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Community-based health programs

1. GENERAL INFORMATION

1.1 Title of practice or experience

Community-based health programs

1.2 Category of practice / experience and brief description

People's participation is the core principle of the community-based health program (CBHP) in the Philippines that differentiates it from the other health programs' approaches. Without people's participation, a CBHP would be just another "band-aid solution". CBHPs give primacy to the organization of the local people before they are implemented. Organizing the people would include activities such as education or consciousness-raising and leadership formation. It ensures people's participation in the planning, implementation and evaluation of the program. Thus, the success of any undertaking that aims at serving the people is dependent on the people's participation at all levels.

1.3 Name of person or institution responsible for the practice or experience

In the beginning, the Rural Missionaries organization of the Philippines was responsible for the practice. As the CBHPs increased in number, autonomous CBHPs were coordinated through the regional and national CBHP agencies. These included the following: Community-Based Health Services in Mindanao; Health Concerns (a pseudonym) in the Cordillera Region; National Ecumenical Health Concerns Committee for Protestant-based health programs; Rural Missionaries for Catholic-based CBHPs; and the Council for Primary Health Care (CPHC) for non-sectarian programs and overall national coordination. At present, the overall national coordination is managed through the Council for Health and Development (CHD).

1.4 Name and position of key or relevant persons or officials involved

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2. THE PROBLEM OR SITUATION BEING ADDRESSED BY THE PRACTICE /INNOVATIVE EXPERIENCE

In September 1978, an international conference on Primary Health Care (PHC), jointly sponsored by the World Health Organization (WHO) and the United Nations International Children's Emergency Fund (UNICEF), attracted delegates from 134 countries to Alma Ata, the capital of the Kazakh Soviet Socialist Republic. The objectives of the conference were basically to define, promote and obtain universal endorsement of and commitment to PHC. Practically all nations became signatories to the Alma Ata Declaration.

The conference **was** a useful opportunity for representatives of different countries to exchange experiences on prior PHC-like programs. But probably the most salient result of the meeting was its unanimous endorsement of the PHC approach as envisioned by the WHO. PHC was identified as the key to

attaining the goal of “Health for All by the year 2000”. “Health for All” had been adopted as a goal by the World Health Assembly in 1977, and was defined as “the attainment by all peoples of a level of health permitting them to lead socially and economically productive lives” (WHO, 1981).

Not only was the WHO’s definition of PHC ratified, but the conference appeared to put the stamp of expert and governmental approval on some of the operational modes supported by the WHO, notably the use of paraprofessionals or auxiliary health workers in lieu of physicians for the rapid extension of services in the Third World. This contradicted the physician-based models promoted by the Soviet Union and Cuba, but was deemed more appropriate in light of the constraints facing developing countries (WHO/UNICEF, 1978: p. 62). At its subsequent (1979) meeting, the World Health Assembly endorsed the Alma Ata Report and Declaration and approved a measure encouraging WHO member nations to formulate national, regional and global strategies of Health for All with PHC playing a central role, especially in developing countries (WHO, 1982: p. 5).

In the Philippines, the government as well as the non-governmental agencies rushed to launch PHC in recognition of the Alma Ata Declaration. The Commitment of the Philippine government to attaining the goal of Health for All in the year 2000 is embodied in the Letter of Instruction (LOI) No. 949 issued by the President of the Republic of the Philippines, the late President Marcos, on October 19, 1979. It mandated the Ministry of Health (MOH) to adopt PHC as an approach *to* the development and implementation of programs which focus on health development at the community level. This reflected the country’s recognition of the inter-relatedness of health and development, expressed as follows:

“The attainment of health for all Filipinos is both a means and an end of the overall national development program of the New Society; ... health and health-related activities of the overall national development program ... (MOH’s LOI 949, 1979).”

However, it has been claimed that PHC has had a long history in the Philippines even before the Alma Ata Declaration or the issuance of LOI 949 (CPHC, 1985; Galvez-Tan, 1987; Pesigan, Caragay and Lorenzo, 1992; Veneracion, 1993; Carabeo, 1994). Some medical practitioners from the private sector had been reaching out to the community from the late 1960s. A few examples of these were De la Paz of the Katiwala Program in Davao City, Viterbo of Roxas City, Macagba of La Union, Flavier of the Philippine Rural Reconstruction Movement, Campos of the University of the Philippines Comprehensive Community Health Program, Solon of the Paknaan Club Institute of Medicine Project and Wale of Silliman University. However, their efforts

were limited to their own territories and they were not able to extend their programs on a national level (Galvez-Tan, 1987).

