1-1-2024

Gains and Challenges of the Barangay Health Worker (BHW) Program During COVID-19 in Selected Cities in the Philippines

Mikhaela Y.T. Baliola
Ateneo de Manila University

Margaret R. Golpe
Ateneo de Manila University

Leslie V. Advincula-Lopez
Ateneo de Manila University

Recommended Citation

Baliolaa M, Golpe M, Advincula-Lopez LV. Gains and Challenges of the Barangay Health Worker (BHW) Program during COVID-19 in Selected Cities in the Philippines. J Health Res. 2024; 38(1):-. DOI: https://doi.org/10.56808/2586-940X.1060

Journal of Health Research
eISSN 2586-940X

Volume 38 | Issue 1 Article 7

2024

Gains and Challenges of the Barangay Health Worker (BHW) Program during COVID-19 in Selected Cities in the Philippines

Mikhaela Ysabelle T. Baliolaa
Development Studies Program, Ateneo de Manila University

Margaret R. Golpe
Development Studies Program, Ateneo de Manila University

Leslie V. Advincula-Lopez
School of Social Sciences, Ateneo de Manila University, Quezon City, PHILIPPINES

ORIGINAL STUDY

Gains and Challenges of the Barangay Health Worker (BHW) Program During COVID-19 in Selected Cities in the Philippines

Mikhaela Y.T. Baliola [a], Margaret R. Golpe [a], Leslie V. Advincula-Lopez [b,*]

[a] Development Studies Program, Ateneo de Manila University, Philippines
[b] School of Social Sciences, Ateneo de Manila University, Quezon City, Philippines

Abstract

Background: **The Philippine Barangay Health Worker (BHW) program extends the accessibility of health care services at the community level. BHWs are trained volunteers who perform various health-promoting and health-educating tasks and provide primary health care (PHC) services within their communities. However, the weak implementation of policies meant to protect their welfare, like the BHW Benefits and Incentives Act (Republic Act No. 7883), translates to challenges that impact the sustainability of the BHW program. This qualitative study aimed to explore the BHWs' experiences with RA 7883 and how its implementation shaped their overall role as frontline health workers during the pandemic.**

Method: **The researchers conducted key informant interviews in selected barangays in Biñan, Laguna, and Project 7, Quezon City. The participants included BHWs, community health workers (CHWs), co-workers, supervisors, clients, city program coordinators, and BHW district presidents. The researchers thematically coded the interview transcripts to analyze the data.**

Results: **The experiences of the BHWs showed how the gaps in RA 7883 implementation influenced the different aspects of their position. The BHWs expressed the need for sufficient support through remuneration and training opportunities to strengthen their competence and confidence in accomplishing their extensive tasks. The politicization of BHW through patronage politics also created inefficiencies that were detrimental to achieving the program's goals.**

Conclusion: **The poor implementation of RA 7883 undeniably affected the BHWs' motivation and the full realization of their roles. These inadequacies hindered the program's goal of equitable and accessible health services.**

Keywords: Barangay health workers, BHW policy, BHW program, Community health, Philippines

1. Introduction

Barangay health worker (BHW) is the local term for community health worker (CHW), referring to community members trained to serve as the first point of contact for patients to the larger health system [1]. The BHW program is the principal approach of the Philippine government to eliminate disparities in the delivery and accessibility of health services between urban and rural areas [2]. Prompted by the global adoption of the Primary Health Care (PHC) framework from the 1978 Alma Ata Conference, it aims to strengthen local health systems through robust primary care networks at the community level. It further champions health empowerment by broadening access to promotive and preventive health information and training BHWs to build communities' self-reliance.

In communities, primary care services are delivered and coordinated through various levels of government. This strategy is a product of implementing the Local Government Code of 1991, enabling local government units (LGUs) to assume more autonomy in governing, funding, and implementing the PHC approach, thereby decentralizing the Department of Health's (DOH's) role. Barangay health stations (BHS), rural health units (RHUs), and city or municipal health offices provide essential

Received 7 February 2023; revised 8 April 2023; accepted 8 April 2023.
Available online 14 September 2023

* Corresponding author.
E-mail address: lalopez@ateneo.edu (L.V. Advincula-Lopez).

https://doi.org/10.56808/2586-940X.1060

health services [3]. Multidisciplinary community health teams, composed of nurses, midwives, physicians, barangay nutrition scholars (BNS), and BHWs, lead service provision [4].

BHWs are frontliners in delivering certain primary care services to barangays (barangays are the "primary planning and implementing unit[s] of government policies, plans, programs, projects, and activities in the community" and serve as "a forum wherein the collective views of the people may be expressed, crystallized and considered, and where disputes may be amicably settled) [5]. They usually belong to their respective barangays. They undergo training from any authorized government and non-government agencies and voluntarily render community services following accreditation by the local health board [2]. As advocates, educators, and disseminators of information on health programs, BHWs are expected to be knowledgeable in basic concepts of family planning and reproductive health, maternal and child health, communicable and non-communicable diseases, and a healthy lifestyle, among others [6]. Previous studies have shown their role's impact on community health, for instance, through their contributions in improving children's nutrition outcomes [7] and in supporting primary postpartum maternal education health care [8]. The Philippine Statistics Authority reported an increase in the number of active BHWs from 200,897 in 2006 to 235,653 in 2015 [9].

The voluntary aspect of their work is integral to understanding their role. BHWs' voluntary provision of primary care services is repeatedly emphasized in legislation and relevant policies. For instance, the Implementing Rules and Regulations of the BHW Benefits and Incentives Act (RA 7883) state that volunteerism must be "consistently promoted and observed by all parties" [2], while DOH's BHW Pocket Handbook encourages BHWs to be dedicated "despite difficulties … and lack of financial support" [6].

While care and concern for the community are admirable motivating factors, the glorification of volunteerism, especially in formal laws and policies, poses the risk of legitimizing the BHWs' role as a form of free labor.

