INTEGRATION, PARTICIPATION AND EFFECTIVENESS: AN ANALYSIS OF THE OPERATIONS AND EFFECTS OF FIVE RURAL HEALTH DELIVERY MECHANISMS

Ledivina V. Cariño and Associates

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CARIÑO AND ASSOCIATES

Philippine Institute for Development Studies

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Mauleon, Team Leader, Project Compassion, Teresa, Rizal; Sister Leonor Barrion, Coordinator, Makapawa; and Mr. Ben Potot, Chairman of the Board, Sudtonggan Human Development Project.

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Parts of this volume were presented in three seminars in 1979 and 1981. The original compendium of health delivery mechanisms, then entitled "Services to the Poor: A Preliminary Look at Existing Mechanisms for Meeting Health Needs" was read in the Annual Convention of the Philippine Economic Society in December 1979. "Integration, Participation and Effectiveness: An Analysis of Five Health Delivery Mechanisms and their Effects," which served as the main integrating report of the Project, was presented in two occasions:

1. At the meeting of the NEDA Social Development Committee, Technical (Deputy Minister) Level on March 11, 1981, and
2. At the seminar on Social Service Delivery and Policy Education and Research at the College of Public Administration, University of the Philippines on June 2, 1981.

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Other members of the RPP staff joined the Project in various capacities. Alex B. Brillantes, Jr., now a doctoral student at the University of Hawaii, joined the survey team in CCHP and co-authored "Beneficiaries' Perspectives" for Bay. Generoso Viñeza, Jr., was in all three Tagalog survey teams and also provided assistance in writing the Bay project papers based on personal interviews with the clients. Anacleta A. Eusebio, Teresita Magno, Leticia L. Manuel, Julieta B. Manso, Teresita Valderama, Chona B. Ursal, and Emmanuel Vidallon also joined the same teams and helped in later copyreading and collation of the manuscripts.

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While we have profited from our interaction wih the aforementioned, the errors of course remain ours, and particularly as overall editor, mine.

LEDIVINA V. CARIÑO
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TABLE OF CONTENTS

Contributors		**V**
Acknowledgements		**VII**
List of Tables and Figures		**XIII**
List of Abbreviations		**XVIII**
Chapter I		
HEALTH SERVICES FOR THE POOR: THE CONCERNS OF THIS VOLUME	Ledivina V. Cariño	**1**
Chapter II		
HEALTH SERVICES FOR THE POOR: METHODOLOGY	Ma. Lourdes S. Joves, Ledivina V. Cariño, and Victoria A. Bautista	**16**
APPENDIX TO CHAPTER II: PROFILE OF RESPONDENTS OF HOUSEHOLD SURVEYS	Victoria A. Bautista	**32**
Chapter III		
PROFILE OF THE COMMUNITIES	Ledivina V. Cariño and Jessica J. Buelva	**38**
Chapter IV		
THE CASE OF THE RHU OF PILAR, BATAAN	Francisco G. Balitaan	**55**
Chapter V		
THE U.P. COMPREHENSIVE COMMUNITY HEALTH PROGRAM	Josie H. de Leon	**69**
Chapter VI		
PROJECT COMPASSION: FOCUS ON TERESA, RIZAL	Reynaldo N. Caraso and Dante T. Fernando	**94**
Chapter VII		
THE MAKAPAWA PROGRAM IN LIWAYWAY	Josie H. de Leon	**115**
Chapter VIII		
THE SUDTONGGAN HUMAN DEVELOPMENT PROJECT	Rebecca P. Albano	**132**

Chapter IX

A COMPARATIVE REVIEW OF THE SELECTED HEALTH DELIVERY MECHANISMS — Ledivina V. Cariño and Ma. Lourdes S. Joves — **149**

Chapter X

THE PARTICIPATION OF CITIZENS IN THE CASE PROGRAMS — Victoria A. Bautista and Ledivina V. Cariño — **165**

Chapter XI

THE EFFECTIVENESS OF THE PROGRAMS — Ledivina V. Cariño and Ma. Lourdes S. Joves — **185**

Chapter XII

TOWARD MORE EFFECTIVE HEALTH CARE FOR THE POOR: CONCLUSIONS AND RECOMMEN-DATIONS — Ledivina V. Cariño — **218**

Appendix

A COMPENDIUM OF EXISTING MECHANISMS FOR MEETING HEALTH AND RELATED NEEDS IN THE PHILIPPINES — Rebecca P. Albano, Ma. Lourdes S. Joves and Josie H. de Leon — **231**

Bibliography

Index of Names

Index of Subjects

LIST OF TABLES AND FIGURES

Chapter I

Figure 1.1 The Conceptual Framework
1.2 Organization Chart of the Baao Applied Nutrition Program, Camarines Sur ,
1.3 The Dimensions of Integration
1.4 The Continuum of Citizen Participation

Table 1.1 Dimensions of Satisfaction wih the Service

Chapter II

Table 2.1 Background of Informants on the Five Case Programs
2.2 Sample Sites and Size: Pilar, Bataan; Bay, Laguna; and Teresa, Rizal
2.3 Occupational Profile of Respondents Across Sample Sites (In Percentage)
2.4 Types of Occupation of Gainfully Employed Respondents Across Sample Sites (In Percentage)
2.5 Types of Occupations of Gainfully Employed Respondents and Accessibility, by Program Site
2.6 Educational Attainment of Respondents Across Sample Sites
2.7 Educational Attainment and Accessibility of Respondents by Sample Sites

Chapter III

Table 3.1 Occupation of Members of Sample Households, Pilar, Bataan
3.2 Family Incomes of Sample Households, Pilar, Bataan
3.3 Levels of Living of Sample Households, Pilar, Bataan
3.4 Occupations of Sample Household Members, Bay, Laguna
3.5 Age Profile of Members of Sample Households, Bay, Laguna
3.6 Family Income of Sample Households, Bay, Laguna
3.7 Level of Living of Sample Households, Bay, Laguna

3.8 Occupations of Members of Sample Households, Teresa, Rizal
3.9 Family Income of Sample Households, Teresa, Rizal
3.10 Level of Living of Sample Households, Teresa, Rizal
3.11 Occupations of Household Members, Liwayway, MacArthur, Leyte
3.12 Household Income of Sample Households, Liwayway, MacArthur, Leyte
3.13 Level of Living of Sample Households, Liwayway, MacArthur, Leyte
3.14 Occupation of Sample Household Members, Sudtonggan, Basak, Lapu-Lapu City
3.15 Income of Sample Households, Sudtonggan, Basak, Lapu-Lapu City
3.16 Level of Living of Sample Households, Sudtonggan, Basak, Lapu-Lapu City

Chapter IV

Figure 4.1 RHU Organizational Chart, Pilar, Bataan

Table 4.1 Profile of RHU Personnel, Pilar, Bataan, 1979
4.2 Ratio of RHU Health Personnel to Population, Pilar, Bataan, 1979
4.3 Immunization of Eligible Population, Pilar, Bataan, 1979
4.4 Birth Attendance of RHU Personnel, Pilar, Bataan, 1979
4.5 Birth Attendance by Agency, Pilar, Bataan, 1979
4.6 Case Referrals to RHU and Hospitals, Pilar, Bataan, 1979
4.7 Consultation and Treatment Statistics of RHU, Pilar, Bataan, 1979
4.8 Accomplishments of the Rural Sanitary Inspector on Environmental Sanitation for 1979 in Pilar, Bataan
4.9 Dental Health Service Statistics, Pilar, Bataan, 1979

Chapter V

Figure 5.1 Original Organizational Structure of CCHP, 1967

5.2 Organizational Chart of CCHP, 1980
5.3 Levels of Health Care of the CCHP
5.4 The Expected Linkage Among the Different Levels of Health Care of the Comprehensive Community Health Program and Ministry of Health

Table 5.1 Residence of Patients of UP-CCHP Infirmary, 1979
5.2 Sources of Funds of CCHP, 1980
5.3 Actual Expenses of the CCHP, 1966-1979

Chapter VI

Figure 6.1 Organizational Chart of Project Compassion
6.2 ProCom's Effective Structure in Teresa, Rizal
6.3 Usual Referral System of Project Compassion
6.4 Alternative Referral System for Project Compassion
Table 6.1 Agencies Coordinating with Project Compassion in Teresa, Rizal and their Activities
6.2 Teresa Project Compassion: Finance and Logistical Support by Agency, 1979
6.3 Expenses of Teresa ProCom, 1979
6.4 Malnutrition of Children 0-6 Years, Teresa, Rizal, 1976 and 1979

Chapter VIII

Figure 8.1 Human Development Training School Curriculum
8.2 Sudtonggan Human Development Project Organizational Chart

Table 8.1 Itemized Income and Expenditures, SHDP, January-October 1980
8.2 Economic Development Indicators, Sudtonggan, 1975-1979

Chapter IX

Table 9.1 Resources Per Person in Area of Service, 1979
9.2 Tabular Comparison of the Case Programs

CHAPTER X

Table 10.1 Perception About the Necessity of Citizen Participation, By Program

10.2 Perception About the Necessity of Participation, By Barangay
10.3 Level of Actual Citizen Participation, By Program and Sample Site
10.4 Actual Involvement of Citizens, By Barangay
10.5 Involved Beneficiaries Satisfied with the Nature of their Participation, By Program
10.6 Reasons for Non-Involvement, As Percentage of Uninvolved Respondents
10.7 Reasons for Non-Involvement, By Barangay (As Percentage of Uninvolved Respondents)
10.8 Summary Table on Relationship of Selected Socio-Economic Variables and Actual Involvement
10.9 Relation of Involvement and Level of Income, By Program Site
10.10 Relation of Involvement and Level of Education, By Program Site
10.11 Relation of Involvement and Type of Education, By Program Site

Chapter XI

Table 11.1 General Health Conditions in Pilar, Bataan, Selected Years
11.2 General Health Conditions in Bay, Laguna, Selected Years
11.3 Health Indicators, SHDP, 1975 and 1979
11.4 Awareness of the Program, By Sample Site
11.5 The Clientele Coverage of the Programs
11.6 Services Provided by Each Program, By Type of Service
11.7 Kind of Actual Services Received, By Target Beneficiaries
11.8 Average Number of Type of Health Benefits Received, By Income Groups and Sample Sites
11.9 Source of Health Care for Sick Members, By Program Site
11.10 Mean Level of Satisfaction Regarding Programs
11.11 Percentage Claiming Satisfaction with Program, By Level of Income
11.12 Strength of Attitude Regarding Satisfaction with Program Personnel, By Program and

I .13 Percent Offering Favorable Comments Regarding Program Personnel, By Program and Area
1.14 Sources of Satisfaction with Respective Program Personnel as a Percentage of Total Respondents, By Sample Site
11.15 Sources of Dissatisfaction with Respective Program Personnel, By Sample Site
11.16 Rank of Programs along Various Measures of Effectiveness, By Program

LIST OF ABBREVIATIONS

Positions and Organizations

AKAP	Alay Kapwa Kilusang Pangkalusugan
AKHDF	Alay Kapwa Human Development Fund
AMHO	Assistant Municipal Health Officer
APCO	Asian Parasite Control Organization
APMC	Association of Philippine Medical Colleges
BAEx	Bureau of Agricultural Extension
BAI	Bureau of Animal Industry
BANP	Baao Applied Nutrition Program
BARMA	Barangay Medical Aide
BDC	Barangay Development Council
BDS	Barangay Development Seminar
BDV	Barangay Development Volunteer
BEC	Barangay Executive Committee
BFD	Barefoot Doctor
BHA	Barangay Health Aide
BHP	Bicol Integrated Health, Nutrition and Population Project
BHS	Barangay Health Station
BHT	Barangay Health Technician
BM	Barangay Medic
BNHS	Barangay Nutrition and Health Scholar
BPI	Bureau of Plant Industry
BRBDP	Bicol River Basin Development Program
BSPO	Barangay Supply Point Officer
BVM	Barangay Volunteer Medic
CBHP	Community-Based Health Program
CCHP	Comprehensive Community Health Project
CDAP	City Development Assistance Project
CEH-MRD	Capiz Emmanuel Hospital Manpower Resource Distribution
CHW	Community Health Worker
CIM-CMSC	Cebu Institute of Medicine - Community Medico-Social Center
CIO	Communications and Information Office
COTC	Chapter Officers Training Course
COV	Community Organizer Volunteer
CPA	College of Public Administration, University of the Philippines
CRS	Catholic Relief Service
DAP	Development Academy of the Philippines
DHC	District Health Center
DLGCD (MLGCD)	Department (now Ministry) of Local Government and Community Development
DMSF	Davao Medical School Foundation

DOH (MOH)	Department (now Ministry) of Health
DPO	District Population Officer
DSSD (MSSD)	Department (now Ministry) of Social Services and Development
DTRI	Dairy Training and Research Institute
ECP	Environment Center of the Philippines
ELNC	Early Learning Nutrition Center
FBO	Finance and Budget Office
FDO	Family Development Officer
FEU-NRMF	Far Eastern University - Dr. Nicanor Reyes Medical Foundation
FIT	Family Ilaw Training
FPOP	Family Planning Organization of the Philippines
FTOW	Full Time Outreach Worker
GSIS	Government Service Insurance System
HBC/CMC	Huntington Beach Clinic/Calabaclabacan Mountain Clinic
HDTS	Human Development Training School
HEART	Health Extension Aide for Region Twelve
HSC	Health Sciences Center
IBRD	International Bank for Reconstruction and Development
ICA	Institute of Cultural Affairs
IHS	Institute of Health Sciences
IIRR	International Institute for Rural Reconstruction
ISWCD	Institute of Social Work and Community Development
JOICFP	Japanese Organization for International Cooperation in Family Planning
KMC	Kansalakan Mountain Clinic
MCHP	Muntinlupa Community Health Program
MDC	Municipal Development Council
MEC	Ministry of Education and Culture
MHD	Manila Health Department
MHO	Municipal Health Officer
MIRDO	Mindoro Integrated Rural Development Office
MIRDP	Mindoro Integrated Rural Development Project
MOH/CARE	Ministry of Health/Cooperative American Relief Everywhere
MPHW	Multi-Purpose Health Worker
MRHW	Multi-Purpose Resident Health Worker
MSSD	Ministry of Social Services and Development
NACIAD	National Council on Integrated Area Development
NASSA	National Secretariat of Social Action
NCCP	National Council of Churches in the Philippines
NCP	Nutrition Center of the Philippines
NCSO	National Census and Statistics Office

NEDA	National Economic and Development Authority
NFERY	Non-Formal Education for the Rural Youth
NNC	National Nutrition Council
NNS	National Nutrition Service
NTTO - HP	National Teacher Training Center for the Health Professions
NSDB	National Science Development Board
OBL	Ospital ng Bagong Lipunan
PATHS	People's Adoption of Total Health Self-Sufficiency
PBSP	Philippine Business for Social Progress
PC	Puericulture Center
PCF	Population Center Foundation
PDAP	Provincial Development Assistance Project
PEC	Project Executive Committee
PGH	Philippine General Hospital
PHN	Public Health Nurse
PHO	Provincial Health Office
PMA	Philippine Medical Association
PNVSCO	Philippine National Volunteer Service Coordinating Office
POPCOM	Commission on Population
PROCOM	Project Compassion
PRRM	Philippine Rural Reconstruction Movement
PUSH	Panay Unified Services for Health
RDC	Regional Development Council
RHM	Rural Health Midwife
RHO	Regional Health Office
RHP	Rural Health Physician
RHU	Rural Health Unit
RIC	Rural Improvement Club
RPP	Research and Publications Program
RSCP	Rural Service Center Project
RSI	Rural Sanitary Inspector
RYDP	Rizal Youth Development Foundation
SB	Sangguniang Bayan (Municipal Council)
SDS	Social Development Seminar
SDW	Social Development Worker
SHDP	Sudtonggan Human Development Projects
SPREAD	Systematic Project for Rural Economic and Agricultural Development
SSA	Secretariat for Social Action
SSS/MSSD	Special Social Services (MSSD)
SSS	Social Security System
SUMC	Silliman University Medical Center
TFAP	Targeted Food Assistance Program
UE-RMMMC	University of the East Ramon Magsaysay Memorial Medical Center

UFC	Under-Fives Clinic
UNEP/NHA MASIP	United Nations Environmental Programme - National Housing Authority Marginal Settlements Improvement Project
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations International Children's Fund
UPCA	University of the Philippines College of Agriculture
USAID	United States Agency for International Development
WHO	World Health Organization

Terms Used in the Health, Nutrition and Population Fields

BCG	Bacillus Calmette - Guerin, vaccination for tuberculosis
DPT	Diphteria Pertussis Tetanus, immunization for diptheria, pertussis (whooping cough) and tetanus
INH	Isonicotinic Hydracide, drug used in the treatment of tuberculosis
MCRA	Married Couple of Reproductive Age
OPT	Operation Timbang
PHC	Primary Health Care
PTB	Pulmonary Tuberculosis
RHCDS	Restructured Health Care Delivery System
URTI	Upper Respiratory Tract Infection

Other Abbreviated Phrases

ARA	Action-Reflection-Action
BN	Basic Need
CO	Community Organization
CP	Citizen Participation
GR	Green Revolution
IEC	Information, Education, and Communication
MIS	Management Information System
PREPF	Population, Resources, Environment and the Philippine Future
PSDJP	Practical Skills Development and Job Placement
QSR	Quarterly Summary Report
RWG	Redistribution with Growth

Chapter I

HEALTH SERVICES FOR THE POOR: THE CONCERNS OF THIS VOLUME

Ledivina V. Cariño

We will pursue economic development for social justice. We will engage the initiative and resources of our people, according to all citizens a rightful share in benefits and obligations. As both the source and object of development, our people will be provided with adequate economic opportunities and social amenities to attain a dignified existence.

- Ferdinand E. Marcos, Speech on Signing the 1978-82 Five Year Development Plan.

Changing Conceptions of Development

"Economic development for social justice": that succinctly sums up the change that has occurred in the conceptions of development since about the middle of the century. Unqualified, the term "development" used to refer to growth, productivity and industrialization, all of which convey a primarily economic orientation. However, the hope that welfare would also increase as benefits trickle down to the masses did not occur, and as a World Bank report had put it:

> It is now clear that more than a decade of rapid growth had been of little or no benefit to perhaps a third of the population. Although the average per capita income of the Third World has increased by 50 percent since 1960, this growth has been very unequally distributed. . . Paradoxically, while growth policies have succeeded beyond the expectations of the First Development Decade, the very idea of aggregative growth as a social object has increasingly been called into question. (Chenery, 1974:XIV)

The dissatisfaction with growth unaccompanied by growing equality has refocused development goals, with economic development seen only as a handmaiden for the increase of people's welfare within a society, a statement made so succinctly by President Marcos in the above-quoted passage.[1]

Accompanying this change is an increasing concern for distributive qualities or for "the sharing within society of (that) welfare" (Mangahas, 1979:3). Yet, even the distributive emphasis is changing. Previously, the concern was centered on some change in the proportion of benefits received by different groups, and was captured in phrases like "decreasing the gap between the rich and the poor." The new emphasis is to seek for, and underscore directly, the

[1] President Marcos' statement suggests that the Philippines has already engaged in a reorientation of its development priorities, a claim many scholars have evaluated elsewhere. See, for example, Dubsky, 1981; Stauffer, 1981; Canoy, 1980; Catilo, 1981; Cariño, 1980; Miranda, 1981; Mangahas, 1979. This will not be further analyzed in this volume.

welfare gains of the poor, through "the satisfaction of needs beginning with the eradication of poverty," as the Hammarksjold Foundation describes its concept of "Another Development" *(Development Dialogue,* 1978:4). This last trend in goal redefinition is not so much a conceptual change as a difference in approach and strategy. Redistribution, after all, implies an increase of attention to the less advantaged group. The advocates of the focus on "basic needs" accept this but believe that redistribution cannot be effected by an invisible, undirected hand which relies mainly on the trickling down of benefits to the poor. Rather, they assert that equity can be better achieved if the major beneficiaries of the new sharing are identified and directly served. The "basic needs" movement therefore criticises its close relatives —"redistribution with growth" (RWG) proponents—on administrative grounds, namely:

1. RWG measures have not achieved intended results because of problems in supply management, as for instance, when increases in incomes of the poor are neutralized by an increase in prices, or when productivity increases are accompanied by lower wages.
2. Critical social services to the poor have been neglected because "the link between government expenditures devoted to social services meeting basic needs and the accrual of benefits to these poor has been tenuous" (Streeten and Burki, 1978:412).

The claim that one will tend to lose sight of the poor if they are not made the explicit objects of concern is manifested linguistically, according to Bryant, in an Indonesian term for the poor, which had the original meaning of "they who are not" (NASSA, 1978:20). This notion of the poor as "the excluded" or at least as "the left out" has some empirical evidence.

Several investigators of the ESIA/WID[2] research, reviewing the literature related to their specific program concern, point out that in many cases, the introduction of technology, the addition of an infrastructure or the provision of a new government service would tend to lead to a further deterioration of the income distribution structure (Paris, 1979; Cariño and Albano, 1979; Sodusta and Abarrientos, 1979). This tends to come about because of several factors, some related to various characteristics of the initial high income-earners (e.g., higher receptivity and capacity to respond to novel approaches); the nature of the programs themselves (e.g., a tendency towards labor-saving bias in technology); "the tendency for public services to be available to big farmers" (Paris, 1979), because these more affluent groups are easier to reach since they live at or near the center and can understand technical language; and even some biases in policy (e.g., considering the poor as high risks for loans, and

[2] ESIA/WID, meaning "Economic and Social Impact Analysis/Women in Development," is a USAID-supported research program studying the impact of several government programs on eleven development concerns, one of which is income distribution.

giving higher priority to irrigated over non-irrigated farms, the latter usually being the poorer of the two).

The problem may also be evidenced at a structural level when one considers not the poor inhabitants directly, but just the areas where more poor people live. For instance, Alvarez and Layo point out that access to various services (public as well as private) is inversely related to the poverty of provinces *(Philippine Sociological Review,* 1979).

In health services which are our main concern, we discover similar disproportions. A well-known fact is the lopsided deployment of medical professionals. The *1970 Physician Manpower Survey* of the Association of Philippine Medical Colleges (APMC) reported that 34 percent of the respondents claimed Metropolitan Manila as their place of work, 22 percent, all other cities, and the remaining 44 percent, the rural areas. On the other hand, based on the 1970 physician registry maintained by the largest local drug company, 38 percent of the total number of doctors in the Philippines are in Greater Manila, 27 percent in other cities and provincial capitals, and only 35 percent in the rest of the country (Cuyegkeng, 1971). In 1973, a Department of Health survey showed that Region IV, which then included the Metro Manila area, had 41 percent of total government physicians and 44 percent of private practitioners. While the area bases and figures vary, the overall conclusion remains that rural areas, which house 68 percent of the population, are served by a proportionately fewer number of physicians.

Looking at the distribution of physicians by the income class of municipalities, the picture becomes even more bleak. Based on an APMC survey and the Department of Finance Classification of Municipalities in 1971, almost 83 percent of the richest municipalities (first to third classes) had more than one physician. By contrast, 70 percent of the poorest towns (sixth and seventh classes) had no physicians at all (Cariño, 1973).

Availability of facilities follows a similar uneven distribution. In 1976, Region IV (including Metropolitan Manila) had 46 percent of total hospital beds, accounting for a bed-population ratio of 1:364. It was the only region with a ratio more favorable than the national figure (1:706). Regions IX and XII, the Muslim areas of Mindanao, had the worst ratios, 1:1595 and 1:1405, respectively. Other poor regions like Eastern Visayas (Region VIII, 1:1111) and Bicol (Region V, 1:1122) were similarly disadvantaged (Department of Health, 1978). While there is no one-to-one correspondence between poor areas and the incidence of poor people, it can be assumed, given the needs for amenities of the rich and the corresponding tolerance of the barest minimum by the poor, that many permanent residents of poorer regions would also tend to be poor.

Even in areas where health care would be available, the quality of services received by the poor would not be comparable to those received by higher income earners. Dequina compared two government hospitals, the GSIS Hospital (now Ospital ng Bagong Lipunan or OBL) and the Philippine General Hospital (PGH) and found out that the latter, despite a high-caliber

staff, compares unfavorably with the OBL in terms of facilities. The PGH suffers from lack of equipment, scarcity of technical manpower and overcrowding. A higher proportion of its patients are poor. On the other hand, the OBL tends to cater to middle-class employees and has fewer low-income patients (Dequina, 1975).

Another factor affecting the poor's access to health care is the prohibitive cost of availing of medical services. The president of the Philippine Hospital Association stated that hospitals could not charge the actual cost of hospitalization because people cannot afford it. Thus, despite Medicare benefits, less and less people who need hospitalization are being taken in as inpatients. Moreover, the cost of medicine and laboratory facilities has also increased. For instance, the price of an x-ray film, 14 x 17 inches, has gone up from ₱9.55 in January to ₱44.80 in March 1980, representing a 337 percent hike in three months. Prices of drugs have also increased though perhaps not in the same degree.

Dr. Pacifico Marcos, Chairman of the Philippine Medical Care Commission, summarizes the effect of these high costs on the poor:

> The poor patient is only given a prescription but if he has no money, he has no medicine. Only nature takes care of him. *(Bulletin Today,* May 26, 1980).

Focusing directly on income classes, Adorna (1976) surveyed 527 patients of different health and nutrition institutions in 1975 and reported that access to these institutions is better for higher income clients. Joves (1979) supports this finding for Bicol and attributes the difficulty of the poor in getting health services to a number of factors, including: (a) their physical location and the means for reaching them; (b) the criteria, standards, and other requirements for determining client's eligibility for the use of the services; and (c) the administrative standards and "supply" conditions of the services like manpower, service facilities, service hours, queueing rules, and the referral system.

Even in Manila itself, Hidalgo (1979) discloses that a disturbing finding of his evaluation of this city's health department (MHD) is that the program was not reaching the neediest groups in the slum and squatter areas and nearly one-third of its clients were not indigent or even medically indigent. Hidalgo points out, however, that the MHD had not made, at the time of his study, any formal statement on who its target beneficiaries are to be.

Tan's 1975 survey vividly shows the disproportion of benefits families of various income levels receive from government health expenditures. She found that while an average health expenditure of ₱112 goes to families earning ₱10,000 and above, only an average of ₱18 is received by those earning from zero to ₱1,000. This implies that the highest income earners are receiving 6.2 times more benefits from *government* health spending than the poorest families.

These findings suggest that the recommendation of the "basic needs" advocates needs to be taken into account in any program that seeks to provide services to the poor. To reiterate, the two points they emphasize are the following:

(1) An explicit policy to direct services to their intended poor recipients is necessary for the satisfaction of basic human needs;

(2) Once the policy has been made, the attainment of the "basic needs" goals becomes essentially an administrative question of how to link and deliver services to target groups, primarily "the excluded," or the poorest of the poor in the country.

At first glance, it appears that while the nature of the policy required is no longer debatable, the form and effects of the administrative mechanism to implement it are still unsettled issues. The latter, therefore, are the main concerns of this study.

To describe and analyze how a basic need is answered by various mechanisms, health care rather than any other social service was chosen. This decision was based on many reasons.

First, poor health appears to be almost a definitive characteristic of being poor. In colloquial terms, the poor are even referred to as "the great unwashed," signifying that clean and safe water, a basic facility, is not available to them. In a similar vein, one author states the following relationship:

> To know that a child is malnourished is to be able to predict with a great deal of confidence that his parents are poor, uneducated, unskilled. . . the conditions which lead to malnutrition are also conditions which affect the intellectual, social and cognitive development of the child. (Quoted from Guerrero, 1981:12).

Those who miss meals, live in unclean surroundings, and have inadequate clothing and shelter more often than not are not merely in a state of poor health but are also poor.

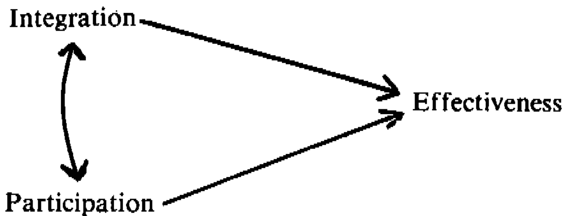
Second, despite such close correlation, it is interesting to note that the poor themselves do not rate health as a priority need. Jaime Galvez-Tan, a physician who has been working with community-based health programs, stated in a 1980 lecture that in most communities he has worked with, health often comes up only as the seventh- or eighth-ranking priority need, if at all. This fact is confirmed in various surveys conducted for this project as well as in earlier studies (Cariño and Viñeza, 1980, Chapter 2; Salcedo, 1978; Asian Social Institute, 1973; Alfiler, 1981; Dorros, 1980).

In the poor's own perspective the more important requirements include money (often mentioned as bluntly as such), means of livelihood, and education. For the community, meanwhile, the needs triumvirate are roads, water and electricity. Health is therefore not considered a salient necessity by the poor although they do not enjoy it and although objective analysis shows that good health is basic not only to a decent life, but also to survival.

Because of these and of the wide variety of organizational alternatives, we in the reasearch team are concentrating on programs that delve, exclusively or in part, on health services. Specifically, we want to compare different organizations which provide health and related social services and which define their intended recipients as poor people or poor communities. The nature and extent of the integration of these organizations is the initial differentiating characteristic we will explore. Also because the "new" conception of development implies people-involvement, the level and kind of participation of community residents constitute another important issue. The overall evaluatory measure, meanwhile is effectiveness, i.e., the ability of the organizations to deliver their particular package of health and related services to their target beneficiaries.

The expected interrelation of these key variables, i.e., integration, participation and effectiveness is illustrated in Figure 1.1.

Figure 1.1 The Conceptual Framework



The following hypotheses will be tested:

1. Integrated approaches to the delivery of health and other services tend to be more effective than sectoral approaches.
2. In turn, participation tends to increase the effectiveness of service delivery.
3. Integration tends to be accompanied and even reinforced by community participation.

Although the major aim is to find out how the two antecedent variables influence effectiveness, we will also try to understand how interdependent these two factors are. Moreover, because they are intrinsically as well as politically and administratively significant, we shall also look into the other accompanying factors and consequences of integration and participation.

To clarify our perspective, we will discuss each of the main concepts below.

Integration

The degree of integration of a program depends on the range of activities it encompasses, and the number of agencies involved in its planning and implementation processes. These two characteristics are identified in Ness' definition:

Integration is the bringing together of specialized and differentiated *units or activities* into a single or more coordinated whole set of activities (Ness, 1975, Emphasis supplied).

One may explicate "range of activities" by referring specifically to health, the area of interest in this study. Based on this, a program is termed sectoral if it purports to cover only the "within health" functions, i.e., any aspect of preventive, promotive, curative and rehabilitative medicine, or a combination of these, including family planning and nutrition services. In our experience, we have not found any organization involved in general health care which is not at the same time performing in some way functions related to family planning and nutrition. The reverse, however, is not true. For instance, some family planning clinics may ignore all other health services. This suggests that the sectoral-integrated distinction may lie in a continuum with specifically family planning-only agencies as the most sectorally confining.

At the other end of the continuum — the integrated—one finds programs involved not only in all or certain aspects of health care, but also in other services such as other social (education, welfare), economic (infrastructure construction, income-generating projects), political (organizational or electoral activities, political re-education), and cultural (e.g., those relating to religion) activities. These activities may have backward linkages to the health sector, like for instance, backyard gardening as a means of ensuring better nutrition, or as an activity to be enjoyed simultaneously with or as a result of improved health care.

This definition while specific to health is in consonance with the meaning given to "integration" in the literature. Although often regarded only as an administrative problem, integration takes the normative assumption that human needs are interrelated and require holistic solutions. The individual's personality is a whole. His problems are systemic and separable only analytically. Thus, the needs of people for health, nutrition, potable water, employment, and even spiritual nourishment are not unrelated. The psychological orientation of the Filipino (which he shares with many other races) to deal with another as a total person rather than as one with compartmentalized roles reinforces this.

The first dimension we have identified, therefore, starts with the client and his needs. We then regard as an index of integration the range of activities offered by the program since that offers many possibilities of meeting a greater proportion of the client's needs. The most integrated scheme in this sense would be:

a service delivery system which can provide all those services needed by a given client or community - constrained only by the state of the art and the availability of resources (Gans and Horton, 1975:32)

The second dimension zeroes in on the administrative question. The Gans and Horton study proceeds to use the following working definition of integration:

> The linking together by various means of the services of two or more service providers to allow treatment of an individual's or family's needs in a more coordinated and comprehensive manner (Gans and Horton, 1975:32)

The emphasis here is on linkage and coordination. To the layman, the most integrated program may appear to be one where all processes and resources are provided by the same agency that provides the service. That, however, is a case of vertical coordination within a single organization where hierarchical authority and unity of command solves and dissolves the integration problem. In this study, that organization is the very antithesis of the integrated program. For a program to qualify as integrated under the administrative dimension, it has to tackle the problem of dealing with several agencies during its planning, implementation and evaluation phases, and in its quest for and use of resources.

The focus of this study, then, is on the manner that agencies involved in health service provision are organized. Clearly we are subsuming several aspects in this dimension, including:

1. the relationship of offices involved in each stage of the program cycle (planning, implementation, and evaluation)
2. the relationship of offices which provide resources for the program, including funds, personnel, etc.
3. the number of offices clients recognize as delivering services.

We have chosen to differentiate programs according to the number of agencies involved in implementation alone, thus focusing on that phase which the client can observe. Where delivery is undertaken by one agency and where service providers are identified as coming from that particular agency or under its auspices, the system is considered to be having a single delivery channel. Within this level, however, a regular government department (where activities are vertically coordinated and integration, in our sense, is no longer necessary since it has only one office for the entire program), will be distinguished from cases of integration where many agencies are involved in various phases (for instance, planning is done by a group coming from different offices or sectors) or in giving support (e.g., funds or personnel come from various sources) but which nevertheless maintain a single delivery channel. To clarify what the category includes, we may cite examples taken from our survey of health delivery mechanisms. The Barangay Health Aides (BHA) project of the Silliman University Medical Center which covers seven barangays in Dauin, Negros Oriental illustrates a single-agency delivery channel. Project planning is done jointly by key personnel of the Silliman University Medical Center Extension Service and the Marina Maternity Clinic. The project was given a building by the Sycip Plantation, Inc. and received financial contributions from various foreign and local Protestant groups. With the cooperation of the home management Bureau of Agricultural Extension and the Rural Improvement Club (for agricultural home management), the Rural Health Unit, and private practitioners, the BHA maintains a clinic which provides health ser-

vices and incorporates community development as part and parcel of health care. The program got its name from the part-time and semi-voluntary workers it trains for clinic work and home visits.

A more complicated set-up with a single delivery channel is exemplified by the Baao Applied Nutrition Program (BANP) in Camarines Sur. Funded largely by the Philippine Business for Social Progress, BANP is managed and supervised by the Secretariat of Social Action (SSA) of the Archdiocese of Caceres. The SSA is a policy-making and planning body. Its cooperating agencies and their direct services include:

(1) The Ministry of Health which provides the BANP participants with such services as physical examination, immunization, deworming, etc.

(2) The Catholic Relief Services which contributes the clinical scales and some commodities used for food supplementation.

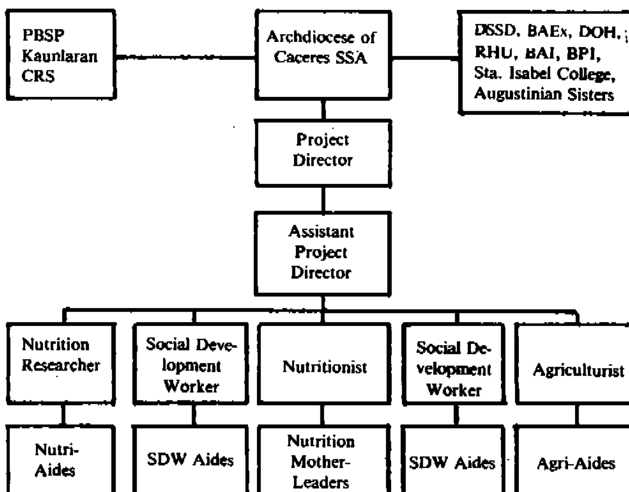
(3) Bureaus under the Ministry of Agriculture which provide technical assistance to the trainees in their respective fields (e.g., swine raising, plant production, etc.)

(4) The Ministry of Social Services and Development which gives financial help to BANP participants engaged in cottage industries.

Despite the number of agencies involved, delivery of services - a combination of community organization, nutrition education and rehabilitation, income generation, and community health - is the task of BANP participants who are community volunteers supervised by professional workers of the BANP.

Figure 1.2 presents the organizational chart of the BANP.

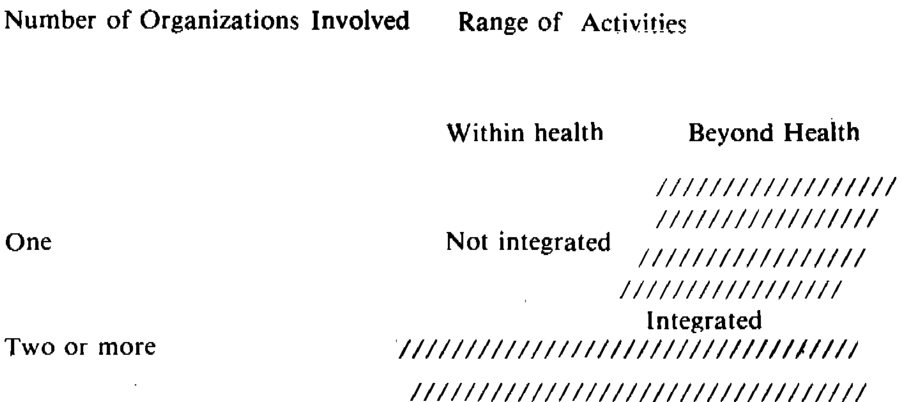
Figure 1.2. Organizational Chart of the Baao Applied Nutrition Program, Camarines Sur



Other programs which provide a number of interrelated services involve more than one agency in delivery. The Barangay Volunteer Medics (BVM) Program, for instance, is a project of the Philippine National Volunteer Service Coordinating Office (PNVSCO) which is operating in eight municipalities all over the country. Primarily a program to train medical volunteers, the BVM is managed and implemented by the PNVSCO in cooperation with local governments and health agencies and associations including the provincial health office, the rural health unit and pharmaceutical firms. As soon as a volunteer medic completes training, he is placed under the direct supervision of the Provincial Health Officer, a private practitioner or a nurse in the locality were he is assigned. These other health professionals continue to render health care in that area, under the name and auspices of their mother agencies.

In summary, a program may be integrated based on its range of activities and the number and relationships of agencies involved in it. This interrelation of the various dimensions is shown in Figure 1.3.

Figure 1.3 Dimensions of Integration



As shown above, a sectoral, single-agency program is classified as "not integrated" and all other combinations merit the modifier "integrated" in varying degrees.

Participation

Like integration, participation covers a wide range of values. We try to capture here the variety of involvements available to community residents. An important aspect is the citizen's role in each stage of the program cycle (Cf. with UN, 1975). Thus, one can distinguish one project from another on the basis of whether a community is simply a passive recipient of a service or when the residents are involved in: (a) implementation alone, (b) planning and implementation, or (c) the total program cycle (planning, implementation, evaluation). The levels of involvement are listed in this order because this is normally the direction in which passiveness graduates into activeness.

In cases where the program is reluctant to give the people power in the community, it usually allows the residents to be simply extensions of the organization or instruments in distributing organizational information and resources. A slightly higher level is reached when the people are asked to assist in service delivery by training a few resident volunteers to be the local variant of barefoot doctors. In the Panay Unified Services for Health (PUSH), the assembly of all community residents even gets involved in selecting the barangay health worker.

Organizations using residents in their programs may be further distinguished into three: those which give full pay to its community health workers (CHWs); those which get volunteers from among community residents; and those whose CHWs are sustained by community support.

The first type involves the hiring of local residents for project work and implies very little community participation. The second may be regarded as somewhat more participative if one considers CHWs as representing the first stage of community involvement. The third clearly involves the highest degree of community participation among the three schemes.

Another level of participation is reached when a community is allowed to plan as well as implement the program's activities. This appears to be the case with the Mountain Clinic projects and the PATHS (People's Adoption of Total Health Self-Sufficiency) of the Philippine Medical Association. The extent to which this is actually accomplished cannot, however, be determined without a more intensive documentation of these projects. In any case, at this stage, the residents are supposed to have an important "say" in what takes place in their community and in the future direction of the program.

When the community decides where it is going and what means it will take, and then undertakes its own activities and even monitors and assesses its own progress, it shall have reached the highest level of participation. Many community-based health programs (CBHPs) see this full flowering of people's power as their ultimate aim. This kind of participation, however, cannot be attained without a control of the major program resources, particularly personnel and funds. A community which decides where to field personnel and is completely self-supporting in financial and other material resources is truly self-reliant. Its obverse is a community which is simply a beneficiary of services and funding of an external agency outside its control. The former is the dream of community organization workers while the latter is the caricature of traditional social service agencies. Most of the present health delivery mechanisms fall between these two extremes.

Citizen participation is thus regarded here as a composite of two major dimensions of people's involvement - its stage in the program cycle and the level of dependence on external or local resources. The magnitude of these varies and points at which qualitative change would take place cannot be pinpointed precisely. Hence, we portray them in Figure 1.4 as tentative points in a continuum.

Figure 1.4 Continuum of Citizen Participation

Areas of Involvement	Passiveness			Activeness
In the Program Cycle	As recipient of service only	In implementation only	In planning and implementation	In planning, implementation, and evaluation
In Provision of Resources				
Finance	Completely dependent on external funding	Dependent on some combination of internal and external funding		Completely self-supporting
Personnel	Fielded by externally based agency	Fielded jointly by outside agency and local community		Completely fielded by local community

Effectiveness

Effectiveness is our measure of performance. Traditionally, it has been defined as "the production of outputs to yield certain desired outcomes" (Uphoff, 1973:374), such desires (or more formally, "goals") usually being taken by the evaluator as a given. This implies that the indicators of performance should comprise various methods of comparison as set by the program administrators themselves. While this is acceptable as a first step, we also agree with the advocates of New Public Administration who have argued that this is not enough, that the study of public administration (and therefore, its evaluatory measures) must be founded "on some clarification of ends, on some area of moral purpose" (Savage, 1971:56). This means accepting social

equity in income and power as a basic goal and standard of performance (Wu, 1973), whether the program has explicitly recognized it as a desired outcome or not. In other words, for any program, it would be fair to inquire: *"cui bono?"* who benefits?

The new emphasis in Public Administration aligns it with the re-thinking of scholars in other disciplines interested in development. However, even without such alignment, we believe it is still relevant to apply a standard in public administration to health delivery mechanisms not all of which are run by government agencies. For here we use "public" in relation to any activity which allocates values in a society in an authoritative manner (Easton, 1953). Whether a program proceeds to perpetuate or diminish "the inequitable distribution of preventable disease," as one medical sociologist had put it (Nicolaus, 1968), that program, whether sponsored by government or not, has managed to allocate values authoritatively. It is therefore "public."

A somewhat more moderate view of public agencies distinguishes between public and private goals following the definition of welfare economists, and regards as public all institutions which distribute goods with indivisible and collective impact (Nadel, 1975; Ostrom, 1971; Olson, 1965).

The discussion of effectiveness will then, whenever possible, delve not only into how the entire population is benefitted by the program but also into the extent to which the poor become the beneficiaries of such program, whether they are regarded as specific targets or not. With this special focus in mind, performance was appraised based on the following set of indicators:

1. Administrative measures of effectiveness, including congruence of program activities and people's needs, comparison of program targets and accomplishments, and changes in community health conditions, as given by statistics and documents gathered by the organizations themselves.
2. The people's awareness of the programs, and
3. The quantity and quality of the services they provide. These would involve an objective look at how and in what ways the program serves the community, and the more subjective one of reporting on the satisfaction of the people receiving the services. The first would encompass the extent of coverage of the program, including: (1) whether or not people are acquainted with the services it offers, and with the program itself; and (2) what services are delivered and received, to what extent, and to whom.

As Gans and Horton state:

> "Effectiveness of service delivery" refers to the availability of service rather than its quality (1975:34).

While it may not be possible to speak definitively of quality, this study went a step further by looking at both availability *and use* of service. Findings here were based not only on output statistics routinely gathered by

the programs themselves but also on the people's recollection of the benefits they received.

In looking at the dimension of satisfaction with the service, beneficiaries were asked to locate themselves in the continuum ranging from "extremely dissatisfied" to "extremely satisfied." Moreover, in an attempt to get clients' perception of quality of the service, an open-ended query was asked them:

> Are you satisfied (or dissatisfied) with the services performed by (program personnel earlier identified by respondent)? If so, why (not)?

In this question, we tried to get an appraisal anchored on specific services and personnel, so that the answer would not be a blanket praise or denunciation of a program. The verbatim answers were then coded into seven factors or dimensions.

Five of the factors have been suggested by Millett (1954:397-400). His labels and definitions of ampleness, equity, timeliness, continuity and progressiveness were adopted. A sixth factor, accessibility, was added following recent studies showing its significance (Schaffer, 1975; Joves, 1979). The seventh dimension related to the demeanor of the service provider. This often refers to whether or not the health personnel workers deliver "service with a smile." This dimension was not among the preliminary codes used since only the beneficiaries' perceptions of the quality of service were being tapped. However, since it was frequently mentioned, we decided to add it in recognition of the personalistic approach of the Filipino which appreciates *cariñoso* service, the perceived human concern, even in the face of what professionals call "technical failure," i.e., death.

Interestingly enough, even in the "impersonal" West, there is something of a return to the house-calling doctor and the bedside manner as evidenced by the rise of hospices for the terminally ill and the recognition of the general practitioner or the family physician as a specialized area within medicine.

Table 1.1 shows the various dimensions of satisfaction discussed here and examples of each taken verbatim from our household surveys.

Contents of This Volume

This Chapter lays out the concerns of the study. Chapter II then discusses the methodology, including the results of the survey of rural health delivery mechanisms that served as the background for the intensive study of five programs. Chapter III describes the sample sites and households based on information from our administrative and beneficiaries' surveys, and documents provided by the program as well as by relevant government and private-sector agencies.

Chapters IV to VIII describe in detail the case programs. They would be of particular interest to readers who want to know about each health organization. Others may prefer to proceed to Chapter IX which summarizes the infor-

mation in these chapters and compares the five health delivery systems in terms of integration and seven other distinguishing features. Information in these chapters are based on interviews with program personnel and other knowledgeable informants, and on documents and other papers of the relevant organizations.

Chapter X deals with citizen participation and its correlates. It is based primarily on the results of the household surveys conducted in each of the sample sites, supplemented by the same sources used in the preceding chapters.

Chapter XI tackles the issue of effectiveness. Findings presented put together data from the household and administrative interviews, and program documents. The last Chapter presents the summary, conclusions and policy implications derived from this study.

Table 1.1 Dimensions of Satisfaction with the Service

Dimension	Definition	Examples	English Translation
Ampleness or adequacy	Adequacy and sufficiency of the service being performed.	"Maayos ang panganganak, magaling"; "Nag-aaral pa lang ang mga doktor at kulang ang gamit."	"Services for child delivery are fine"; "Doctors are just trainees, so not very effective and (they) lack equipment."
Equity	Availability of the service to everyone, regardless of personal circumstances.	"Madaling malapitan kahit walang pera"; "Mahal, kailangang may pera ka para sa gamot."	"(They) can easily be approached even without money"; "Expensive, you have to have a lot of money so you can have medicines."
Timeliness	Availability of service whenever it is needed.	"Pagdadala ng pasyente, nauuna pa ang interview kaysa gamot"; "Tiyuhin diyan namatay sa katatanong. Hindi inaasikaso agad"; "Mabuti, naampat agad ang pagdurugo."	"When you bring a patient, the interview comes first before giving medicines." "My uncle died there because of too many questions. They don't give immediate attention"; "Fine, my bleeding was stopped at once."
Continuity	Sustained nature of the service.	"Nagpupunta dito at kinukumusta kami, magaling na manggagamot;" "Nagtitimbang ng mga bata, pero minsan lang."	"He comes here and inquires about our condition; a good doctor"; "(She) weighs children but only once."
Progressiveness	Ability of the service to improve over time.	"Magaling noong bago, pero hindi na sa ngayon"; "Hindi ningas-kugon, mabuti pa rin hanggang ngayon."	"It ran well at the start but no longer." "Not flash in the pan, runs well until now."
Accessibility	Ease of the client in getting service.	"Dahil nakakatulong pag andito, maski hindi sila sa Center, maski hindi dalhin sa bayan ay tinutulungan talaga."	"They help us even if we do not go to the Center, even if we meet them (and ask their help) outside the Center."
Demeanor of Service Provider	"Service with a smile".	"Mabait, laging nakangiti."	"Kind, always smiling."

Chapter II

HEALTH SERVICES FOR THE POOR: METHODOLOGY[3]

Ma. Lourdes S. Joves, Ledivina V. Cariño
and Victoria A. Bautista

This Chapter presents the methodology used in this study and starts with a description of how the compendium of health delivery mechanisms was compiled. This description is followed by an explanation of the criteria used for the choice of five intensively-studied programs and areas. Then the selection process for the key informants in the administrative survey and the respondents for the house-to-house interviews is presented. Closing the Chapter is a discussion of the limitations of the study. A "Profile of Respondents for the Household Survey" is appended to this Chapter.

In order to tackle the issues raised in the conceptual framework, our first task was to determine the range of health delivery mechanisms operating in the country with emphasis on those located in rural areas. This turned out to be more difficult and time-consuming than the phrase "get-a-list" would normally convey. Since no comprehensive lists were immediately available, we had to make our own survey in a snowball fashion, starting with those affiliated with or known to health agencies, foundations and other institutions in the broad field of social development. However, despite diligent efforts, it was not possible to make a complete listing of all health delivery organizations, particularly many of the so-called community-based health programs (CBHPs). Most of these were small-scale undertakings, information for which could only be gotten serendipitously (for instance, one of us may hail from there or may have traveled to such area of operations for various purposes). Angara, who made the most comprehensive attempt at a CBHP list, mentions that there are as many as 98 such projects, 19 of which he and the WHO Team had been able to visit (Angara, 1978; 4-5). However, no agency keeps a comprehensive list and the team had to go to every likely government, academic, religious and private-sector establishment to discover the wide variety of these delivery mechanisms. A related problem is that few of these organizations keep project papers and documents. When they do, circulation is so limited that copies are difficult to get. The lack of written reports also implied that the person in charge (who would however be likely to be in the field) had to be interviewed, or a visit to the actual field of operations had to be made. Thus, the survey of health delivery mechanisms conducted often provides only barebones information, even on a project that is definitely ongoing, and lists the central sponsoring agency rather than individual projects in the field.

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[3]Some parts of this chapter, specifically the discussion of the compendium of health delivery mechanisms, previously appeared in Cariño (1974a) and was presented in the 1979 Annual Convention of the Philippine Economics Society.

A second major problem encountered is the variation present even within a specified sponsoring organization. For instance, the Carigara Catchment Area Project and the Comprehensive Community Health Program, both under the University of the Philippines, have different objectives, components and delivery modes. There are also differences among MOH regional projects, activities sponsored by the Philippine Business for Social Progress (PBSP), etc. This means that for organizations having a number of projects, the information and data that could be obtained from the central office would not be sufficient.

Third, a number of these projects are being operated on a pilot basis, preparatory to a large-scale program or replication in one or two other areas if found workable. Some are simply ad hoc, running as long as there are funds and community/professional interest to sustain them, only to fold up if these run out. Others are regular projects or programs which the sponsor is committed to undertake on a long-range basis.

Another limitation is that the study team relied generally on published papers, project papers, and short interviews with central office personnel but did not see the implementation of the projects. Thus, discussion of the programs, except for the five case programs, refers more to formal statements rather than to actual conditions. The sponsors' seriousness of intention to stay in the health field, the extent of the institutionalization of the organization and its commitment to any particular approach can only be gauged if one goes to the field. This limits what can be said about the services provided and the degree of community participation, two very crucial variables for the analysis. A more thorough evaluation along these lines had been made only for the case-organizations.

A Compendium of Health Delivery Mechanisms

There are perhaps over a hundred programs and projects currently operating, all aiming to deliver a package of health services to various areas of the Philippines. The study team was able to get a detailed compendium for about thirty of these and more limited information on a number of others using primarily Angara (1978), NASSA (1978) and Galvez Tan (n.d.).[4]

The results of the survey and the description of how the health systems tended to vary in terms of sponsorship, area coverage, the type of person delivering the services, the kind of area served, the content of the service package and the extent of community participation, are presented below.

Sponsorship. The most obvious way of differentiating among the health delivery systems is to inquire into what agency runs their program. Ordinarily, this would refer to who initiates the project, who is responsible for its opera-

[4] A description of the organizations with adequate information is listed in the Appendix.

tions, and who funds it. In practice, though, this turns out to be a complex variable, with a project having a different initiator, implementor and fund-giver. In addition, in many cases, the sponsorship is not clear since many projects enjoy joint sponsorship or involve other agencies as cooperators after they have been launched (e.g., the Carigara Catchment Area project of the University of the Philippines, Region VIII, Ministry of Health, and Ministry of Local Government and Community Development).

We have grouped projects according to what agency or agencies are acknowledged formally by the organization as its sponsor. According to Angara, dealing with community based health programs (CBHPs) alone, there are 16 projects sponsored by government, 49 by churches, 7 by educational institutions and 6 by voluntary establishments and private foundations (Angara, 1978; pp. 33-34). We were not able to make a compendium for each of the 98 projects, but judging from our own list, Angara's already seems to be understated as regards those sponsored by educational institutions and voluntary establishments.

Among the programs in the survey are those run by government agencies (e.g., the Ministry of Health, the Nutrition Center of the Philippines, the Ministry of Social Services and Development, the Commission on Population), including their national and regular programs, and special projects such as the HEART (Health Extension Aides for Region Twelve), the Anemia Surveillance Project sponsored by the National Nutrition Service, and NCP's Nutrition Surveillance Project and Barangay Nutrition and Health Scholar Project. There are also projects under the aegis of new government offices specially created for such programs or projects [e.g., the Panay Unified Services for Health (PUSH)].

A number of hospitals and universities, especially their schools of medicine, operate residency training combined with a health service delivery program. Included here are the Philippine General Hospital's Muntinlupa Community Health Program, Capiz Emmanuel Hospital's health outreach program, the Barangay Health Aides Project of the Silliman University Medical Center, and the community health programs of the University of the East (UE), Nicanor Reyes Memorial Foundation, Far Eastern University (FEU), and the clinics of the U.P. College of Medicine in Manila and Institute of Health Services in Tacloban. Church groups, particularly the National Secretariat for Social Action (NASSA), the Rural Missionaries of the Philippines, and the Franciscan and the Redemptorist Missionaries for the Roman Catholic Church, and the National Council of Churches in the Philippines (NCCP) for Protestants, have also initiated several community health programs. Other private-sector organizations also provide various types of health services. They include non-profit corporations such as the Philippine Rural Reconstruction Movement (PRRM) and the Philippine Business for Social Progress (PBSP), both of which have many projects with health figuring as an important component. Other village health projects are initiated by voluntary associations such as the PATHS (People's Adoption of Total Health Self Sufficiency), a project of the

Philippine Medical Association, and other organizations which have their home base outside the Philippines, e.g., the Institute of Cultural Affairs (ICA).

Area Coverage. This ranges from services provided throughout the nation (typically done only by regular government agencies) to those covering one municipality (e.g., Baao Applied Nutrition Program and the Community Health Program of the Philippine General Hospital in Muntinlupa, Rizal), or a group of municipalities (e.g., Anemia Surveillance Project covering ten towns in Pangasinan). Other projects work in the barangay or village level, as exemplified by most CBHPs which are sponsored by voluntary establishments without a nationwide organization, or at the sitio level as demonstrated by the ICA-Project in Sudtonggan, Lapu-Lapu City. Some other programs have a region as their target area (e.g., Barefoot Doctors for Region IX, and Project HEART in Region XII), while others are implemented at the sub-regional level covering a number of provinces and cities (e.g., the Barangay Nutrition and Health Scholar Project in Metro Manila, the Bicol Integrated Health, Nutrition and Population Project in the Bicol River Basin Area, and the Mindoro Integrated Rural Development Program).

Still others are found in different areas of the country, depending on: (1) the preference of the proponent (as in PBSP, PRRM, and the UE and FEU community health programs); (2) the geographical divisions of the implementing organization (as in the NCCP Projects and the Makapawa programs of the Rural Missionaries which operate on the parish level, or the Mountain Clinics in Kansalakan and Calabaclabacan, each also serving outlying barangays and sitios); and (3) the local officials' ability to meet certain criteria for inclusion (as in the Katiwala Project initiated by a religious group but which has been adopted by the Regional Development Council of Region XI as an approach to social development, and the PATHS Project where local officials of selected barangays have to show concurrence and cooperation).

Kind of Areas Served. As implied above, many sponsors set their own criteria for any area's inclusion into their program. These are not always clearly spelled out, and some may not be followed strictly in practice. Several ways of defining the target of a project have been used. One may require that the areas covered are "depressed," this defined in varying ways. Project PUSH uses a complex set of social indicators to group Panay municipalities according to their relative level of depression. The extent to which this requirement is followed may, however, be open to question since:

> the project barangays are generally located in clusters close to the poblacion to facilitate monitoring and supervision of Barangay Health Workers by the Rural Health Unit (Guerrero; 1979: 5).

Other programs or projects require their site to be depressed, medically underserved, or showing acute health needs. This is the major criterion in programs like the Barefoot Doctors Project, Katiwala Project, Capiz Emmanuel Hospital's Outreach Program, Nutrition Surveillance Project, and the PUSH

(which is aimed at 600 depressed barangays in the island of Panay). A few others, despite lack of formal pronouncements as regards their criteria for selecting project sites, seem to consider (as may be gleaned from their objectives) the people's immediate need for health services as a guiding factor in establishing a health program in the locality (e.g., Mountain Clinic Projects, Barangay Health Aides Project as well as the Community Health Programs of UE and FEU). The various CBHPs, such as the MAKAPAWA in Samar and Leyte use the following criteria:

a. "depressed": an area where basic services are lacking or not found.

b. "strategic" in the sense that significant social, political or economic problems affect the community, e.g., farmers whose land will be converted into a plantation or factory site or fishermen who are taken advantage of by big time trawl fishermen.

c. "far from the parish center". In pilot areas, however, a place accessible from the center could be chosen initially.

d. "central barrio in the sense that it has a sphere of influence over other barrios" (Galvez Tan. n.d.: 42).

Another way of choosing is exemplified by PATHS which tries to meet both the health needs of the people and the project need for success. Thus the criteria for selection of a barangay are two-fold:

(1) "preferably one that does not have an operating health center or entity to service barangay health needs," and

(2) "a barangay with some income potentials to be developed, to have an easier base of introducing measures for economic upliftment." (PMA, n.d.: 21).

To a certain extent, the PBSP also checks out the income potential of the community, since it prefers projects that would eventually be self-supporting.

A third criterion used for site selection is the willingness of the people, including government officials, to support the program (e.g., Procom, Katiwala, PATHS, IHS Project, CCHP, and Sudtonggan Project). In fact, most of the programs studied, though not strictly requiring this criterion at the start of the project, could not have operated without community organizations or unorganized residents cooperating with or participating in the program.

These three main ways of specifying target areas are not necessarily mutually exclusive. However, the need criterion would be primary if one wishes to serve the poor, since extremely depressed areas may find difficulty in showing potentials for high income growth within the project life.

Type of Person Delivering Service. The service may be provided by a health professional such as a physician, nurse, midwife, sanitary inspector or nutri-

tionist in the MOH programs, or by persons about to join their ranks (called "underboard" physicians or nurses in Philippine parlance) as in university-sponsored projects. However, a multi-purpose health worker (MPHW) especially trained by the program or agency may be relied upon to take care of health problems under varying degrees of supervision by the health professional. In some cases (full-time outreach workers of the Commission on Population, for instance), these MPHWs are hired by the agency and assigned to an area within its coverage. Increasingly, however, these MPHWs are expected to come from the barangay they are to serve. In fact, many organizations have a system by which residents of the community screen and choose their own MPHW (as in many CBHPs), or participate in the screening process, with the sponsor having the final say (as in the Philippine Medical Association's PATHS). The PUSH project has a requirement that if a barangay nominee fails in the training program, that barangay will be dropped from the coverage of PUSH for that year.

Among the MPHWs, there also exists a great variation in incentives. Many are expected to do purely voluntary work (like the participants of the resident worker's training programs, mothers' classes, hilot training programs, and youth volunteers of the Comprehensive Community Health Program initiated by the U.P. College of Medicine); others are provided with small allowances or honoraria (most government programs such as the Barangay Nutrition Scholar of the Nutrition Council of the Philippines, which provide thirty pesos a month); while a few others are being funded from income-generating projects undertaken by community organizations (like the ICA project and the Barangay Health Aides Project).

Content of the Package. This category takes two dimensions: (1) services available in the area, and (2) the incorporation of the program into a referral system that usually extends beyond the area of residence of the direct recipients of benefits. As regards the first, some agencies concentrate on the traditional health services, including maternal and child health, family planning, nutrition, medical care, and environmental sanitation. Among these are the regular programs of the MOH, NCP, and POPCOM and the UP projects such as the Muntinlupa Community Health Program and the Comprehensive Community Health Program at Bay, Laguna. Note that none of these programs focuses only on medical care nor ignores the environmental and integrated nature of a person's need for health services.

All other programs tend to have a more comprehensive approach which marry not only medical care and the promotion of a healthy environment, but also economic projects (piggery, gardens), such non-health projects, however, being linked to the promotion of health by the project sponsors and personnel. They may differ from each other because that was the mandate according to the Presidential Decree or other documents that created them or because that was the decision of the sponsors or the community.

Generally, only the agencies with a health care focus fit their programs into a multi-tiered referral system, allowing an individual to get secondary care (attendance by a physician) or tertiary care (condition generally requiring hospital services). CBHPs generally lack this linkage although there are some which coordinate the MOH system in their respective areas. A project that provides both beyond-health services and a referral system is the Carigara Catchment Area Project with the Carigara Emergency Hospital as the provider of tertiary level services. Combinations like this assure a community of a total health care system.

Extent of Community Participation. The residents of a village covered by a program can always participate in a program as passive recipients of services frequently seeking health care only in times of dire stress. This is best exemplified by the community health programs of UE, FEU, UP, and NCP's Nutrition Surveillance Project.

Most of the agencies in the survey tend to seek a more active role for the communities than that. Several possibilities have been tried:

(1) Community participation in implementation. Here the community may deliver or assist in the delivery of services. Frequently, this is accomplished through a member of the community; in the health field, this is usually a woman. This person may be designated by program personnel as in MOH's volunteer paramedics and traditional healers, and POPCOM's lay motivators for the family planning program. Others are chosen by community leaders (PATHS) or by the community assembly (PUSH, CBHPs). This person lives in the community, is assumed to understand its people and health problems, has a certain stature so that her neighbors would listen to her, and has undergone training (from a few weeks to as long as six months).

Occupying the lowest tier of the program's service delivery system, this community representative provides basic/primary health services. In some cases, she performs additional functions such as conduct of IEC (information, education, communication) activities (as in the Barefoot Doctors Program) and baseline surveys (as in the Barangay Nutrition and Health Scholar Project), and motivating the community to participate in the project (as in the Bicol project).

Sometimes, a community network expected to facilitate implementation of services does not materialize, and community leaders become participants to the program purely on an ex-officio basis. In one case, program officials were asked if they preferred participation to service delivery, since the municipal health officer implementing the program felt that this was a real dichotomy. The program officials chose delivery, and community participation has since been maintained on no more than a token basis, while program-appointed community organizers have resigned (Santiago, 1979).

(2) Community participation in planning and implementation. At their best, CBHPs seek community participation at both these levels. Initially, a com-

munity organizer works through a parish priest or another leader in the barrio who introduces him to the barrio folks so that he can in turn inform the people about the program, conduct a social investigation, and identify small neighborhood groups (called *hugpo*) which would in turn select the leader-teacher-health worker. This local person is thus expected to interest the community in mobilization, document the health situation, and initiate small projects affecting community health. Later the leaders of all *hugpos* sit down together for action-reflection-action sessions which focus not only on problems affecting health but on all issues related to the transformation of structures hindering the barrio's progress (NASSA, 1978: 50).

Other examples in this category are the MSSD programs, PUSH, HEART, and UNEP/NHA's MASIP wherein aside from change agents involved in the provision of services, barangay residents are consulted and encouraged to identify community needs and problems, formulate solutions and plans of action, as well as participate in plan implementation.

(3) Community participation in financing projects. Another level is the extent to which the community participates in the financing of activities within the area. This usually takes place as a later stage in the people's assumption of responsibility over the programs operating in their area. It is rare for a project to get started with largely local support. However, many sponsors turn over responsibility to the area residents after a designated period of time, or after the community has shown its capacity to underwrite the projects. Sometimes, as in the Barangay Health Aides Program at Dauin, Negros Oriental, this may entail taking over the payment of the small honoraria for the multi-purpose health worker. In other situations, the community may fund even the construction of health centers themselves. This may take place in areas where the program concerned includes income-generating projects (Institute of Cultural Affairs Project at Lapu-Lapu City).

A number of programs (e.g., Mountain Clinic Projects, Katiwala, Baao Applied Nutrition, ProCom, and the IIRR, PRRM and PATHS Projects), encourage income-generating projects to finance or support certain community activities, increase local income and self-sufficiency, and inculcate self-reliant rather than mendicant attitudes among the rural folks even without intending to relinquish the project's management or supervision to the community. The examples in this group do not only have people showing interest (and later capability) to finance the projects but also getting involved in the other phases of program development - e.g., selected local representatives trained to be change agents and first-hand providers of the program's services, local citizens involved in the identification of the area's needs, problems and solutions, and community organizations mobilized and committed to solve (or help solve) their own problems. Hence, where there is community participation in financing projects, it may be assumed that such communities also participate in the project's planning and implementation.

Trends

Although the compendium of health delivery mechanisms in this study is far from being comprehensive, a few discernible trends can be identified.

Many programs of health and other services are being directed to areas which are depressed, medically underserved, showing acute need for health services, isolated or remote and without any operating health center in the community. The extent of depression is defined in a variety of ways by the government (e.g., NEDA or MSSD) or the proponent agency, or is identified in baseline surveys. Hence, many (if not most) of these programs are really intended for the poorer sectors of communities throughout the country.

Nearly all of these projects, regardless of sponsorship, have recognized the need for non-professional health workers, locally recruited and trained to become first-level providers of needed services. In certain cases, they perform additional functions like Information, Education, Communication (IEC) and motivation activities, baseline surveys, referrals, or even the formulation of a barrio health plan. As change agents assisting the health professionals (doctors, nurses, nutritionists, etc.), these persons serve on a full- or part-time basis, with or without remuneration from the sponsoring agency or from community-initiated income-generating projects, and are committed to carry out an important role in the upliftment of local conditions. These community representatives answer to different names. These include barangay supplementors (Anemia Surveillance Project), barangay health/medical aides (Bicol IHN Project, Mountain Clinic Project, SUMC Project), barefoot doctors, barangay nutrition and health scholars (NCP Program), barangay/community health workers (CBHPs, Makapawa, PUSH), "Katiwala" (or trusted, reliable person), health extension aides (HEART), rural reconstruction worker (PRRM, IIRR), or simply community volunteers or leaders (ProCom, Baao Applied Nutrition Program, MSSD Programs).