It was only when the Rural Missionaries of the Philippines launched their pilot community-based health programs (CBHPs) in 1975 that a nationwide movement commenced. The Rural Missionaries first studied the prototypes mentioned earlier and, using the Catholic Church network, initiated programs in Luzon (Isabela), Visayas (Leyte) and Mindanao (Lanao del Norte). Their experiences were eventually adopted by the Protestant National Council of Churches in the Philippines in 1977 and Alay Kapwa Kilusang Pangkalusugan (AKAP) in 1978, both of which established nationwide networks. At present, these CBHPs have national and regional coordinating bodies. The Council for Health and Development (CHD) oversees the national coordination.

The Ministry of Health commenced a Research and Development project in PHC in 1978 with technical and funding support from international organizations such as the WHO. However, it was only in 1981 that the nationwide implementation of PHC started. As of 1985, according to Department of Health documents, the "Primary Health Care approach [was] officially working in all barangays [communities] except for one per cent of these wherein there [was] an unstable peace and order situation."

Five years before the adoption of PHC in the country, the CBHPs already practiced its basic principles. Although the CBHPs have jointly worked with the government through the Department of Health in the propagation of PHC, it did not take long for them to feel that there was a lack of political will on the part of the government to correctly implement PHC. While CBHPs recognized the Alma Ata Declaration, they claimed that it fell short of accurately diagnosing the root of the health problems in the country. The comprehensive concept of PHC had reverted to selective PHC as a result of political, economic and practical factors. PHC became equated with episodic campaigns and basic services couched in child-survival rhetoric (e.g., Growth Monitoring, Oral Dehydration, Breastfeeding and Immunization).

The poor health situation of the Philippines is a reflection of the poverty of the people. The common health problems of the people include malnutrition, high infant mortality rate, poor environmental sanitation, lack of safe potable water supply, high incidence of communicable diseases, maldistribution of health personnel and facilities, and prohibitive cost of medical care.

The health-care system in the country as a whole has been and is still highly dependent on the West in terms of technology, organization, training, education and research. This kind of dependency has made the health system inadequate and ill-equipped to handle the health problems of a country (or a region) that is largely underdeveloped.

3. DESCRIPTION OF THE PRACTICE/INNOVATIVE EXPERIENCE AND ITS MAIN FEATURES

Guiding principles

The CBHP is one of the methods to address the health needs of the people. It does not provide the solution to health problems but assists and facilitates in laying the foundation of a health system that is governed by the people at the community level. CBHPs are programs that aim to respond to the basic health needs of the people through education, training and services. It is a method or process of giving or transferring knowledge, skills and power to the people so that they become more responsible for their health. It strengthens the people's resolve to demand their basic right to good health. Therefore, the CBHP is a method of health-care development with and for the people at the community level.

The CBHP accords primacy to the organization of the people before it is implemented. Organization would include activities on conscientization and leadership formation. It ensures people's participation in the planning, implementation and evaluation of the program. The organizing aspect encompasses the philosophy of the health program that is holistic, that is, the health problems of the community are recognized to be inter-related with the economic, political and cultural problems of the society. The philosophy of the CBHP is seen in the perspective of the realization of a transformed health system.

The formation of an alternative health system which has preferential options for the poor and deprived must be accompanied by the transformation of social and economic structures. The perspective of community health work assumes that the health problems of society are not merely technical but are inter-related with the economic, political and cultural structures of society. Thus, no health program can solve the problems; they can only help set up the conditions and prerequisites for the achievement of a transformed health system. The solution to the health problems would therefore be structural and long-term in nature. However, on the immediate range, a response to the health problems is by having a health program that has a health component, an organizing dimension, a philosophy of a structural approach to health problems and a community counterpart, a program that is a venue of exposure for health professionals to harness their special skills and training to serve the people.

In **moving** toward the laying of a foundation for a transformed health system, any health program should be holistic in its approach; be people-oriented; and encourage responsibility, confidence, initiative and primary decision-making at the community level. Its components should include organizing, education, health skills training and appropriate curative medicine, re-

search, technology and self-reliance.

In the process of the implementation of a health program with the above-mentioned components, a transformed health system is foreseen, that seeks to serve the needs of the majority and encourages people's participation and one that is self-reliant.

Essential elements of CBHPs that have been recognized and described include the following:

- (a) the community knows, feels and accepts responsibility for community health, not just the health of the individual;
- (b) the community taps and develops its own resources to meet health needs, including personnel and material resources, organizations and institutions at all levels; and
- (c) community priorities are the priority focus of the programs.