More recently, during the COVID-19 lockdowns, BHWs actively delivered PHC services despite mobility restrictions and additional pandemic mitigation tasks. The Commission on Population and Development (POPCOM is the central agency tasked with formulating policies, overseeing, and coordinating the implementation of population-related programs and strategies in pursuit of socioeconomic development) [10] and DOH trained BHWs to provide three months' supply of contraceptives to patients who could not visit the health center [11]. They also continued to deliver prescription medicines, schedule immunizations, perform prenatal checkups, and refer clients for consultations to the local health centers [12]. As a result, some municipalities saw an increase in the BHWs' caseload as more patients preferred visiting smaller RHUs for PHC to seeking outpatient services in tertiary facilities [12]. The value of the BHWs' contribution to delivering community care is thus evident—they play a critical role in bridging the community to the larger health system [13].

BHWs support communities' well-being by ensuring health programs reach the underserved population. More importantly, as members of the same communities they serve, they possess intimate knowledge of the communities' health needs and issues, rendering them essential voices of inclusion [14]. Furthermore, in response to the COVID-19 crisis, the BHW role had evolved to assist the Barangay Health Emergency Response Team (BHERT) in covering essential pandemic responses such as active contact tracing and monitoring of community members under quarantine. However, despite the enacted policies to support their role and work, perennial challenges to policy implementation remain. These challenges hinder BHWs from effectively fulfilling their tasks and serve as barriers to full and adequate recognition of their role in community health. Recommendations for enhanced training processes, more equitable benefits, and more explicit definitions of their role date back to as early as the 1990s [15].

Considering the strained public health infrastructure in the country, as well as the growing significance of robust local health systems prompted by the COVID-19 pandemic, this qualitative study explores the BHWs' experiences with RA 7883 as the primary policy supporting their role. The narratives shared by BHWs illustrate how implementing the policy, or the lack thereof, shapes their overall experiences as frontline health workers in communities during a pandemic. Aside from BHWs, the experiences and perceptions of their co-workers, supervisors, and patients about the BHW role were gathered to understand their experience comprehensively.

2. Policies shaping the BHW program

Republic Act No. 7883 formally recognizes the contributions of BHWs to primary care. Since they belong to the communities they serve, they are expected to understand the community well and "respond to local, societal, and cultural norms and

customs to ensure community acceptance and ownership" [16]. Beyond linking communities to needed services, the potential of their role to shape policy discussions as "social justice advocates" has been recognized in the literature [14]. With firsthand knowledge and experience in how socioeconomic conditions impact communities' needs, CHWs worldwide occupy a unique position that enables them to best illustrate such stories and issues to policymakers. The World Health Organization's recommendation for task sharing within the health system reinforces the significance and value of the BHWs' role. While CHWs do not replace the services of formal health facilities, they complement "weak or inaccessible points" [17].

In 2019, a Magna Carta of BHWs was proposed to standardize their honorarium and expand existing benefits to include one-time retirement cash incentives, career and educational advancement opportunities, health benefits, and insurance coverage, among others [18]. With sufficient trainings, supervision, and remuneration, BHWs can help address gaps in service delivery and expand the reach of health services [19]. Overall, they are critical contributors to the government's whole-of-society approach to universal health coverage, which promotes a robust primary care system that acts as the "navigator, coordinator, and initial and continuing point of contact" of patients in the formal health system [20].

Stipulations in legislation indicate more sustainable support for BHWs, but gaps remain in its implementation. Studies have repeatedly emphasized BHWs' general discontentment over their training, as this impacts their awareness and knowledge of specific health services, confidence, and, more importantly, patients' perceptions and feelings of trust [15,21−23]. Providers' self-perceptions of their roles have been acknowledged as influential factors in service provision [24]. Overall, such difficulties in their work compromise the quality-of-service delivery and the sustainability of the BHW program [1].

Expanding the competency of BHWs to improve the accessibility of services relies on sustainable support, including adequate resources in the form of fair remuneration, training and educational opportunities, incentives, and other benefits. Thus, it is necessary to examine related policy implementation and address the gaps, especially considering the changes brought about by the pandemic. As BHWs are key partners in community health care and critical components of an integrated system of care, this research explores the possibility of institutionalized measures to promote their well-being.

3. Methods

Guided by a constructivist paradigm, this research explored the in-depth experiences and insights of BHWs on the implementation of RA 7883. This paradigm focuses on the participants' dynamic construction of knowledge from their own lived experiences. This approach highlights how social interactions create meaning and calls for the researchers' reflexivity on their contexts, as these influence the interpretation of the participants' meanings [25,26]. To allow participants to describe their experiences, this study utilized qualitative data collection methods.

A content analysis approach was used to analyze data and identify common themes among the participants' responses. The themes for the research were derived from Campbell and Cornish's three related social contexts that affect the BHW program's approach as a health intervention: the material, relational and symbolic contexts [27]. The material context refers to the physical and economic conditions that relate to access to physical assets, incentives, and opportunities for health workers to apply their skills. The relational context comprises of social relationships and networks that have the potential for transformative communication. Lastly, the symbolic aspect refers to cultural meanings, such as social norms, values, and beliefs, that BHWs attach to their perception of their roles and personal motivations. The interactions of these contexts help identify enabling and restricting factors that influence the BHW program's effectiveness.

3.1. Selection of study sites and participants

The researchers chose participants from selected barangays in the City of Biñan in Laguna, CALABARZON Region, and Project 7 in Quezon City (QC) in the National Capital Region (see figure below). Biñan is a peri-urban area with 24 barangays and a population of 407,437 [28]. It is a significant economic and industrial hub in Laguna Province, situated southeast of Metro Manila. Meanwhile, Project 7 is in the southwestern part of QC. With over 2.96 million people, QC is the largest and most populous city within Metro Manila [29].

By choosing a peri-urban and an urban location, the researchers observed variations in the implementation of RA 7883 in different LGUs under a decentralized health system. They communicated with the leaders or captains of selected barangays to get their endorsement to proceed with the interviews. Data collection was conducted simultaneously at both sites.

