs. Only 5% of the households have piped water.

Artesian wells as water supply sources were most predominant in Regions 8 (61%) and 10 (46%). In turn, open wells were commonly found in Regions 5 (65%) and 8 (37%). Private pumps abounded in Castillejos, Zambales (77%), and in about a fifth of the homes in Naawan, Misamis Oriental (19%). In Bogo I, Cebu, a variety of water sources were reported: artesian wells (31%), public faucets (27%), open wells (23%) and piped water (17%). (See Table 34).

More than half of the households visited have their own toilets (60%). The ranking of regions, in terms of the percentage of households with toilets, is as follows:

Rank	Region	Percentage with Toilets
1	9	99%
2	10	87%
3	3	82%
4	7	58%
5	5	36%
6	8	30%

Burning and composting of garbage are the customary ways of disposing of waste (mentioned by 42% and 24% of the respondents, respectively). About 20% dump their garbage in some place far from their homes. Some (9%) said that their garbage is being collected and 5% dump waste near their homes.

Burning of garbage is most commonly practised in Regions 10 (79%), 3 (52%) and 5 (42%). Composting of wastes is popular in Region 9 (60%), and to some extent in Region 3. Garbage collection is enjoyed only by the residents of Bogo I in Cebu. Garbage dumping (far from residence) is common in Region 8.

More than 415 of the households visited had no fences (81%). Most of the fenced yards were in Regions 8 (35%) and 3 (44%).

A majority of the respondents (62%) kept animals inside their houses. Among the animals kept inside the house, dogs head the list, as indicated by 46% of the respondents. Cats were next on

the list (43%) and chickens (3%). Rarely are pigs kept inside the house but 0.33% mentioned that they allow these animals inside their homes. A slightly higher number of respondents (0.44%) have birds inside their house.

Similarly, most respondents (70%) keep animals inside their yards. Half of them keep chickens and about 15% have pigs. Others (15%) mentioned that they have either carabaos or cows while 11% keep goats. Dogs are kept by some 9% of the households while ducks, geese and other fowls are kept by 3%. A few (1/2%) keep cats.

Of the respondents who kept animals in their yard, most allowed them to roam freely around the yard like -- chickens, ducks and other fowls, dogs and cats, although some fence them in or put them in cages. Other animals, like pigs, goats, carabaos and cows, are usually tied up and seldom allowed to roam freely around the yard.

As a last measure of sanitary practices, the interviewers were asked to rate the general cleanliness of the households. The surroundings of the respondents' homes were generally clean with no garbage or waste visible (44%). About 37% of the households were observed to have very little garbage present in their surroundings. Seventeen percent (17%) had some garbage or animal waste present around the homes, and only a few, about 2%, were rated as unsanitary, with highly visible wet garbage or animal waste in their surroundings. Eight hundred or 89% of the respondents had no stagnant water around or under their homes.

B. Nutrition Profile

The indices for nutritional status which were used in this documentation include the identification of:

1. food sources of the household
2. number of meals per day in each household

1. Sources of food

A meal may consist of rice, vegetables and fish. Which of these are available to the households? Through what means?

Earlier, it was seen that a variety of animals were kept in the yards of the respondents. Which of these are consumed by the families? The animal most frequently slaughtered for food is the chicken. Respondents kill their chickens whenever there are visitors, to feed to hired field hands, to feed to sick children, and if it is the only available food to the household.

Goats, ducks and other fowl are obviously not preferred viands. They are usually slaughtered for food only when necessary -- when hired workers have to be fed, when no other food is available, or when important visitors arrive.

Carabaos, cows and dogs are rarely used for family consumption. They are usually reserved for special occasions, such as weddings and fiestas.

About half of the households visited had vegetables in their own yard (47%). The majority of these were in Regions 5 (91%), 3 (86%) and 9 (85%). In addition to vegetables, 69% had fruit trees and 48% grew bananas. Fruit trees abounded in

most of the regions, except Regions 8 (50%) and 7 (37%). Bananas were mostly planted in Regions 5 (93%), 9 (67%), 10 (48%) and 3 (45%). Thus, the barangays of Cebu and Eastern Samar consistently surface as the areas with minimal self-sufficiency in fruits and vegetables. Instead, the households in Bogo I were observed to abound in decorative trees or shrubs (70%). Half of those in Dolores, however, grew fruit trees.