In a CBHP, the initial goals, objectives and plans are open-ended and flexible. It considers the community's felt needs and not those defined by the health professionals. The program staff try to inspire, advise, motivate and demonstrate, but do not make decisions for the community. The community is strongly involved in all areas where decision-making is needed. CBHPs are therefore built from the grassroots up and are not handed down by the medical doctor or by institutions.

Any program directed toward the community will not work without the essential element of community awareness and community involvement in its planning and implementation (Galvez-Tan, 1985; Quesada, 1985). It must involve those who suffer from disease and poverty, and it must let them take the decisions and responsibility for their own health care. Unless the people in the community comprehend what the program is all about, prior preparation and involvement with the people will be to no avail. The programs may work for a time, but they will not endure.

In CBHPs, the basic principle is one of working with, and not giving to, the community to improve health. Finally, health by the people, rather than health to the people, is aimed at. The communities will, therefore, be on their way to becoming self-governing, self-sustaining and self-reliant.

Evolution and growth

Since 1973, non-governmental CBHPs have been part of the Philippine health-care system. In the beginning, these programs centered mainly on teaching paramedics in far-flung, neglected rural communities. In due time, CBHPs learned to uphold, support and eventually become part of the common people's aspirations and struggles (Council for Primary Health Care or CPHC, 1985).

In 1973, three nuns from the organization Rural Missionaries of the Philippines commenced discussions on a developmental approach to health care. They envisioned a health program that would meet the most essential needs of the poor. At the same time, they wanted to turn away from the paternalistic orientation of previous programs (CPHC, 1985; Baboon, 1993).

In order to conceptualize a health program that is truly responsive to the health and development needs of the people, the nuns undertook a deeper study of the health situation and the existing health-care system. They saw that what was preventing good health for many Filipinos was poverty brought about by social inequalities. They realized that the existing public health-care system consisted mainly of charitable curative services, and was urban-based, medical doctor-centered and largely inaccessible to the most needy. Private medical services were way beyond the reach of the majority. Thus, the concepts and role promoted by the new health program reflected a deep dissatisfaction with the prevailing state of the health-care system.

In response to the health system's urban-centeredness, the program tried to reach out to the most remote and neglected rural communities. Instead of adopting a charitable orientation, it encouraged the people's acceptance of responsibility for their own health. It enabled them to recognize and be proud of their own resources. Rejecting the medical personnel-dependent concept of health care, the program trained local community members in basic health knowledge and skills. These were the first steps towards self-reliance in caring for their community's health.

In contrast to bureaucratic decision-making on health and related matters, the program advocated people's participation. Community members were encouraged to reflect on their health situation, to plan ways of improving it, and to take group action. In 1974, the Rural Missionaries' Health Team was formed. It was composed of two nurses and one chemist. They acted as a mobile team. Together with a few concerned health professionals, they gave paramedic training to local community leaders in rural and urban poor areas, mainly in Luzon. This was in line with their thinking that health education and prevention were more vital to health promotion than curative services.

The Team produced the *Community Health Worker's Manual* and *Trainer's Guide to Community Health*. The manual emphasized the "why's" and the "how to's" of treating common diseases in the community. This manual served as a valuable reference material to the health programs and health workers for many years. The Team visited existing non-governmental health programs throughout the country to find out how they were operating. At the same time, they actively promoted their idea of a self-reliant health program to different Catholic dioceses and groups.

What the Team attempted to do was to bring education and the wonders

of modern medical science to the people in the barrios or villages. It took less than a year for them to realize the inadequacy of their mobile-services approach. The paramedic-training component was good as an advance on the previous system. But experience proved that it was not enough for a mobile team to visit communities periodically and offer such training. They saw the need for closer integration with the people at the village level and to know first hand the daily life of the people, their problems (including non-health ones) and how they viewed their situation.

This realization provided the impetus for the Rural Missionaries to set up pilot programs where staff could live in the community on a long-term basis. In July 1975, pilot programs were started in three dioceses in the three major areas of the country: Isabela province in Luzon, Leyte province in the Visayas, and Lanao del Norte in Mindanao.

In June 1976, the first joint staff meeting to evaluate the three pilot programs of the Rural Missionaries was held. The staff made use of structural analysis*. This strengthened the view that the health situation of the people was but an element of a bigger social situation and that it was influenced by, as well as influenced, the social context.

The recognition of the structural causes of ill health inspired the development of CBHPs to a new level. The structural approach to health problems was a step forward in that it exposed the interconnections of the health system with other social systems: economic, political and cultural. Thus, a more holistic and thereby more accurate picture of health emerged. Moreover, structural analysis introduced the idea of the health program as an agent of change, of "influencing rather than being influenced by". The analysis showed that concern should not just be directed to changing the health system but also to influencing all the other systems, to effect change in the whole social structure.