The researchers did face-to-face and online key informant interviews with 22 total participants, consisting of 9 BHWs, 3 co-workers, 2 supervisors, 6 clients, and 2 family planning city coordinators. The focus on family planning is important as it is a critical health program given the high fertility rate in the country in 2019, the former Philippine president declared teenage pregnancy as a National Social Emergency [30]. The pandemic further strained the accessibility of essential health services as resources were diverted to the COVID-19 response and other health programs were left understaffed [31,32]. Thus, it was vital for POPCOM and the DOH to train BHWs to ensure the continued delivery of such essential health services [11].

In QC, the health department also handled its own group of CHWs who worked alongside BHWs and performed the same tasks and responsibilities. However, CHWs were considered as contractual employees of the city whereas BHWs were health volunteers from their respective barangays.

To be included in the study, BHWs must be knowledgeable on the different priority health programs of the DOH and have had prior experience advocating for and disseminating information about the programs. Informed by the assumption that their length of service shapes their performance, competence, and quality of service, less experienced BHWs are further considered to have served for less than a year, while more experienced ones have served for more than a year. Their co-workers and clients must have worked with them and interacted with them, respectively, for at least six months. Information was collected from multiple sources to achieve data triangulation and include the perspectives of other stakeholders on the performance of BHWs in providing health services.

The study used a purposive sampling technique guided by inclusion characteristics to recruit initial BHW research participants. The succeeding participants were identified using a snowball sampling scheme through the BHWs' referrals. As such, the study results have limited generalizability to all the BHWs in the country [25]. However, it provides an in-depth understanding of the BHW role at a specific point in time in the selected localities.

3.2. Data collection and management procedures

The researchers prepared three sets of interview guides to probe into the respective experiences and expertise of the BHWs, their co-workers, and clients. These were structured according to the framework used, and questions were developed and categorized into the three social contexts. Generally, the questions for the BHWs revolved around the BHWs' experiences with training, their allowances and incentives, interpersonal relationships with patients, and personal motivations.

The questions for clients delved into their experiences interacting with and receiving health services from the BHWs to capture their perspectives on the quality-of-care they provide. Those for co-workers pertained to their observations, perceptions, and contributions of the BHW role within the broader health system. The researchers adjusted the questions for the city coordinators and BHW presidents to look into leadership positions and experiences in implementing BHW policies in their localities.

The researchers did the interviews from March to October 2022, lasting from 30 min to 1 h. All interviews were audio recorded. The researchers transcribed the audio recordings verbatim to produce digital transcripts.

3.3. Data analysis

The recorded interviews were subjected to thematic analysis to identify and analyze emerging themes across the datasets. All of the participants' real names were also replaced with pseudonyms during data analysis and the writing of this article to comply with confidentiality agreements. The researchers coded preliminary observations and ideas, then combined codes into more general themes later in the study process. The resulting patterns and themes are presented in this article in the form of narratives, coupled with verbatim quotes from the research participants.

3.4. Ethical considerations

The University Research Ethics Office of Ateneo de Manila University approved this study on February 22, 2022.

4. Results

Of the 22 participants, half were from Biñan, Laguna, while the other half were from Project 7, QC, Table 1. Their profiles are detailed in the table below. All participants were female, aged 25−65 years. The BHW profession is largely a gendered role, with women comprising over 98% of the workforce from 2009 to 2016 [33]. This is due to the prevailing gender norms that associate caregiving roles in community health work with mothers' nurturing, caring, and educating tasks. Thus, women are often encouraged and even expected to take on care work within their community.

Table 1. Sociodemographic characteristics of the research participants.

BHWs and CHWs						
Participant	Locality	Sex	Age	Role	Educational attainment	Length of time rendering or using health services (years)
1	City of Biñan	F	30	BHW	High school	4
2	Quezon City	F	55	BHW	Vocational course (caregiving)	1.5
3	City of Biñan	F	55	BHW	Midwifery diploma (2 years)	10
4	Quezon City	F	59	BHW	High school	11
5	Quezon City	F	65	CHW	High school	13
6	City of Biñan	F	36	BVW/assisting BHW	High school	3
7	Quezon City	F	40	CHW	High school	7
8	City of Biñan	F	55	BHW (district president)	High school	22
9	Quezon City	F	56	BHW (district president)	College	25
Co-workers						
10	City of Biñan	F	54	BNS	High school	3
11	City of Biñan	F	32	DOH nurse	College	8.5
12	Quezon City	F	33	Population program officer	College	7 months
Supervisors						
13	City of Biñan	F	48	Midwife (supervisor)	College (midwifery)	24
14	City of Biñan	F	52	Program coordinator	College	10
15	Quezon City	F	28	Medical officer supervisor	Doctoral	8 months
16	Quezon City	F	55	Program coordinator	Doctoral	19
Clients						
17	City of Biñan	F	30	Client	High school	2
18	Quezon City	F	40	Client	High school	7 months
19	City of Biñan	F	37	Client	High school	11
20	City of Biñan	F	38	Client	High school	15
21	Quezon City	F	41	Client	College	10
22	Quezon City	F	25	Client	College	1

Years of service among BHWs/CHWs, co-workers, and supervisors ranged from 7 months to 25 years, but the majority had been in service for more than 5 years. Meanwhile, clients had been accessing health services from 7 months to 15 years.

Half of the participants had either a vocational diploma or a college degree or higher, while the other half had a high school diploma. Two BHWs obtained a vocational diploma (midwifery and caregiving) before becoming health workers.

4.1. Roles and responsibilities of BHWs

BHWs cover a broad scope of work in delivering primary care services. Under the supervision of barangay health centers' midwives, they support service delivery of DOH's priority programs and assist in "bringing down vaccines to the community," providing maternal, newborn, and child nutrition services, keeping immunization records, and sharing information on family planning services. The referral system in health services is also under the BHWs' responsibilities, as they "help report, refer, and follow-up patients to the health center." They look for health facilities and coordinate with ambulatory services for emergencies, such as mothers going into labor. A BHW district president from Biñan shared that they "help [patients] look for hospitals with cheaper health services since not all [the patients] have money."