There is also a definite trend towards involving citizens, local organizations, or the entire community in various phases of program development. The non-professional health workers just mentioned form the lowest tier of the program's service delivery system. As Gilbert says, it is "when service recipients choose people like themselves for positions that influence service delivery decisions that they are guaranteed access and accountability" (Gilbert, 1972). In addition to selected representatives assisting in the provision of services, a number of the health mechanisms encourage the area residents to participate in program planning - i.e., to identify community needs, problems, and solutions, to help in the selection of representatives to be trained as auxiliary workers and in the assessment of their performance, or to signify their preferences for the time, location, and type of services to be offered. Here, citizen participants exert a more substantive influence; participation is redistributive because the pattern of decision-making authority and control is shared between the agency and the persons served. Hence, programs become more democratic and responsive to client needs, and hopefully grow to be

more effective, as more people (or the entire community) participate(s) in program planning and implementation.

Not a few of the programs in the compendium have gone beyond the first and second levels of citizen participation by promoting self-reliance and self-sufficiency among the clientele. These communities not only identify local resources but also finance or at least support various projects by themselves. There is an increasing awareness among program administrators of the need to encourage the service recipients to initiate or undertake income-generating activities such as backyard gardening, livestock raising, handicrafts, etc.

Where there is citizen participation in the financing of community projects, there is also involvement in program planning and provision of services; hence, power is truly in the hands of the people. If a program's success or failure largely depends on the extent of real community participation, then one should continue to involve clients in decisions affecting them and to draw their commitment to resolve their own problems, with minimum agency supervision or guidance.

It is interesting to note the positive direction towards integration. This trend takes the form of coordination and cooperation of agencies sharing similar goals and performing health-related services, or weaving services beyond health into a systematic delivery mechanism that will address the health needs as well as other social and economic requirements of the community. Participants come from government agencies, private local or international organizations, religious groups, professional associations, community socio-civic organizations, or interested families and individuals.

Integration by agency can be demonstrated by the commitment of agencies sharing common goals to provide financial/funding support to the proponent agency. Many programs/projects, whether government- or private-sponsored, draw additional funding from external sources. Most coordinating agencies manifest their commitment in terms of manpower and logistic support (buildings, vehicles, and other equipment), materials and other supplies (contraceptives, nutrition supplements, office supplies, etc.), technical assistance (such as training) or related services provided directly to intended clients.

The second type of integration is by function and is illustrated by programs like PATHS, Katiwala, and NCCP Projects, where delivery of health services is the focus although other social and economic projects are undertaken to provide a holistic approach to poverty redressal. Thus, there is a growing awareness among agencies to integrate other sectors of development into their health delivery systems. This tendency is, however, more obvious in privately initiated programs, while university/hospital-based programs, except the SUMC project in Dauin, Negros Oriental, tend to provide only health services.

Five Case Organizations

Based on this survey and on the team's definition of integration, five programs which combine the two dimensions of this variable in different ways were chosen. The five case programs representing the four cells shown in Figure 1.3 are the following:

a. Rural Health Unit, Ministry of Health (RHU/MOH). With a single organization within the traditional health field, this represents the sectoral approach in our study and serves as the control or comparison program. All the others are integrated in some way.

b. Comprehensive Community Health Program (CCHP), University of the Philippines. This represents agencies delivering services within the traditional health sector using multiple channels for delivery.

c. Project Compassion (ProCom). It represents beyond-health activities with multiple delivery agencies under joint private-government sponsorship.

d. The Sudtonggan Human Development Program (SHDP) of the Institute of Cultural Affairs (ICA).

e. Programa han katilingban para sa Maupay na Panlawas (Makapawa).

The last two are both single-agency service providers involved in beyond-health activities, operating under the aegis of non-governmental offices.

The distinction in the last two shows our attempt to use sponsorship as a selection variable. The programs represent all the major types of sponsors found in the survey of rural health delivery programs: national government (RHU); private sector and local government (ProCom); university (CCHP); religious (Makapawa); and private non-religious (ICA).

To be able to understand how these differences in integration affect effectiveness, it was necessary to study how these programs actually deliver services. This meant choosing specific areas as research locales. Fortunately, a lot of assistance and cooperation were extended by program administrators who were contacted as soon as the programs were chosen. Although receptivity to research like ours was not a criterion for selection, we were fortunate in having been accepted and encouraged by the personnel of every program in the list, whether intensively studied or not. The common interest is improving health care and the sense of doing something both worthwhile and novel obviously contributed to the goodwill enjoyed by the team in every phase of this research.

In all cases, sites which showed programs at their best were selected so that mechanisms could be evaluated on the basis of the most adequate resources and the finest personnel available. In this manner, shortcomings could be seen not as problems of implementation but of conceptual apparatuses. Given the real world, though, this still turned out to be utopian, for even in original pilot areas, scarcity and failure reared their ugly heads, frequently effecting changes

even in the program's conceptual framework. In spite of this, the best examples of each program were still studied in order to be fair when comparing them with each other. For the same reason, we chose only projects that have been in operation for at least two years. This would allow some time for the project to show some impact on the health status of the communities. This turned out to be not too limiting: many projects that had to be left out were hardly a year old (PUSH, HEART, etc.) while the youngest among the ones picked out were over three years old (Makapawa, ProCom).

For CCHP and ICA, there were, in effect, pre-ordained choices. The CCHP operates in only four municipalities of Laguna, but its center is Bay, a farming and fishing town along Laguna de Bay (from where it got its name). On the other hand, ICA is now sponsoring the development of over thirty communities in the Philippines but its original project is the Sudtonggan Human Development Program (SHDP) located in Sudtonggan, a sitio of Barangay Basak, Lapu-Lapu City. The SHDP is also the only project where the ICA has deemed the people ready to completely take over.

Liwayway in MacArthur, Leyte, like Sudtonggan, is the first of its kind. Although not among the original Makapawa sites, Liwayway nonetheless is a pilot area for the alternative approach devised to strengthen the community and religious bases of the program after its initial two years. Liwayway is a depressed barrio whose residents were interested enough in its growth that they volunteered their community to be a Makapawa area in late 1976.

Project Compassion is present in 17 municipalities and five cities in nine provinces. Its most successful project according to interviews appears to be a chartered city. However, because of its size, urbanism, and non-depressed status, and because being a city, it has special powers not available to the average rural municipality, we decided it would not be comparable with the other sample areas and gave it up. Teresa, Rizal then became our ProCom site since it possessed many of the factors opposite to the reasons we gave up the city and it is roughly the size of Pilar, Bataan: it is largely rural although very close to Metro Manila; and despite its status as a Class 1-6 municipality, it has a high malnutrition rate, signifying a poverty condition.

Both Liwayway and Teresa were recommended highly by their sponsors.

The area representing the RHU was the most difficult to choose since the Ministry operates nationwide. An early decision was to choose an area comparable in size and occupational structure to either Bay or Teresa. In addition, convenience factors such as the use of Tagalog and accessibility to Manila were also considered. These two characteristics were dictated by the team's limited transportation and personnel resources. Nevertheless, the "best-foot-forward" principle was not forgotten. Hence, a municipality where the RHU has a complete personnel complement and where there was no other health facility aside from the RHU and its barangay health stations was selected. The latter allowed the team to observe the RHU's effects when the people are totally dependent on it.

To study the delivery mechanisms and their administrative aspects, administrators and sponsors of the program in Manila or elsewhere were interviewed whenever possible. Structured interviews for staff specialists, multipurpose workers and unipurpose workers in the project sites were also administered. For programs going beyond health, all personnel involved in health plus at least one representative of each additional sector were interviewed. The structured interviews were only starting points; narratives of relevant experiences often followed and clarified these. In addition, program documents such as clinic records, annual reports and similar materials were used to get additional information.

A total of 80 key informants were interviewed. A breakdown of the informants' background per program is shown in Table 2.1.

Table 2.1

Background of Informants on the Five Case Programs

	RHU	CCHP	Pro-Com	Maka-pawa	SHDP	Total
Background of Informants						
1. Administrators						
a. From lead agency or their cooperators	4	5	8	10	8	35
b. From community	—	—	—	—	5	5
2. Staff specialists or professionals	2	4	—	2	—	8
3. Multipurpose workers	5	5	—	2	5	17
4. Unipurpose workers	—	—	—	—	2	2
5. Political leaders or leaders of citizens' associations	—	3	4	6	—	13
Total	11	17	12	20	20	80

For the beneficiaries' surveys, two slightly different sampling designs were followed. For Liwayway and Sudtonggan (which are both sub-muni-

cipalities, respondents from the whole area covered by each program were sampled, using the follwing formula:

$$n = \frac{N\,Z^2.\ p(1\text{-}p)}{Nd^2 + Z^2.\ p(1\text{-}p)}$$

Where:

n = sample size

N = total population of the area

Z = value of the normal variable (1.96) for a reliability level of 0.95

p = largest possible proportion (0.50)

d = sampling error set at .075

For Liwayway, the sample size was 91 or 75.8 per cent of households. The corresponding number in Sudtonggan is 98 out of 174 households. For the municipalities of Bay, Teresa, and Pilar, these procedures were followed:

(a) From the municipal map, we divided barangays into two groups: those adjacent to the poblacion, and those remotest from it.

(b) Then one barangay was randomly chosen to represent the "near" barrios, and another, the "far" barrios. All barangays in the poblacion constituted the third sample area.

(c) Within each area, sampling was done following the formula used for Sudtonggan and Liwayway.

The process yielded the sample sites and their respective sample sizes shown in Table 2.2.

It can therefore be seen that despite relatively small sample sizes, the survey studied the selected barangays quite intensively, with the lowest proportion being over one out of every five households. The use of distance from the poblacion is a proxy variable to accessibility, a factor that has been found by earlier studies to affect effectiveness (Joves, 1971). The proxy was effective except in Teresa where we found out later that the barangay remote from its poblacion is quite accessible (with jeepney lines) to the center of Morong, Teresa's neighbor-municipality. Where services are not concentrated in the poblacion, the use of distance as a measure of access also turns out to have limited value.

Table 2.2

Sample Sites and Sizes: Pilar, Bataan; Bay, Laguna; and Teresa, wrizal

	Site	Actual Number of Households	Sample Size	Sample as a Percentage of Total Households
Pilar, Bataan (RHU)				
Poblacion		595	131	22.0
Near Barangay	Wawa	182	88	48.3
Far Barangay	Diwa	136	79	58.1
			298	
Bay, Laguna (UP-CCHP)				
Poblacion		276	109	39.5
Near Barangay	San Antonio	420	120	28.6
Far Barangay	Sta. Cruz	194	102	52.6
			331	
Teresa, Rizal (ProCom)				
Poblacion		187	90	48.1
Near Barangay	Bagumbayan	189	89	47.1
Far Barangay	Prinza	112	67	59.8
			246	

A core protocol written in English served as the point of departure for the community surveys. It was modified to suit the requirements of each program. These differed, among others, in the number and type of services offered, the degree of community involvement fostered, the use of paraprofessionals, etc. The interview schedules were translated into the vernacular of the areas - Cebuano in Sudtonggan, Waray in Liwayway and Tagalog for Bay, Pilar and Teresa. Interviewers from the Research and Publications Program of the College of Public Administration, University of the Philippines (CPA-UP) augmented by researchers of the Local Government Center and the Administrative Development Center, extension units also of the CPA-UP, conducted the surveys in the Tagalog-speaking areas. For the other two surveys, regular College researchers who were natives of Cebu and Leyte were fielded to head the teams in their respective areas. The Sudtonggan survey utilized faculty and staff of University of the Philippines at Cebu. The Liwayway interviews were conducted by their counterparts in UP Tacloban and the Divine Word

College there. Both Visayan teams also translated their responses into English. All interviews were made in the weekends following the training of interviewers. Data from both the program personnel and the households were gathered, depending on the site, from November 1979 to April 1980.

Coding, editing, and tabulations were all done in Manila. Both computerized and manual computations were made in analyzing the data.

Limitations of the Study

A major limitation of this research is the number of programs studied. There are over thirty programs in the survey of agencies, and from 70 to 100 other community-based health programs (CBHPs) many of which are known only by the name of the site. To study only five of these clearly underrepresents the variety of activities, mechanisms and effects that their rich universe can supply. Moreover, we realize that even the five programs may not be represented fairly. The Pilar RHU, particularly, although it shares many characteristics with other RHUs, is still only one of about 1,700 such units throughout the country. The Liwayway Makapawa, if regarded as an example of CHBPs, is one out of about 100 such projects. Moreoever, despite conscientious efforts at digging all available information, we still did not succeed in getting comparable data for all the programs and the sites.

First, the programs had different starting dates, objectives, services and population coverage, hence statistics they gathered cannot be expected to be uniform. Second, the research inquired into integration, participation and effectiveness, factors which could be defined in ways different from ours and which concern the program administrators in varying degrees, if at all. Hence, data from the administrative and household surveys and from program documents were uneven in their usefulness and relevance for our purposes. Third, our study though based on a variety of instruments is really just a "snapshot" of long-running operations. There is still a wealth of information that has not found its way into this volume because a more intensive look would require more time, personnel and resources than were available. Moreover, the factors we have used to characterize the program and the site may interact to produce something not duplicable anywhere else. Nevertheless, we believe that our purposive sample has captured the range of the more important variables. Because of this, we feel we can say something meaningful, if not definitive. In addition, we realize that our attempt to evaluate programs underscoring the gains of the poor and using the lens of both the program administrator and people may be a novel approach and because of this we may be forgiven many shortcomings.

Despite that courageous statement, we remain humble in the knowledge that in the light of these limitations, there remains a mountain of work that we should do to further reinforce our commitment to greater equity.

APPENDIX TO CHAPTER II

PROFILE OF RESPONDENTS OF HOUSEHOLD SURVEYS

Victoria A. Bautista

Since household surveys constitute one of our major sources of data particularly in Chapters IV, X, and XI, description of the characteristics of the respondents is presented below.

Sex Profile

Majority of the respondents are females (65.3 per cent) out of an over-all total of 1,064 respondents for all projects. Only a small percentage are males (34.6 per cent).[5] The predominance of females holds for all the programs taken singly and across the different poblaciones and barangays. This result may be explained by the fact that females assume more responsibilities at home and therefore, were more readily available than males when the survey was conducted. This holds true in spite of the fact that the interviews were conducted on weekends to give the males a greater chance of being represented in the survey.

Occupational Background

An examination of the occupational profile of respondents reveals that majority (60.4 per cent) are gainfully employed. The remaining (39.6 per cent) do not have jobs (Table 2.3). The large percentage of persons without gainful employment could perhaps be attributed to the effect of sex. Majority in the no-occupation category (92.4 per cent) are females.

A comparison of the occupations of respondents across the different projects shows that the respondents from Sudtonggan, Liwayway and Bay have similar characteristics. They have more gainfully employed respondents (77.6 percent, 70.3 per cent, and 64.1 per cent, respectively) than those from Teresa (50.0 per cent) and Pilar (55.7 per cent). This trend may perhaps be explained by the fact that Sudtonggan has an abundance of local industries which open possibilities for both men and women to be absorbed into the labor force. Liwayway, on the other hand, is largely an agricultural community which also opens opportunities for both sexes to be employed. Bay respondents are not far behind Liwayway because Bay is also largely an agriculture-based community. Teresa and Pilar are different in that they have mixed occupational bases due to the proximity of well-developed industrial complexes (Metro Manila Area for Teresa and the Bataan Oil Refinery for Pilar respondents).

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[5] Since respondents were randomly sampled only within each poblacion or barangay, the initial tables show the findings by sample sites. In cases where the distribution of respondents is similar across all areas, and little information would be lost by combining them, the composite results are presented in this section. This is only for ease of presentation and comprehension and we have not thereby disregarded sampling rules.

Table 2.3

Occupational Profile of Respondents Across Sample Sites (In Percentage)

Profile	Pilar (RHU)	Bay (CCHP)	Teresa (ProCom)	Liwayway (Makapawa)	Sudtonggan (ICA)	Total
Not employed	44.3	35.9	50.0	29.7	22.4	39.6
Gainfully employed	55.7	64.1	50.0	70.3	77.6	60.4
Total	100.0	100.0	100.0	100.0	100.0	100.0
	(n = 298)	(n = 331)	(n = 246)	(n = 91)	(n = 98)	(n = 1064)

Source: Household Surveys

Gainfully employed respondents were further examined for the types of occupations they were engaged in. They were classified into one of the following categories depending upon their involvement.

1. "Higher White Collar" (or HWC) if they were engaged in administrative, executive, managerial, professional and technical activities.
2. "Lower White Collar" (or LWC) if they were engaged in clerical work, sales, service, transport or communication work and other activities not classified as manual labor but which do not require as much training as the HWC group.
3. **"Blue Collar" (BC) if they were involved in manual labor such as craftsmen and production process workers (excepting those engaged in agricultural activities.**
4. "Agricultural" if they were engaged in farming and other farm-related jobs and fishing.
5. "Others" if they cannot be subsumed into any of the four preceding categories.

It can be seen in Table 2.4 that 81.2 per cent of Liwayway respondents are engaged in agricultural types of jobs. Bay also reflects this pattern with 44.8 per cent of its respondents engaged in agriculture. Sudtonggan, on the other hand, has a predominance of blue-collar workers (55.3 per cent) or respondents because of the availability of such employment in the SHDP-run rock and and abaca industries.

Teresa and Pilar show that the highest percentages of their respondents are engaged in lower white collar work (48.8 per cent in Teresa and 39.8 per cent in Pilar).

Table 2.4

Types of Occupations of Gainfully Employed Respondents Across Sample Sites (in Percentage)

Types of Occupation	Pilar	Bay	Teresa	Liwayway	Sudtonggan	Total
Higher White Collar (HWC)	9.0	9.0	17.9	1.6	2.6	8.9
Lower White Collar (LWC)	39.8	29.2	48.8	3.1	9.2	31.1
Blue Collar (BC)	13.9	6.6	13.8	4.7	55.3	15.4
Agricultural (Agr)	31.9	44.8	14.6	81.2	17.1	36.0
Others	5.4	10.4	4.9	9.4	15.8	8.6
Total	100.0	100.0	100.0	100.0	100.0	100.0
	(n = 166)	(n = 212)	(n = 123)	(n = 64)	(n = 76)	(n = 642)

Source: Household Surveys

On the whole, it may be observed that majority (91.1 per cent) of the gainfully employed respondents for all projects are clustered in agricultural, blue collar and lower white collar work. Only a small percentage (8.9 per cent) are involved in higher white collar occupations. This is irrespective of the site examined.

Variations in occupational profile for Bay, Teresa and Pilar may be observed when cross-tabulated with accessibility (See Table 2.5). More respondents from the poblacion are engaged in higher white collar work than those outside of the poblacion. Perhaps this may be explained by the sociological fact that the poblacion is the center for economic and socio-political activities and therefore, provides more opportunities for white collar work. An atypical case is

Teresa where respondents living far from the center are closer in characteristics to those in the poblacion than respondents living near it. This may be due to the proximity of that distant barangay to the poblacion of the adjoining municipality of Morong, Rizal. Therefore, the Teresa case does not necessarily negate the statement made earlier about the possible effect of accessibility to an urban center on a community's occupational profile.

Table 2.5

Types of Occupations of Gainfully Employed Respondents and Accessibility, by Program Site

A. Pilar

	Poblacion	Near Barangay	Far Barangay
HWC (Higher White Collar)	15.1	5.5	2.6
LWC (Lower White Collar)	45.2	38.1	31.6
BC (Blue Collar)	13.7	14.5	13.3
AGR (Agricultural)	21.9	36.4	44.7
Others	4.1	5.5	7.8
Total	100.0	100.0	100.0
	(n=73)	(n=55)	(n=38)

B. Bay

	P	N	F
HWC	18.9	2.8	4.5
LWC	40.5	23.9	22.4
BC	5.4	5.6	9.0
AGR	21.6	60.6	53.7
Others	13.6	7.0	10.4
	100.0	100.0	100.0
	(n=74)	(n=71)	(n=67)

C. **Teresa**

	P	N	F
HWC	30.8	2.6	15.1
LWC	48.1	52.6	45.5
BC	11.5	23.7	6.1
AGR	9.6	13.2	24.2
Others	0.0	7.9	9.1
	100.0	100.0	100.0
	(n=52)	(n=38)	(n=33)

Source : Household surveys

Educational Attainment

On the whole, the educational attainment of all respondents across the different projects is very low. Majority (63 per cent) are in the educational levels of 0-6 years. Seven per cent did not answer the question on educational background.

Sudtonggan has the lowest level of educational attainment with 81 per cent of respondents obtaining 0-6 schooling level. This is followed by Liwayway, Pilar, Bay, and Teresa, in that order. (See Table 2.6). Significantly, the two programs which involved citizen participation had more educationally deprived respondents than the three other projects without it. Teresa has the best educational level among the five; this is understandable considering that Teresa is the least rural among them.

Educational Attainment and Accessibility

Accessibility of respondents to the poblacion has an effect on level of educational attainment. That is, the nearer to the poblacion, the higher the educational attainment of respondents. The farther one is from the poblacion, meanwhile, the lower the level. This may be explained by the typical tendency of the economically well-off who can afford to send their children to school to cluster in urban areas which offer more schools. This is substantiated in Table 2.7 showing that the proportion of respondents in the range of 7- and-above years of schooling progressively decreases as one gets out of the poblacion. For example, 63 per cent of respondents for Teresa from the poblacion have attained this level. Only 48 per cent and 33 per cent of the respondents near and far from the poblacion, respectively, have achieved this. The same trend holds for both Pilar and Bay.

Table 2.6
Educational Attainment of Respondents Across Sample Sites

Level of Attainment	Pilar	Bay	Teresa	Liwayway	Sudtonggan	Total
0 - 6	64	63	49.5	73	81	63
7 +	33	32	49.5	27	15	34
DK/NA	3	5	1.0	0	4	3
	100	100	100.0	100	100	100
	(n=298)	(n=331)	(n=246)	(n=91)	(n=98)	(n=1064)

Source: Household Surveys

Table 2.7
Educational Attainment and Accessibility of Respondents, by Sample Sites

Level of	Pilar			Bay			Teresa		
Attainment	P	N	F	P	N	F	P	N	F
0 - 6	63	62	56	37	75	75	36	52	66
7 +	33	32	44	61	22	13	63	48	33
DK/NA	4	6	0	2	3	12	1	0	1
	100	100	100	100	100	100	100	100	100
	(n=131)		(n=79)		(n=120)		(n=90)		(n=67)
		(n=88)		(n=109)		(n=102)		(n=89)	

Source: Household Surveys

Summary

Majority of the respondents are females and are engaged in agriculture, blue-collar, and lower white collar types of jobs. Educational level is low as they concentrate for the most part in the 0-6 educational levels.

Variations in socio-economic profile are noticeable among the three program sites of Pilar, Bay and Teresa. As expected, more respondents from the poblacion are engaged in higher white collar activities and have acquired higher schooling. This may be explained by the tendency of the better off to flock to more urban centers where most social services are available.

Chapter III

PROFILE OF THE COMMUNITIES

Ledivina V. Cariño and Jessica J. Buelva

Estimates of the proportion of families at or below the poverty threshold level vary widely, given the lack of consensus on indicators and the sampling problem.[6] Whatever figures are used, though, the conclusion is inescapable: poverty is pervasive in the country. In health terms, despite some improvement in the health condition of the nation's population since the turn of the century (seen for instance in the improvement of life expectancy to 62 years and reduction of birth and death rates), the health status of the Filipino is still generally low. The poverty of the country in these terms would be indicated by the high infant mortality rate (22.2 deaths per thousand live births), small proportion of well-nourished children (21.9 percent), high incidence of mortality and morbidity from preventable communicable diseases, absence of satisfactory toilets (in 68 percent of households) and lack of potable water (in 55 percent of households) (MOH: 1978).

Except the RHU, all the programs under study have selected a particular site because of some characteristic that marks it as poor. Nevertheless, none of the sites would probably fall at the extreme level in comparison to the rest of the country. For one thing, as a testimony to the improved national road network, their *poblaciones* are all accessible through relatively good roads. Whether the town is class 1-6 (as Teresa) or Class 5, like Bay, the center is imposing, with edifices like the church and the municipal halls co-existing with *carinderias* which serve lunch to drivers of jeepneys and tricycles and which sometimes double as beerhouses in the evenings. The bustle of the poblacion especially on market day raised initial doubts on the choice of such areas as sites for studying service delivery systems to the poor. Indeed, the initial encounter reminds one of a post-1972 ditty —

(Sa lalawigan naroon ang kasaganaan (In the provinces is **where there is abundance).**

There are, however, practically no roads to speak of and the seeming prosperity fades out as one travels to the barangays, indeed even in streets just behind the plaza. Frail structures of nipa and bamboo dot the countryside and one's romantic illusions about rural life is punctured by the sight of so many

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[6]Using the threshold level suggested by Abrera (1975) and applying it on the family income distribution given by the NCSO (1975), for instance, one can estimate that about 80 percent of families receive incomes at or below the point at which they can provide for only the minimum requirements for the basic needs of food, clothing and shelter. The poverty line for rural families that year is estimated at ₱7,738 per annum while median family income is about 42 percent less or ₱4,480 per annum. These figures, however, may overestimate the extent of poverty. For more discussions and statistics on this subject, see Miranda (1981) and Mangahas (1979).

children, too many of whom have bloated stomachs that suggest malnutrition and disease.

The project sites, in a sense, are like many rural areas of the country — poor but not extremely depressed. This may be because accessibility is itself one of the variables affecting choice of sites among the program sponsors. This does not imply, however, that such sites are inappropriate for this kind of study which seeks to look into how the very poor can be served, for within these sites are many of the most hard-up families. However, it does mean that our statements should be read with that in mind. The programs may be less (or more) effective had the communities been much more isolated or much more dependent on the outputs of the programs under consideration. Thus, to reach the very poor in very depressed areas, stronger or different efforts than those utilized here by health programs might be needed.

This Chapter briefly describes the characteristics of each of the sites of the case programs. Information comes from any sources - statistics of the program under study, documents of government, religious and private-sector agencies, results of the household surveys conducted for this project, and observations and unstructured interviews in the areas. Definitions of indexes adopted or constructed for this study will be spelled out as they are introduced in the text.

Each profile locates the community geographically and economically. A description of the demographic, occupational and socio-economic characteristics of the residents is also given. The profile likewise provides a description of the health care facilities available and the current health situation of the people and the town.

Comparable information for all sites were originally sought but this was not possible for the following reasons: different definitions of indicators; different priorities/functions/dates of operation of the programs and hence different program statistics; nonsystematic ways of collecting and stating data; certain "force majeure" situations (such as a fire in Sudtonggan in 1979) and similar unavoidable factors.

Pilar, Bataan

About 124 kilometers from Manila lies Pilar, a fourth class municipality of Bataan. It is adjacent to Balanga, the capital, a second class town, and Orion and Bagac, both fourth class municipalities. Pilar is regarded as the rice granary of the province and also produces corn, coconut, sugarcane and vegetables. Fishing is its next major source of income because it is along the coastal shores of Manila Bay.

In 1977, Pilar had a population of 15,969, 75 percent of which are classified as rural. The urban area is basically the Poblacion with a population of 3,967. The areas that make up the Poblacion comprise several blocks found on both sides of the national road that connects Balanga to Manila.

The near-barangay site is Barangay Wawa, only a kilometer away from the center. Wawa, with a population of 940, is a fishing village accessible from the center by trimobile or "coney" (jeep). The far-barangay site is Diwa or Uyong which has a population of 731 persons. Diwa lies about eight kilometers from the Poblacion. Although situated in the uplands of Pilar, Diwa is at the foot of the *Dambana ng Kagitingan,* a memorial to the dead of the Battle of Bataan. Thus, it is serviced by good roads.

Based on the household survey, Pilar has a young population, with the biggest proportion of persons 15 years old and below located in Diwa, the far-barangay. This large number of dependents is confirmed by the fact that almost 77 percent of total household members there are without gainful employment, compared to 67 percent in Wawa, and 64 percent in the Poblacion.

The modal occupation in both poblacion and Wawa is at the lower white-collar (LWC) category, followed by farming and fishing. In Diwa, the distribution is bi-modal, with LWC and agricultural jobs each accounting for one-third of the employed household members.

Table 3.1

Occupations of Members of Sample Households
Pilar, Bataan

Occupation	Poblacion N	Poblacion (%)	Near N	Near (%)	Far N	Far (%)	Total N	Total (%)
None	490	(64.3)	409	(67.5)	352	(77.2)	1251	(68.6)
Gainfully employed	271	(35.7)	197	(32.5)	104	(22.8)	572	(31.4)
TOTAL	761	100.0	606	100.0	456	100.0	1823	100.0

Employment of Gainfully Employed Members	Poblacion N	Poblacion (%)	Near N	Near (%)	Far N	Far (%)
Higher White Collar	36	(14.9)	9	(4.6)	2	(1.9)
Lower White Collar	103	(42.7)	86	(43.6)	33	(31.7)
Blue Collar	52	(21.6)	26	(13.2)	26	(25.0)
Agricultural	29	(12.0)	62	(31.5)	33	(31.7)
Others	21	(8.7)	14	(7.1)	10	(9.6)
TOTAL	241	100.0	197	100.0	104	100.0

Source: Household Surveys

In the terms of household income,[7] the far-barangay (Diwa) is the worst off, with almost half of families receiving incomes from the no-income up to ₱499 levels. The near-barangay is somewhat better off in that its low-income group is, at 27 percent, smaller than its counterpart in the Poblacion (31 percent). All Pilar areas, however, have at least 67 percent of their household receiving incomes below ₱1,500. (Table 3.2).

Table 3.2

Family Incomes of Sample Households, Pilar, Bataan

	Poblacion		Near		Far		Total	
	N	(%)	N	(%)	N	(%)	N	(%)
Low income	41	(31.3)	24	(27.3)	39	(49.4)	104	(34.9)
Medium income	48	(36.6)	38	(43.2)	23	(29.1)	109	(36.6)
High income	18	(13.8)	6	(6.8)	2	(2.5)	26	(8.7)
DK	24	(18.3)	20	(22.7)	15	(19.0)	59	(19.8)
TOTAL	131	(100.0)	88	(100.0)	79	(100.0)	298	(100.0)

Source: Household Surveys

Poverty is further shown by the level of living index, a composite measure which assigns points to appliances owned, type of water, toilet and lighting facilities, and kind of housing materials used. Out of a maximum possible of 72 points, households are adjudged low for gaining only up to 24 points; medium, between 25-48; and high, 49 and above. Using this measure, it was discovered that the situation deteriorates as one goes farther from the Poblacion since 34 percent of households there are low, compared to 39 percent in Wawa, and a distressing 61 percent in Diwa (See Table 3.3).

[7] This was computed based on the answer to the query: "Magkano po ang inyong buwanang kita; kasama ang ibang pinagkakakitaan?" (How much is your monthly income; including other sources?) The cut-off points are convenient round figures: no income up to ₱499 monthly as low income; ₱500-1499 is called here as the medium income, and ₱1500 and above as the high income. The sample sites had big proportions of poor families similar to the country's distribution. Based on the National Census and Statistics Office (NCSO) Special Release No. 382, (June 12, 1981), the estimated number of families in each income category for the whole Philippines as of the third quarter of 1980 is roughly as follows: ₱499 and below - 42.5 percent, ₱500-1499 - 42.2 percent and ₱1500 and above, 14.3 percent.

Table 3.3

**Levels of Living of Sample Households
Pilar, Bataan**

Level of Living	Poblacion N	Poblacion (%)	Near N	Near (%)	Far N	Far (%)	Total N	Total (%)
Low (1-24)	44	(33.6)	34	(38.6)	48	(60.7)	126	(42.3)
Medium (25-48)	48	(36.6)	38	(43.2)	27	(34.2)	113	(37.9)
High (49-72)	39	(29.8)	16	(18.2)	4	(5.1)	59	(19.8)
TOTAL	131	(100.0)	88	(100.0)	79	(100.0)	298	(100.0)

Source: Household surveys

Pilar's birth, death and infant mortality rates in 1979 (19.9, 3.7 and 35.2, respectively) are lower than the national average (31.82, 8.39 and 68.0).[8] Pilar deaths from pulmonary TB are much more than the national level (85.12 as against 59.0). Majority of households (57.0 percent) have toilets but only 23.3 percent of total households have satisfactory facilities.

Health care services are exclusively provided within the municipality by the main health center in the Poblacion and five barangay health stations (BHS), all clinics of the Rural Health Unit, the municipal-level office of the Ministry of Health. However, there is a provincial hospital in Balanga and a smaller facility provided by the Philippine Medicare Commission in Orion.

Bay, Laguna

Bay, a fifth class municipality on the north central part of Laguna, was the capital of the province until 1668. It is just past the university town of Los Baños and is 68 kilometers from Manila. A farming and fishing town, Bay is at the mouth of Laguna de Bay. Bay is also known to Manilans as the source of multi-colored bougainvilleas and other flowering plants which are for sale from practically every house by the side of the national road.

In 1979, Bay had an area of 4,867 hectares and a population of 21,521. Its death rate and level of malnutrition are lower than the nation's 5.24, and 35 percent, respectively. In addition to the RHU and its barangay health stations

[8]The figures for birth and death rates (1975-1980) are based on the PREPF projections report, Population Institute, University of the Philippines. The infant mortality rate was obtained from the Inter-Agency Committee on Population and Vital Statistics.

and the CCHP facilities, the municipality enjoys the services of several private practitioners. The latter appear to have come only since the CCHP started since Campos (1975) claims that there were no medical doctors in the area prior to the start of the program.

The sample areas are the Poblacion, San Antonio to represent the near-barangays, and Sta. Cruz, to represent the far-barangays. The most populous of these is San Antonio, with 2,744 inhabitants compared to the Poblacion with 1,783 and Sta. Cruz with 1,337. As in most towns, the Poblacion has a more complex occupational structure than either of the two barangays. Its modal occupations would be low white collar jobs available at the Poblacion itself, or the bigger towns of Los Baños and San Pablo City, which are within commuting distance. By contrast, the other two are much more dependent on agriculture (48.5 percent for San Antonio and 41.1 percent for Sta. Cruz) compared to 20.8 percent for the Poblacion. (See Table 3.4)

Table 3.4

Occupations of Sample Household Members, Bay, Laguna

	Poblacion		Near		Far		Total	
	N	(%)	N	(%)	N	(%)	N	(%)
Occupations								
None	453	(67.2)	459	(65.9)	468	(72.2)	1380	(68.4)
Employed	221	(32.8)	237	(34.1)	180	(27.8)	638	(31.6)
Total	674	(100.0)	696	(100.0)	648	(100.0)	2018	(100.0)
Employment of Gainfully Employed Members								
Higher White Collar	50	(22.6)	20	(8.4)	5	(2.8)		
Lower White Collar	68	(30.8)	53	(22.4)	37	(20.5)		
Blue Collar	26	(11.8)	18	(7.6)	39	(21.7)		
Agriculture	46	(20.8)	114	(48.10)	74	(41.1)		
Others	31	(14.03)	32	(13.5)	25	(13.9)		
Total	221	(100.0)	237	(100.0)	180	(100.0)		

Source: Household Surveys

The large number of unemployment can be attributed to a young population which is, however, somewhat older than the national average of 36.7. (See Table 3.5.)

Table 3.5

Age Profile of Members of Sample Households, Bay, Laguna

Age	Poblacion		Near		Far		Total	
	N	(%)	N	(%)	N	(%)	N	(%)
15 and below	277	(35.0)	338	(39.1)	285	(41.1)	900	(38.3)
Above 15	514	(65.0)	526	(60.9)	409	(58.9)	1449	(61.7)
Total	791	(100.0)	864	(100.0)	694	(100.0)	2349	(100.0)

Source: Household Surveys

In looking at income levels and the level of living index, the Poblacion is found to be the best off economically, followed by San Antonio and then Sta. Cruz (See Tables 3.6 and 3.7). With almost three out of four households with incomes below ₱1,500, however, Bay's income distribution is similar to the nation's.

Table 3.6

Family Income of Sample Households, Bay, Laguna

Income Level	Poblacion		Near		Far		Total	
	N	(%)	N	(%)	N	(%)	N	(%)
Low Income	28	(25.7)	54	(45.0)	42	(41.2)	124	(37.5)
Medium Income	49	(44.9)	31	(25.8)	35	(34.3)	115	(34.7)
High Income	23	(21.1)	6	(5.0)	8	(7.8)	37	(11.2)
DK	9	(8.2)	29	(24.1)	17	(16.7)	55	(16.6)
Total	109	(99.9)	120	(99.9)	102	(100.0)	331	(100.0)

Source: Household Surveys

Table 3.7

Level of Living of Sample Households, Bay, Laguna

	Poblacion		Near		Far		Total	
	N	(%)	N	(%)	N	(%)	N	(%)
Low (1-24)	20	(18.4)	56	(46.7)	51	(50.0)	127	(38.4)
Medium (25-48)	48	(44.0)	51	(42.5)	43	(42.2)	142	(42.9)
High (49-72)	41	(37.6)	13	(10.8)	8	(7.8)	62	(18.7)
Total	109	(100.0)	120	(100.0)	102	(100.0)	331	(100.0)

Source: Household Surveys

Teresa, Rizal

This town of Rizal is about 35 kilometers east of Manila and is just an hour's ride from Cubao, the shopping district of Quezon City. It is surrounded by the municipalities of Antipolo, Angono, Morong, and Tanay. Teresa is still engaged in agriculture but the rapid industrialization and commercialization of its neighbors and its nearness to Manila are transforming its economy and increasing its population very rapidly. A growth rate of nine percent per annum was registered between 1960 and 1970. Since then, growth has tapered off and was down to 2 percent in 1977. The birth rate in Teresa is slightly lower than the entire country's (27.3 percent) and its death rate slightly higher (10.4 percent).

Teresa was included in the ProCom network because of two sets of reasons. The first set considers the need of the town for such a program, and the second, its capacity to absorb it and make it work. The factors related to need include the following findings of the ProCom training specialist in his preliminary municipal survey in 1978:

1. Average family size: 6.62[9] higher than the Philippine average of 6.0 persons per family;
2. Level of malnutrition: 20 percent of pre-school children weighed are normal and 10 percent were third degree malnourished, the latter much higher than the national average of 5.3 percent.

[9] The NCSO for 1977 gives a slightly lower average family size (6.36).

3. Low food production: supply of rice is short of effective demand by about 10,000 cavans from farms averaging 65 cavans per hectare;

4. Low family income: 77 percent have monthly incomes of ₱83 or less, with fifteen percent having incomes of ₱583 and above;[10]

5. High level of wasteful consumption: the annual consumption of beer, liquors, cigarettes and soft drinks which ProCom considers as wasteful expenditures was estimated to be ₱1.37 million, thrice the municipality's annual budget.

6. Poor garbage disposal and toilet facilities;

7. The lack of factories in the area and consequent high unemployment rate partly traceable to the desire of people to work within Teresa.

The second set of reasons comprehends the level of community readiness for a project such as ProCom. It includes the town's strategic location (in the center of Rizal Province) and accessibility to Manila, as well as the expected support of the town itself. The latter is based on the fact that the mayor of Teresa acts as such fulltime and has been an active member of various government-sponsored activities. Moreover, the municipal government has expressed willingness to support and finance ProCom in Teresa, a fact which prompted the governor of Rizal to request for the inclusion of Teresa in the program, along with the more rural municipalities of Baras and Pililla.

The town of Teresa has better facilities than most of the other sample areas. Nevertheless, many households do not enjoy urban amenities. Electricity is the source of lighting of only 69 percent in spite of the presence of the Rizal Electric Cooperative and another electric plant maintained by the Filipinas Cement Corporation. Water is provided by the Teresa Waterworks System but it serves only 48 percent of households. The others rely on artesian wells, pumps, open wells and rain water. As regards toilet facilities, fully 56 percent of households have satisfactory toilets but 20 percent still have no toilets at all. Garbage disposal is largely by burning; only 18.5 percent are collected by the municipality.

Health care is provided in Teresa by the RHU as well as several private practitioners. The people also have access to emergency hospitals in Morong and Antipolo, and farther on, to bigger facilities in Pasig and Metro Manila.

Teresa's population in 1977 was 13,981 with an average family size of 6.36 members. There are nine barangays. The sample areas, in addition to the Poblacion, are Bagumbayan, the near-barangay, and Prinza, the far-barangay. The population numbers 1,175 for the Poblacion, 958 for Bagumbayan and 605 for Prinza.

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[10]The survey in Teresa revealed an income structure which is better than this. See discussion below.

Reflecting its location at the edge of the metropolis, Teresa's three sample areas are populated by employees of offices and factories in Rizal and Metro Manila (See Table 3.8). The biggest group of gainfully employed household members in the poblacion are lower white-collar workers, followed by high white-collar workers, including professionals and managerial personnel. In Bagumbayan, the biggest percentages are blue-collar, lower white-collar, and service/other workers. It is only in Prinza where agricultural workers are as big a group as lower white-collar employees. In this instance, the expectation that level of ruralness and dependence on agriculture will be higher the farther one goes from the poblacion is fulfilled.

In terms of family income (Table 3.9), Teresa can still be classified as poor with almost three fourths overall earning less than ₱1500 a month, like Bay and the nation at large. The biggest group of low income earners is in the near barangay with the Poblacion and Prinza having a more comparable income distribution.

Table 3.8

Occupations of Members of Sample Households, Teresa, Rizal

	Poblacion		Near		Far		Total	
	N	(%)	N	(%)	N	(%)	N	(%)
Ocupation								
None	349	(67.8)	315	(63.0)	266	(66.3)	930	(65.7)
Employed	166	(32.2)	185	(37.0)	135	(33.7)	486	(34.3)
Total	515	(100.0)	500	(100.0)	401	(100.0)	1416	(100.0)
Occupations of Gainfully Employed								
Higher White Collar	41	(24.7)	6	(3.3)	27	(20.0)	74	(15.2)
Lower White Collar	73	(44.0)	55	(29.7)	37	(27.4)	165	(34.0)
Blue Collar	35	(21.1)	57	(30.8)	15	(11.1)	107	(22.0)
Agricultural	10	(6.0)	20	(10.8)	38	(28.2)	68	(14.0)
Others	7	(4.2)	47	(25.4)	18	(13.3)	72	(14.8)
Total	166	(100.0)	185	(100.0)	135	(100.0)	486	(100.0)

Source: Household Surveys

Table 3.9

Family Income of Sample Households, Teresa, Rizal

	Poblacion		Near		Far		Total	
	N	(%)	N	(%)	N	(%)	N	(%)
Low Income	22	(24.4)	55	(61.8)	15	(22.4)	92	(37.4)
Middle Income	45	(50.0)	22	(24.7)	24	(35.8)	91	(37.0)
High Income	12	(13.3)	7	(7.9)	9	(13.4)	28	(11.4)
DK	11	(12.2)	5	(5.6)	19	(28.4)	35	(14.2)
Total	90	(100.0)	89	(100.0)	67	(100.0)	246	(100.0)

Source: Household Surveys

In level of living terms, the Poblacion is shown to be more markedly affluent than the other two areas (See Table 3.10). Again, however, it is the far-barangay which is less depressed than the near-barangay. Prinza's better showing over Bagumbayan in the income and level of living indexes may be explained by the fact that it is quite close to the Poblacion of the neighboring town of Morong. Thus, although it has more agricultural workers, it also includes households whose other members augment the family till. In this case, then, Teresa is an exception to the general expectation that poverty is positively related to distance from the Poblacion.

Table 3.10

Level of Living of Sample Households, Teresa, Rizal

Level of Living	Poblacion		Near		Far	
	N	(%)	N	(%)	N	(%)
Low (1-24)	16	(17.8)	39	(43.8)	20	(29.8)
Middle (25-48)	36	(40.0)	42	(47.2)	28	(41.8)
High (49-72)	38	(42.2)	8	(9.0)	19	(28.4)
Total	90	(100.0)	89	(100.0)	67	(100.0)

Source: Household Surveys

Barangay Liwayway, MacArthur, Leyte

Liwayway is a village of small hills, a feature which was captured in its old name "Mombon." It is part of the new municipality off Tacloban City carved out to honor the American "liberator" who returned via the Gulf of Leyte. Liwayway itself is about three kilometers from the poblacion of MacArthur.

The main sources of livelihood are farming and fishing. Although it is an inland area, the people fish on the coast of MacArthur bordering another barangay.

The 1979 population of Liwayway is 842, with households numbering 119 making the average household size higher than the national mean.

Liwayway is one of only five barrios in MacArthur which maintains a complete elementary school. It also has a Roman Catholic chapel, a stage, a dancing hall and a nursery. Liwayway is deficient in most other facilities. Transport is provided almost exclusively by remodelled motorcycles which can carry as many as eight passengers. Pumps are the only safe source of drinking water but only a few are still usable. The secondary source, spring water, is not safe, and accounts for the high degree of gastroenteritis and similar diseases in the area. In addition, like most of Leyte, Liwayway also suffers from schistosomiasis and is thus regularly visited by technicians and malacologists of the Schistosomiasis Control Project based in Palo, Leyte. Toilet facilities would not be a problem were the adequate ones (up to 81 percent, according to one survey) functional. With water a major problem in the area, though, only sixty percent of adequate toilets are usable.

More than three-fourths of household members registered in the no-occupation category (84.0 percent), but this was because even those below 15 were included. Otherwise, the highest category was in the agricultural (46 or 12.2 percent) sector. Other categories had relatively small and insignificant figures. Table 3.11 shows the occupational distribution of household members.

Household Income. Majority of sampled households had incomes below ₱500/month. Forty-seven or 51.7 percent were in this income bracket, including Liwayway as a much poorer area than the previous three sample sites. However, monthly incomes could not be determined in 31.9 percent of households (29) either because they did not know, had irregular incomes, or did not want to answer such a sensitive question. (See Table 3.12)

Level of Living. Because of the difficulty experienced in eliciting correct responses for income, an alternative measure was also used, namely, the level of living index. Using this, it was found out that the majority of households in Barangay Liwayway had low levels of living. This seems to confirm the correctness of the choice of Barangay Liwayway as a Makapawa area. It is to be recalled at this point that one of the criteria used by the program is the area's depressed state. (See Table 3. 13.)

Table 3.11

Occupations of Household Members
Liwayway, MacArthur, Leyte

Occupation	N	(%)
None	316	(84.0)
Higher White Collar	4	(1.1)
Lower White Collar	5	(1.3)
Blue Collar	4	(1.1)
Agricultural	46	(12.2)
Others	1	(0.3)
TOTAL	376	(100.0)

Source: Household Surveys

Table 3.12

Household Income of Sample Households
Liwayway, MacArthur, Leyte

Income Per Month	N	(%)
Low Income	50	(55.0)
Middle Income	10	(11.0)
High income	2	(2.2)
DK	29	(31.9)
TOTAL	91	(100.0)

Source: Household Surveys

Table 3.13

Level of Living of Sample Households,
Liwayway, MacArthur, Leyte

Level of Living	N	(%)
Low (1-24)	53	(58.2)
Medium (25-48)	37	(40.7)
High (49-72)	1	(1.1)
Total	91	(100.0)

Source: Household Surveys

For health care, Liwayway residents can go to the RHU of the *Poblacion* or the government hospital and the private hospital both in the adjacent town of Abuyog. In addition, Liwayway serves as a pilot area of the Institute of Health Sciences (IHS) in Tacloban City, a branch of the University of the Philippines experimenting on, among others, combining health services of the regular RHU with community organizers trained by the Institute. These have worked well with the Makapawa program. Makapawa itself has trained ten community health workers from among the barrio residents. However, an IHS survey reveals that while half of the pregnant women avail of the prenatal check-up provided by the Makapawa and other medical programs, most of them still call for the traditional *hilot* for delivery.

Sudtonggan, Barangay Basak, Lapu-Lapu City

Lapu-Lapu was the Chieftain of Mactan who refused to acknowledge Spanish hegemony and killed Ferdinand Magellan, the Hispanic "discoverer" of the archipelago. In his honor, a largely agricultural territory, occupying the greater portion of Mactan Island, was named by a special charter as Lapu-Lapu City. The city qualifies as Class 1-C and has a 1975 population of 79,485 people. At present, the City boasts of some urban amenities such as the Mactan International Airport, the Mactan Export Processing Zone, a few factories and the beach resorts which dot its eastern coast.

Five kilometers from the center of Lapu-Lapu City and a kilometer off the Basak Highway lies the project area which encompasses the whole sitio of Sudtonggan. Everywhere in these one hundred hectares one sees fields of huge rocks which according to tradition shielded Lapu-Lapu from the Spaniards and the resistance forces from the Japanese during World War II. For centuries, these rocks have frustrated all attempts by Sudtonggan inhabitants to farm and earn adequate income. Today, these same rocks provide the materials needed by an industry which supplies tiles for flooring and wall decor of homes as far as Manila.

Before the Project, Sudtonggan was locked in a cycle of poverty and resignation which characterizes many rural barangays in the country to this day. Sources of income were limited to subsistence farming, fishing and rope weaving. Infant mortality was high at twelve deaths in 1975 (out of a population of less than 1,000). School attendance in the neighboring sitio was hampered by the rock fields and by the family's need for the older children to supplement their meager income. Given these problems, there were only ten children in school in 1975. Like other Lapu-Lapu City residents, many Sudtonggan residents got frustrated because the better economic and educational opportunities were all to be found in the cities of Cebu and Mandaue, where competition was keen. Even the nearest health facility was located in the center of Lapu-Lapu City.

Today, Sudtonggan boasts of three self-supporting industries namely, the rock, the buri furniture and the craft industries. The latter also has its tourist

shop. Other amenities include the Sudtonggan Health Center, the Early Learning Nutrition Center for pre-schoolers, the Sudtonggan Elementary School (only Grades 1 to 3 as of SY 1980-81), Sudtonggan's own source of electricity, and 25 covered wells. The facilities are being managed by a staff who are Sudtonggan residents themselves.

More serious health needs are referred to health and medical institutions in the cities. At present, the Sudtonggan Health Center serves as the first-level health unit of the community. It is manned by one or two Sudtonggan residents trained on health supplemented by once-a-week visits of a health professional from either the Opon Emergency Hospital, the Lapu-Lapu City Health Office or medical institutions in Cebu, depending on arrangements with SHDP.

In December 1979, Sudtonggan had about 1,100 residents from about 174 households. The survey of 98 households in the area shows that a significant portion of the sample household population (46.4 percent) are young (ages 15 years old and below). This may partly explain why about 65 percent of the sample population have no jobs as shown in Table 3.14.

Table 3.14

Occupations of Sample Household Members, Sudtonggan, Basak, Lapu-Lapu City

Occupation	No.	(%)
None	325	(64.9)
HWC	3	(.6)
LWC	21	(4.2)
BC	134	(26.7)
Agricultural	16	(3.2)
Others	2	(.4)
Total	501	100.0

Source: Household Surveys

The largest group among those gainfully employed are the blue collar workers (26.7 percent) which includes the rock, buri furniture and the craft workers. This provides an indicator of the effect of SHDP on Sudtonggan's employment profile.

In terms of family income, slightly more than half (52 percent) of the households surveyed had low income (₱499 and below) as shown in Table 3.15. The relatively low economic level of residents is reinforced by the low core in the measure of the level of living of sample households as shown in Table 3.16.

Table 3.15

Income of Sample Households
Sudtonggan, Basak, Lapu-Lapu City

Income Level	No. of Households	(%)
Low Income (₱499 and below)	51	(52.1)
Medium Income (₱500-₱1499)	41	(41.8)
High Income (₱1500-₱2499)	6	(6.1)
Total	98	100.0

Source: Household Surveys

Table 3.16

Level of Living of Sample Households,
Sudtonggan, Basak, Lapu-Lapu City

Level of Living Measure	No. of Household	(%)
1 - 24	69	(70.4)
25 - 48	29	(29.6)
49 - 72	—	(—)
Total	98	100.0

Source: Household Sutveys

Summary

The profiles underscore a denominator common to all five program sites – that of being poor. The characteristics depicting poverty, however, differ. While some sites have a large percentage of their households falling under the low-income category or having a low level of living index, the others evince poverty through poor health conditions indicated by a high percentage of malnourished children, high infant mortality rate, and high morbidity and mortality rates from preventable diseases.

Our household surveys reveal that more than half of the population of each site are without gainful employment (68 percent for Pilar and Bay; 65 percent

for Teresa and Sudtonggan and 84 percent for Liwayway). In general, this is because of the young population in each household which results in too many dependents. This is further aggravated by the large percentage of the households which are in the lowest income level (below ₱500). Pilar has 35 percent of the surveyed households falling under this; Bay has 37.5 percent; Teresa, 37.4 percent; Liwayway, 51.7 percent and Sudtonggan, 52 percent with another 42 percent falling only in the middle category (₱500-1499).

The level of living index also attests to this fact, with many households in the sites having a low level of living index (Pilar, 42 percent; Bay, 38 percent; Teresa, 29.8 percent; Liwayway, 58.2 percent and Sudtonggan, 70.4 percent).

The health conditions at the sites further demonstrate the people's poverty. For instance, deaths resulting from pulmonary TB in Pilar are much higher than the national figure. Majority of the children in Teresa are malnourished with only 20 percent having normal weight and 10 percent being third degree malnourished. Liwayway suffers from a high incidence of gastroenteritis and schistosomiasis because of the absence of a safe source of drinking water. Only Bay has a better record than the country in terms of, for instance, death rate and malnutrition.

In summary, Sudtonggan can be considered as the most depressed area among the five. It is followed by Liwayway, with Bay, Pilar, and finally, Teresa, as the best off among the community sites. Despite this array, each continues to show characteristics that manifest conditions of poverty. More important, each area has a large percentage of people who qualify as indigent or medically indigent and require assistance in meeting their health needs.

Chapter IV

THE CASE OF THE RHU OF PILAR, BATAAN

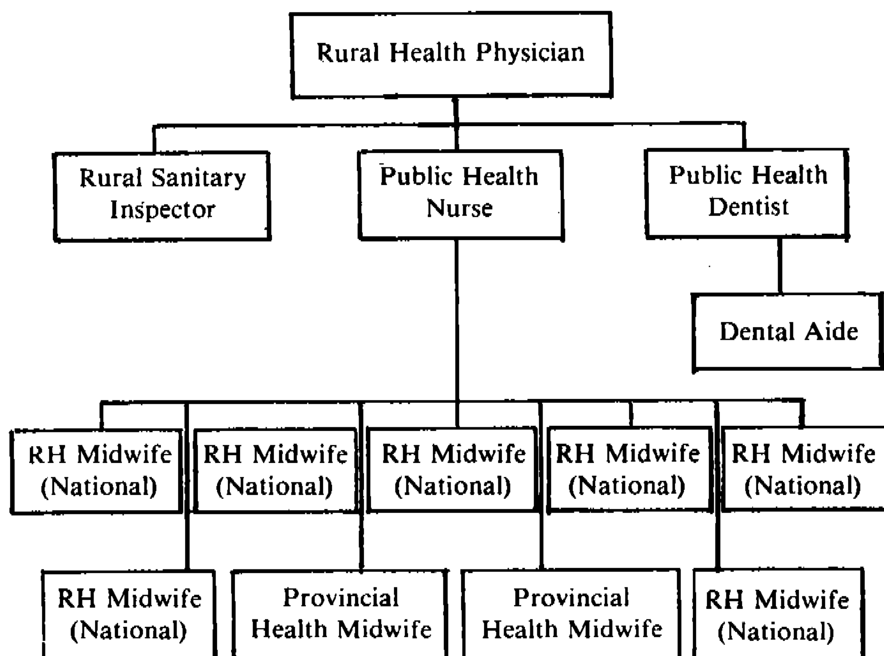
Francisco G. Balitaan

Following the structure of the Ministry of Health (MOH), the RHU of Pilar is similar to other RHUs in the country. It represents the Ministry at the municipal and barangay levels. As defined by the Ministry, the RHU is charged with the delivery of basic health services which are promotive, preventive, curative and rehabilitative in nature.

Administrative Profile

At the helm of the rural health organization (See Figure 4.1) is the Municipal Health Officer (MHO), also known as the Rural Health Physician, the new name of the MHO under the restructured health care delivery system (RHCDS). The MHO represents the Minister of Health at the municipal level. His functions and duties are: (1) to attend to the administration of rural health

Figure 4.1 RHU Organizational Chart, Pilar, Bataan



Source: RHU Documents

services; (2) to provide epidemiological and environmental health services to the community; (3) to serve as the clinician of the unit; (4) to act as the medico-legal officer of the community; and (5) to ensure the continuing education of the public in matters of health (MOH, Manual on Rural Health Unit Operations).

In Pilar, the MHO is assisted in his duties and responsibilities by the following health personnel: a public health dentist, a rural sanitary inspector, a public health nurse, nine midwives and a dental aide.

The public health dentist (1) provides leadership for the orderly development of the needed dental services and facilities, (2) performs clinic procedures, (3) initiates and participates in the development of dental health education, (4) establishes and maintains good relationships with the RHU and public school authorities, and (5) performs administrative functions such as accomplishment and submission of reports, etc.

The rural sanitary inspector performs two sets of functions. One set is on public health administration which includes participation and assistance in the planning and implementation of community health services, staff meetings/conferences, preparation of sanitation reports and establishment of working relationship with community organizations. The other major function of the rural sanitary inspector is on environmental sanitation which includes provision and maintenance of water sanitation, excreta and sewage disposal, food sanitation, solid waste management, insect and vermin control, public place sanitation, environmental protection, inspection and health education.

The public health nurse (1) participates in the planning and evaluation of the health programs for the community, (2) implements the nursing aspect of the community health program, (3) carries out medical functions as specified in the operational manual for nursing personnel, (4) administers and supervises nursing and midwifery services in the community, (5) plans and participates in educational programs for self, nursing and midwifery personnel and students, other professional and community groups, and (6) initiates research activities for nursing and participates in other studies related to health (MOH Manual).

The public health midwife (1) works with the public health nurse (PHN) in planning and evaluating health services at the barangay level, (2) provides midwifery services in the barrio, (3) carries out medical and nursing functions as specified in the operational manual for nursing personnel, (4) guides volunteers or clerks assigned to clinic and other health activities, (5) accomplishes and submits reports of activities and needs for supplies including vaccines, health education and repairs of equipment to public health nurse, and (6) participates in development programs for herself, other midwifery personnel, students, and other community workers.

Health care services are provided by the health personnel of the Municipal Rural Health Unit and several extension health centers. The main health center

is in the Poblacion. It provides medical services and consultation (both dental and general services) to the residents of the community.

Specifically, the main health center is expected to serve the residents of the Poblacion and the barangays adjacent to it such as Burgos, Del Rosario and Rizal. In accordance with the restructured health care delivery system, the RHU has extended its services to the different barangays by deploying additional midwives. For instance, Diwa, Sta. Rosa, Wawa, Alauli and Bantan Munti each has a barangay health station manned by a Rural Health Midwife.

Of the nine assigned rural midwives in Pilar, only two are paid by the Provincial Government of Bataan. The rest are under the Ministry of Health. Five of the midwives are assigned to the barangays and the remaining four to the Poblacion. There is no medical clinic or hospital in the municipality and while the municipality has four doctors, these physicians practice their profession either in Manila or in Balanga. Hospital services and other specialized medical services are availed of in the nearby town of Balanga, the capital and commercial center of Bataan.

Under the restructured health care delivery system, the midwives serve as the primary and first level of contact and arrangements for referrals of patients. These midwives are trained and allowed to conduct examinations, make diagnosis and treat patients in accordance with guidelines of the MOH on the restructured health care delivery system.

Aside from providing basic medical and general health services in the Barangay Health Station, midwives also conduct home visits to perform health education, maternal and child care, immunization, environmental sanitation and other functions assigned to them by the Municipal Health Officer. At the barangay level, therefore, the rural health midwife has integrated (though to a limited extent) the functions and duties of the doctor, sanitary inspector, and public health nurse who are based in the Poblacion.

Conditions beyond the capability of the midwives are referred to the nurse or the sanitary inspector. Both the nurse and the sanitary inspector are based in the Poblacion, and are expected to refer all non-normal, high risk and other conditions beyond their capacity to the third-level, i.e., the physician or municipal health officers. Further care would be provided through a system of referrals to a district/provincial hospital, regional hospital or central referral hospital.

The health personnel of Pilar's RHU, with the exception of some new recruits, have had intensive training on the restructured health care delivery system provided by the Regional Training Center of the MOH Region III (Table 4.1). The MHO had a two-week orientation while midwives underwent a four-week orientation on their new duties and responsibilities in the RHCDS. Training included pill dispensing, medical care, family planning and

nutrition. The practicum was provided by the Provincial Health Office (PHO) and the RHU.

The overall situation in the country shows a lack of health personnel particularly in the remote communities in the rural areas. Thus, the MOH has set the target number of people that the health personnel of the RHU should be able to reach and serve. Except for the rural health midwife who must be able to reach and serve at least 5,000 people, each of the rural health physicians, public health nurses, public health dentists and rural sanitary inspectors must be able to reach and serve 20,000 people. As seen in Table 4.2, the number of the population served by each health personnel of the RHU approximates and is even better than the required target of the Ministry.

Table 4.1

Profile of RHU Personnel, Pilar, Bataan, 1979

Personnel		Age	Educational Attainment	No. of Years in Position	With or Without Training
Rural Health Physician		37	M.D.	5 years	/
Sanitary Inspector		49	BSBA (2nd yr)	23 years	/
Public Health Nurse		24	BSN	2 mos	x
Rural Health Midwife	1	26	Midwifery	2 years	/
Rural Health Midwife	2	25	Midwifery	3 ½ yrs.	/
Rural Health Midwife	3	53	Midwifery	26 years	/
Rural Health Midwife	4	45	Midwifery	20 years	/
Rural Health Midwife	5	43	Midwifery	4 years	/
Rural Health Midwife	6	23	Midwifery	2years	/
Rural Health Midwife	7	24	Midwifery	2 mos.	x
Rural Health Midwife	8	22	Midwifery	1 year	/
Rural Health Midwife	9	27	Midwifery	1 year	x

/ — with training on RHCDS
x — without training on RHCDS

Table 4.2

Ratio of the RHU Health Personnel to Popu'ation, Pilar, Bataan, 1979

Health Personnel	Pilar Ratio	MOH Standard
Rural Health Physician	1:18,536	1:20.000
Public Health Dentist	1:18,536	1:20,000
Rural Sanitary Inspector	1:18,536	1:20,000
Public Health Nurse	1:18,536	1:20,000
Rural Health Midwife (average)	1:2,059	1:5,000

Considering the area to which each midwife is assigned gives an even better personnel: population ratio. It is only in Sta. Rosa, Balut I and Balut II where a midwife serves more than the municipal average. In the Poblacion and Diwa, two of our sample areas, the population covered by each midwife is close to the mean of the municipality. In Wawa, the ratio is much better than the Pilar mean and the national target.

Area of Assignment	Total Population Served (1977)
Main Health Center	1,766.511
Alauli and Nagwaling	1,478
Sta. Rosa, Balut I and Balut II	3,830
Wawa	940
Diwa, Pantingan and Liyang	1,701
Bantan Munti and Wakas South	954
Total	10,669.5

Financial and Logistics Support

Since the RHU is the extension of the Ministry of Health at the municipal level, its resources are part of the budget of the Ministry allotted to the regional and provincial health offices in the country. Local contributions include funds given by the Puericulture Center (PC) of Pilar which owns the building occupied by the RHU in the Poblacion. The PC used to augment per-

[11] The number is derived by adding the population of barangays covered by the midwives assigned in the Main Health Center (7066) and then dividing it by the number of midwives covering the whole area (4). The team was not able to get the population of each catchment area for 1979.

sonnel resources with a helper and a nurse but it discontinued this assistance in 1978 due to lack of funds.

In delivering health services, our interviews reveal that the RHU of Pilar has been hampered by the inadequacy of resources like medicine, supplies and equipment (office and medical), lack of health personnel, insufficient gasoline allowance, lack of funds, and the perennial problem of low salary rates of health personnel. The low level of resources is not unique to the Pilar RHU. A study of the support for health services based on field interviews in other areas — two provinces each in Region I and Region VI — shows the same problems (Cariño, Alfiler and Albano, 1980).

In 1979, for instance, the total salary of the RHU personnel was only ₱85,589.37, with the MHO receiving only ₱13,767.60. Midwives averaged only ₱500 a month (₱6,000 per annum). The MHO's gasoline allowance was only ₱2,400.00 for the year. The travelling allowances of the rest of the personnel was only ₱8,520.00. The total budget for maintenance and operations was only ₱99,869.37. Of these, assorted medicine and other medical supplies allotted to the RHU for the year amounted to ₱29,741.80.

Medicine and other supplies are supposed to be distributed to the RHU of Pilar once every quarter but the RHU staff consider themselves lucky to be allocated a few boxes of assorted medicine once a year. Worse, the medicine often do not meet the requirements of the RHU and the community. Thus, not only is the quantity of medicine insufficient, its kind and quality are also inappropriate.

In terms of equipment, the RHU does not even have surgical equipment and supplies (gauze, gloves, etc.) for minor operations. The Center has been robbed twice during the previous years and it only has a limited number of medical equipment. The RHU has made the necessary requisition but up to this writing, no equipment has been sent yet.

The Rural Health Physician (RHP) is very much aware of these problems. However, he claims he can not do much to solve them. Although the RHP is supposed to be the direct representative of the Ministry of Health at the municipal level, in reality, he has very little control over budgeting, financial and operational resources. This is because major decisions regarding allocation and distribution of resources such as medicine, supplies, equipment as well as matters regarding personnel recruitment, training, budgeting requirements, policies and programs are made at the regional and national levels.

Monitoring and Evaluation

The RHU itself is part of the national system of health offices and reports its activities to the provincial health office (PHO) which in turn, reports to the Regional Health Office (RHO). Offices at Manila are largely central support units and staff bureaus which provide rules and standards for activities all the way down to each local unit.

Under the existing set-up of the Ministry of Health, the Provincial Health Office is responsible for administering, supervising, monitoring and evaluating the activities, policies and programs of all Rural Health Units. Once a month, the PHO calls a conference/meeting of all rural health physicians to discuss the implementation of the health delivery system in the whole province. At the RHU level, a weekly meeting is held among the staff wherein new policies, plans, activities, problems and strategies are discussed. Furthermore, health personnel submit monthly workload/accomplishment reports to the rural health physician. These reports are consolidated by the rural sanitary inspector (RSI) into an annual accomplishment report of the RHU and are then submitted to the Provincial Health Office.

Monitoring of health activities and preparation of health sanitation reports at the barangay level are done and prepared by the Rural Health Midwives assigned to the various barangays. The midwives are supervised by the Public Health Nurse but the overall supervision is the responsibility of the Rural Health Physician.