Alongside the use of structural analysis to analyze health problems, CBHPs, by this time, emphasized the need for strong community-organizing work complemented by the training of volunteer community health workers (CHWs). These trained CHWs, together with program staff who were closely integrated into the communities, would provide health services appropriate to the needs of the communities.

In terms of actual activities, this period saw the improved skills training of CHWs who were elected by the village people. **Also**, health surveys were undertaken in order to prioritize needs and to formulate plans of action. Case finding was done in order to give proper treatment and to directly follow up

* Structural analysis is a way of studying the organization and characteristics of a given society by looking into its economic, political and cultural systems and their interaction.

recipients of care. Coordination with government rural health units in terms of reporting disease incidence was intensified.

Through shared assessments and staff development activities, consolidation of the original pilot areas and expansion to nearby communities were undertaken. The Rural Missionaries assisted other dioceses in establishing their own programs and recruiting staff who were people-oriented and committed to community development work. The CBHP approach was also advocated for health professionals, priests, nuns and lay church workers by way of seminars and conferences. Philippine efforts were shared with other countries through attendance of CBHP staff at international conferences.

At this time, CBHPs were serving the purpose of testing alternative concepts of health and development. One aspect was the feasibility of a health program geared toward health promotion and disease prevention rather than toward cure. According to Galvez-Tan (1985), these were the questions confronting the team then: "Would the people accept such an approach with its inherently slow effects and quiet impact? To what extent would the program be able to mobilize local resources (material and human) without resorting to monetary rewards for CHWs?" (p. 3).

In 1977, the second evaluation workshop of the pilot programs was conducted. Its distinct outcome was the re-affirmation of the crucial role that community organizing played in CBHPs. Therefore, there was a need for CBHP staff, including health professionals, to undergo training in community organizing (Pagaduan and Ferrer, 1983; CPHC, 1985).

Community organizing at this time was still new to programs and organizations engaged in development work. Its application in the Philippine socio-political setting needed to be explored, considering that the concepts and methods of community organizing were originally applied in poor communities in the United States of America.

Community organizing taught a number of creative ways of organizing people around issues, identifying and developing local leaders, planning and preparing for small and eventually bigger mobilizations, and collective reflection on actions. But some essential questions were overlooked, such as: What do we want to change in present Philippine society? Towards what kind of transformation are we working? Community organizing lacked a longer-term perspective so that its creative methods could not be used by organizers to progressively heighten people's awareness and progressively build genuine people's organizations (Quesada, 1985; Population Center Foundation (PCF), 1990).

Despite the limitations of community organizing as understood and practiced at this time, the method did provoke critical thinking. In some areas, the health workers confronted local issues such as lack of health services or

the absence of medicines. A few immediate demands were won. However, reaction to such efforts was swift. The CBHP, from the start, had been under a cloud of suspicion as a “subversive” program. With its revitalized organizing component, opposition heightened.

Some program organizers who were rigid in their application of community-organizing methods eventually became frustrated or stopped their programs altogether. Some tended to fall back on the health component, developing this more fully while the organizing work remained superficial. Other CBHPs forged ahead. With the help of other development programs which had learned their lessons earlier, and by the sheer dynamism of people’s organizations, these program organizers learned in practice what genuine people’s organizing meant (CPHC, 1985).

Because the programs facilitated more substantial integration of the staff with the most deprived lot in the communities, the social roots of ill health became more evident. The unfavorable health situation was seen to be caused by poverty which could in turn be attributed to such factors as landlessness, usury and the high price of agricultural inputs versus the low price of farmers’ produce. There was no effective channel to voice the farmers’ problems, much less to answer them. The seeming hopelessness of the situation bred fatalism and passivity. Superstitious beliefs only reflected the farmers’ desperate search for palliatives (Carabeo, 1994).

The religious men and women and the health professionals behind the CBHPs arrived at a profound and far-reaching conclusion. The underlying causes of health problems in society were deeply embedded in the social, economic and political structures of that society. The way to lasting good health for the Filipino people was through a radical restructuring of unjust systems, through wide-ranging social transformation. Health programs alone, even those similar to the CBHP, were not the answer to health problems. But they could be of great value in initiating and contributing to the process of social transformation.