4.2. Pandemic-posed challenges

At the onset of the pandemic, the BHWs' extensive scope of work further expanded to accommodate essential pandemic responses such as contact tracing, vaccination drives, and barangay lockdowns. Many participants expressed dissatisfaction with the increased workload, not to mention the disproportionately low benefits and incentives. The proposed 2019 Magna Carta of BHWs recommends the ideal ratio of 1 BHW per 20 households. However, according to the Biñan BHW district president, some barangays in the city, which have a population of roughly 42,000−50,000, only have 7−10 BHWs serving the community.

As the barangay manages the BHWs, it also decides on additional non-medical tasks for them. These include responding to health queries from residents or assisting residents' registration for the national ID. One BHW from QC shared that BHWs helped identify households needing aid during the pandemic. A co-worker from Biñan explained that in their barangay, BHWs also monitored the mobility of community residents during lockdowns, an initial strategy used by the government to

contain the spread of COVID-19. As this extra responsibility was outside the BHWs' typical scope of work, they needed to "attend to the duty at night" after their regular daily shifts at the health centers.

4.3. The CHW and BHW divide

The structure of the BHW program in QC classified health workers into two cadres: the BHWs, volunteer community members paid and managed by their local barangays; and the CHWs, contractual employees paid by the city government. The respondents heavily emphasized this difference because it had implications in matters such as BHW benefits, employment status, and remuneration. On the other hand, the City of Biñan did not employ CHWs, as BHWs also worked at city-level health centers.

All BHW and CHW participants agreed that they shared the same tasks and responsibilities, primarily the provision of appropriate PHC. The QC BHWs frequently collaborated with the CHWs during area visits to "assist the health center personnel." The CHWs confirmed that they had a synergistic relationship with the BHWs, as they were a "great help" when they needed to gather information about clients or required assistance in tracking them.

Aside from employment status, skill level could be a differentiating factor between BHWs and CHWs. BHWs were not required to undergo extensive training, unlike CHWs, who had to train for over a year. Regarding task designation, there were "specific jobs" done only by BHWs, such as fetching patients for COVID vaccination. In contrast, the CHWs were assigned to serve as "marshals and recorders" and take the patient's vital signs. CHWs appeared more "skilled" in conducting medical examinations than BHWs.

One BHW shared how she sometimes did menial tasks such as delivering documents or paying bills. She expressed how this could be tiresome, but she had learned to accept it as "part of the job."

It seemed that CHWs performed more advanced health-related responsibilities than BHWs. The latter performed administrative duties and some basic health care tasks. This distinction highlights a gap in the existing BHW policy as it does not reflect this division. CHWs and BHWs are considered of the same caliber, although a difference in skill level affects the types of tasks each can do. It is only at the LGU-level practices that such division is apparent.

4.4. Gaps in the BHW training system

Training is intended to equip BHWs to deliver quality health services to patients. It is also instrumental to BHWs' motivations, prompting them to apply the knowledge and skills they have gained. For BHWs to become accredited health volunteers, they must undergo a five-day basic training through seminars conducted at the city health offices and DOH.

The more experienced BHW participants in this study had undergone this process. Newer BHWs learned the ropes through the technical assistance of their supervisors. An assisting BHW from Biñan found her training experience insufficient, as she "does not know what [support] to give to patients." A program coordinator from the same city could not recount any basic training provided exclusively to BHWs. Instead, their BHWs were sporadically "invited to nurses' seminars" when there were available slots. Another newer BHW admitted relying on her learning from previous caregiving courses. She had not attended any training after she became a BHW. If given the opportunity, she "wants to attend all sorts of training and seminars" to expand her knowledge and "better serve the community." These responses suggest a link between the BHWs' knowledge and skills level and their confidence in providing health services.

In QC, training was required for CHWs but not for BHWs. CHWs attend training sessions organized by the city health department and DOH to learn about the different national health programs. One BHW shared that the health department would invite them to participate alongside the CHWs during these sessions. This strategy illustrates that the LGU plays a prominent role in health program implementation and capacity building.

Conversely, some seasoned BHWs found their training experiences sufficient and believed these were core components of their role. However, they all expressed the need for additional and regular refresher courses, since "there are things they forget." According to the provisions of RA 7883, BHWs are entitled to receive continued training to help revisit, update, and reinforce their knowledge and skills from the initial training.

4.5. Remuneration, benefits, and incentives

The following section discusses the challenges BHWs face regarding remuneration. RA 7883 acknowledges the importance of providing BHWs with material support and benefits to strengthen and advance their services. These also affect the BHWs' symbolic esteem and recognition within the health system, influencing their motivations, retention, and performance in the program.

4.5.1. The ununiform allowance scheme

As volunteers, BHWs receive honoraria and allowances from their respective barangays for their service. However, due to the decentralized health system, there is no national standardized rate for this remuneration. The amount largely depends on factors such as the financial capacity of barangays and LGUs and the BHWs' length of service, assigned area size, and level of seniority.

The Biñan LGU releases the BHWs' monthly allowances quarterly or biannually, ranging from Php 1500 (USD 26) to Php 4000 (USD 69). According to the BHW district president, the LGU implemented this in around 2017, after the BHW Federation of Laguna Province lobbied for better remuneration. Before 2017, or during her first 10−12 years of service, she did not receive any allowance. While other BHWs, co-workers, and supervisors had grievances about the amount of remuneration, she found the current system "good enough compared to what they had before; it is better than nothing." However, it is necessary to note that she had other sources of income and all her children were already employed.

At the onset of the pandemic, Biñan BHWs also received a hazard allowance. In early 2022, the LGU also provided a meal allowance worth Php 3500 (USD 63). There was variation in the distribution of these allowances, however. Some barangays had yet to receive their risk allowance. Others additionally provided free meals to health workers on duty.

