フィリピン国感染症基礎調査報告書

調査参考資料編

昭和57年6月

国際協力事業団

フィリピン国感染症基礎調査報告書

調 査 参 考 資 料 編

I. Primary Health Care in National Development

OPENING REMARKS

J. C. AZURIN
Deputy Minister of Health
Philippines

Honorable Juan Ponce Enrile, Minister of National Defense; His Excellency Ambassador Tanaka of Japan; Dr. Nakajima, WHO-WPRO Regional Director; Ambassador Arao Ohta, IMFJ; the Honorable Delegates to the 8th SEAMIC Workshop, Members of the Staff of the Ministry of Health, Distinguished Guests, Ladies and Gentlemen:

On behalf of the Ministry of Health and the SEAMIC Coordinating Committee of the Philippines, I wish to bid all of you a very warm welcome!

Today we are living in a world undergoing significant changes because of rapidly improving technologies. In the field of health, the changes that have occurred during the past 80 years have been more meaningful than those that have occurred during the past 2,000 years. Sophisticated technology has brought wonderful advances and has benefited mankind. An outstanding example is the eradication throughout the world of smallpox, the most dreadful scourge known to mankind during the past 10,000 years.

Change is a process by which the future invades our very lives and we must be aware of it, not only from the viewpoint of history, but from the day-to-day experiences of living individuals. The health delivery system is a case in point. Heretofore, the health delivery system has to try to catch up with the rapidly growing population and changes in technology. Governments today, whether developing or developed, have come to realize that they can no longer afford the health demands of their populations. The concept of primary health care has emerged to meet the fact that health is no longer a privilege but the right of every individual. The government of the Philippines has come to realize that it can no longer afford to subsidize fully the health needs of its population. The concept of primary health care involves intersectoral linkages and community participation, and the Ministry of Health serves only as a catalyzer. It involves the total participation of every sector in government and private organizations in the health delivery system. It demands that individuals in every community must participate in the maintenance of their own health. While the Ministry of Health is the organization mainly responsible for the dispensation of health services, in the concept of primary health care, it is only an agency which stimulates the delivery of health services to the population.

We are embarking on a unique workshop that is going to take the participants to three different provinces in three regional areas of the Philippines. In each of these provinces there have been developed different stages of primary health care. As we observe these stages of development, we will be aware of weaknesses and difficulties and the strategies to overcome these difficulties.

In each of these areas, the individuals that have been involved in the development of primary health care will sit down with you to discuss their work. These are ordinary workers at the village level, technical people from various fields of endeavor, doctors, nurses, and midwives. They will emphasize the different sectors which must go into the development of primary health care. As we go from one area to another, there will be many points which should be intensively discussed to give us a firm grasp of how primary health care may be evolved. Out of these discussions there must emerge—a clear concept of the components of primary health care; the different sectors and agencies that are involved; the manner in which a community may be organized; the agency that must be primarily responsible in the organization of community participation; the persuasion that must go into the participation of each individual in every community in the maintenance of his own health; and finally all of these at the minimum cost possible.

As we go around the three regions of our country, you will find the real Filipino—his way of life, the friendly and happy way he conducts the business of everyday living. The real Filipino is friendly and, behind a ready smile, hides a firmness of purpose coupled with a zest for living. You will also notice the beauty of our rural areas, each region different from the other.

At the close of this conference, it is fervently hoped that every participating country shall develop a framework of how primary health care should be organized in their own country to ensure that it results in an effective health delivery system.

I wish to acknowledge with deep gratitude the collaboration of SEAMIC and the World Health Organization in the holding of this workshop.

I reiterate our warmest welcome to all of you!

REMARKS

HIROSHI NAKAJIMA
Regional Director
Western Pacific Regional Office
World Health Organization

I wish to thank the Chairman of the Organizing Committee, Dr. Azurin, for inviting me to address this official opening of the Eighth SEAMIC Workshop today. Unfortunately, I am unable to be present as I am now in Geneva attending the meeting of the WHO Executive Board. I am particularly happy, however, that the World Health Organization has collaborated with the Government of the Republic of the Philippines and SEAMIC in organizing this workshop on primary health care.