Relationship With Other Agencies

All RHUs are expected to integrate the operations of the different privately-owned and - operated hospitals and clinics into an overall health service system of the municipality. Since Pilar does not have a single private hospital or clinic, however, its integration function is not put into use. Before, though, Pilar used to have a puericulture center which employed a midwife and a helper to assist the RHU personnel. The center was a project of a civic club composed mostly of women who elected a Board of Directors and a set of officers to run the organization. To finance its activities and pay the salaries of the midwife and the helper, the puericulture center raised funds through raffles and bingo socials, voluntary contributions from civic-minded citizens of the community, and solicitations from the municipal council. Also, through the assistance of the Philippine Charity Sweepstakes Office, the center was able to construct a building which now houses the RHU. By July 1978, however, the puericulture center stopped the services of the midwife and the helper because of its inability to pay their salaries. From that time on, its building has been occupied by the RHU, but expenses for various repairs and maintenance are still being shouldered by the center through proceeds from its fund-raising activities. Plans are now being considered again by the puericulture center to hire one midwife and a helper for the continuance of its community services.

Another agency, the Population Commission, through its family planning program utilizes the RHU (physically and administratively) in delivering its services to the community. The POPCOM provides the guidelines and gives the instructions to the midwives who help implement the family planning program in the community. In addition, POPCOM provides the supplies and medicine such as condom, pills and other family planning paraphernalia. The RHU provides the office space, health personnel and other logistical support.

The midwives are involved in the implementation of the family planning activities of the POPCOM/RHU and underwent training provided by the Regional Office of the MOH at San Fernando, Pampanga in cooperation with POPCOM.

Accomplishments of the RHU (1979)

Following the health policies and guidelines of the Ministry of Health (MOH), the RHU undertakes and implements a number of activities designed to provide health services and medical care to the people. Not all activities listed in the Manual for Rural Health Unit Operations are performed by the respective health personnel of the Pilar RHU. Most of its activities are concentrated on the following programs: communicable disease control, tuberculosis control, maternal and child health care, family planning, nutrition, environmental sanitation, dental care, and medical care.

Communicable Disease Control

For controlling communicable diseases, children as well as registered pregnant mothers were given priority in immunization. Immunization was given in two rounds. The first round was given from January to February with 1.5 percent of the population aged 3-8 months as the target group for receiving BCG, DPT, and oral polio vaccines. The second round was given in June and July, with the school entrants and "wrong"[12] children as the targeted group. Other targeted groups included those who received DPT. Another 1.5 percent of the population were targetted for BCG and polio 2 vaccines.

Tetanus toxoid was given to mothers whose incidence of tetanus neonatorum was high. A second booster was also administered to said mothers. Mothers who are pregnant are usually given their vaccination one month before delivery.

The RHU of Pilar failed to have a 100 percent accomplishment in its efforts to give immunization to the target population. It had, however, a relatively high level of accomplishment (shown in Table 4.3), despite the persisting problem of lack of sufficient drug supply, resulting in the transfer of its clients to private physicians.

Tuberculosis Control

Included in this program were the following: case findings, treatment and follow-ups. Patients found to have symptoms of TB were given two sputum examinations. If the examination turned out to be positive, the patient was referred to the Chest Center of the province for X-ray. Cases were then registered with and taken in the program of the RHU for treatment. Patients were given medications and injected with INH and streptomycin. In 1979, actual cases registered for National Tuberculosis Program numbered 547.

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[12] "Wrong" children refers to those not included in the first target group.

Maternal and Child Health

In 1979, there were 370 registered births. About 264 or 71.4 percent were attended by the health staff of the RHU and the rest by other medical professionals from the nearby towns of Pilar and hilots in the area. As expected, majority or about 82.2 percent of the delivery cases were attended to by the RHU midwives. Forty cases or about 15.2 percent were attended to by former Puericulture Center personnel and the remaining seven or 2.6 percent were attended to by the Public Health Nurse (PHN) of the RHU. A similar distribution was observed in post partum cases attended.

Family Planning

The target for new acceptors of family planning methods as required by the Ministry is 12 percent of the eligible population between the ages of 15-45 years old. In 1979, Pilar had a population of approximately 7,276 belonging to that age group. Twelve percent or about 873 of that group represented the target for family planning acceptors. In 1979, the RHU of Pilar had advised a total of 1,111 family planning acceptors. It can be noted that the RHU surpassed the target of the Ministry.

Table 4.3

Immunization of Eligible Population, Pilar, Bataan, 1979

Eligible Population		Number Immunized	Percent Accomplishment
DPT_1	253	220	87.0%
DPT_2	224	182	82.7%
BCG	632	581	91.9%

Source: RHU Annual Report (1979).

Table 4.4

Birth Attendance of RHU Personnel Pilar, Bataan, 1979

	Deliveries Attended		Post Partum Attended	
Municipal Health Officer	—	—	—	—
Public Health Nurse	7	2.6	7	2.2
Rural Health Midwife	217	82.2	275	84.6
Puericulture Center	40	15.2	41	12.6
Hilot	—	—	2	0.6
TOTAL	264	100.0	325	100.0

Source: RHU Monthly Reports (1979)

Table 4.5

Birth Attendance by Agency, Pilar, Bataan, 1979

	No.	(%)
Rural Health Unit	264	(71.4)
Non-Rural Health Unit	106	(28.6)
Total	370	100.0

Source: RHU Monthly Reports (1979)

Table 4.6

Case Referrals to RHU and Hospital, Pilar, Bataan, 1979

	Public Health Nurse (PHN)	Municipal Health Officer	Hospital
Pre-Natal	1		1
Delivery			6
Post Partum			3
0 - 6 years old		6	3
Total	1	6	13

Source: RHU Monthly Reports (1979)

Nutrition

In coordination with the MOH/CARE Philippines, the RHU has undertaken the Targeted Food Assistance Program (TFAP) to reduce the degree of malnutrition in the municipality. The third and second degree malnourished pre-schoolers and the pregnant and lactating mothers were the main targets. Operation Timbang (OPT) was undertaken wherein infants aged 0 - 72 months andpre-schoolers were weighed and examined. Also, mothers with health problems were organized into mothercraft classes. These beneficiaries were provided with monthly food rations. Food commodities given were non-fat dry milk, corn, soya milk and rolled oats. In implementing this program, barangays and the local nutrition committee were also utilized.

In 1979, 50 mothercraft classes were organized. In addition, about 107 mothers were reached, and some 110 malnourished children were visited. A total of 653 infants and pre-schoolers wereweighed under the OPT.

The implementation of the TFAP had not been so successful since the

mothers participating in the program could not sustain interest in the nutrition program. Once their malnourished children were weighed and taken in under the program, the mothers were no longer as cooperative with the midwives as before. This situation was most observable for barangays like Holo, Liyang, and Pantingan.

Medical Care

This program includes attending to medical cases, consultation and treatment. Seventy percent of the eligible population (determined as 43 percent of the municipal population and set by the Department of Health) is the target number for consultation and is distributed as follows: MHO - 10 percent of total consultation; PHN - 20 percent; RHM - 70 percent. For treatment, a similar sharing between the MHO, PHN and RHM is followed but the target for treatment is equivalent to all consultations multiplied by 2.88. About 10 percent of treatment cases are expected to be referred to hospitals or private practitioners.

For 1979, consultation and treatment cases were distributed among the health staff of the RHU as seen in Table 4.7.

Table 4.7

Consultation and Treatment Statistics of RHU, Pilar, Bataan, 1979

	Consultation			Treatment		
	Target	Accomplishment	%	Target	Accomplishment	%
MHO	558	507	90.9	1,607	1,201	74.7
PHN	1,116	238	21.3	3,214	460	14.3
RHM	3,905	3,548	90.9	11,246	16,095	143.1
Total	5,579	4,293	77.0	16,067	17,756	110.5

Sources: RHU Annual Report (1979)
MOH Region III Guidelines for Computation of Total Activities.

It can be observed that the overall accomplishment of the RHU for consultation is only 77.0 percent. The accomplishments of the health personnel, although still short of the target, were relatively satisfactory except for the PHN which was very low at 21.3 percent. A consistent pattern is also evident

for treatment cases done by the PHN. An inquiry made revealed that the RHU did not have a nurse for several months during 1979. The former PHN left the service and it took several months for the RHU to be able to recruit a new nurse.

For treatment cases, the RHU surpassed the target by 10.5 percent. Most of the treatment cases were done by the Rural Health Midwives surpassing their target by 43.1 percent. The performance of the MHO and the PHN (for the reason cited above) was below their annual targets. One probable explanation for the low level of accomplishment of the MHO is that he rarely spent his time at the RHU. The survey of the clients' perspectives also confirmed that the MHO is not well-known to the residents of the community. In the poblacion, the MHO ranks only second to a rural health midwife assigned to the main Health Center while in Wawa and Diwa, he ranks only fifth (out of 8 mentioned) and fourth (out of 7), respectively.

Environmental Sanitation

Targets for environmental sanitation are also set by the MOH; however, specific targets for Pilar RHU have not yet been worked out by the Rural Sanitary Inspector and the Provincial Health Office. Table 4.8 shows the RHU's accomplishments in this area.

Table 4.8

Accomplishments of the Rural Sanitary Inspector on Environmental Sanitation for 1979 in Pilar, Bataan

Activity	Accomplishment
Water-Supply Examined	11
Water Supply Disinfected	—
Toilet Inspected	416
Toilet Construction Supervised	30
Establishment Inspected/Corrected	667
Sanitary Permit Issued	184
Health Certificate Issued	53
Medical Check-Up of Food Handler	53

Source: RHU Monthly Accomplishment Reports (1979)

Dental Health Service

For dental health services, the following targets were set by the MOH: Number of children attended - 6.6 percent of total population; Number of adults attended - 0.4 percent of total population; Pre-natals attended - 30 percent of pre-natal registered; Supervised tooth brushing - 20 percent of Grade I-VI public school.

As shown in Table 4.9, the accomplishments of the RHU on dental health services fell short of the targets set by the Ministry. The inability of the RHU to meet dental health requirements had been attributed to the lack of dental equipment in the RHU dental office.

Table 4.9

Dental Health Service Statistics, Pilar, Bataan, 1979

Activity	Target	Accomplishment
Children Attended/Protected	1,223	49
Adults Attended/Protected	74	30
Pre-natals Attended/Protected	-	18
Children supervised in tooth-brushing and mouth rinsing with .2% or .5% Sodium Flouride Solution	-	302

Source: RHU Accomplishment Reports (1979)

Some Observations on the Health Care Delivery System

Some changes have been introduced as a result of the restructuring of the health care delivery system, among which are: (1) training of RHU personnel, particularly the rural health midwives, and orientation of all health staff on the RHCDS; (2) development and implementation of a support system on logistics, supervision and management information system (MIS) for the RHU; (3) establishment of barangay health stations in addition to the existing main health center; (4) assignment of a resident midwife in each barangay health station; and (5) adoption of a minimum staffing complement for each RHU which consists of one MHO, one public nurse, one midwife and one sanitary inspector.

Overall, these changes have resulted in an improvement in the delivery of health services. The training and orientation on the RHCDS, for instance, had

made the health personnel more knowledgeable, informed and capable of delivering basic health services. The development and implementation of a support system on logistics, supervision and management information system has facilitated, to a certain extent, the monitoring and evaluation of health activities and projects. In addition, the establishment of barangay health stations and the assignment of a resident rural health midwife to each barangay health station has provided for a wider coverage and more health services to the population in the rural areas. Finally, the adoption of a model staffing complement has ensured the availability of basic health services to the residents in the community.

The restructured health care delivery system has made health services more accessible to the people, particularly in the rural areas, by training midwives and transfering to them some responsibilities of the rural health physician and the public health nurse. However, it has also resulted in the perception of work overloads among some midwives (this, despite the very favorable ratio of midwives to population served). Although rural health midwives are providing more health services and reaching more people than the rest of the RHU personnel, their capability and, hence, credibility in providing basic health services other than the traditional function of attending to maternal and child care, has raised some doubts among clients who still prefer the services of the physician.

There exist other constraints which continuously hamper a more effective, efficient and improved delivery of health services. The limited budget, not only of the RHU but of the entire Ministry of Health itself, is a persistent complaint of RHU personnel. Other problems such as non-availability of vehicles for treating patients in remote areas, and the lack of other logistical support such as gasoline and maintenance funds are also major problems.

Despite these problems, however, the RHU was able to deliver its services effectively to its clients. This assessment is based not only from the output statistics discussed here, but also from the point of view of the beneficiaries themselves, as will be discussed in subsequent chapters.

Chapter V

THE U.P. COMPREHENSIVE COMMUNITY HEALTH PROGRAM

Josie H. de Leon

In May 1963, a section on Comprehensive Community Medicine was established by the Department of Medicine of the University of the Philippines College of Medicine. This showed a serious attempt on the part of the academic sector to redirect the focus of medical education from a Western-oriented model to one which is more responsive to the needs of an underdeveloped country like the Philippines. A comprehensive community health program (CCHP) which sought to reorient the health care delivery system from the kind that catered more to "sophisticated needs" and conditions of Western countries to one which would be more consistent with Philippine needs and conditions was formulated.

In line with this, the medical curriculum was to be restructured in accordance with Philippine health needs. This meant that the areas of study were to be focused more on the microbiological level, e.g., cholera, typhoid, malaria, rather than on the environmental level, e.g., pollution resulting from industrial waters and agricultural pesticides and herbicides, the latter being more associated with the health needs of developed countries. However, it was only during the middle part of 1965 that this concept was finally implemented with the creation of separate rural and urban comprehensive community medicine programs under the UP College of Medicine.[13]

The rural program was initially attached to the UP College of Agriculture's extension services for rural communities. UP medical interns were fielded together with UPCA's agricultural extension workers in the selected areas of Pila and Los Baños, Laguna which then served as UPCA's extension service areas. Eventually, the program became a separate undertaking of the UP College of Medicine with the UPCA becoming one of its major participating units.

While the CCHP was primarily initiated by UP, the cooperation and help of other agencies, especially the then Department of Health, had to be secured before the program's plans could be implemented.

Corollary to this, a Memorandum of Agreement was signed between the UP and the Department of Health (DOH) on October 1, 1966 which allowed the Comprehensive Community Health Program (CCHP) to assume responsibility for the health care of the entire population of selected areas in Laguna. The DOH would provide the supplies to the health centers, but health services

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[13]The urban comprehensive community health program was in Leveriza, Pasay and operated until late 1974.

would be provided by the CCHP, and the CCHP would be responsible for all health centers and facilities in the area.

Part of the program's plan included the establishment of health centers in the barrios that were to be manned by multipurpose health workers trained by CCHP, and of a district health center that was to function as an intermediate level between the municipal and provincial levels of health care. The introduction of this level was intended to free the next higher (provincial) level of clinical cases which the district level could very well handle.

Two barangays in Pila (Pansol and San Miguel), one barangay in Los Baños (Mayondon), and 3 barangays in Bay (Calo, Maitim and Puypuy) were chosen as pilot areas.

In May 1967, health care for the whole municipality of Bay including the poblacion was placed under the supervision and control of CCHP.

The choice of Bay was deemed ideal for the following reasons:

1. It was a microcosm of the Philippine rural setting with all types of villages — coastal, lowland and upland — no industries, and no private medical and dental practitioners;
2. The size and population was manageable for purposes of effective supervision;
3. The town was accessible to Manila and its barrios were accessible to the town proper;
4. It was near a UP unit (Los Baños) where "logistical support can be drawn at any time"; and
5. It was also a pilot area of other projects like Operation SPREAD (Systematic Project for Rural Economic and Agricultural Development) a joint project of the National Economic Council and United States Agency for International Development (USAID). (Campos, 1975)

The receptiveness of the municipal government in Bay was also a factor in the choice of Bay as site of the CCHP. The municipality allowed the use of a vacant lot in the poblacion for the construction of the community hospital and the CCHP building.

The program secured initial financial support from the Rockefeller Foundation and later from the National Science Development Board (NSDB). The program also obtained the cooperation of the Department of Education which relinquished to the CCHP its authority over the School Health Program in Bay (Campos, 1975).

The program was formally launched in Bay on January 24, 1967 as part of the Comprehensive Community Health Program of the UP College of Medicine, with Dr. Paulo C. Campos as its first Director. It had three deputy directors for each of its divisions: training and research, rural, and urban divisions. Each division, except for the Rural Division, had an administrative assistant from UP. (See Figure 5.1.)

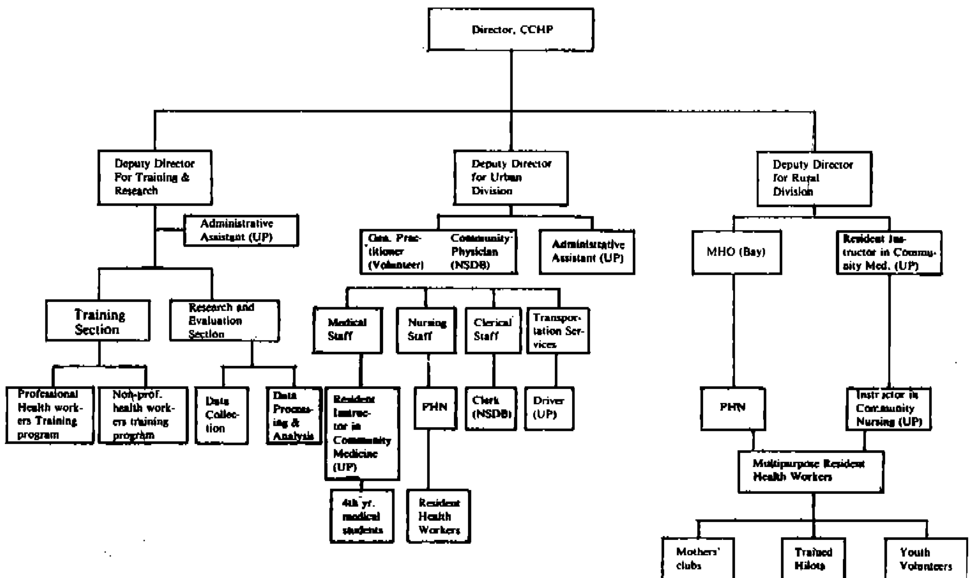
The CCHP Annual Report for 1977 listed the following objectives of the program:

1. to train students to become more effective workers in rural communities through a social laboratory that would enable them to see the realities, problems and effective strategies used in the development of communities;
2. to develop strategies for a comprehensive health service delivery at the primary level that will complement the national health service delivery plans; and
3. to provide services to the community through existing agencies with the active participation of the people.

The above objectives conform with the three general activities that were subsequently undertaken by the program — teaching and training, research, and extension services.

Bay served as the "staging area" of a program that was later expanded to include neighboring towns such as Victoria, which, like Bay, became an experimental area, and Los Baños and Calauan, which became the control areas.

Figure 5.1 Original Organizational Structure of CCHP, 1967



Source: Campos, Paulo C., *Comprehensive Community Health,* U.P., 1975, p. 70.

The CCHP History

When the program was originally initiated in 1967, decisions regarding program direction and implementation were made by the College of Medicine with the help of the CCHP Forum, an advisory body composed of representatives from the other participating units of UP, i.e., the Colleges of Agriculture, Dentistry, Pharmacy, Nursing, and Arts and Sciences, the then Institute of Hygiene (now Institute of Public Health), and from the government sector, namely, the Department of Health (DOH) and the Department of Education. A representative from the Rockefeller Foundation also attended meetings of the CCHP Forum.

While the CCHP Forum was functioning as a de facto policy-making body, it was never officially recognized by the UP Board of Regents. Only the CCHP Director was acknowledged as the legitimate representative of CCHP in all matters pertaining to the program.

With the subsequent entry of other UP units like the Population Institute, the College of Home Economics, the Institute of Social Work and Community Development, and the School of Allied Medical Professions, the CCHP became multi-disciplinary in nature and was elevated in 1970 by the UP Board of Regents to the status of a university program (Gasmen, 1979). The Board of Regents also established the CCHP Board as the policy-making body of the CCHP. The Board was intended to be a purely collegial body, with members drawn from the units of the university participating in the program. The formation of the CCHP Board was, in effect, a formalization of the policy-making functions exercised by the Forum.

One of the main activities of the program was the development of Multipurpose Resident Health Workers (MRHWs) trained in the delivery of primary health care to the barangays. This eventually became part of the extension services rendered by the program for rural communities. Another was the training of *hilots* and other indigenous health workers in primary health service delivery.

The activities of the RHU were to be confined to public health functions and to clinical cases that could not be handled by the MRHWs.

The participation of the people in the community was also deemed essential in the successful implementation of the program. Indeed, the household was considered the first level of health care by the CCHP. Classes for mothers, fathers, and the youth were, therefore, organized to familiarize them with the basics of primary health care. To implement this, CCHP instructors and staff often stayed in the barrios, conducting classes, handling medical cases, and also participating in and learning from the barrio people's way of life, especially their health practices, biases as well as prejudices.

The CCHP was probably more than enthusiastic in attaining its avowed ob-

jectives. In its attempt to fully control and administer the health sector of its pilot areas, certain problems surfaced which led program implementors to rethink and re-examine the thrust of the program (UP-CCHP, 1975-76).

One of the major weaknesses identified was the failure of the program to introduce innovations or changes in the then public health structure. In other words, the CCHP as an experimental program was not able to integrate its operation into the structure of the Department of Health. Instead, it attempted to establish an "autonomous" or "independent" structure.

More than anything else, the involvement of the Rockefeller Foundation probably contributed to this inability of the CCHP to consider the DOH as the traditional agency in charge of delivering health services in all the rural areas of the country (UP-CCHP, 1975-76). Indeed, while the entry of Rockefeller had helped prop up the program in the initial stages of its implementation, the very support which helped to make the program a success developed CCHP into a "showcase"program which, as experience showed, had made its replication in other areas difficult because of the absence of similar funding and support.

With the withdrawal of Rockefeller support in 1972, the University was forced to underwrite all the expenses of the program. Since the University did not have the financial capability to do this, it chose to support only the training of its students in the program, including the salaries of its instructors and administrative personnel (Gasmen, 1980). CCHP had to look for research funding from outside sources which came principally from the National Science Development Board (NSDB). The Rural Division and its extension services, as represented by the Infirmary, had to rely on self-generated income.

Since the UP emphasized and, in fact, supported only the training program for its students, the Division of Training became an entity separate from the Division of Research. The Division of Extension Services and the Administrative Division were also established and the Rural Division abolished. By 1975, the Urban Division had also been phased out because of financial difficulties.

A CCHP Advisory Council was also established. This was to be composed of representatives of the different agencies participating in the program, i.e., UP Board of Regents, Department of Health, Department of Education, National Science Development Board, the Provincial Government of Laguna, Rockefeller Foundation and two other members to be chosen by the Board of Regents upon recommendation of the UP President. This body, however, was never organized (Gasmen, 1979). It seems that the rather motley composition of the Advisory Council members was the major factor in the decision to recall the plan. What was implemented instead was the incorporation of the DOH, through the Provincial Health Officer, into the CCHP as official member of the CCHP Board.

The original structure of the CCHP placed the CCHP Director at its helm.

The RHU was supposed to be only a component unit under the CCHP. The Municipal Heath Officer (MHO) and Public Health Nurse (PHN) were to be under the supervision of the Deputy Director for the Rural Division.

This set-up would primarily utilize the health sciences students of UP in delivering basic health services to the rural communities, principally Bay, as part of their actual training in the field. Exposure of students and instructors to conditions prevailing in rural communities was expected to result in an awareness and a clearer understanding of the problems that beset rural medical practitioners. It was hoped that this experiment would lead to specific solutions regarding problems encountered in rural practice.

Undoubtedly, this arrangement is most advantageous for the CCHP because the administrative structure would not only rationalize the health service delivery activities of the RHU to conform to what CCHP had envisioned was the correct approach, but would also allow for the complete control by CCHP of the training activities of the UP students in the area.

What the CCHP did not anticipate, however, was the potential conflict that would be created because of this new structure. For instance, the RHU, the traditional service provider, would, in effect, have an ambivalent status, because while technically, it is under the CCHP by virtue of a memorandum of agreement, it cannot dissociate itself in so short a time from the traditional health delivery system network of which it has, for decades, been a part.

The CCHP was, in 1972, also beset by other problems. The Community Hospital was not earning enough to enable it to become financially viable. The SSS loan which the CCHP had negotiated could not be repaid from funds generated through the operation of the hospital. The UP could not prevent the foreclosure of the mortgage because of certain legal constraints. For example, it was not allowed by law to invest in profit-making corporations nor in corporations where auditing and accounting procedures were not within the control of the University.

The CCHP was, however, able to negotiate with the Provincial Government of Laguna for the purchase of the hospital building in 1979. The Program is now in the process of formulating a memorandum of agreement with the Office of the Governor of Laguna, the Health Sciences Center of UP and the UP Foundation, Inc., for the operation of the hospital.

While the withdrawal of Rockefeller support resulted in certain dislocations in program planning and implementation, it also had some positive effects. The CCHP became more flexible in planning and implementing certain programs. This was not possible before because administration felt they had to secure Rockefeller Foundation approval first.

New directions of the program were also experimented upon. By 1977, the outpost model had already been implemented in other areas of Laguna. This was a radical departure from the Bay CCHP Model of fielding a multi-

disciplinary team of students per barrio (UP-CCHP, 1978). The outpost model fielded one student per barrio who worked more as a generalist community worker rather than as a health worker. This approach departed from the Bay approach because its point of entry was the community organization, not health. Thus students were involved not only in medical problems but in community activities like the construction of a hanging bridge and mediating in social conflicts. The outpost model thus implemented what has been central to the CCHP concept all along—that health problems cannot be solved in isolation from pressing community problems. A research study on this model was due for completion in June 1980.

Another approach being experimented upon by the CCHP is the training of medical interns as assistant municipal health officers (AMHOs), capable not only of delivering medical services, but also other services like environmental sanitation, health education, communicable disease control, etc. This role of interns integrates them with the RHU system of health delivery. Its implementation implicitly recognizes that planned health programs should operate within the framework of the DOH health care delivery system.

This recognition of the DOH as the traditional health service provider has in fact been incorporated in the redrafted memorandum of agreement of December 1977 between the UP and DOH. The agreement placed the overall responsibility for delivery of basic health services in CCHP areas back to the DOH. The CCHP would only coordinate with the policies and programs of the DOH regarding health care and rural health practice. The CCHP would also help in the study of health problems and recommend approaches for the improvement of health care delivery of the DOH through its organized bodies at each level. This document also provided that the Director of Health for Region IV like the Provincial Health Officer was also to be a member of the CCHP Board.

The memorandum of agreement between the UP and the Department of Education whereby the Department relinquished to CCHP authority over the school health program in Bay also underwent a similar transformation. The school health program is gradually being transferred back to the school personnel (UP-CCHP, 1979). Teachers are being trained to assess, detect and attend to common ailments of school children. The serious cases will, in turn, be referred to the RHU or other specialized agencies.

The program has also started to place on equal footing all the three activities of training, research and service. This may however be rather difficult to implement because of the limited funding of the CCHP.

In January 1979, the Health Sciences Center (HSC), an autonomous body of the University of the Philippines composed of all its medical units, was instituted with the CCHP under its supervision. As of 1980, the HSC is still too new to influence and direct any changes in the CCHP.

Administrative Machinery

As of 1980, the CCHP's policy-making body is the CCHP Board composed of representatives from each of the participating units of the University and from the Ministry of Health (formerly Department of Health). The present Chancellor of the Health Sciences Center is the Chairman of the Board.

The Board has an Executive Committee composed of five board members. This Committee looks into problems encountered by the Program and reports them to the Board regularly.

The Program itself is headed by a Director. Directly under him are two staff offices. One is the Communications and Information Office which is in charge of all activities relating to communications strategies and programs and their implementation and evaluation. The CIO publishes the Newsletter and the Focus, produces the radio program on health topics aired on DZLB, as well as audio-visual aids and pictorials, and orients visitors. The other staff office is the Finance and Budget Office which takes care of preparing the budget and monitoring program expenses. (See Figure 5.2.)

The Program has four divisions representing its four activities: Training, Research, Extension Services, and Administrative Services. Each Division is headed by a Deputy Director, except for the Division of Administrative Services which is headed by an Administrative Officer. The Training Division handles all training activities of students from all the participating UP units.

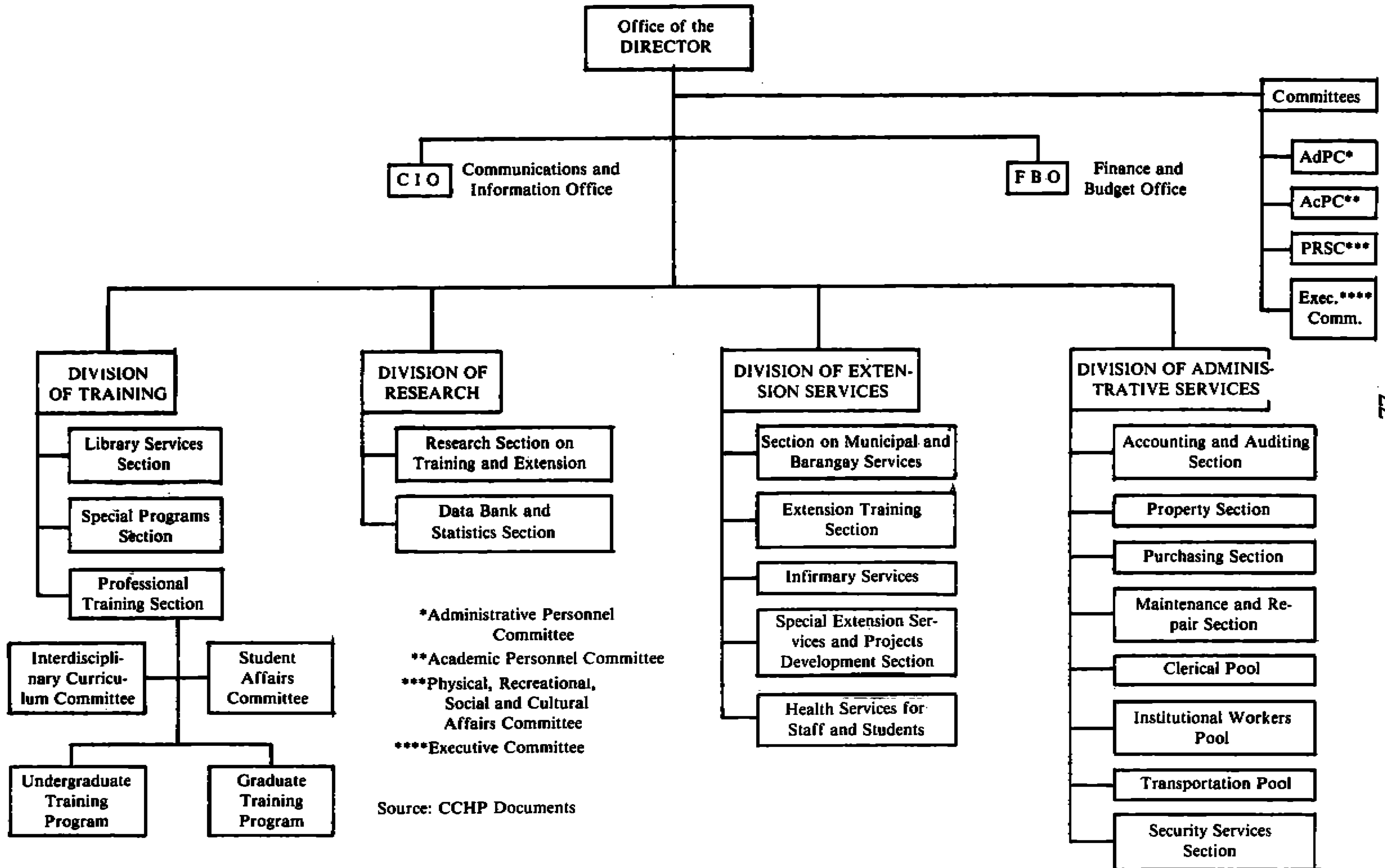
The Research Division coordinates all research activities of the program and assists in the planning and evaluation of all individual research projects.

The Division of Extension Services is in charge of planning, implementing and evaluating strategies for delivery of health services at the primary level. Training of paraprofessionals is under the Division's Extension Training Section as this is considered a strategy for improving primary health care services. The CCHP Infirmary is part of the extension services of the CCHP for Bay and its surrounding areas and communities. This division also has a section on Municipal and Barangay Services which provides direct "community services to existing operational areas of the CCHP at the municipal and barangay levels through the Rural Health Units of the Ministry of Health, and other private and public agencies" (UP-CCHP, 1978). There is also a section for Special Extension Services and Programs that coordinates with other agencies (e.g., the Regional Health Office) regarding special extension services in newly opened areas of the Program.

The Division of Administrative Services is in charge of personnel, equipment, accounting and security services.

The CCHP also has four standing committees: the Executive Committee, the Physical, Recreational, Social and Cultural Affairs Committee, the Academic Personnel Committee, and the Administrative Personnel Committee.

Figure 5.2 Organizational Chart of CCHP, 1980



The Executive Committee composed of the Director and the heads of the four Divisions takes care of the problems that need immediate solution.

The Physical, Recreational, Social and Cultural Affairs Committee is in charge of promoting better relationships, health and outlook of employees.

The Administrative Personnel Committee and the Academic Personnel Committee help in the recruitment, selection and promotion of administrative and academic employees, respectively.

Linkage With Other Agencies

Coordination with other agencies is inherent in the nature of CCHP as a vehicle originally formed to integrate all health service functions into one unit. Because the experiences of CCHP in the implementation of this plan required certain reformulations, CCHP has all the more found need to coordinate actively with different public and private agencies without necessarily absorbing these agencies into its program.

The CCHP has revived the organizations it formed in the communities during the early period of the program's implementation namely, the mothers' classes, fathers' classes and youth volunteers' classes. It holds regular community meetings with barangay council leaders in the planning, implementation, and evaluation of health plans.

Since 1976, it has coordinated with the Non-Formal Education for the Rural Youth (NEFRY) in the community development activities specifically the leadership Training Program.

It has initiated a Developmental Communications Program for Community Health which maintains a radio program, named Tinig ng CCHP, at DZLB, UPLB. Through DZLB, linkage with other agencies is maintained, with the regular monthly DZLB cooperators' meeting serving as the venue.

Its Barangay Health Technician Training Program, started in 1979, is a joint project of the CCHP with other agencies such as the PHO of Laguna and the different RHUs; the Philippine Business for Social Progress in Lamot, Calauan; the Cocofed Chapter in Pagsanjan; the Dairy Training and Research Institute (DTRI) of UPLB in Jalajala, Rizal; and the different barangay and municipal councils of the areas concerned. These agencies help not only in terms of recruitment and selection of trainees but in some instances also in funding. The community members are also briefed on the role of these BHTs so that these graduates can be fully utilized by the communities concerned.

The CCHP has closely coordinated with the Provincial Health Officer (PHO) of Laguna concerning areas other than Bay, such as the placement of interns in Victoria, Calauan, Los Baños, Pila, Calamba and Sta. Cruz; the Pharmacy Aides Program and establishment of Botika sa Nayon in Kalayaan, Dambo, Kabulusan, Pagsanjan and the UP Land Grant in Siniloan; Com-

munity Development in Puthotuntungin in Los Baños; Dental Training Program for midwives in Calamba, Laguna and the Second District of Laguna; the utilization of CCHP Laboratory Services in RHUs of Laguna; staff development for RHU personnel; and the organization of a task force in Laguna to handle environmental sanitation problems (UP-CCHP, 1979).

All barrio health subcenters in Bay are operated by the CCHP which provides the basic equipment and office supplies. Medicine is provided by both the PHO and the CCHP, although it is claimed that delivery of supplies from the CCHP is more efficient than from the PHO's (RHU and BHT Interviews, 1980).

There has also been a special linkage of the provincial government of Laguna since 1975 regarding the operation of the Community Hospital. The UP Foundation, a private organization which is already handling the accounting and auditing sections of the CCHP Infirmary, has also been tapped to handle the finances of the Community Hospital.

Method of Health Service Delivery

Four levels of health care have been indentified by the CCHP in the early stages of the program's planning and implementation. The first level of health care is the household, which includes traditional medical practitioners like hilots. Households are included because parents are considered as "general practitioners" who can administer home remedies and take preventive measures for health problems at home before referring the cases to traditional healers like *arbolaryos* or to professional medical practitioners like doctors. This observation is the basis for the organization by the CCHP of fathers', mothers' and youth volunteers' classes. The participants are taught by CCHP professionals and students basic health practices, e.g., care of pregnant women, family planning, care of the new-born and the pre-school child; immunizations, control of communicable diseases; control of prevalent diseases in the area; environmental sanitation, etc.

Home care services (house visits, follow-ups) are to be an integral part of this level of health care. The intention is to be able to manage the treatment of more illnesses at home, thus avoiding the high cost of hospital care. At the same time, it would provide health workers with a "better understanding of the home as a setting for the dynamics of health and disease" (Campos, 1975).

The CCHP also decided to absorb into the program the traditional *hilots* by embarking on a training program that would familiarize them with the proper practice of midwifery. This decision was based on findings that hilots were still widely patronized in Bay. With their present attitudes, beliefs, practices and habits, these hilots could pose a danger to the health and welfare of mothers and babies. Their proper training and supervision will therefore not only benefit the people but also leave the professional health provider more time to attend to serious cases.

The barrio or barangay is classified as the second level of health care. A multipurpose resident health worker (now known as the barangay health technician, BHT) is trained by CCHP in primary health care including environmental sanitation, immunizations, motivational work in maternal and child care, family planning, and barrio leadership. He is considered a member of the CCHP health team, which also includes the MHO, the UP instructor in community nursing, clerks, interns, and fourth year nursing students.

The BHT mans the barrio clinic, a health subcenter in the barrio created by the CCHP. Each barrio was supposed to have one multi-purpose worker but because of the limited number who were trained (partly due to insufficient funding), a BHT has to cover a minimum of two barrios. The barrio subcenter is equipped with facilities for consultation, well-baby care, prenatal care, first aid, immunization, environmental sanitation and school health services. It has a stock of the more commonly used medicine like antipyretics, analgesics and anti-diarrheal preparations. It also maintains a health file for every family in the barrio.

BHTs receive salaries from the program and are not allowed to accept payment for services rendered. The public health nurse and the municipal health officer supervise the activities of the BHTs.

The third-level of heatlh care is the primary health center at the poblacion. This is at the same level as the rural health unit (RHU), which directly supervises the BHT. The intention is that the delegation of routine health activities to the BHTs would allow the PHN and MHO more time to attend to more serious cases and to plan health activities.

The fourth level of health care is the district. District here refers to the "North Central Health District of Laguna" (CCHP Forum, n.d.) composed of the municipalities of Los Baños, Bay, Calauan and Victoria (See Figure 5.3), which were later all integrated into the CCHP program. This level, an innovation introduced by the CCHP, deviates from the usual health care plan implemented by the MOH. This level serves as the intermediate link between the municipal and provincial levels of health care. It has provisions for a community hospital and a health center equipped with an outpatient department and a clinical and epidemiological laboratory.

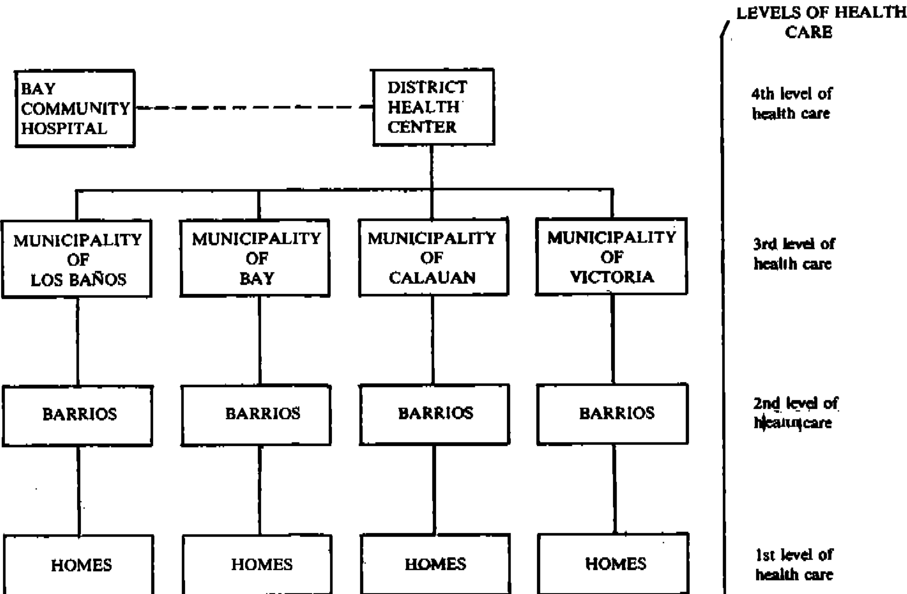
The Community Hospital was expected to serve the residents of this district. The hospital would provide accessible in-patient care at relatively lower cost. The community hospital would also filter cases which would otherwise be referred to the next higher levels of health care, namely, the provincial and regional levels.

However, there were certain events that limited the full implementation of this four-tiered level of health care and forced the program to introduce modifications. For the household level, the CCHP was able to organize classes for fathers, mothers, and youth but the functioning of organizations was not sustained for a time. This perhaps happened because no special funding was

provided for this purpose. At present, there is a renewed interest within CCHP to reorganize these groups as active community leaders for health programs and activities. Mothers' Class Training Program is currently one of its special programs. Previously trained mothers are utilized for health and nutrition activities in this program. This is part of the ongoing search of CCHP for new methods and strategies in health service delivery.

Figure 5.3

Levels of Health Care of the CCHP



Source: Campos, Paulo C., *Comprehensive Community Health,* U.P. 1975, p. 71.

Home care services were and are still being performed by CCHP student health teams.

The CCHP was more successful in training hilots in Bay and in its environs under its Hilot Training and Other Types of Training for Indigenous Health Workers (UP-CCHP, 1979). In fact, all hilots in Bay, except, for four who are scheduled for training in 1980, have been trained under this program and continue to receive ongoing education from CCHP.

The barrio level as the second level of health care has been maintained. Changes in the organizational structure of CCHP in 1977, however, resulted in corresponding modifications in the implementation.

It will be recalled that the original organizational structure of the CCHP integrated the RHU into the program's network and made the MHO responsible to the Deputy Director for the Rural Division. In line with this, RHU activities were defined to be mainly those concerning public health (e.g., environmental sanitation, preventive medicine and control of diseases, public health nursing and nutrition, school health and health activities). These activities were based on a public health program especially developed for Bay. However, with the redrafting of the new memorandum of agreement in 1977 between the Department (Ministry) of Health and the UP, responsibility over primary health services delivery in Bay was again formally placed in the hands of the Ministry of Health (UP and DOH, 1977). The CCHP, particularly its Extension and Training Divisions, will still coordinate with the RHU, but the RHU is now again directly under the PHO.

BHTs are now under the supervision of the public health nurse (PHN) of the RHU (there has been no MHO since 1979). The PHN, in turn, is now responsible to the PHO and not anymore to the CCHP Director for the Rural Division. Under the reorganized CCHP, the position of CCHP Director for the Rural Division no longer exists. The CCHP staff, however, are always present in the staff meetings of the RHU. Rural Health Midwives (RHM) who are members of the RHU staff under the Restructured Health Care Delivery System of the MOH, now man the barrio subcenters together with the BHTs. Ideally, each BHT and RHM should be assigned to only one barrio. However, because of the limited number of BHTs and RHMs (5 BHTs and 2 RHMs), each is given two or more barrios to cover, except for Barangay San Antonio, the biggest barangay in terms of population, which has its own RHM. This limited number of BHTs and RHMs is probably due to financial constraints on the part of the MOH and the CCHP.

The BHT and the RHM are different in two respects. First, BHT receives his training from the CCHP while the RHM should be a midwifery graduate and have a license to practice issued by the Professional Regulation Commission upon passing the proper competitive examination. Second, the salary of the BHT is slightly higher than that of the RHM.

The activities of BHTs range from treatment and referral of patients, home visits, assistance and/or attendance in delivery of family planning motivation and referral, to construction of toilets.

From the above, it can be gleaned that the basic health services the BHTs deliver are quite comprehensive since they range from medical care, maternal and child health, family planning, nutrition to communicable disease control and environmental sanitation.

The BHTs, together with RHMs, hold regular Saturday meetings with the RHU and CCHP staff as part of their continuing education program. Participants come not only from Bay, but also from the neighboring town of Los Baños.

In addition to the BHTs and RHMs, student teams are also assigned to specific barrios where they coordinate with the resident health workers in delivering health services. Each student team assigned to a barangay is composed of medical clerks and student nurses who stay for an average of 5.5 weeks in the barrio. Sometimes, there would also be dental clinicians, veterinary clinicians, and physical and occupational therapy students.

Monitors (faculty members who follow up activities of a given discipline, e.g., medical monitor has medical students), preceptors (faculty members who follow up inter-disciplinary activities of a student team) and other extension service staff also coordinate with the RHU head. They assist in supervising the activities of students who are assigned in the barangays of Bay that have been classified as community laboratories for purposes of training. At present, only the barangays of the Poblacion and two other adjoining areas are not included as community laboratories.

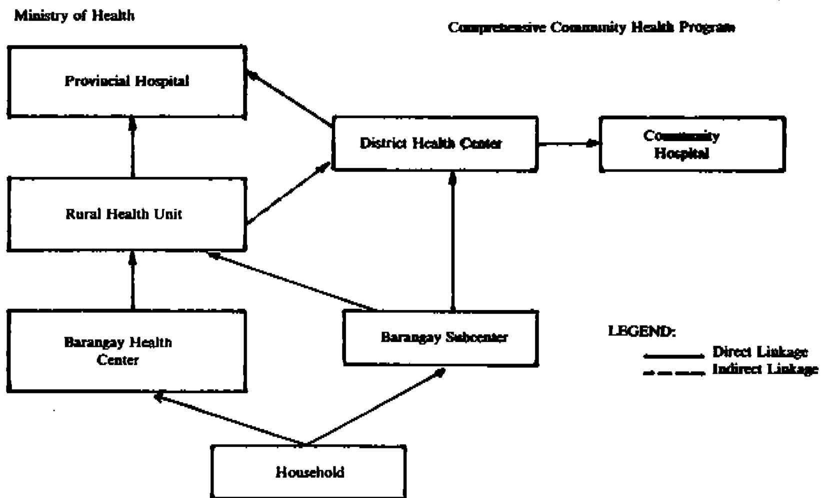
Participation of non-health units like the ISWD is not as regular as that of the health units. The Population Institute is currently not participating. The College of Agriculture, on the other hand, participates through its different units e.g., the Department of Developmental Communications for DZLB broadcasts, the Department of Agricultural Extension for adult education programs, and the Dairy Training and Research Institute for joint extension and research programs (Gasmen, 1980).

The third level of health care delivery is still the RHU. Since there is no MHO, more serious cases which cannot be handled by BHTs and RHMs are usually referred to the Infirmary.

Based on the discussion above, the equivalent levels of health care for MOH and CCHP, may be depicted in Figure 5.4.

Figure 5.4

The Expected Linkage Among the Different Levels of Health Care of the Comprehensive Community Health Program and Ministry of Health



Source: Discussion

Figure 5.4 shows how the CCHP could have been absorbed into the MOH network. The original memorandum of agreement between the UP and MOH provided that the Deputy for the Rural Division of CCHP will be directly responsible for the RHU and will link with the PHO regarding health activities for the municipality of Bay. Now that the CCHP is supposed to coordinate only with RHU activities and the RHU is now responsible to the PHO, what was developed is that the barangay levels of health care, where CCHP is firmly entrenched, refer more complicated cases to the DHC. Therefore, either the RHU is functioning as the barangay subcenter for the poblacion areas, or the DHC is absorbing what is supposed to be RHU functions. Based on what has been observed regarding the operation of both units, it seems that the tendency has been towards the former rather than the latter. This is inevitably bound to create under-currents of dissatisfaction among RHU personnel, although that was not the intention.

The District Health Center or the UP-CCHP Infirmary as it is now known, is the fourth level of health care. It is one of the entities established by the CCHP to deliver basic health services for out-patients. Intended to serve the catchment area of Bay and the adjoining areas of Calauan and Los Baños, it has indeed functioned as one, judging from the number of patients coming from these areas who have sought infirmary services (UP-CCHP, 1979).

Although the Infirmary is mainly for outpatient services, it also has, to a limited extent, facilities for in-patient services. It is manned by three full-time nurses, five midwives, a pharmacy aide, dietary aide, dental aide, medical technologist, X-ray technician, and a dentist. It also has, on a part-time basis, seven physicians, two pharmacists, two nutritionists, one dentist, one occupational therapist, one physical and occupational therapist, and one physical therapist (UP-CCHP, 1979).

In addition, students of medicine, physical and occupational therapy, pharmacy, dentistry, and nutrition, as well as medical interns, underboard nurses and midwives, pharmacy aides and barangay health workers are regularly assigned to the District Health Center as part of their training and exposure to health service delivery at the primary level. The Municipal and Barangay Service of the Extension Division (Figure 5.3) is the unit of the CCHP that is directly concerned with the delivery of primary health services. This is the unit that coordinates with the RHU.

Fifty-two percent of the stocks of the hospital was initially owned by the University and the rest by private practitioners. However, because of certain legal problems concerning ownership mentioned earlier, the hospital became solely a private entity. Subsequently, ownership was transferred to the Province of Laguna which bought the rights to the hospital and attached it to the provincial hospital operation.

The Pharmacy Aides Training Program, a new program, was launched in 1979 by the Extension Services Division. This program was born out of a need

to train community members in the use of available medications. These pharmacy aides are trained to man the "Botika sa Nayon" (village drugstores). In one particular barangay, mothers were trained as pharmacy aides to man the Botika on a rotation basis. Herbal medicine gardens are also being put up in these botikas in response to a growing interest of pharmacy aides in the use of indigenous sources of medicine.

Trainees for this program come from other areas of Laguna aside from Bay like Kalayaan, Pagsanjan, Damba, Kabulusan, Calanan and Los Baños and Jala-jala, Rizal.

A Dental Aides Training Program for Midwives was also put up by the CCHP to train midwives in dental care services. An evaluation study on this shows that these trained midwives were able to integrate their functions with the dental care services and became more effective in delivering health services (UP-CCHP, 1979).

There are also Health Services for staff, students, and other community participants under the Extension Services Division. This provides health protection to foster families (families where students live during their stay in the barrio) and to students, staff and other persons performing extension services.

Program Outputs

The effectiveness of the program can be evaluated in terms of its specific outputs or services rendered in the household, barangay and municipal health care levels.

Since our study is confined to Bay, it is difficult to use CCHP statistics because it also renders services to the neighboring areas of Los Baños and Calauan, and to areas further north like Kalayaan and Sta. Maria aside from the Bay area. Some beneficiaries of the program even come from areas outside the province of Laguna (UP-CCHP, 1979).

In terms of direct community services, for instance, the UP-CCHP Infirmary records for both in-patients and out-patients reveal that except in the case of patients admitted to CCHP Infirmary, majority of those serviced do not come from Bay.

Table 5.1 shows the place of origin of persons availing of the services at the UP-CCHP Infirmary.

Table 5.1 Residence of Patients of UP-CCHP Infimary, 1979

Residents	Patients Admitted to UP-CCHP Infirmary		Dental Patients		Patients X-rayed at UP-CCHP Infirmary	
	Number	(%)	Number	(%)	Number	(%)
Bay, Laguna	394	(60.0)	632	(36.0)	504	(40.4)
Los Baños, Laguna	170	(25.9)	982	(56.0)	461	(36.9)
Calauan, Laguna	55	(8.4)	103	(5.9)	85	(6.8)
Other towns of Laguna	26	(4.0)	19	(1.1)	145	(11.6)
Other provinces	12	(1.8)	17	(1.0)	54	(4.3)
Total	657	(100.0)	1,753	(100.0)	1,249	(100.0)

Source: CCHP Annual Report 1979.

Training programs under its Extension Services Division are continually being expanded to include non-Bay areas in line with its continuous search for new programs and strategies in health service delivery. For instance, trainees for its Pharmacy Aides Training Program come from the following municipalities:

Municipality	Number of Trainees
Kalayaan, Laguna	4
Pagsanjan, Laguna	3
Jala-jala, Rizal	1
Calauan, Laguna	3
Bay, Laguna	12
Los Baños, Laguna	4
Total Number of Trainees	27

For its Barangay Health Technician Training Program, the fifteen trainees came from the following:

Municipality	Barangay	Number of Trainees
Los Baños	Mayondon	2
	Maahas	2
	Tadlak	3
	Bayog	4
Jala-jala	Palaypalay	1
	Pinagsanjan	1
Calauan	Lamot	1
Bay	San Antonio	1
5 Municipalities	8 Barangays	15 Trainees

Source: UP-CCHP, 1979.

Another difficulty encountered is the absence of clearly defined program targets for specific time periods. Except in the case of barangay and municipal health care services that are delivered through the RHU (which is required to set program targets as a matter of MOH policy), it is hard to determine whether or not the program has been able to meet its specified objectives.

A rough index of effectiveness, however, can be done if we compare program outputs for the years 1978 and 1979 in household, barangay and municipal health care levels and in extension training programs. Our discussions are based on the "Results of Extension Programs of UP-CCHP for 1978 and 1979," which is part of the CCHP budgetary documents.

In this report, there is definitely an increase in the number of in-patients and out-patients. From 535 in-patients and 6952 out-patient consultations in 1978, there were 658 in-patients and 7688 out-patient consultations in 1979. There was, however, a slight decrease both in the matter of prescriptions filled (1173 for 1978 as against 985 for 1979) and in the number of X-ray examinations (1426 for 1978 as against 1249 for 1979). Surprisingly, too, there has been a decrease in the number of meals served per month (340 in 1978 as against 263 in 1979). This could probably be an indication that the Infirmary has been hard pressed in coping with the needs of its clients. This observation is strengthened by the fact that there has been a decrease in income generated for the UP CCHP Infirmary from ₱211,959.71 in 1978 to ₱197,439.96 in 1979.

There has been an increase in the number of students fielded in Bay and other areas under CCHP in some UP units, like occupational therapy, den-

tistry, pharmacy, and the participation of new units like Veterinary Medicine. However, there was also a decrease in the number of students fielded in other units like medicine, physical therapy, and nutrition.

The number of underboard nurses and midwives who participated increased from 3 to 8.

Regarding the area of municipal and barangay services, there was a 38.2 per cent decrease in the number of patients attended to in the different barangay clinics from 1978 to 1979. However, it was observed (by the program staff) that morbidity dropped to that exact level (38.21 percent) compared to that of 1978.

Some of the targets set were more than met. For instance, 78 percent of all pregnancies were followed up for 1978 (the target was 75 percent) and for 1979, 80.25 percent were followed up (as against the target of 70 percent). In 1978, too, only around 70 percent of pre-schoolers were weighed, whereas in 1979, all pre-schoolers were weighed.

For BCG vaccinations, 87 percent of infants were immunized in 1978. The target was only 80 percent. For 1979, however, all 3-14 month old babies were targetted but only 61.60 percent were given BCG; 81.8 percent of 644 grade one children were also given BCG. There was also a significant increase in the number of sputum examinations done for PTB control, from 126 in 1978 to 560 in 1979.

The number of those who graduated from mothers' class training program also increased from 11 in 1978 to 20 in 1979.

There were, however, areas where targets were not met.

A target of 70 percent for tetanus toxoid vaccinations of pregnant women was set but only 169 or 46.10 percent were reached for 1978. This was, however, compensated for in 1979 when 87.55 percent were immunized, an increase of 41.45 percent from 1978.

The proportion of births delivered by doctors, nurses, midwives and hilots remained comparatively the same for 1978 and 1979. For 1978,.12.7 percent of births were attended to by doctors, 16.3 percent by midwives and 74.2 percent by trained hilots.

Regarding environmental sanitation, the target set in 1978 for the construction of toilet was to cover 5 percent of the households without toilets (or 66 households). However, only 48 toilets were actually constructed. Again in 1979, the target was set for 174 households, but only 46.0 percent (80 households) of the target was reached.

The program seems to have been concentrating more on primary health activities like medical care, maternal and child care, and communicable disease control as evidenced by the fact that targets in these areas were generally met. Activities like environmental sanitation and public health nursing are not given much priority.

The CCHP has, however, been most successful in training indigenous and resident health workers. There was an increase in the number of BHTs trained, from 8 in 1978 to 15 in 1979. In addition, new programs have been devised like the pharmacy aides training program and the training of midwives as dental health providers. Continuing education is also being conducted for previously trained *hilots,* pharmacy aides, *herbolarios* and BHTs. There has also been an increase in the linkages of CCHP with other agencies from 1978 to 1979. As of 1979, eight agreements have already been reached with other agencies for various projects.

There has also been an expansion in health services for staff, students and other community participants. While only 22 of the staff finished their annual physical examination in 1978, 106 personnel were examined in 1979. In addition, all foster families of UP-CCHP interns were examined.

Financial and Logistical Support

Initial funding for the UP-CCHP came in the form of a Rockefeller Grant. This was used mainly for the construction and remodelling of the building and dormitory and the purchase of equipment and vehicle. By 1978, funding for the UP-CCHP was already mainly internal, which means that the UP system finances the major activities of the program, principally the training program. In fact, about 83.7 percent of the total monetary support comes from the UP.

Other sources of funding come from donations by barangay members for repair of barangay health centers, operations of the botika sa nayon and other community projects. Other supplies received by barangays are commodities given by CARE through the Bureau of Agricultural Extension as part of the nutrition services of the CCHP in the barrio clinics. Other non-cash resources are direct inputs of other agencies in joint service projects for the community.

Funding for research comes mainly from NSDB research grants. Other private sources donate small amounts for maintenance and operating expenses from time to time. "Direct donations from infirmary operations" (hospital fees) also constitute another source of funding. In 1979, though, its share in the overall source of fund was 6 per cent smaller than its share in 1978.

The allocation of these funds is different now than in the initial years. At the time of the Rockefeller grant, the biggest chunk went to capital costs and equipment. In recent years, however, personnel expenses get the largest share. (See Table 5.3.)

Table 5.2

Sources of Funds of CCHP, 1979

Item	1978 Amount	%	1979 Amount	%
UP System	₱858,996.00	70.8	₱1,012,964.00	83.7
Direct Donations of Patients from Infirmary	210,959.71	17.4	197,439.96	16.3
Research Projects	141,090.00	11.6	—	
San Miguel Corporation, for repair of Infirmary office	1,500.00	.2	—	
	₱1,212,545.71		₱1,210,403.96	

Source: CCHP Documents

Table 5.3

Actual Expenses of the CCHP, 1966-1979

Item	Initial[1] (Oct. 1966-Dec. 1977)	1978[2]	1973[3]
Capital Costs/Equipment	₱203,734.00	₱11,500.00	₱ —
Maintenance Operating Expense	25,000.00	330,410.21	179,796.00
Personnel Services	38,217.00	849,257.00	788,528.00
Contingent/Reserve	68,277.00	—	—
Security Services/ Special Purposes	—	21,378.00	44,640.00
Total	₱335,228.00	₱1,212,545.21	₱1,012,964.00

[1]Rockefeller Grant

[2]Includes NSDB Grant

[3]Purely UP Funding

Source: CCHP Documents

Program Control

As a university program, the CCHP has been in operation for over twelve years. It was, however, only during the last three years that concrete steps have been taken in order to be able to conduct an evaluation of the program. Together with the National Teacher Training Center for the Health Professions (NITC-HP), a unit under the newly constituted Health Sciences Center, the Research Division of CCHP is currently formulating a system-wide evaluation design entitled "The CCHP Evaluation: A Totalistic Approach," that is capable of measuring the effect of its different services, i.e., training, research, extension and administration on the CCHP and the impact of CCHP services on the communities it has operated in, particularly Bay.

However, earlier evaluations have been conducted by the Program in specific areas. For example, the Interdisciplinary Curriculum Committee of the Division of Training regularly evaluates the core curriculum of its Community Health Field Practice Program, a training program designed for undergraduate students of eleven participating units of the University.

Feedback regarding the curriculum is solicited from students, faculty and the community. Changes in the environment are taken into account in making curricular revisions.

Another unit, the Communication and Information Office (CIO), conducts a monthly staff meeting to review CIO's existing activities, identify and analyze problems encountered and suggest solutions.

Evaluations of specific areas of operations are also being conducted. For instance, the NSDB has funded the "Development of a Training Model in Community Work," a research study started in 1977 which also includes an evaluation of effectiveness of the outpost approach in community development.

In 1978, an evaluation of the Training Program for Paramedics trained at UP-CCHP was also initiated where the opinion of 50 percent of the paramedic course graduates who attended a CCHP-sponsored homecoming was elicited, specifically on their training and experiences after training. Regular meetings and continuing education of previously trained paramedics are being conducted with the RHU staff. However, it seems that the evaluation indices have not been thoroughly or clearly defined.

The CCHP is probably more systematic in monitoring its activities based on specific plans it has formulated. General quarterly staff meetings are conducted to monitor the progress of its training, research and service functions.

CCHP is also required to submit an annual report to the UP. In addition, an executive review of the budget by UP is held yearly where budget plans are drawn by CCHP and are adjusted by UP to conform to projected plans and actual budgetary allocations available.

Problems

One of the more critical problems that the program has encountered is fund-ing. Observations from all quarters, e.g., the staff, students and beneficiaries of the program, almost always mention the lack of supplies, equipment, medicine, vehicles and budgetary allotment for gasoline, etc. Hardest hit are the extension services, particularly the Infirmary where even an ocular inspection of the building would show that very little maintenance and improvement have been done since the program was first introduced in 1965.

The CCHP staff has been able to elicit from students feedback regarding the program's training activities. This principally concerns the training period in the barrios. The students have felt that the period was too short to really familiarize them with the social, cultural, and health conditions of typical rural communities. Some were even of the opinion that the rural communities of Bay were already saturated with medical personnel. For instance, people demanded house calls for even the most minor of ailments which can very well be taken care of in the barrio clinics. Indeed, Bay could not anymore be described as a typical rural community in the Philippines. The proliferation of private clinics and doctors in Bay with facilities for more sophisticated medical needs not ordinarily found in a rural town, e.g., ECG, X-ray, laboratory examination, attests to this fact.

Of course, there were also other students who thought that the period of stay was actually too long and quite boring, but they tend to be in the minority.

It was also quite surprising that despite the rather long period that the CCHP has been in operation in Bay, the staff, students and BHTs still complain of the attitude of those availing of CCHP services. For example, there have been instances when community members go to the clinics for consultation without bringing the patient. They also allege that many people remain ignorant of the benefits of immunization.

There seem to be some problems of coordination between the CCHP staff, including students, and certain local government officials. One student nurse cited an instance where school deworming activities had to be stopped because of the failure of the barangay to inform the school principal (the school teachers had previously been informed) that 20 centavos would have to be collected from each student dewormed. Comments were even heard from the principal that school children were being used by CCHP as guinea pigs for training purposes. This problem was eventually settled through a meeting with the barrio council. The very fact, though, that this problem should even arise was quite surprising considering the fact that the school health program was, up to recently, an integral part of the CCHP health service delivery system.

This problem of coordination could probably be explained by the fact that the RHU and the CCHP use different methods in delivering health services. For example, while the RHU gives medicine for free, the CCHP does not,

justifying this stand in terms of a refusal to encourage a dole-out system of delivering services. The school principal was probably expecting that the medicine would be given for free as the RHU does.

On the other hand, it is quite understandable that certain misunderstandings regarding RHU-CCHP roles would arise. For one thing, salaries of BHTs are higher than those of RHMs. Then, salaries for CCHP instructors are also higher than the salary the MHO receives. It is no wonder that the MHOs, both of Bay and Los Baños, have since transferred to CCHP. Aside from the higher pay, there seem to be more opportunities for advancement under the UP-CCHP system.

This state of affairs has left the people confused as to the quality and quantity of services to be expected from either health service delivery unit. On the one hand, they want free medicine; on the other hand, they want quality service. In this respect, the CCHP has muddled more than clarified the role that the RHU should assume. It started as an integrative body for health service delivery with the RHU in Bay as one of its component units. Now it is functioning as a separate unit branching to other areas including those outside of Laguna. Nevertheless, CCHP officials interviewed now recognize that RHU's role within the health service delivery system and agree that the CCHP should regard this as the basis for all proposed health programs and approaches.

There also seems to be confusion regarding the activities that should be emphasized. CCHP policy planners have stated that instead of just training, the research and service activities should also be given equal emphasis. However, interviews with CCHP instructors indicate that some still think of CCHP mainly as a training institution. Perhaps it must be first made clear among CCHP staff members themselves what their functions are and what should be given emphasis. In another light, this development is quite natural since the very role of CCHP in the rural community is continually changing to adapt to the different experiences it has encountered in its long years of existence. This is why the CCHP staff has left the need for an integrated evaluation.

This development has, fortunately, not prevented the CCHP to continuously search and experiment for new methods and strategies that would result in a more effective health service delivery.

Chapter VI

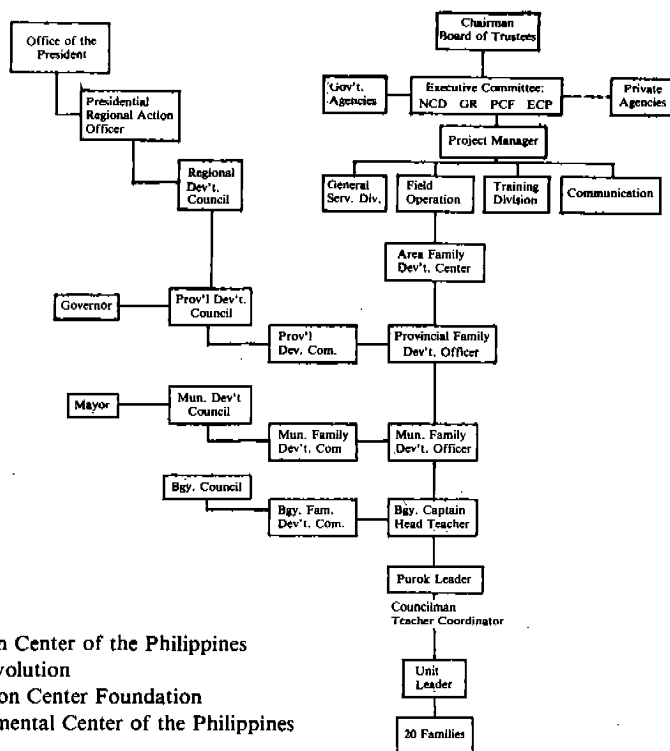
PROJECT COMPASSION: FOCUS ON TERESA, RIZAL

Reynaldo N. Caraso and Dante T. Fernando

Project Compassion (ProCom) is a private foundation which seeks to integrate nutrition, family planning, green revolution, environmental management and sports and cultural development in one package. It was created shortly after the meeting called by the First Lady following her state visit to the People's Republic of China in 1976. The meeting was attended by the Executive Directors of the Nutrition Center of the Philippines, the Green Revolution, the Population Center of the Philippines, and the Environmental Center of the Philippines. These men became the members of the Executive Committee, ProCom's policy-making and decision-making body. They are assisted by two advisory councils - one from the government and another from the private sector. The Board of Trustees supervises and controls the business and the affairs of the Corporation, and has Mrs. Imelda R. Marcos as the Chairman. The original organizational set-up is diagrammed in Figure 6.1.