This period also included several historical landmarks:

- (a) The National Council of Churches in the Philippines (NCCP) sponsored a consultation conference which paved the way for the establishment of the National Ecumenical Health Concerns Committee (NEHCC). The NEHCC, in turn, spurred the setting up of CBHPs by various Protestant churches and groups.
- (b) Alay Kapwa Kilusang Pangkalusugan (AKAP), a non-governmental organization which advocated community-based tuberculosis control programs, was started.
- (c) The first national consultation of health professionals working in CBHPs was held. It mandated the setting up of the non-sectarian Council for Pri-

mary Health Care (CPHC) to service and coordinate various CBHPs on a nationwide scale.

A substantial number of program documents and manuals were published and were widely disseminated in this period. These included:

- (a) A report of the first staff workshop of diocesan CBHPs;
- (b) Fr. Orlando Carvajal's *Of Myths and Realities: A Structural Approach to the Health Problem* (1976); and
- (c) Jaime Galvez-Tan's series of articles, *Programa Hun Katilingbanon Para Hun Maupay Nga Panlawas (MAKAPAWA): A Community-Based Health Program; The Philosophy of Community-Based Health Programs, and Strategies and Methods in Building Community-Based Health Programs: The Samar-Leyte Experience* (1978).

In the succeeding years, CBHPs in various regions tried to find their own ways to maximize the use of the programs as support for genuine people's organizing while recognizing the concrete conditions in their regions.

CBHPs joined with other programs organizing along sectoral lines (e.g., organizing farmers, fishermen, rural women and youth). As an entry point, CBHPs provided valuable initial information about the communities. But in areas where the people had strong grassroots organizations, CBHPs acted as a support program. This meant that more time and effort was spent on improving the health component since basic organizing work had been accomplished (CPHC, 1985). For example, the people's organizations could be relied upon to select service-oriented and strongly motivated health workers from among their ranks. It was no longer necessary for the CBHP staff themselves to identify potential CHWs and to generate community support for them. Once the local people's organization agreed to establish a CBHP in their community, the staff could count on their cooperation and support.

More effort was also directed to increasing the awareness of medical and allied health professionals and students. First, there was the need to convince them of the structural causes of as well as the solutions to the problem of ill health. Second, there was the need to draw them toward sharing their special knowledge and skills with the people so that the health needs of the vast majority of Filipinos would be met.

The growth and strength of CBHPs were witnessed in the significant improvements in the content and methods of health and leadership seminars that contributed to the continuing consolidation of CHWs' knowledge, skills and attitudes in health and leadership. A sizable number of CHWs were now trainers themselves. They were a boost to understaffed programs since they could be relied upon to teach basic skills to new CHWs.

CHW associations were being set up at different levels – diocesan, subregional and regional. This was particularly evident in areas like Mindanao

where most of the older and more advanced programs were located. These CHW organizations provided a venue for sharing and for mutual support in difficult times. These organizations were also proof that health care can be “in the hands of the people”.

CBHP staff had expanded too, both in numbers and in the capacity to meet increasing and more complex requirements of the programs. Most important of all, the majority remained steadfast in their devotion to the cause of the people for whom they worked. Increased coordination of autonomous CBHPs was now made possible through the establishment of regional and national CBHP agencies. Some examples of these agencies included the following: Community-Based Health Services in Mindanao; Health Concerns (a pseudonym) in the Cordillera Region; the NEHCC for Protestant-based health programs; Rural Missionaries for Catholic-based CBHPs; and the CPHC for non-sectarian programs and overall national coordination. Such agencies serviced the training, education and research needs of CBHPs within their scope of responsibility. They monitored progress as well as facilitated exchange of experiences and resources.

Two developments external to CBHPs served to buttress the continued growth of the programs. One was the acceleration of organizing efforts among the grassroots in the rural areas. The other was the activation of institutional health workers, students and professionals in the cities to campaign for the CBHPs’ interests, as well as to bring to public attention the worsening health conditions of the people (CPHC, 1985).

With the growing number of people’s organizations in the rural areas, the CBHPs had been relieved to a large extent of the responsibility for undertaking basic organizing work. Their role now was to assist people’s organizations in meeting the health requirements of their communities. This meant sharing with the leaders and their members the analysis of the national and local health situation. It involved helping them to choose their CHWs based on criteria mutually agreed upon by the community representatives and the staff. It entailed planning a series of health training workshops wherein knowledge and skills were gradually expanded. Health education and medical services were also undertaken. In this way, the CHWs became immediately useful to the community and they were able to apply their newly acquired abilities.