The implementation of primary health care poses various challenges and difficulties. The concept, however, is not new; it had been developed and applied in a number of countries even before attention was focused on it at the International Conference on Primary Health Care in Alma-Ata and the World Health Assembly.

Before primary health care was given world-wide endorsement by WHO, most developing countries were reluctant to describe their own individual efforts to solve their problems in this area because of fear of criticism. The fact that they lacked the sophisticated facilities and technology available in developed countries was also, no doubt, a source of embarrassment. Happily this attitude no longer exists.

The World Health Assembly further underscored the importance of primary health care implementation by adopting resolution WHA32.30 which sets the goal of an acceptable level of health for all by the year 2000 and identifies primary health care as the major component of the strategy for achieving such a goal. The resolution invites Member States to make known their national strategies for the attainment of this goal.

It can be assumed that all countries are now at various stages of primary health care implementation. Each country may also have its own definition or concept of primary health care, which is a good reason for promoting exchanges of experience so that countries may learn from each other. I am particularly pleased, therefore, that WHO has been invited to collaborate in this Workshop, which will be conducted along the lines of a travelling workshop. The participants will visit and observe primary health care projects in Legaspi, Cebu, and Leyte, and will exchange views and experiences; in particular, during the workshop sessions, they will attempt to develop and improve on a framework for primary health care in their own countries, in the light of their observations and experiences.

I am sure you will note from your conversations and from your discussions during this

workshop a few differences in the interpretation of primary health care. For instance, some authorities regard primary health care as an approach which integrates at the community level all those elements that are necessary to make an impact on the health status of the people. Others define it in terms of its content, which is no different from that of a basic health service. Still others consider it a part of the health care delivery system, where contact is first made by the people. These differences in definition are more apparent than real, and they are more a difference in the focus of emphasis on different aspects of the subject: the approach, the content, and the service delivery structure. The most important consideration is its philosophical basis comprising the following components: that primary health care envisages the total health coverage of the population; that the community is involved as an active participant; that the resources of the different sectors are mobilized to address the problem of community development in a coordinated and unwasteful manner; and that the technology used to improve and protect the health of the population is both relevant to the identified problems and available at an affordable cost.

WHO is fully committed to the goal of health for all by the year 2000, and its different regions have formulated regional primary health care strategies for achieving this goal, with primary health care as the principal approach. With the support of the Member States, the Organization in both the Western Pacific and South East Asia Regions will exercise to the full its constitutional functions of coordination and technical cooperation to ensure, first, that support is given to developing countries in their efforts to develop primary health care; second, that developed countries are informed of the situation elsewhere and are encouraged to extend cooperation to developing countries; and third, that international cooperation is effectively channelled to high priority areas.

Before I conclude, let me state that WHO is particularly pleased to collaborate with SEAMIC, under the able leadership of Mr. Arao Ohta, in its efforts to disseminate knowledge and experience in primary health care through the sponsorship of workshops and other activities. Such collaboration and coordination among international agencies will facilitate the attainment of health for all by the year 2000. Allow me once more to express my appreciation to the Government of the Republic of the Philippines for having invited WHO to collaborate in this workshop.

Thank you for your attention.

ARAO OHTA
Executive Director
International Medical Foundation of Japan

In July last year, ASEAN ministers of health met in Manila, virtually for the first time, for closer cooperation. On the other hand, SEAMIC, which is composed of ASEAN members and Japan, has been launching multilateral operations.

Hoping these two approaches may meet together, I would like to extend my sincere congratulations on commencing the workshop. In my view, the current workshop has several significant points.