Figure 6.1

Organizational Chart of Project Compassion



LEGEND:

1. NCP — Nutrition Center of the Philippines
2. GR — Green Revolution
3. PCF — Population Center Foundation
4. ECP — Environmental Center of the Philippines

The ProCom has a five-pronged objective:

1. To increase the production of vegetables, fruits, livestock, poultry and fishery products and elevate their consumption to recommended nutritional levels;

2. To improve the nutritional status of families and prevent the occurrence of malnutrition;

3. To motivate eligible couples to have only that number of children they can properly rear, educate, and support and to provide family planning information and services;

4. To develop enviromental awareness by providing information on environmental management and to motivate the family toward the improvement of its surroundings and environment; and

5. To develop community spirit among the people.

By November 1975, the new private foundation had operating programs in 82 cities and municipalities. By 1980, however, this had declined to 22.

The Compassion approach is distinctive in that it delivers the five sectoral programs to the very doorstep of the family by using a single organizational channel, the barangay network. Furthermore, it discourages dependence on the project. Rather, it fosters self-reliance by identifying and utilizing the resources available to the families and providing them with minimum external assistance.

Turn-over of project management to the citizens is expected to take place when the following conditions are met:

a. When the local government is able to manage the problem in the whole municipality;
b. When the barangay network is functioning as it should be or when it is institutionalized (i.e., the citizens recognize the existence of the network and use it);
c. When the citizens have become self-reliant;
d. When the citizens have accepted the program as their own;
e. When the integration of the five sectoral programs has been accomplished.

Planning

When the ProCom agents came to Teresa in May 1976, there was no integrated organization at the municipal level and the various agencies were functioning independently of each other. ProCom then conducted a Social Development Seminar and organized a Municipal Family Development Council immediately after. Following the requirements of DLGCD 76-110 dated October 25, 1976, the Municipal Family Development Council was changed to the Municipal Development Council. The MDC was organized sometime in 1977. However, ProCom left Teresa for a while because it had no

operating funds. Although the MDC was an officially required Council it did not function well during this period.

When it came back months later, the second Municipal Social Development Seminar was conducted on October 18-19, 1973. The MDC then set out to perform its functions which include the formulation of an Integrated Development Plan in accordance with local needs, available resources and the sectoral programs established by the National Government. In addition to this planning function, the MDC is also expected to formulate studies for the systematic and effective coordination of project development and management and to coordinate and integrate the implementation of these activities conducted by both public and private entities. It is also supposed to render technical services and assistance to component local units as well as to receive such from the local units.

The Municipal Development Council is composed of all the agencies and local organizations stationed in the municipality of Teresa (Total membership must not be more than 15 as stipulated in DLGCD 76-110). The mayor approves the plans presented to him. He also provides assistance and support in the formulation of the plan.

The Tripartite Agreement between the local government, POPCOM and ProCom allows the District Population Officer (DPO) and the Full Time Outreach Workers (FTOWs) to be utilized by ProCom in implementing its activities; the DPO and FTOWs will then be under the direct supervision of the ProCom. Thus, in Teresa, the DPO from POPCOM is also the Family Development Officer (FDO). He is in charge of the distribution of contraceptives (for POPCOM as DPO) and at the same time represents the citizens of Teresa in the MDC and acts as the mayor's action man when implementing the plans decided in the meetings (for ProCom as the FDO).

The citizens are involved through the planning stage during the Chapter Officers Training Course (COTC) conducted by the local ProCom staff. The barangay officers, unit leaders and chapter officials make plans based on the problems identified during chapter meetings and in the Quarterly Summary Reports. The plans of the community are presented to the assembly. These are then collated into a problem-oriented development plan by the mayor. This Action Plan is divided into the five sectoral groupings of ProCom and finalized by the MDC. Through its committees focusing on nutrition, Green Revolution, environmental management and sports and cultural development, the mayor then presents this to the Sanggunian for inclusion into the Municipal Development Plan of Teresa.

Implementation

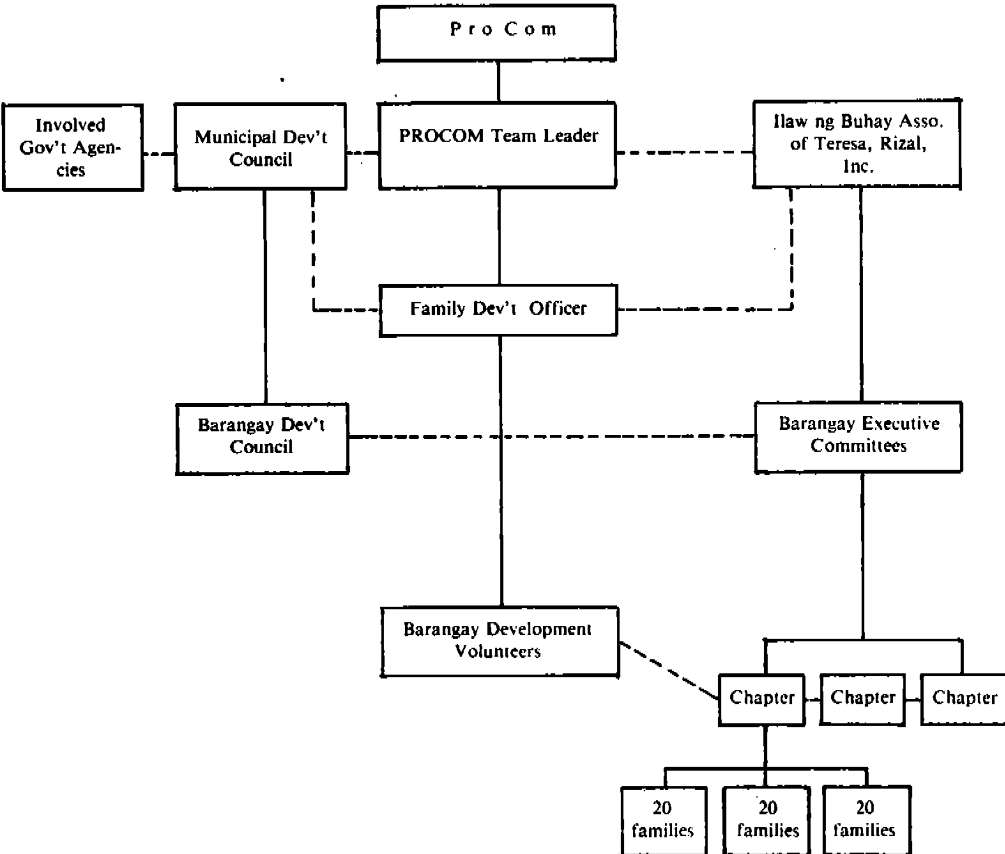
The ProCom implementation scheme relies not only on its small staff and group of volunteers, but also on other government agencies (including the municipal development council discussed above) and a network of citizens'

organizations known as the *Ilaw ng Buhay,* Tagalog for "Light of Life." (See Figure 6.2.). These Ilaw ng Buhay chapters are composed of families who have been trained by ProCom in its five-pronged thrust, such training being called the Family Ilaw Training (FIT). The role of each of these agencies and organizations in the ProCom is discussed in the succeeding section.

The ProCom Staff

The ProCom staff in Teresa is composed of the Team Leader, the DPO/FDO and the Barangay Development Trainors. The latter two are paid honoraria for their part-time service to ProCom. The team leader is the only full-time representative of ProCom in Teresa and advises the MDC concerning the formulation, implementation and evaluation of the Integrated Development Plan. The absence of a "true" staff is due to the emphasis on community self-reliance by ProCom which provides the community only limited areas of support (e.g., consultations, materials, referrals).

Figure 6.2
ProCom's Effective Structure in Teresa, Rizal



The Family Development Officer (FDO) is the action officer who acts as the link between the Development Council and the extension workers as well as the barangay network. The present FDO is being groomed to be the action man when the ProCom staff relinquishes the project's management to the local government. Currently, he acts as the mayor's action man in the implementation of the integrated development plan. Whenever an activity in the development plan is not being pursued, he is supposed to approach the sponsoring technical agency and remind it of its commitment. Together with the ProCom staff, Barangay Development Volunteers, barangay officials and unit leaders, he organizes the Family Ilaw Training (FIT).

The FDO, as a member of the MDC, airs the immediate problems of a locality and makes sure they are considered during monthly meetings. With the help of the ProCom staff, he also acts on these problems whenever possible. Otherwise, he approaches (through the referral system) the technical agency which can provide the needed assistance.

The FDO is an overburdened personnel for he also performs evaluation and monitoring functions aside from the functions mentioned earlier. He collates the quarterly reports of the Development Volunteers and prepares the final output to be submitted to the ProCom team leader. Also, he prepares monthly reports of the various Ilaw Chapters. Furthermore, he guides, and assists the Ilaw Association and chapters in identifying and mobilizing local human and material resources in carrying out their specific activities.

There are nine Barangay Development Volunteers (BDVs) in Teresa, acting as extension workers of the ProCom. They were formerly called Development Trainors, and underwent five days of training for this work. They assumed the BDV positions when they finished training the people regarding the five sectoral programs in the FIT. The BDVs are public school teachers selected for their credibility.

As BDVs, they organize the Ilaw ng Buhay chapters in their respective villages and act as their advisers. They make home visits in order to follow up on what they had taught. With the help of the FDO, they make referrals to technical agencies. Moreoever, they participate in Ilaw chapter projects like the Operation Timbang, beautification, tree planting, etc. They collate the results of the survey conducted by the different unit leaders in the barangays under their jurisdiction. For their efforts, the BDVs receive honoraria amounting to ₱90 per quarter.

Citizen Involvement in Implementation

The Ilaw ng Buhay. Citizen involvement in Project Compassion has been engendered by the system called Family Ilaw Training (FIT). The FIT is a social development seminar for household heads, held for two to three consecutive nights under the tutelage of three Development Trainors or BDVs. The training focuses on the five-sectoral programs of ProCom. At the end

of the seminar, participants divide themselves into units of twenty families (representing contiguous residences) and elect their Ilaw ng Buhay officers. The selected unit leaders represent the unit's family heads and supervise and manage the development activities and needs of these families.

An Ilaw chapter is composed of three or more units. All the chapter presidents within the jurisdiction of one barangay constitute its Barangay Executive Committee. The BEC was organized in order to coordinate the activities and efforts of three or more Ilaw Chapters in a barangay. A Chairman is elected from among the presidents, and represents the BEC in the Barangay Council

In addition, the Municipal Ilaw ng Buhay Association of Teresa was organized in February 1979 with the help of the ProCom staff. Its members are the various presidents of the Ilaw Chapters. Three months after its organization, the Ilaw ng Buhay Association of Teresa was granted by the Securities and Exchange Commission the full rights and privileges of a corporation.

The Chairman of the Board of Directors sits in the Municipal Development Council representing the Ilaw Association as a private group. The Association:

1. Cooperates with the MDC in developing the Integrated Development Plan;
2. Disseminates information from the MDC to the various Ilaw Chapters;
3. Advises and supports Ilaw chapters on activities to be undertaken;
4. Works with the ProCom and the various public or private agencies to achieve the purposes of the corporation;
5. Raises funds or contributions in kind for its projects and activities by means of donations, investments, cooperative undertaking, etc.

The Family Ilaw Training (FIT). Originally the ProCom designated a unit leader for every twenty families to deliver its services to his family group. However, this strategy encountered some problems like inactivity, buck-passing, and misinterpretation of ProCom information. As a remedy, the national office devised the Ilaw ng Buhay Movement which is based on a new approach called Family Ilaw Training.

As a first step in organizing the Family Ilaw Training, the barangay captains are informed of the activity. The barangay captain then disseminates this information to each unit leader who in turn informs the 20 household heads under his jurisdiction. Supplementary information campaigns are conducted in schools by the teachers, or in individual houses by the ProCom staff.

The training is conducted by the three Development Trainors assisted by the ProCom staff. Their initial task is to convince the participants to commit themselves to the movement, after presenting and discussing the problems of Teresa. The participants are then challenged to minimize or solve these problems through their collective effort.

The training touches on the five-sectoral programs. In the nutrition aspect, the participants are taught to recognize and cook food which are nutritious yet cheap. The development trainors also teach them the proper ways to prepare and cook food. Moreover, they are asked to ignore unscientific food taboos and to unlearn their wrong buying habits. Nutritious food and vegetables are shown to them. Nutritious food is identified as "gulay-buhay" (vegetables for life) while the term "gulay-patay " (vegetables for the dead) is associated with non-nutritious food.

In family planning, the participants are shown the advantages of having a limited number of children and the difficulties of large families. The couples are encouraged to practice family planning. They are taught the different methods of family planning (rhythm, pills, IUD, etc.) from which they can choose the method to use.

Green Revolution is a program intended to teach the participants to cultivate the proper food crops in their backyards. If they do not have a piece of land to cultivate, they are asked to practice communal gardening. The program is not only intended to increase food production but also to augment incomes of the participants. The people are provided seeds and seedlings.

In environmental management, the trainees are taught the proper ways to dispose of their waste and garbage. Furthermore, they are also taught to construct drainage canals. Lectures on the importance of the cleanliness of the community and sanitation as well as water purification methods are given.

The sports and culture program is designed to encourage community participation and community spirit. Special emphasis is given to native sports and culture.

At the end of the training, the participants elect the chapter officials who will manage and supervise the activities of the chapter after the FIT. This is expected to generate more member commitment and community participation.

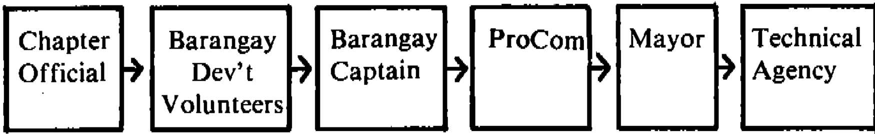
ProCom finished training the families in all the nine barangays of Teresa under the Family Ilaw Training (FIT). However, there remains a need for re-education or re-training of the families to intensify their commitment to the program. Frequent follow-ups of the training are also important. The latter are done by actual home visits to the families in the barangays. Remedial classes are held not only to re-train participants but also to be able to involve families who were not able to attend the FIT. ProCom's strategy has been to concentrate and intensify all its efforts in Teresa before expanding to the neighboring towns of Cainta, Antipolo, etc.

Referral System. When some activities of the chapters need technical advice and support from a government agency, use of the referral system is encouraged. The chapter officials and unit leaders approach the barangay development volunteer for advice on whom to approach for a given assistance. Together with the BDVs, the chapter officials then go to the barangay captain who in

turn goes to the ProCom staff, and the latter presents the problem to the mayor who provides them support or otherwise refers them to a technical agency. (See Figure 6.3).

Figure 6.3

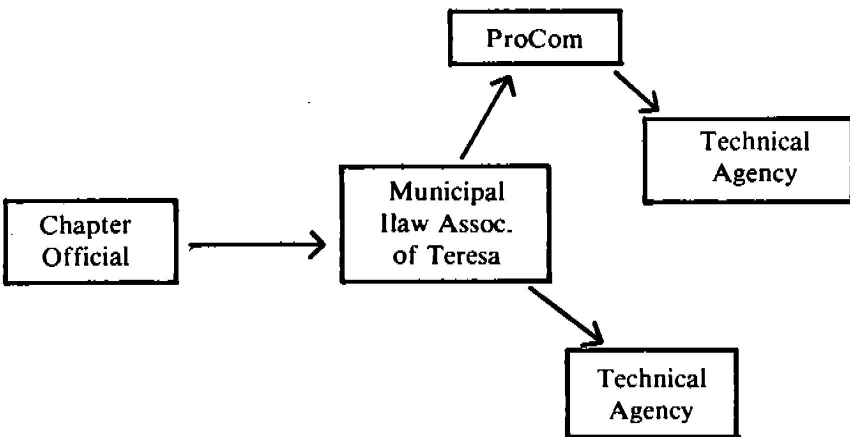
Usual Referral System of Project Compassion



Sometimes, chapter officials seek the help of the Municipal Ilaw Association, Inc. If the corporation can provide assistance, the system is terminated at this stage (Figure 6.4). However, there are times when the Association does not have the funds and materials to support the activities, and there is need for the Ilaw Association to go either to the relevant technical agency (if he knows the government officer concerned) or to ProCom (if he does not know the public officer) for referral.

Figure 6.4

Alternative Referral System for Project Compassion



Other Forms of Citizen Participation. The citizens are expected to be actively engaged in the different ProCom activities from the planning to the implementation stage. Every month, the chapter members meet to discuss the problems. With the help of the BDV who sits with them, they plan together the activity

they are supposed to do for the coming period. Citizens also participate in the evaluation of the project (also to be discussed in the Monitoring/Evaluation section of this chapter).

The activities are implemented by the members themselves. The chapter officials go around their chapter and collect special fees to finance selected activities. Both the fees and the activities have been agreed upon in previous chapter meetings. The unit leaders, chapter officials and the BDVs are volunteers who work for the development of the community without pay. In other words, commitment to the project by a substantive number of residents has already been developed.

The citizens also actively work together with the technical agencies concerned. For instance, for a nutrition activity, the MSSD and ProCom get involved — the former provides food assistance, the latter disseminates the information to the citizens. The citizens go to the feeding center and bring with them their children (aged 0-6 years old). The unit leaders, chapter officials and barangay captains assist in the weighing of the children. They help identify malnourished children. Furthermore, with the help of the technical agency, they prepare the food to be given to those who are malnourished.

Also at the barangay level is the Barangay Development Council. The BDC is composed of the Barangay Captain, Councilmen, teachers and a representative from the Ilaw Association. It formulates plans and activities which are to be implemented at the Barangay level.

Having undergone a training course called the Barangay Development Seminar (BDS) under the aegis of the ProCom, the officers are able to recognize the problems in the barangay. Furthermore, they were taught to plan, implement and evaluate activities, and identify the resources available, thus, minimizing misallocation of resources.

The BDC regularly holds meetings where problems are discussed and possible solutions are raised. Having an appropriation amounting to ten percent (10%) of the real estate taxes, 70 percent of which will be used for barangay's development, it is financially capable of pursuing its goals. Whenever it has no adequate resources, it uses the referral system taught in the development seminar.

Coordination with Other Agencies

Table 6.1 shows how activities are actually implemented, including the agencies with which ProCom coordinates, and the kind of assistance provided.

Financial and Logistical Support

Although ProCom's general intention is to teach the community to be self-reliant, some external sources have contributed to its support, particularly for

Table 6.1

Agencies Coordinating with Project Compassion in Teresa, Rizal and their Activities

Activities*	Agency Coordinated with	Supports/Assistance
I. Family Planning		
1. Lectures in family planning	POPCOM; MOH	personnel
2. Distribution of Information, Education and Communication materials	POPCOM	materials, personnel
3. Distribution of contraceptives	POPCOM	contraceptives, personnel
4. Film Showing	PROCOM - POPCOM	personnel, equipment, films
5. Referrals (Vasectomy, ligations, insertions)	POPCOM, MOH	personnel, equipment, supplies
II. Nutrition		
1. Food assistance of malnourished children in Dulumbayan & Dalig	MSSD	day, care workers, social Workers, foods
2. Food assistance		personnel, supplies
3. Operation Timbang	BAEx MEC, Ilaw ng Buhay Association, MSSD	personnel
III. Green Revolution; Food Production		
1. Lectures on Food Production	BPI, BAEx	personnel
2. Distribution of seedlings	BPI	seedlings, personnel
3. Lectures on plant - - Budding - Grafting - Technical care - Orcharding	BPI	personnel
4. Construction of Barangay nurseries	BPI	personnel
5. Swine and Goat Dispersal	RYDF (Rural Youth Dev't. Foundation)	goats, swines, personnel
IV. Environmental Management		
1. Lectures on sanitary toilets, proper garbage disposals	MOH, Ilaw Association	personnel
2. Operation Linis (one day a month)		
3. Placing of trash can	Ilaw Association	trash can
4. Home fencing, beautification	Barangay Council	
5. Construction of shallow-dug-wells	Ilaw Association	materials, equipment
Health Protection Vaccinations, Injections	MOH	medicines, personnel, equipment, supplies

Source: Interview with Mr. Pedro Mauleon, Team Leader.

Table 6.2

Teresa Project Compassion: Finance and Logistical Support by Agency, 1979

Agency	Amount	Percent of Total Resources
1. Local Government	₱48,918.50	30.97
2. Project Compassion	28,858.00	18.27
3. Chapters	24,456.00	15.48
4. Rural Service Group	19,900.00	12.60
5. Commission on Population	11,600.00	7.34
6. Ministry of Social Services and Development	5,600.00	3.54
7. Ministry of Social Services and Culture	4,075.00	2.58
8. Bureau of Plant Industry	3,185.00	2.02
9. Ministry of Social Services and Development	3,020.00	1.91
10. Ministry of Local Government and Community Development	1,700.00	1.08
11. Ministry of Health/ Rural Health Unit	1,575.00	1.00
12. Bureau of Agricultural Extension	1,395.00	0.88
13. Individual Groups	1,050.00	0.66
14. Bureau of Forest Development	1,000.00	0.63
15. Teresa Parish Council	600.00	0.38
16. Association of Barangay Captains	500.00	0.32
17. Local Sinacolo Organization	300.00	0.19
18. National Nutrition Council	200.00	0.13
19. Ilaw Association	30.00	0.02
	₱157,962.00	

Source: ProCom Documents

Table 6. 3

Expenses of Teresa ProCom, 1979

Expenses during data gathering	Amount	Percent
Pre-SDS Activities (determining the needs of the community training, preparation)	₱ 280.00	1.71
Social Development Seminar Expenses (Actual Survey)	745.00	4.55
Expenses for "Save the Children Week" and Community Conference (1 week)	3,355.25	20.47
Family Ilaw Training Expenses (33 FITS)	5,830.00	35.57
Honoraria:		
a. Municipal Family Development Officer (₱300/month x 9 months)	2,700.00	16.47
b. Nine Barangay Development Volunteers	2,450.00	14.95
Chapter Officers Training Course		
1. Chapter officials		
2. Unit Leaders		
3. Barangay Supply Point Officer	908.00	5.54
Barangay Development Volunteers Orientation Training and Board of Directors of Ilaw	123.10	0.74
Total Expenses	₱16,391.35	100.00

Source: ProCom Documents

activities at the national level or for facilities used by more than one project area. Each foundation contributed to the initial funding, amounting to ₱5.9 million for the Project's first 18 months of operation. UNICEF provided equipment like bullhorns and transportation facilities.

For 1979, ProCom spent ₱28,858.00 in Teresa (Table 6.2) contributing 18.2 percent of total expenditures. Of this amount, ₱16,391.35 was used to fund the Social Development Seminars, Family Ilaw Training, Survey, etc. (Table 6.3).

Also in 1979, ProCom sponsored 33 FITs, costing ₱5,830 or 35.57 percent of their total contribution. From Table 6.3, we can see that ProCom incurred the biggest expenses on the FIT activity. This is followed by the amount paid to extension workers in the form of honoraria. The honoraria of the FDO and DBVs totalled ₱5,130.00 or 17.7 percent of total expenditures.

The interest of the local government in the various activities is reflected by its contributions to total expenditure. Total outlay contributed by the MDC and BDC amounted to ₱48,918.50 which is 31 percent of the total expenditure. This assistance came in the form of cash, materials and equipment.

The chapters also shared in the costs. Activities of the various chapters include the establishment of nurseries, fencing, general cleaning drive, placing of drums around the barangay, etc. The total costs amounted to ₱24.456.00. The chapters got this amount from solicitations from the chapter members. Family members were charged membership fees by the Ilaw chapters. ProCom rules require that this fee must not be less than two pesos per family.

Another major source of funds for the 1979 activities was the Rural Service Group which contributed ₱19,900.00 for the repair of basketball courts and for the provision of garbage drums and cans and street signs and names.

The participating agencies also shared in the project cost. The most important is the Population Commission whose total contribution was ₱11,600 in the form of contraceptives, information education and communication materials, etc. Eight other government agencies gave small contributions ranging from two hundred pesos to ₱5,600 for the year.

Project Monitoring and Evaluation

Unit leaders conduct monitoring activities and prepare summary reports using instruments sent by the Central Office. For the ProCom Quarterly Summary Report, the unit leaders gather data from families under their jurisdiction through home visits and interviews of the family household head. Each family is asked on the five aspects of the program. For instance, for nutrition, data gathered include the number of malnourished children, the "junk foods" they buy (vetsin, liquor, etc.) and number of children fed and treated in the feeding center. For family planning, the number of births and deaths are

gathered, while for green revolution, the number of gardens established, plants and vegetables cultivated and livestock reared are looked into.

The Quarterly Summary Report also reflects the sources of water, the garbage and waste disposal methods, and the number of family members who participate in the native sports and cultural activities.

The unit leader makes a summary of the data gathered from families in his unit, which provides useful information on its problems. The Barangay Development Volunteer (BDV) then collates the reports of the unit leaders under his control to make the Chapter Quarterly Summary Report. Likewise, he consolidates all the chapter reports to make the Barangay Quarterly Summary Report.

The BDV submits the Summary Report to the Family Development Officer, who in turn, collates all the data gathered. He consolidates all the Barangay Reports to make the Quarterly Summary Report for the municipality of Teresa.

The ProCom staff, together with the FDO, analyzes the results of the QSR. They may use incremental analysis, comparing the QSR of the period with that of the preceding period and of the baseline survey. A cause and effect method is also used to trace changes back to the unit. Through the process, the staff is informed of the problems of the community. The analysis is then forwarded to the Central Office in Manila.

Evaluation is accomplished regularly by the MDC. Every month, it convenes in order to review the integrated development plan. The council members assess whether the activities have been accomplished or not and whether these activities have been effective in solving the problems in the community. If an activity has not been accomplished, careful replanning and resetting of the goals are done. Also, the lead agency is prodded by the MDC to pursue the activity in the next period.

The Sinag Team, an independent agency hired by the UNICEF, is doing an intensive study of ProCom. It aims to document the process and mechanism for the delivery of services as well as to measure the program's impact on the beneficiary communities.

Analysis of Outputs

What did the Project Compassion in Teresa accomplish in terms of its various component activities?

Nutrition Activities. For the nutritional area, ProCom's activities involved food production assistance for family welfare, and assistance to malnutrition-affected children. Their strategies involve the Green Revolution for the former and children's nutrition program for the latter (i.e., Operation Timbang, immunization, treatment in malwards or nutrihuts, daycare and feeding services,

and food assistance at home). It is difficult to evaluate program effectiveness in nutrition because the inconsistency of the project reports is disconcerting. Moreoever, the impact of Operation Timbang, may be done only for those beyond six years old. The ProCom data as of September, 1976 showed 1093 cases of malnutrition (assumed to refer to Teresa children in the 0-6 years bracket). The ProCom's May 1978-September 1979 report pinpointed the malnourished children at 181 for 2nd-degree cases, 217 for 3rd-degree cases, and 1076 for the total number of children.

An undated ProCom-POPCOM progress report mentioned 468 2nd-degree cases, 147 3rd-degree cases, and 1,774 at the 0-6 years bracket. The 1976 figure had malnutrition cases greater than the total number of children in the May 1978-September 1979 report; this is not likely, considering that with the town's growth rate, there could not be more children in 1976 than in 1978-1979. Using the 1978-1979 report and the ProCom-POPCOM report (assumed to be newer as it had more children, i.e., 1,774), there was a reduction of 3rd-degree cases from 20.2 percent in 1978-1979 to 8.3 percent and an increase in 2nd-degree cases from 16.8 percent in 1978-1979 to 26.4 percent. This implies that some 32 percent of 3rd-degree cases became 2nd-degree cases which would be in consonance with but rather short of the program's goal to reduce malnutrition cases by 50 per cent. However, there is no improvement in 2nd-degree cases (expected to be reduced by 25 percent) even after accounting for 3rd-degree cases who became 2nd-degree malnourished.

Table 6.4

Malnutrition of Children 0-6 Years
Teresa, Rizal, 1976 and 1979

	September 1976		May '78 Sept. '79		N.d.		June 1979		October 1979	
	No.	%	No.	%	No.	%	No.	%	No.	%
1st degree	602	—	N.a.	—	605	34.10	249	—	280	—
2nd degree	412	—	181	16.80	468	26.40	140	—	174	—
3rd degree	79	—	217	20.20	147	8.30	47	—	103	—
Total Malnourished	1093	—	N.A.	—	1220	—	436	—	557	—
Total Children	N.A.	—	1076	—	1774	—	N.A.	—	N.A.	—

Source: ProCom Documents

Table 6.4 shows the number and percentage of malnourished children in Teresa. One notes here the fluctuations which are difficult to explain within each barangay. One also wonders why the number of malnourished children given feeding assistance exceeds the total number of malnourished children or why from June 1979-August 1980, there was a worsening in nutritional status (e,g., the June 1979 report put 3rd degrees at 47 and 2nd degrees at 140; the initial August 1979 figures were at 102 and 174, respectively).

Green Revolution Activities. Lectures on food production and plants were conducted by BPI and BAEx, but ProCom does not record these activities. ProCom contributes seeds if it has stock but this activity is usually done by BPI. There are six barangay nurseries (eventually, each barangay will have one) in existence; it is only Bagumbayan among the three surveyed areas which does not have one yet. Construction cost of the nurseries is usually borne by the barangay with technical assistance from the BPI. In 1979, ProCom donated: (a) 360 packets of various green leafy vegetables, (b) 9 kilos of mustard and upland kangkong, (c) 10 kilos of squash seeds, (d) 5 kilos of pechay, (e) 15 kilos of upland kangkong, (f) 10 kilos of ipil-ipil, and (g) 5 kilos of pole sitaw.

ProCom, together with the Rizal Youth Development Foundation (RYDF), also got involved in animal dispersal. There were a total of 23 goats, 14 swine, and 5 cattle donated in 1979. However, 13 goats died, one got lost and one pig died.

ProCom staff and Ilaw Association members often cite the lack of seeds as a problem that hampers the continued performance of food production activities. The deaths of goats are suspicious (the respondents surmised they were probably eaten); the FDO also cites problems with the headcount of newborn animals.

This particular sector will have to rely more on seeds produced by municipal nurseries if it hopes to improve its inventory and prevent "stock-outs" of seeds. With respect to livestock-raising, a community herding program (i.e., animals are collectively cared for and consumed by the whole community or barangay) might be more appropriate than raising of livestock by individual households.

Family Planning Activities. The family planning activities were intended to double the levels of continuing family planning users from 15 percent to 30 percent, for the period August 1979 to July 1980. However, only 12 percent have actually been added. Besides, 93 percent of the respondents surveyed by ProCom still have family sizes from 3-10 members, with 63 percent having 5-10 members.

Lectures on family planning are included in mother's classes which already touch on the five sectoral programs. The lectures are done in coordination with the Rural Health Unit (RHU) which is responsible for the conduct of

classes. ProCom gets directly involved only if the RHU needs lecturers or training materials. At present, the classes are irregularly held.

Information, education and communication (IEC) materials are given to Barangay Supply Point Officers (20 volunteers for Teresa) and they are responsible for distribution to schools, barangay captains, and the RHU. On an irregular quarterly basis, ProCom usually receives IEC materials of the comics type and two or three versions of posters for family planning.

In July 1980, there was a lack of contraceptive supplies at the FTOW/DPO level. Where there ought to be a four-month stock, only a one-month supply remained. The BSPOs, however, who are required to have at least a three-month stock, had complete supplies. At the FTOW level, 2,617 cycles of pills and 1,194 dozens of condoms were distributed. The BSPO received 1,463 cycles of pills and 1,018 dozens of condoms for distribution to the acceptors. Ten referrals were recorded in 1979, and two film showings (1977 and 1979) were done.

The true indicators of the effectiveness of this sector are reduction in fertility rates, reduction in family size, and eventual improvement in the socio-economic profile of Teresa. This has yet to occur in a significant manner.

Environmental Management Activities. Operation Linis and the beautification program are being encouraged in all the nine barangays. So far, though, placing of trash cans has been done only in the Poblacion. There are also home fencing activities, but the three surveyed areas are not among the areas involved so far. Construction of shallow dug wells is for all the barangays and was started in August 1980 (the Poblacion had already constructed two). Health protection activities like vaccinations and injections are conducted regularly, usually in schools but ProCom is usually not involved here.

As many as 10,000 ipil-ipil trees were scheduled to be planted during the start of the rainy season of 1979 but only 3,091 trees were planted in the rainy months from July to December (they could not plant more trees in the first six months of the year due to inavailability of seeds).

The streets of Teresa are clean. However, about 20 percent of the families still did not have toilets in 1978 and 21 percent had no proper garbage disposal. The 1979 target was for a 20 percent increase in the number of families using sanitary toilets. Lack of construction materials, among other factors, resulted in only a 2 percent increase. Beyond the streets, some problems still exist. Children who are barefooted, unclothed and unkempt still roam the surroundings. During the rainy season, the surroundings become infested with harmful pests. Adequate disposal is also very rare.

Training Activities. There have been several training seminars conducted since the start of the program, each lasting for only two days at most. Right at the start of the program in 1976, barangay development seminars for barangay captains and councilmen, purok leaders and heads of civic organizations.

which should familiarize them with the program, were completed in the nine barangays.

The Social Development Seminar (SDS) was held in October 1978 for representatives from various agencies and ministries and the local government. The seminar was conducted after results of the first baseline survey (conducted in July 1978) were evaluated. It lasted for two days and had 33 participants. As soon as the SDS was over, the Family Ilaw Training (FIT) was instituted in October 1978, starting with a FIT demonstration at May-iba, the most depressed area. For two consecutive nights, FITs intended for household leaders were conducted in the remaining barangays, beginning with the more depressed barangays. By April 1979, these trainings had been completed in the 9 barangays and 33 chapters. For distant chapter sites, the FITs were conducted during the daytime.

Recently, the need for retraining has been expressed by the ProCom staff, and the FDO suggested that training/retraining should be done at least once a year. (One was scheduled for July 1980 but for one reason or another, failed to push through.) For the nine BDVs (three teams of three members each) per barangay, a Barangay Development Volunteers Orientation Training was conducted prior to the FITs. These volunteers were selected teachers from the local school. The Chapter Officers Training Course (COTC) had three classes with three barangays involved per class. Each class had 76, 75 and 76 participants, respectively.

All of the training programs were inadequate in terms of time and content (mostly due to financial constraints). One could hardly expect peak performance from the participants who attended these training programs. Thus, there were experiences of having unit leader sending guesses or errors in their reports like the reported malnutrition cases and household heads forgetting the seminars as soon as the novelty wears off.

An inquiry into the project's monitoring system shed light on the level of assimilation on topics discussed in the SDS (FITs, Chapter Officers' Training Course). The ProCom officer claimed that the monitoring system was strictly observed, i.e., the unit leaders conducted regular home visits and interviews of residents for their Quarterly Summary Report (QSR). The authors, in contrast, found out that such system was not rigidly followed. Some of the unit leaders failed to make follow-ups. Instead, they only recorded whatever they heard. There was even an instance when the unit leader did not know what a QSR was.

At the grassroots level, many residents/participants of the FTI did not know their BDVs and Barangay Supply Points.

If these training programs then expect to contribute to program success, it is imperative that they have a "beefier" content, inculcated in the participants through more effective and efficient means of communication.

Sports and Cultural Activities. Another program component that ProCom undertakes is sports and cultural development. For the period 1978-1979,

sports competitions and festivals drew some 900 participants in the various native sports. About 500 family members participated in cultural activities such as folk dancing and singing, zarzuela, balagtasan, rondalla, harana, etc.

Action Planning

ProCom commits itself to make action plans (usually for a period of one year) containing information on activities, goals, participants, cooperating agencies/groups, resources, and manner of implementation. The action plan is made on a sectoral basis (i.e., nutrition, green revolution, family planning, environmental management, sports and cultural development). There seems to be few problems encountered in planning; in fact, there are forms available to ProCom which are relatively easy to fill up. Evaluation reports, however, indicate problems with implementation like difficulty to obtain more acceptors, inability to construct chapter nurseries and closure of demonstration area due to poor maintenance. The action plan in terms of the activities to be performed is quite comprehensive. The evaluation report for the period August 1979-July 1980 as related to the action plan submitted to the mayor (with a period of implementation up to December 1979) evaluates performance but not the activities designed to meet their goals; this may be the root cause of most of the difficulties in implementation. This is especially true for the family planning sector. Content activities for all five sectors could be increased or decreased, for example, depending on whether or not they boost performance. Overall, the action plan is technically workable, and most of the targets for a year's time are quantified, usually expressed in terms of the size of the target population (MCRAs, families, "buntisables"[14] unit leaders). As per the latest evaluation report, nutrition activities were the most successful, family planning has problems with its acceptors; while environmental management and green revolution activities are hindered by lack of resources.

It is the monitoring and information system which must be immediately improved by ProCom. For example, the May 1980 Census recorded about 2,000 more than the ProCom figure for total number of residents. However, if ProCom uses the census figures, its performance will appear to be deflated (in percentage). One might also look back to the problems regarding malnutrition figures.

Problems

Since its introduction in 1976, ProCom in Teresa has been encountering various problems. ProCom is plagued by a high demand for retraining by the citizens. This is because many of the participants feel that the FIT was insufficient to make them knowledgeable. Moreover, there are some participants who have not unlearned their bad habits and practices. Therefore, there is a

[14]Taglish term coined by ProCom to refer to women in the reproductive ages (i.e., Tagalog "buntis," pregnant, with English suffix "able.")

need for ProCom to reinforce its training programs in order to make the participants adhere to its teachings and principles.

ProCom's effectiveness is also hindered by the reluctance of some unconvinced citizens in the community, or even by lack of commitment on the part of some barangay captains.

Financial problems have limited the operations. Although they have developed the approach, the system and the integrated plans, these can only be achieved largely on the basis of the Project's financial position. For the year 1980, the FDO estimated that ProCom would need an increase of ₱5,000.00 for the regular sectors of the program.

Because of the commitment of the ProCom agents to the municipality of Teresa, the mayor and staff developed mutual trust and understanding with each other. This has led to mild jealousies by other local agencies. However, this has not been much of a problem since the mayor has been very tactful in dealing with the situation.

The multipurpose workers, when interviewed, mentioned areas that need attention like lack of seeds, check-up of women's diseases, and lack of contraceptives, pills and condoms.

ProCom aims to help increase food production. The increase of rice production has taken place. However, proceeds from livestock raising have not increased and have been causing headaches to the staff because there is no Bureau of Animal Industry office in the town that can be consulted on animal raising and protection. Another agency absent in the town is the Bureau of Forest Development, an office which can help them in choosing the sites for forest development and in implementing the "energy conservation" program.

Conclusions and Recommendations

Project Compassion has made some perceptible positive effects in the town of Teresa. It has revitalized the Municipal Development Council to function as stipulated by DLGCD 76-110. The initial phase resulted in the Council's formulation of the Integrated Development Plan, which is problem- and resource-oriented.

Unlike before when the agencies were working independently of each other, the coming of ProCom has encouraged the agencies to weave their efforts together in a synchronous matrix. Yet, there remain instances of lack of coordination. We have mentioned in earlier sections of this Chapter, situations when one agency conducted certain activities within the ProCom program without informing it. However, the ProCom mechanism does allow for maximum utilization of meager resources by minimizing overlapping of activities.

The success of the program can be indirectly measured through the citizen's active involvement in the various activities. Their commitment to the program

can be ascertained from the citizen's willingness to support the program activities through actual participation in the planning, implementation and evaluation stages. Moreover, they have been providing funds needed to accomplish a program by paying their membership and special assessment fees to their respective Ilaw Chapters.

Although ProCom was able to mobilize several citizens, it failed to motivate other citizens who are not convinced of the program's goals and objectives. This is further intensified by the tendency of some chapter members to be inactive and/or to return to what ProCom considers as their "old bad habits." At the same time, most of the activities have centered on family betterment rather than social action-type projects. This situation does not increase the saliency of and the desire to participate in, community organizations.

Thus, ProCom needs to further re-educate this "critical mass." Re-education of this group can be achieved by sponsoring development seminars aimed to make the group aware of the project's significance. A series of lectures that will motivate them to work closely together with government agencies is also a necessity. The lecture series must be more comprehensive, strict and rigid, and must focus on how the people can develop themselves through individual activities. and social organization.

A requisite of training, though, is a larger amount of funding. This is a perennial problem of Project Compassion. This would not pose much of a problem if ProCom could utilize the Ilaw ng Buhay Association, Inc. to generate more funds. The Association can levy the chapter members of certain amount of cash aside from their membership fees. Moreoever, the Association can sponsor activities that will generate sufficient cash, i.e., premier showings, zarzuelas, dance parties, sale of materials, etc.

ProCom can also seek the assistance of the provincial government. The latter can give the materials cash and technical support.

The problems the ProCom in Teresa faces are numerous. Nonetheless, this chapter ends on a positive note. ProCom staff interviewed perceive that they have pushed ProCom to a level that has largely improved its mechanism, thus making the Program more dynamic, effective and humane in its approach.

Chapter VII

THE MAKAPAWA PROGRAM IN LIWAYWAY

Josie H. de Leon

Philosophy and Orientation

In 1973, the Rural Missionaries of the Philippines initiated an innovative approach to health care delivery known as the community-based health program (CBHP). The general objective of the program was to improve the health situation in the rural areas through organized, participative community action. The community-based health program looks at existing health problems of communities from a holistic viewpoint where solutions cannot be realized without considering the economic, political, and cultural problems of society.

Taken in the Philippine context, the entire health service delivery system is seen as "homologous, in correspondence and harmony with the present macro social system which provided ... services more to a few in the urban areas than to the many in the rural areas" (Tan, n.d.)

Although the CBHP approach has postulated that the ultimate solution is a total restructuring of the "economic, political and cultural aspects... of the whole social order," it has, nevertheless, recognized that

> social structures will not change unless challenged by. . . transformative micro actions; one of which is the restructure of the health care delivery system in specific small communities (Tan, n.d.).

The CBHP approach underscores the involvement of members of the community not only as mere recipients but as active participants in all aspects and stages of the program. Leaders from the rural communities are chosen and trained as paramedics or paraprofessional health workers capable of delivering primary health care services to the people. Dependence on "Western" medicine and health practice is de-emphasized and the use of herbal preparations or traditional healing practices is instead encouraged and developed. This approach necessarily entails the organized collective effort of the residents themselves, using the resources readily available in their area, working together towards total human development and thereby building strong, "authentic Christian" communities.

Brief History

The CBHP approach was first implemented by the Rural Missionaries in three pilot areas: Ilagan, Isabela in Luzon; Palo, Leyte in the Visayas; and Iligan, Lanao in Mindanao. It was formally introduced in August 1975 in Leyte

as Makapawa which literally means "to light or to enlighten." It is the acronym of the Waray dialect translation of community-based health program or Programa han Katilingban para sa Maupay na Panlawas.

Ten depressed barangays were selected as rural sample sites, namely: Barangays Aringit, Yapad and Dumarag in Pastrana; Barangays Pilit, Tibac, Bulod, Victoria and Milagrosa in Sta. Fe; Barangay Libertad in Palo; and Barangay Pasulhogon in Babatngon. These original areas were selected on the basis of the following criteria:

1. "areas with greatest health needs;
2. "areas far from health resources;
3. "areas without community health programs;
4. "the interest of the parish priest and the Rural Health Units; and
5. "the favorable response of the people" (Makapawa, n.d. :4).

In October 1975, two months after the implementation of the Makapawa health program, a separate program was also launched by St. Paul's Hospital in Tacloban City. This was called the Under Fives Clinic. The Clinic's supervision was assigned to Sr. Leonor Barrion, M.D., O.S.B., who at the same time was the Chairman of the Makapawa Advisory Board.

The Under Fives Clinic was mainly a health extension service of the hospital to help the Christian Children's Fund families in the squatter areas surrounding the St. Paul's Hospital in Tacloban. This area eventually became the first urban CBHP area in Tacloban City.

Since the thrust of both programs was on health and since the coordinator of both programs was Sr. Leonor Barrion, they were merged after two years into one diocesan community health program. This merger meant that the activities of the two programs were to be integrated into the activities of the Diocese of Palo.

In July 1978, the Rural Missionaries formally turned over the administration of the program to the diocese.

At present, there are 12 rural and 9 urban CBHP areas in the diocese.

Program Components and Objectives

The program has two main components: the community organization and the health program. This means that the CBHP approach recognizes that the key to the success of any self-reliant community health program is the formation of an organized, participative community. Health workers from the community are to be developed and use of scientifically efficacious herbal and other forms of traditional medicine is to be encouraged.

According to the Makapawa documents the objectives of the program,

taken within the context of "building Christian communities," are:

1. to bring about an awareness of the situation where existing structures (or institutions) prevent the attainment of basic human needs for the many;
2. to bring about community action to promote total human development;
3. to develop self-reliance of the people on personal and local resources; and
4. to increase people participation in decision-making.

Two additional objectives were later incorporated, namely:

1. to provide for primary health care by the people through a community-based health program in line with the original objectives; and
2. to implement all program activities in the context of the "Living Word of God."

Citizen participation in planning, implementation and evaluation of community programs is, therefore, a necessary component of the CBHP approach.

The Makapawa Development Process

The Makapawa Report divides the process of its development into three stages, each stage consisting of a preparatory phase, a seminar phase, a follow-up phase, and an evaluation phase. Stage One is roughly equivalent to the first two years of the program from 1975 to 1977; Stage Two is approximately from 1977 to 1979; and Stage Three is from 1979 to the present.

The preparatory phase can be considered as the planning phase of the organization; the seminar and follow-up phases correspond to the implementation phase; and the analysis is the evaluation phase.

Stage One (1975-1977)

Planning or Preparatory Phase. The planning or preparatory phase consists of the formation of the Makapawa Advisory Board, the top-level organization that was intended to serve as the vehicle for coordination among groups and individuals interested in implementing a community-based health program for Leyte. The Advisory Board was composed of the Bishop of the Diocese of Palo as honorary chairman, a Catholic parish priest, two Catholic nuns (one was a doctor and the other was the treasurer-secretary), one government doctor, one private medical practitioner and three nurses connected with government health agencies.

Since the Advisory Board was formed principally to generate participation and cooperation among the religious sector and the health professionals in

both the public and private sectors, general information and orientation meetings were conducted to introduce the program's objectives, targets and procedures to interested individuals, groups, and communities.

The Makapawa CHWs, in turn, served as implementors of the various health programs in their respective communities.

To formalize this relationship, a memorandum of agreement was signed by the Makapawa and the Regional Health Office of the MOH stating the specific areas of responsibility and working relationships of each.

It was therefore important at the outset that the sympathy and cooperation of the Municipal Health Officer be secured. Since the program was always implemented at the parish level, it was equally important that the parish priest, who acted as coordinator and monitor, supported the program.

Once the program was accepted at the parish level, an informal baseline survey was to be conducted by the community organizer and the most needy and responsive barangays chosen. The CHW trainees were then to be elected by the respective communities.

Implementing Stage (Seminar and Follow-up Phases). A baseline survey was conducted by the CHW trainees to equip themselves with basic working knowledge about the community and to help the staff understand the community better.

This seminar phase consisted of a two-week live-in seminar, one-week practicum and field trips to government and private hospitals and rural health units. Local resource persons like the RHU staff and government doctors and private practitioners in the area were asked to deliver lectures on the following topics: fundamentals of health care; nutrition, maternal and child health care; immunizations, common diseases and their prevention; environmental sanitation; family life and responsible parenthood; first aid, basic pharmacy; mental health; reporting statistics and record-keeping. Topics on ideology of commitment and service to the people, structural analysis of the health situation, pastoral thrust of the CBHP and community organization skills, were also taken up (Tan, 1974). The field practice consisted of forming health committees in the respective barangays of the trainees as guided by the Makapawa staff.

Because the program was initially a project of the Rural Missionaries of the Philippines, two sister-nurses served as coordinators. They constituted the second level of the organization.

At the third level of the organization was the Makapawa staff composed of one physician, one health educator who, as the community organizer (CO), conducted a social investigation of the selected areas, and one office secretary who handled communication and records. The Makapawa staff was usually introduced to the community during a parish gathering or parish council meeting.

At the fourth level was the community. Sixteen community leaders selected by their respective barangays were trained as community health workers (CHWs).

From the start, the role of the Rural Health Unit and various health institutions, hospitals, agencies and groups had been clearly delineated: they were to be a "resource and support group" for the Makapawa. In particular, this meant that they were to:

(a) act as resource persons in CHW training;
(b) provide transportation facilities during the training and follow-up of the areas;
(c) provide a center for an on-going education of the CHWs;
(d) provide referral services for patients requiring professional health care; and
(e) become a source of medicine and laboratory facilities.

The community was also mobilized to contribute to the training and expenses of the CHWs through contributions, fund raising, etc.

Follow-up, which was still part of the implementation phase, consisted of monthly clinics, fund raising for medicine and other expenses through benefit dances, contributions and donations, membership fees, solicitations of medicine from government and private agencies, strengthening of the referral system with RHU and public and private hospitals, monthly review classes for all CHWs, Botica sa Barrio, and visits by the staff to the communities regularly and by rotation.

From the above, it can easily be discerned that Makapawa activities during this stage concentrated on the health program component without a corresponding effort in organizing the community. The CHWs, health committees and the community members, therefore, did not clearly perceive their respective roles within the CBHP structure. The people still viewed themselves as mere recipients or beneficiaries of the program and exerted little effort in participating in the planning and implementation of activities.

It was therefore understandable that people's interest and "initial enthusiasm" declined when the Makapawa doctor was transferred to another area. This lack of interest was further aggravated by the discontinuance of the distribution of free medicine and the holding of regular clinics.

There were two perceptible effects of this situation on the CHWs. One was that some CHWs became inactive because fewer and fewer people participated in the activities (clinic services, fund-raising, etc.) offered by the Makapawa. The other effect was that other CHWs were forced to perform curative functions to the few who still availed of the irregular Makapawa clinic services. Of course, the CHWs were hardly equipped to deliver the kind of medical service a doctor usually provides; hence, this relative inadequacy further contributed to the waning interest of the people to participate in the program's activities.

Evaluation Stage. An evaluation of the program conducted by the Makapawa staff and the active members of the Advisory Board after two years resulted in specific changes in the implementation of the programs. Among the problems that surfaced are the following:

1. Inadequate social preparation. This led to the CHWs' lack of understanding of their role in the community and their inability to see health in the context of economic, social, political and cultural structures in the community. This inadequate preparation also resulted in a corresponding inability on the part of the community organizers to spot the real leaders of the community since some selected CHWs did not even have any leadership potential.

2. Concentration on health service activities. This not only reinforced the tendency of the people to look at the program as a dole-out but also contributed to their vacillating interest in the program since health was not perceived by the people in the community as a priority need. In some instances, too, people's participation was motivated not by reasons of commitment, service or desire to change existing structures but by other considerations like access to free health services and discount for medicine and hospitalization, etc.

3. Staff-centered activities. This resulted in the difficulty of identifying the real leaders of the community. Aside from contributing to the dependence of the people on the Makapawa staff, this staff-centeredness also discouraged people from participating more actively in the planning, implementation and evaluation aspects of the program.

4. Prolonged absence of the CHW trainees from home and work. This prevented prospective trainees from joining the live-in seminar. Aside from this, the cost of participation was high when computed against unearned wages, transportation and food costs, etc.

5. Too dispersed pilot areas. Some areas could not simply be followed up because of their relative inaccessibility from the main road.

From these "learning experiences," changes or reformulations were made. This is what Makapawa describes as Stage Two in the process of its development into a CBHP.

Stage Two (1977-1979): The Reformulation Phase

Planning Phase. In 1977, the Makapawa (rural) and the Makapawa-Under Fives Clinic (urban) were integrated into one community health program under the Diocese of Palo. Therefore, from a purely health service program, it now became a church program. The health component was thus deemphasized and the program was introduced to the people as a religious activity. With this change in emphasis, there was a corresponding modification in the organization.

A Board of Directors was created at the top level of the organization, the diocesan level, composed of the Bishop of Palo and the Project Director. With the reclassification of the program into a church program the Pastoral Action Secretariat Executive Secretary and the diocesan Social Action Director were also included as ex-officio members of the Board.

The Advisory Board was retained but the membership was changed. The members of the Board of Directors and the priests of parishes where the Makapawa program operates now composed the Advisory Board. With the entry of Makapawa as a church program, the members of the two Boards come entirely from the religious sector. This is partially attributed to the dissatisfaction of the previous Advisory Board and staff with the level of participation and support of members coming from the other sectors.

The Makapawa staff constituted the second level of the organization which was made up of the coordinator, the community organizers of both urban and rural areas, a mobile health team composed of the doctor or nurse, midwife and paramedics, and an office secretary.

At the parish level were the parish priest, the Makapawa community organizer, and the health team.

At the lowest level, the community, were the community leaders, the trained community organization volunteers (COVs), and the paramedics or CHWs. Each COV and CHW headed a *hugpo,* a group of ten to fifteen families within a community.

The COVs held weekly "Interhouse Bible Reflections" (IBR) which usually included assessment and evaluation of accomplishments. To make the Makapawa areas more manageable (since the areas were really too far spread out for progress to be effectively supervised and followed up), only the areas considered to have the greatest need and potentials for development were trained. These were Aringit and Yapad in Pastrana and Milagrosa, and Bulod and Victoria in Sta. Fe. However, the remaining areas were not really dropped since their CHWs continued to attend the monthly seminars conducted by health professionals from the Makapawa staff.

Because it was observed that one community organizer could not effectively oversee all the Makapawa areas, each of the retained project areas was provided a community organizer.

In addition, one barangay in another municipality (Liwayway, MacArthur) was selected as a Makapawa area to implement the "new strategies and approaches. . . learned from the previous experience."

Implementing Phase, Seminar Phase and Follow up Phase. Reacting to the previous experience in "Stage One" of the program, certain changes were also implemented in the conduct of the seminar. For instance, the time, frequency of training, and topics to be taken up were decided upon by the trainees.

Training was now held in the barrios. Ir was no longer necessary for the CHW trainees to be away from their families for a long period of time. Costs to the participants were now very minimal. Each hugpo also selected its CHW trainees.

CHW trainees were also trained as community organizers and facilitators for the "Interhouse Bible Reflections."

It was also during this period that the use of herbal and traditional medicine and acupressure was emphasized. This specific step reflected the attempt of the Makapawa to use methods and techniques that were familiar to the trainees or relatively simple for the CHWs to absorb.

What is significant here is that CHWs were now being trained to be real multipurpose workers: primary health workers, community organizers and teachers. As a consequence, other needs of the community apart from health surfaced, e.g., economic needs, irrigation problems, etc. This further resulted in the expansion of the activities covered by the program. For example, fund-raising was conducted for projects like repair of chapels, installation of common water pumps and income-generating activities, etc. This shows an increasing integration of the services being delivered by the CHWs.

The community took a more active role in decision-making, planning, evaluation and implementation of Makapawa activities.

Evaluation and Analysis Phase. Through a continuing evaluation of the program, certain weaknesses of the new system were also spotted. The Makapawa Report listed the following:

(a) The assignment of one community organizer (CO) per area led to community dependence on the CO. To some extent, some COs became "little kings" in their community. Aside from this, the set-up was very costly and did not maximize the capabilities of a CO.

(b) Since the Makapawa was not introduced initially as a health service program, it took a long time before health was perceived as a community need, thereby wasting available health manpower.

(c) Leadership centered on the upper strata of the community. Because of this, the CHWs and leaders tended to develop into an elite group.

(d) Projects initially conceived as income-generating proved to be not only unproductive but also a source of conflict among members of the community because of funds mismanagement.

(e) There was "poor RHU coordination with Makapawa" because of the lack of RHU health personnel to supervise and help with the ongoing training of CHWs and the lack of the medicine and facilities available for the RHU patients.

(f) Needs of the grassroots were not met because vital community issues were not significantly discussed and solved nor were "major objectives of the program achieved."

In response to these problems as seen by the Makapawa staff, certain changes in the methods and strategies were again made. This is classified by Makapawa as Stage Three.

Stage Three (1979-Present)

To prevent the development of what the Makapawa staff termed as "little kingdoms," the team approach to community organization was implemented whereby a team of COs are assigned several communities to cover. More accessible central barrios are chosen and parish priests, barangay officials and RHU personnel are oriented on the CBHP approach before actual entry to the community. Moreover, their active involvement and participation are consciously solicited.

Under this new set-up, the preliminary social investigation is done by the CO. Her effort is concentrated on the poorer groups in the community, and correspondingly, leaders from the lowest-income sector are encouraged to join the training.

The CHW trainees are now chosen both by the staff and the community. The curriculum for CHW training was also modified. While all trainees are given general instructions on health and remedies, those who show more consistency and commitment in attending sessions are given more systematic and specialized training as CHWs.

The sequence in the study of diseases was adjusted to fit Philippine seasonal patterns for occurrence of diseases and to conform with the immediate needs of the community.

Community core leaders now initiate and monitor various activities in the community in coordination with the barangay council. Both core leaders and CHWs are carefully chosen to ensure that they come from the poorer sectors of the community.

Various committees are created to answer the different needs of the community, e.g., Finance, Education, Health, IBR Facilitator Committee, Liturgy Committee, etc.

Health activities are now implemented by programs, e.g., TB Control Program, Nutrition Program, Sanitation and Health Education Program, etc. CHWs are given specific tasks like being in-charge of the nutrition program, the Under-Fives clinics program etc.

To date, regular follow-up and supervision are being done by the staff with the aim of gradually withdrawing assistance to encourage independence. It is

planned that CBHP areas will have continuous support and follow-up from the parish.

The final evaluation of this stage has not yet been done as this stage is only in its first year of operation.

However, certain points can already be observed. For one thing, there is a return to health activities. There is a continuing development of core leaders and an attempt to involve all sectors of the community, like the parish priest, the barangay officials and traditional governmental health agencies like the RHU.

Since the aim of the CBHP approach is to build self-reliant participative communities, the intention is to eventually pull out the COs from these areas and organize communities in other places.

Method of Health Service Delivery

The health service delivery system of the Makapawa hinges on the capability of the community health worker to provide primary health care to the members of the community. The Makapawa staff provides for the training of these workers and holds regular Under Fives Clinics in communities that have already been organized. Each child who comes to the clinic is provided a card which serves as his clinical record.

General health problems of the members of the community are referred to CHWs. Whenever they can, the CHWs attempt to diagnose and cure the illness without referral to the health professional of the Makapawa, the RHU, the hospital or any private practitioner. It is only with cases they cannot handle that CHWs refer these patients to health professionals. Nevertheless, it is the CHW who follows up the progress of the patient after consultation.

CHWs are also trained to prepare herbal preparation for simple illnesses like coughs, diarrhea, fever, etc.

What makes the CHWs different from other multipurpose workers is the fact they are also leaders of the community and as such, are also concerned with community problems other than those relating to health. Preference is also given to CHW trainees who are from the poorer sections of the community.

Financial and Logistical support

The largely voluntary nature of the program makes it difficult to quantify the support that the program has received in terms of actual professional, medical, para-professional and clerical services and donations in kind like medicine and equipment.

Initial two-year funding came from the Misereor, an international church-connected organization. Funding for the next two years was taken over by the

CEBEMO, another international church-oriented organization. Exact figures were not available but the original project proposal provided for the salaries of one doctor, two nurses and four community organizers who were to be paid ₱800.00 each monthly. Each was supposed to be provided with a motorcycle and a ₱150.00 allowance for fuel and maintenance. In addition, ₱10,000.00 was allocated for each year of the program operation for the purpose of continuing staff development. CHWs were also to be given ₱5.00 daily allowance while in training. Apparently, this was not strictly followed because the original plan of providing equal salaries for the CO's and the medical professionals was never implemented. Even the salaries for the four original COs were different, ranging from ₱250 to ₱300 monthly, with ₱50 allowance for transportation and another ₱50 for living allowance. The transportation allowance was provided in lieu of the motorcycles which the program coordinator felt was not really necessary because public transport was available most of the time.

The present (1980) salaries for COs have already substantially increased to a total of ₱730 monthly, representing ₱450 in basic salary, ₱230 in living allowance, and ₱50 in travelling allowance.

To get a clearer picture of the program's expenditures, the following financial statement for the period *January-June 1980* was obtained:

Expenditure	Amount
Personnel	₱34,247.85
Medicine and vaccine	11,233.00
Transportation/Travel	2,073.90
Medical Kit	2,200.00
Secretarial (part-time)	898.75
Miscellaneous	549.60
Total	₱51,203.10

This list does not include items like cotton balls, merthiolate, alcohol, etc. which are donated from time to time by local drug companies. Drug companies from abroad have also donated vaccines for polio, measles and rubella, and drugs in their generic form like antibiotics and vitamins, etc. The Ministry of Health has also given Makapawa DPT and BCG vaccines, whenever available.

Professional medical and clinical services rendered through St. Paul's Hospital are provided to Makapawa beneficiaries, who can avail of their services free of charge, including hospital confinement, as the need arises. Medicine samples are also given to these beneficiaries.

Program Monitoring and Control

The system of monitoring and control utilized by the Makapawa program is mainly internal. At every stage of the process, steps are undertaken to ensure that a regular evaluation of the program is made. CHWs and core leaders meet with the community organizers to assess the strengths and weaknesses of the program. This is what Makapawa terms as Action-Reflection-Action (ARA) type of evaluation, and is very similar to the Maoist concept of criticism-self-criticism. Since core leaders and CHWs are more often than not also members of the Parish Council and since the parish priest is a vital link in the Makapawa process, he participates in the evaluation of program progress..

The reports of these monthly evaluations are submitted by the CHWs and core leaders to the community organizer, who in turn submits his own monthly report to the Makapawa coordinator.

Each community used to have separate staff evaluations but this was later modified so that there is now a common planning and evaluation by the staff for the different CBHP communities. Also, in the staff's "search (to) improve the service to the people," it holds quarterly evaluations of the program (Makapawa, n.d.).

The Advisory Board also undertakes its own regular program evaluation based on reports submitted by the staff.

Program Integration

The program concept envisioned the integration of the economic, political and cultural aspects of the community in solving problems. This focus coincides with the second dimension of integration used in this study. Given the framework, the administrative mechanism that would implement this concept had to consider and be capable of performing a rather wide range of activities. As stated in the Makapawa's program documents, however, health will only be used as a point of entry into the communities.

Indeed, when the Makapawa started out its operations, it was successfui .. penetrating the chosen communities because of its health component. Looking now into the operation of Makapawa, what is immediately discernible is its continuing emphasis on health activities.

Although other activities have not been totally set aside, the focus at present is still on health more than any other activity.

It will be recalled that when the barangay of Liwayway was chosen as the new pilot area in the latter part of 1976, the Makapawa was already conscious of the growing dependence of the people on the Makapawa for the solution of the health problems in their communities. To correct this the community organizer assigned to the community was not introduced as a nurse but as a church worker. The residents themselves never suspected that the CO was a

nurse because her initial activities — conducting a baseline survey of the community, looking for potential community leaders, finding the means to settle the irrigation dispute with the neighboring community, etc. — were geared more towards organizing the community than delivering health services.

The program staff did not, however, anticipate that since health needs still ranked low in the priority list of needs of the community it will take a long time before these needs are identified and voiced out. Realizing the seriousness of health problems in the area and knowing that they are wasting valuable health expertise, the program staff, after six months of operation in Liwayway, decided to inform the community of the availability of professional health care services for residents in the person of the assigned CO who was also a qualified nurse. The relative inexperience of Makapawa in directing political and economic-related activities could also have been a factor in its decision to re-activate and stress the health component of its program.

The Makapawa is a single-agency service provider in the terms of the first dimension of integration identified by this project. Nevertheless, it always recognized its need to link up with many agencies in the course of program delivery. Thus, the original intention in the formation of a Makapawa Advisory Board was for it to act as coordinating mechanism of the three sectors participating in the program - government, private (secular) and religious.

Government. Linkage with the government was established through the inclusion of one government doctor and three government nurses in the Board. A memorandum of agreement was signed between the Makapawa and the Regional Health Office defining each other's responsibilities and providing, among others, for the training of Makapawa community health workers by the Diocesan Health Program Staff and the MOH (then DOH) personnel. It was intended that the two will "work together in whatever ways feasible for the accomplishment of integrated health services for the people of this Region. . . [Agreement of Working Relationships for Joint Health Program, Diocese of Palo (Makapawa) and Regional Health Office No. VIII].

Indeed, there were many instances when personnel from the RHO were asked to participate as lecturers in CHW training. The Makapawa was sometimes also a recipient of medicine and vaccines from the Region.

However, from the region to the municipality is a long way and it seems that the Makapawa encountered problems in establishing linkages with the rural health unit and the Municipal Health Officer of MacArthur. Given the way both she and the Makapawa defined her duties, the assigned CO was naturally more concerned with settling the irrigation dispute (with the neighboring barangay of Danao) which was what the community considered as their number one problem. This activity entailed a lot of shuttling between offices, such as the National Irrigation Administration, National Systems Irrigation Improvement Project, the MLGCD, municipal government, and the Barangay of Danao. There were also other issues raised by the community residents like

the investigation of the Barangay Roads Funds and the complaints against absentee and tardy teachers of the school in Liwayway. On top of all these problems, there were also complaints against the MHO which were voiced publicly in a seminar on farm management at the Farmer's Training in MacArthur. It was alleged, for instance, that the MHO was often not available for consultation and that he sells medicine that is supposed to be given out for free. This situation did not help in any way in the coordination of activities between the Makapawa and the RHU. Instead, it fostered the people's negative attitude towards the RHU as an institution and made the Makapawa CHWs refer cases (which could be sufficiently taken care of at their level) to higher levels of health care like hospitals in Abuyog and Tacloban.[15]

On the other hand, services which the barangay could have enjoyed through the RHU like the Mobile Tulungan and immunization campaigns were not undertaken by the MHO, allegedly because there is already an overlapping of activity.

Other instrumentalities of the government in Liwayway are the Barangay Council, the Barangay Development Council, the Sangguniang Bayan and the UP Institute of Health Sciences (UPIHS).

The Barangay Development Council (BDC) is still a relatively new structure in the barangay and therefore not yet active in community affairs. Nevertheless, there is coordination with this organization because the representative of the religious sector to the BDC is also a Makapawa CHW.

Links with the Sangguniang Bayan (SB) and the Samahang Nayon are also maintained because a recently-elected member of the SB is a Makapawa CHW. Moreover, the president of the Samahang Nayon is the most active CHW of Makapawa.

The Institute of Health Sciences (IHS) is relatively new in the area, having chosen Liwayway as a pilot community only in 1979. Its staff also encountered the same difficulty as the Makapawa in coordinating with the RHU in the area. However, they were able to solve this largely through their persistence and their encouragement of the MHO's participation in IHS activities. Their success can be partly attributed to the fact that they did not have to contend with other community problems the way the Makapawa staff did.