In addition to backyard sources of food, 67% plant vegetables in the fields expressly for household use. This was particularly true in Regions 9 (96%), 5 (86%) and 10 (83%). Only about half of the households in Region 3 plant vegetables for home consumption, and less do so in Regions 7 (45%) and 8 (42%). Vegetables are most abundant from May to September. February, on the other hand, was cited as the least productive month.

The market is the usual source of fish or shellfish for half of the households. Forty-four percent (44%) get their supply of marine products from the seas or rivers. About 4% buy at the seashore; others (1.33%) from fish vendors or peddlers. Very few obtain their supply from ricefields or fishponds.

Residents of Castillejos (92%), Bulan (89%) and Bogo (81%) rely heavily on the markets for their fish supplies. Fishing in seas or rivers provides food for households in Dolores (99%), Liloy (71%) and Naawan (61%).

Half of the respondents buy their rice at the market (55%). The next most common source of rice is the ricefield tilled by the family, cited by 19% of the respondents. About 2.5% said that they buy their rice at sari-sari stores, and 2% get their supply from ricefields tilled by relatives. Others (1.22%) obtain theirs from ricemills; while less than 1% buy from the National Food Authority (NFA)/National Grains Authority (NGA) outlets.

Rice is bought in the markets mostly by residents of Regions 7 (80%), 3 (74%), 5 (69%), and 10 (63%). Those who till their own fields for rice come from Region 9 (61%), and a few from Region 5 (28%).

Generally, therefore, the markets provide most of the food requirements of the barangay households themselves. In about half of the instances fish and shellfish are also procured through individual efforts.

Ninety-two percent of the households eat three times a day, while about 1-1/2% eat only once or twice a day. The rest eat as often as six times in a day.

The most common food items included in meals are rice, bread and other cereals, as cited by 98% of the respondents; fish and other marine products were mentioned by 93%. Another common food, according to 84% of the respondents, is vegetables. Tubers and other root crops are included in the meals of some 21% of the households. Only 17% usually have meat and poultry in their meals. Bagoong is also present in the diet of some

13% of the households, while coffee and chocolate are staple in the meals of 12%. About 9% usually include eggs in their meals, 8% typically consume dried fish, tuyo, daing or tinapa. Fruits find their way in to the meals of 6% of the households, while milk and milk products are commonly consumed by only 2-1/2% of respondents. The rest have hotdogs, hamburgers, chorizo, sugar or salt.

In Region 3, a typical diet includes (aside from rice) fish and other marine products (91%), vegetables (83%) and meat or poultry (61%). In Region 5 and 8, a typical meal consists of rice, fish (5%), vegetables (97% and 61%, respectively) and root crops or tubers (75% and 40%, respectively). Households in Regions 7, 9 and 10 prefer fish (about 90%) and vegetables (about 85%) with their rice. These are supplemented with dried fish products.

C. Child Care Practices

Practices related to the care of infants and children below the age of three were documented in relation to two factors: nutritional care and the immunization history of young children.

1. Milk preferences for infants and young children

About 40% of the households (37.4% respondents) had children younger than 3 years old. When asked what type of milk was usually fed to the babies, more than 90% claimed that they give their infants breast milk. Less than half (47%) had ever used powdered milk, condensed milk (44%) or evaporated milk

(24%). Even fewer were the families who give their babies fresh milk (carabao or cow), skimmed milk or soymilk.

The majority of the mothers interviewed believed that breast milk is best for babies (80%). Powdered milk was considered best by only 6%, and even less thought highly of other milk sources.

The respondents were further asked their reasons for considering breast milk as the best type of milk. The answers given may be classified in terms of the following elements: 1) the property of milk; 2) the effects of milk on children; 3) economical reasons; and 4) convenience reasons.