1. It has been my firm conviction that in order to develop SEAMIC activities on a sound basis and to provide for their subsequent growth, some kind of organization should be set up in each of the SEAMIC countries that will correspond to the SEAMIC Executive Committee, the so-called SEAMIC-Tokyo. Thus, at the SEAMIC Conference 1979, which was held at the undersecretary level in Tokyo, it was "unanimously organized that there was a need for setting up an efficient form of coordinating mechanism in each participating country to support the SEAMIC activities." In response to the urge, the Philippines first established such a mechanism

in July last year, setting the lead among the SEAMIC countries. We hope that this mechanism will be able to function in a way similar to "SEAMIC-Tokyo." Members of the Organizing Committee for this workshop are virtually identical to what I have just referred to as "SEAMIC-Philippines," and I am personally very pleased to witness this significant development in the Philippines. Moreover, I look forward to similar moves taking place in the other SEAMIC countries as well.

2. The present workshop will open a new phase in the planning of SEAMIC workshops. I recall that at the 5th Workshop in Manila in 1978, the theme of Primary Health Care (PHC) was taken up virtually for the first time. Although the 5th Workshop ended with rather conceptional arguments, the following workshop in Kuala Lumpur, in 1979, proceeded a step further in the new direction: attempts were made during the animated discussions to seek the appropriate health indicators for PHC. The results, however, were somewhat less rewarding than expected because neither time nor the general circumstances were then ripe enough to tackle such a complex problem. At the 7th workshop, which was held in Jakarta in 1980, the functions of the health center were reviewed and the possibility of the health center generating appropriate health indicators was explored; and, for the first time, a field trip was included as part of the program. The idea of including a field trip derives from the thought that a workshop, while dealing with PHC, limits its activities to a lecture room and may not properly reflect the real needs of PHC at the grassroots level. From this viewpoint, the excursion to Nagrak in the Sukabumi Regency in West Java Province was planned, and I believe that that field trip had a favorable impact on the workshop participants, giving them fresh ideas for planning future workshops on PHC within the SEAMIC framework. Now comes the current workshop. When I visited Manila last February to speak with Dr. Azurin about laying a basis for planning the workshop, Dr. Azurin and I readily agreed on the following points as I understand them: a) The workshop should concentrate on field observations and minimize classroom formulas, and b) It should take a "travelling" form so that participants could make comparative observations on the spot.

These basic requirements were elaborated on by the Organizing Committee, and the results have been shaped into the program that you now have in hand. Thus, I can assure you that the present workshop is opening the way to some new approaches in the history of SEAMIC workshops.

3. This workshop is unique in the sense that multilateral collaboration has been an important aspect from the preparatory stage onward, involving the contributions of not only Manila and Tokyo but also of a third partner: Jakarta.

In order to achieve fruitful results from any event, preparations must play a major role. The sites for the workshop have been carefully selected by the Organizing Committee. Furthermore, a great deal of thought and effort have gone into preparing orientation materials which are indispensable for any activity of this nature particularly for this type of workshop. To assist in such preparations, we asked Jakarta, which was the host of the previous workshop, to dispatch a well-qualified person who would be responsible for drafting a keynote paper for this workshop and for visiting each of the projected sites. Dr. S. L. Leimena, who was recommended by Jakarta, proved to be very well-qualified indeed. He was entrusted to draft the paper, and, together with Philippine and Japanese experts, traveled to all the proposed sites. I believe that his paper will constitute a valuable basis for the proceedings of this workshop.

4. I would like to mention, as the last point, something about the participation of some of the WHO-recommended countries. As the SEAMIC activities develop within a multilateral framework among the current SEAMIC countries (which incidentally are ASEAN member countries), the sense of membership is growing steadily and becoming more conspicuous due to the consolidation of ASEAN countries. During the SEAMIC Conference 1979, which I mentioned earlier, it was "agreed that SEAMIC should concentrate on consolidating its structure within the current six countries"; on the other hand, "the product of the SEAMIC activities could widely be utilized also for non-SEAMIC countries, since there is no boundary

in the scientific community." Planning for the SEAMIC programs is conducted by the SEAMIC member countries on a multilateral basis. But SEAMIC is not a closed project. It could benefit by enlarging its activities and by collaborating with other countries. Primary Health Care is of paramount concern to all developing countries. Through our involvement with PHC, SEAMIC has been closer to WHO. Thanks to the valuable cooperation of WPRO (WHO's Western Pacific Regional Office), we have been able to invite representatives from WHO/WPRO countries to this workshop. I am very happy at having an opportunity to share our accomplishments with a larger community.