The working relationship that the Makapawa CHWs enjoy with the IHS students fielded in the area is more harmonious than with the RHU personnel. The CHWs have shared with these students their health skills, specifically,

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[15]Because of its experiences in Liwayway, greater efforts were exerted by Makapawa to establish closer links with regular health service providers in other areas of operation. In addition, conflicts with the MHO were ironed out and at present, there is a smooth working relationship with the RHU in Liwayway. Also, a new memorandum of agreement was signed with the MOH (August 1980) that further clarified the role of the Makapawa and the MOH (including regional, city and municpal level) in the implementation of a primary health care program.

in the preparation of herbal medicine. In turn, the IHS students have assisted the Makapawa in its regular clinics and have taught the CHWs how to use the thermometer, the sphygmomanometer, etc.

The students, however, felt that they were duplicating the activities of the Makapawa in such activities as the holding of clinics, conducting immunizations, etc. The IHS nursing coordinator, in fact, expressed apprehension about operating in Makapawa areas because of the negative attitude that had developed among the people vis-a-vis the RHU. Since one of the objectives of the IHS program is to establish links between the RHU and the community, IHS students fielded in this area found that the situation has made it difficult for them to achieve this objective.

Private-Sector Agencies. The strongest link of the Makapawa with the private sector is found in the area of funding. Church-connected private funding organizations supply the bulk of the operating expenses of Makapawa. Medicine and vaccines, both from abroad and from local drug companies, are received by the program although not on a regular basis.

St. Paul's Hospital in Tacloban also helps the program by providing for hospitalization, sometimes even for surgical expenses of Makapawa-referred patients, who are often indigent. Consultation is also given free by its residents and doctors.

Ordinary citizens also contribute labor and supplies (like cement for the construction of water pumps) when needed. Sometimes, the CHW advances money to make TLC (tamarind, luya and calamansi), a herbal preparation for colds. People often request for this but do not even offer a token payment since probably, few can really afford it.

Since the Makapawa is mainly voluntary, CHWs render their services and time for free. Sometimes, they even donate money to the program.

Religious Organizations. When the program was reclassified into a church program in 1977, the religious direction of the program was strengthened, the composition of the Board was changed and representatives from the government and the private sectors involved in health were formally removed from the Board.

Coordination with the religious is not a problem because all members of the Advisory Board are from this sector. In addition, all parish priests of Makapawa areas are automatically members of the Board.

Program Outputs

The very nature of a community-based health program such as the Makapawa underscores the necessity of community participation in the

delivery of basic health services. Initial Makapawa activity in the communities has therefore been the organization of associations or the utilization of existing organizations from which community leaders can be identified. Nevertheless, the Makapawa consciously tries not to limit its selection of leaders or potential CHWs from these groups alone since they are often controlled by the upper class members of the community.

Most of the CHWs chosen have either been active members or have shown leadership potential in the community. Of the six in Liwayway who were able to complete the course, one was recently elected as member of the Sangguniang Bayan, one is the Barangay Council Secretary, one is the representative of the religious sector to the Barangay Development Council, and the other is the president of the Samahang Nayon.

Looking into the different activities undertaken by Makapawa, one sees a concentration on health activities like consultation and treatment of illnesses and referral of patients; immunization; home visits; conducting of mothers' classes, maternal and child health care, and sanitation campaign; and preparation of herbal medicine and training of CHWs. Makapawa takes note of the number of families (not households) covered as against the number of CHWs. In Barangay Liwayway, there were 138 families as against 10 CHWs. However, only five CHWs are active now. This gives an average of about 27 families per CHW.

It is not clear whether this is the actual target of Makapawa since specific program targets and accomplishments are not available.

Immunizations, consultations and treatment of illness are usually done through regular barrio clinics conducted by the staff who schedule their visit around the different Makapawa areas. Regular updating seminars are also conducted for CHWs. Arrangements are now being made for CHWs to be trained as "hilots" under the MOH/RHU program.

Aside from health activities, the Makapawa also undertakes economic activities but on a smaller scale. These include the encouragement of backyard gardening to augment food production and income-generating activities like holding of benefit dances for various purposes (e.g., ingredients needed for herbal preparations, repair of chapels, etc.). These activities have, however, not been conducted as a regular feature of the program. Besides, different Makapawa areas have different needs; hence, the activities of Makapawa along this line have been on a case-to-case basis. In the case of barangay Liwayway, it has been along the lines of helping settle the irrigation dispute, and, indeed, this latter activity has helped the organization of Makapawa in that area.

The case-to-case approach could also account for the absence of specific and clearcut program targets for each area. This is the reason why social investigation is conducted in every area Makapawa intends to operate. However, results of this social investigation were not available for Liwayway. This accounts for

the difficulty of comparing, for instance, the health status of Liwayway before and during program operation.

The Makapawa has indeed successfully developed a mechanism whereby a variety of services can be delivered by one person, namely the CHW. It has trained the CHW to be self-reliant, to depend not on Western medicinal preparations but on indigenous sources like local herbs and plants. The Makapawa has also formulated simple instructions in the preparation of herbal medicine for such common illnesses as coughs, fever and diarrhea which would not require any advanced knowledge in pharmacology. It has even gone further by teaching these CHWs to become community organizers, teachers, fund raisers and civic leaders.

The voluntary nature of the service rendered by the CHWs has not only helped in reducing the cost of primary health care, but has also contributed to the spirit of commitment and dedication present in Makapawa core leaders and CHWs, in a degree that is not easy to find in the other areas our research team studied.

The Makapawa has been responsible for developing and inculcating a sense of awareness among the CHWs and core leaders of the overall situation that exists in the Philippines today, this subject being part of the curriculum which all CHWs undergo. As to whether this awareness has permeated and spread to the grassroots is, however, hard to perceive.

It may also be that the chosen CHWs are by themselves a different class. They are basically idealistic and committed towards making this world a better place to live in, even if it means sacrificing much of their time, effort and money. As stated by one CHW, *"Pipikit ka ba sa problema ng barangay? Kung tunay kang Kristiyano, tutulong ka sa nangangailangan."* ("Will you close your eyes to the problems of the village? If you are a true Christian, you help those in need.")

However, despite the active participation of the CHWs in the community, the CHWs themselves find it difficult to elicit active and regular support for the program from the people in the community in terms of donations, and regular attendance in UFCs and the like.

The people are still crisis-oriented when it comes to seeking medical attention and the practice of preventive medicine is still not accepted among the community members. Other needs like economic needs are given more priority than health needs. In a country like the Philippines, this may be regarded as only logical: the problem is more of what to put into the stomach rather than what to do to maintain a good state of health. A program like the Makapawa recognizes this priority and prepares a program in order to answer not only the health but also the economic needs. At present, however, its ability to respond to health needs is greater than its capacity for a totally integrated program.

Chapter VIII

THE SUDTONGGAN HUMAN DEVELOPMENT PROJECT

Rebecca P. Albano

The Sudtonggan Human Development Project (SHDP) operationalizes a unique integrated system whereby a self-reliant economic structure not only provides employment but also supports the delivery of social services, including health, to the community.

The SHDP is the Philippine pilot project of the Institute of Cultural Affairs, Inc. (ICA), an international organization engaged in assisting communities in the planning and implementation of comprehensive community development projects in various parts of the world. It traces its beginnings to a mandate of the World Council of Churches in 1954 for the church to be more involved in "God's world." It shed off its Protestant linkage as it became involved in inner-city programs in Chicago and went on to the Third World, drawing its resources from grants, gifts and contributions from governments, philanthropic organizations, trusts, business corporations, and private individuals in the West and in the countries in which it has projects.

The ICA, incorporated in the Philippines as a non-profit entity, started its training courses in community development methods in 1967 but it was only after 1973 that the Institute decided to establish a pilot project to demonstrate the effectiveness of a comprehensive approach to community development. This was realized in 1976 with the initiation of the SHDP. Since then, the lessons learned from Sudtonggan have brought about the establishment of the Langub Human Development Project in Davao City in 1973, the Human Development Training School (HDTS) in Sudtonggan in 1978, the Mactan Island Cluster Human Development Project in 1979, and the initiation of the approach in nineteen other communities in Lapu-Lapu City in 1980 in cooperation with the Nutrition Committee of that City. The SHDP has also served as the pilot project for communities in the ICA network in other countries including India and Jamaica.

The choice of Sudtonggan as the ICA pilot project in the Philippines was made after a year of survey of both rural communities and urban neighborhoods in and near metropolitan Cebu. The decision, according to the ICA staff, was based on the following reasons: (1) The relative accessibility of Sudtonggan to the Mactan International Airport and to the seaport of Cebu City would be convenient for both foreign and domestic observers and participants; (2) The depressed condition and the seemingly pervasive feeling of hopelessness and resignation of the Sudtonggan community would dramatize the impact of the project; (3) Both the public and the private sectors in Cebu and Lapu-Lapu City have pledged their support for the project, and more important (4) the people of Sudtonggan have expressed their willingness and readiness to work for the project.

After four years of hard work with its own share of difficulties and successes, under the guidance of ICA, the management of SHDP was turned over to the community in May 1980. While ICA continues to maintain its training school in Sudtonggan, its role has been reduced to an advisory one in the SHDP.

The ICA Approach

The ICA approach views comprehensive community development as the simultaneous growth of the economic, social and cultural aspects of community life. This is based on the following premises:

(1) That widespread participation of community residents in the planning and implementation of all programs is necessary from the outset;

(2) That economic, social and cultural programs must be simultaneously implemented for impact; and

(3) That external assistance, including that of the ICA's, is necessary only at the start to initially finance the programs and to develop local leadership.

With these premises, the approach starts with the "Consult," a six-day intensive interaction among a group of consultants of varied backgrounds from the ICA, the local public and private sectors and the community. This sets the general directions the community would take in the following years. The Consult is set to:

(1) define the "operating vision" or dreams of the community;
(2) draw out the "contradictions" or constraints to the realization of these dreams;
(3) gather and organize practical proposals to overcome the constraints;
(4) define the specific steps or "tactics" for the programs; and
(5) define the precise structures and required resources within which the specific programs and tasks will be carried out, taking into account existing conditions and resources.

Although the framework of the Consult has been set, the content differs among communities as reflected in the Consult Summary Statements, the documentation of the Consult. At the time of our field visit, we compared the Consult Summary Statements of the four communities of the Mactan Island Cluster Project (1979). The "contradictions" identified and the solutions do not seem to be *de cajon* or canned. Although some tactics are similar, the over-all thrust for each does not seem to be a mere copy of the others but take into account the uniqueness of the resources and problem sets found in each community.

After the Consult, program implementation commences with the ICA auxiliary staff assisting the community in building support systems for the project and training residents in the management of the programs.

The Human Development Training School (HDTS) in Sudtonggan as the base of the replication scheme of the ICA is geared towards practical training in rural development and fuller understanding of the ICA approach. The six-week course is divided according to its general areas of concern: (1) economic development, (2) human or cultural development, and (3) social development. The curriculum design is shown graphically in Figure 8.1 including its unique terms for its activities.

Figure 8.1

Human Development Training School Curriculum

ORIENTATION	Cycle I Economic Development		HERITAGE TRIP	Cycle II Human Development		URBAN TRIP	Cycle III Social Development		COUNCIL
	Modules Cooperative Agriculture	COMMUNITY AWAKENMENT		Modules Living Environment	PROFOUND HUMANNESS		Modules Preventive Care	CORPORATE	
	Appropriate Industry			Community Identity			Functional Education		
	Community Services			Corporate Patterns			Community Welfare		
		LAB			LAB			LAB	
	Round Table			Round Table			Round Table		

Source: The Institute of Cultural Affairs, "Emergence of a Human Village: Documenting the Development of Sudtonggan, 1976-1980." May 1980.

The classroom sessions are conducted on a lecture-discussion basis with the faculty members ranging from Sudtonggan project workers and residents, ICA staff and other resource speakers. Emphasis is placed on the reactions and interactions of the participants and on their contact with Sudtonggan residents and their activities.

The heritage trips of historical spots and government agencies in Cebu and other neighboring areas aim to develop in the participants a sense of national identity including their own place in history. The urban trip makes them experience first-hand the realities of modern living - i.e., the disco, the hotel, the movies and the shopping centers which they had only heard of through the

radio and other modes of mass media. Although the curriculum design has been set, each training session develops its own content and character. ICA has held five training classes since 1978 to the present (1980). The present ICA staff, composed of seven Americans and one Filipino, speak the dialect (Cebuano) and live simply and frugally with their families in the HDTS compound in the fringe of Sudtonggan. They replaced the first ICA staff in Sudtonggan, who have moved on to other ICA project areas.

Project Initiation: The Sudtonggan Consult[16]

The Sudtonggan Consult was held from May 23-29, 1976. The participants (or "consultants") numbered about one hundred fifty (150), one-third of whom were residents of Sudtonggan, another one third came from all over the country and the last third were foreigners. Visiting consultants from both public and private sectors represented a broad spectrum of expertise, skills and experience. Likewise, the attending Sudtonggan residents represented a cross-section of the whole community. Meanwhile, other residents assisted in the "housekeeping" chores of the Consult. Some residents today still look back with happy memories to their own experiences during the week-long Consult and its aftermath during which, in their enthusiasm, they worked nine months at ten hours a day, six days a week, without any remuneration.

The Sudtonggan Consult was based on some presuppositions, namely that: (1) the project would be a demonstration of comprehensive development for any defined community; (2) the project would work even if the potential location was characterized by an apparent hopelessness and the absence of community projects; (3) both social development and economic growth are necessary to make an impact; and (4) both local and outside perspectives are needed for relevance.

For effective economic development at the local level, the following assumptions were made: (1) the project must be conceived as a self-contained independent economic entity; (2) schemes to increase the flow of money into the community must be devised; (3) most of the funds from external sources must be retained and circulated in the community as long as possible; and (4) while strengthening its economy, the community must take into account the realities of the outside world.

To attain the desired level of social and cultural development, the project must accept the basic premises that all community problems must be dealt with simultaneously and that social symbols are necessary to mobilize community effort. To establish the support systems for effective implementation, some assumptions have been made: (1) the coordinated effort of both public and

[16]Most of the information in this section was drawn from The Institute of Cultural Affairs, "Sudtonggan Human Development Project: Consultations Summary Statement," May 1976.

private sectors is required; (2) the widespread participation of community residents in the implementation of all programs is necessary at the outset; (3) the presence of a catalytic staff is needed for a period of time to generate momentum for leadership development; and (4) dramatic indicators of socio-economic development must occur within 6 to 12 months from the initiation of the project.

Based on these premises, the first task of the Consult was to define and operationalize the vision of the future shared by the people of Sudtonggan. The "consultants," divided into five teams, discerned the vision from the Sudtonggan residents' stories, their hopes and fears, their frustrations and their dreams. It was only after such lengthy informal talks that the operating vision of Sudtonggan emerged. The consultants regrouped the 112-item list of needs into three major components: (1) "providng community services," which include basic utilities and essential care; (2) "expanding village enterprises" to attain a self-sufficient economy through farming, industries and fiscal management; and (3) "releasing the human potential" through revitalization of the local cultural forms and community education to build on for the future. This task was premised on the idea that only when a community is aware of its vision of the future can it start to move toward development.

Given the operating vision of the people of Sudtonggan, the Consult proceeded to the second task, which was to identify the deterrents and blocks to its fulfillment. The teams, again proceeding from interactions with the community, identified 139 deterrents and blocks, which were consolidated into fifteen basic social contradictions. This task assumes that effective socio-economic development cannot occur by directly achieving the goals of the operating vision but rather by dealing first with the underlying contradictions or blocks. Some of the defined contradictions are the following:

(1) The strong family traditions which have supported its members through times of need, also obligate its members to contribute as soon as possible to the family income, thus impeding the acquisition of skills and resources;
(2) Production is family-based, thus, assets, e.g. land, are immediately disposed of to meet a family crisis;
(3) Living at the subsistence level has deterred Sudtonggan residents from involving themselves in uncertain ventures;
(4) The absence of social services, e.g., health education and transport, has curtailed the production capacity of the community;
(5) The subsistence level of production has also deterred the accumulation of capital for the acquisition of new technology, which in turn contributes to low production (a vicious cycle);
(6) Informal community leadership, based along family lines, functions only when immediate issues arise and participation has been reduced to passive obedience to authority.

The Consult then proceeded to the third task of defining the practical pro-

posals as a direct response to the defined underlying contradictions. It came up with 24 proposals or projects which were categorized into three main categories; namely: (1) social development proposals which dealt with the developmental functional skills of the people and the broadening of educational opportunities; (2) community design proposals, which took into account the community structures which will sustain the development of Sudtonggan; and (3) economic cooperation proposals which considered proposals to bring about economic independence and growth.

The fourth task of the Consult was to define the tactics or concrete steps required to implement the proposed projects. Working again in teams according to areas of expertise, each team worked out (from their assigned set of proposals) an inclusive set of concrete actions to effect the proposals.

The last task of the Consult was to define the precise structures or forms within which the specific tactics are implemented, taking into account the existing conditions and resources within and outside Sudtonggan. The Consult came up with fourteen actuating programs which include the following:

Community Services	:	1. Sudtonggan Health Clinic
		2. Sudtonggan Nutrition Center
		3. Sudtonggan Utilities Project
Community Education	:	4. Early Learning Center
		5. Village Schooling Institute
		6. Functional Skills Academy
Community Formation	:	7. Sudtonggan Community Center
		8. Community Improvement Association
Community Agriculture	:	9. Land Food Project
		10. Sea Food Project
		11. Animal Husbandry Project
Community Commerce	:	12. Fiscal Services Association
		13. Sudtonggan Trading Company
		14. Sudtonggan Industrial Complex

More specific projects and activities were defined within each identified program. A four-year phasing of activities was then formulated to establish and strengthen the programs in Sudtonggan. In the first year, the programs would be launched and the core of community leaders trained by the ICA staff. The second year would involve the expansion of the programs and training of more residents for active participation in community development. The third year would be directed towards the establishment of local autonomy of the projects. The fourth year would witness the maturation of the project and the complete take-over of local leaders of both economic and social development programs of Sudtonggan from ICA.

Concomitant to this phasing of activities was a broad four-year estimate of the cost of each program broken down into capital costs, salaries and operating expenses by phase. This estimate of costs requires financing from ex-

ternal sources to enable the project to break the cycle of a subsistence economy. But over the four-year period, a progressive decrease of external funds was expected as the projects began to generate their own incomes.[17]

The implementation of the actuating programs required the involvement of a catalytic force or auxiliary staff, which, in the initial phases of the project, continually motivated and directed the community's attention and understanding of the development task on hand. This auxiliary function was assumed by the ICA staff.

Project Implementation

After the Consult, the Sudtonggan Human Development Project was born and work started. From the 14 identified actuating programs, the community indicated three top priorities: increased income, accessible schooling and health services. Projects were simultaneously started: intensification of existing sources of income, introduction of new local industries (e.g. animal husbandry, handicraft), the pre-school, the infant's school, facility development, health training, nutrition education, water system, and other projects. Some projects proved to be economically impractical in implementation and were abandoned. Such setbacks have not discouraged the residents of Sudtonggan but have instead encouraged them to develop and strengthen the viable ones to the point that by 1979, SHDP had stabilized three local industries - the rock, the buri furniture and the abaca-craft. Twenty percent (20%) of the gross sales of these industries have financially supported the delivery of community and social services, including health and nutrition.

At the time of the research team's field visit, Sudtonggan boasts, among others, of having: (1) a health clinic manned by a trained full-time health worker (paramedic); (2) a primary school; (3) an early learning nutrition center; (4) 22 water pumps all over Sudtonggan; (5) a project-run electric generator; (6) a tourist shop for the handicraft display; and(7) a project office staffed by local Sudtonggan residents.

The organization and mechanisms by which SHDP manages its programs may be understood further in the following sections.

Organization and Administrative Mechanism

The Structure. SHDP organized the community into a set of overlapping guilds and puroks representing functional and areal groupings. The self-contained, integrated organizational structure of SHDP is shown in Figure 8.2.

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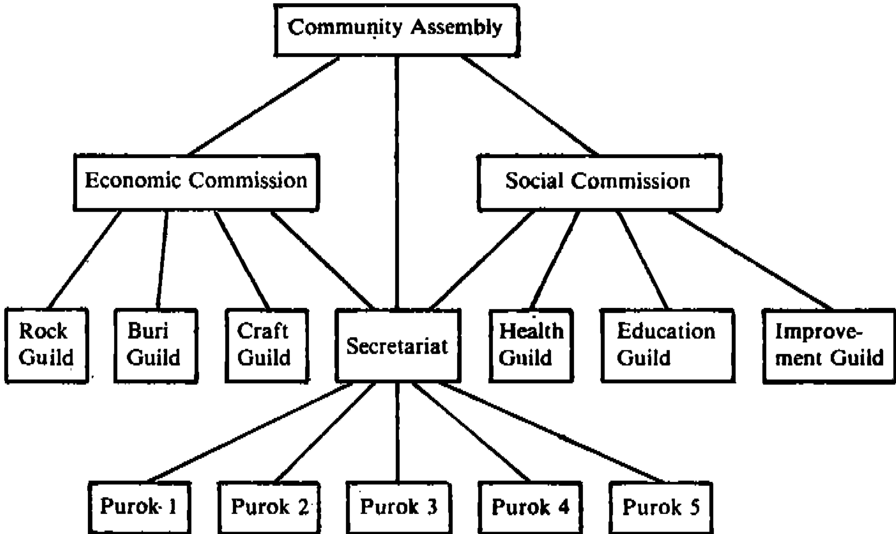
[17]Unfortunately, a fire in December 1978 destroyed most of the early records of the SHDP. A lot of this information is reconstructed here, but the financial magnitude and sharing could no longer be recalled accurately.

Figure 8.2

Sudtonggan Human Development Project Organizational Chart



Source: SHDP Documents

Geographically, Sudtonggan was divided into five zones or *puroks.* Within each *purok,* teams composed of about six families each were formed. The teams were organized to ensure a closer monitoring of the families' needs for services and their greater involvement not only in the development of their neighborhood but also of their purok, and ultimately, in the development of Sudtonggan as a whole. Purok meetings, held monthly or oftener as the need arises, encourage the residents to participate in the decision-making process affecting the development of Sudtonggan.

Each purok annually elects its representative to the Board of Directors, which oversees the development of the Project with the Chairman of the Board acting as the project general manager. The Board of Directors and project

staff comprise the Secretariat which manages the day-to-day activities of the Project.

The Community Assembly, which includes all the residents of Sudtonggan, is convened once or twice a year to hear the report of the Project administration, including its problems and future plans. This also becomes an occasion for a social get-together for all the residents.

As also shown in the chart, community residents involved in each industry and social program were organized into a guild to perform the basic planning, implementation and evaluation functions within their respective concerns. These guilds were then grouped into the respective economic and social commissions to ensure the coordination of the development of the guild relative to the development of the community as a whole.

The Project Staff. As mentioned earlier, the Board of Directors, with the project staff (all Sudtonggan residents), is responsible for the management of SHDP. The Chairman of the Board as project manager, heads the project staff, which is composed of a project bookkeeper, a staff assistant (concurrently, the rock industry manager), two health workers (in the clinic), three ELNC teachers and two utility workers.

Commitment rather than education was the requisite in the selection of the project staff to be trained by the ICA. The present project staff have an average of four years of formal education. During the initial phase of the SHDP, the basic training technique applied was the "shadow" method with minimum formal lectures. Initially, the volunteer/selected Sudtonggan resident became the "shadow" or understudy of an ICA staff member for some defined tasks. Then for the same length of time, they switch roles so that the ICA staff member becomes the "shadow" to ensure better understanding of the said tasks.

To reinforce this training project, staff members have participated in the Human Development Training School both as trainees and guest faculty. A number of Sudtonggan project staff members and involved residents have also been abroad for training and for broadening their perspectives. Some have served as ICA staff in other ICA community development projects in the country or abroad. Among these is the present Chairman of the Board (concurrently project manager), who has since been asked to return to Sudtonggan to soften any adverse effect of the turnover.

The SHDP project office, located in the midst of the village, shares its building with the Health Clinic. Built from solicited construction materials by voluntary Sudtonggan labor, the bungalow has a small office with a large conference room, a library and a relatively large one-room health clinic. The conference room serves as the venue for the monthly Board meetings, the weekly Project staff planning sessions, guild meetings and other needs.

While the Board members render voluntary services, the regular project staff members are paid a daily rate of seven pesos (₱7.00) or about ₱150 per

month as of December 1980 except for one or two members who receive higher rates. This relatively low rate brought about a staff composed mostly of women, who would thus remain accessible to their households at all hours of the day.

The SHDP Financial Scheme. The maintenance of SHDP and its programs, including the payment of the project staff's wages, has been made possible by a sharing mechanism evolved by the ICA. In brief, the Project receives all the sales income of the Sudtonggan industries and disburses it in the form of weekly pay to the industry workers, salaries to the Project staff and maintenance and operating expenses of project programs. To allow for Project administrative and program costs, twenty percent (20%) of the industries' income is withheld by the SHDP.

The magnitude of these financial activities may be seen in the income generated and disbursed by SHDP. For the ten-month period, January-October 1980, its income and expenditure were tentatively pegged at ₱286,970 and ₱281,477, respectively. Although these figures were not itemized, SHDP's book of accounts which reflects only transactions involving bank deposits and withdrawals for the same ten-month period presents a more detailed picture of SHDP's operations as shown in Table 8.1. It clearly shows the conversion of the community income - the twenty percent (20%) withheld from the industries - into the project administrative expenses and the operating costs for health, nutrition and ELNC services.

The amount of income brought in by SHDP becomes more significant when one realizes that: (1) this is generated internally from Sudtonggan; (2) this supports not only the workers' families but also the delivery of community services to Sudtonggan residents; (3) the project staff did not have any formal education to make the system work; and (4) this fund was practically non-existent just four years before (1976).

Economic Program

The economic program in a sense is the foundation for the operations and the activities of SHDP. Although treated as co-equal with the social and cultural programs for the comprehensive development of Sudtonggan, it provides the operating funds for these other activities.

Before the initiation of SHDP, the only source of income available in the village were subsistence farming, small-pond fishing, minimal rock-cutting, and rope weaving on a labor-consignment basis. Work available outside the area were manual in nature, in the factories and at the pier, but even this faced stiff competition from higher educated and more qualified workers.

Today, SHDP has three well-established, locally based industries, namely: the rock, the buri-furniture and the abaca-craft industries. Among the economic industries drawn up by the Consult, these were the only ones which proved viable. High maintenance and operating costs of other projects, e.g., poultry, animal husbandry and expanded fishing industry, proved uneconomical and were given up.

Table 8.1

Itemized Income and Expenditure, SHDP, January-October 1980[1]

	Income	Expenditures
Donations	-	-
Administrative	₱ 93.45	₱ 31,428.65[3]
Electricity	3,609.79	7,429.94[4]
Health	192.50	3,425.50
Nutrition	—	3,093.40
ELNC	26.00	3,457.50
Community	39,740.78[2]	—
Agriculture	—	—
Buri Industry	23,621.90	25,766.60[5]
Craft Industry	31,318.73	30,571.60[5]
Rock Industry	103,871.97	111,608.22[5]
Others	2,750.80	492.60
Total[6]	₱ 205,225.92	₱217,274.01

Source: SHDP Book of Accounts

[1]The figure only reflects transactions involving bank deposits and/or withdrawals (i.e., exclude direct expenditures from cash income).

[2]The income of the community is about 20% of the actual income from the industries.

[3]Administrative expenditures include the wages of the project staff and the maintenance expenses of public utilities.

[4]This reflects the high cost of diesel and crude oil. The facilities were turned over to the Mactan Electric Company at the end of 1980.

[5]These are mainly the wages of the respective industry workers.

[6]The balance does not take into account the beginning balance of the period described and its collectibles.

The industries, at present, provide work for about 150 Sudtonggan residents on piece-work basis. In 1979, the income of the workers increased drastically from that of 1975 as shown in Table 8.2.

Table 8.2

Economic Development Indicators, Sudtonggan, 1975 and 1979

Indicators	1975	1979	% Increase
Average annual per capita income	₱416	₱1,445*	347%
Estimated average annual family earnings	1,460	6,504*	447%

*Outside income figures not included

Source: ICA, "Emergence of a Human Village: Documenting the Development of Sudtonggan, 1976-1980," May 1980.

Although the 1979 figures are not impressive in absolute terms, SHDP has at least provided the opportunity by which families can augment their meager income.

Each of the industries has organized its respective guilds as a means for participation in decision-making within the industry. Guild discussions keep the larger community welfare, which they support, in perspective.

The Rock Industry. This industry tapped the very resource that isolated Sudtonggan from the rest of the City and partly kept it in a subsistence economy. These were found all over the village and were dark and forbidding in appearance, many weighing several hundred kilos and measuring many cubic meters. Sudtonggan residents resigned themselves to the presence of these rocks and sometimes used them as stairs for their homes. A few had started to strip the rocks into tiles but the back-breaking work it entailed produced low-quality blocks which could not be marketed.

In the Consult, this economic barrier was envisioned as a possible source of income. Still it took three years to establish the rock industry. Problems ranged from upgrading the crude tools and rejecting below-standard tiles to problems of marketing, labor and overhead costs. There existed also the perennial temptation for the individual cutters to take side orders with lower but more immediate pay instead of holding out for bigger contracts at higher prices through SHDP. The average income of a rock cutter has increased from about

a monthly income of ₱50 in 1975 to about ₱200 in 1979. This industry employs about 30 to 40 male workers with an SHDP-paid female industry manager.

The Buri Furniture Industry. The industry, started in early 1977, operates on a labor-consignment basis. A large furniture exporter in Cebu City supplies the raw materials to Sudtonggan and collects the finished product with the option to reject those with poor workmanship. Two factory buildings have been built by SHDP with voluntary labor from the residents. The work force of this industry is presently dominated by the elder residents in the community with an average monthly income of about ₱120 per worker in 1979. At present, there are about 40 workers.

The Abaca Craft Industry. The Consult conceived of this industry as an offshoot of the small traditional rope-making industry existing in the area. The craft guild with the project staff has not only trained the younger residents in macrame but has also undertaken aggressive marketing strategies to find buyers for its products. The industry regularly delivers its products to tourist shops in Cebu City and engages in small-scale exportation. A craft store alongside its factory has become a tourist stopover during tours of Mactan Island. In 1979, the average monthly income per worker was pegged at about ₱160 per month for approximately 50 craft workers.

Aside from industries within Sudtonggan, SHDP also made possible the training and employment of some twenty men of Sudtonggan in a private factory in Cebu City. Negotiations to absorb more Sudtonggan residents in factories in the Mactan Export Processing Zone are underway.

The Social Programs

SHDP is committed to the welfare of Sudtonggan residents. After the Consult, a pre-school (the Early Learning Nutrition Center) and a health clinic were established as the initial social service delivery systems in Sudtonggan. To monitor the needs of the community each team within a purok has a volunteer health caretaker and a school aide.

The Health Program. This program was designed as a response to one of the three priority needs cited during the Consult by the Sudtonggan residents. Since then, it has reflected some dramatic progress in the health condition of the village. Sudtonggan's infant (age 0-2) deaths per year dropped from 12 in 1975 to 3 in 1979. Its yearly birth rate has also dropped by 39 percent (from 49 in 1975 to 30 in 1979). For the same period, malnutrition decreased from 85 percent to 24 percent of the children with ages 0 to 6[18].

The Sudtonggan Health Clinic is the foundation of the health program. After the Consult, the SHDP solicited assistance from the Lapu-Lapu City Health Office and the Opon Emergency Hospital for the provision of medical services to the community. Aside from these, a medical school assigned its in-

[18] Further comparisons cannot be made again because the baseline health data for 1975 were burned with the ICA staff house.

terns on rural practice to Sudtonggan. Simultaneous with the basic health services rendered by these agencies, some Sudtonggan residents underwent on-the-job training in the delivery of basic health services as clinic workers. A few residents had undergone observation and training in health agencies in Cebu City.

The Health Guild, composed of health workers, the Board of Directors and interested residents, supervises the over-all health activities and monitors the health status of the community. It has undertaken special health campaigns on deworming, family planning, immunization, prenatal care, the control of skin diseases and respiratory infections and nutrition.

The operation of the Health Guild is premised on the fact that, armed with basic knowledge, the community residents are in the best position to determine their health needs. Government health resources, which are scarce, must be solicited to serve the needs of the community. To illustrate this: about two years after the Consult, when government's and concerned outsiders' enthusiasm had subsided and no medical personnel was available in Sudtonggan, the Guild wrote and presented a community petition to the Regional Health Director for at least regular once-a-week visits of public health personnel. They were granted their request, thus reinforcing the point that in unity is power. As of this writing, the two clinic workers are again drafting a request for a regular visit of an MOH doctor to their community and are soliciting medicine for their supply.

SHDP maintains one or two health clinic workers to take charge of the clinic and to initiate health activities in the community. The range of tasks of the clinic worker includes:

1. administering first aid treatment,
2. giving medicine for common illnesses;
3. maintaining the medicine stock,
4. scheduling the doctors' clinic day,
5. assisting the doctor,
6. making special home visits,
7. maintaining the village health chart and the family health records,
8. monitoring medical cases,
9. weighing babies monthly,
10. scheduling mothers' class, and
11. referring cases to hospitals.

The health clinic worker plans her activities weekly together with the other project staff members. She also assists the project staff in administrative tasks when the need arises.

The volunteer health caretakers in the puroks are expected to monitor the health needs of their respective areas. As such, their tasks include:

1. making weekly home visits,
2. monitoring minor sickness,

3. recruiting residents for health-related seminars/classes,
4. reporting purok health status to clinic worker, and
5. referring cases to the clinic or hospital.

The Sudtonggan Health Clinic also maintains a good stock of medicine, which are either donated or purchased. These are sold or credited to the residents at minimal costs for the maintenance and replenishment of medicine and supplies.

The once-a-week visits of health personnel from outside agencies to Sudtonggan are occasions not only for consultation and treatment but also for lectures on the area of expertise of the visiting personnel. Mothers are gathered by the health aides to the Clinic for such lectures or seminars.

Although still deficient in some aspects, e.g., lack of permanent professional medical services, the SHDP health program provides the basic health services to the community and the easier access to health agencies and facilities in the cities.

The Education Program. Realizing that education is crucial in permanently breaking the cycle of a subsistence economy, Sudtonggan identified the education program as a priority in the Consult. The program started with the establishment of a pre-school for about a hundred 2-to-6 year-olds in 1976. In the school year 1979-1980, of the registered 70 children in the Sudtonggan Early Learning Nutrition Center (ELNC), about 50 to 60 pre-school children attended school daily. For these children, the Project provides free lunch and two snacks daily to supplement their nutritional intake. (The children bring their staple food, i.e., rice or corn, for lunch.) SHDP supports the food expense of the ELNC at about eighty to one hundred pesos (₱80-₱100) weekly as of early 1980 from its community fund.

The establishment of the Sudtonggan Elementary School is by itself a landmark for the project. The residents cite it as a proof that working as one, a community can make things happen. Despite a rule that no school can be established within two kilometers of an existing school, regional education officials approved the establishment of a school in Sudtonggan on the basis of a strong petition of Sudtonggan residents in 1977. Elementary school attendance rose from 10 in 1975 (in the school in the sitio across the rock field) to 110 in 1979 (in Sudtonggan Elementary School, grades 1 to 3).

Aside from the leadership training course conducted by the Human Development Training School of the ICA in Sudtonggan, the SHDP, especially during its initial stages, conducted adult education, functional literacy and second language classes taught by some ICA staff and elementary school teachers. The ICA also provided for domestic and foreign trips of some Sudtonggan residents for further training and exposure to the world outside the village.

Public Utilities Program. As part of its social development program, the SHDP maintains public utilities. Under the guidance of the ICA staff, it was

able to solicit water pumps and an electric generator for the community. The Improvement Guild generated voluntary labor in the community to build structures to accommodate these facilities.

Before SHDP, Sudtonggan had two open wells with uncertain potableness to serve its water needs. By 1978, SHDP had put up 22 water pumps scattered all over the area. Likewise, before the Project, its lighting sources were oil or kerosene. Through representation, SHDP acquired the generator which supplies most of Sudtonggan with electricity, the source of envy of residents from the surrounding areas. Saddled with high electric overhead costs, SHDP has already petitioned for the take-over of the Mactan Electric Company. This petition has been approved and by 1981, SHDP expects to be relieved of the costs of maintaining its own source of electricity.

The Cultural Program

The primary objective of the cultural program is to provide and maintain the motivation and enthusiasm of Sudtonggan residents for what SHDP stands for. This is interwoven into all the programs and activities of SHDP. This motivation is constantly reinforced by the different guilds and community leaders. When problems and complaints on any program surface, the residents are reminded of the underlying principles of SHDP.

Cultural activities sometimes called "celebrations" are also undertaken to reinforce the unity of the community. This "celebrative life" includes cultural and other excursions, dances and fairs, movies and sports tournaments not only among Sudtonggan residents but also with other ICA project communities in Mactan Island. Each month of the year is assigned a program around which special activities are planned, e.g., nutrition month, living environment month, and others. Cultural activities are usually planned according to the focus of the month.

A strong rallying point pursued by ICA/SHDP is the belief in one's abilities as a force towards good. In the ELNC, children are taught songs such as the following Pre-school Ritual (ICA, 1980):

Leader : Who are you?
Children : I'm the greatest!
Leader : Where do you live?
Children : In the universe!
Leader : Where are you going?
Children : To change the world.

Concluding Statements

The word "change" aptly summarizes the process Sudtonggan has been going through since May 1976, the initiation of SHDP, to the present. Although still far from the fulfillment of its visions of a better quality of life, Sudtonggan is well on its way. The ICA integrated system of development in which a self-reliant economic structure provides employment and supports the delivery of community services has proven viable so far in Sudtonggan.

Now the ICA has deemed it opportune to withdraw from the SHDP and to allow the community to manage its programs by itself. For this purpose, the SHDP is now functioning independently, with its Board of Directors and Secretariat composed completely of Filipinos who hail from the sitio of Sudtonggan itself. This is another stage of change in this small sitio of Barangay Basak in Lapu-Lapu City where the desperation, hopelessness and apathy, which commonly characterize the rural areas in the country to this day, have, in the last four years, been transformed to hope, self-confidence and enthusiasm for the future.

Chapter IX

A COMPARATIVE REVIEW OF THE SELECTED HEALTH DELIVERY MECHANISMS

Ledivina V. Cariño and Ma. Lourdes S. Joves

This chapter is a comparison of the case programs discussed in the preceding five chapters. To reiterate, these are the Rural Health Unit of the Ministry of Health in Pilar, Bataan; the University of the Philippines-Comprehensive Community Health Program (CCHP) in Bay, Laguna; the Project Compassion (ProCom) in Teresa, Rizal; the Makapawa in Barangay Liwayway, MacArthur, Leyte; and the Institute of Cultural Affairs (ICA/SHDP) Project in Sudtonggan, Barangay Basak, Lapu-Lapu City.

As mentioned in Chapter II, these programs were selected to represent various points in the continuum of integration. How they compare in terms of integration, sponsorship, program orientation and other factors will be the concern of this chapter. However, the role of local residents in the program - another distinguishing factor - will be discussed in a separate chapter since participation is the second key variable.

Integration

Among the five programs, only the RHU may be identified as sectoral. It is therefore used here as the control or comparison program. The four other case programs merit the adjective "integrated," either by combining health care activities with those outside the traditional health field, or by linking the activities of two or more providers while maintaining either single or multiple channels for delivery. A description of the programs along this variable follows.

The RHU: A Sectoral Program

The RHU in Pilar, like all rural health units throughout the country, concentrates on health services. The RHU is the arm of the government ministry for the implementation of health programs at the municipal level. Nevertheless the RHU is not a pure sectoral case in that the MOH as a whole has incipient elements of the integrative mode. Thus, nutrition and family planning, the major responsibilities of two separate government entities (National Nutrition Council and Commission on Population) are delivered as part of the package of services of the MOH's restructured health care delivery system (RHCDS). The two agencies have agreed to use the MOH's delivery system since their respective services are provided to practically the same group of target clients.

Duplication of effort and inefficient use of resources are expected to be minimized as a result of using one organizational network for the provision of interrelated services. (It may also be recalled that the health sector has traditionally encompassed nutrition and family planning.)[19]

The CCHP: Integration within Health Using a Multiple-Agency Scheme

CCHP's standing as a multi-channel program lies largely in its attempt to link up organizationally with the Provincial Health Office of the Ministry of Health, for that purpose absorbing (or being absorbed by - it is not clear which) units of the Ministry of Health in its area of operation.

In working out its organizational thrust, the CCHP signed a memorandum of agreement with the Ministry which spells out their areas of cooperation. CCHP then created the District Health Office, an intermediate level between the Provincial Health Office and the RHU, to service the group of municipalities within its catchment area. At Bay, the RHU and the clinic and hospital of the CCHP co-exist in the poblacion. In barangay health stations with assigned rural health midwives (RHMs), the functions of CCHP personnel assigned to the area are integrated with the RHM's duties. RHMs usually take care of the record keeping, manning of the station, and follow-up of patients. In areas without RHMs, CCHP Barangay Health Technicians man the station with CCHP personnel support.

The CCHP Board is now headed by the Chancellor of the Health Sciences Center, University of the Philippines. The Program itself is run by the Director with three line divisions, all headed by Deputy Directors. For our purposes, the most important divisions are that of Training and Extension Services. The Division of Extension Services is in charge of planning, implementing and evaluating delivery services at the primary level. It includes the CCHP Infirmary, the training of *hilots* and other paraprofessionals, and a section for municipal and barangay services which provides "direct community services to existing operational areas of the CCHP at the municipal and barangay levels through the Rural Health Unit . . . and other public and private agencies" (CCHP, 1978:7). The quotation provides a glimpse to the ambivalent integration of CCHP and RHUs in the area.

Project Compassion: Integration beyond Health with Multiple Delivery Channels

The Project Compassion concept envisions the integrated delivery of a five-pronged program through a network of barangay organizations managed by

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[19]However, the POPCOM has recently developed a separate delivery system for the field areas in order to intensify the campaign for more recruits and continuing users of family planning contraceptives.

the Mayor at the center. As such, it would be an integrated single-agency program in our terms. As interpreted and implemented in Teresa, however, a more complicated model more closely approximating a multi-agency approach has emerged. This is based on the fact that the agencies implementing the programs which ProCom is supposed to integrate, continue to deliver such services independently. A discussion of the evolution of ProCom in Teresa may clarify this subject.

In May 1976, upon its entry into the municipality, Project Compassion agents created a Municipal Family Development Council following its first Social Development Seminar. Composed of government and private-sector organizations, this Council became the Municipal Development Council or MDC (dropping the word "family") in the following October, after DLGCD circular no. 76-110 was circulated. A few months later, when its funds ran out, ProCom left Teresa for about a year, during which the MDC became moribund. It was reactivated in May 1978, with the Mayor as honorary chairman. The MDC was then subdivided into five sectors following the ProCom model (nutrition, green revolution, family planning, environmental management, and sports and cultural development). At about the same time, a Tripartite Agreement between the municipal government, the Commission on Population and ProCom named the POPCOM as the ProCom's implementation arm in Teresa. Following this, the POPCOM's District Population Officer (DPO) became the ProCom's Family Development Officer (FDO). He also now represents the citizens of Teresa in the MDC and acts as the mayor's action man in implementing plans approved during MDC meetings. The Full-time Outreach Workers (FTOWs) under him at POPCOM are also placed under the direct supervision of the ProCom.

Meanwhile, the ProCom staff is headed by the Team Leader (also called Training Specialist) who advises the MDC on the formulation, implementation and evaluation of the Integrated Development Plan, the result of the MDC-cum-ProCom's efforts. Under him are Barangay Development Volunteers (BDVs) who are ProCom-trained public school teachers. They organize *Ilaw ng Buhay* chapters in their respective jurisdictions. These are associations of families at sub-barangay levels.

Despite this involved network reaching down to the family level, implementation of the activities of the five sectors in Teresa still does not proceed on a single-agency scheme. A number of government agencies do participate in ProCom activities, especially in the area of training and education. However, their regular services still go on independently of ProCom and indeed are incorporated in the ProCom scheme under the name "referral system." Using this, individual citizens can seek technical assistance and advice from government agencies more expeditiously. For the most part then, ProCom provides a system for problem identification, planning and evaluation by the community, and for training and increasing the level of awareness of the people - thus, a channel for special services. But delivery of health, nutrition, environmental management, and family planning are made directly by the relevant technical

agencies even for activities which they undertake for ProCom. Perhaps when the Mayor assisted by the Municipal Development Council takes over from the ProCom, and the role of the local chief executive as the area manager becomes a national policy, the ProCom concept of a single municipality-wide agency for delivery will become a reality.

Makapawa: Integration beyond Health with Single Agency

Introduced by the Rural Missionaries of the Philippines, Makapawa is sponsored by the Roman Catholic Church in Leyte. It is headed by the Bishop of the Diocese of Palo as honorary chairman. Originally, an Advisory Board was composed of members of the religious sector and health professionals from both public and private agencies. Since 1977, a Board of Directors has been created and the Advisory Board reorganized, so that both would be composed conpletely of members from the religious sector. The move followed an evaluation which showed that the major weaknesses of the program lay in the relative overemphasis on health and staff-centered activities, both of which vitiated the thrust towards community direction of the program. (For instance, since health was not regarded by the people as a priority need, the program's stress on it led the people to wait for Makapawa's lead rather than take responsibility for its administration.) In addition, it found lay people less active than expected. The 1977 changes then reiterated the centrality of the community's involvement and the active role of the church in bringing it about. A Memorandum of Agreement signed by Makapawa and the Region VIII Health Office in 1975 provided that the Rural Health Unit would serve as a "resource and support group" in the parishes where Makapawa operates. As such, the agreement also spelled out that the Community Health Workers (CHWs) would serve as extension workers of the RHU and would receive training and supervision from Ministry personnel at the appropriate levels. Had the memo been implemented as agreed upon, the Makapawa workers and the MOH hierarchy would have formed a single referral system from barangay up to provincial and regional level. In Liwayway, however, Makapawa CHWs undertake their health activities independent of the RHU and refer cases they cannot handle directly to secondary health care levels such as hospitals in Abuyog and Tacloban, bypassing the municipal clinic. It may also be stressed at this point that the community-based approach of Makapawa is different from the community-oriented approach of the RHU which is located in the community but which generally plans its programs from outside it.

Another institution operating in Liwayway is the Institute of Health Sciences which fields student nurses to undertake activities similar to what the Makapawa is doing. Although a potential for duplication and conflict obtains, the IHS students and CHWs have developed informal coordination and assisted each other in their activities.

Given this kind of organizational framework, we regard the Makapawa as an integrated program relying on a single agency. It is unlike the CCHP, the tasks of which are sometimes delivered directly but sometimes channelled through RHUs. In Liwayway, the RHU and the Makapawa undertake their respective activities separately, both generally ignoring a mandate for coordination signed by their respective heads. The IHS and Makapawa undertake similar activities and intersect each other at various points but have not formally delineated their respective roles to achieve something more than informal (and sometimes accidental) coordination.

The SHDP: Integration Beyond Health with Single Agency

Although the SHDP is classified in integration terms like the Makapawa, it is different from this program in a number of ways. While Makapawa in Liwayway and the MOH in MacArthur do not work together in Sudtonggan, the counterpart Ministry unit goes to the sitio upon the invitation of the SHDP.

The SHDP exemplifies the case of a program which draws resources from many sources at every stage of the program cycle, but which nonetheless maintains a single delivery channel. Thus it draws funds from international sources (religious and private philanthropic organizations), local foundations as well as private corporations. Representatives of these organizations, however, do not sit in the board. Its major planning exercise, the "consult" is attended not only by community residents and the SHDP staff but by outsiders like religious leaders, businessmen and representatives of government agencies. Yet the "vision" or plan which emerges from it is put together by the Sudtonggan Human Development Program (SHDP), the local implementing agency. From the very beginning, it has been manned largely by community leaders with the technical assistance of full-time staff of its sponsor, the Institute of Cultural Affairs (ICA). Even programs it does not provide are arranged for and take place under its auspices - for instance, the opening up of a primary school in the area, which became possible because the program found a willing donor for the school site and mobilized voluntary labor to construct its building. All activities are then seen as emanating from a single institution. Thus, the ICA project is regarded as another example of integration by a single agency for beyond-health activities.

Other Characteristics of the Programs

The compendium of health delivery systems clearly shows that the programs can be described not only in integration terms but also along a number of other important variables. The way these characteristics combine in the five case programs was given in a detailed manner in Chapters III to VIII. In this section we shall cull from these detailed presentations seven factors which were found to be most useful for summarizing the distinctive features of the pro-

grams. These are: sponsorship; focus and scope of operation; nature of activities; type and responsibilities of personnel; funding sources; linkage with government; and program orientation.

Sponsorship

The RHU in Pilar as already mentioned is the regular government program in health. The CCHP is sponsored by a state university but its board and funding sources include many other agencies which makes it different from a regular government health program.

Project Compassion is a unique case in that although it has been organized by private foundations, it is implemented and largely supported by local governments. This has been made possible by the fact that the organizing entities are non-profit corporations founded by the First Lady.

The Sudtonggan and Makapawa projects were initiated and are still operated by private institutions. However, they differ in that the Sudtonggan project was sponsored by an international non-sectarian organization and the Makapawa was initiated and is run by the local arm of the Catholic church.

Locus and Scope of Operation

Three of the projects have the municipality as the locus of operation (Pilar in Bataan for MOH, Bay in Laguna for CCHP, and Teresa in Rizal for ProCom). The other two are in sub-municipal areas: the entire barangay of Liwayway in MacArthur, Leyte for the Makapawa and the sitio of Sudtonggan in Barangay Basak, Lapu-Lapu City, for the SHDP.

Except for Pilar which is part of the MOH program implemented nationwide, the study sites were chosen by their sponsors because they were considered as "depressed" areas before the start of project operation. For instance, for the CCHP, one factor that influenced the choice of Bay initially was its lack of medical and dental practitioners (in the mid-sixties). The ICA considered Sudtonggan's state of poverty as one of the reasons for its selection as the site of a global demonstration project. Likewise, in choosing its sites (including the choice of Liwayway), Makapawa selects a community "with the greatest health needs, far from health resources, and without a community health program." Even the inclusion of Teresa, which is a first-class town, was justified on the basis of some characteristics that would qualify it in some way as "depressed."

The grounds cited include the following: (1) "farming as the means of livelihood; (2) a high unemployment rate among the residents who do not wish to be employed outside the municipality; (3) widespread malnutrition; and (4) absence of factories in the area " (Interview with the Teresa ProCom Team Leader, February 1980). These conditions were later confirmed by the preliminary municipal survey conducted by a ProCom training specialist.

Nature of Activities

The MOH and UP programs deliver purely health services to the populace. The Restructured Health Care Delivery System in Pilar (as in all rural areas throughout the country) provides a comprehensive package of health care services, namely: maternal and child health, medical and dental care, control of specific diseases, disaster control, environmental sanitation, food and drug supervision, laboratory services, and health education. Nutrition and family planning activities are also undertaken in coordination with other agencies. Under present MOH policies, each RHU is obliged to plan its health program in collaboration with the community within the frame of the national plan but adapted to local needs. However, community participation in planning and the consequent adaptation of the usual RHU package to the peculiar needs of Pilar seem not to have occurred.

Similarly, the CCHP's package of health services, made available to needy clients in cooperation with the RHU, consists of: medical care, maternal and child care including family planning and nutrition, environmental sanitation, communicable disease control, health education, public health nursing, vital statistics, other health-related activities like dental services, Botica sa Barangay, and community organization (CO). CO work, however, is being pursued only to facilitate the CCHP staff's operation. Other non-health services were contemplated to be delivered by CCHP but participation of such units as the Institute of Social Work and Community Development in the program has been ad hoc rather than an integral part of the CCHP package of services.

The other three programs incorporate health as well as other social and economic services. Expressly established in response to a need for an *integrated* development approach to meeting certain basic needs of the people, Project Compassion puts together nutrition, family planning, green revolution, environmental management, and sports and cultural development in one package. The different activities sometimes cross over these sectoral boundaries.

The Makapawa delivery system consists of two major components: the health program and community organization. The latter is intended to encourage the people to help themselves identify and solve their own problems according to their own priorities and to rely more on local resources. Hence, whereas health services are being provided by the Makapawa staff, the organized community residents tackle other social, economic, political and even religious activities like repair of chapels, installation of common water pumps, operation of the Botica sa Barangay, the village drugstore, weekly interhouse Bible reflections, and discussion and action on such problems as irrigation, land ownership, planting techniques, income-generating projects, etc.

The ICA project in Sudtonggan also believes in and utilizes the integrated approach to human development, thus combining economic and social programs into a single delivery system for the residents. For the economic programs, the Sudtonggan Human Development Project has established three locally-based industries, namely: the rock industry, the buri furniture industry, and the abaca craft industry. These income-generating projects have not only augmented local income derived largely from subsistence farming and fishing, but have likewise supported the social (particularly health) requirements of the community. The social programs undertaken by the SHDP include: (1) the health program which responds to the health needs of the village residents through the medical services provided by the Sudtonggan Health Clinic and the special health campaigns conducted by the Health Guild, (2) the education program consisting of the conduct of a pre-school, special classes for adult education, functional literacy or second language teaching and leadership training courses, and the operation of an elementary school established on the basis of a strong petition of the residents despite a government regulation that no school should be established within two kilometers of an existing school, and (3) the public utilities program which has provided water pumps and an electric generator for the community.

In sum, two of our case programs deliver a comprehensive package of health services, while the three others combine health with economic, social, and even cultural, political and religious activities. These three organizations, along with a number of other programs in our survey have stressed the value of extending their efforts to help the poor beyond just health - i.e., blending health services into the other basic needs of any person or the community so that the person (or every member of the community) may be in harmony with his total environment.

Personnel

The RHCDS in any municipality is the responsibility of the medical team composed of a doctor, nurse, dentist, sanitary inspector, and midwives. Each member of the team performs specific functions and duties and observes a referral system whereby at the first level, the midwife responds to simple types of health problems; at the second level, the nurse and sanitary inspector are expected to do more complex services; and at the third level, the physician handles cases beyond the capabilities of the second-level health workers. In certain areas, the RHU staff has trained and utilized civilian, mostly women, volunteers (variously called paramedics, barefoot doctors, health auxiliary workers, or health aides/technicians) as well as the traditional midwives (hilots) to supplement the work done by the rural health midwives; they are most useful during outbreaks of epidemics or disasters as additional providers of services.

The CCHP, in providing health services to the people in coordination with the RHU staff of Bay, makes use of such health personnel as medical profes-

sionals, students (from various health disciplines as medicine, nursing and veterinary medicine as well as home economics, physical/occupational therapy, dentistry, etc.) and barangay health technicians (BHTs). The BHTs are recruited from among the residents, and are trained and paid by the CCHP to deliver basic health services.

Project Compassion in Teresa involves various types of personnel in its planning, implementation, and evaluation activities, namely: the local government officials (i.e., the Municipal Development Council, the Sangguniang Bayan, and the Barangay Development Councils), the community organization (named Municipal Ilaw Association of Teresa) and its leaders at various levels, field agents of government agencies in the municipality, the ProCom staff consisting of the team leader (assigned by the ProCom National Office) barangay development volunteers (BDVs), and the family development officer (FDO). The FDO is the POPCOM's District Population Officer given an honorarium by the ProCom to act as the coordinating link between the Municipal Development Council and the BDVs. The BDVs are public school teachers chosen to serve as development trainors and extension workers of the ProCom and receive honorarium for these functions. As extension workers, the BDVs: (1) organize the Ilaw Chapter meetings and act as advisers to the chapters in their respective jurisdictions; (2) make home visits for follow-up; (3) assist in referrals; (4) collate the survey conducted by the different unit leaders; and (5) participate in community projects such as Operation Timbang, beautification; tree planting, etc.

Personnel for the Makapawa's delivery system comprise the Makapawa staff (composed of the coordinator, the community organizers in urban and rural areas, a mobile health team consisting of the doctor, nurse and midwives, and an office secretary) who go around all the barangays covered by the program; religious leaders (e.g., Bishop of Palo, parish priests, etc); barangay officials who are enjoined to participate in the program; community health workers (CHWs); community organizer-volunteers (or COVs); and the community residents organized into several committees. The COVs and CHWs are chosen from the poorer sectors of the community and are trained to perform their respective roles in the program: the COVs initiate and monitor various activities in the community in coordination with the barangay council, while the CHWs provide general basic health services (including herbal preparations for simple illness) and are concerned also with non-health problems of the community.

The SHDP is largely handled by community residents who undertake the various economic and social projects for their own development with medical staff from government agencies and private clinics and hospitals (when available) delivering services that cannot be handled by the resident clinic workers, and the ICA auxiliary staff providing advice, assistance, and guidance until the project shall have been completely turned over to the community. The clinic workers (trained and paid from the project's income-generating activities) serve as providers of primary health services and are

assisted by equally-trained volunteer health caretakers who monitor the health needs of their respective *puroks* (zones within villages). The health caretaker's counterpart for the educational program is the school aide.

Funding Sources

The RHCDS, as a government program, derives its resources from the national government through the MOH. Material (such as medicine, medical and office supplies, logistics and equipment) and financial (salaries of personnel, traveling expenses, etc.) resources are allotted to regional and provincial health offices throughout the country. In addition, salaries of some staff as well as some maintenance and operating expenses are contributed by the local government.

The CCHP operates largely from the regular appropriation coming from the state university (which forms 83 percent of the program's total budget), and the funds generated from the Infirmary's activities (17 percent). Occasionally, some private institutions (e.g., the San Miguel Corporation) give financial support to the UP health program in Bay, Laguna. In-kind resources may be received from other agencies, notably the MOH, and the Bureau of Agricultural Extension as well as from community residents.

An examination of ProCom's financial statement for CY 1979 reveals that it is one project which is able to draw cooperation, participation, and support from several sectors in the community. Funding for the ProCom in Teresa is shared among the local government (31.0%), the various government agencies with field offices in this municipality (21.1%), private groups and organizations including the Catholic parish council (29.6%), and the ProCom national office (18.3%). Although one of the program's goals is to establish self-reliant, participative communities, the national office largely absorbs the costs incurred for the social development seminars, Family Ilaw Training, presurvey activities and actual survey, information campaigns and community conference, and the honoraria paid to the Family Development Officer and the BDVs.

The budgetary requirements of the Makapawa program come from international church-affiliated organizations like CEBEMO, Pontifical Mission Society, and Misereor. The funds of this church-administered program are channelled through the diocese. In addition to medicine provided by the Regional Health Office, supplementary resources for the program are generated from indigenous sources like local herbs and plants and from community-initiated fund-raising projects or donations solicited by the staff (e.g., medicine from private drug companies).

Initially, the SHDP was financed by the ICA, a non-profit international agency concerned with establishing self-reliant communities in various parts of the world. Since then, the SHDP has evolved a system whereby the project receives the income of all Sudtonggan industries and apportions at least 20 per-

cent of these for salaries of the Program staff, the provision of social services as well as maintenance and operating expenses of Program facilities. Following this, the social development programs of the SHDP (e.g., the health program and the Early Learning Nutrition Center) are funded from the income generated by the industries. Other needs of the community like medicine, voluntary services of a doctor, water pumps, an electric generator, etc., have been solicited by the residents from various sources.

Although bearing in mind that a number of resources are donated and/or provided in kind, we nevertheless attempt here to give a comparison of the funds available for each program. Gleaning from the figures given in Chapters IV to VII, a comparison of the resources used by each program is shown in Table 9.1.

Table 9.1

Resources Per Person in Area of Service, 1979

	Program Costs	**Population**	**Resources Per Person**
RHU (Pilar)	₱126,250.17	18,536	₱6.81
CCHP (Bay)	1,012,964.00	21,521	47.07
ProCom (Teresa)	177,212.95	14,989	11.82
Makapawa (Liwayway)	102,406.20	842	121.62
SHDP (Sudtonggan)	281,446.56	1,100	255.86

Based on these figures, it appears that inputs provided for the RHU and ProCom are the lowest, followed by CCHP, while Makapawa and SHDP have the greatest leeway in resources. Makapawa, it may be recalled, draws a lot of its funding from international church organizations. The costs include a mobile health team which, however, is available (at no added cost) for other Makapawa areas. In a sense, then, the figure overestimates the resources going to Liwayway. The case of SHDP is different from all the others inasmuch as funds shown are generated internally from the industries run by the Program itself. The figures thus represent the SHDP's attempt to return to the community through health, education and nutrition services and wages of industrial workers, funds that the community itself has raised.

Linkage with Government

The RHCDS is planned, administered and funded by the government through the Ministry of Health, the agency charged with the operation of the health program of the government. In the field, MOH services are extended through the Ministry of Health, the agency charged with the operation of the municipality. As such, it should coordinate with the other government agen-

cies performing health-related functions (e.g., POPCOM, National Nutrition Center, MSSD, and MEC) and with private organizations (e.g., Catholic Relief Services) operating in the area. In addition, it tries to integrate the different privately-owned and -operated hospitals and clinics into an overall health service system of the municipality. In Pilar where there is not a single private hospital nor clinic, the RHU's scope or mandate for coordination with other agencies is really minimal.

The CCHP is a state university program. It has a working relationship with the RHU in Bay (as defined in a Memorandum of Agreement) whereby the RHU maintains overall responsibility for health care in the area and the CCHP coordinates with the RHU in providing supplementary health services and performing research and training activities for the total health delivery system in the municipality. The CCHP's Infirmary performs higher-level medical activities (for a minimal fee) than the RHU-provided services; hence, specialized cases are referred by the RHU to the Infirmary.

Project Compassion was established at the instigation of the First Lady to involve the private sector in the government's efforts towards national development using an integrated development approach. The project is planned at the national level by the office created by four private foundations: the Nutrition Center of the Philippines, the Green Revolution, the Population Center of the Philippines, and the Environmental Center of the Philippines. It is implemented in selected areas throughout the country through the local government and as such, derives considerable funding from the local government unit. It draws participation from the field offices of a number of government agencies and private organizations in the municipality of Teresa.

The SHDP and the Makapawa are both non-governmental programs but seek government services and active linkage with its various instrumentalities. Thus, the Sudtonggan agency solicits assistance from the Lapu-Lapu City Health Office, the Opon Emergency Hospital, and the Regional Health Office for the provision of medical services. Similarly, the Makapawa program has a formal working relationship with the Regional Health Office to define their respective areas of responsibility and delineate their roles and functions in the community. The RHU staff, other government doctors, and the private (including the religious) sector are enjoined to participate through lectures on specified topics in the training of CHWs, provision of voluntary health services and free medicine to the community, and membership in the Advisory Board. Even at the lowest level, the Barangay cooperates in the activities of the Makapawa. In Barangay Liwayway, however, there is difficulty of coordination between the RHU and Makapawa staff, despite a Memorandum of Agreement. Its program orientation (to be discussed below) has also resulted in some difficulties in its attempts to link with government.

Program Orientation

This concept may be defined in terms of three factors: (1) the method of delivering services; (2) the identified target of these services; and (3) the ideological underpinnings of the program.

Delivery Mode. The MOH and UP programs offer a package of health services to people who come to the poblacion clinics or barrio stations to seek health care. As such, they may be called agency-based programs.[20] In other words, under this delivery system, the programs perform medical activities largely to people who recognize a need for them and who initiate the interaction.

On the other hand, for ProCom, SHDP, and Makapawa, organizing the community is a necessary component of the delivery mechanism because they believe that the welfare of the people is largely within their reach and rests on their initiative. Hence, while health and other services are made available to village residents, the program staffs try to motivate and mobilize the residents in identifying their problems, setting priorities among their felt needs, utilizing indigenous resources, implementing their plans to solve their self-perceived problems, and evaluating their accomplishments. In addition, the personnel of SHDP and Makapawa carry out an aggressive scheme emphasizing home visits and seeking out program participants, a system open to but not much stressed by the RHU and CCHP. The ProCom is between the two pairs of programs in this regard. On the one hand, it actively seeks out participants to the program like the SHDP and Makapawa. On the other hand, its main activities have been focused on training so that the residents do not receive services directly from ProCom although their involvement and demands are vigorously elicited.

To summarize: the RHU and CCHP both provide vital health services to recipients in the community who seek these out, thus acting as agency-based programs. The other three programs use a community-based system. In these cases, the client's demands are important inputs into the system. At the same time, there is a concomitant push to get the clients to make such demands on the program. The focus is not on delivering services to clients, but on having both agency and client involved in the provision of services.

The Service Targets. The MOH is pledged to provide health services to all sectors of the population. Thus, it regards everyone within its catchment areas as part of its target clientele. This seems to be implicit also in the CCHP. ProCom also seeks to reach everyone through its strategy of using a hierarchy of levels, starting with the family unit.

The Makapawa is different in that it has explicitly opted for the poor as its main participants especially in its attempts to organize the community. The SHDP is similar to the RHUs, CCHP and ProCom since it does not specifically identify the poor as its main target. This may, however, be an academic point in this sitio where income levels are uniformly low, unlike in other areas where some elite groups can still be identified.

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[20]The term "agency-based" defines the usual mode of delivery only. It does not say that services provided are not expected to meet the needs of the community. If they do, the programs may also be described as "community-oriented."

The Ideological Underpinnings of the Program. How do the programs view government's role and their own in improving the life of the people in the rural areas? The most extreme viewpoint is represented by Makapawa which teaches the community, as part of its training programs, that their present situation is a result of center-periphery relationships, and that their poor health situation is an index of that problem. While falling short of calling for a restructuring of these relationships, this Makapawa stance has made its programs from time to time suspect in the eyes of the government. To Makapawa, however, this view is part of the movement to build authentically Christian communities where everyone is enlightened and able to comprehend the reasons for certain structural conditions and also takes responsibility for the progress of his community. In line with this, Makapawa has endeavored to incorporate traditional methods of healing into its services. This includes massages and use of herbal medicine without, however, necessarily accepting that these and their appurtenances are all effective and without rejecting the elements of Western medicine that are useful in dealing with the communicable respiratory ailments most prevalent in rural villages.

The CCHP and the RHU are like the Makapawa in their encouragement and use of tested indigenous practices. The CCHP, however, is much more advanced in this respect, having incorporated herbal medicine in its strategy since its inception. The remaining two programs use Western medicine, drugs and technology almost exclusively and have not trained their staff or community residents in the use of indigenous forms of health care.

All these four programs are more conservative in ideology than the Makapawa, in the sense that they take present structural arrangements as given. In this respect, the SHDP is somewhat to the left of the other three in that it has attempted to create something of a commune in the sitio of Sudtonggan, with all functions and services under the program. However, unlike radical programs, it seeks to integrate the sitio more fully into the economic life of the larger society through that communal strategy.

Summary

The characteristics of each program in terms of the dimensions discussed in this Chapter are summarized in Table 9.2. It succinctly shows that although the choice of programs was largely dictated by the factor of integration, the use of the case study method has made it difficult to isolate this variable from a host of other important distinguishing features of a health delivery system.

The earlier discussion has thus shown the richness of the cases worked on, underscoring the fact that integrated organizations come clothed in many ways. This factor will somewhat complicate the analysis in later chapters. Nevertheless, by being aware of these elements, we hope we can be more discriminating and comprehensive in making an analysis of the factors affected by integration.