In some areas in the country, particularly in the Cordillera, the community health nurses (CHNs) played a key role in the establishment of CBHPs. In setting up a CBHP in the community, the CHNs utilized several strategies and implemented programs to contribute to the attainment of their collective visions, missions and goals. The approach adopted hinged on a development framework that locates health work in the wider context of development work. As such, it was viewed as a holistic and comprehensive approach. The core of

such an approach revolved around organizing the poor and depressed communities they served. This involved the continuous and arduous process of making the people aware of their conditions and mobilizing them to take a direct hand in solving their own problems. The experiences of the CHNs revealed a wealth of insights, particularly in the use of the community-organizing process as a powerful tool in empowering the people.

In community organizing, the CHNs went through different phases, but not distinct steps, in establishing a CBHP. In the initial phase the CHNs evaluated the community's needs and planned an organizational structure composed of potential health workers who were eventually trained to service the community. Thus, the formation of a health organization eventually incorporated other community concerns as a result of continuing awareness-building by the community involved.

After the CHNs had identified the area or village where they could start their organizing efforts, they had to identify potential leaders, who were formed into a core group. A member of the team was given the role of a community organizer. In cases where no other member of the team had formal training in community development or organizing, the CHN accepted the role.

The CHNs guided the core group in carrying out their initial activities. Constant home visits were proven to be effective in ensuring accomplishment of their group and individually assigned activities. Planning was not the only activity that needed the guidance of the community organizer. In implementing the plans which had been agreed upon, the community organizer also had to be one with the core group. Other members of the team were also encouraged to participate in as many activities as possible. They served as role models for the core-group members. This facilitated the team's integration with the group and with the community. It assisted in showing their sincerity in helping the people. Also, an important activity in which the CHNs guided the core-group members was the timely evaluation of their actions and activities.

After the core group had been formed and trained, other members of the community were encouraged to form and join a community organization. This organization was envisaged to facilitate community participation in health and other development activities. The organization-building phase signaled the start of community self-management of the development program.

The organization-building experiences of the CHNs fell into two different approaches, namely: establishing a Barrio/Village Health Care Council without necessarily **forming a** community-wide organization, and establishing a community organization complete with a leadership structure at its helm. The determining factor as to which approach was adopted was the prevailing conditions in the community at the time the organization was being established. The ultimate aim was to form a structure or organization that would

coordinate and become responsible for all the community-wide health and development activities.

By establishing a health organization prior to expansion into a community-wide body, community activities were centered at the committee level, thereby minimizing bureaucratic decision-making. On the other hand, the second approach, which involved the outright formation of a functional community organization, facilitated the dissemination of information, training of community residents and their mobilization to act on common concerns. Through the second approach, the community could be easily linked with other organizations at the municipal and provincial levels at a later time.

The CHNs worked on four major activities in this organization-building phase, namely: pre-organization-building activities; organizing and setting up the *barrio* health committee; training and education of the organization; and mobilization of the health organization.

4. DESCRIPTION OF THE INSTITUTION RESPONSIBLE AND ITS ORGANIZATIONAL ASPECTS

While the Rural Missionaries organization was initially responsible for overseeing the CBHPs, a number of regional and national CBHP agencies were subsequently set up to assume the role of coordinating amongst the growing number of autonomous CBHPs. Examples and brief descriptions of such agencies have been provided in the preceding section.

Twenty years after their founding, in July 1989, CBHPs formed their national consortium – the Council for Health and Development (CHD). Through the consortium, CBHPs have vowed to unite and work to build a people's health movement that will strengthen the broad movement for social change. They have formulated a declaration of their Vision, Mission, Goals, Strategies and Programs that should guide health work. With the formation of the national consortium, CBHPs look forward to better coordination and better services for their beneficiaries. The CHD continues to improve through better communication and utilization of resources among members.

5. PROBLEMS OR OBSTACLES ENCOUNTERED AND HOW THEY WERE OVERCOME

The problem of inaccessibility to health services has been solved by setting up health structures within the respective areas. Many communities have set up a cooperative Botika sa Barangay (Community Pharmacy) that stocks

both chemical drugs and herbal medicines. Guided by the principles of rational drug use and traditional healing practices, the community pharmacy provided medicines to the people at a low cost. The money earned was then returned to the community fund. Even neighboring *barangays* benefited from the available drugs (Baboon, 1993).

In one instance, the CBHP in Ilagan, Isabela, set up a referral center. Here, CHWs diagnosed patients and referred those needing secondary or even tertiary health care to hospitals. The referral center became a venue for the CHWs' continuing education. With the guidance of health professionals with whom they discussed the cases, the CHWs were able to develop their diagnostic skills. The clinic also had laboratory facilities run by the CHWs themselves.