I sincerely hope that, during this workshop, each representative of the participating countries will be able to gain more knowledge and experience to improve the community's welfare.

Thank you.

HIDEHO TANAKA
Ambassador of Japan

Dr. Azurin, Deputy Minister of Health and Chairman of this Workshop; Deputy Minister Isabelo Castro, Ministry of National Defense; Dr. Mercado of WHO; Mr. Arao Ohta of International Medical Foundation of Japan; Distinguished Delegates, Guests, Ladies and Gentlemen:

It is a great honor and pleasure for me to have this opportunity to address all of you at this 8th Southeast Asia Medical Information Center, or SEAMIC, Workshop which is hosted by the Ministry of Health, in cooperation with the World Health Organization and International Medical Foundation of Japan.

Needless to say, the problem of health is one of the most basic and the most important human needs and I cannot but pay a high tribute to all of you present here today who engage yourselves in this valuable undertaking. I have taken note of your activities with keen interest and followed them closely, since the success of the programme in the medical field would highly depend on the exchange and dissemination of information among the member-nations as well as with other countries, a task which is the very essence of SEAMIC objectives.

It is also noteworthy that, since the last workshop held in Japan, SEAMIC has worked closely hand-in-hand with WHO, thus contributing more efficiently to the attainment of the objectives.

I am convinced that the present workshop, conducted in the form of a "Travelling Workshop," will help enhance the technical level of primary health care projects in the Philippines and contribute to the development of human resources in this field. I believe that this is in line with one of the major pillars of the economic cooperation programme of my Government as expressed by Prime Minister Suzuki in his recent visit to ASEAN countries.

To exemplify the intention of the Japanese Government to contribute to human resources development in the medical field in this country, may I take this occasion to point out that the Government of Japan has donated to the Philippine Government an institute, the Institute for Tropical Medicine, which will be under the supervision of the Philippine Ministry of Health. The institute is to be in operation in April of this year and is expected to contribute to the control, if not total eradication, of tropical diseases within the Southeast Asian countries.

In closing, allow me to express my profound admiration for the efforts of the people involved in this workshop, especially Dr. Azurin and his collaborators, whose untiring efforts have made this project a very promising one. I am sure that this workshop will be a success and bring about fruitful and meaningful results in the health conditions not only of this country but of all those which are covered by the activities of SEAMIC.

Thank you.

KEYNOTE ADDRESS

JUAN PONCE ENRILE
Minister of National Defense
Philippines

I express my utmost regrets in being unable to join you this morning due to highly pressing official matters.

I am honored, however, to be given the opportunity to keynote this conference.

As President Marcos once said, "Common problems of development that face the nations of our region call for determined measures from each of us to banish isolation and establish an environment of total cooperation in all fields of endeavor."

It is in this spirit, of course, that you are gathered here to reassess and perhaps strengthen further the bonds of cooperation among our respective nations in the particular area of primary health care. We do acknowledge the support of the World Health Organization for this noble effort, which I am confident will result in more meaningful health programs of our respective nations and peoples.

Like the struggle against poverty and ignorance, the battle against disease has always held a high priority in the agenda of nations in the Asean-Pacific region, especially for developing nations like ours. The imperative of healthy and well-nourished people to provide the energy and dynamism needed for development must be continually underscored.

To be sure, a healthy nation begets a healthy economy. Disease could lead to stagnation and discontent, which could in turn prejudice the welfare of future generations.

It is in this light that the Philippine Government has always sought to strengthen the intersectoral linkages within its national health delivery system. Time and again, the policy has been emphasized that both the private and the public sectors must be fully committed and involved in this effort. Such a policy springs from the need to maximize our resources for social amelioration and development at a time when we face the common constraints arising from prevailing challenges and uncertainties in the world economy.

As part of its main mission to maintain national stability, the Ministry of National Defense has been engaged in the delivery of essential social and economic services in the far-flung areas of our country, to include medical assistance and health care.