Breast milk was thought to be the most nutritious of the different types of milk (68%) because it contains nutrients from the food ingested by the lactating mothers. Other recognized properties of breast milk were: it does not cause LBM (7%), it is sanitary and has no foreign substances (6%), and it does not become stale (5%).

Given these properties, it was believed that infants fed on mother's milk become fat and healthy (21%) and are more resistant to disease (16%). Consequently, the child may grow stronger and faster (6%). Breastfeeding also results in a closer relationship between infants and their mothers (2%).

Aside from its healthful effects on infants, breastmilk is considered the best because it is free (22%). Besides, it is convenient to use, there being no need to prepare any "formula".

Seventy-six percent (76%) of the respondents report that infants are given milk until they are about two years old. Nine percent of the families give milk until the child is three years of age, and only 8% feed children milk until their fifth year.

Generally, therefore, mothers with infants observe good feeding practices, and were knowledgeable about the advantages of breastfeeding.

2. Solid foods for young children

A majority of the mothers introduce their babies to solid food when the latter are between the ages of three and six months (43%). Only 14% introduce solids at earlier stages of infancy and 34% wait until the sixth to the twelfth month. An insignificant number wait till the child is over a year old.

Food which is eaten by older family members is usually fed to infants when they are between six and 12 months old (52%). Six percent (6%) give adult food to younger children; 13% wait till the child is 1-1/2 years of age, and 19% do so only when the children are almost two.

Thus, supplemental feeding generally starts during the second quarter of the infants' lives, and solid foods are shared by adults and babies alike when the latter are almost a year old.

If the typical family in the barangay is able to have a balanced diet (as they report to us), then their babies receive sufficient nutrients in their first two years. These

nutrients would be transmitted primarily through the mother's milk and in terms of supplemental solid food adults share with their babies. The feeding practices reported by mothers lend credence to the overall nutritional status reported by program implementors.

3. Immunization history

In Chapter 6, it was noted that some 52% of the young children have been immunized (Table 24). The mothers' verbal reports were largely consistent with records obtained from the BHS. It was also pointed out that most of the mothers had fairly adequate knowledge concerning the value of immunization for young children.

D. Treatment of Sick Family Members

The practices followed by the households when dealing with symptoms of illnesses differ somewhat by region.

Whether the ailing family member is a young child or an adult, the most common treatments include medicinal preparations (79% and 80%, respectively), herbal treatments (30% and 26%) and injections (10% and 8%).

In region 3, however, medicine and injections are preferred to herbs (89% and 38%, respectively) in the treatment of sick infants and younger children. In Regions 8, 9 and 10, about half of the households use herbal treatments. In fact, in Eastern Samar, treatment used is almost equally divided between medicinal and herbal. Injections, however, are not reported as treatments for younger children in Regions 7, 9 and 10. (See Table 35).

Trends in the use of these treatments for adults were similar across the regions (Table 36). Herbal medicine is more commonly used in Regions 8, 9 and 10. Those in Zambales prefer injections to herbs, while the opposite is true within Regions 5 and 7.

It was also shown in Chapter 6 that health personnel, more than hilot and herbolarios are consulted for treatment of symptoms. This, coupled with the practices observed by the households when attending to ailments, augurs well for the implementation of PHC approaches to effective disease prevention and control.

E. Summary

The profile of health, nutrition and sanitation practices in the barangays visited may be summarized as follows:

First, the practices concretely depict the need for improved sanitation in the communities. Water supply sources have to be increased in most of the localities and more toilets are needed in Regions 5, 7 and 8. Residents also have to be better educated concerning the proper care of domestic animals, and the proper disposal of garbage. Fortunately, perhaps as an offshoot of community cleanliness campaigns, most of the yards in the barangays are clean.

Second, the usual sources of protein for families are marine products. Rice is the staple source of carbohydrates and vegetables provide vitamins and minerals to most of the households. Meat is plentiful only in Region 3 (61%). Hence, without considering the per capita intake of food, the typical meals of the families apparently meet the basic food requirements. Unfortunately,

individual intakes were not verified, and nutritional levels cannot be reported for each barangay. Nonetheless, reported practices tend to support nutrition statistics. They may also be indicative of the effects of nutrition campaigns undertaken in the various barangays.