In another example, in Bonggao, Tawi-Tawi, the people themselves were able to convert a community surgical hospital into a primary referral hospital. The hospital used to cater for only a few residents who could afford the specialized services it offered. The CBHP helped reorient the hospital staff, including the administration, to primary care. From a purely Western mode of treatment, the hospital began to offer traditional modes of treatment such as acupuncture, herbal medicine, ventosa, moxibustion and pranic healing. The poor were able to afford the hospital's services.

At first, according to Sr. Eva, one of the pioneers of the CBHP, the bishop was against the hospital's reorientation. Later on, however, people began to see the advantages of this set-up. From its traditional role of giving "extension" services to the poor community, the hospital in Tawi-Tawi instead became an extension of the community. Its services are now determined by the needs of the people. There was better rapport between Christians and Muslims in that area as they got together and actively participated in finding solutions to their health and economic problems.

6. EFFECTS OF THE PRACTICE/INNOVATIVE EXPERIENCE

Through the CBHPs, people began to discover their potential and power to effect changes in their communities. Through proper health education, people were able to manage common illnesses such as colds and coughs, measles, diarrhea, fever and tuberculosis, among others. They were also able to launch campaigns to prevent the onset of diseases endemic to their area such as malaria. Environmental sanitation and safe water supply were some of the projects undertaken by the communities.

The people became aware, not only of their health problems but, as a result of CBHPs' holistic approach to health care, also of their economic and political status in Philippine society. Hence, their heightened awareness led

the people to challenge existing structures and to transcend “traditional” roles. Thus, peasants now confronted the landlord-tenant relationship and the urban poor confronted the national housing problem. Women now took on more decision-making roles in the community and encouraged their male counterparts to help at home.

Having evolved from the earlier concept of a paramedic-training program, CBHPs could take pride in health programs that attended to the health needs of the community members from the primary to the secondary and tertiary levels. **CBHPs** also developed a referral network where medical cases beyond the program’s capacity were referred and transferred to other programs, health professionals or hospitals.

7. SUITABILITY AND POSSIBILITY FOR UPSCALING

After a community organization and/or a *barrio* health committee had already been established and the community residents were already actively participating in community-wide undertakings, the consolidation and expansion phase in the establishment of a CBHP followed. At this point, the different committees set up during the organization-building phase were already expected to function by way of planning, implementing and evaluating their own programs, with the overall guidance coming from their leaders. Any consolidation work strengthened the whole community organization, especially its working committees.

Consolidation referred to the process of molding the community organization into one cohesive unit (Health Concerns’ *Annual Program Report*, 1993). It basically entailed strengthening the leadership group and uniting the membership in terms of the orientation, direction and objectives of the health program.

Expansion work referred to the activities of the community organization in widening the area of influence of the community development program. In expansion, the leaders and members of the community organization were able to apply and further develop their skills in development work, aside from assisting other communities in establishing their own health program.

Such upscaling prepared the community for the eventual phase-out of the CHNs and was achieved through various strategies such as education and training; networking and linkaging; conducting mobilization on health and development concerns; implementation of livelihood and related development projects; and developing “secondary” leaders.

The primary objective of education and training was to unify the members/residents on the goals, objectives, activities and methods of the program

through regular planning and evaluation sessions, consultations, committee meetings and general assemblies, small group discussions and formal training sessions.

Networking and establishing linkages was another strategy found useful in consolidating the gains in organizing work. In this method, permanent structures in place of the non-governmental organization should take on the lead role of assisting the community organization once the CHNs have been phased out of the area. At this point, the linkages with service delivery agencies should have been formalized. Basic services could then continue even without the assistance of the nurses or the non-governmental organization.

Since community problems were only manifestations of issues that were of much wider scope, it was the social responsibility of the organization to join larger networks, municipality- or province-wide, with parallel goals and objectives. Among the activities and/or networks which community organizations could join were municipal/provincial CHWs' associations; region-wide CHWs' consultations with the Department of Health; region-wide health training; alliances in support of health issues such as the implementation of the Generics Act; and alliances to promote PHC and CBHPs.

Mobilization as a strategy was significant during this phase of the organizing process because of its proven effectiveness in developing the positive attitude of each organization member toward another and providing learning experiences related to the theories of leadership and management taken up during the leadership skills training. At this time, mobilization was not only limited to local health issues alone but included broader concerns. For example, the CHWs were involved in a province-wide campaign for immunization for control of tuberculosis. Mobilizations like these recognized the capabilities of the CHWs and leaders as incentives. Community-level mobilization was usually initiated and coordinated by the different committees of the organization or by the village health committees. The team at this point is preparing for its phase-out, and thus needs to develop the community residents' capability in managing the program by involving them in the different mobilization activities.