Over the past decade, more than four million individuals have been treated by military doctors under the civic action programs of the Armed Forces of the Philippines. Such programs fall under the umbrella of what we call the home defense concept, which aims in part of striking at root causes of dissidence and discontent by involving the military organization in the enterprise of popular uplift and social amelioration.

Through one of the adjuncts of the Defense Ministry, the Veterans Memorial Medical Center (VMMC), we are also engaged in a medical program covering 120,000 veterans and their dependents all over the country. Last year, the VMMC treated 298,442 patients, or a daily patient load of 817 individuals. The center also maintains 19 contract annexes within various hospitals that serve our veterans and their dependents in the provinces.

Through the VMMC, medical training and research are also conducted to hone the skills of our doctors and hospital staff. We maintain continuous liaison with medical schools in the training of interns. Our own doctors at times are sent out to the field on a rotation basis to support civic action programs.

Our role in the national health delivery system is also highlighted by our active participation, through the Office for Civil Defense, in the extension of medical relief and rehabilitation services in calamity areas. At the present time, this Civil Defense arm is organized along intersectoral lines, with the different government ministries at the top of the organization and more than 20,000 emergency disaster coordinating councils at the grassroots.

The Defense Ministry has continually explored broader areas of cooperation with other government agencies involved in the national health delivery system, as in the field of public health education, where further linkages have been strengthened between civilian and military efforts, in logistic and transport matters, whether they concern evaluation of persons from the hinterlands or the delivery of health personnel and supplies to target areas, or in the construction of hospitals and health centers, an activity where our military engineers have been actively involved.

We have always been prepared to devote our available manpower, material resources, and facilities in the pursuit of such activities because we are fully aware that the quest for stability in our society cannot be won by mere force of arms, but rather, by the application of meaningful and concrete socio-economic measures designed for the physical and moral uplift of the people.

I know, of course, that your respective nations have evolved their own enlightened system of medical care delivery and I am certain that we can share in this our respective lessons we have learned in pursuing this common enterprise.

In almost all fields of endeavor, there is a growing configuration of close regional interests in Southeast Asia and the Pacific Region, born out of our common problems, our common aspirations, and common ideals.

It is in this regard that we give this conference its due significance——as an effort to enrich the collective search for stability, social justice, and progress in this part of the world.

I am grateful for this privilege and I thank you for giving me an opportunity to convey my own humble views in an area of vital concern that transcends our national boundaries.

Indeed, Asians must be strong not only in order to survive, but also to build their respective nations in the vision of greatness and freedom.

I wish you the best of success in this undertaking.

Thank you.

CLOSING ADDRESS

ENRIQUE M. GARCIA
Minister of Health
Philippines

They say there is a time for everything: a time to live and a time to die, a time to laugh and a time to cry, a time to speak and a time to remain silent. One of the most embarrasing, self-recriminating times in one's life is to realize that he has spoken and opened his mouth but only to put his foot in it. I hope this is not one of those times.

They also say that the world would be a much better place to live in if people would say to one another what one "nicely" feels—at the precise moment when he feels it, and when it should be said.

So I would like to begin by saying, in all sincerity, that I missed being with you on opening day and that I am very happy to now catch up with you, no matter how fleetingly, and meet all of you.

I am confident that Deputy Minister Azurin has done justice to our Filipino hospitality trait as you went about seeing a little of our country—what we have done, what we are trying to do, and whatever offerings we could afford, to make you both more knowledgeable about medical information, Primary Health Care "Philippine Style," and fairly comfortable during your short stay with us.

For as you went about meeting our people and gauging our "medical quality of life," I was meeting old and new friends from nearby countries, savoring their hospitality and scenic beauty, learning about their health programs. All of us have been learning more about each and the other during this past week. Only when we know more about each other can we understand, can we be more understanding about the successes and failings the other may have. Then we know where we can help one another as we come together in workshops such as this.