Table 9.2

Tabular Comparison of the Case Programs

Factors	Rural Health Unit, Ministry of Health	Comprehensive Community Health Program	Project Compassion	Makapawa	Sudtonggan Human Development Program
Location	Pilar, Bataan	Bay, Laguna	Teresa, Rizal	Liwayway, MacArthur Leyte	Sudtonggan, Basak, Lapu-Lapu City
Integrative Mode	Sectoral	Integrated within health using a multiple-agency scheme	Integrated beyond health with multiple delivery channels	Integrated beyond health with single agency	Integrated beyond health with single agency
Sponsorship	Government	State University	Private and Local Government	Private (Catholic)	Private (non-sectoral)
Locus of Operation	Municipality	Municipality	Municipality	Barangay	Sitio
Nature of Activities	Health Only	Health Primarily	Social services, including health	Health as entry point only, with economic, political, social and religious programs	Economic and social services including health
personnel	Medical professionals primarily	Medical professionals and students, para-professionals at barangay level	Medical professionals, community organizers, local government employees	Community organizers, religious, mobile health team	Community residents, (occasional) government nurse and physicians, ICA staff.

Factors	Ministry of Health	Comprehensive Community Health Program	Project Compassion	Makapawa	Sudtonggan Human Development Program
	Pilar, Bataan	Bay, Laguna	Teresa, Rizal	Liwayway, MacArthur Leyte	Sudtonggan Human Basak, Lapu-Lapu City
Funding sources and magnitude	National and local government; resources low in magnitude	National (U.P.); resources moderate	Local government and cooperating national government and private-sectors agencies; resources low	Largely from Diocese, except for some contributions of foreign religious organizations and local residents	Initially, ICA; now funded out of income of projects and local contributions; resources high
Linkage with government	Government agency	State university	Sponsored in an area by its local government	Few links, often suspected by government	Uses government services and seeks active linkage with it
Program orientation	Agency-based; services available to all (no specific target clientele); Uses Western and indigenous medicine with emphasis on the former	Agency-based; services available to all uses Western medicine, with use of indigenous sources encouraged	Community organization-based; services available to all; uses Western medicine	Community-based; poor as main clientele; uses and emphasizes indigenous sources of medicine, and harmonizes it with Western medicine.	Community-based; services available to all; uses Western medicine

Chapter X

THE PARTICIPATION OF CITIZENS IN THE CASE PROGRAMS

Victoria A. Bautista and Ledivina V. Cariño

Participation may be hypothesized to play a critical role in mobilizing people to receive and utilize services effectively. Moreover, one may expect that the citizens appreciate more the services delivered by a program if they had been involved in the different phases of its conceptualization and implementation. This Chapter examines the validity of these statements for the programs and sample sites of this study. Particularly, it discusses participation as a component of the program concept, the beneficiaries' perceptions on the necessity of participation, and their actual involvement in the different phases of program implementation. Some characteristics of community residents (i.e., income, educational attainment and occupational background) are also related with the beneficiaries' perspectives on the need for participation and actual involvement.

Participation as a Component of the Program Concept

The programs under study differ in terms of the kind of citizen participation they encourage and generate. The RHU does not at present involve the residents in planning and evaluation. To a certain extent, it seeks citizen participation in implementation through the conduct of mothers', fathers', and youth classes, a traditional health education technique. The CCHP goes a step farther with its use of a barangay health technician (BHT) chosen from among the residents in the area and trained in primary health care delivery and barrio leadership. Except for the fact that he/she is indigenous to the barrio he is assigned to, and has lower educational qualification, the BHT, who is paid by the program, functions like the rural health midwife (RHM) in the RHU's barangay health station.

Project Compassion has a complex structure for involving the people. Its first activity in any area is a Family Ilaw Training (FIT) which touches on the five sectoral programs. At the end of the FIT, participants elect the leader of their unit (a group of twenty families). Two or three Ilaw units in turn compose a chapter whose presidents in each barangay organize into a Barangay Executive Committee (BEC). The BEC chairman sits as the Ilaw associations' representative in the Barangay Development Council (BDC), a body composed of the barangay captain, teachers and the BEC head. [It may be recalled that the ProCom representatives at the Barangay level are the Barangay Development Volunteers (BDVs) who are public school teachers.] The BDC is ex-

pected to plan and implement activities at the barangay level. It is linked to the Municipal Development Council through the ProCom hierarchy, since BDC members do not sit at the municipal level body. It is the MDC, limited to 15 members by the MLGCD, which writes out the integrated development plan. That plan is a part of the Municipal Development Plan of Teresa and is legitimized by approval of the *Sangguniang Bayan* (Municipal Council).

Ilaw chapters are federated into a municipal *Ilaw ng Buhay* (Light of Life) Association of Teresa, a registered corporation.

Although the ProCom organization is pervasive throughout the municipality, people's participation does not extend to actual decision-making at the municipal level, except in "advisory" and "supportive" roles given to the Federation.

The Makapawa has also evolved a system aimed at maximizing community participation. It organizes the barangay into groups of families called *hugpo* and into functional committees, such as finance, liturgy, etc. In addition, community core leaders called COVs and community health workers (CHWs) are designated and trained to plan and implement activities in each *hugpo.* These are chosen by the staff and the residents from among the poorer members of the community. The Makapawa fields one community organizer per barangay; he is expected to leave once the community is judged self-reliant.

The people are involved in evaluation to a greater extent in Makapawa than any of the other programs. Drawing from the Maoist concept of the action-reflection-action cycle, criticisms of the program and of their specific roles in it are encouraged and take place frequently. The transition of the Makapawa from a specifically health program to a church program (what it identifies as Stage 2 to Stage 3) in fact came as a result of evaluation sessions with the people.

The ICA/SHDP seeks total participation by the people in planning, implementation and evaluation activities. This starts as early as the "Consult," the activity which brings together local residents, government officials, private sector corporations and organizations, and ICA staff in order to discuss their community's present conditions and analyze underlying contradictions (obstacles), practical proposals, tactics and actuating programs to concretize the operating vision of the people for the development of their community. The results of five such Consults in various areas of Lapu-Lapu City were examined to determine if an unnerving consistency binds the reports. The write-ups appear different enough to be the work of different people (rather than guided by ICA staff with possibly identical diagnosis and cure for every illness). This is at least our first evidence that some actual involvement from citizens does take place at these Consults.

Once the goal has been laid down and the ICA entry into the area allowed, training for self-reliance and mobilization occurs and concrete programs and projects are undertaken with the people. To this end, there is a complex of

guilds organized by place or zones corresponding to geographic subsites, or by functions (e.g., health, rock industry, Early Learning Nutrition Center) with an overall board of directors made up of local residents. Each activity has a corresponding local committee and person in charge (e.g., health caretaker). ICA staff serve as advisers at least until May 1980 when they are expected to turn over the management of the SHDP completely to the sitio residents.

When the SHDP was first organized, the ICA discovered a number of men and women whom they trained to head zones and guilds. These persons have proven to be dedicated and to have strong leadership capacities. Because of this, ICA had taken in some of them as part of its full-time staff and assigned them to other communities. Others had been hired by private companies outside Sudtonggan. Because the ICA had felt some resistance to the pulling out, this "first team" was re-assembled in January 1980 to ease the projected transfer.

In the SHDP, the involvement of the people takes many forms. There are people involved in the guilds as leaders or members, and others , particularly in the industries, participating as employees or piecework wage-earners. Thus, some contribute voluntary labor; others receive minimal honoraria or stipend; while others are paid at the market rate for their services. Generally, the rates each receives are known to all community members since they are set in meetings conducted during working hours by the relevant guild. The proceeds of income-generating projects are also widely known. Certain percentages are allotted to the overhead of the SHDP as well as to non-earning projects such as the ELNC and cultural activities with the rest going to the direct laborers.

Planning meetings, which differ according to scope, take place daily for certain activities and weekly or monthly, for others. During our interviews, we found that for many Sudtonggan residents, "planning," (even in its Cebuano equivalent) was too technical a term to use. Meetings at which they set targets for the week and decided on wage rates and assignments were affairs that were not set apart from the life of the community. Guild meetings (for economic activities) could take place during break time of working days. Zone meetings included a lot of community singing and games and were informal though productive. The board, however, meets every Monday to plan the week's activities in a formal session. Something of an annual evaluation takes place in an assembly which looks back on the preceding twelve months. When we visited the site, such an assembly had just taken place. Cartolina papers were on a big board, each showing a category of activities (economic, identity, etc.). Under each were thumb-tacked 3" x 2" sheets where different people (as shown in the varying handwriting) had written in what their perceptions were on the accomplishments of the program. Under "economic", there were a lot of tags showing how many buri/rope/rock products they have done, also how many pigs were raised, how many bank accounts had been opened, etc. Under "identity," a sheet is memorable (for us). It said "American air of happiness." We would think of it again when difficulties about the transition from ICA to local hands would confront us in this study.

Role of Local Residents in Initiating the Program

It is interesting that for four of the cases under study, citizen interest was a criterion for the program-launching in those particular areas. The only exception is the MOH program which is mandated to operate nationwide regardless of clientele interest.

The choice of Bay as the site of the CCHP was based, among others, on the receptiveness of the municipal government to the proposed program. In fact, the then mayor of the town actively articulated his interest in having his municipality chosen instead of the initial pilot area, where problems with the local government were felt.

Similarly, the town of Teresa was selected as one of the pioneer ProCom areas in Rizal because the local government was willing to support and finance the project, and the residents were generally receptive to and participative in government-sponsored activities for the community.

In Sudtonggan, both the public and private sectors indicated their interest in cooperating with the ICA project. More important, the citizens also showed willingness and readiness to work for their own amelioration. These factors served as significant considerations for the final choice of this very poor village as the site of the ICA project.

Then again, the initiation of the Makapawa program in Liwayway was solicited by some community representatives (e.g., community leaders, parish priest and some members of the MacArthur parish council).

Roles of Citizens in the Phases of the Program Cycle

Beyond their role in initiation, there is also a growing trend among program managers to encourage service clients to participate in specific phases of program development and administration. The extent of citizen participation in the case programs cited here varies.

The MOH program represents the extreme level where residents of the community participate only as recipients of the program's services and have no other roles in planning, implementation and evaluation. Recently, the MOH has sought more active community participation. Thus, in addition to individual medical consultations with the RHU staff, the people of Pilar, Bataan attend meetings, seminars, mothers' and fathers' classes and health and sanitation campaigns. The increased number of activities have, however, not altered the traditional role given to clients of government programs, which is to be simply beneficiaries of MOH services.

Nonetheless, the RHCDS has attempted to be more responsive by expanding its coverage with the creation of health stations in the barangays. These are staffed by rural health midwives who are required to live in the barangays to which they are assigned. The CCHP goes a little beyond this level by involving

a selected community representative in the service delivery system. The trained Barangay Health Technician serves as the first-level provider of health services in the community. In addition, the CCHP staff aims to organize the barrio folks but only for such purposes as mothers' and fathers' classes, Operation Timbang, youth volunteers, fund-raising, etc. through which the program's health educational activities are achieved. The MOH and UP programs are similarly situated in this regard. However, the mechanisms for citizen involvement which they have already initiated can serve as a vehicle for meaningful community participation if the participants were encouraged to voice out their needs and problems and if the program staff truly take into account citizen ideas in program decisions.

Project Compassion, SHDP, and the Makapawa program all seek to develop citizen power. These three programs aim at creating self-reliant communities where the community residents themselves, after having been trained by the program staff, can run a program, be in charge of policy and managerial aspects, and negotiate the conditions under which "outsiders" may change them. How do service recipients in these programs participate in various phases of program management?

In ProCom, one way citizens participate is through designated members of the community who perform certain functions. These are: (1) the BDVs who are public school teachers serving as extension workers of the ProCom; (2) unit leaders of the Family Ilaw Training (FIT) who supervise and manage the family development activities and needs of approximately 20 families; and (3) Ilaw Chapter officials (comprising some three units) performing supervisory and management functions at the next level. The other formal mechanisms for citizen participation is through the Barangay Development Council composed of the barangay captain and councilmen, teachers, and a representative from the Barangay Executive Committee (which consists of three or more chapters). The BDC identifies problems in the barangay, formulates plans, identifies the resources available and implements and evaluates prioritized activities. The Ilaw Association through its various levels undertakes community activities related to the five aspects of Project Compassion.

The unit leaders are also involved in monitoring activities and preparation of summary reports on the activities undertaken by individual families in relation to nutrition, family planning, green revolution, environmental management, and sports and cultural development. During home visits, they gather data on the number of children fed and treated in the feeding center, number of children, births and deaths in the family, number of gardens established, livestock reared, garbage and waste disposal methods used, number of family members who participated in the native sports and cultural activities, etc.

The Makapawa project similarly aims to establish self-reliant and participative communities by motivating the village residents to organized action for planning, implementing and evaluating activities for their own welfare. Various committees are created to answer the different needs of the community, e.g., finance, education, health, interhouse Bible reflection, liturgy, etc.

For the moment, there has not been a single, established economic industry that will generate income for the community's needs. However, the residents in Makapawa-covered areas have handled and solved various problems using local initiative and resources. These include action in areas such as irrigation, land ownership, planting techniques, repair of chapels, installation of common water pumps, etc.

Among the case programs studied, the ICA project in Sudtonggan has attempted the highest level of citizen participation. Here, all the residents of this remote sitio of Lapu-Lapu City are organized into a community assembly which meets once or twice a year. The assembly serves as a forum where community problems and plans are discussed and issues and questions are raised and settled. Sudtonggan is geographically grouped into five puroks, each consisting of four to six teams. A team, in turn, is composed of some six families headed by a team captain who is assisted by a health caretaker and a school aide to monitor the needs of the families within their team. Through purok meetings, the residents participate in the decision-making process affecting their development. Each purok is represented in the Board of Directors which is responsible for the overall management of the project. The project is administered through six guilds representing the six components of the economic and social programs. The guilds form the basic planning, implementation, and evaluation functions within their respective sectors and are grouped into the respective economic and social commissions which relate the guilds' objectives and activities to the total development of the community.

Under the ICA project, Sudtonggan residents participate in *planning* through purok meetings and community assemblies: *implementation* through the work of clinic health worker, health and education caretakers, voluntary labor services for physical improvements, volunteer administrative work in the guilds, commissions and board of directors, and paid services in the economic projects; and *financing* of the administrative cost of the project and of the social development programs through income-generating industries. With this set-up established, the ICA staff is ready after only four years to relinquish the administration of the project to the Sudtonggan residents who have shown capability in managing their own community's development.

Perception of the Necessity of Citizen Participation

The household survey included questions on the beneficiaries' perceptions of the need for citizen participation as a program component, prior to an assessment of actual involvement.

Table 10.1 reveals that the highest percentage of respondents (91.2%) who perceived the necessity of participation was from Liwayway. This is a significant finding because Makapawa has been purposely established with citizen participation in mind.

Nevertheless, the incorporation of participation is not the decisive factor in the people's responses as can be gleaned from the fact that Sudtonggan

residents which have a total participation program in their midst were relatively less convinced of its need. Only 67.4 percent of the Sudtonggan respondents gave a favorable response regarding participation. A quarter of the respondents openly claimed that it was not important while a little over 7 percent chose not to answer the question. The higher percentage of negative attitude may be the result of apprehensions about the future administration of the SHDP since the survey was conducted when the ICA was about to leave. This may be akin to children about to leave the parental home for the first time, whose excitement on attaining independence is counterbalanced by the fear of having to make decisions by themselves, without guides or controls from parents - i.e., ICA staff whose style of supervision and administration they were already used to.

It is surprising to see that Pilar was second to Liwayway in terms of percentage of respondents who gave an affirmative response on the necessity of participation. Pilar respondents were subjected to a traditional mechanism that did not incorporate citizen participation. Perhaps, the importance given by the beneficiaries to citizen participation may be a rich starting point for RHU administrations in improving the beneficiaries' assessment on the effectiveness of the RHU delivery mechanism.

Table 10.1

Perceptions of the Necessity of Citizen Participation By Program

	Pilar	Bay	Teresa	Liwayway	Sudtonggan
Yes	90.3	80.1	85.4	91.2	67.4
No	1.7	3.9	3.3	1.1	25.5
NA/DK	8.1	16.0	11.4	7.7	7.1
Total	100.0	100.0	100.0	100.0	100.0
	n = 98	n = 91	n = 331	n = 246	n = 298

Source: Household Surveys

ProCom and CCHP were the fourth and fifth in rank . Between the two, Teresa has the higher percentage of beneficiaries who considered participation as valuable. About 85 percent considered it necessary vis-a-vis 80.1 percent of the CCHP beneficiaries from Bay.

The overall high percentages of those favorably disposed to participation in all areas should be viewed as a signal that people-involving programs are acceptable and could be welcomed in rural areas.

Perception of Participation, By Barangay. No significant differences across the three barangays studied in Teresa and Pilar were noted. Hence, irrespective

of the type of barangay, favorable attitude regarding participation was noted from the beneficiaries of the two projects.

Bay's pattern is typical of the poblaciones and far barangays, where nearly the same percentage accepts the importance of citizen participation (in the range of 86-89%). By contrast, the near barangay had only 66.7 percent giving an affirmative opinion. This low percentage may be due to the large number (31.7%) of respondents who chose not to answer the question. This may be attributed to the fact that the RHU is the one known to deliver the services in the area and should therefore be the agency with which they should become involved. The RHU, however, is also part of the integrated effort of CCHP. (See table 10.2).

Table 10.2

Perception of the Necessity of Participation, By Barangay

	Pilar			Bay			Teresa		
	P	N	F	P	N	F	P	N	F
Yes	87.0	94.3	91.1	86.2	66.7	89.2	85.6	85.4	85.1
No	2.3	-	2.5	10.1	1.7	-	1.1	6.7	1.5
NA/DK	10.7	5.7	6.3	3.7	31-7	10.8	13.3	7.9	13.4
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
	n=131	n=88	n=79	n=109	n=120	n=102	n=90	n=89	n=67

Source: Household Surveys

Actual Level of Participation of People in the Programs

In comparing the reported involvement of the people by cases, it is gratifying to note that programs which have strongly maintained that they are participatory top the list. (See Table 10.3.) Makapawa particularly has succeeded in mobilizing most of the people. Although it is in second rank, the showing of Sudtonggan is surprising because one expected its involved citizens to be more, considering its numerous opportunities for participation, even including employment in the industries the program had established.[21]

[21]Further study of the original questionnaires reveals that most of those who were not occupying leadership positions and were not highly educated responded that they were *not* participants in planning, implementation and evaluation. It seems that the question was confusing the people in Sudtonggan because they were aware of a large number of residents who met frequently in formal sessions to set targets and plan for the SHDP activities for a week or so at a time. This is the group they considered "participants." Attendance in assemblies and membership in puroks and guilds - because less intensive than the work this group did - were not considered by them as "participation."

Table 10.3

Level of Actual Citizen Participation By Program and Sample Site

	Poblacion	Near	Far	Entire Program Area	Rank
Pilar - RHU	34%	53%	23%	35%	4
Bay - CCHP	31%	56%	34%	44%	3
Teresa - ProCom	41%	29%	29%	29%	5
Liwayway - Makapawa	NA	NA	NA	64%	1
Sudtonggan - SHDP	NA	NA	NA	47%	2

Note: Figures show that percentage of people who answered "yes" to the question: "Have you participated in the planning, implementation and/or evaluation of the program?"

Source: Household Surveys

The low proportion of people involved in the CCHP and RHU is not surprising given the largely passive involvement they have sought. However, ProCom's position is lower than expected. Its concept of a very strong thrust toward mobilization and participation appears to be largely absent. A closer look at the activities and components of the *Ilaw* package may explain why citizen participation is not sustained. The fact that many ProCom-sponsored activities are in education and training rather than actual delivery or in planning or evaluation has already been mentioned. If one studies the FIT training content, it will be clear that its thrust is to develop family members to be responsible citizens in their individual capacities rather than for them to work together in community-wide activities for the promotion of the sectoral objectives. The emphasis is then on civics, not social action. For these reasons, we have categorized ProCom along with the RHU and CCHP, as a largely non-participative program.

Actual Involvement in the Program, By Barangay. An analysis of the possible impact of the type of barangay on actual involvement reveals a variable pattern (See Table 10.4). For example, Bay's near and far respondents are more involved than those of the Poblacion.

In the case of Teresa, both poblacion and far-barangay respondents are more involved than the near barangay. The reverse is true for Pilar. The poblacion and "far" respondents are less involved than the near-barangay.

Table 10.4

Actual Involvement of Citizens By Barangay (in Percentages)

	Pilar			Bay			Teresa		
	P	N	F	P	N	F	P	N	F
Involved	29.0	50.0	26.6	27.5	33.3	33.3	38.9	19.1	29.9
Not Involved	63.4	50.0	59.5	65.1	35.0	51.0	46.7	60.7	56.7
NA	7.6	-	13.9	7.3	31.7	15.7	14.4	20.2	13.4
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
	n=131	n=88	n=79	n=109	n=120	n=102	n=90	n=89	n=67

Source: Household Surveys

Satisfaction with Involvement. Further inquiry was made among the respondents who claimed involvement in the programs. They were asked whether or not they were satisfied with the nature of their involvement (Table 10.5). As expected, the two "integrated with participation" programs had the highest percentages of satisfied beneficiaries who became involved in the respective projects found in their locale. Liwayway had 96.6 percent involved respondents who were satisfied. Sudtonggan is a close second with 93.5 percent. As may be recalled, both had involved the clientele in planning and implementation.

ProCom ranks third with 84.7 percent of satisfied respondents. This may be due to its training of local leaders in the dissemination of its services. In fact, between ProCom and CCHP, the first has more massively involved members of the community in the delivery of services. However, involvement has not been realized in the planning stage unlike SHDP and Makapawa. This may be the reason why the percentage of satisfied beneficiaries of ProCom is not as high as Makapawa's and SHDP's.

Nearly three-fourth of the involved beneficiaries of both CCHP and the RHU were satisfied with the nature of their involvement. This figure is less than the one observed for ProCom. Perhaps, CCHP had relatively less satisfied involved beneficiaries than ProCom because a smaller number of the local population were tapped to deliver its services. Another factor, which CCHP shares with the RHU, is their limited objectives compared with ProCom's. CCHP and RHU only tackle health-related services vis-a-vis ProCom's multisectoral approach.

Table 10.5

Involved Benefeciaries Satisfied with the Nature of their Participation By Program

Site	Number	Involved Beneficiaries Satisfied with the Nature of their Participation Percent
Liwayway	58	96.6
Sudtonggan	46	93.5
Teresa	72	84.7
Bay	104	76.0
Pilar	103	74.8

Source: Household Surveys

Reasons for Non-Involvement. The non-involved respondents were asked the open-ended question: "Why did you not become involved in the program?" Significantly, the primary reasons that stood out across sites is the claim that they were "too busy to be involved" as they were saddled with other responsibilities. This reason is more frequently mentioned in areas with integrated-citizen participation (CP) approaches than in the other three sites.

Among the non-CP projects (CCHP, ProCom and RHU), the second prominent reason given was that the program "does not involve people." Among the three, however, Teresa respondents had the least percentage of respondents who claimed this, possibly because training of indigenous leaders is in fact pursued by the Project as an additional aim in service delivery. Not surprisingly, few respondents from the projects with CP claimed this as a factor for non-involvement.

A third reason for non-involvement is lack of knowledge of the project. Some 9 to 13 percent of non-involved beneficiaries of CCHP, ProCom and RHU mentioned this. Only 4.2 percent in Liwayway stated this reasons. An unexpected result is in Sudtonggan — a big percentage (16%) of its non-involved beneficiaries claimed lack of knowledge.

The last major reason for non-involvement was lack of interest. Significantly, Sudtonggan respondents had the highest percentage of non-involved respondents claiming this. This is an important finding as far as SHDP is con-

cerned: a big number of beneficiaries have openly signified their unfavorable sentiments, auguring a difficulty in increasing participation from present levels.

No respondent from Liwayway claimed this whereas the three remaining projects had percentages in the range of 4.2 percent to 9.2 percent, which are still smaller than Sudtonggan's. (See Table 10.6.)

Reasons for Non-Involvement, By Barangay. The type of barangays seem to affect the reasons given by respondents for non-involvement. For example, being occupied or being busy was more prominent as a reason for near - and far - barangay respondents than the poblacion respondents. This is because the peripheral areas have more inhabitants engaged in income-generating activities, being the more depressed areas. A typical case is the far-barangay of Teresa which had the least percentage of respondents claiming this reason among the three barangays surveyed.

Table 10.6

Reasons for Non-Involvement, As Percentage of Uninvolved Respondents

	Pilar	Bay	Teresa	Liwayway	Sudtonggan
Program does not involve people	17.8	28.5	10.9	8.3	2.0
No time/busy	54.0	47.9	54.4	66.7	64.0
No knowledge of the project	9.8	13.3	10.2	4.2	16.0
Not interested	9.2	4.2	7.3	0	16.0
Others	9.2	6.1	17.4	20.8	2.0
Total Responses	n = 174	n = 165	n = 138	n = 24	n = 50
Total Respondents Not Involved	174	165	134	24	50

Note: Multiple responses permitted
Source: Household Surveys

This may be due to the fact that the far barangay relies less on the program than the poblacion and near barangay (recall that this village has access to Morong).

Furthermore, accessibility seems to affect non-involvement. This is attested to by the fact that less respondents in the poblacion area compared with the near - and far - barangays claimed non-involvement because of "lack of knowledge of the project." Also, the fact that more poblacion respondents reasoned that the "project does not involve the people" is an indication of their greater awareness of the components of the project than the near- and far-barangays. (See Table 10.7.)

Table 10.7

Reasons for Non-Involvement by Barangay, As Percentage Uninvolved Respondents

	Pilar			Bay			Teresa		
	P	N	F	P	N	F	P	N	F
Program does not involve people	25.3	9.1	12.8	36.6	14.3	28.5	11.9	12.1	7.9
No time/busy	45.8	63.6	59.6	40.8	52.4	53.9	54.8	65.5	36.8
No knowledge of the project	7.2	9.1	14.9	9.9	19.1	13.5	7.1	13.8	7.9
Not interested	7.2	9.1	12.8	8.5	2.4	0	4.8	8.6	7.8
Others	14.5	9.1	0	4.2	11.9	3.9	21.4	0	39.5
Total number of responses	83	44	47	71	42	52	42	58	38
Total number of respondents not involved	83	44	47	71	42	52	42	54	38

Note: Multiple Responses Permitted

Source: Household Surveys

Involvement and the Socio-Demographic Variables

An examination of the effect of various socio-economic variables on involvement shows the significant impact of education on involvement in Teresa and Sudtonggan.

The effect of income and occupation on involvement is significant only for Bay. Furthermore, Pilar is another case where occupational background of respondents had an effect on involvement. (See Table 10.8.)

Table 10.8

Summary Table on Relationship of Selected Socio-Economic Variables and Actual Involvement

1. Income and Involvement	
a. Pilar	not significant
b. Bay	significant at $<$.05
c. Teresa	n.s.
d. Liwayway	n.s.
e. Sudtonggan	n.s.
2. Education and Involvement	
a. Pilar	n.s.
b. Bay	n.s.
c. Teresa	s.
d. Liwayway	n.s.
e. Sudtonggan	s.
3. Occupation and Involvement	
a. Pilar	s.
b. Bay	s.
c. Teresa	n.s.
d. Liwayway	n.s.
e. Sudtonggan	n.s.

Involvement increasing with income is statistically significant for Bay (See Table 10.9). The trend set in Bay is also noticeable in Pilar and Teresa but the relationship is not statistically significant, possibly because variations by class levels are not big. These findings may signify that unless programs seek out the poor's involvement, participation will tend to be a rich man's prerogative with a possible loss of the articulation of, and attention to needs felt by, the poor, which citizen participation and involvement are supposed to effectuate. No

significant differences between income categories are noted in Sudtonggan and Liwayway possibly because majority of the respondents cluster in the low and middle income categories. However, a possible curvilinear effect of income level may be noticed in these areas, that is, the highest frequency of involvement may be observed in the middle income group than in the lower and upper classes.

A progressive increase in involvement is noticeable with higher educational levels across the different programs except Bay where those with no educational attainment showed a higher frequency of involvement than those with at least an elementary education. The impact of education on involvement is statistically significant in Teresa and Sudtonggan (See Table 10.10.).

The effect of occupation is significant only in Bay and Pilar (See Table 10.11). More specifically, the unemployed are less involved than those engaged in white-collar or blue-collar activities. This low involvement may be because of low education and the lack of ability to articulate their needs. It is interesting that in Liwayway and Sudtonggan, the two programs that have participation as a strong program component, all occupational groups tend to be involved in the same degree. However, the percentage of participation is different in each case- in Liwayway, the bigger group is participative regardless of occupation while in Sudtonggan, the reverse is true. As we have explained earlier, the finding in Sudtonggan appears to refer to acceptance of leadership positions rather than just involvement as a mere member of the community.

Table 10.9

Relation of Involvement and Level of Income By Program Site

Pilar

Involvement	Low Income		Middle Income		High Income	
	N	(%)	N	(%)	N	(%)
With involvement	33	(34)	44	(42)	12	(52)
Without involvement	64	(66)	60	(58)	11	(48)
	97	(100)	104	(100)	23	(100)

α = .05, degrees of freedom (df) = 2, Table (Tab) X^2 = 5.991, X^2 computed (comp.) = 3.095 (n.s.)

Bay

Involvement	Low Income		Middle Income		High Income	
	N	%	N	%	N	%
With involvement	32	(31)	44	(45)	18	(50)
Without involvement	71	(69)	54	(55)	18	(50)
	103	(100)	98	(100)	36	(100)

Comp. χ^2 = 6.21 (s.)

Teresa

Involvement	Low Income		Middle Income		High Income	
	N	%	N	%	N	%
With involvement	24	(33)	30	(38)	10	(38)
Without involvement	48	(67)	48	(62)	16	(62)
	72	(100)	78	(100)	26	(100)

Comp. χ^2 = .40 (n.s.)

Liwayway

Involvement	Low Income		Middle Income		High Income	
	N	%	N	%	N	%
With involvement	29	(66)	8	(89)	1	(50)
Without involvement	15	(34)	1	(11)	1	(50)
	44	(100)	9	(100)	2	(100)

Comp. χ^2 = 2.195 (n.s.)

Sudtonggan

Involvement	Low Income		Middle Income		High Income	
	N	%	N	%	N	%
With involvement	23	(46)	21	(53)	2	(33)
Without involvement	27	(54)	19	(47)	4	(67)
	50	(100)	40	(100)	6	(100)

Comp. χ^2 = .925 (n.s.)

Table 10.10

Relation of Involvement and Level of Education By Program Site

1. Pilar	Education					
	None		1 + 6		7 +	
	N	%	N	%	N	%
With Involvement	1	(17)	60	(34)	37	(44)
Without Involvement	5	(83)	116	(66)	48	(56)
	6		176		85	

α = 105, df = 2, Tab. X^2 = 5.991 Comp. X^2= 3.255 (n.s.)

2. **Bay**

With Involvement	5	(42)	57	(36)	38	(45)
Without Involvement	7	(58)	101	(64)	46	(55)
	12		158		84	

Computed $\chi^2 =$ (n.s.)

3. **Teresa**

With Involvement	1	(17)	28	(26)	43	(47)
Without Involvement	5	(83)	79	(74)	48	(53)
	6		107		91	

Computed $\chi^2 =$ 11.52 (s.)

4. **Liwayway**

With Involvement	3	(50)	39	(67)	16	(89)
Without Involvement	3	(50)	19	(33)	2	(11)
	6		58		18	

Computed $\chi^2 =$ 4.34 (n.s.)

5. **Sudtonggan**

With Involvement	5	(22)	32	(56)	7	(58)
Without Involvement	18	(78)	25	(44)	5	(42)
	23		57		12	

Computed $\chi^2 =$ 8.38 (s.)

Table 10.11

Relation of Involvement and Type of Occupation, By Program Site

	Occupation					
	No Occupation		White Collar		Blue Collar/ Agricultural Workers	
	N	%	N	%	N	%
Pilar						
With Involvement	33	(27)	33	(43)	31	(44)
Without Involvement	89	(73)	43	(57)	39	(56)
	122	(100)	76	(100)	70	(100)
$\alpha = .05$, df = 2, Tab. $x^2 = 5.991$, Comp. $x^2 = 8.119$						
Bay						
With Involvement	26	(28)	36	(51)	65	(36)
Without Involvement	66	(72)	34	(49)	108	(64)
	92		70		173	
Comp. $\chi^2 = 10.19$ (s.)						
Teresa						
With Involvement	18	(29)	44	(40)	65	(34)
Without Involvement	45	(71)	67	(60)	124	(66)
	63		111		189	
Comp. $\chi^2 = 5.05$ (n.s.)						
Liwayway						
With Involvement	13	(65)	2	(67)	15	(28)
Without Involvement	7	(35)	1	(33)	39	(72)
	20		3		54	
Comp. $\chi^2 = .382$ (n.s.)						
Sudtonggan						
With Involvement	9	(41)	3	(33)	12	(39)
Without Involvement	13	(59)	6	(67)	19	(61)
	22		9		31	
Comp. $\chi^2 = 0.152$ (n.s.)						

Summary: Integration and Participation

In the five case programs, integration and participation are very strongly linked. SHDP and Makapawa, the two programs which integrate beyond-health activities in a single agency, are also the programs that include citizen involvement as a major component of their service philosophy. As expected, they lead in the proportion of community residents claiming actual involvement in the program's planning, implementation and evaluation activities. On the other hand, the programs which, though integrated, use a multiple-delivery scheme (CCHP and ProCom) or a sectoral approach are less seeking of resident participants.

Despite these, integration and participation do not interrelate in a simple one-to-one correspondence. One explanation may lie in the fact that characteristics of the programs other than integration may provide independent influences on participation, or reinforce its effect. For instance, leadership by non-physicians may be more open to citizen penetration of health programs. This is perhaps because the ordinary person would not be put off by the assumed expertise of the other participants (CF. Altensletter and Bjorkman, 1979). Administration by non-physicians may not, however, necessarily bring about citizen control, since in the sample, ProCom which does not have a single medical professional in Teresa, still was not able to generate a lot of citizen involvement.

Another factor that affects actual participation is the program's orientation or philosophy. When programs regard themselves as service-providers solely and when what is to be delivered is judged to be adequately determined by program officials, the articulation by clients or target beneficiaries of their needs and demands are unlikely to be sought. Thus the program's rhetoric favoring participation should be accompanied by an actual listening to felt needs; the test of their acceptance of its significance is to produce a big body of involved community residents.

Citizen participation had been found to be most satisfying if the citizens become involved in as many phases as possible, including planning, implementation and evaluation. This is illustrated by both Makapawa and Sudtonggan which are also the areas in which the highest levels of satisfaction in participation are expressed.

Aside from program characteristics, certain attributes of the people push them towards participation. In studying the effects of educational background on actual involvement, the findings state that persons with high educational attainment perceived the need for participation and actually became involved in Teresa and Sudtonggan. This is perhaps because higher educational levels enable them to better understand the purpose and methods of the project. This is reinforced by the activeness of high-income holders in Bay, an area whose program does not seek out citizens except as passive recipients or trainees. Fur-

thermore, employed persons are more inclined to be involved as shown by Pilar and Bay respondents. The lesson from these is that participation, if it is desired, would be an elite affair unless, as in SHDP and Makapawa, active recruitment of poor families for the participative roles is undertaken. There should be no lack of takers because the surveys also found that a very large number of respondents believe that their participation is necessary for the successful planning, implementation and evaluation of social programs.

Chapter XI

THE EFFECTIVENESS OF THE PROGRAMS

Ledivina V. Cariño and Ma. Lourdes S. Joves

How have the people and their communities been served by the five programs under study? This chapter will assess program effectiveness through an analysis of information from both the program administrators and the client-communities. Three indicators of effectiveness can be extracted from program documents, namely: (1) the congruence of program activities with people's needs; (2) comparison of targets and accomplishments; and (3) changes in community health conditions. As gauged by the household surveys, effectiveness from the perspective of the beneficiaries and the community at large include the following; (1) the people's awareness of the program; (2) program coverage; (3) the benefits specifically received by the poor; (4) the access to the programs during illness; and (5) various indicators of the level of satisfaction.

After a discussion of how the programs rate on each of these, we will attempt to link the results with the integrative, participative and other qualities of the programs which we have tackled in earlier chapters.

Administrative Measures of Effectiveness

The indicators used here cover data gathered by the programs in routine annual reports, budgets and the like. While these are all useful for internal monitoring and control purposes, the raw data were not always gathered. When collected, they were rarely analyzed for purposes of effectiveness by the program managements. This is true even in the two programs - SHDP and Makapawa - which are quite conscious of the importance of evaluation. For this reason, we faced the absence of vital information, discrepancies of data with each other and inadequate records management - the usual bane of researchers using secondary data. In addition, comparison across programs is further rendered difficult by the following factors: (1) Statistics kept by the different programs vary; (2) Each had different baseline years and situations; (3) Time periods for outcomes and impact are very short for SHDP, ProCom and Makapawa; and (4) They undertook diverse activities in each community. One must also bear in mind that the statistics used here were given by the programs themselves. Hence, the desire to get and present comprehensive comparative data was not fully met. The discussion that follows therefore is indicative of results of program outputs rather than definite judgments along an effective-ineffective dichotomy.

Responsiveness of the Services to Needs

Program effectiveness may be measured in terms of whether or not the

needs served are congruent with the actual needs of the community. There are no hard statistics here to show this congruence and relevance. As a surrogate indicator, it may be mentioned that Makapawa, ProCom and Sudtonggan have each conducted a survey to determine the needs of the people before launching their respective programs in the community. The ProCom preliminary municipal survey (based on secondary data and ocular inspection) revealed that malnutrition, low food production, and poor waste and garbage disposal are the foremost problems in Teresa. The ProCom staff then convinced the people and the town officials of the need for an integrated approach that works on the principle of self-reliance to solve these problems. Hence, the final launching of ProCom in Teresa was justified on the basis of the community's need for those particular services.

The Makapawa program, too, operates within a very flexible structure where health serves only as an entry point, while other activities may be undertaken in answer to the other (non-health) problems of the residents. Thus, irrigation problems, income-generating activities, installation of water pumps, repair of chapels, political re-orientation, and religious nourishment have been done to meet the people's needs. Note, however, that when health care which they were professionally prepared to render did not surface as a major need of the people, the Board decided to introduce the Makapawa personnel as medical professionals, thus increasing the salience of the health aspect for the people.

In Sudtonggan, the identification of needs was more formal and was sought through a "consult." A number of community representatives together with some local (both from public and private sectors) and foreign consultants met for one week to define and operationalize their vision of Sudtonggan's future. More specifically, the consult participants identified the community's needs and the constraints to their fulfillment and combined these to draw up practical projects as well as concrete steps and structures to implement the proposed projects. In effect, the Sudtonggan Human Development Program was established in response to the community's needs as perceived and prioritized by the people themselves. Hence, the services provided by the program are what the clients see as really necessary for their progress and development.

The illustrations above tend to indicate that as far as these three programs (ProCom, Makapawa and SHDP) are concerned, the respective services they provide answer the real felt needs of the community residents, and as such tend to enhance program effectiveness. Although neither the RHU and the CCHP felt the community's pulse as to their priorities, this does not imply that their concentration on health services was not responding to basic needs of the community since a look at Pilar and Bay's health conditions, after several years with these programs, would still provide an immediate objective measure of need. Community surveys appear to be merited in cases where the program is ready to deal with a variety of activities and is also willing to let the people's definition of their priorities be the controlling force.

Comparison of Targets and Accomplishments

The Sudtonggan and Makapawa projects do not set targets for volume of activities or services to be provided nor for the number of people/clients to be served; hence, only ProCom, CCHP and the RHU programs can be discussed in this section. Even for these three programs, setting of targets is not done for all services rendered. ProCom, in particular, sets targets for certain activities and clients to be reached but these do not parallel data on the corresponding accomplishment reports. For instance, the Action Plan for 1979 aimed to conduct sanitation campaigns specifically for 439 families found to be resorting to unsatisfactory garbage disposal and 414 families found to be using non-watersealed toilets. However, annual reports present data on the results rather than the actual accomplishment or progress of such activity - i.e., number of households using satisfactory toilets and garbage disposal. Accomplishments then cannot be compared to targets, thus making it difficult to assess effectiveness using this indicator.

For the RHU program, tentative targets are set at the Regional Health Office (RHO), which are modified at the provincial level to suit local conditions. For the year 1979, the performance of the RHU in Pilar vis-a-vis targets was very satisfactory in such services as immunizations and medical consultations; satisfactory in the number of births attended to by the RHU staff and pre-natals registered; and below satisfactory in dental health services. Performance exceeded targets in other activities like pre-natals visited at home, family planning acceptors, and medical treatment. The below-par performance in dental health services can be explained by lack of dental equipment and the fact that the services of the dentist are shared with other towns close to Pilar. Nevertheless, the general performance of RHU services vis-a-vis targets can be regarded as more than satisfactory, considering the fact that the targets used as benchmarks were those made at the regional level. Hence, the RHU program, despite limited resources (e.g., medical supplies) and some administrative problems, is effective in terms of serving its target clients.

In providing health services to the community, the CCHP is guided by targets set for activities jointly undertaken with the RHU. Some of these were more than met as in pregnancies seen or followed up in 1978 and 1979, infants immunized in 1978, pregnant women given tetanus toxoid vaccinations in 1979, pre-schoolers weighed in 1979; while others fell short of the planned targets, as in construction of water-sealed toilets in 1978 and 1979 and vaccinations for pregnant women in 1978.

Based on these figures, there is no clear pattern to prove the program's effectiveness in being able to reach and serve its targets.

Changes in Community Health Conditions

For any health program, an almost preordained measure of effectiveness would be whether or not the area has improved its health situation during the

period the program has operated in the community. In Pilar, the RHU's territory, vital statistics show a general improvement in general health conditions (Table 11.1). This includes a decrease in crude death rate and infant mortality since 1968, and in the incidence of leading diseases in the area including gastroenteritis and pulmonary tuberculosis. Not only are the rates decreasing, but they are now all at a level below national averages. This improvement can at least be partly attributed to the RHU activities. For instance in 1979, it gave 983 immunizations, examined 547 cases for TB treatment, handled 71 percent of the 370 registered births and advised 96 acceptors and 1,015 users of family planning, not to mention 4,293 cases of medical consultations and 17,758 of treatment.

In Bay, the changes since CCHP was launched are even more striking, as Table 11.2 shows. Cases of upper respiratory tract infections (URTI), intestinal parasitism, gastro-enteritis and pulmonary tuberculosis (PTB) have decreased dramatically to the point that the first two mentioned which were ranking 1 and 3, respectively, as leading causes of illness in Bay in 1967 have disappeared from the top ten list in 1979. Likewise, infant mortality and crude death rates have decreased and are now also lower than the Philippine level. It may, however, be mentioned that prevention of disease may not be making as dramatic a headway, if the increase in number of adequate toilet facilities will be used as indicator: in 1968 households with adequate facilities comprised 41 per cent of the total, and it was only up to 46 per cent in 1978.

Table 11.1

General Health Conditions in Pilar, Bataan, Selected Years

	1969	1979
Birth rate	25.2/1,000	19.9/1,000
Crude death rate	6.5/1,000	3.6/1,000
Infant mortality rate	53.3/1,000	32.5/1,000

Leading Causes of Morbidity	1978 Rank	1978 Rate per 1,000	1973 Rank	1973 Rate per 1,000
Gastroenteritis	1	31.93	2	5.5
Brochitis	2	17.9	1	6.6
Influenza	3	9.3	3.5	1.7
Pneumonia	4	1.1	3.5	1.7
P.T.B.	5	1.0	5	1.1
Measles	6	1.0	6	.4
Malignant Neoplasm	7	.33	7	.22
Non-TB Meningitis	8	.1		

Source: RHU, Vital Health Statistics, 1973-1979
Pilar, Bataan

Table 11.2

General Health Conditions in Bay, Laguna, Selected Years

	1968	1966	1979
Birth rate	29.4/1,000	28.2/1,000	30.6/1,000
Death rate	7.9/1,000	4.4/1,000	2.7/1,000
Infant mortality rate	59.3/1,000	40.3/1,000	41.0/1,000

Source: 1966 Annual Report of MHO to PHO, MOH
Comprehensive Community Health Program Health
Sciences Center, Bay, Laguna. Hand-out, 1979

Leading Causes of Morbidity	1967 Rank	1967 Rate per 1,000	1979 Rank	1979 Rate per 1,000
URTI	1	949	*	11.2
PTB	2	318	5	
Intestinal parasitism	3	275	*	
Wounds	4	259	*	
Gastroenteritis	5	202	2	59.8
Pneumonia	6	160	1	136.8
Hypertension	7	140	*	
Bronchitis	8	129	*	
Tonsilitis	9	107	*	
Peptic ulcer	10	95	*	
Influenza			3	48.1
Measles			4	14.4
Mumps			6	3.6

*Not a leading cause of illness in 1979. Table includes all diseases accounting for more than one sick person per thousand in 1979.

Source: CCHP Documents

Again the burned SHDP baseline records do not allow an exhaustive comparison of health conditions before SHDP and at present except for some indicators as shown in Table 11.3.

Table 11.3

Health Indicators, SHDP, 1975 and 1979

	1975	1979	Percentage (Decrease)
Yearly Births	49	30	(39%)
Yearly Infant Death (age 0-2)	12	2.5	(80%)
Severely malnourished (age 0-6)	85	25	(61%)

Source: Institute of Cultural Affairs. "Emergence of a Human Village: Documenting the Development of Sudtonggan, 1976-1980." May 1980.

These drastic decreases in the number of yearly births, infant deaths and severely malnourished children are but small indicators of the achievements of SHDP for the health of Sudtonggan. Some of the concrete accomplishments of SHDP include: (1) building of a health clinic, equipped with medicine and staffed by health-trained Sudtonggan residents: (2) training of mothers as health guardians of the family and the community; (3) establishment of the Early Learning Nutrition Center and infant feeding classes to supplement and improve nutrition habits; and (4) installation of 25 covered wells as source of uncontaminated water for the community.

In Liwayway, although the Makapawa conducted a pre-entry survey to determine the overall health and economic condition of the community, these program statistics were still not available as of the time of the survey. Figures from the Provincial Health Office for Barangay Liwayway were also unavailable.

One available statistic is the 1979 death rate which is 11.55 deaths per thousand population. This is still definitely higher than the average for the entire municipality of MacArthur for 1979 which is 6.80/1000. The sample statistics for Liwayway as far as number of deaths is concerned is fairly accurate.

PROCOM does not deal directly with total health care, but focuses on nutrition. Using one ProCom source, there has been no change in second and third degree malnutrition in Teresa between 1976 and 1979, the level being 30 per cent and 20 per cent of children below six, respectively. Using another set of

data provided by ProCom, the change would be from 5.4 per cent in 1976 to 2.4 per cent in 1979 for second degree malnutrition, with third degree malnutrition in 1979 given as 7.16%.[22] If the second source is to be believed, the trend is towards an improvement of the nutritional state, attributable in part to the ProCom's involvement in deworming, provision of food assistance and lectures on, and commodity assistance for, home gardens since nutrition has been its particular focus. However, the state of the record-keeping leaves a lot of room for doubt.

Given program statistics then, three programs — RHU, CCHP and SHDP—can definitely trace the improvement of some community health conditions at least to some extent to their interventions. Hopefully, ProCom and Makapawa may be achieving the same results but statistical data currently available are not enough to confirm this with definiteness. For this reason, we will rely heavily on the results of the surveys in an attempt to judge the program's effectiveness.

Effectiveness from the Beneficiaries' Perspective

To supplement information from the programs we sought the opinion of the respondents in the sample sites to provide us their own evaluation of the programs. Some queries, such as those on satisfaction, gave the respondents a chance to directly give their opinions and attitudes regarding the program in their village. Before this was done, however, those who were not aware of the program, or if they knew about it, never availed of its services, had to be screened out. These preliminary questions provided clues to the program's effectiveness, although the respondents were not yet asked to render judgment on the program.

Awareness of the Program

Before the community can evaluate the program, the people must first be aware of its existence. Although knowledge about the existence of a program would not necessarily mean that the program is effective, the level of awareness may be regarded as the bottom line, the first step towards a possible acceptance or rejection. Among our programs, the best known is the Rural Health Unit in Pilar, followed closely by the Liwayway Makapawa and Sudtonggan projects, then the CCHP at Bay, and finally ProCom in Teresa, as a rather distant tail-ender. The popularity of the RHU is understandable, since as the regular government program which has outreach stations throughout the municipality, it has existed the longest. The ranking of the two barangay programs is also not surprising since they have headquarters in the barangays themselves and are thus visible to the barrio people. The moderate popularity

[22] This is not the only instance of discrepant figures. Statistics on garbage disposal systems and toilet facilities also show conflicts. Annual reports also tend to look like "replays," for circulation as nice monographs rather than for serious study.

of the CCHP may be traceable to its peculiar relationship with the RHU at Bay, which has made it difficult for the target beneficiaries to accord it a definite identity which could then clearly separate it from the Ministry's regular clinics. ProCom's relative anonymity may also stem partly from its multi-agency approach since few activities carry the name "Project Compassion." Another explanation may lie in the fact that ProCom renders very little direct service except training and organization of families.

Awareness appears to be related to the program's accessibility. The strength of this variable is highlighted by the fact that areas where the program operates have more aware respondents than those which are not sites of the programs. Thus, all three of the RHU samples, the Poblacion and far-barangay of CCHP-Bay, the poblacion of Teresa (for ProCom) and the two barangay-based programs have comparable high figures. Lower levels of awareness are manifested in areas without direct access to service sites. (See Table 11.4.)

Table 11.4

Awareness of the Program, By Sample Site

Sites	Percentage Claiming Awareness of Project				
	Poblacion	Near Barangay	Far Barangay	Entire Area	rank
Pilar (RHU)	84	100	91	92	2
Bay (CCHP)	85	68	78	76	4
Teresa (ProCom)	74	46	58	59	5
Liwayway (Makapawa)	-	-	-	89	3
Sudtonggan (SHDP)	-	-	-	97	1

Source: Household Surveys

The Coverage of the Programs

What proportion of the people benefits from the programs under study? Table 11.5 shows that the cases appear to be categorized by their degree of coverage into three groups - the SHDP and Liwayway Makapawa in the first, CCHP and the RHU at Pilar in the second, and Teresa's ProCom at the other extreme. Except for the exchange of positions of Makapawa and RHU, this

result is closely related to program awareness. Moreover, the first group's overwhelming coverage appears to manifest that community-based programs are more likely to deliver services on an intensive basis. This is not a simple function of access or small size of the area because an analysis of the results by barangay does not show that the poblaciones have particular advantages over other program sites in this regard. Rather, what seem to be decisive are: (1) the commitment of the program to participation, (2) the active nature of the delivery, and (3) the extensiveness of the services available.

Let us discuss each of these in turn.

1. **The program's commitment to participation.** It may be no coincidence that the programs leading the array in Table 11.5 are two of the three programs committed to involving the people. In the case of these two, the choice of what activities to pursue came from an attempt to feel the people's pulse. For the SHDP, it was through the "Consult," while for Makapawa, it was through a longer "social preparation." On the other hand, the ProCom's activities in Teresa, while also seeking people's participation, were based on the assessment of needs by program officials.

Table 11.5

The Clientele Coverage of the Programs

Sites	Recipients as percentage of Total Respondents	
	At Municipal Level	**At Barangay Level**
ICA/SHDP (Sudtonggan)		97.9
Makapawa (Liwayway)		93.8
RHU (Pilar)	77.8	
1. Poblacion		45.8
2. Near		94.3
3. Far		74.6
CCHP (Bay)	72.5	
1. Poblacion		85.3
2. Near		67.5
3. Far		64.7
ProCom (Teresa)	54.8	
1. Poblacion		65.5
2. Near		46.1
Far		52.2

Source: Household Surveys

2. **The active nature of the delivery.** We have already noted that the RHU is agency-based, with persons needing services having little choice but to initiate their incorporation into the service delivery system by going to the clinic, calling for a doctor, etc. This is also true of ProCom. Where ProCom tries an active stance, it is usually to get people involved in training, an organizational strategy which is planned from above with little push from the people. While CCHP is also agency-based, the fact that its large staff composed of students will be evaluated on community medicine, seems to encourage more community work than would otherwise be the case with full-fledged medical professionals.

For Makapawa and Sudtonggan, residents are sought — delivery is effected by neighbors who make home visits and the like, and their involvement where it involves training are in projects for which the people have expressed a need. In Makapawa's case, the strong emphasis on preventive medicine and learning from the practices of the people has made it almost imperative for the program to seek out beneficiaries rather than the other way around.

3. **The variety of the available benefits.** Earlier, the program concepts showed that three of the programs integrate beyond-health activities, while CCHP and RHU concentrate on health services (with the former adopting a multiagency approach). The empirical documentation of this differentiation in integration is shown by the numbers and kind of services reportedly being received by beneficiaries. In the survey, the respondents were given a list of services claimed to be provided by the program. Each of them was also asked which benefit they have received. Respondents then say which service they have availed of regardless of frequency or regularity. The lists are reproduced in Table 11.6 to give the reader some idea of the range of services provided by the five programs.

In Table 11.7, the number of services claimed to be received by the respondents is shown. Here, it can be observed that the program delivering the most services is also the most integrated. That is, the SHDP spreads benefits over health, economic and social aspects on an almost equal basis. Teresa's ProCom beneficiaries also receive a wide variety of services but the non-health benefits are much fewer. Makapawa is third, with health services predominant and economic benefits not widely enjoyed. The other two programs, as expected, offer exclusively health services.

Table 11.6

Services Provided by Each Program, By Type of Service

A. RHU and CCHP

RHU Health Only	CCHP Health Only
1. Disaster control/first aid	1. Consultation in clinics
2. Pre-natal/post-natal services	2. Home visits
3. Training of hilots	3. Pre-natal/post-natal services
4. Control of communicable diseases	4. Deworming
5. Dental services	5. Control of communicable diseases
6. Environmental sanitation (Campaigns, construction of toilets, wells, etc.)	6. Dental services
7. Laboratory services	7. Health Education
8. Supervision of food and medicine	8. Training of BHWs/hilots
9. Health Education	9. Family Planning
10. Nutrition Education/Operation Timbang	10. Operation Timbang
	11. Nutrition Education
11. Family Planning	12. Environmental sanitation
12. Giving of medicine	13. Construction of toilets
	14. Giving of medicine
	15. Treatment of poultry/livestock

B. Project Compassion

Health	Economic	Social
1. Health Education/First Aid 2. Control of communicable diseases 3. Giving of medicine 4. Deworming 5. Dental services 6. Family Planning a) lectures b) distribution of contraceptives c) pre-natal/post-natal services 7. Nutrition a) Giving of nutritious foods b) Lectures on cooking & feeding c) Operation Timbang 8. Environmental sanitation a) Lectures on garbage disposal b) Construction of toilets c) Distribution of toilet bowls d) Construction of artesian wells	1. Green Revolution a) Backyard gardening b) Distribution of seedlings 2. Income-generating activities a) Cottage industries b) Poultry and livestock raising	1. Leadership training a) Mother's Club b) Family Ilaw Training c) Day Care (MSSD)

C. Sudtonggan Human Development

Project Health	 Economic	 Social
1. Health center services (FP, nutrition, etc.)	1. Rock industry	1. Early learning nutrition center
2. Health caretaker services (Monitoring and home visits)	2. Craft industry	2. Elementary school
3. Health and nutrition (education/lectures)	3. Buri industry	3. School aide services
4. Infant feeding program	4. Savings account program	4. Adult education/vocational training program
5. Mothers' class	5. Cooperative farming	5. Advance technical training program
6. Environmental sanitation/ beautification		6. Water supply system
7. Toilet construction		7. Electrification services
		8. Community improvement/construction

D. **MAKAPAWA**

Health	
1. Treatment and control of diseases	7. Preparation of herbal medicines
2. Home visits	8. Referral of patients
3. Consultation in clinics	9. Maternal and child health care
4. Training of paramedics	**Economic**
5. Mothers' class	1. Food production through vegetable garden
6. Sanitation campaigns	2. Income-generating activities

Source: Program-documents

Table 11.7

Kind of Actual Services Received By Target Beneficiaries

Projects	Types of Services: **Health** Average Kind of Services per household	**Economic** Average Kind of Services per household	**Social** Average Kind of Services per household	**Total** Average Kind of Services per household	**Rank**
Pilar (RHU)	4.9	0	0	4.9	5
Bay (CCHP)	6.6	0	0	6.6	2
Teresa (ProCom)	4.7	.2	.5	5.4	4
Liwayway (Makapawa)	6.9	.4	0	7.3	1
Sudtonggan (SHDP)	2.0	1.3	2.7	6.1	3

Source: Household Surveys

Variety, however, encompasses not only integration across sectors. Although the SHDP has an even distribution of the type of services it offers, one notes that it has a low average in health benefits per household. This is not necessarily to be criticized. It may be recalled that of the five cases, only the ICA-sponsored program does not use health as its primary focus or entry point. Meanwhile, the Liwayway Makapawa and CCHP are shown to offer the greatest number of health services per household, followed by the Teresa ProCom and the Pilar RHU.

What needs explanation, however, is the fact that SHDP is only third in total benefits per household. This represents an understatement because the economic and social services it provides are long-term rather than oneshot treatments. Examples are employment in the buricraft industry and enrolment in the Early Learning Nutrition Center. Thus, it is able to help a client along many areas of need in a continuous manner. Meanwhile, it may also be noted that a wide variety of activities which allows a client to enjoy various health services can make a program achieve a strong impact on individual persons, even if no other part of their daily living is affected.

The Benefits Received by the Poor. Do poorer households benefit most from the programs? Table 11.8 shows that the answer to this query appears to be negative. Bearing in mind that the floor for the highest income group in our sample is only ₱1,500 and thus not necessarily affluent by Manila standards, one is still surprised by the obvious facility with which members of this category are able to avail of program benefits.

This is most evident in Bay, Laguna, particularly among those who live in barangays outside the poblacion. CCHP's apparent favor for the higher income groups may be explained by the fact that this is the only program under study which charges fees for its services in the infirmary and hospital. While the rates are minimal, it would nevertheless tend to make the services more accessible to those who have cash over the very poor. This point will be discussed again in the explanation of satisfaction levels and sources.

It may be observed that in Liwayway and Wawa, Pilar's near-barangay, services also tend to increase as one goes up the income ladder. However, differences between groups are small and the programs are marked by a high average number of benefits received. Thus, it may not be fair to read an apparent discrimination against the poor in these cases.

In Teresa's near-barangay, Bagumbayan, services also tend to increase with higher income, a finding that is the exact opposite of the result in its poblacion and far-barangay. In the latter, it is the poor who tend to receive slightly more services. This positive result may be due to ProCom's emphasis on activities which check malnutrition, certainly a poor family's plague. ProCom also gives out contraceptives, nutrition-rich foods, seeds and medicine, all of which are welcomed particilarly by indigent households.

In Sudtonggan and Pilar's Poblacion and far-barangay, it is the middle group which receives more services, though again not significantly more than those for the other two groups. Nevertheless, what stands out in this comparison is the fact that in cases where the poorer groups are the main recipients, their benefits are not more pronounced than those availed of by the higher-income groups. On the other hand, in Bay which is the only site where benefits increase with income, the rich had a definite advantage over the other two income groups. This suggests that the very poor have not been the chief beneficiaries of the programs under study although four of them aim to redress existing imbalances in the first place.

No program stands out in devoting more energies to serve the poor, although the higher number of services particularly in Liwayway, Pilar and even Bay can manage to insure that all groups can avail of many important health services.

Table 11.8

Average Number of Type of Health Benefits Received, By Income Groups and Sample Sites

	Pilar	Bay	Teresa	Liwayway	Sudtonggan
Poblacion					
Low Income	4.8	4.4	4.3		
Middle Income	5.3	5.4	3.5		
High Income	5.1	5.6	3.4		
Near					
Low Income	5.8	6.6	2.4		
Middle Income	7.0	9.6	4.1		
High Income	7.2	11.3	5.0		
Far					
Low Income	3.4	7.6	5.3		
Middle Income	3.8	5.9	4.9		
High Income	3.5	13.0	4.4		
Total					
Low Income	4.6	6.3	4.1	6.1	1.8
Middle Income	5.7	6.0	4.0	7.1	2.3
High Income	5.5	6.9	4.3	7.5	2.2

Source: Household Surveys

Access to Program During Illness

One index of the effectiveness of health programs is the people's access to it when they seek care due to illness. The cases studied are not equally equipped to provide this service. The RHU in Pilar and CCHP in Bay have regular personnel and facilities for treating persons brought to them for treatment, while Makapawa in Liwayway has a mobile health team which comes once a week and a trained health worker who lives in the community. The SHDP is visited by a physician or nurse from the Lapu-Lapu City Health Office who comes once or twice a week. On other days, Sudtonggan has a health caretaker at the clinic who keeps family medical records. This caretaker, however, is not a paraprofessional in the level of Makapawa's CHW or CCHP's BHT. The residents may also seek treatment from Opon Emergency Hospital, Cebu Institute of Medicine and the City Health Office with which the program maintains an affiliation. The ProCom does not have any arrangement for providing direct health care.

In the household survey, respondents were asked if any member of their family had gotten sick in the last twelve months and if so, from what institution treatment was sought. Responses were differentiated as to whether attention was given by program personnel, the RHU or some other medical practitioners or facility (clinics, hospital); by traditional doctors such as *arbularyos* (herb doctors) or *hilots* (midwives or massage healers); by other alternatives such as self-medication, application of herbs; or in some cases (mentioned only in Liwayway) by *"kulam"* (sorcery or witchcraft). Differential access of income classes to the programs were not made because of the small sample sizes when cross-tabulated with the type of medical attention received.

Table 11.9 shows that in all the sample sites, physicians, nurses and midwives from private clinics, government or private hospitals, and other institutions were the most frequent source of treatment, especially in Pilar. In the Poblacion and the near-barangays, an average of 1.5 visits to/from these personnel per sick person was reported.

In Pilar where the case-program is the RHU, reliance on it was highest in the far-barangay, diminishing as one goes nearer the poblacion. However, traditional doctors held court most frequently at the far-barangay (where that was expected) and the center (where it was not expected), competing with the RHU itself in the latter. In Bay, the CCHP and the RHU appear equally important at the center of the municipality where both maintain clinics. They change places in the barangays, depending on which program has an assigned personnel there. However, it may be noted that although there is no barangay health technician (BHT) in the near-barangay, the CCHP was able to serve it just half as much as the RHU, perhaps because its residents went to the poblacion for treatment. In the farther barangay where access to the center is more difficult, almost a fourth relied on the CCHP's paraprofessional. Her presence in the village may also account for the nearly negligible visits to traditional doctors in this area.

ProCom has no facilities for direct health care. Reliance of Teresa residents on private practitioners is next only to Pilar. It is however disturbing to find as much reliance on traditional doctors in a relatively urban area as in this town.

Table 11.9

Source of Health Care for Sick Members By Program Site

A. Pilar

Sources of Health Care	Poblacion No.	Poblacion Percent Sick	Near No.	Near Percent Sick	Far No.	Far Percent Sick	Total No.	Total Percent Sick
Program (RHU)	28	18.8%	39	37.1%	37	56.1%	104	32.5%
Other professionals	230	154.4	160	152.4	57	86.4	447	139.7
Traditional doctors	33	22.1	46	4.4	30	45.4	109	34.1
Other alternatives	25	16.8	6	5.7	8	12.1	39	12.2
No. health care received	0		0		0		0	0
Total sources	316		251		132		699	
Total sick persons	149		105		66		320	
Average sources used per sick person	2.1		2.4		2.0		2.2	

B. Bay

Sources of Health Care	Poblacion No.	Poblacion Percent Sick	Near No.	Near Percent Sick	Far No.	Far Percent Sick	Total No.	Total Percent Sick
Program (CCHP)	34	26.6%	19	14.8%	32	35.9%	85	24.6
Professionals	(33)	(25.8)	(19)	(14.8)	(9)	(10.1)	(61)	(17.7)
Paraprofessional (BHT)	(1)	(0.8)	(0)	(0)	(23)	(25.8)	(24)	(6.9)
RHU	37	28.9	38	29.7	7	7.9	82	23.8
Other professionals	24	18.8	48	37.5	64	71.9	136	39.4
Traditional doctors	15	11.7	14	10.9	2	2.2	31	8.9
Other alternatives	35	27.3	14	10.9	9	10.1	58	17.9
None received*	0		4	3.1	0		4	1.1
Total sources	145		137		114		396	
Total sick persons	128		128		89		345	
Average Sources per sick person	1.1		1.0		1.3		1.1	

C. Teresa

Sources of Health Care	Poblacion No.	Poblacion Percent Sick	Near No.	Near Percent Sick	Far No.	Far Percent Sick	Total' No.	Total' Percent Sick
Program		n.a.		n.a.		n.a.		n.a.
RHU	7	6.4%	6	6.8%	0		13	5.0%
Other professionals	90	81.8	73	82.9	52	86.7	215	83.3
Traditional doctors	19	17.3	14	15.9	25	41.7	58	22.5
Other alternative	9	8.2	1	1.1	11	18.3	21	8.1
None received	0		0		0		0	0
Total sources	125		94		88		307	
Total sick persons	110		88		60		258	
Average sources/sick person	1.1		1.1		1.5		1.2	

D. Liwayway and Sudtonggan

Sources of Health Care	Liwayway No.	Liwayway Percent Sick	Sudtonggan No.	Sudtonggan Percent Sick
Program	30	30.6%	5	4.7%
Professionals	(28)	(28.6)	(5)	(4.7)
Paraprofessional	(2)	(2.0)	(0)	
RHU/City Health Office	10	10.2	2	1.9
Other professionals	33	33.7	75	70.8
Traditional doctors	17	17.3	10	9.4
Other alternatives	33	33.7	27	25.4
No health care received**	10	10.2	0	
Total sources	133		119	
Total sick persons	98		106	
Average sources used per sick person	1.4		1.1	

Source: Household Surveys

Note: Multiple responses allowed. Percentages are based on total number of sick persons.

*Program in Pilar is the RHU.

**Figures in this row are not included in total sources availed of but are in total number of sick persons.

In many ways, the medical treatment picture in Liwayway is the worst in the sample since:

1) It had the biggest proportion of sick people who were not taken for treatment at all;

2) It is the only area mentioning sorcery as an alternative curative measure;

3) It had the smallest proportion assisted by the RHU and other professionals combined which are all outside the barangay. Because of this access problem, these physicians must have treated only those who could not be cured by other means. In this light, the ability of the Makapawa health team to reach almost a third of the sick is remarkable, considering that they are in the area at most once a week.

SHDP does not provide curative medicine except when visited by CHO personnel. This accounts for the low proportion who got assistance from SHDP. Unlike Makapawa, however, residents are encouraged to seek help from and have access to clinic and hospital facilities with which SHDP has affiliated. In a sense, then, most of the patients who received medical treatment were indirectly benefitted by the program itself. The relatively high proportion of residents using other alternatives also seems to be a program result (not necessarily positive): 20 of the 27 in this category mention self-medication, possibly using drugs available from the SHDP clinic itself.