Third, about half of the mothers with young children observe favorable child care practices, both in terms of both feeding patterns and preventive disease practices. Community support for maternal/child care and immunization campaigns may be harnessed from among these households, so that others in the localities can be similarly educated.

Fourth, household practices in the treatment of health complains point to the importance of providing adequate supplies of medicine and for establishing functional BSBs. The use of herbal medicine also needs to be encouraged, particularly in Luzon.

PART FIVE: RESULTS AND RECOMMENDATIONS

The documentation of PHC along the lines delineated by the framework is now complete. What remains to be done is to summarize the results obtained in terms of the project objectives, to compare these findings with those depicted in the Phase I report (whenever possible), and to identify areas of implementation which require improvement.

11. SUMMARY OF FINDINGS

This documentation effort has focused on three areas of concern, namely:

1. Documentation of actual experiences in primary health care
2. Description of program factors and community variables at play during PHC implementation
3. Identification of PHC implementor's perceptions and assessments of PHC

The results of the study concerning these objectives will be reiterated in the following discussion.

IMPLEMENTATION OF PRIMARY HEALTH CARE

A. Social Preparation Activities

1. Ministry of Health personnel at the regional, provincial and municipal levels took the lead in introducing the PHC approach to the interagency (PHCC) committees at these levels. Local officials, together with BHSMs and BHWs, participated in the conduct of community assemblies to orient barangay residents on the health strategy. Informational activities often accompanied the conduct of orientation seminars and assemblies. These included print materials, mass media channels and, in limited cases, audiovisual aids.

2. Training seminars were held at all levels of program implementation to impart the essential concepts of PHC to interagency representatives and to grassroots workers. While these seminars focused on leadership, organizing and plan-

ning skills at program levels, grassroots implementors were trained extensively for the delivery of various health services. In a few instances, leadership skills, project development and food production methods were also taught to the BHWs.

3. Family planning and natal services remained the predominant tasks of the BHSMs, despite their training in the other PHC elements. PHCCs in the barangay, in turn, were assigned to implement PHC activities, assist sick persons and undertake health education within the communities

B. Establishment of Linkages

1. Intersectoral committees for PHC at program levels are usually those involved in the planning and complementation of social development objectives. These include Regional Development Councils, Social Development Councils and the National Nutrition Council. Most of the PHCCs were established in 1981 and include representatives from most of the development - oriented ministries of government. PHCC meetings provide the venue for planning and supervision of PHC activities at lower levels of program implementation. However, these meetings are held on an irregular basis.

2. Within the barangays, PHCCs are often composed of various individuals recruited by the BHSMs. In a few areas, they were elected by the constituents to serve on the committee. Many of the PHCC members are new to community health service delivery, although some are informal and formal leaders of the areas, in other respects.

   Aside from the PHCC, intersectoral linkages take the form of joint implementation of various activities or complementation of agency efforts at the barangay level. In the perception of BHSMs, many collaborative efforts transpire with MECS representatives. For the BHWs, however, joint activities with MSSD are more often remembered.

3. Intersectoral collaboration is achieved largely through joint planning activities (between the PHCCs and the BHSMs, the BHWs and BHSMs, or among these parties and the residents). Implementation is also undertaken through the efforts of the PHCCs, the BHWs and the BHSMs.

   Linkages between the barangays and the program implementors are maintained through the use of records and monitoring forms for PHC. These are usually filled out by the BHSMs.

C. Initial Implementation of PHC Activities

1. Community residents mostly reported the following activities as having been implemented in their areas: cleanliness and nutrition campaigns, toilet construction projects, FP and immunization. Only about half were aware of herbal gardening projects or BHW training programs.

2. The extent to which these activities were known in the various barangays varies across regions. Apparently, PHC efforts have been most extensive in the barangays of Regions 9 and 10, followed by those in Regions 5 and 7, and least in the areas of Regions 3 and 8.

3. Household visits were reported by very few of the community residents. Of the instances reported, the visits were usually intended to complete community health surveys, to ask housholds to join planned activities, to teach them about herbal medicine, and to promote nutrition. BHS midwives, BHWs, sanitary inspectors and local officials undertook these household surveys and mobilization efforts.