Excerpts from the opening day speeches coincide with my thoughts.
I do believe we can: "Consolidate efforts in our countries, with modifications, all five of us; Collaborate with guest countries that we may enlarge our activities; Coordinate with WHO, the "who is who" in world health guidance."

Dr. Mercado's speech in Director Nakajima's behalf forecasts that better methods will emerge in the implementation of Primary Health Care in this part of the world when: "Individual efforts to solve problems in each country—which we used to be shy about presenting—can now be candidly presented—the good and the disappointing experiences all told, the different interpretations will finally surface during this family of countries workshop .... This is sharing in its splendor."

My background before being, literally and truly, catapulted to Minister of Health as "Orchestrator and Pilot" of health strategies and programs in our country, was one of clinics and surgery, hospital-based, naturally. At this stage of my life, having been honed to the art of being "open" in mind, ears, and heart to continuous learning, I have, in my short span in the Ministry of Health, fallen in love with public health work and the surveillance of health and welfare programs designed to improve the quality of life and level of health of my people.

I met the Minister of Health of Singapore who was not a doctor. The Deputy Minister of Hongkong was one of the top orthopedic surgeons before he was appointed Deputy Minister. I know what they felt starting on the job. I have been given several titles since I went over to public health life: a breath of fresh air, a kibitzer, a bull in a porcelain shop. I have had to study and work a lot, for the public health subject I took decades ago had metamorphosed in concept, coverage, and implementation. I have had to attend innumerable conferences—as opening or closing speaker and avid listener. I have been all over the country,

from its highest point in the north to its lowest island in the south, getting to know my people; rural folks, co-workers, our front-liners in the field, their problems, local conditions, their aspirations.

My first few months on the job seemed an interlude in frustration and near despair. But months of learning with enthusiasm from my management group, health directors, and experiences flavored with sustained interest, gradually replaced this frustration with a growing interest and, finally, with an *obsession*, an obsession to help my people, to improve, even in a small way, their quality of life and medical care delivery. To me, the surgeon and the teacher, this transformation, this metamorphosis, has been a personal mini-miracle.

I relay this information to you, because I imagine this is what those people in the barangays, urban rural areas whom we will teach, train and cultivate to become allies in health work, will go through within themselves. But we should be able to teach them what they must become, for the sake of their very own community and its survival and because it will be a work of love and service. This is what we will be asking from people in every community. It is our task to teach the chosen ones to make primary health care a reality, an actuality. It is, therefore, imperative that we exude dedication, enthusiasm, sincerity and competence in the teaching processes.

Without needing to go into the primary health care intricacies, for these have been presented at your workshop by our bionic Dr. Amparo Banzon, I can only say that all of us involved in this thrust will be judged by the durability and stability of the primary health care momentum. For this is the strategy of 56 countries as ours. This "we" in this country refers to all levels of our Ministry as well as inputs of other Ministries, government, non-government agencies, and *the community people*. Truly, primary health care is an "all-for-one and one-for-all" collective effort, a medium for loving and caring, where give and take, flexibility, versatility, and resourcefulness are valuable ingredients for success.

We will make necessary adjustments in the budget. Rural areas will be getting a bigger proportion than previously, and hospitals will be critically evaluated for judicious and proportionate appropriations. The preventive and promotive health efforts will henceforth be given a bigger slice of the budgetary pie. We have embarked on herbal medicines propagation, for medicinal preparations have become expensive, beyond the reach of the low income group. We will take a step backward to enable us to move forward by revival of traditional medical practices.

All these are being "rejuvenated" for we feel these will have a role in the teaching and practice of our health workers for primary health care.

We will continue pursuing the improvement of health care delivery despite roadblocks as poverty, over population, malnutrition, shortage of resources and manpower, urban decay. We have positive factors in the support of the government, the fortitude of my co-workers in the Ministries, and the indomitable spirit of the Filipinos.