Another strategy employed was the implementation of income-generating projects. This component of the program was envisioned to generate funds for the community organization for use in implementing its various health activities. Under this scheme, the organization was given seed capital which members could lend to community residents for micro-enterprise investments or, collectively, for a consumers' agricultural or marketing cooperative. The proceeds of the lending activities or the profits of the community enterprise were accumulated and served, in turn, as seed capital for similar activities in other depressed communities at a later date.

The identification and development of “secondary” leaders or second-liners – people who could take on the role of the core-group members in the event that some became inactive – was another method adopted. In this method, the same principles that guided the formation of the core group and the barrio/village health committee were employed. Developing secondary leaders was usually not a separate activity from those in the organization-building and consolidation phases. It was easier to develop “secondary” leaders if they were included in all activities initiated or coordinated by the community organization.

Expansion work was less demanding than consolidation work; since the nurses and non-governmental organization had gained extensive experience in site selection, the task of looking for another project area should be less difficult. In searching for expansion sites, the same principles and processes applied in the initial search for project areas were followed. To facilitate project implementation in both the old and the new sites, the expansion area(s) needed to be contiguous to the old sites so as to facilitate mobility of the community organizer and the other staff. The expansion site(s) should be in the same Department of Health catchment area as the old site(s), so that political conflict would not exist between the new and the old project sites.

Expansion work was closely linked to consolidation work. Expansion was based on the strength of consolidation. Thus, no expansion was initiated if the community organization was not yet capable of planning, implementing and evaluating programs for the community’s identified health needs. Furthermore, the expansion of the program to other communities was an opportunity for the team to consolidate the community organization established. Members of the barrio/village health committee acted as organizers, trainers or even consultants to the expansion communities.

8. SIGNIFICANCE FOR (AND IMPACT ON) POLICY-MAKING

The Alma Ata Declaration of 1978 was seen by many as a breakthrough, for it officially declared the pursuit of health as inseparable from the struggle for a fairer, more caring society. The Declaration was a response to the failure of Western medicine to meet the health needs of a large portion of the world’s population. It adopted a comprehensive approach to meeting people’s basic needs through Primary Health Care. The approach called for strong community participation, accountability of health workers and health ministries, and social guarantees to make sure that basic needs of the people were met.

The trend in health care has been toward focusing on the welfare and future of the whole community rather than toward individual health care. This

trend can be traced to the experience of the CBHP, which grew from being a paramedic-training program to a community-based health program. Going by the vast and rich experience gained by the people in setting up a CBHP, it has been proven that with proper education, training and encouragement, the people can take care of their own health.

In transforming the health system to meet the health needs of the people, health programs should be comprehensive or holistic in their approach, people-oriented and self-reliant. Health is seen as only one component in the development of the community. Priority should be placed on using health as a way to motivate people to improve their standard of living and their quality of life rather than on emphasizing the acquisition of high-quality and sophisticated medical skills and treatment. The people should start to see that their health problems are related to food-production problems, nutrition, water supply, housing, education, income and its distribution, employment, communication and transport, and, ultimately, to political decisions. Physical health is not the only concern, as mental and social health should also be accorded due consideration. The total well-being of a community and its people is targeted.

Further, organizing and community development, which the people involved in the development of CBHPs nationwide already practiced, must be given importance. Though the development of CBHPs nationwide was initially slow, the CBHPs, implemented by health nurses, professionals and organizations, have expanded and strengthened to respond to the health problems of the people.

9. POSSIBILITY AND SCOPE OF TRANSFERRING TO OTHER COMMUNITIES OR COUNTRIES

Considering that many countries around the world endorsed the Alma Ata Declaration of 1978, it is thus possible for other countries to adopt the approach that the CBHPs in the Philippines have adopted to respond to the health needs of the people. The Declaration adopted a comprehensive approach, which called for active community participation to meet the people's health needs through PHC. This approach was also reflected in the development framework that guided the CBHPs. In countries where the existing health-care system falls short of meeting the needs of the people and lacks a community orientation, CBHPs could be utilized and developed. CBHPs are critical of the traditional approaches to health work and favor models based on empowerment and long-term solutions to social, political and economic injustice. They utilize a structural analysis of poverty and its effect on health. Using this analysis, poverty is viewed as a result of the inequalities of the socio-eco-

conomic and political system rather than as a product of personal deficits. Thus, health problems and poverty cannot be solved through modifying health behaviors and individual lifestyles.

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