4. "Successfull" PHC activities were identified by about half of the grassroots implementors. These included cleanliness campaigns, toilet construction projects and herbal gardening. In all instances, the successful activities involved community participation in the planning and implementation phases.

5. The most pressing problems of the communities are economic in nature, such as unemployment, unaffordable food prices and food shortages. Despite these needs, PHC activities have centered on health service delivery. Reports of livelihood and income generating projects under PHC were not generally reported.

PROGRAM SUPPORT AND COMMUNITY SUPPORT FACTORS

A. Program Support for PHC

1. Workplans for PHC are integrated with the development plans of some provinces. However, at the municipal level, PHC implementing guidelines are largely absent. Instead, the PHC-related activities of the various implementors are those already contained in their respective agency guidelines.

2. Structurally, the ingredients for excellent technical assistance for PHC exist at program levels and across agencies. What are lacking, however, are stricter monitoring and feedback mechanisms to ensure complementation and integration of various services, and to avoid duplication of efforts by the different line agencies.

3. Meetings of the PHCCs are usually held on an irregular basis and far between. Moreover, agency representation in the committees is often done on an ad hoc basis. These practices make the job of supervising, planning and monitoring PHC activities difficult.

4. Both midwives and barangay health workers report that their motives in undertaking PHC efforts revolve around a "helping" orientation. Despite this positive motive, complaints about delayed salaries and allowances may hamper their field mobilization and implementation activities.

B. Community Support for PHC

1. Service delivery structures for health abound in the various municipalities, from barangay health stations to district hospitals. Private clinics and hospitals are likewise located in accessible places.
2. Health-related activities which have often been implemented across the regions include Operation Timbang, mothercraft classes and food assistance projects. Environmental sanitation projects were reported in only four or six municipalities.
3. Respiratory and gastrointestinal ailments are the predominant causes of morbidity in the regions visited. The most frequent causes of mortality are pneumonia, TB and circulatory diseases.

The leading causes of morbidity and mortality, therefore, are those which may be successfully controlled and prevented through the full blown introduction of PHC elements.

4. The common sources of potable water are artesian wells and open wells. Backyard toilets are also found in about three-fourths of the households. The lowest number of backyard toilets was reported in Regions 5 and 8. In these areas, only about a third of the households had toilets. Obviously, emphasis on environmental sanitation in PHC is warranted in most areas.

5. The usual meal of the barangay housheolds consists of rice and fish, or rice and vegetables. Many raise animals for home use (usually chickens) and about half plant their own vegetables. However, the market remains the usual source of rice and fish.

6. Half of the infants and young children have been immunized against BCG and/or DPT and oral polio. Breastfeeding is a common practice and mothers consider breast milk to be more nutritious than powdered or evaporated products. Milk is usually supplemented by other foods when the infants are on their third to sixth month. These practices may have been the results of intensive efforts directed at improving maternal and child health.

7. Treatments for health complaints are usually decided by the household heads and housewives. These remedies often taken the form of medicinal preparations. Herbal medicine is more commonly used in the barangays in Regions 8, 9 and 10 than in the other places. Improved provisions for medicine and herbal treatments should thus be encouraged.

PERCEPTIONS ON PRIMARY HEALTH CARE

A. Cognitions of PHC Objectives and Goals

1. Program level implementors consider PHC objectives to include the promotion of health, mobilization of communities for self-reliance in health and the development of inter-sectoral linkages. Among the community health workers, the delivery of health services is perceived as the main objective of PHC. The promotion of communitry self-reliance is not a frequently cited goal.

2. Less than half of the program implementors or barangay health workers could articulate the similarities and differences between PHC and clinic-based service delivery. The stated similarities pertain to the nature of health servies provided by either approach. Dissimilarities, in turn, refer to methods of implementing these services.

3. As a concept, PHC is not generally known by the community residents. The different activities which have been implemented in their barangays are not consciously associated with a primary health care strategy. More IEC efforts appear necessary to convey the meaning of PHC.