To sum up: in all sample sites except Bay proper, the source that proved most available is the category "other professionals." This is in addition to care provided by the RHU and the programs themselves. This reliance on professional care more than on any other alternative may itself be an effect of the existence of health programs in these areas since the only comparable available figures suggest that medical attention, particularly in Pilar, would be much higher than in the rest of the nation (Pilar, Boncaras and Santos, 1976).

In terms of the programs themselves, the RHU in Pilar, CCHP and Makapawa have been able to treat sick patients in varying degrees, with the far-barangays in Pilar and Bay most dependent on the respective program than other areas within them. The SHDP contribution has been lower and more indirect in this regard.

One insight that may be drawn here is that the program's presence especially in the poorer barangays (e.g., San Antonio in Bay, Sudtonggan) may be able to draw households away from reliance on the untrained traditional healers to professional health care. This would be less true in areas like Liwayway and Pilar where efforts have been made to orient these *albularyos* into more scientific ways of treating sick people.

Another instructive point is illustrated in Bay and Sudtonggan where CCHP and the RHU in the former and the SHDP clinic and all other medical facilities in the latter seem to have been able to fill in for the other whenever the presence of facilities and/or expertise for either one is not there. Each appears to augur well for the possibility for different programs to provide complemen-

tarities rather than competition, a major reason for seeking an integrative approach. Although the programs have not necessarily worked out their territorial cooperative linkages very well, the people may already be doing that by seeking the closest or most appropriate facility available when needing treatment for illness.

Satisfaction

After getting an appraisal of the programs through indirect questions to the respondents, we now zero in on their responses when their direct evaluation is elicited. The queries here move from general statements of satisfaction/dissastisfaction to specific details of their reactions to program personnel and the factors that make for a positive or negative assessment.

Level of Satisfaction. Effectiveness can also be evaluated by asking respondents directly how satisfied they are with a particular program. The ratings range from "5" as "very satisfied" to "1" as "very dissatisfied." The programs as arranged by level of satisfaction are shown in Table 11.10.

Makapawa leads the programs while the SHDP ranks (lowest), though still at a level between "satisfied" and "neutral." Earlier, it was suggested that the SHDP's wide scope of services may render it superior to the others in ministering to the complex needs of individuals. It appears from these results, however, that more benefits in one aspect rather than a few extending through several areas are better appreciated by the community. Sudtonggan's relatively low rating may also be traced to the fact that with transition to self-management taking place, services at present are not handled as efficiently as they used to be. In addition, apprehensions regarding the departure of the sponsors may also account for this.

Table 11.10

Mean Level of Satisfaction Regarding Programs

Site	Program	Mean Level of Satisfaction
Liwayway	Makapawa	4.42
Bay	CCHP	4.08
Teresa	ProCom	4.06
Pilar	RHU	3.92
Sudtonggan	ICA/SHDP	3.59

Source: Household Surveys

Looking at the level of satisfaction by income groups (See Table 11.11), one discovers that with one exception, the income groups in all areas do not differ in their assessment of the program by more than 18 percentage points. One can say that based on the recipient's judgment, there is no marked class difference in treatment by the programs. The exception is Liwayway which had both low and middle-income groups enjoying the highest satisfaction level (92 and 100 per cent, respectively). The high-income category only had a 50 per cent level, though. However, high income earners numbered only two in the sample. Nevertheless, this may be indicative of a poor-biased approach that Makapawa actually ascribes to.

Another point to observe is that again except for one, the trend is for a higher proportion of the middle-income groups, relative to the other two, to report satisfaction. It has already been seen that they are not the recipients of the most number of services; thus this finding cannot be explained by relating it to the number of services received. The explanation may, therefore, lie in the tendency of many members of the middle income groups to participate in the programs. As such, they gain more understanding and can then be expected to be more sympathetic to programs even if they do not benefit substantially from them.

The only exception for this "peaking" satisfaction among the middle-income groups is Bay where proportionally more high income earners are satisfied than in any other site. Since the most participative of income groups in Bay are the high-income respondents, the explanation above would still hold. We may hazard a guess at still another reason: of all the programs under study, it is only CCHP which charges fees. These are for services given at its infirmary and hospital and are rather minimal. For the poor, the fees are just within reach but for the rich, they are very low relative to what they can afford. This may then put their level of satisfaction higher than that of the lower income groups. This explanation is bolstered by the fact that "equity" is most frequently mentioned as a source of satisfaction and "inequity" as the most frequent source of dissatisfaction in relation to the CCHP. Respondents citing it as a source of satisfaction commend the low fees and the fact that it is the same for everyone - implying that they are people who can afford the fees. On the other hand, respondents calling the CCHP "unfair" say almost the same thing - that they are charged the same fees for all, regardless of income, a complaint that is likely to come only from lower-income groups.

On the whole then, the programs have managed to please their constituents. In terms of income classes, generally the middle-income earners have been most satisfied, followed by low-income and then high-income families except for Bay, as earlier explained. This result tends to be related to the level of participation of income groups rather than the programs' behavior towards members of various income classes.

Table 11.11

Percentage Claiming Satisfaction with Program, By Level of Income

	Low	Middle	High
Pilar	83.5	88.3	70.8
Bay	86.2	88.2	92.9
Teresa	79.5	92.3	80.0
Makapawa	92.3	100.0	50.0
Sudtonggan	56.0	63.4	50.0

Source: Household Surveys

Satisfaction regarding Program Personnel. As a further check of both awareness and satisfaction, those who claimed to know of the program were asked to give the names and positions of administrators or staff members they personally know or know about. Asking about program personnel was a way of concretizing the referent of the responses based on the belief that Filipinos related to programs personalistically. Then this query was posed:

> Kayo ba'y nasisiyahan sa mga paglilingkod na ginawa ni __ __? [Are you satisfied with the services given by *(program personnel identified?)*]

Whether the answer was positive or negative, the next question was an obligatory open-ended probe: why or why not?

The main reason for this question was to get at the qualitative sources of satisfaction and dissatisfaction. However, the fact of providing an answer may in itself give a clue to the strength with which a given favorable or unfavorable attitude is held. Table 11.12 shows that for all areas except the barangays in Teresa, program personnel were sufficiently well-known so that a big majority of respondents used the opportunity to voice their assessments openly. This is a large proportion especially considering the difficulty of the question. The poor showing in Teresa jibes with the low level of awareness of the program shown earlier.

Table 11.12

Strength of Attitude Regarding Satisfaction With Program Personnel, By Program and Area

Sites		Poblacion	Near	Far	Total
Pilar	RHU	77.9%	97.7%	87.3%	86.2%
Bay	CCHP	76.2	63.3	76.5	71.6
Teresa	ProCom	71.1	47.2	55.2	58.1
Liwayway	Makapawa				83.5
Sudtonggan	SHDP				99.8

Note: Figures show percent mentioning sources of satisfaction/ dissatisfaction with program personnel to total respondents

Source: Household Surveys

The responses themselves echo the findings regarding level of satisfaction discussed in an earlier section. As may be observed in Table 11.13, overwhelming majorities give positive comments on the programs. The one exception is in Sudtonggan where only 59 per cent answering this question responded with statements favorable to the program. This finding then is a validation of the scale used in determining levels of satisfaction.

Table 11.13

Percent Offering Favorable Comments Regarding Program Personnel, By Program and Area

Sites		Poblacion	Near	Far	Total	Rank
Pilar	RHU	73.5%	90.7%	82.6%	81.7%	4
Bay	CCHP	88.0	92.1	82.1	87.3	2
Teresa	ProCom	90.6	88.1	78.4	86.7	3
Liwayway	Makapawa				93.4	1
Sudtonggan	SHDP				58.8	5

Source: Household Surveys

Sources of Satisfaction. In an attempt to gauge quality of the services offered, respondents were asked to give their own reasons for being satisfied/dissatisfied with the program under consideration. As mentioned earlier, answers were coded into seven evaluatory characteristics. (See Table 11.14.)

By far, most of the responses centered on adequacy of the service. The array is led by ProCom, followed by SHDP, CCHP, RHU and Makapawa. This relates to the perceived competence of the staff, the efficacy of the medicine they dispense, the solutions they give to particular problems, and the ampleness of the services they provide. In effect, this is the *sine qua non* of every program, specially one touching on such a basic need as health. The client's frequent voluntary mention of adequacy gives one confidence in the program themselves.

The second factor most frequently mentioned (in all except Liwayway where it comes a close third) refers to a person's way of relating to others. The prominence of this factor attests to the fact that Filipinos are personalistic and seek warmth - the human touch - in their transactions with even impersonal agencies. This seems to be a natural accompaniment to competence if a program is to succeed in relating to the community.

The third factor is accessibility, here comprehending not only physical availability but also the social ease of reaching the program personnel. The latter includes the fact that a physician makes house calls or can be roused even in the evening hours and thus always "near." Physical access should of course not be ignored. Accessibility in fact was most appreciated in Liwayway which is served by a community-based health program, and in Bay and Pilar where barangay health stations decrease the distance between a health clinic and the people.

The next three factors are rated almost equally in importance if one goes by the number of free mentions by respondents. These are equity, continuity and timeliness.

Equity is especially mentioned in Bay and Sudtonggan. The people satisfied in this regard cite that the personnel treat everyone equally *("hindi timitingin ng tao")* and charge the same fee for everyone. The latter statements refer to Bay only, since the other programs do not charge any fees.

Timeliness connotes the availability of the program at the time services are needed and is especially prized in Liwayway and Bay. Continuity underscores the availability of follow-ups in service. The absence of mentions for Sudtonggan for these two may be a reminder for the program to beef up on these dimensions.

Progressiveness is the least mentioned factor in all the programs. This brings to mind the oft-decried problem of the *ningas-kugon*[23] tendency in Filipino ex-

23"Flash-in-the-pan" tendency marked by great intensity and enthusiasm in the beginning, followed almost immediately by lukewarm responses.

perience with innovations. This may imply that the continued improvement of the programs over time is a missing element in all the programs.

Table 11.14

Sources of Satisfaction with Respective Program Personnel As A Percentage of Total Respondents, By Sample Site

Sources of Satisfaction	Pilar	Bay	Teresa	Liwayway	Sudtonggan	Overall Rank
Adequacy	78.7% (4)	91% (1)	97.6% (1)	62.7% (1)	95.7% (1)	1
Favorable relational qualities	36.7 (2)	34.2 (2)	31.3 (2)	31.3 (3)	43.5 (2)	2
Progressiveness	0	2.7 (7)	0		1.5 (6.5)	7
Continuity	0.5 (6)	9.2 (6)	1.2 (4.5)	4.5 (5)	0	5
Accessibility	14.5 (3)	20.6 (3)	1.2 (4.5)	34.3 (2)	2.2 (4)	3
Equity	1.9 (4)	14.7 (4)	0	1.5 (6.5)	4.4 (3)	5
Timeliness	1.5 (5)	9.8 (5)	2.4 (3)	8.9 (4)	0	5
Total number of responses	227	336	111	97	67	
Total number of satisfied respondents	207	184	83	46	67	

Note: Rank of factors in each program site given in parenthesis

Source: Household Surveys

Sources of Dissatisfaction. As seen in Table 11.15, a total of 61 respondents gave negative comments. This is a small proportion of the sample reflecting a generally high level of satisfaction relative to program personnel. Nevertheless, these remarks, because they are given by those who feel strongly against the program, should be studied as a clue to how program administrators can improve delivery of services. Pilar got the most remarks focusing on inadequacy and inaccessibility. Bay's negative comments centered on inequity and inadequacy, Sudtonggan's on inadequacy. The few remarks on ProCom were distributed along four dimensions.

We do not wish to dwell too much on this because of the small numbers involved. However, the following seem noteworthy: (1) Makapawa did not receive a single complaint; (2) The protests alluding to inequity in the CCHP partly reinforce the earlier findings that suggest that the rich may require a second look at the competence and manner of delivery of program personnel in those areas.

Table 11.15

Sources of Dissatisfaction with Respective Program Personnel, By Sample Site

Sources of Dissatisfaction	Number Mentioning Each Service Pilar	Bay	Teresa	Liwayway	Sudtonggan
Inadequacy	25	5	2	0	7
Poor relational qualities	6	1	3	0	3
Discontinuity	7	0	3	0	0
Inaccessible	12	0	0	0	0
Inequitable	7	7	0	0	1
Not timely	1	1	3	0	0
Not progressive	1	3	0	0	0
Total number of responses	59	23	9	0	11
Total number of dissatisfied respondents	38	12	4	0	7

Note: Multiple Responses allowed
Source: Household Surveys

A Comparison of the Effectiveness of Programs

Summary. Table 11.16 summarizes the standing of the programs along the measures of effectiveness. Bearing in mind that none of the programs actually rate as "ineffective" using any of the measures, some appraisal based on the ranking obtained is still called for. It can easily be observed that the Liwayway Makapawa has compiled the best record, appearing no worse than third (in level of awareness, when the percentage it got is very close to second-ranking RHU). It has provided the highest average number of benefits per household, whether it is reckoned only in terms of health or overall. Thus, although it is the highest income group that gets the most services, the wide clientele coverage, the big number of benefits received (not to mention the fact that preference for the high income group is not marked), and its ability to provide health care during illness all combine to give it a high effectiveness rating. The respondents reward its services with high satisfaction, measured both through its location along the continuum of satisfaction-dissatisfaction as well as in terms of remarks expressed in praise of program personnel.

The Sudtonggan program ranks second in effectiveness since it is the best-known program and its services have been received by almost everyone in the community. It has also been effective in improving the community's health status, particularly in dramatically decreasing the proportion of malnourished children. Even the fact that it is the middle-income group which has received the most benefits and which has appraised themselves as being most satisfied does not detract from this favorable appraisal, because this group of families is still quite poor in comparison to the entire Filipino population. Moreover, while it does not really have facilities for treatment, it has sought the services of nearby clinics to provide medical attention for its sick residents. What does detract from this fine estimate is the surprisingly low satisfaction towards the program expressed by its beneficiaries. This result may also be related to the finding of low participation discussed earlier; when people who are actually involved in decisions claim non-participation, there may be dissatisfaction with the way their decisions are being implemented. In addition, the low satisfaction may manifest the high expectations generated by dramatic changes in the initial years of implementation but which the program was unable to sustain over a much longer period (because high levels of fulfillment have already been attained). This may also be traced to the apprehensions of a community about the departure of sponsors. Such fears about independence is also manifested by the recipients after the ICA retires from the scene. This suggests that program administrators will first have to win the people's confidence in their ability to run the program independently since a community-based program like this cannot go on if people continue to be ambivalent about the program.

The third program in the list is the CCHP which has been effective in combatting various types of illnesses over its twelve-year existence in Bay. It is also second in the mean number of benefits given per household, and in the level of satisfaction of its beneficiaries. However, its achievements vis-a-vis its targets

Table 11.16

Rank of Programs along Various Measures of Effectiveness, By Program

	RHU	CCHP	ProCom	Makapawa	SHDP
Responsiveness of Services to Needs	Yes	Yes	Yes	Yes	Yes
Comparison to Targets Accomplishments	Satisfactory in all aspects with targets	Satisfaction in some areas	*	No targets made	No targets made
People's level of awareness	2	4	5	3	1
Clientele coverage	3	4	5	2	1
Number of benefits received per household	5	2	4	1	3
Who benefits most?	Middle	High (markedly)	Middle	High	Middle
Access to Program during illness	Good	Good	n.a.	Good	Poor (direct); Good (indirect)
Satisfaction level	4	2	3	1	5
Who are most satisfied	Middle	High	Middle	Middle	Middle
Number of favorable comments (rank)	4	2	3	1	5
Overall rank	4	3	5	1	2

*Change data not adequate or not available.

Source: Earlier tables in this Chapter

are not always satisfactory. Also, using the *cui bono* criterion, CCHP does not fare very well. The higher-income group appears to receive more benefits than the poorer people (low and middle-income levels). This is reinforced by the fact that the rich also register more satisfaction toward the program, and that remarks about equity are made as regards the CCHP in Bay. While there is no evidence that the poor had ever been turned away by CCHP, the results still cause one to ponder on the possible consequences of service which do not seek out the most needy group. Recalling the CCHP's standing on participation, it was also the higher-income group which claimed to have been most participative. Since involvement in CCHP is more in the nature of receiving services than the citizens working in behalf of others, this finding further underscores the *cui bono* problem.

The RHU is well-known in the community probably due to its long years of operation. It has generally reached targets it has set. Available vital statistics show that changes in community health conditions over time have been favorable, a fact that may account for the RHU's popularity in Pilar. In terms of proportion of people benefitted, it stands in the center of the five-organization array with many residents of the Poblacion and the far-barangay of Diwa claiming non-utilization of its services, despite their accessibility, an assertion belied however by Diwa's heavy reliance on the RHU at least for curative medicine. The number of benefits received also tends to be lower compared to the other programs, with all income groups receiving similar benefits (with a slight edge for the middle group).

The people's satisfaction with the RHU is fourth in the list, although still at the positive level. The middle-income group is the most satisfied. The rich are clearly not better served than this middle-income level since they (rich) receive less benefits and express lower levels of satisfaction.

Project Compassion is the fifth in the array. It is not clear from its statistics how successful ProCom has been in improving nutrition in Teresa but it has not, in any case, been successful in getting itself known. This is probably because a smaller proportion of the population benefits from it than from any of our other programs. We have explained this by looking at ProCom's service orientation which combines an emphasis on training seminars and on direct assistance to specific persons or families, activities which have individual rather than community-wide benefits. In addition, ProCom has focused on the creation of formal organizations as a major task, while officials decide on what projects should be undertaken in the area. These have resulted in a program that emphasizes citizen's involvement but which gets relatively low levels of participation from the community. The people have appraised ProCom favorably, but its clientele coverage and the benefits it has given have put it in the lowest rank.

Integration and Effectiveness

How then is effectiveness related to the two variables - integration and participation? There is no simple answer to this question. There seem to be certain

characteristics related to integration that push towards effectiveness. The single-agency delivery scheme of SHDP and Makapawa, absent in ProCom and CCHP, can be pointed to as one factor. In a sense, the modus vivendi of the CCHP and RHU at Bay, where health providers in each barangay come from either one of the programs and do not compete, is another example since at the village level, only one organizational network is in evidence. The fact that the RHU which is a single-delivery system has a low rank leads one to study another factor shared by the first two programs - beyond-health activities which answer the needs of human beings for physical, economic, social and even religious well-being. Integration, as mentioned earlier, has an ideological basis - i.e., that human needs are actually not disjunctive but systemic and require a holistic approach to their solution. Program effectiveness is expected to be enhanced because the interrelated needs of the individual can be reached and solved in one organizational network of services. The empirical confirmation of this is well-illustrated by the SHDP and to a lesser degree by Makapawa.

Integration also suggests itself when fragmented and discontinued provision of services that are actually intertwined prevents the prospective client from actually using or benefitting from the needed services, a possibility the ProCom's network and referral system tries to avoid. It thus increases the accessibility of services to their intended beneficiaries.

Despite the potential beneficial effects of integration, it may also bring about unintended consequences. For one, the comprehensive method of serving persons in need in the face of limited resources may actually force the project staff to concentrate on only a single or few components rather than the entire package. The CCHP is one example. It intended to extend services beyond the limits of health - namely agriculture, home economics, social work and community development, physical/occupational therapy - but it was not able to actually do these as a regular, purposive activity for some reason or another. In fact, some health functions like environmental sanitation and public health nursing are not accorded high priority.

The Makapawa, too, though formally aiming to deliver a comprehensive package of services to the people, is able to focus only on the health component and to respond to non-health matters only when the need arises. With regard to this problem, some issues thus remain to be settled: under what range or mix of services does integration operate most effectively? What size of a jurisdiction can a given package of interrelated services be efficiently provided and effectively utilized by its target clientele? The five cases provide different answers to these queries despite the general finding that integration is in many ways preferable to the sectoral approach.

In addition, integration, while seeking to remedy the problem of rivalry between or among agencies performing related functions, may actually bring about competition and jealousy and thus work against effectiveness. Two of the programs demonstrate this tendency. The CCHP has encountered difficul-

ty in gaining acceptance and credibility with some participating agencies. Or, since the CCHP services and medicine are availed of for a minimal fee while these are for free at the RHU, comparison by clients may put one or the other program in an unfavorable light.[24]

On another front, the two service agencies may compete for personnel because the CCHP medical staff receive higher pay than their RHU counterparts. As a result, many from the RHU staff including the former MHO of Bay have transferred to the U.P. unit.

The Makapawa in Liwayway, also, has had difficulty in coordinating with the RHU. To avoid possible competition or rivalry, a Memorandum of Agreement has been signed between the Makapawa and the Regional Health Office to define working relationships in the areas concerned. Despite this, however, the RHU did not coordinate very well with the Makapawa because it felt threatened perhaps by a new project/organization that seeks to encompass a broad range of services in solving the problems of the clients. Because the Makapawa has been able to respond to non-health problems of the community, more residents prefer to see the Makapawa health staff than the traditional (RHU) health providers. The Institute of Health Sciences also provides health services in the area, duplicating the health-related functions of Makapawa. In effect, two service agencies may compete for the same service users in one jurisdiction.

Still another unintended effect of integration may be lack of accountability and an increased organizational level between the recipients and the service providers. This is best exemplified in ProCom where the participating agencies deliver their services independently while the role of the ProCom level remains unclear. Is it better for people seeking sectoral services to go to ProCom staff as the coordinator of the services or directly to the concerned agency providing the service? Which agency is accountable to the clients - the sectoral agency or the coordinating body? Does the ProCom team leader actually coordinate the planning and provision of the supposed "integrated" services or does it collate only the reports on their respective achievements? These issues have to be settled to insure the effectiveness of programs that link a number of on-going services by different agencies, like ProCom does.

Participation and Effectiveness

It was mentioned earlier that integration seems to push towards participation and effectiveness. The experience of SHDP and Makapawa, both integrative and participating, bolsters that contention. In these cases, the service

[24]For instance, some community residents critical of the RHU in this regard criticize this as a "dole-out mentality which fosters dependence." On the other hand, anti-CCHP individuals call the charging of fees discriminatory against the poor.

users are motivated to participate in the affairs concerning them - in the planing, financing, delivery of services, and evaluation of a project that seeks to address the allied needs of the individual and the family, that treats human problems in their entirety and that professes to be accountable for the "total" development of the person. When service clients get involved in the project processes and activities that affect them, they are guaranteed access and accountability. Consequently, a participative service system is more responsive to recipient needs and demands than a system where decision-making is reserved only for professional persons.

However, ProCom's rating on effectiveness makes us moderate that statement by involving a type of citizen participation not apparent in Project Compassion's beyond-health integration and participative approach. In that program, administrators seem to already make judgments on what the people's needs are and use their formal organization and training programs as ways of getting the point across. In addition, ProCom's emphasis seems to be the assistance of individuals and the provision of services for persons in their individual capacities. This underscores the need to encourage not only citizen participation per se, but an involvement that relates individual actions to the corporate life of the community and which allows indigenous residents to set objectives for their community instead of delegating this by default or misunderstanding to program officials.

Another aspect of participation shown by the community programs is their attempt to seek out the poorer members of the community as formal and informal leaders of the program. However, it did not necessarily translate to this same group being better served than other community members. This may require another seeking out - this time not in terms of duties and responsibilities, but in terms of the benefits to be received. As earlier studies have shown, unless direct measures to serve the poor are made, programs will tend to benefit the richer individuals first, if only because their status, usual high education and leadership positions already make them more able to take advantage of whatever services are going to be made available.

Chapter XII

TOWARD MORE EFFECTIVE HEALTH CARE FOR THE POOR: CONCLUSIONS AND RECOMMENDATIONS

Ledivina V. Cariño

The earlier parts of this volume have described and compared five health delivery mechanisms as they have operated in as many locales in the country. This Chapter recapitulates our findings, draws our conclusions and puts forward our recommendations for the attainment of more effective health care, especially for the poor.

The areas chosen were: Pilar, Bataan; Bay, Laguna; Teresa, Rizal; Barangay Liwayway, MacArthur, Leyte; and Sitio Sudtonggan, Barangay Basak, Lapu-Lapu City. These areas differ in size of population, economy, occupational structure, level of development and health status conditions. Although they are not equally depressed, each houses families which are very poor and which can profit from innovative approaches to health care delivery. Except for the Rural Health Unit and the specific program present in each area, each sample area has no other facilities for medical care available to indigent members within their immediate geographic area. Again, except for the RHU site, each sample area was chosen because it was recommended by program administrators as a locale in which they have been successful in carrying out their projected activities.

Integration, Participation and Other Program Characteristics

The five programs were chosen initially on the basis of their differences along the variable of integration. The RHU is designated in this study as the "sectoral" program, while the other four have varying levels of integration. The first, the Comprehensive Community Health Program, integrates activities largely within the health sector only but uses a multiple-agency scheme, including the regular Ministry of Health System. The second, Project Compassion, links health with services in agriculture, population, environment and cultural and sports development and also uses more than one agency - the RHU, government agricultural agencies and private-sector groups.

Makapawa and the Sudtonggan Human Development Program are both community-based programs providing beyond-health services, and use a single agency for delivery. The Makapawa is a Catholic-run program which uses health care and medical professionals as entry points but its staff seeks to provide services in answer to whatever needs are felt in the community. By contrast, the Sudtonggan Human Development Program of the Institute of Cultural Affairs devotes itself to the administration of cottage and community

industries, education, nutrition and other social services, and community "celebrations" with health care as a small part of its over-all scheme. Health care is provided by health caretakers designated by the SHDP and personnel of the Ministry of Health and other medical facilities who come under the aegis of SHDP. Thus although the concept of integration in this study is limited only to two dimensions, there is still a lot of variation even within these two aspects.

The programs may also be contrasted by looking at their sponsorship, area of coverage, nature of activities, linkage with government, personnel, funding and program orientation. Using this scheme, the RHU can be described as governmental in sponsorship and funding, nationwide in scope, run by medical professionals, agency-based and using largely Western medical methods and strategies. The CCHP is similar to the RHU in the role played by physicians and in its service orientation. It is sponsored by the College of Medicine, University of the Philippines, in a town in Laguna and draws its funding from the University. It maintains organizational links, though not always close, with the MOH at the provincial and municipal levels.

ProCom is run and largely funded by the local government which sponsors it but owes a lot of its vigor to the national programs in population, nutrition, green revolution and environment and their counterpart private foundations established by the First Lady. It also receives small contributions from national agencies operating in the municipality. Limited to only 22 towns at present, it is dominated by laymen rather than medical professionals, and uses a system of community organizations, volunteers and training and direct assistance in providing its five-pronged program (nutrition, family planning, green revolution, environmental sanitation and sports and cultural development).

The SHDP and Makapawa are comparable in many respects. Both operate at sub-municipal levels, train and use indigenous residents, and are non-governmental. They differ in their sponsorship, linkage with government and program orientation. The SHDP is private but non-sectarian and draws support and resources from both government and big private corporations, whenever available. Though its approach to health care is not agency-based, its medical orientation is towards Western methods and technologies. On the other hand, the Makapawa is Catholic, and its linkage with the government is ambivalent. An existing memorandum of agreement providing for close cooperation and coordination with the MOH is not being implemented. Its service orientation is community-based and it also encourages tested traditional medicine and challenges the reliance on Western medicine.

The distinctions among the programs regarding participation can be traced to their characteristics as regards integration, role of medical professionals and program orientation. The RHU involves the people only through traditional health education activities such as mothers' classes and the like. CCHP, similar to the RHU except in integration, does the same but goes a step farther

by training selected residents as multi-purpose health workers in their respective barangays. The ProCom scheme involving the people uses trained residents also. It attempts to be more participative than CCHP; but it relies more on formal organizations than community mobilization and in the end, gets a lower level of actual participation than either of the first-mentioned programs. Sudtonggan and Liwayway both seek and encourage involvement of all persons in the community at all stages of the program cycle — planning, implementation and evaluation. Community self-management is their major objective. The surveys show that both have partly attained this objective, based on the number of people who say they have participated in various stages of the program cycle. Liwayway is still strongly tied to its sponsor, however, while Sudtonggan has already been adjudged ready to sever from the "apron strings" of the ICA. Apprehensions about the possible results of this autonomy seem to be at the root of the Sudtonggan residents' relatively low favorability towards the necessity of participation in community affairs. By contrast, respondents in all the other areas registered stronger convictions as regards the view that community involvement is necessary.

Program Effectiveness

A number of measures of effectiveness have been used, namely: certain administrative indicators, the people's awareness of the program, its clientele coverage, and the people's level of satisfaction. As regards the first: three programs attempted to gauge people's needs before operating in their areas, CCHP relied on the judgment of the program planners, while the RHU as a national program simply assumed that their services were necessary. An objective appraisal shows that all programs under study respond to certain problematic situations found in the communities, whether they are identified as "priority needs" of the people or not. Also, targets for accomplishments are not always set, except by RHU and CCHP. For these reasons, this study concentrated on the comparison of health conditions in the areas over time. In this regard, the RHU, CCHP and SHDP were found effective in improving general health conditions in their respective communities as indexed by changes in certain vital statistics over time; data in Teresa are confusing, whereas in Liwayway, baseline data were not available.

People's awareness of the program was highest for Sudtonggan, followed closely by Pilar and Liwayway, then Bay and as a distant fifth, Teresa. This can be explained by relating it to the people's access to program services - two of the top three are based in the communities themselves (SHDP and Liwayway) while the RHU has a clinic or a health station in each of the sample sites. The RHU, in addition, has been operating for the longest time and, with a nationwide coverage, has factors that could increase knowledge about its existence. The relatively low level of awareness regarding CCHP and ProCom may be traced to their multiple-agency delivery scheme. In Bay, the RHU and CCHP merge at certain points while retaining separate organizations and staffs, a factor that does not help in distinguishing between them. In

ProCom's case, the multiple-agency framework is highlighted by its emphasis on training and creation of organizations which do not bear the name "Project Compassion," thus not contributing to an awareness of what the ProCom is and what it does for the community.

Clientele coverage also varies according to program, with SHDP and Makapawa on top, followed by RHU and CCHP (the pairs being closer to each other than to the other set), and then ProCom, benefitting relatively much fewer respondents. The wide scope of the first two programs can be traced to the fact that they are based in the communities under study, and that these receive an intensive set of services, a factor related to integration. Both feature a combination of services - some benefitting individuals directly, such as employment in an income-generating project within the program, while some are meant to have community-wide impact, including sanitation campaigns, community celebrations and administration of utilities. The first kind of services can be done or received without citizen participation while the second practically requires a group of individuals to interact for planning and implementation if not for evaluation. Such coverage then would also be related to the level of citizen participation.

Another measure determines how many residents have benefitted from the program. Using the average number of services received by each household, one finds the programs to be arranged in this order: Makapawa, CCHP, SHDP, ProCom, RHU. This appears partly to be a function of access (with community-based programs in first and third ranks). It may also be partly attributable to the active nature of the delivery which encourages program implementors to work in the community rather than within the clinic. Meanwhile, the RHU is largely clinic-based while the ProCom works through formal organizations, both serving passive recipients who are not actively sought out.

Do the poor benefit most from these efforts? The answer seems to be in the negative. It is disturbing that there is a marked advantage received by the richer group in San Antonio and Sta. Cruz, the two barangays of Bay. This may be partly due to *minimal* fees charged for availment of infirmary services which would relatively be more difficult for poor people to afford, a fact mentioned by some respondents in their own appraisal of the CCHP's services. What is especially disturbing is that none of the programs serve the poor groups to a greater extent than the rich, although in most cases, the benefits received by the poor are not significantly lower than those received by middle or high income groups. While Makapawa and SHDP seek out poorer members to participate, a similar campaign to get them to receive services to a greater extent than the rich may be necessary.

To get at benefits more concretely, interviewees were asked from where their households get health care for persons who have been sick in the last twelve months. The responses were instructive: the most popular curative mode in all sample sites was professional health care, particularly from non-program and

non-RHU physicians, nurses and hospitals. The reliance on professional care may be because of the location of programs there, so that local people are now made more aware of and desirous of enjoying scientific medicine. The programs themselves have served about a sixth to a third of all sick people in a community, with the exception of ProCom (which has no curative component) and SHDP (which relies largely on its affiliate facilities for providing this service). The farthest (and poorest) barangays in Bay and Pilar have tended to get the most service from their corresponding programs, a surrogate measure of how well the poor have benefitted. We are unable to rank the programs based on this indicator, though the RHU, CCHP and Makapawa all rate as "good" or "satisfactory;" while the SHDP rates poor in direct service (because of no facilities and personnel for medical treatment) and satisfactory in providing indirect care (through its affiliates).

To gauge the satisfaction of respondents, we asked them to locate themselves in a satisfaction-dissatisfaction continuum, and to give their own comments on the performance of program personnel. Both indicators ordered the programs in exactly the same way, with the Makapawa in first rank, followed by the CCHP, ProCom, RHU and Sudtonggan. The first two are the same programs leading in number of benefits given per household. Except for Sudtonggan's position, this array and mean services would in fact be almost identical. It is then SHDP's rank that is problematic. What appears to be at work here are problems related to the turnover of the SHDP, at the time of the survey, from the ICA's American staff to Filipino full-time personnel. One may also ask if this does not raise questions about the level of self-reliance reached by Sudtonggan if residents register ambivalence such as this about the effectiveness of the program.

Who are the most satisfied? There is generally no difference in the satisfaction level of income groups. To a slight degree, it is the middle-income groups which have been most satisfied. This is not because they have always received the most benefits. Rather this may be related to their level of participation. It is likely of course that people who feel they "own" a program - because they participate in it - would express more satisfaction about the directions it is taking.

On the whole, the programs have been able to improve community health conditions, make the people aware of their existence, deliver services to a large proportion of the population including the poor, and manage to satisfy its intended beneficiaries. The programs may then be said to all have a salutary effect on the communities they have served.

Nevertheless,the programs based on all the indicators can still be ranked to determine the factors that tend to increase effectiveness of programs. The line-up would tend to be: Makapawa, SHDP, CCHP, RHU and ProCom. The ranking may be related to the following independent variables.

Integration. The first two programs in the array - Makapawa and SHDP - aim at an integrated delivery of a variety of activities with single-agency

schemes that are less confusing to both program administrators and clientele. By contrast, multiple-agency delivery systems appear to have affected both CCHP and ProCom adversely. The CCHP has been better able to withstand this disadvantage because it has tended to locate itself where the RHU is absent, thus presenting the village with a non-competitive situation vis-a-vis the RHU. Meanwhile, the RHU's concentration on health programs, a characteristic shared with CCHP, may be a negative factor, despite a single-agency channel that is easily recognized by clients.

The commitment towards integration also seems to lead to an active rather than passive stance in delivery, a vigorous seeking out of people rather than simply waiting for them to come to the clinic (an occurrence that usually takes place only when the person is already sick). The active nature of the delivery would thus be more likely to draw health care away from treatment of diseases to their prevention. In addition, the attempt to provide services that can take care of the total person may be more welcome by, and more beneficial to, the community to be served. Both Makapawa and SHDP have attempted to do this. However, the fact that SHDP's wide variety of services is not rewarded by high satisfaction on the part of the people, and that ProCom's attempt to introduce a five-pronged approach is not appraised highly, should probably caution planners against offering so many services when the program cannot maintain enough personnel to provide all these services. In this regard, the training of multi-purpose workers - tried by Makapawa and CCHP but not by SHDP - may be useful complement to a holistic delivery scheme.

Participation. Again, the first two programs include citizen involvement as part of their program philosophies. The low ranking of ProCom — though also participative in conception — shows some aspects of participation that tend to be neglected or glossed over. First, commitment to participation requires that the people will really be allowed to provide directions that the community would take: it should not simply be a means of mobilizing people to accept directions of the sponsors.

Second, activities in participative programs should encourage the persons to interact with others; they should not only be for individual improvement. Again, the ProCom example may be cited here, where activities encouraged were individual-type solutions (doing away with smoking and drinking, and eating the right food) and with less stress on enhancement of health care that the community residents can do together. Programs of self-improvement, unaccompanied by social action, will, in the long run, be done by persons acting alone, thereby discouraging further citizen involvement in community self-management.

Third, organizing should come after the people have had some taste of directing community activities, not before. Otherwise, the association could become a mere social club rather than one able to plan and deliver social services. The Makapawa barangay underwent a long period of community preparation before creating the hugpos. Even these were groups of co-equal

members rather than groups divided into officers and members. By contrast, ProCom had formal organizations created after the short Family Ilaw Training and only their officers got involved in activities beyond the immediate area of the twenty-family groups.

Other Implications of the Findings

In the preceding pages, we have been rather critical of the programs that we have intensively studied. However, we must take note of the fact that although the areas in the sample cover a wide range in the development continuum, their residents have been able to enjoy more medical attention in case of illness and death than inhabitants of other areas. This greater access of the people living in these communities can therefore be credited to the fact that programs to serve their health and other needs are operating in the community.

In addition, the most successful are programs which are based in the community, try to touch on the holistic needs of the human person, and challenge the people themselves to take responsibility for their own state of health. Their approach centers on the prevention of illnesses, the improvement not only of individual facilities but of the entire community environment, and the attempt to assist the people to improve the other dimensions of their personality, including economic, political and even spiritual well-being.

Linkage of Special Programs with Regular Schemes. One problem that is raised, however, is to what extent one can rely on special programs like these in reaching the host of other communities in need of health care. One answer appears to be that already tried out by the Ministry of Health, through its restructured health care delivery system which establishes barangay health stations that are more accessible to people outside municipal centers. The relative success of the Pilar RHU seems to attest to the efficacy of this approach.

Yet one must also recognize that national resources are limited and analyze how the country can utilize the available resources of university, religious and other voluntary groups which are willing to get involved in the delivery of social services to rural areas. The case studies have shown that in two instances, conflict with the RHU and the possible duplication of its services have been the result of the entry of another health program in Bay and Liwayway, despite efforts of administrators of both programs (and the Ministry) to come to some agreement for coordination of efforts. This seems to be capable of actual implementation, as the happy experience of Sudtonggan in this regard shows. Coordination, if not actual integration, would seem to be urgently required, especially since we have found that success of community-based programs over time can be maintained only with adequate linkage with the continuing and pervasive government health program. Again, the example of Sudtonggan comes to mind. Bay's modus vivendi with the RHU may thus provide the initial model of a scheme to integrate the program into a referral system that goes beyond the community and which is able to provide the people more complex medical services when they are required.

Service Orientation and Philosophy. In general, the programs have been effective in delivering health and related services and in satisfying most of the people in the communities. However, we have also noted a disturbing sign that there may be repeated here a trend (already maintained by advocates of the basic needs approach) that unless the poor are explicitly made the object of social programs, they will not receive benefits from these programs to a degree that would redress past inequities. We have seen that both the SHDP and the Makapawa have been successful in involving the poor in their participative schemes when they made special efforts to seek them out for specific roles in their delivery system. However, they have stopped short of making them priorities as recipients of services. Hence, the people's greater participation in the programs did not necessarily lead to greater benefits for them. Bearing in mind the experience of Bay, too, it appears that such an explicit orientation to provide the poor with more services may be required. Otherwise, the almost automatic advantage of the richer segments over the poor will continue to be maintained.

Recommendations[25]

The exploration and analysis of the five programs suggest a number of strategies that would help in ensuring an improved system of providing health and related services, particularly to the poor. These include:

1. The provision of primary health care;
2. The integration of health care with other services, coupled with citizen involvement and a system of linking community programs with higher levels and more sophisticated services;
3. The implementation of the policy to make the delivery of health care a joint responsibility of the public and private sectors;
4. The explicit seeking out of poorer members of the community.

Primary Health Care

Many of the features we have found that would increase the effectiveness of health programs are, happily, already incorporated in a new approach that the Philippine government has just accepted as a means of improving delivery of health services (but has not yet been fully implemented). This strategy is called "primary health care" (PHC), defined as

> essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost that the community and the country can afford; it forms an integral part both of the country's health system of which it is the nucleus and of the overall social and economic development of the country (WHO, 1978:8).

[25]This draws freely from and, in important ways, revises Cariño, 1980. That paper was based on lessons gained from the initial analyses of the data for this project.

As may be easily noted, PHC is not a totally new approach in that much of it simply restates the functions of public health as it has been traditionally defined.[26] It departs from previous government practice and policy in three essential points:

a. In using "means acceptable to them (the people)," PHC signifies the acceptance of indigenous systems of medical care and traditional practices, where these are not harmful to individuals;

b. In seeking "full participation of the community," PHC attempts to involve the people in all phases of the health program — planning, implementation and evaluation;

c. In regarding itself as "an integral part of overall . . . development of the country," PHC recognizes the role of health as an entry point for development.[27] These issues bear reiteration because, taken to their logical conclusion, they have revolutionary implications not only to the health system, but also to the nation as a whole.

The PHC approach implies a devolution of power to the people beyond that which has actually been exercised by barangays and other local governments since the related movements of decentralization and community development of the mid-1950's. It gives the central government only advisory and staff roles in the evolution of community health programs while it provides resources to enable these same communities to discover what it means to take responsibility for their own health. It challenges health professionals to share their complex technical expertise even to the extent of accepting (1) that traditional or indigenous health approaches may be quite relevant and useful, and (2) that good health practices may be relegated to the background by persons whose major worries concern where the next meal is coming from.

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[26]The classic definition of public health is that it is. . . "the science and art of (1) preventing disease, (2) prolonging life, and (3) promoting *health and efficiency through organized community effort* for

a) the sanitation of the environment,
b) the control of community infections,
c) the education of the individual in personal hygiene,
d) the organization of medical and nursing services for the early diagnosis and preventive treatment of disease, and
e) the development of a *social machinery to insure every one of a standard of living adequate for the maintenance of health,* so that organizing these benefits will enable every citizen to realize his *birthright of health and longevity.* (Winslow. 1920. Emphasis ours.)

We are grateful to Dr. Melchor Jacinto, Professor of Public Health, University of the Philippines, for bringing this definition to our attention.

[27]On these three points, cf. Angara, 1978:2,3.

The study also suggests that the approach most similar to PHC - that used by community-based health programs such as SHDP and Makapawa - has worked in micro-situations like a sitio or barangay. Furthermore, such programs tend to be open-ended and permissive in that people's capabilities for self-reliant action are encouraged even if they do not regard health as the priority need. At the same time, the long-range success of community programs appears to require some linkage with a supportive system that allows for flexibility to respond to different community demands while it maintains a reliable means of providing for health and medical care, whenever and wherever it is required. This suggests, then, that the PHC policy may not be implemented nationwide right away, but should start at strategic depressed communities. At the same time, the health professionals at these communities should be retrained to deal with their new roles as community educators and advisers as well as dispensers of medical services.

Integration, Citizen Involvement and Incorporation into a Referral System

Steps should be taken to ensure that health services are not provided in isolation and separate from the provision of other needs of the people in the community. Integration of services, if possible beyond health, should be the goal. Recognizing that the government has different sectoral agencies to provide these services separately, there must be a mechanism for greater coordination of these agencies at the grassroots level. Here the community residents must be seen not only as clients and beneficiaries, but also as articulators of demands and partners in the planning, implementation and evaluation of social programs. The SHDP has attempted to do this initially in its "consult" and has sustained it through its continuing training and education projects. It has also linked up with agencies answering needs high on the priority ranking of the people. What is noteworthy here is that these agencies have come into Sudtonggan under the aegis of the people's program.

What SHDP lacks is a mechanism to link a sitio or a barangay up to higher levels: ProCom has developed (but has not adequately implemented) such a scheme. What is therefore recommended is an adaptation of the SHDP strategy at the grassroots level, combined with the ProCom concept of using a municipal-level body along with a hierarchy of people's organizations which register their demands, set up plans and get involved in the implementation and evaluation of the activities they set in motion.

The body being suggested here may be a task force or committee of the present municipal development council rather than the whole MDC since the MDC may not be able to devote a large proportion of its time in the discussion of issues related to health alone. Members of this committee should include laymen as well as health professionals so that this system can allow for the continuation of citizen involvement in health programs begun at the community level. The laymen should be knowledgeable about their health needs but not be in awe of medical professionals and technology so that some measure of citizen control could really be effected (Altenstetter and Bjorkman, 1979). In

this manner, health would become the responsibility of the total community, with health professionals and other members of the health and other technical bureaucracies supportive of community participation, willing to play an educative and unobtrusive role in the community's activities but available to provide more complex medical services should these become necessary. This citizen involvement would be manifested at all levels of health planning, implementation and evaluation.

Joint Public-Private Sector Efforts

The study has also shown that single-agency schemes seem to be more effective in answering the needs of the people. While it may not be possible to have a single multi-purpose worker in each barangay capable of answering the multifarious needs of the people from health to agriculture, it may still be practical to expect at least a lack of duplication of efforts in health and related services at the grassroots level. This may imply that there should be a concerted effort to concretize the oft-declared government policy that the delivery of health care is a joint responsibility of the public and private sectors (Pilar, Boncaras and Santos, 1976). This is particularly salient now that the Philippines has joined the primary health care movement where the strengthening of program linkage among government and non-government efforts is called for at all local and national levels (MOH, 1980).

An integration of the public and private sectors is thus but a logical extension of existing policy. It is especially urgent because while the country does not have an abundance of health resources, there are areas where they are redundant and duplicative. The government should thus take private sector deployment of health resources into account when planning its own; where a private practitioner/clinic program exists, government should not waste costly resources by locating there also. A system of providing subsidies or grants to private individuals, clinics and health programs may be instituted, its size depending on such factors as location, presence of other facilities, uniqueness of service (e.g., being the sole clinic, providing specialized care), etc. At the same time, these facilities or programs should be built into the referral system so that they can be used by clients of community programs which do not have physicians in their staff, or which are in need of more technical services like surgery, etc.

In areas where voluntary programs are present, government health activity should be devoted to inspection, regulation, training and provision of specialized services. Where the facilities and staff of the voluntary sector are not able to provide primary health care to all residents, government and the respective program may divide the territory, as in the CCHP's concept or provide consultants who come regularly, like Makapawa's mobile health team, or Sudtonggan's public health nurse who is contributed by the City Health Office. This system would in effect allow government resources for health to be extended, a necessity considering how low they already are on a per capita basis.

Policy Preference for the Poor

The recommendations will not be complete without a consideration of various ways by which health services can be provided through an explicit seeking out of poorer members of the community who would otherwise be without adequate health care. This requires several approaches:

a. **Location in difficult and extremely depressed areas.** The communities under study are shown to have registered better results than the national average in various vital statistics although their initial levels were rather low. A high proportion of the members of the community have also been able to reach medical professionals. In fact, the results have been better than expected, compared to national averages. Thus the government must continue to ensure that services are available to these poorer areas by continuing its barangay health stations, by providing more incentives for professionals to reside there, and by supporting other sponsors who wish to locate in such areas.

b. **Active nature of delivery system for health.** An emphasis on prevention of disease and health education cannot come about if the service provider waits for the people to go to his clinic, since a person will not go to physicians unless he considers himself extremely ill. This would be exacerbated, among the poor, by the lack of social facility to deal with professionals and the apprehension that they will have to pay for treatment they do not have money for. Moreover, public health measures are more likely to benefit the poor who can be expected to live in worse surroundings than those who are better off. Thus an active delivery system which seeks out the poor through home visits, neighborhood meetings, involvement in community-organized health projects and the like should be effected.

c. **Regulation of Prices and Availability of Medicine.** When illnesses occur despite diligent and active efforts towards prevention and control, the price and availability of drugs and treatment become important considerations. Keeping these within the reach of the medically indigent requires several approaches:

(1) The utilization of herbal medicine and indigenous systems of care under the control and regulation of the Food and Drug Administration or a similar agency;

(2) Research into the systematic packaging of herbal and other locally available medicine, so that they are widely disseminated while meeting high safety standards;

(3) The use of generic drugs in prescriptions which would be just as effective as well-advertised brand names of multinational and local drug companies;

(4) The control of prices of these drugs so that they are within the reach of the masses;

(5) For the dissemination of other drugs: the use of such devices as *botika sa baryo* or village drugstores so that the people can obtain needed drugs without incurring high transport costs, time losses, etc.

Some of these measures, especially price control and research, are outside the health sector as it is now defined and thus require coordination with other agencies.

d. **Graduated fees for health services.** When fees are deemed unavoidable (because of high cost of facilities, low funds of sponsors, and the desire to discourage dependence on the service providers), fees or charges must take into account a person's ability to pay: subsidies for the indigent and medically indigent, and higher charges for those with higher incomes. This should be the only differentiation by income groups; services given to each must be comparable to that given to the others. In some hospitals in Manila, this is done by allowing a patient to occupy any bed according to a first-come-first-served basis, rather than according to what he can afford to pay. The fact that a patient can or cannot pay would then be a matter between him and the admissions officer; physicians and nurses rendering services would not necessarily know his financial status.

However, in view of the rapid increase in the cost of services, there may remain only a precious few who would be able to afford hospital facilities unless medical insurance is made available. In this connection, the expansion of the present medicare system should be studied with the end in view of increasing its beneficiaries. Farmers and fishermen - among the poorest in the society - should be able to avail of them. In addition, expansion should also mean the provision of benefits for medical consultations without hospital confinment. Given the dearth of beds and the high cost of maintaining hospitals (and the high price charged to patients beyond medicare assistance), as well as the need to stress health promotion and prevention, preventive physical check-up and out-patient consultations should be encouraged. To promote maternal and child health, medicare should be available for pre- and post-natal care as well as deliveries. However, it may be limited to only a small number of pregnancies in the interests of family planning.

This policy can be regarded as a corollary of the public-private sector integration. Subsidies may be given to individual patients through the medicare system, or in the form of grants to institutions (with all individuals able to avail of their resources *gratis* or on a graduated scale of fees, depending on need). In this connection, the National Health Service of Great Britain and similar institutions in other countries may be studied as a point of departure for Philippine models. (Thursz and Vigilante, 1975). Attempted along with PHC and the concretization of other policy proposals in favor of the poverty groups, this system would do much to make health care and medical services truly available to all the people, particularly the poor.

Appendix

A COMPENDIUM OF EXISTING MECHANISMS FOR MEETING HEALTH AND RELATED NEEDS IN THE PHILIPPINES

Edited by Rebecca P. Albano, Ma. Lourdes S. Joves
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The following compendium of additional regular and experimental modes of delivering health and other social services (aside from those discussed intensively in this volume) is arranged alphabetically by name of project.

However, the reader should be cautioned about this listing. First, despite diligent efforts, it has not been possible to make a complete listing of all health delivery organizations, particularly many of the so-called community-based health programs (CBHPs). Second, variations in the delivery mechanisms occur even within a specific sponsoring organization. Third, a number of these projects are being operated on a pilot basis, or for other reasons, and would not be permanent. Lastly, we have generally relied on published project papers and some short interviews with central office personnel; the implementation of the projects were seen only in a very few cases.

Alay Kapwa Kilusang Pangkalusugan (AKAP)

The Alay Kapwa Kilusang Pangkalusugan (AKAP) is a private, non-profit organization committed to promoting primary health care. Health services are delivered to economically depressed sectors of the population, with emphasis on tuberculosis (TB) control. Community health workers are trained in basic skills, including TB control, health education and other aspects of health care. The AKAP works in coordination with other agencies, health professionals and individuals who have knowledge of or who are actually engaged in the delivery of primary health services. The AKAP also develops appropriate educational materials on community health. Because the AKAP views health from a holistic standpoint, technical assistance is also provided in agriculture, fisheries, food production, sanitation, etc. Funding comes from foreign Roman Catholic funding organizations.

Alay Kapwa Human Development Fund (AKHDF), NASSA

In 1975, the National Secretariat of Social Action (NASSA) launched the Alay Kapwa Human Development Fund (AKHDF) aimed at providing monetary assistance to social action projects that have educational, organizational and economic components. Project sites are depressed urban and rural communities. Grantees of the fund are usually small community projects which may or may not be income generating, or projects at the initial stage of growth where funds are forthcoming but where time is a decisive factor in its

[28]Anacleta A. Eusebio assisted in the initial editing of the original longer report of the same title.

implementation. The maximum amount that may be granted to a project is ₱10,000.00. Assistance comes in the form of advances, loans or outright grants. Requests usually come from the social director of a diocese, from organizations like the parish council, and from individuals. Sources of funds are the Lenten Action Collection, religious congregations and foreign Church-connected funding agencies.

Anemia Surveillance Project

The Anemia Surveillance Project of the National Nutrition Service (NNS) of the Ministry of Health (MOH) was established in October 1979 to conduct a one-year pilot project to determine the effectiveness of a delivery system for iron supplementation for pregnant women. The Project covers ten selected municipalities of Pangasinan. Responsible for the planning and implementation of the Project are the NNS, the Regional and Provincial Health Offices including the respective Rural Health Units (RHUs) and the identified barangay supplementors. The cooperating agencies include the National Nutrition Council, Nutrition Center of the Philippines, the Ministry of Social Services and Development (MSSD), Bureau of Agricultural Extension, and the Rural Improvement Clubs (RICs).

Baao Applied Nutrition Program (BANP)

The BANP serves as a prototype scheme for delivering nutrition and health services to the rural areas. The Project initiated in 1974 covers five rural barangays in the Municipality of Baao, Camarines Sur. Addressing itself to children up to age four and to pregnant and nursing mothers, the Project has as its major components nutrition (as its entry point), community organization, nutrition education and rehabilitation, supervised and implemented by the Archdiocese of Caceres (Bicol) through its Secretariat for Social Action, with technical assistance and a five-year grant from the Philippine Business for Social Progress (PBSP). Among the cooperating agencies are the Catholic Relief Service, the MOH thru its RHU, the MSSD, the local office of BAEx, Bureaus of Animal Industry and of Plant Industry (BAI and BPI) and the Augustinian Sisters.

Barangay Health Aides of Dauin, Negros Oriental (BHA)

The BHA project was conceived by the Extension Service Department of Silliman University Medical Center (SUMC) and the Marina Maternity Clinic (the Project implementor) as a health service delivery mode in a rural community. Ultimately, it is to be operated by an auxiliary health worker native to the community. The Project covers seven barangays in Dauin, Negros Oriental. Among its sponsors are Protestant churches and civic-minded individuals with technical assistance from the agriculturists of Silliman University and BAEx for health and supplementary income-generating projects.

Barangay Mediks Programme (BM) Laguna

The BM Programme is a joint project of the Diocese of San Pablo, Laguna and the Laguna PHO to improve the health of the people of Laguna. Initiated in 1974, the project covers seven municipalities of the province. The BMs are community-selected, community-based medical auxiliaries to supplement the RHU and BHS health personnel. The BMs training include (1) an eight consecutive weekend seminar on health services administered by the PHO and RHU personnel and on spiritual leadership by a lay church worker of the Diocese, and (2) an in-service training at the local emergency hospital and local drugstores. Upon completion of their training, the BMs are awarded their diplomas and a kit of basic medical instruments with their Community Health Workers Manual for reference. Supervision and technical assistance are rendered by the RHU and the BHS personnel. Monitoring and evaluation are the responsibility of the Diocesan Committee with the actual work done by the Diocesan Coordinator. Financial support comes mainly from the Diocese with support from private institutions and individuals.

Barangay Nutrition and Health Scholar Project (BNHS)

The BNHS project of the Nutrition Council of the Philippines (NCP) aims to strengthen the national nutrition program at the barangay level through the training of the barangay residents and the provision of nutrition and health services to the program's target clientele. In 1977, the Project covered the 13 municipalities and four cities of Metro Manila with the participation of Metro Manila Health Commission, UNICEF, the local governments and the Barangay Councils. Since then, the Project has expanded nationwide with the cooperation of Regional Health Offices of the MOH and its local units.

Barangay Technicians for Health Project (BTH), Nueva Ecija

The BTH Project is a joint attempt of the Provincial Health Office (PHO) of Nueva Ecija and the Philippine Rural Reconstruction Movement (PRRM) to make health care services easily accessible to rural communities. The strategy is distinctive in that before the training of BTHs, the community leaders undergo a leadership training program designed by the PRRM to develop their capability to identify their community's needs and to plan and implement projects with minimal outside support. These trained community leaders then hold community assemblies for the selection of BTHs. The 4-week BTH training jointly handled by the PHO and the PRRM includes a week (the second) wherein the trainees return to their community for a practicum and a survey of the community's needs. Monitoring of the BTH activities is the responsibility of the RHU through its Barangay Health Station (BHS) midwife. Monthly reports of the BTHs are consolidated into an RHU-wide report as (1) basis for the regular meeting of the Municipal Health Officer (MHO) and the BTHs and as (2) the BTH performance report to the PHO.

Barangay Volunteer Medics Training Program (BVM)

The BVM training program of the Philippine National Volunteer Service Coordinating Office (PNVSCO) was initiated in 1973 primarily to improve health conditions in the rural areas through the training of volunteer paramedic health workers in areas where professional health workers are scarce or not available. Among its areas of operation are Abra, Kalinga-Apayao, Quezon, Nueva Ecija, Sorsogon, Oriental Mindoro, Negros Occidental and Bukidnon. The PNVSCO is mainly responsible for the training program while the local health agencies (e.g., the Provincial Health Office and the RHU) or the local sponsoring entities supervise the implementation of the program. Aside from health activities, training includes lectures from BAEx, BAI for supplementary health activities.

Barefoot Doctors Project of Region IX (BFD)

The BFD Project was conceived by the Office of the Regional Commission IX (ORC) and the Development Academy of the Philippines (DAP) after assessing the existing health care delivery system in the Region. The project covers 97 barangays in five provinces of Region IX, namely: Sulu, Basilan, Tawi-Tawi, Zamboanga del Norte and Zamboanga del Sur. Selection was mainly based on acuteness of needs for health services and distance from existing health facilities. While the ORC administers the program, the Regional Health Office coordinates the implementation through the PHO and the RHUs, the local governments assist in the selection of the health workers and DAP organizes and supervises the project consulting staff. The BFD project was designed to develop a health service delivery system for Region IX at the barangay level.

Bicol Integrated Health, Nutrition and Population Project (BHP)

The BHP was envisioned as the major social development component of the Bicol River Basin Development Program (BRBDP). The Project goal is to raise the quality of life of the residents of the identified 400 barangays of the provinces of Camarines Sur and Albay through improved health and nutrition, and the achievement of self-reliance in health. The Regional Health Office of the MOH has been designated as the lead agency, with BRBDP as the coordinating agency for all government agencies with direct or indirect interest in health. The program is integrated into the existing health delivery system with the addition of the Barangay Health Aides (BHAs) to supplement the services of the Rural Health Midwives. The BHAs undergo a six-week formal training on health-related activities to be undertaken in the respective barangays. The initial financial support is drawn from the United States Agency for International Development (USAID) and the Philippine Government.

Bohol Maternal and Child Health-Based Family Planning Project

The Bohol Maternal and Child Health-Based Family Planning Project is a project of the Ministry of Health. Started in 1974, it is a program that aims to

deliver family planning services under a well-organized maternal and child care program. Midwives, barangay health workers and traditional birth attendants, aside from doctors and nurses (hilots), are made an integral part of the health service delivery scheme in order to increase the availability and quantity of health and family planning services in the rural areas of Bohol province. Services provided are family planning, treatment of simple illnesses, prenatal and postnatal care, first aid, reporting of communicable diseases and unsanitary conditions, training of hilots to conduct safer birth deliveries, sick-baby and well-baby care, immunizations for BCG and DPT, and general medical services. The project received technical assistance from the World Health Organization and the Population Council. External funding was also provided by the United Nations Fund for Population Activities.

Caibaan Project of the Divine Word University, Tacloban City

Barrio Caibaan in Tacloban City was chosen as an impact area for the various socio-economic and pastoral projects of the Divine Word University (DWU). One of these projects is the Caibaan Health Center, which is under the College of Nursing of DWU and St. Paul's Hospital. It is staffed by student nurses, volunteer nurses and the faculty and staff of DWU and St. Paul's Hospital, who take care of the health needs of the barrio and sitios of Caibaan. Services provided are mothercraft, nutrition education, immunizations, general medical care, etc. Other related projects undertaken in Caibaan in coordination with the university are an irrigation project and a seminar on the mechanics of tractor operation. Hand tractors were acquired through funds provided by Misereor and St. Martin de Tours Parish in Twello, Holland.

Capiz Emmanuel Hospital-Manpower Resource Distribution (CEH-MRD) Project, Roxas City

The Capiz Emmanuel Hospital-Manpower Resource Distribution (CEH-MRD) Project aims to make available to the rural areas scarce medical manpower through the training of community members to serve as paramedics in the depressed areas of Roxas City. CEH personnel/clinical instructors and students from the Filamer Christian Institute College of Nursing (FCI-CN) are utilized as trainors and health service providers. Part of the material and drug requirements of the project are also provided by the CEH and the FCI-CN. Services include health, family planning, nutrition, environmental sanitation and immunization. Started in May 1977, the project is funded by the Ford Foundation and implemented through the Population Center Foundation.

Cebu Velez Hospital/Cebu Institute of Medicine-Community Medico-Social Center (CIM-CMSS)

The CIM/CMSS Center was established in response to the requirement of the (then) Department of Education and Culture for the training of medical students in community medicine. The Center has three programs: (1) a health center in Pakna-an, Mandaue City, (2) a rural hospital program at the Apo Ce-

ment Company Hospital in Tinaan, Naga, and (3) an urban program in a slum area in Cebu City. Its main objectives are to sensitize the medical students to the community and the socio-economic and cultural factors involved in the epidemiology of disease and to deliver primary health care services at the village level. The Pakna-an Health Center, the main undertaking of the program, made arrangements with local health units to coordinate its activities with theirs and thus avoid duplication in its service delivery. To stabilize and ensure continuity of program, the Pakna-an Center has maintained a core staff, trained local Medical Auxiliary Workers (MAWs) and involved the local barangay leaders in planning, implementation and evaluation of its activities. The CMSS Center is maintained primarily by the CIM Department of Preventive and Community Medicine.

Day Care Services and Supplementary Feeding Program, Ministry of Social Services and Development (MSSD)

Day Care Centers were initially established after the floods of 1972 to provide needy pre-schoolers with an integrated social development program alongside a nutritional feeding scheme. Since then, this has been expanded into a national program of the MSSD. Day Care Centers benefit not only the pre-school children but also their working mothers through membership in mothers' clubs. These centers serve pre-school children through social development activities under the "mental feeding" component of the service. Day Care workers are specifically trained for this program. Aside from MSSD, the program has drawn support from the Nutrition Center of the Philippines (NCP), the Catholic Relief Services (CRS), United Way, local World Food program, local governments, civic organizations and the parents themselves.

Far Eastern University: Dr. Nicanor Reyes Medical Foundation, Department of Community and Family Medicine (FEU-NRMF)

The FEU-NRMF Tulungan Health Center was established in Barrio Magsaysay, Tondo (Manila) for the following objectives: (1) to train primary health care physicians, (2) to serve as a community laboratory in an urban setting for medical students, and (3) to extend comprehensive, family-oriented health care services to the community. In fulfilling its objectives, the program has sought and coordinated the participation of other agencies and the involvement of the community residents in the planning and implementation of its activities. Financial support to the program is being provided mainly by FEU-NRMF with assistance from the Association of Philippine Medical College (APMC) - Josiah Macy, Jr. Foundation, the Board of Medical Education-Philippine Charity Sweepstakes Office Financial Grant, the Ministry of Health and the Tondo General Hospital.

Institute of Health Sciences (IHS): UP College of Medicine, Tacloban

The IHS was established in 1976 by the University of the Philippines, College of Medicine in response to the growing problem of inadequate health

manpower in the rural areas in the context of the "brain drain" of medical professionals not only to foreign countries but also to urban areas. Its main objectives are: (1) to produce a broad range of manpower to serve the depressed barangays in Region 8; and (2) to design and test program models for health manpower development replicable in the rural areas of the country. Among the program strategies which the IHS has implemented are the following: (1) the step-ladder curriculum, which integrated the entire range of health-allied courses, including medicine, into a single, continuous, and unified curriculum; (2) the evaluation of the student services' performance by the faculty, the local RHU and the community for eligibility to the next level of training; (3) the focus on training on community-health aspects of medicine; and (4) the establishment of linkages with other government agencies for training and utilization of IHS graduates.

The program also has a built-in Research and Development Program (R & D) to continually validate and adjust the IHS curriculum to ensure its relevance to the needs of the rural community. R & D is maintaining community-based health programs in three areas: Gandara in Western Samar, and Carigara and Baybay in Northern Leyte. The IHS program is a collaborative project of the Provincial Government of Leyte, the Ministry of Health (Region 8), and the UP College of Medicine.

International Institute of Rural Reconstruction, Silang, Cavite

The International Institute of Rural Reconstruction (IIRR) is a private, non-profit organization specializing in training and research on rural development. Incorporated in the United States in 1960, its program is accomplished through affiliated national programs of selected countries of the Third World. In the Philippines, the affiliated national program is the Philippine Rural Reconstruction Movement (PRRM). Although it has its central office in the United States, Silang, Cavite was also chosen as the IIRR site for its operational research and leadership training programs because of "the similarity of the economic and social conditions of its peasant people and those of other developing countries." In May, 1969, five barangays of Cavite were chosen as initial pilot areas but its area of operations has since been expanded to include three more Cavite municipalities. An integrated four-fold program of rural reconstruction is implemented incorporating the following fields: livelihood or economic development, education, health and self-government. Services are delivered through field specialists and village development (multipurpose) workers. The IIRR is supported through funds contributed by American foundations, corporations and individuals.

Kansalakan Mountain Clinic (KMC) and the Huntington Beach Clinic/ Calabaclabacan Mountain Clinic Projects (HBC/CMC), Guihulngan, Negros Oriental.

Fr. John Peterson established KMC in 1972 and the HBC/CMC in 1973 to respond to the health needs of the mountain communities of Guihulngan, Negros Oriental. Covering a total population of 65,000, the Projects have the

following objectives: (1) to meet the population's health needs, (2) to impart knowledge on the preventive and promotive aspects of medicine, (3) to train Barangay Medical Aides (BARMAs) to be able to render first level health services and (4) to increase local self-sufficiency especially in terms of health needs. Aside from the BARMAs, local officials and residents are involved in the planning and implementation of program activities. The major donors/sponsors of the clinics are Catholic parish churches in California Inc., the Powerallo Fund and the local health unit which assigns medical professionals on rural service.

Katiwala Project, Davao Medical School Foundation (DMSF)

The Katiwala Project is essentially a project on primary health care, which is the major concern of the Institute of Primary Health Care of the DMSF. The Project, called *"Kaunaunahang Katiwala ng Kalusugan"* (meaning "First Guardian in Health) but shortened to "Katiwala," provides services, including the training of Katiwala workers (community residents), to enhance self and community reliance in health with emphasis on its promotive and preventive aspects. Income-generating, health-related projects, such as backyard gardening and poultry-raising, have been integrated into the Katiwala activities. The Project traces its roots to a health intervention scheme by a unit of the Christian Family Movement in Davao City. To discourage dependency of the clients on the program in 1972, the Development of People's Foundation took over and reoriented the program into a health care cooperative. DMSF took charge in 1976.

The Regional Development Council (RDC) of Region XI, the highest policy-making body in the region, has adopted the program as its main social development program after a very favorable assessment of the Katiwala Project.