In QC, the difference in employment status between BHWs and CHWs distinguished the types of incentives received. The BHWs' allowances typically ranged from Php 2500 (USD 43) to Php 4400 (USD 76). CHWs, on the other hand, were considered city health office employees and received a monthly salary of Php 13,000 (USD 226). Moreover, as part of the LGU's recognition of the works of all city frontliners during the community lockdowns, CHWs received a special risk allowance, equivalent to 25% of their salaries. While this amount significantly increased their previous wages, QC CHWs remarked that it was still insufficient to meet their families' daily needs. In contrast, the BHWs did not receive any such allowance or hazard pay.

Aside from financial remuneration, incentives included mobile phone load, which was necessary for their work, and bonuses on special occasions. Two BHWs shared that because of their service and dedication, their children were able to complete their education under scholarships provided by the city mayor or the barangay captain. Other BHWs did not mention these, indicating the variability of benefits across barangays. Most BHWs thus expressed discontent over the inconsistent incentive scheme across different barangays. A co-worker from Biñan commented that they "know BHWs from other barangays receiving more than just mobile phone load."

Despite deficiencies in the remuneration system, the BHWs shared the same sentiment on why they continued to serve: **they feel fulfilled in their work, and their desire to help their communities overrides the health challenges they have endured.** Their concern for their communities' health enabled them to communicate and interact with patients effectively; without this intrinsic motivation, patients "will not see their sincerity and will not listen to the BHWs." A BHW from Biñan shared how she disliked being referred to as "BHW *lang*" (just a BHW) because their "volunteerism comes from the heart." They did not serve to "just write and take [patients'] vital signs." A BHW of 22 years claimed that she "would not have lasted this long" if she "were not happy with the work."

4.5.2. Retirement package or the lack thereof

With the voluntary nature of the BHWs' role, there are no set guidelines for their "retirement." It is often based on the BHWs' decision and physical condition to resign from "volunteering." One BHW with many years of service in Biñan hoped to receive "retirement benefits" as a recognition of her dedication to helping the communities:

> We wish to receive retirement [benefits], at least for our service … it will not be for nothing … other barangays have that.

The preceding sections clearly illustrate that despite the policy recognizing the importance of supporting the material needs of BHWs, there are numerous gaps in the prompt and adequate distribution of much-needed remuneration and incentives. While financial incentives may be secondary to BHWs, as they prioritize their service to the community, their general dissatisfaction with the current arrangements indicates that they have yet to achieve proper and uniform remuneration for work they do.

4.6. Politics of the BHW program

The BHW program is infused with influences from local politics, both at the barangay and city levels. The appointment of BHWs is largely informal. One BHW in QC explained that of the 131 listed BHWs in her district, only 80 (61%) were active. Some barangays merely "itemize" or list the names of BHWs in compliance with the law. In many barangays, BHWs are coterminous with the incumbent barangay captain. It is not rare for barangay captains to appoint BHW supporters from the community to

"reciprocate said support with allowances" or fulfill "political promises," akin to a patronage system.

However, when administrations change, BHWs have no job security, as they may leave upon the appointment of a new barangay captain or be dismissed, especially if they are supporters of the incumbent. This practice was widespread in both Biñan and QC. Some research participants recounted stories of fellow BHWs who had been arbitrarily dismissed from service.

There have been calls to change these pervasive practices, but with little progress. In QC, the District BHW president expressed disappointment with the local government incentives being applicable only to CHWs. Despite collective efforts to lobby for better incentives and working conditions for BHWs, she was discouraged by the lack of change and commitment from the LGU.

> We are not under the city government, so we do not have much influence. We have presented our case to the mayor … for the long-term solutions, only the city-paid employees benefit.

Even though RA 7883 formally recognizes the BHWs' rights to organize and participate in recommending policies and guidelines related to their responsibilities, they hold very little political influence and bargaining power with the local officials. Informal political practices, such as the patronage system and arbitrary appointments and dismissals, are significant barriers for BHWs to fulfill their roles successfully and adequately as health care providers. This situation leads to inefficiencies and diminished service quality, as LGUs must constantly recruit and train new BHWs.

5. Discussion

Overall, the BHWs described their role as integral health service providers at the grassroots level. However, despite the breadth of their service, they all shared challenges and hurdles within the BHW program. These obstacles ultimately affected their motivation and performance. The following section further analyzes these implications.

5.1. An evolving role in a devolved health system: challenges in the BHWs' training structure

As the formal health system was overwhelmed by the massive number of COVID-19 cases, the local health systems were forced to rely on small community health teams to manage and contain the transmission of the virus. The BHWs' already extensive area of responsibilities further expanded to accommodate urgent pandemic responses. However, their experiences illustrate gaps in the training structure that is supposed to support and equip health workers with essential skills.

On their own, the newer BHWs who did not undergo basic training tackled and learned additional tasks during the pandemic, from active contact tracing to monitoring COVID-19 patients in the community. More experienced BHWs also struggled. During the pandemic, LGUs were forced to halt the already scarce refresher courses. The skills and knowledge training of BHWs is considered an essential non-material incentive that ensures the effective delivery of quality health services to patients. Its ineffective provision impacts the BHWs' competence and diminishes their confidence in providing quality care.

The findings of this study demonstrate the inconsistent implementation of the basic BHW training system. With various actors engaged in providing the BHWs' training, its quality and implementation have become inconsistent. For example, studies have found that non-government organizations (NGOs) more frequently sponsor health workers' capacity-building, and there are instances where BHWs seek external training opportunities themselves [34]. While the mentorship of the BHWs' supervisors serves as an alternative pathway to learning the necessary skills, the inability of the LGUs to formalize proper and sustainable training programs overloads the cadres of health workers. The situation further complicates the BHWs' poorly defined scope of work and exacerbates their under-recognition as competent health workers. Despite the stipulations of RA 7883 and DOH's 2009 memorandum reiterating support for BHWs, standard training modules and courses have yet to be published. Recently, the World Health Organization (WHO), in partnership with DOH, announced the need for technical assistance to update and revise the 2015 BHW Pocket Handbook. In addition, online training modules must be developed, considering the COVID-19 situation [35].