B. Attitudes on PHC

1. BHWs and BHSMs were generally optimistic that the community residents would be responsive to PHC activities. Getting people to be involved in health promotion was not perceived to be problematic.

2. Instead, what these community workers deemed as problems were the insufficiency of medicinal supplies and the limited number of health workers. Thus, strengthened logistics and manpower support were recommended.

3. Program implementors echo the view of community health workers. Logistics, coordination, supervision and manpower were cited as problem areas, along with the need for improved training programs for midwives and BHWs.

4. Among community residents, the Botika sa Barangay was considered as a positive factor because of its accessibility as a medicinal supply point. However, commercial drugstores and the RHUs remained as the preferred sources of medicine. It was recommended that drug samples should not be sold in the BSBs, and that the variety of stocks be increased so as to respond to many more health complaints.

C. Work Attitudes of Personnel

1. More often than not, BHSMs and BHWs reportedly enjoy good working relationships. This aspect of their work may thus support health service delivery.

2. Opportunities to meet people and to help the needy were considered as sources of job satisfaction by BHWs and BHSMs. On the other hand, sources of dissatisfaction include the lack (or insufficiency) of material support for doing community work within PHC.

CONGRUENCE OF FINDINGS: Phase I and Phase II Documentation

Given these findings from the field, the next question to be asked is: "To what extent are these processes similar to those obtained from secondary sources (Phase I)?" In evaluating these findings, three things must be remembered:

First, that the two sets of data were collected about a year apart.

Second, that the focus of Phase I was on developing regional progress indicators for PHC, and that barangay or municipal indices are not consistently reported.

Third, that the discussion will extrapolate the status of regional PHC implementation from the experiences of 17 barangays.

A. Social Preparation

1. Status of BHW Training

Table 37. Status of Trained BHWs in 6 Regions for Two Years

Region	1983[6/]		1984	
	No. of BHWs	Ratio to HH	No. of BHWs	Ratio to HH
3	6,636	1:108	8,466	1:97
5	2,164	1:250	9,126	1:59
7	4,598	1:136	3,504	1:76
8	3,436	1:138	339	1:83
9	23,909	1:15	8,731	1:19.3
10	16,254	1:25	3,249	1:25

In two of the regions which were studied, there was an appreciable increase in the number of BHWs trained for PHC within a one-year period. The greater difference may be noted in Region 5, where more than 7,000 additional BHWs were trained in 1984 (Table 37). In Region 3, almost 2,000 new BHWs were also trained. These additional manpower development efforts diminished the BHW per household ratio in the two regions - from 1:250 to 1:59 in Region 5 and from 1:108 to 1:97 in Region 3.

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[6] From PCF. A Progress Report on the Status of the Implementation of the PHC Approach in the Philippines. Metro Manila: 1983, p. 19.

While the number of trained BHWs in Regions 7 and 8 dwindled in the past year, the training efforts still served to decrease the BHW:HH ratios. In Region 7, it fell from 1:136 to 1:76, and in Region 8 this was lowered to 1:83 from 1:138.

The ratio of BHWs to households remained unchanged in Region 10 (1:25) and increased slightly in Region 9.

B. Initial Implementation of Activities

Reports on the PHC activities of provinces were available in 1983 for Zambales, Sorsogon, Zamboanga del Norte and Misamis Oriental.

The PHC activities undertaken at that time included environmental sanitation projects, herbal gardening, manpower training (BHWs), provision of safe water supplies and livelihood projects. Thus, the types of activities initiated in 1984 were essentially similar, but were supplemented by nutrition, FP and immunization campaigns.

C. Intersectoral Linkages

In both 1983 and 1984, the MECS and the MSSD were singled out as the agencies which collaborated most often on PHC activities. To a lesser extent, the following agencies were also mentioned in 1983: MA, POPCOM, MAR, PNRC, PCA, NMPC and

and MPWH. Nongovernmental organizations included the CRS, the Jaycees, archdioceses and some private companies. Again, these agencies were seen to have been involved in PHC work in 1984 (See Chapter 9), along with NEDA, NNC, and MLG, among others.