Mindoro Integrated Rural Development Project (MIRDP)

The MIRDP was established in 1975 as a project under the integrated area development program of the Philippine Government. Its main objectives are: (1) to help correct regional, economic and social imbalances, (2) to assist the national food sufficiency program, and (3) to develop an integrated project management system. It has seven components: namely, watershed protection, irrigation, roads, Calapan port, agriculture, schistosomiasis control and assistance to the Mangyan community. It covers the two provinces of Mindoro Island - Mindoro Oriental and Mindoro Occidental. The National Council on Integrated Area Development (NACIAD), the governing body of all integrated rural development projects, established the Mindoro Project Executive Committee to serve as the policy-making and governing body of MIRDP and the Mindoro Integrated Rural Development Office (MIRDO) as the coordinating and implementing agency. Respective government agencies have been tasked as lead agencies for the specific components, including the Ministry of Health (for schistosomiasis control). Financial loan assistance has

been granted by the International Bank for Reconstruction and Development (IBRD).

Muntinlupa Community Health Program (MCHP)

The MCHP is a health outreach project of the Philippine General Hospital (PGH) primarily designed to transfer the technical know-how of PGH residents to the community through local rural health unit (RHU) personnel. The project which operates on three principles — namely, training, research and service — serves as a training ground for PGH interns and residents. Its main objectives are: (1) to develop a more effective health care delivery system, (2) to conduct an effective health education campaign, and (3) to develop a favorable attitude among the people towards self-help projects. The PGH serves as the planning body. The project staff, which include the PGH-Department of Family Medicine, residents, interns and research assistants, coordinate their activities with the Muntinlupa RHU staff.

National Council of Churches of the Philippines (NCCP) Projects

The NCCP is an association of Protestant member churches and six affiliates in the Philippines. While its main objective is the attainment of Christian unity, it has widened its sphere of operation to include activities affecting the "social and civic life of the nation." Headed by a chairman and three vice-chairmen, NCCP has four commissions to oversee its major concerns. These are: (1) the Christian Education, (2) the Mass Media, (3) the Evangelism and Ecumenical Relations, and (4) the Development Social Concerns Commissions. The last commission concerns itself with the delivery of social services, including health. Actual implementation is undertaken by the local pastors of the member churches. While the NCCP helps in terms of funding and personnel, the training of local church groups for community health and the planning and implementation of their own projects are emphasized. The activities are usually coordinated with related local government and private agencies. Assistance is also provided by foreign Protestant church associations.

National Secretariat of Social Action (NASSA) Projects

The NASSA is a non-stock, non-profit federation of about sixty diocesan social action centers of the Catholic Church. The basic policies of NASSA are decided upon by the General Assembly during its annual convention and directed by the fifteen-members. NASSA National Committee is composed of a national director and the three regional executive secretaries for Luzon, Visayas and Mindanao. The national and the regional offices have no projects as such. Each diocesan center takes responsibility for social action programs and projects in its area, including self-help projects, cooperatives and other community projects. Initial support to the NASSA was provided by international organizations such as the Misereor. Meanwhile, NASSA has started pursuing efforts towards self-reliance for its programs.

Nutrisnak Feeding Project, MSSD Region IX

This is a food assistance intervention scheme to rehabilitate severely malnourished preschool children of Region IX. Processing and manufacture

of high-nutrition food supplement is undertaken by the MSSD Region IX Nutrition Center. This feeding project is made the point of entry of intervention schemes of the nutrition program which includes nutrition education and information, health, food production and family planning.

Nutrition Surveillance Project, Nutrition Center of the Philippines (NCP)

The Nutrition Surveillance Project is a nationwide project of the NCP for the prevention of malnutrition. The target clientele of the project include the pregnant women, the newborn, the under-six children and the schoolers. Piloted in Albay in 1977, the Project has established a data collection system for monitoring progress from the barangay and provincial levels to the NCP. Among the cooperating agencies are the National Nutrition Council (NNC), MOH, MSSD, BAEx, the Population Commission (POPCOM), Project Compassion, the Catholic Relief Services (CRS) and the NCP's Barangay Nutrition and Health Scholars (BNHS). Assistance is also provided by the UNICEF.

Panay Unified Services for Health (PUSH)

The PUSH project was initiated to improve the health status of the 600 identified depressed barangays in Panay Island which is composed of the provinces of Iloilo, Antique, Aklan and Capiz. Under the responsibility of the Regional Development Council (RDC) of Region VI, the Project attempts to achieve its objective through the establishment of an integrated barangay-based health service delivery system. Implementation of the program would be the responsibility of the 600 trained Barangay Health Workers (BHWs) under the supervision of their respective Rural Health Units (RHUs). The program relies heavily on community participation for its success. The PUSH Project Executive Committee, headed by the NEDA Region VI Executive Director, was established by the Regional Development Council (RDC) to oversee the planning, implementation, monitoring and evaluation of the project. Being an RDC project, PUSH is an inter-agency undertaking with the MOH as the lead agency. It is being supported by a loan/grant agreement between the national government and the USAID.

People's Adoption of Total Health Self-Sufficiency (PATHS) Project, Philippine Medical Association (PMA)

The PATHS Project was initiated by the Philippine Medical Association (PMA) primarily to involve its physician-members in the human and community development of the country particularly in public health. Having an active membership of about 13,000 physicians in its ninety component medical societies, PMA intends to cover the whole country with an initial target of ninety barangays (i.e., one barangay per component society). The PATHS Project components include: (a) a primary health care delivery system acceptable and within the capabilities of the community, (b) a health education and training program for the community, (c) a pre-paid health plan based on community needs and citizen's affordability, and (d) a program for the develop-

ment of income-generating potentials of the community through cottage industries and other activities. Under the PATHS project, participation of the community is a must, with the PMA and other agencies merely providing direction and support. The implementation of the project is the responsibility of a local PATHS committee in each component society. The other supporting agencies include the POPCOM, the NCP, the MOH and other local agencies and organizations.

Philippine Business For Social Progress

The Philippine Business for Social Progress (PBSP) is a non-stock, non-profit, private foundation committed to harnessing the resources of the private sector to help alleviate the country's socio-economic problems. Founded in 1970, it serves primarily as an organization for the rational funding and support of social development activities, including the formation of community organizations. Its principal operating funds are derived from member-firms who voluntarily contribute one percent of their annual net profit to the Foundation. The thrust of the PBSP is towards three areas: human resources development, food production and small business. The emphasis is towards integrated community development action. Assistance is channelled to the low income sectors of the population through proponent-organizations who have the capability, time and willingness to manage the projects.

Philippine Family Planning, Parasite Control and Nutrition Integrated Programme

In 1976, the Japanese Organization for International Cooperation in Family Planning (JOICFP) and the Asian Parasite Control Organization (APCO), both based in Japan, conceived of a new strategy aimed at arresting the leveling off of family planning acceptors and, at the same time, decreasing the number of family planning dropouts. This strategy would integrate the parasite control and nutrition programs into the family planning program. Parasite control was chosen as the point of entry because of its immediate and visible effects to the health and well-being of community members. Known as the Family Planning, Parasite Control and Nutrition Integrated Programme, the strategy was pilot-tested in six Asian countries—Philippines, Taiwan, Republic of Korea, Thailand, Malaysia and Indonesia. In the Philippines, the integrated program was implemented in four depressed communities in October, 1976, under the sponsorship of the Family Planning Organization of the Philippines (FPOP) in coordination with the Ministry of Health (MOH), Commission on Population (POPCOM) and the UP Institute of Public Health. The project sites selected were: Kawit, Cavite; San Pedro, Laguna; Caramoan, Camarines Sur; and Davao City. Existing manpower resources of the collaborating agencies were tapped for the program which were complemented by medical technicians and driver/audiovisual technicians of FPOP. Financial and material resources as well as equipment and facilities were all provided by the Japanese agencies.

Philippine Rural Reconstruction Movement

One of the oldest existing community development programs is the Philippine Rural Reconstruction Movement (PRRM). Founded in 1952, the PRRM uses an integrated approach in helping solve the problems of the poorer sectors of Philippine society. The components of this approach are livelihood, education, health and self-government. Barrio technicians are trained as community organizers, and community members are encouraged to solve their problems through their own efforts. The PRRM has inspired the formation of the following institutions: barrio council, barrio charter, Presidential Assistant on Community Development, barangay health center, botica sa barrio and the Samahang Nayon. The most extensive community development program of PRRM has been in dissident-infested Central Luzon (1954). The PRRM is currently coordinating the Cooperatives Development Program in Cagayan Valley, with assistance from MLGCD and the local barangay councils. It is based in Nieves, San Leonardo, Nueva Ecija.

Project HEART of Region XII

The Project HEART was established by the Sangguniang Pampook (or the Autonomous Government) in Region XII as part of the total development effort for the region. The Project intended to determine the viability of the institutionalization of a barangay-based health service delivery system through the training and services of a Barangay Health Worker (BHW). The two-year project would cover one hundred barangays of twenty municipalities in the five provinces of the region. The training of BHWs will enable them to deliver primary curative, preventive and promotive health services at the barangay level, to link the barangay with the regular health delivery system and to integrate all health and health-related activities in the barangay. The overall project supervision is undertaken by a Project Executive Committee (PEC) directly responsible to the Office of the Regional Commissioner. The Regional Health Office Director (RHO) serves as the Project Director with the Provincial Health Officer (PHO) as the Provincial Coordinator and the assigned coordinator from the Rural Health Unit staff (RHU) as the immediate supervisor of the BHWs. Major support is provided by the ORC (Region XII), the RHO, the MLGCD and the Development Academy of the Philippines. Financial support to the Project HEART was provided by USAID.

Rural Service Center Project (RSCP) of MLGCD

The RSCP, now known as the City Development Assistance Project (CDAP), is a project of the MLGCD aimed to improve the management capabilities of city governments in responding to the people's needs and in promoting citizen participation in the planning and implementation of the projects. The Project is an offshoot of the Provincial Development Assistance Project (PDAP) also of the MLGCD but which had the province as its focus of operations. Initially, the RSCP will cover sixteen chartered cities for the period FY 1978 to FY 1981. Among its service strategies are: (1) the training of key ci

ty officials in local government administration in the United States, (2) the strengthening of the city's administrative staff through professional staff development, (3) the management, technical and leadership training of barangays to enhance citizen participation in project planning and implementation and (4) the coordination of the activities of various national and local service agencies, (e.g., MSSD, MOH, Ministry of Labor, Ministry of Industry, etc.) for the development of the area. The RSCP is supported by a grant agreement with the USAID.

Special Social Services, MSSD

The Special Social Services program extends welfare and social services to the youth and adults with special needs. Services extended range from counseling of emotionally disturbed children to residential services for the aged. Under this program, MSSD maintains specialized reception centers such as: (1) the Reception and Study Center for the abandoned or orphaned children, (2) the Nayon ng Kabataan for emotionally disturbed children, (3) Elsie Gaches Village for mentally retarded children, (4) Marillac Hills for abused and wayward girls and women, (5) V. Madrigal Rehabilitation Center for delinquent boys, (6) Asuncion Perez Center for unwed mothers, (7) Golden Acres for the aged, (8) Jose Fabella Center for transient beggars and adult retardates and (9) Halfway Homes for the reintegration of released prisoners and mental patients into society.

United National Environmental Programme - National Housing Authority Marginal Settlements Improvement Project (UNEP-NHA MASIP)

The Marginal Settlements Improvement Project (MASIP) aims to demonstrate the efficacy of the integration of the techno-physical, socio-economic and administrative systems for the improvement of quality of life of the slum dweller and the upgrading of his environment. With the assistance from UNEP, MASIP is the responsibility of NHA. It has eight component projects which range from housing and health to income-generating activities. A MASIP Special Project Staff, headed by a project director, was organized to supervise the implementation and evaluation of the project. While other agencies including the Quezon City Planning and Development Office, NEDA, U.P. Institute of Small-Scale Industry and others serve as consultants, a number of others participate directly in the project, e.g., U.P. Institute of Environmental Planning, MOH, Metro Manila Commission, MSSD, and others.

University of the East-Ramon Magsaysay Memorial Medical Center Community Health Projects (UE-RMMMC).

The UE College of Medicine (now the UE-RMMMC), in response to the need for community medicine in its curriculum, launched a community medicine training laboratory in Limay, Bataan in 1963 for its medical students. Later, more community health projects were established such as the San Pedro Pro-

ject in San Pedro, Laguna and the Tulungan Community Health Project in Tondo, Manila (as its urban project). The main objective is to develop in the students competence for identifying, planning and providing the health needs of the community and in so doing, to improve the health condition in the area. The projects are mainly in coordination with the local government and health agencies including the RHUs. Initial support to these projects is provided by Malacañang, MOH and the USAID (for the Limay Project).

World Vision Philippines

World Vision Philippines is a Christian, humanitarian organization dedicated to assist children, families and communities become economically and spiritually self-reliant. An international organization, it started operating in the Philippines in 1957 as a child sponsorship program; since then, it has adopted a broader, holistic development approach in its assistance activities and expanded its beneficiaries to include the families and communities of these children (Children-in-community). Services are rendered in the following areas: health services and training; agriculture and income generation; social services; and Christian education and evangelism. Rural folk are trained under its COLT (Community Leadership Training) Program in the areas of scientific farming/fishing, community organization, health and nutrition, livelihood skills, etc. In this connection, it has coordinated with the International Institute for Rural Reconstruction in Silang, Cavite for the training of its community organizers. It has also been involved in relief and rehabilitation of refugees, flood and typhoon victims and prisoners. World Vision derives its funds from contributions in its support countries — United States, New Zealand, Canada, Australia and Europe. Various Christian organizations, international agencies and local government agencies have also cooperated with World Vision Philippines in terms of extending assistance ranging from material to technical help.

BIBLIOGRAPHY

Abrera, Ma. Alcesis. "A Probe into the Philippine Poverty Threshold." Unpublished undergraduate thesis, University of the Philippines School of Economics, 1974.

Adorna, Cecilio. "Distribution of Health Resources in the Philippines." Master's thesis, University of the Philippines School of Economics, 1976.

Alfiler, Ma. Concepcion P. "Comparative Case Studies of Community-Based Projects in Health and Family Planning: An Integrating Report," University of the Philippines, College of Public Administration, April 1981.

Altenstetter, Christa and James Warner Bjorkman. "Planning and Implementation: A Comparative Perspective on Health Policy." Discussion Paper Series, International Institute of Management, Berlin, August 1979.

Alvarez, Gabriel and Leda Layo. "An Empirical Analysis of Selected Access Indicators," *Philippine Sociological Review* 27 (January 1979).

Angara, Andres. "Observations on Rural Health Care Delivery Systems in the Philippines, 1978." World Health Organization, Regional Office for the Western Pacific Bureau Regional Du Pacifique Occidental, December 1978.

______________. *Personal Communication,* August 1980.

Asian Social Institute. *An Evaluation Research of the PRRM's Barrio Development Program in Laguna: A Baseline Study.* Manila: Asian Social Institute, 1973.

Association of Philippine Medical Colleges. "Physician Manpower Survey," 1970.

Binamira, Ramon P. "The Need for an Integrated Approach to Social Development in Underdeveloped Countries — A Look at Project Compassion, Philippines." Working Paper, UNICEF, April 1977.

Bulletin Today, "Act on High Cost of Medicare," May 26, 1980.

Campos, Paulo, C., ed. *Comprehensive Community Health.* Manila: National Science Development Board, 1975.

Canoy, Reuben. *The Counterfeit Revolution: Martial Law in the Philippines.* Manila: Philippine Editions Publishing, 1980.

Carbonell-Catilo, Ma. Aurora. "The Social Justice Content of Agrarian Reform Policies and their Consequences on Rural Development." Ph.D. dissertation, University of the Philippines, College of Public Administration, April 1981.

Cariño, Ledivina V. "Policy Directions for Health in the 1980's. Paper submitted to the President's Center for Special Studies, June 1980.

——— "Services to the Poor: A Preliminary Look at Existing Mechanisms for Meeting Health Needs in the Philippines." Paper read before the Philippine Economics Society, December 5, 1979. (Referred to in the text as Cariño 1979a)

———"Some Considerations Regarding the Representativeness and Responsiveness of the Philippine Bureaucracy," in M. Ladd Thomas and Raul P. de Guzman, *Bureaucratic Theory, Bureaucratic Practice,* Manila: Philippine-American Educational Foundation, 1979. (Referred to in the text as Cariño 1979b)

———"The Role of the Professions in the Philippine National Development." Public Administration Special Studies Series No. 2. College of Public Administration, University of the Philippines, February 1973.

———and Rebecca P. Albano. "The Impact of Feeder Roads: A Research Design." Economic and Social Impact Analysis/Women in Development (ESIA/WID) Project. Discussion Paper No. 76-24. Diliman, Quezon City: Philippine Center for Economic Development, August 1979.

———Ma. Concepcion P. Alfiler and Rebecca P. Albano. "Support for Health Programs: A Functional Analysis of the Ministry of Health." Report Submitted to the Ministry of Health, October 1980.

———and Emma B. Viñeza (ed.) *The Indang Experience: Lessons from the First CESDP Barrio Immersion.* Makati, Philippines: Development Academy of the Philippines, March 1980.

Chenery, Hollis, *et al. Redistribution with Growth.* London: Oxford University Press, 1974.

Cuyegkeng, Jose. "The (External) Migration of the Philippine Medical Graduate — Its Magnitude, Causes and Solutions." *The Filipino Family Physician* 9 (October-December, 1971).

Dequina, Donna. "A Study of the Utilization of Medical Facilities (Facili of PGH and GSIS Hospital)." Unpublished undergraduate th(University of the Philippine School of Economics, 1975.

Dorros, Sybilla Green. "Initiating Popular Participation at the Barangay Level: A Case Study of the Community Health Development Project at Carigara." *Philippine Journal of Public Administration* 24 (January 1980).

Dubsky, Roman. "Social Development, Social Policy, and Technocracy: The Philippine Experience." *Philippine Journal of Public Administration* 25 (January 1981).

Easton, David. *The Political System: Inquiry into the State of Political Science.* New York: Knoph, 1953 (Ist. ed.).

Gans, Sheldon P. and Gerald T. Horton. *Integration of Human Services: The State and Municipal Levels.* New York: Praeger Publishers, 1975.

Gardner, Sidney, *et al.* "Services Integration in HEW: An Initial Report," 1971.

Gasmen, Sergio S. "The CCHP Board." July 28, 1979. (Typewritten.)

______. UP-CCHP, Interview, 1980.

Gilbert, Neil. "Assessing Service Delivery Methods: Some Unsettled Questions." *Welfare in Review* 10 (May-June 1972) 25-33.

Guerrero, Sylvia. "Social Realities and the Administration of Justice." Discussion Paper for the Seminar-Workshop on "Administration of Justice: Focus on the Poor" sponsored by the UP Management Education Council, Quezon City, August 7-8, 1981.

______.The Impact of the Panay Unified Services for Health (PUSH): A Progress Report, ESIA/WID." Eight Workshop, November 30-December 1, 1979.

Hammarksjold Foundation. "Another Development in Health," *Development Dialogue.* 1978.

Hidalgo, Antonio, "Evaluation of a Health Program," *Philippine Sociological Review* 27 (January 1979).

Institute of Cultural Affairs. "Emergence of a Human Village: Documenting the Development of Sudtonggan, 1976-1980." May 1980.

———. " Sudtonggan Human Development Project: Consultation Summary Statement." May 1976.

Joves, Ma. Lourdes S. "Accessibility of Government Health Services in Bicol River Basin Area," Bicol Studies Series No. 10. College of Public Administration, University of the Philippines, 1979.

"MAKAPAWA." Unpublished Paper (n.d.)

Mangahas, Mahar and Bruno Barros. "The Distribution of Income and Wealth: A Survey of Philippine Research." Discussion Paper, Institute of Economic Development and Research, School of Economics, University of the Philippines, 1979.

Millett, John David. *Management in the Public Service.* New York *et. al.:* McGraw Hill Book Co., Inc., 1954.

Ministry of Health. *Manual on RHU Operations* (n.d.).

———."Primary Health Care: Philippine Policy Paper." June 3, 1980 (Mimeographed.)

Miranda, Felipe B. "Poverty: Political, Economic and Social Thoughts." Paper Presented at the President's Center for Special Studies Workshop on Poverty, July 1981. An Appendix of "A Concept of Justice." Unpublished paper, 1981.

Nadel, Mark V. "The Hidden Dimension of Public Policy: Private Governments and the Policy-Making Process," *Journal of Politics* 37 (February 1975).

National Secretariat of Social Action (NASSA). *Community-Based Approach to Health,* March 1978.

Ness, Gayl. *The Evaluation of Integration in Family Planning Programs,* UP College of Public Administration, 1975.

Nicolaus, Martin. "Alternative." Remarks made in the Convention of the American Sociological Association, 1968.

Olson, Mancur. *The Logic of Collective Action: Public Goods and the Theory of Groups.* Cambridge, Mass.: Harvard University Press, 1965.

Ostrom, Vincent and Elinor Ostrom. "Public Choice: A Different Approach to the Study of Public Administration." *Public Administration Review* 31 (March/April 1971).

Paris, Tirso. "The Measurement of Progress and Impact of Small-Scale Ir-

rigation Projects: A Review of the Literature," ESIA/WID (Micro) Discussion Paper No. 79-02, Philippine Center for Economic Development, University of the Philippines, 1979.

Philippine Medical Association. "Philippine Medical Association Adopts a Barangay Project." Project Proposal, n.d. (Mimeographed.)

Philippine (Republic) Ministry of Health. *Short-Term Health Plan,* 1978-1982. Manila, 1978.

Philippine (Republic). National Census and Statistics Office. *Special Release No. 382.* June 12, 1981.

Pilar, Municipality of. Municipal Development Staff. *Socio-Economic Profile* 1977

Pilar, Nestor, Emma Boncaras, and Grace Santos. "Social Development Policies and Programs in the Philippines: Focus on the Delivery of Health Services," *SPAR Series,* College of Public Administration, University of the Philippines, September 1976.

Project Compassion. *Primer on Project Compassion.* n.d.

———. *Project Compassion Progress Report,* 1975-1977.

———. *Status and Prospects, May 1978-September 1979.* Program Document, 1979.

Rural Health Unit. *Annual Report 1979.* Pilar, Bataan.

——— *Monthly Accomplishments Reports,* 1979.

Salcedo, Erlinda. "The Carmona Urban Resettlement Action Research Project (Baseline Period, 1972-73)." Quezon City: Institute of Philippine Culture, 1978.

Santiago, Carmen E. "The Social Preparation of the Community Towards the Partnership Approach to Health Care." Typescript, 1979.

Savage, Peter. "Contemporary Public Administration: The Changing Environment and Agenda" in *Public Administration in a Time of Turbulence.* Edited by Dwight Waldo. Scranton: Chandler Publishing Co., 1971.

Schaffer, Bernard, ed. "Special Issue on Accessibility," *Development and Change,* 6 (April 1975).

Sodusta, Jesucita and Ernesto Abarrientos. "The Impact of Integrated

Agricultural Production and Marketing Project (IAPMP): A Review of Literature and Methodological Considerations," ESIA/WID (Micro) Discussion Paper No. 79-07, Philippine Center for Economic Development, University of the Philippines, 1979.

Stauffer, Robert B. "The Philippine Development Model: Global Contradictions, Crises and Costs," *Philippine Journal of Public Administration* 25 (January 1981).

———. "The Philippine Political Economy: (Dependent) State Capitalism in the Corporatist Mode." Typescript, July 1981.

Streeten, Paul and Shahid Javid Burki. "Basic Needs: Some Issues," *World Development,* 6 (1978).

Tan, Jaime. "Strategies and Methods in Building Community-Based Health Programs: The Samar-Leyte Experience" in *Guide for Community-Based Health Programs* by the Rural Missionaries of the Philippines (Manila: Rural Missionaries of the Philippines, 1974).

———. "The MAKAPAWA: A Community-Based Health Program." n.d. (Mimeographed.)

———. "The Philosophy of Community-Based Health Program" in *Guide for Community-Based Health Programs* by the Rural Missionaries of the Philippines (Manila: Rural Missionaries of the Philippines, 1974).

Teresa, Municipality of. Municipal Development Staff. *Socio-Economic Profile* (1978).

Thursz, Daniel and Joseph Vigilante. "Meeting Human Needs: An Overview of Nine Countries," *Social Service Delivery Systems,* An International Annual, 1 (1975).

United Nations. *Popular Participation in Decision Making for Development.* New York, 1975.

University of the Philippines. Comprehensive Community Health Program *Annual Reports,* July 1975-December 1976; 1978; 1979.

——— and Department of Health. *Revised Memorandum of Agreement,* December 1972.

University of the Philippines at Los Baños, Center for Policy and Development Studies. "Economic Implications of Masagana Programs," *Effective-Delivery of Extension Services and the Masagana Programs: First Agricultural Policy Conference,* College, Laguna, 1972.

Uphoff, Norman T. "An Analytical Model of Process and Performance for Developing Indicators of Administrative Capability," *Philippine Journal of Public Administration.*

Uphoff, Norman T. "An Analytical Model of Process and Performance for Developing Indicators of Administrative Capability," Philippine Journal of Public Administration, 17 (July 1973).

Winslow, C.E.A. "The Untilled Field of Public Health." March 1920. Cited by John J. Hanlon, *Principles of Public Health Administration.* St. Louis: C.V. Mosby Company, 1950.

World Health Organization and United Nations Children's Fund. *Primary Health Care,* International Conference on Primary Health Care, Alma Ata USSR, 6-12 September 1978.

Wu, C.Y. "Refining Concepts of Performance in Development: Effectiveness, Profitability and Productivity," *Philippine Journal of Public Administration.* 17 (July 1973).

INDEX OF SUBJECTS

A

AKAP *see* Alay Kapwa Kilusang Pangkalusugan (AKAP)

AKHDF *see* Alay Kapwa Human Development Fund (AKHDF)

AMHOs *see* Assistant Municipal Health Officers (AMHOs)

APMC *see* Association of Philippine Medical Colleges (APMC)

ARA *see* Action-Reflection-Action (ARA)

Abaca craft industry, 144, 156

Accessibility, definition of, 15

Action-Reflection-Action (ARA), 126, 166

Adequacy, definition of, 15

"Agency-based" programs, 161n

Agricultural Extension, Bureau of, 8, 89

Agricultural workers, 33, 34, 35, 36

Agriculture, Ministry of, 9

Alay Kapwa Human Development Fund AKHDF), NASSA, 231-232

Alay Kapwa Kilusang Pangkalusugan (AKAP), 231

Albularyos, 205 *see also* Arbolaryos, Arbularyos, Herbolarios

Ampleness, definition of, 15

Anemia Surveillance Project, 232

Animal Husbandry Project, 137

"Another development," 2

Arbolaryos, 79 *see also* Albularyos, Arbularyos, Herbolarios

Arbularyos, 201 *see also* Albularyos Arbolaryos, Herbolarios

Aringit, Pastrana, Leyte, 116, 121

Assistant Municipal Health Officers (AMHOs), 75

Association of Philippine Medical Colleges (APMC), 3

B

BANP *see* Baao Applied Nutrition Program (BANP)

BDC *see* Barangay Development Council (BDC)

BDS *see* Barangay Development Seminar (BDS)

BDVs *see* Barangay Development Volunteers (BDVs)

BEC *see* Barangay Executive Committee (BEC)

BFD *see* Barefoot Doctors Project (BFD)

BHA *see* Barangay Health Aides (BHA)

BHP *see* Bicol Integrated Health Nutrition and Population Project (BHP)

BHT *see* Barangay Health Technician (BHT)

BHWs *see* Barangay Health Workers (BHWs)

BM *see* Barangay Mediks Programme (BM)

BNHS *see* Barangay Nutrition and Health Scholar Project (BNHS)

BSPO *see* Barangay Supply Point Officer (BSPO)

BTH *see* Barangay Technicians for Health Project (BTH)

BVM *see* Barangay Volunteer Medics (BVM)
Baao Applied Nutrition Program (BANP), 9, 232
cooperating agencies, 9
organizational chart, 9
Bagumbayan, Teresa, Rizal, 46, 47, 48
Barangay Development Council (BDC), 102, 106, 128, 165-166, 169
Barangay Development Seminar (BDS), 102.
Barangay Development Volunteers (BDVs), 98,151, 157, 165
compensation, 98
functions, 98, 107, 169
Barangay Development Volunteers Orientation Training, 111
Barangay Executive Committee (BEC), 99, 165, 169
Barangay Health Aides (BHA), 8-9
Barangay Health Aides (BHA) of Dauin, Negros Oriental, 232
Barangay Health Technician (BHT), 80, 82, 150, 157, 165, 169
Barangay Health Technician Training Program, 78, 87
Barangay Health Workers, (BHWs), 11
Barangay Mediks Programme (BM) Laguna, 233
Barangay Nutrition and Health Scholar Project (BNHS), 233
Barangay Nutrition Scholar, 21
Barangay Supply Point Officer (BSPO), 110
Barangay Technicians for Health Project (BTH), Nueva Ecija, 233
Barangay Volunteer Medics Training (BVM) Program, 10, 234
Barefoot doctors, 11
Barefoot Doctors Project (BFD), 19, 234
Basak, Lapu-Lapu City, 148
Baseline surveys, 22
"Basic needs" movement, 2, 5
Bay, Laguna, 27, 70, 71, 168, 205, 218
barrio health subcenters, 79
demography, 42, 43, 44, 182, 190
geography, 42
health care facilities, 42, 43, 188
health care services, 43, 202
occupation, 43
poblacion, 43-44
San Antonio, 43. 44, 45, 82, 205
Sta. Cruz, 43, 44, 45
site for Comprehensive Community Health Program (CCHP), 70
socio-economic conditions, 43 44, 54
"Best-foot-forward," 27
Bicol, 4
hospital facilities, 3
Bicol Integrated Health, Nutrition and Population Project (BHP), 234-235
Bohol Maternal and Child Health-Based Family Planning Project, 234-235
Botica sa Barangay, 155
Botika sa Nayon, 78, 85
Bulod, Sta. Fe, Leyte, 116
Bureau of Agricultural Extension *see* Agricultural Extension, Bureau of
Buri furniture industry, 144, 156

C

CBHP *see* Community-Based Health Program (CBHP)
CCHP *see* Comprehensive Community Health Program (CCHP)
CEH-MRD *see* Capiz Emmanuel Hospital Manpower Resource Distribution (CEH-MRD)
CHWs *see* Community Health Workers (CHWs)
CIM/CMSS *see* Cebu Velez Hospital/ Cebu Institute of Medicine-Community Medico-Social Center (IIM/CMSS)
CiO *see* Communications and Information Office (CIO)

COs *see* Community-Organizers (COs)

COTC *see* Chapter Officers Training Course (COTC)

COVs *see* Community Organizer Volunteers (COVs)

CP approaches *see* Citizen Participation (CP) approaches

Caceres, Archdiocese of, 9

Caibaan Project of tne Divine Word University, Tacloban City, 235

Capiz Emmanuel Hospital-Manpower Resource Distribution (CEH-MRD) Project, Roxas City, 235

Carigara Catchment Area Project, 17,22

Carigara Emergency Hospital, 22

Catholic Relief Services, 9

Cebu Velez Hospital/Cebu Institute of Medicine-Community Medico-Social Center (CIM-CMSS), 235-236

"Celebrations", 147

Chapter Officers Training Course (COTC), 96, 111

Citizen Participation, 10-12, 25, 76, 98-102, 165-167, 168-170, 171, 172-173, 183, 216-217, 223-224, 227-228
  factors affecting, 183-184
  level of, 172-173
  perception of, 170-172

Citizen participation approaches, 175

Clinic workers, tasks of, 145

Communications and Information Office (CIO)
  functions, 76, 91

Community agriculture, 137

Community assembly, 22, 140, 170

Community-Based Health Program (CBHP), 11, 16, 18, 19, 21, 22, 31
  components and objectives, 116-117
  health delivery systems, 115
  history, 115-116
  objectives, 115, 116-117
  site selection for, 20

Community-Based Health Program (CBHP) approach, 124

Community-based system, 161

Community commerce, 137

Community design proposals, 137

Community education, 137

Community formation, 137

Community Health Field Practice Program, 91

Community health programs, 19

Community Health Workers (CHWs), 11, 118-119, 124, 130-131, 152, 157, 166
  functions, 124
  salaries, allowances, etc., 125
  trainees, 118, 122, 123

Community Hospital, 74, 79, 80

Community Improvement Association, 137

Community leaders, 22

Community network, 22

Community organization (CO), 155

Community Organizer Volunteers (COVs), 121, 157, 166

Community Organizers (COs), 23, 122, 123, 124, 125, 127
  salaries, allowances, etc. 125

Community-oriented approach, 152

Community participation, 10-12
  in health services, 6
  in planning, 22
  in planning and implementation, 22-23
  in financing projects, 23

Community representatives, 24
  duties, 22

Community services, 137

Comprehensive community development, ICA approach, view of, 133

Comprehensive Community Health Program (CCHP), 17, 21, 26, 27 69n, 150, 156, 157, 171, 188, 206

accomplishments, 187
activities, 71, 72, 73, 75
administrative machinery, 76, 78
and Laguna Provincial Government, 74, 79
and Non-Formal Education for the Rural Youth (NEFRY), 78
and RHU in Bay, Laguna, 76, 78, 79, 82, 83, 84, 87, 92, 93, 150, 160, 192, 201, 220, 224
and the Provincial Health Officer of Laguna, 78-79
and the University of the Philippines, 69, 72
approaches, 74-75
budget, 91
characteristics, 150, 154-162, 219
citizen participation 165, 168-169, 173
committees, 76, 78
community meetings, 78
coverage, 192-193
curriculum, 91
description, 115
divisions, 70, 73, 76
educational activities, 169
effectiveness, 186, 187, 188, 191, 192, 212-214, 220-222
establishment, 69-70
evaluation, 85-89, 91
financial and logistical support, 73, 74, 89, 158
functions, 218-219
health care facilities, 201
health care services, 79-85, 87-89, 155, 188, 205; chart, 81
health service delivery, 79-85, 161, 194
history, 72-75
home care services, 79
hospital building, 74
ideological underpinnings, 162
initiation of, 168.
integration with RHU in Bay Laguna, 150
launching, 70
linkage with government, 160
linkages, 78-79
monitors, 83
objectives, 71, 187
organizational chart, 71, 77
organizational structure, 73-74, 76-78
outputs, 87-89
personnel, 156-157, 201
plans, 69-70
primary health activities, 88
problems, 74, 92-93
reorganization, 82-83
respondents' non-involvement in, 175
respondents' perception of participation, 171, 172
respondents' satisfaction with involvement in, 174
responsiveness to needs, 186
services, 85, 87-89
site selection for, 70
sponsorship, 154
staff meetings, 91
staff salaries, 93
status, 72
student teams, 83
training programs, 78, 79 84-85, 86, 87, 88, 89, 91
weaknesses, 71, 73

Comprehensive Community Health Program (CCHP) Advisory Council, 73

Comprehensive Community Health Program (CCHP), Board, 72
composition, 76
executive committee, 76
functions, 76, 78

Comprehensive Community Health Program (CCHP) Forum, 72

Comprehensive Community Health Program (CCHP) health team, 80

Comprehensive Community Health Program- Ministry of Health, (CCHP-MOH)
levels of health care chart, 83

Consult *see* Sudtonggan Consult

Consult Summary Statements, 133

Continuity, definition of, 15

Contraceptives
lack of supply in Teresa, Rizal, 110

Coordination, 8
and integration, 8
Craft guild, 144

D

DPO *see* District Population Officer (DPO)
Dambana ng Kagitingan, 40
Danao, Liwayway, Leyte, 127
Dauin, Negros Oriental, 8
Day Care Services and Suplementary Feeding Program, 236
Demeanor of Service Provider, definition, 15
Dental Aides Training Program for Midwives, 85
Department of Finance *see* Finance, Department of
Department of Health *see* Health, Department of
"Depressed" area, 19, 116, 154
definition, 20
Depression, 24
relative level of, 19
Development, definition of, 1
Development priorities
reorientation of, In
Developmental Communications Program for Community Health, 78
Diocesan Health Program Staff, 127
Diseases, 49, 54, 188
Dissatisfaction
source of, 210-211
District Health Center, 84
District Health Office, 150
District Health Office, 150
District Population Officer (DPO), 96, 151, 157
Diwa, Pilar, Bataan, 40, 41
Dumarag, Pastrana, Leyte, 116

E

ELNC *see* Early Learning Nutrition Center (ELNC)
ESIA/WID *see* Economic and Social Impact Analysis/Women in Development (ESIA/WID)
Early Learning Nutrition Center (ELNC), 52, 137, 144, 146-147, 167
Eastern Visayas, hospital facilities in, 3
Economic and Social Impact Analysis/ Women in Development, (ESIA/WID), 2n
Economic cooperation proposals, 137
Economic development, 1
Education
and involvement, 178, 180-182, 183
Educational attainment and accessibility, 36
Effectiveness, 6, 12-14
administrative measures of 185-191
definition, 12
factors affecting comparison of, 185
of health services programs, 185-217
indicators of, 13, 185
Environmental management, 94, 95, 100, 110
Equity, definition of, 15
"Excluded," 2, 5

F

FDO *see* Family Development Officer (FDO)
FEU-NRMF *see* Far Eastern University Dr. Nicanor Reyes Medical Foundation, Department of Community and Family Medicine (FEU-NRMF)
FIT *see* Family Ilaw Training (FIT)
FTOWs *see* Full Time Outreach Workers (FTOWs)
Family Development Officer (FDO), 151, 157
functions, 98, 107
Family Ilaw Training (FIT), 97, 98, 99-100, 111
composition, 165-166
objective, 173

organization, 99
unit leaders, 169
Family income, 38n, 41, 44, 46, 47, 49, 52, 54
Family planning, 7, 63, 94, 95, 109, 110, 188
lay motivators for, 22
Family Planning clinics, 7
Family planning users, 109
Far Eastern University: Dr. Nicanor Reyes Medical Foundation, Department of Community and Family Medicine (FEU-NRMF), 236
Filipinas Cement Corporation, 46
Finance Budget Officer, 76
Finance Department of, 3
First Development Decade, 1
Fiscal Services Association, 137
Food production, 109, 113
Full Time Outreach Workers (FTOWs), 96, 110, 151
Functional Skills Academy, 137

G

GSIS Hospital *see* Ospital ng Bagong Lipunan (OBL)
Government health expenditures, 4
"The great unwashed," 5
Green revolution, 94, 95, 109, 100, 107
Guild meetings, 167
Gulay-buhay, 100
Gulay-patay, 100

H

HBC/CMC *see* Huntington Beach Clinic/Calabaclabacan Mountain Clinic Projects
HDTS *see* Human Development Training School (HDTS)
Hammarksjold Foundation, 2
Health care services, 42, 51, 56, 57, 72, 79-85, 87-89, 155, 188, 190, 191, 194, 196, 198-199, 203, 205
sources of, 202-203
Health caretakers, tasks, 145-146
Health centers, 56-57
Health conditions, 49, 54, 187-191
Health delivery mechanisms/programs, 16, 17-25, 149
accessibility of, 201-204
accomplishments, 187
agencies involved in, 8, 18
area coverage, 19-20, 192-193
beneficiaries, 199-200
characteristics, 153-162, 218-220
church organizations involved in, 18
citizen participation, 168-170, 172-173, 216-217, 223-224, 227-228
community awareness of, 191-192
community participation, 10-12, 22-23
effectiveness, 185-191, 212-214, 216-217, 220-223
funds, 158-159
hospitals involved in, 18
integration, 222-223, 227-228
linkages and coordination, 8
linkage with special programs, 224
linkage with the government, 159-160
locus and scope of operation, 154
nature of activities, 155-156
objectives, 187
package content, 21
personnel, 156-158
persons involved in, 20-21
private organizations involved in, 18-19
respondents' non-involvement in, 175-177
sponsorship, 17-19, 154
trends, 24-25
universities involved in, 18
Health delivery mechanisms, survey of
limitations, 16-17, 31, 131
methodology, 26-31
problems, 16-17
sampling designs, 28-29
Health delivery organization, 16
Health, Department of (DOH), 3, 69, 75

see also Health, Ministry of
Health Guild, 145
Health, Ministry of, 9, 127, 128, 149, 150-160, 228
Health organizations, 6, 11
Health, poor, 5
Health professionals, 20, 24
Health services, 1, 3, 4, 6, 21
community participation in, 10-12
policies for the poor, 229-230
Health protection activities, 110
Health Sciences Center (HSC), 75
Health status, Filipino, 38
Health surveys, 4
Health workers, non-professional, 24
Herbal medicine, 85
Herbolarios, 89
see also Albularyos, Arbolaryos, Arbularyos
High income-earners, 2

33, 34, 35, 36
Hilot Training and Other Types of Training for Indigenous Health Workers, 81
Hilots, 72, 79, 81, 89, 130, 150, 156, 201
Hospital facilities, distribution of, 3
Hugpo, 23, 121, 122, 166
Human Development Training School (HDTS), 132, 140, 146
curriculum, 134-135
Huntington Beach Clinic/Calabaclabacan Mountain Clinic Projects (HBC/CMC) in Guihulugan, Negros Oriental, 237-238

I

IBR *see* Interhouse Bible Reflections (IBR)
ICA *see* Institute of Cultural Affairs (ICA)
IEC materials *see* Information, Education and Communication (IEC) materials
IHS *see* Institute of Health Sciences (IHS) of the UP College of Medicine, Tacloban City
IIRR *see* International Institute of Rural Reconstruction (IIRR)
Ilagan, Isabela, 115
Iligan, Lanao, 115
Ilaw ng Buhay Association of Teresa, Rizal, 98-99, 114, 151, 166, 169
composition of, 97, 99
Ilaw package, 173
Immunizations, 188
Improvement Guild, 147
Income and involvement, 178-182, 183
Income distribution structure, deterioration of, 2
Information, Education and Communication (IEC) materials, 22, 24, 110
Institute of Cultural Affairs (ICA), 26, 27, 140-141, 146-148, 153, 158, 166-167
community development approach, 133-135
history, 132
integrated system of development, 148
staff, 133, 135, 157
Institute of Cultural Affairs (ICA) Project *see* Sudtonggan Human Development Project (SHDP)
Institute of Health Sciences (IHS) of the UP College of Medicine, Tacloban City, 51, 152, 236-237
Integrated-citizen approaches, 175
Integration, 6, 7, 10, 183-184
and effectiveness, 214-216
and participation, 183-184
definition, 7, 8
dimensions, 10
types, 25
Inter-Agency Committee on Population and Vital Statistics, 42n
Interhouse Bible Reflections (IBR), 121, 122
International Institute of Rural

Reconstruction (IIRR) in
Silang, Cavite, 237
Interviews, structured, 28
Involvement, 10, 174
and socio-economic variables,178-182
levels, 10

K

KMC *see* Kansalakan Mountain Clinic (KMC) in Guihulugan, Negros Oriental
Kansalakan Mountain Clinic (KMC) in Guihulugan, Negros Oriental, 237-238
Katiwala Project, Davao Medical School Foundation (DMSF), 19, 238

L

LWC *see* Lower White-Collar (LWC)
Laguna Provincial Government and CCHP, 79
Land Food Project, 137
Langub Human Development Project in Davao City, 132
Lapu-Lapu City, 51
Lapu-Lapu City Health Office, 52, 144
Lay motivators, 22
"Left out, the", 2
Less advantaged group, 2
Leveriza, Pasay, 69n
Libertad, Palo, Leyte, 116
"Little kingdoms," 123
Livestock raising, 109
"Living Word of God," 117
Liwavway, MacArthur, Leyte, 27, 49-51, 121, 126, 127, 128, 130, 168, 205, 218
Danao, 127
demography, 49
economy, 49
geography, 49
health care facilities, 49, 51, 203
health care services, 51, 203, 205
health conditions, 49
occupations, 49
socio-economic conditions, 49, 54, 206
Local Government and Community Development, Ministry of (MLGCD), 166
"Lower White Collar" (LWC) workers, 33, 34, 35, 36, 40, 47

M

MCHP *see* Muntinlupa Comminity Health Program (MCHP)
MDC *see* Municipal Development Council (MDC)
MHD *see* Manila Health Department (MHD)
MIRDP *see* Mindoro Integrated Rural Development (MIRDP) Project
MIS *see* Management Information System (MIS)
MLGCD *see* Local Government and Community Development, Ministry of (MLGCD)
MOH *see* Health, Ministry of (MOH)
MPHW *see* Multi-purpose Heatth Worker (MPHW)
MSSD *see* Social Services and Development, Ministry of (MSSD)
MacArthur, Leyte
Municipal Health Officer, 127, 128
Mactan Electric Company, 147
Mactan Export Processing Zone, 144
Mactan Island Cluster Human Development Project, 132, 133
Makapawa, 26, 27, 31, 149, 152-162
Board of Directors, 121, 152
characteristics, 218-220
citizen participation, 166, 169-170, 172, 173
community-based approach, 152
coordination with religious organizations, 129
coverage, 192-193

delivery system, 155
development process, 117-124
economic activities, 130
economic services, 198
effectiveness, 186, 187, 190.
191, 192, 212-213, 220-223
evaluation stage (1975-1977), 120;
(1977-1979), 122, 123
financial and logistical support,
124-125, 158
health activities, 130
health care services, 194, 198-199,
205
health service delivery, 124, 161, 194
health survey, 170
ideological underpinnings, 162
implementing phase (1977-1979),
121-122
implementing stage (1975-1977),
118-120
initiation, 168
linkage with government, 127, 160
linkage with private-sector agencies,
129
meaning, 16
monitoring and control, 126
objective, 169
participation of other institutions
and agencies, 152-153
personnel, 157, 201
philosophy and orientation, 115
planning phase (1975-1977), 117-118;
(1977-1979), 120-121
problems, 120
program integration, 126-127
program outputs, 129-131
reformulation phase, 120-123
resource and support group for, 119
respondents' non-involvement in,
175, 176
respondents' perception of partici-
pation in, 170
respondents' satisfaction with
involvement in, 174
responsiveness to needs, 186
seminar and follow-up phases
(1975-1977), 118-120
sponsorship, 154
staff, 118, 121
weaknesses, 122-123

Makapawa Advisory Board, 127, 152
chairman, 116
composition, 117
Makapawa (rural) Makapawa-Under
Fives Clinic (urban), 120
Malnutrition, 5, 45, 54, 64, 108-109,
144, 190-191
Management information system
(MIS), 67
Manila Health Department (MHD), 4
Marina Maternity Clinic, 8
May-iba, Teresa, Rizal, 111
Medical consultations, 188
Medical services, cost of, 4
Memorandum of agreement
UP-DOH, 69, 70, 75, 82
UP-Dept. of Education, 75
UP-MOH, 84
Middle-income groups
level of satisfaction, 206
Milagrosa, Sta. Fe, Leyte, 116, 121
Mindoro Integrated Rural Development
Project (MIRDP), 238-239
Ministry of Agriculture *see* Agriculture,
Ministry of
Misereor, 124
Mombon *see* Liwayway
Mothers' Class Training Program, 81
Mountain Clinic projects
community participation in, 11
Multi-purpose health worker (MPHW),
21
incentives for, 21
Multipurpose Resident Health Workers
(MRHWs), 72
Municipal Council, 166
Municipal Development Council
(MDC), 113, 151, 166, 227
composition, 96
contribution to Project Compas-
sion, 106
creation and organization, 95, 96
functions, 96
membership, 96
objectives, 96

Municipal Development Plan of Teresa, 166
Municipal Family Development Council, 95, 151
see also Municipal Development Council
Municipal Health Officer (MHO), 55, 56, 57, 60, 65, 66, 127, 128
see also Rural Health Physician
Municipal Ilaw ng Buhay Association of Teresa, 99, 106, 157
creation and organization, 99
functions, 99
Municipal Social Development Seminar, 95, 96
Muntinlupa Community Health Program (MCHP), 239
Muslim areas of Mindanao, hospital facilities in, 3

N

NASA *see* National Secretariat of Social Action (NASSA)
NCCP *see* National Council of Churches of the Philippines (NCCP)
NNS *see* National Nutrition Service (NNS)
NSDB *see* National Science Development Board
National Census and Statistics Office, 38n
National Council of Churches of the Philippines (NCCP) Projects, 239
National Economic Council, 70
National Nutrition Council, 149
National Science Development Board (NSDB), 70, 73, 89
National Secretariat of Social Action (NASSA), 2, 17, 231, 239
New Public Administration, 12-13
Non-involvement, reasons for
by barangay, 176-177
by respondents, 175-176
"North Central Health District of Laguna," 80
Nutrisnak Feeding Project, MSSD Region IX, 239-240
Nutrition, 94, 95, 100
Nutrition Council of the Philippines, 21
Nutrition services, 7, 64-65, 102, 107-109
Nutrition Surveillance Project, Nutrition Center of the Philippines (NCP), 240

O

OBL *see* Ospital ng Bagong Lipunan (OBL)
Occupations, 53-54
and involvement, 178-182
"Operation Linis," 110
Operation Timbang, 64, 107, 108
Opon Emergency Hospital, 52, 144
Ospital ng Bagong Lipunan (OBL), 3, 4
facilities of, 4
"Other professionals," 205

P

PATHS *see* People's Adoption of Total Health Self-Sufficiency (PATHS) Project
PBSP *see* Philippine Business for Social Progress (PBSP)
PGH *see* Philippine General Hospital (PGH)
PHC *see* Primary Health Care (PHC)
PNVSCO *see* Philippine National Volunteer Service Coordinating Office (PNVSCT)
POPCOM *see* Population Commission (POPCOM)
ProCom *see* Project Compassion (ProCom)
PRRM *see* Philippine Rural Reconstruction Movement (PRRM)
PTB *see* Pulmonary Tuberculosis (PTB)
PUSH *see* Panay Unified Services for Health (PUSH)

Palo, Diocese of, 116, 120
Palo, Leyte, 115
Panay municipalities, 19
Panay Unified Services for Health
(PUSH), 11, 19, 21, 240
Paramedics, 121
Paraprofessionals, 150
"Participants," 172n
Participation, 10-12
and effectiveness, 216-217
in decision-making, 117
Pasulhogan, Babatngon, Leyte, 116
"Peaking" satisfaction, 206
People's Adoption of Total
Health Self-Sufficiency (PATHS)
Project, 19, 20, 21, 240-241
community participation in, 11
Pharmacy Aides Training Program,
84-85, 86
Philippine Business for Social Progress,
(PBSP), 9, 20, 241
Philippine Charity Sweepstakes Office,
61
Philippine Family Planning, Parasite
Control and Nutrition Integrated Programme, 241
Philippine General Hospital (PGH), 3-4
facilities, 4
Philippine Hospital Association, president, 4
Philippine Medical Association, 11
Philippine Medical Care Commission, 4
Philippine Medicare Commission in
Orion, Bataan, 42
Philippine National Volunteer Service
Coordinating Office (PNVSCO), 10
Philippine Rural Reconstruction Movement (PRRM), 242
Physician Manpower Survey, 3
Physicians, distribution of, 3
Pilar, Bataan, 205, 218
demography, 39
Diwa, 40
economy, 39, 40
geography, 39, 40
health care facilities, 41, 42
health care services, 42
health conditions, 42, 188
occupations, 40, 53
Poblacion, 39, 41
socio-economic conditions, 41 54
Wawa, 40
Pilit, Sta. Fe, Leyte, 116
Poblacion, Bay, Laguna, 43, 44
Poblacion, Pilar, Bataan, 39, 41
Poblacion, Teresa, Rizal, 46, 48
Poor, the, 1, 2, 3, 4, 5
38, 39, 178, 184, 206
benefits for, 199-200
Population Commission (POPCOM),
61-62, 96, 149, 151
contribution to Project
Compassion (ProCom), 106
Population Institute *see* U.P. Population Institute
Poverty, 38, 41, 51, 53, 54
eradication of, 2
Poverty line, 38n
Primary Health Care (PHC), 80
definition, 225-226
characteristics, 226
Prinza, Teresa, Rizal, 46-48
Program orientation
definition, 160
service targets, 161
Program personnel, evaluation of,
207-208
Progressiveness, definition of, 15
Project Compassion (ProCom), 26, 27,
150-0-152, 150n, 171
accomplishments, 187
action plans, 96, 112
and the Ministry of Social
Services Development (MSSD), 102
Barangay Quarterly Report, 107
Board of Trustees, 94
characteristics, 154, 155, 157, 158,
160, 161, 163-164, 220
citizen participation, 96, 98-102,
165-166, 169, 171, 173, 217
conclusions and recommendations, 113-114
coordination with other agencies,

102, 103, 104, 105, 106
coverage, 192
creation and organization, 94
description, 94, 95
economic services, 196, 198
effectiveness, 107-112, 113, 186, 187, 191, 192, 214, 217, 220-222
environmental management activities, analysis, 110, 112
evaluation by Sinag-Team, 107
evaluation reports, 112
evolution, 151
Executive Committee, 94
family planning activities, analysis, 109, 110, 112
financial and logistical support, 102-105, 113, 158
functions, 218
government agencies participation in, 151-152
green revolution activities, analysis, 109, 112
health care services, 191, 194, 196, 198, 199
health service delivery, 161, 194
implementation, 96, 97
information system, 112
initiation, 168
linkage with the government, 160
monitoring and evaluation, 106
nutrition activities, analysis, 107-109, 112
objectives, 95, 187
organizational chart, 94
outputs, analysis, 107-112
personnel, 157
planning, 95, 96
problems, 112-113
Quarterly Summary Report, 106-107, 111
referral system, 100-101
respondents' non-involvement in, 175
respondents' perception of participation in, 171
respondents' satisfaction with involvement in, 174
responsiveness to needs, 186
social services 196, 198
sponsorship, 154
sports and cultural activities, analysis, 111-112
staff, 97, 151
structure, 97
training activities evaluation, 110-111
unit leaders, 106, 107

Project Heart, 242

Project sites, 38-39
criteria for selection, 19-20

Provincial Health Office (PHO), 58, 60-61, 78, 79, 82, 150

Provincial Health Officer of Laguna and Comprehensive Community Health Program (CCHP), 78-79

Public health, definiton of, 226n

Public health dentists, sunctions, 56

Public health midwife, functions, 56

Public health nurse, 61, 80, 82, functions, 56

Public utilities program, 146-147

Puericulture Center (PC), 59, 60, 61

Purok, 139, 158

Purok meetings, 139

R

RHCDs *see* Restructured Health Care Delivery System (RHCDS)

RHMs *see* Rural Health Midwives (RHMs)

RHU *see* Rural Health Unit (RHU)

RSCP *see* Rural Service Center Project (RSCP)

RWG *see* "Redistribution with growth" (RWG)

Recommendations, 225-230

Redistribution, definition of, 2

"Redistribution with growth" (RWG), 2

Referral systems, 151, 156
alternative referral system, 101
multi-tiered referral, 22

usual referral system, 101
Region IV
hospital facilities, 3
medical professionals, 3
Region V, hospital facilities in, 3
Region VIII, hospital facilities in, 3
Region IX, hospital facilities in, 3
Region XII, hospital facilities in, 3
Regional Health Office, 118, 127
Respondents, 29, 171
dissatisfaction, sources of, 210-211
dissatisfaction with program personnel, 211
education attainment, 36-37
evaluation of program personnel, 207-208
occupation, 32-36
satisfaction, level of, 204-207
satisfaction, sources of, 209
sex, 32
socio-economic conditions, 37
Restructured Health Care Delivery System (RHCDS), 55, 57, 67-68, 156, 168
"Results of Extension of UP-CCHP for 1978 and 1979" report, 87
Rizal Electric Cooperative, 46
Rizal Youth Development Foundation (RYDF)
involvement in Procom, 109
Rock industry, 143, 144
Rockefeller Foundation, 70, 72, 73, 74, 89
Roman Cathölic Church in Leyte involvement in Makapawa, 152
Rural areas, 3
Rural family income, 38n
Rural Health Midwives (RHMs), 57, 61, 82, 150, 165
Rural Health Physician (RHP), 55, 60, 61
Rural Health Unit (RHU) in Bay, Laguna, 74, 80, 83, 84, 87. 150, 160
activities, 82
and the Comprehensive Community Health Program, 76, 78, 79, 80, 82, 83, 84, 87, 92, 93, 160, 201, 220, 224
characteristics, 219
staff salaries, 93
targets, 187
Rural Health Unit (RHU) in Liwayway, MacArthur, Leyte and Makapawa, 119, 122, 152-153
role, 119
Rural Health Unit (RHU) in Pilar, Bataan, 26, 27, 31, 55-68
accomplishments, 62-67, 188
activities, 188
administrative ofile, 55-59
and Population Commission, 61
and Project Compassion (ProCom), 110
characteristics, 149, 154-156, 158, 159. 160, 162, 163, 164
citizen participation, 168, 171, 173
community oriented approach, 152
coverage, 192
educational activities, 168
effectiveness, 186, 187, 188, 214, 220, 222, 224
evaluation, 60-61
financial and logistical support, 59-60, 158
functions, 55
health care services, 56, 57, 155, 188, 194, 198, 199, 205
health centers, 56-57
health facilities, 201
health service delivery, 161, 194
ideological underpinnings, 162
integration, 61, 222-223
linkage with government agencies, 159-160
monitoring, 60-61
nature of activities, 155
organizational chart, 55
personnel, 57, 58-60, 156, 201
problems, 60
relationships with other agencies, 61-62
respondents' non-involvement, 175
respondents' perception of participation, 171
respondents' satisfaction with in-

volvement in, 174
responsiveness to needs, 186
scope, 154
sponsorship, 154
staff salaries, allowances, 60
supplies and equipment, 60
targets 161, 187
Rural Improvement Club, 8
Rural Missionaries of the
Philippines, 115, 116, 118, 152
Rural salary inspector, 61
functions, 56
Rural Service Center Project (RSCP) of MLGCD, 242
Rural Service Group contribution to ProCom, 106

S

SDS *see* Social Development Seminar (SDS)
Social Development Seminar (SDS)
SHDP *see* Sudtonggan Human Development Project (SHDP)
SSA *see* Secretariat of Social Action (SSA)
St. Paul's Hospital, Tacloban City, 116, 129
assistance to Makapawa, 129
Samahang Nayon, 128
San Antonio, Bay Laguna, 43, 44, 45, 82, 205
Sangguniang Bayan, 128, 166
San Antonio, Bay, Laguna, 43, 44, 45, 82, 205
Satisfaction, 2
dimensions, 14
level, 204-207
sources, 209-210
Satisfaction regarding program personnel, 207-208
Schistosomiasis Control Project, Palo Leyte, 49
Sea Food Project, 137
Secretariat of Social Action (SSA), 9
Self-reliance, 95, 97, 117
Service delivery
dimensions of satisfaction, 15
effectiveness, 13-14
persons involved in, 19-20
"Shadow" method, 140
Silliman University Medical Center Extension Service, 8
Sinag-Team
functions, 107
Site selection
criteria for, 19-20
Slums
health services for, 4
"Snapshot," 31
Social development proposals, 137
Social Development Seminar, 95, 96, 111, 151
Social justice, 1
Social preparation
inadequacy, 120
Social services, 2, 6, 7
Social Services and Development, Ministry of (MSSD), 9
Special Social Services, MSSD, 243
Sponsors, 17-19
types, 26
Sports and cultural development, 94, 95, 100
Squatters
health services for, 4
"Strategic" area, definition of, 20
Sudtonggan, Basak, Lapu-Lapu City,
51-53, 139, 168, 170, 218
abaca craft industry, 144
buri furniture industry, 144
demography, 51, 52, 144, 190
economy, 51, 52, 141
geography, 51, 132
health care facilities, 52
health care services, 203
health conditions, 51, 190
malnutrition, 144
occupations, 52-54
"participants," 172n
residents, needs of, 136

school attendance, 51
social service delivery systems, 144-147
socio-economic conditions, 51, 52, 53, 54
Sudtonggan Community Center, 137
Sudtonggan Consult, 135-138, 143 144, 153, 666, 193
assumptions, 135-136
constraints to its fulfillment, 136
function/tasks, 133, 136-137
participants, 135
phasing of activities, 137
presuppositions, 135
programs, 137-138
proposals/projects, 137
Sudtonggan Elementary School, 52, 146
Sudtonggan Health Center, 52
Sudtonggan Health Clinic, 137, 144, 146
Sudtonggan Human Development Program (SHDP), 26, 27, 132-148, 149, 153-162, 171, 172n
abaca craft industry, 156
accomplishments, 190
Board of Directors, 139-140, 145, 148, 170
buri furniture industry, 156
characteristics, 154, 156, 157, 158-159, 160, 161, 162, 218-219
citizen participation, 166-167, 170, 171, 172, 173, 216-217
community assembly, 170
coverage, 192-193
cultural program, 147-148
economic program, 141-143, 156
economic services, 197, 198
education program, 146, 156
effectiveness, 186, 187, 190, 191, 212-213, 220-222
financial scheme, 141, 158, 159
guild meetings, 167
Health Guild, 145
health personnel, 201
health program, 144-146, 156
health service delivery, 161, 194
health services, 197, 198, 199
ideological underpinnings, 162
implementation, 138
Improvement Guild, 147
income and expenditure, 142
industries, 141-144, 156
initiation, 168
management, 140
medical care provided by, 205
office, 140
organization and administrative mechanism, 138-149
organizational chart, 139
personnel, 157-158
planning meetings, 167
public utilities program, 146-147, 156
respondents' non-involvement, 175, 176
respondents perception of participation, 171
respondents' satisfaction with involvement in, 174
responsiveness to needs, 186
rock industry 156
services, 156
social programs, 144, 156
social services, 197, 198, 199
sponsorship, 154
staff, 140
staff salaries, 141
zone meetings, 167
Sudtonggan Industrial Complex, 137
Sudtonggan Nutrition Center, 137
Sudtonggan Trading Company, 137
Sudtonggan Utilities Project, 137
Sycip Plantation, Inc., 8

T

TFAP *see* Targeted Food Assistance Program (TFAP)
Targeted Food Assistance Program (TFAP), 64
Team leader, functions of, 97
"Technical failure," 14
Teresa,Rizal, 27, 45-46, 94, 168, 218
Bagumbayan, 46-48
demography, 45, 46
economy, 45, 46
health care facilities, 41

health care services, 190-191
health conditions, 45, 54, 108-109, 188, 190-191
May-iba, 111
Municipal Development Council, 95, 96, 106, 113, 151, 166, 227
occupations, 46, 47, 54
Poblacion, 46-48
Prinza, 46-48
socio-economic conditions, 46, 47, 48, 54

Teresa Waterworks System, 46

"They who are not," 2

Tibac, Sta. Fe, Leyte, 116

Timeless, definition of, 15

Traditional healers, 22

Training Program for Paramedics, 91

Tripartite Agreement, 96

U

UE-RMMMC *see* University of the East-Ramon Magsaysay Memorial Medical Center Community (UE-RMMMC) Health Projects

UNEP-NHA MASIP *see* United National Environmental Programme-National Housing Authority Marginal Settlements Improvement Project (UNEP-NHA MASIP)

UNICEP, contribution to ProCom, 106

USAID, 70

Under Fives Clinic, 116

Unit leaders, 106
reports of, 107

United National Environmental Programme-National Housing Authority Marginal Settlements Improvement Project (UNEP-NHA MASIP), 243

University of the East-Ramon Magsaysay Memorial Medical Center Community Health Projects (UE-RMMMC), 243-244

University of the Philippines, 73 and the Comprehensive Community Health Program (CCHP), 69, 72

U.P. Board of Regents, 72

U.P. CCHP Infirmary, 79, 87, 150
hospital fees, 89
patients, 85, 87
staff, 84

U.P. College of Agriculture, 69, 83

U.P. College of Medicine curriculum, 69, 70, 72

U.P. Foundation, 79

U.P. Institute of Health Services, 128

U.P. Institute of Social Work & Community Development, 82

U.P. Population Institute, 83

Upper respiratory tract infections (URTI), 188

Uyong *see* , Pilar, Bataan

V

Victoria, Sta. Fe, Leyte, 116, 121

Village Schooling Institute, 137

W

Wawa, Pilar, Bataan, 40

"Within health," 7

Workers, classification of, 33-36

World Health Organization (WHO), 226

World Vision Philippines, 244

"Wrong" children, 62n

Y

Yapad, Pastrana, Leyte, 116, 121

Z

Zone meetings, 167

INDEX OF NAMES

Abarrientos, Ernesto, 2
Abrera, Ma. Alcestis, 38n
Adorna, Cecilio, 4
Albano, Rebecca P., 2, 60, 132-148, 231-244
Alfiler, Ma. Concepcion, 5, 60
Altenstetter, Christa, 227
Alvarez, Gabriel, 3
Angara, Andres, 16, 17, 18, 226n
Balitaan, Francisco G., 55-68
Barrion, Leonor, 116
Bautista, Victoria A., 16-31, 32-37, 165-184
Bjorkman, James Warner, 227
Boncaras, Emma *see* Viñeza, Emma B.
Buelva, Jessica J., 38-54
Burki, Shahid David, 2
Campos, Paulo C., 43, 70, 71, 79, 81
Canoy, Reuben, In
Caraso, Reynaldo N., 94-114
Carino, Ledivina V., 1-15, 2, 3, 5, 16-31, 16n, 38-54, 60, 149-230, 225n
Catilo Ma. Aurora, In
Chenery, Hollis, 1
Cuyegkeng, Jose, 3
De Leon, Josie M., 69-93, 115-131, 231-244
Dequina, Donna, 3, 4
Dorros, Sybilla Green, 5
Dubsky, Roman, 1n
Easton, David, 13
Eusebio, Anacleta A., 231n
Fernando, Dante T., 94-114
Gans, Sheldon P., 7, 8, 13
Gazmen, Sergio S., 73, 83
Gilbert, Neil, 24
Guerrero, Sylvia, 5, 19
Hidalgo, Antonio, 4
Horton, Gerald T., 7, 8, 13
Jacinto, Melchor, 226n
Joves, Ma. Lourdes S., 4. 16-31, 29, 149-164, 185-217, 231-244
Layo, Leda, 3
Mangahas, Mahar, 1, 38
Marcos, Ferdinand E., 1
Marcos, Imelda R., 94
Marcos, Pacifico, 4
Millett, John David, 14
Miranda, Felipe B., In, 38n
Nadel, Mark V., 13
Ness, Gayle, 6, 7
Niclaus, Martin, 13
Olson, Mancur, 13
Ostrom, Vincent, 13
Paris, Tirso, 2
Peterson, John, 237
Pilar, Nestor N., 205, 228
Salcedo, Erlinda, 5
Santiago, Carmen E., 22, 205
Santos, Grace, 228
Savage, Peter 12
Schaffer, Bernard, 14
Sodusta, Jesucita, 2
Stauffer, Robert, 1n
Streeten, Paul, 2
Tan Jaime Galvez, 4, 7, 20, 72, 73, 83, 115, 118
Thursz, Daniel, 230
Uphoff, Norman, 12
Vigilante, Joseph, 230
Viñeza, Emma B., 5, 205, 228
Winslow, C.E.A., 226n
Wu, C. Y., 13