5.2. Second-rate treatment of BHWs

To optimize the delivery of health services, WHO recommends task sharing in health service delivery as an efficient option for health workers. For this to become successful, there must be sufficient resource support and an in-depth understanding of the symbolic notions BHWs attach to their work.

The distinction between BHWs and CHWs points to a fundamental difference between the roles they play within the health system. This creates tension and further ambiguities in the BHWs' role, not to

mention the tendency of the LGU to assign BHWs additional workloads outside their health-performing tasks. While some BHWs may see these other tasks as merely an extension of their volunteer work, there is a discernible effect on the BHWs' productivity, motivation, and retention.

Asweto et al. (2019) remark that "a balanced workload improves CHW productivity, and the benefits of addressing productivity include greater efficiency, increased job satisfaction, and higher quality of care" [36]. Thus, the workload of BHWs must also be "compatible with their other responsibilities" [36] to balance their other roles within the community.

5.3. A remuneration model built on the principle of volunteerism

In recognition of the BHWs' function in advancing primary health care, RA 7883 states that they are entitled to benefits, including hazard and subsistence allowances, opportunities to pursue higher education after years of service, scholarship grants for their children, and special training programs, subject to the calculations and financial capacities of their respective LGUs [37].

The low compliance with RA 7883 demonstrates the challenges of a decentralized health system for city-level health governance. Additionally, the BHWs' collective feelings of undervaluation and dissatisfaction over low and delayed allowances, coupled with the inconsistent implementation of risk benefits, threaten the sustainability of the BHW program. On paper, RA 7883 promotes "the observance of volunteerism by all parties." [2] The BHW handbook further supports this, stating that "despite difficulties … and lack of financial support," [6] BHWs are expected to be committed. To overcome discontent about the inadequate financial remuneration, participants cited volunteerism and other intrinsic motivators such as care, concern, and desire to help others. This is a form of rationalization that effectively normalizes volunteer work as an acceptable form of cheap or free labor. As articulated by WHO, however, "there is virtually no evidence that volunteerism can be sustained for long periods" [38].

Material incentives help enhance BHWs' motivations and performance as a means of economic empowerment while promoting social embeddedness by lending them credibility among community members. Balancing these multiple BHW motivators will ensure the successful delivery of health services to communities and, in the long run, may further boost the BHWs' "symbolic recognition and esteem," [27] thereby impacting the BHWs' performance, motivation, retention, and economic aspirations positively.

5.4. Politicization of BHWs

In the years following the Alma Ata Declaration, there have been mixed results of CHW programs around the world, including criticisms of the program's lackluster performance and inability to meet expectations [39]. Political favoritism is a significant challenge many programs face, including the inappropriate selection of CHWs who are ill-qualified to perform their responsibilities [40]. The local health system also struggles with this challenge because the volunteer status of BHWs makes them beholden to the person with appointing powers. The recruitment and retention of BHWs tend to be arbitrary. Those with personal connections have social leverage, which seems to have more weight than the necessary skills and experience.

The politicization of BHWs denotes the tensions between local autonomy and national health program standards. Local autonomy "relaxes national control" and creates more variation in civil service conditions across regions [41]. With less oversight at the national level, variations such as these make the BHW program susceptible to corrupt practices. This observed gap renders the system ineffective and inefficient in attaining its goal of improving access to quality health services.

6. Conclusion

This study argues that the gaps in the implementation of RA 7883, also known as the Barangay Health Workers' Benefits and Incentives Act, impact the BHWs' role in providing PHC services. The varying amounts of allowances in different locations, unequal distribution of benefits, and inconsistent training program implementation undeniably affect the BHWs' motivation, evidenced by their collective dissatisfaction over their experiences with the BHW program. Compounded with minimal skills and confidence without formal training, these inevitably limit their capacity to support health service delivery. The research participants noted inadequacies in the training design for BHWs and remuneration, including the absence of a retirement package for BHWs. The clear demarcation of national and local governments in the devolved health services in the Philippines further complicates these gaps.

Although the BHWs claimed during the interviews that material incentives were only

secondary motivation, as they valued more intrinsic motivators, it is still critical to address the identified weaknesses in policy implementation. This will result in more optimized and equitable service delivery, allowing for the full realization of the BHW role as an essential component of an integrated health system.

7. Recommendations

Based on the study's findings, the researchers present three recommendations. The first is to streamline the role of BHWs. In QC, ambiguities remain in specific tasks for CHWs and BHWs. In both research sites, the particular functions in delivering health services should be further fleshed out in a post-COVID-19 scenario. There is a need to distinguish the roles of BHWs from other health workers explicitly. This demarcation of duties prevents relegating the BHWs to auxiliary services, thereby underutilizing the rich resources they can provide. In the past, such ambiguities resulted in BHWs performing various functions except for health-related duties.

The second recommendation is for government to develop and strictly implement a standard minimum package for BHW allowances, benefits, and incentives. Considering the BHWs' discontent with their current remuneration, upgrading the scale with additional retirement benefits will do wonders in recognizing the valuable contributions of BHWs to PHC.

This study's last and final recommendation is to enforce a stricter implementation of the BHW program. The experiences of BHWs show that the problem lies primarily in the program's poor performance, characterized by inconsistency and insufficiency in addressing the needs of BHWs and their clients within their communities. Health agencies and local governments must ensure all BHWs are adequately trained, especially newer recruits who had been prevented by the pandemic situation from undergoing capacity building. Basic training with regular refresher courses is non-negotiable for BHWs providing PHC. This should be comprehensive and standardized across all LGUs to provide BHWs with the necessary technical knowledge to support patient needs within the context of PHC.