D. Problems in PHC Implementation

Problems cited in 1983 by regional reports include the following:[7]

1. interagency linkages
2. communication and monitoring
3. uncooperativeness of barangays
4. lack of skills of BHSMs and BHWs
5. poor leadership qualities of community leaders
6. logistics (funds for IGPs, medicinal supplies)
7. poor interest of volunteer workers
8. peace - and - order
9. political interference
10. nonmonetary incentives for BHWs.

On the provincial level, the following were problem areas:[8]

1. inadequate social preparation
2. discontinuity of projects due to political intervention

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[7](From Regions 7, 8, 9, and 10), Ibid.

[8](From Zambales, Sorsogon, Zamboanga del Norte, and Misamis Oriental), Ibid.

3. poor intersectoral collaboration
4. poor logistics (funds, supplies)
5. lack of training programs
6. unrealistic targets

In Phase II, problems often cited included some of these same factors (Chapter 9) such as: personnel limitations (number, training and qualitifications); lack of funds; inadequate incentives for community health workers; and interagency coordination on activities and schedules. In Mindanao and Samar, peace and order problems remain deterrents to PHC activities; in other areas, poor IEC efforts were mentioned as a problem.

To a large extent, therefore, problem areas identified in 1983 continued to affect PHC goals a year later. A positive note in the latter findings, nonetheless, is that there were no overriding complaints concerning social preparation and the disinterest of communities in PHC. Instead, community willingness to be involved in PHC was perceived by the community health workers.

E. Botika sa Barangay

In 1983, the largest number of BSBs was reported in Region 10, followed by Regions 5, 9, 8, 7 and 3.[9/] In 1984

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[9] Ibid, p. 21

(Table 4.1) the BSBs in Region 3 had increased by 66% and by 4 1/2% in Region 7. In contrast, almost 10% of BSBs in Region 8 were no longer functional after a year. Dropouts were also noted in Regions 9 (7.6%), 5 (4.6%). Fortunately, the number of BSBs which ceased to function in Region 10 was very small: less than one percent. Generally, therefore operational BSBs tend to remain open even after a year.

Table 38. Number of Functional BSBs in Past Two Years

Region	Functional BSBs 1983[10]	1984	Percent Change
10	1,547	1,545	-0.17
5	1,376	1,312	-4.65
9	1,255	1,159	-7.65
8	955	865	-9.42
7	838	876	4.53
3	649	1,078	66.10

This two-phase study indicates that the state of PHC implementation in two years has improved in the following aspects:

1. in terms of the number and ratio of BHWs for households
2. the variety of PHC projects/elements introduced
3. the number of participating line/NGO agencies

[10]Obtained from regional reports, MOH Regional Offices

Furthermore, the relative statibibility of BSBs was seen from the amassed information. Few changes have been noted, however, in terms of solving the problems which plague implementation.

12. *RECOMMENDATIONS*

As a final objective of this documentation project, some directions for improving or enhancing PHC implementation are identified in this chapter. These recommendations are derived from the PHC objectives themselves, in relation to observed processes and accomplishments of the strategy in the areas visited.

ON SOCIAL PREPARATION ACTIVITIES

In order to maintain the community focus of PHC, the following are recommended:

1. More extensive community orientation and informational meetings are needed to introduce the PHC concept, particularly in terms of its goal of maintaining health through community self-reliance. From the documentation, it appears that program implementors rather than barangay residents have received a wider variety of training exposure. Thus, they appreciate the PHC process better than ordinary residents, who are not even consciously familar with "primary health care."

2. A complementary strategy to the first recommendation is to re-emphasize organizing and mobilization methods in the training of BHSMs. From their own reports, the midwives are trained for the delivery of health services associated with PHC, as well as for community organization and community

development. In their actual work routine, however, these midwives have concentrated on service delivery rather than organization. Reorientation on the importance of the community component in PHC thus appears necessary.

3. Another complementary effort is to enhance community involvement in the selection of barangay PHCC members. Three-fourths of the PHCC members interviewed had been recruited by midwives and local officials. Such a procedure fails to guarantee that these persons enjoy credibility in the barangays or that they have leadership qualities. Popular election, in contrast, will better identify the accepted and influential members of the communities.