Additionally, establishing an integrated monitoring and evaluation system into the program will support its stricter implementation—regularly involving BHWs in barangay- or LGU-level discussions of community programs will enable decision-makers to gain a more comprehensive understanding of their health workers' needs and issues [42]. This will substantially inform future actions relating to improving, upgrading, and adjusting the training program according to the BHW's needs and the changing context of the community.

The recommendations underscore the importance of improving the BHW program's management, capacity-building, and evaluation as these have a positive multiplier effect that can impact the program's performance and the health benefits in the Philippines. Globally, community health programs such as the BHW program are recognized as linkages of underserved communities to essential health services, and providers of critical support to other healthcare providers. However, the problems plaguing these programs in developing countries share parallels with the Philippine experience. Thus, there is a dire need to adapt the design of other community health programs to the needs of the health workers to effectively carry out their duties and responsibilities. These recommendations may provide insights on different opportunities and challenges that policymakers from other countries can utilize to study, inform, and formulate policies for community health programs that account for their own unique contexts.

Funding

The Thesis-to-Paper Conversion Grant from Ateneo de Manila University supported the writing of the results of the study.

Conflict of interest

None.

Acknowledgments

We are grateful for the support of the Development Studies Program of Ateneo de Manila University, Ms. Jessica Claudio, and Dr. Dennis B. Batangan, for providing us with insightful feedback, constructive criticisms, and many other perspectives that helped us grow as researchers. We also thank our research participants for sharing their experiences.

References

[1] Mallari E, Lasco G, Sayman DJ, Amit AML, Balabanova D, McKee M, et al. Connecting communities to primary care: a qualitative study on the roles, motivations and lived experiences of community health workers in the Philippines. BMC Health Serv Res 2020;20(1):860. https://doi.org/10.1186/s12913-020-05699-0.

[2] Department of Health [DOH]. The barangay health workers' benefits and incentives Act of 1995 (R.A. 7883): implementing Rules and Regulations. 2023 Jan. Available from: https://doh.gov.ph/sites/default/files/basic-page/RA%20No.%207883%20Implementing%20Rules%20and%20Regulations.pdf.

[3] Phillips DR. Primary health care in the Philippines: banking on the barangays? Soc Sci Med 1986;23(10):1105−17. https://doi.org/10.1016/0277-9536(86)90269-8.

[4] Aytona MG, Politico MR, McManus L, Ronquillo K, Okech M. Determining staffing standards for primary care services using workload indicators of staffing needs in the Philippines. Hum Resour Health 2022;19(1):129. https://doi.org/10.1186/s12960-021-00670-4.

[5] Department of Interior and Local Government. The local government code of the Philippines, book III - local government units. 2023 Jan. Available from: https://www.dilg.gov.ph/PDF_File/reports_resources/dilg-reports-resources-2016120_5e0bb28e41.pdf.

[6] Department of Health. Barangay Health Workers' pocket handbook: towards effective service provision and improved health outcomes. Manila: Health Human Resource Development Bureau; 2015.

[7] Strengthening Partnerships. Results, and Innovation in Nutrition Globally [SPRING]; Advancing Partners & Communities [APC]. How do community health workers contribute to better nutrition?: Philippines. Arlington, VA: SPRING Project; 2016. Available from: https://www.spring-nutrition.org/sites/default/files/publications/tools/spring-apc_country_slide_doc-phillippines_29_nov_2016.pdf.

[8] Yamashita T, Suplido SA, Llave C, Tuliao MT, Tanaka Y, Matsuo H. Understanding postpartum healthcare services and exploring the challenges and motivations of maternal health service providers in the Philippines: a qualitative study. Trop Med Health 2015;43(2):123−30. https://doi.org/10.2149/tmh.2014-40.

[9] Philippine Statistics Authority. Number of nutritionists, medical technologists, sanitary engineers, sanitary inspectors, and active barangay health workers (BHW). 2023 Jan. Available from: https://openstat.psa.gov.ph/PXWeb/pxweb/en/DB/DB__3E__CH__HN/0053E3D5170.px/?rxid=9e8cdefb-4c0e-4c38-a22c-5e4e13eafb42.

[10] Commission on Population and Development [POPCOM]. History. 2023 Jan. Available from: https://popcom.gov.ph/history/.

[11] Department of Health [DOH]. Commission on population and development [POPCOM]. 2020 Annual report: Responsible Parenthood and Reproductive Health Act of 2012. Manila: POPCOM; 2021.

[12] Bayani DBS, Tan SG. Health systems impact of COVID-19 in the Philippines. CGD working paper 569. Washington DC: center for global development. 2021. Available from: https://www.cgdev.org/sites/default/files/WP569_Health_systems_impact_of_COVID_in_the_Philippines.pdf.

[13] Querri AG, Ohkado A, Kawatsu L, Bermejo J, Vianzon A, Recidoro MJ, et al. Assessment of the role of community health volunteers in delivering primary health care in Manila, the Philippines. J Int Health 2020;35(1):15−25. https://doi.org/10.11197/jaih.35.15.

[14] Pérez LM, Martinez J. Community health workers: social justice and policy advocates for community health and well-being. Am J Publ Health 2008;98(1):11−4. https://doi.org/10.2105/ajph.2006.100842.

[15] Lacuesta MC, Sarangani ST, Amoyen ND. A diagnostic study of the DOH health volunteer workers program. Philippine Popul J 1993;9(1−4):26−36.

[16] Lehmann U, Sanders D. Community health workers: what do we know about them? The state of the evidence on programmes, activities, costs and impact on health outcomes of using community health workers. Geneva: WHO; 2007.

[17] Sacks E, Morrow M, Story WT, Shelley KD, Shanklin D, Rahimtoola M, et al. Beyond the building blocks: integrating community roles into health systems frameworks to achieve health for all. BMJ Glob Health 2018;3(3):e001384. https://doi.org/10.1136/bmjgh-2018-001384.

[18] House of Representatives (Philippines). An Act providing for the Magna Carta of barangay health workers. H. No. 10699. 2022. Available from: https://hrep-website.s3.ap-southeast-1.amazonaws.com/legisdocs/third_18/HBT10699.pdf.

[19] World Health Organization Department of Reproductive Health and Research [WHO/RHR]. Johns hopkins bloomberg school of public health. Family planning: a global handbook for providers. Baltimore and Geneva: CCP and WHO; 2018.

[20] The Seventeenth Congress of the Philippines. An Act instituting universal health care for all Filipinos, prescribing reforms in the health care system, and appropriating funds therefor. The Official Gazette 2019. Available from: https://www.officialgazette.gov.ph/downloads/2019/02feb/20190220-RA-11223-RRD.pdf.

[21] Herrin A. Development of the Philippines' family planning program: the early years. In: Robinson WC, Ross JA, editors. The global family planning revolution: three decades of population policies and programs. Washington, DC: World Bank Group; 2007.

[22] Haw NJ, Pecache NE, Albiola N, Chan KF, Dela Cruz KG, Gotianse CS, et al. Factors affecting family planning service delivery by community health workers in District 2. Quezon City, Philippines: a cross-sectional study. Social Medicine; 2016. p. 22−9.

[23] Laing JE. Family planning community outreach in the Philippines: major findings of the community outreach surveys. Philippine Socio Rev 1982;30(1/4):101−11.

[24] Nagai M, Bellizzi S, Murray J, Kitong J, Cabral EI, Sobel HL. Opportunities lost: barriers to increasing the use of effective contraception in the Philippines. PLoS One 2019;14(7):e0218187. https://doi.org/10.1371/journal.pone.0218187.

[25] Creswell JW, Creswell JD. Research design: qualitative, quantitative, and mixed approaches. California: SAGE; 2018.

[26] Given L. The SAGE encyclopedia of qualitative research methods1. California: SAGE; 2008.

[27] Campbell C, Cornish F. How can community health programmes build enabling environments for transformative communication? Experiences from India and South Africa. AIDS Behav 2012;16(4):847−57. https://doi.org/10.1007/s10461-011-9966-2.

[28] Philippine Statistics Authority. 2020 Census of population and housing (2020 CPH) population counts declared official by the president. 2021 July. Available from: https://psa.gov.ph/content/2020-census-population-and-housing-2020-cph-population-counts-declared-official-president.

[29] Philippine Statistics Authority. Highlights of the Philippine population 2020 census of population and housing (2020 CPH). 2021 July. Available from: https://psa.gov.ph/population-and-housing/node/164811.

[30] Gita-Carlos R. Addressing teenage pregnancies declared as 'national priority'.. 2021 June. Available from: https://www.pna.gov.ph/articles/1145373#:~:text=The%20Philippines%20has%20recorded%20a.

[31] Pierson D, See AB. The pandemic is fueling a baby boom in the Philippines. For some, that's bad news. Los Angeles Times; 2021 January 6. Available from: https://www.latimes.com/world-nation/story/2021-01-06/the-philippines-girds-for-a-baby-boom-after-years-of-declining-birth-rates.

[32] National Economic Development Authority. Region IX. Couples urged to continue family planning amid COVID-19 crisis. 2023 Jan. Available from: https://nro9.neda.gov.ph/couples-urged-to-continue-family-planning-amid-covid-19-crisis/.

[33] United States Agency for International Development [USAID]. Department of health; human resources for health 2030. Human resources for health masterplan: situational analysis. 2019 December. Available from: https://hrh2030program.org/wp-content/uploads/2020/08/x12.3_HRH2030PH_HRHMP_Situation-Analysis.pdf.

[34] Dodd W, Kipp A, Nicholson B, Lau LL, Little M, Walley J, et al. Governance of community health worker programs in a decentralized health system: a qualitative study in the Philippines. BMC Health Serv Res 2021;21(1):451. https://doi.org/10.1186/s12913-021-06452-x.

[35] World Health Organization Representative Office for the Philippines. Call for proposals: technical assistance for the revision of barangay health worker's (BHW) reference manual and development of online training modules. 2023 Jan. Available from: https://www.who.int/docs/default-source/wpro−-documents/countries/philippines/calls-for-proposal/call-for-proposals_barangay-health-worker-s-(bhw)-reference-manual_revised.pdf?sfvrsn=dbc31b16_5.

[36] Asweto CO, Alzain MA, Andrea S, Alexander R, Wang W. Integration of community health workers into health systems in developing countries: opportunities and challenges. Fam Med Community Health 2016;4(1):37−45. https://doi.org/10.15212/FMCH.2016.0102.

[37] Official Gazette. Republic Act No. 7883. 1995. Available from: https://doh.gov.ph/sites/default/files/policies_and_laws/Ra07883.pdf.

[38] World Health Organization [WHO]. Task shifting: rational redistribution of tasks among health workforce teams. Global recommendations and guidelines. Geneva: WHO; 2008.

[39] Berman PA, Gwatkin DR, Burger SE. Community-based health workers: head start or false start towards health for all? Soc Sci Med 1987;25(5):443−59. https://doi.org/10.1016/0277-9536(87)90168-7.

[40] Rifkin SB. Lessons from community participation in health programmes: a review of the post Alma-Ata experience. Int Health 2009;1(1):31−6. https://doi.org/10.1016/j.inhe.2009.02.001.

[41] World Health Organization [WHO]. Decentralization of health-care services in the South-East Asia region. Report of the regional seminar. Bandung, Indonesia: New Delhi: WHO; 2010. p. 6−8.

[42] Kananura RM, Ekirapa-Kiracho E, Paina L, Bumba A, Mulekwa G, Nakiganda-Busiku D, et al. Participatory monitoring and evaluation approaches that influence decision-making: lessons from a maternal and newborn study in Eastern Uganda. Health Res Pol Syst 2017;15(2):107. https://doi.org/10.1186/s12961-017-0274-9.