4. Measures must be instituted to improve the community image and credibility of the BHWs. As noted from the results, BHWs function for PHC only part of the time. As such, few have managed to reach out to the families supposedly under their care. Consequently, BHWs are not generally recognized to be knowledgeable on health matters. "Hilot" and "herbolarios" are even considered to be more health-wise than the BHWs. Again, the passive image of the BHWs which emerges from the survey may be traceable to an inadequate orientation on PHC and on poor leadership qualitifes for community work.

5. Finally, more conscious effort must be made to involve members of the community directly in the planning and implementation of PHC activities. In the instances where successful PHC efforts were reported, members of the barangay participated in all phases of the identified projects. Such a move may also diminish the obvious dependence of the community on health professionals for health solutions, and enable them to become more self-reliant in making decisions related to their health, nutrition and sanitation problems.

ON PROCESSES FOR COLLABORATION

The emerging picture of intersectoral linkages for PHC is vague and ambiguous. While structural provisions have been made (in terms of PHCCs), the procedural mechanisms are inconsistent and weak. The following steps are thus suggested:

1. Workplans which would concretely delineate interagency functions and roles for PHC must be developed. Otherwise, the present state of affairs will continue; that is, each participating agency works out its own schedules and projects for the barangays. As such, the BHWs and BHSMs are not always conciously aware of the interplay between these separate agency efforts and their own activities in PHC.

2. The planning, supervision and evaluation process at program levels must be more dynamic. This means more frequent meetings, updated monitoring and feedback reports and regular representation at the PHCC meetings. Only in this way can the problems at the grassroots be immediately identified and solutions worked out. Monitoring of supplies, manpower, and IEC requirements may also be improved through more frequent interactions of program implementors.

3. Positive collaborative efforts between BHWs and BHSMs must be encouraged further. Good working relations have thus far been reported by these individuals. Rewards or recognition for these efforts must be institutionalized and emulated by future workers in PHC. The corresponding material and nonmaterial incentives for these workers must also be readily available, so as not to dampen their enthusiasm for service.

ON ACTIVITIES FOR IMPLEMENTATION

The documentation reveals that certain health services related to some of the elements of PHC have been extensively undertaken. Elements which have not been widely attended to include the constant provision of essential drugs and the prevention and control of diseases. In line with these observations, the following are suggested:

1. Priority must be given to the adequate provision of medicines for common health complaints. In this connection, efforts must be taken to supply BSBs with good quality, low-cost drugs and other medical supplies. The BSBs have been found to be popular with residents because of their accessibility. Adequate supplies for the treatment of health complaints will improve the patronage of BSBs within the barangays.

2. Health education in disease prevention and control should be stepped up so that morbidity and mortality profiles rooted in respiratory and gastro-intestinal complaints, as well as the incidence of circulatory diseases, can be reduced.

3. Mothers with favorable child care attitudes and practices can be mobilized to assist in the further dissemination of appropriate health knowledge among others in the barangays. The findings indicate that about half of the housewives recognize the value of breastfeeding, immunization and family planning for health maintenance. Their own examples can be used to motivate other mothers to undertake the same practices.

4. More income-generating activities and food production projects must be systematically pursued. While it is true that health problems comprise a common felt need in the communities, economic difficulties are also cited very frequently. External

intervention in the economic affairs of the barangays appears warranted because the residents themselves perceive short-term (and largely ineffectual) solutions to these problems. Skills training and the infusion of credit for livelihood and food production activities must be programmed within the PHC.

These are some of the recommendations pertinent to the improved implementation of primary health care. As noted in an earlier chapter, there is no apparent resistance from the various sectors involved vis-a-vis the concept and the elements of PHC. The perceived problems rest with its operations and may therefore be overcome through policy decisions, logistics support, and re-orientation of its implementors. Finally, it may be best to remember that community self-reliance is a way of life. Its development thus cannot be pegged to short-term goals, but can be achieved only through patience, circumspection and empathy with the people.