We will push health education further, so more and more of our people will learn to cope with the basic causes of illnesses and pay more attention and concern to social and environmental factors conducive to healthful living. To put it succinctly, "health is the resultant of moment-to-moment interaction between the individual and his environment," which encompasses economic, natural, socio-cultural, educational, and political conditions, which are, inevitably, subject to changes. So it is that our government gives priority to food production, nutrition, family planning, agricultural development, ecological preservation. The Ministry of Local Government and Community Development is charged with the challenge of community development which is not possible if health conditions are poor. Indeed, linkages, intersectoral and multilateral approach, are essential.

I would like to cite the valuable contributions and inputs of international organizations, WHO, UNICEF, SEAMIC, to mention a few, in the amelioration and gradual solution of our health problems.

In the final analysis, health of the populace is so important, so vital to national development and progress, that it should not be left solely to the medical and paramedical people.

The ultimate in a relevant health care delivery system is to develop an integrated, self-sustaining, self-reliant manpower system oriented to the existing resources and needs of each and every community. With a little help from us, people in the community, if duly motivated and guided, can learn to face their problems squarely and dedicate themselves to devise their own remedial strategies.

Ladies and gentlemen, if most of these we can bring about, we shall have justified and complied with our assigned tasks as health managers and catalysts. And from all these, we shall derive that exclusive self-satisfaction that can only come from a job well done. Thank you to all of you; may we meet again——and good day.

I. INTRODUCTION

This workshop, which is the eighth in the series sponsored by the Southeast Asian Medical Information Center (SEAMIC), is a sequential development of the preceding workshops focussing on Primary Health Care (PHC).

Previous discussions centered on such issues as the philosophy and prevailing concepts of PHC, the formulation of models of the health care delivery system in each participating country utilizing such PHC concepts, and the elucidation of their various aspects—ranging from planning and organization to operation and monitoring and finally to assessment and evaluation.

The present workshop, held in Manila with the Philippines as host and with eight countries participating, concentrated on the role of PHC in national development. A significant innovation introduced was the visits of the participants to three different areas in the country to actually observe ongoing PHC projects utilizing widely disparate approaches. While the movement of the group entailed elaborate logistical arrangements, especially because of the time constraints, it was amply rewarded by the opportunities afforded the participants to observe firsthand the various projects, to dialogue with the implementors and to appreciate the manifold problems and influences affecting their implementation in the field. Thereby, it is hoped that the exchange of ideas and experiences among participants will help improve PHC activities in their own countries and reinforce their respective commitments to the attainment of "Health for All by the Year 2000."

This report chronicles the workshop proceedings and field observations.

II. OBJECTIVES OF THE WORKSHOP

1. To observe different approaches in the development of primary health care
2. To discuss specific problems and measures for implementation and improvement of primary health care based on each participant's experience
3. To develop and/or improve a framework for primary health care in participating countries
4. To define the role that international organizations like SEAMIC and WHO can play in contributing to the improvement of primary health care

III. ORGANIZATION

The Workshop had before it the following:

1. Reports on the implementation of Primary Health Care in the three provinces in the Philippines (Sorsogon, Cebu, and Leyte) that were visited by the workshop participants: a) Primary Health Care in the province of Sorsogon; b) Sudtungan Human Development Project in Lapu Lapu City; c) The Utilization of Various Delivery Systems of Primary Health Care in Consolacion, Cebu: Their Effectiveness; and d) An Innovative Strategy for Health Manpower Development and Distribution.

At the opening of the first plenary session, the participants elected National Economic and Development Authority Director Fleur de lys Torres of the Philippines as chairman of the Workshop. After assuming the chair, Director Torres appointed Dr. Silas Laurens Leimena of Indonesia as Vice-chairman and Dr. Harbhajan Singh of Malaysia as Chief Rapporteur.

In addition the following delegates were appointed rapporteurs for the discussion in the corresponding provinces: a) Dr. Shigekato Kaihara—Sorsogon and Albay; b) Dr. Uma Rajan—Cebu; c) Dr. Jamroon Mikhaanorn—Leyte.

2. Country Reports: a) Guam; b) Indonesia; c) Korea; d) Japan; e) Malaysia; f) Singapore; g) Thailand; h) Philippines.

On the first day, Dr. Raja Ahmad Noordin presented his paper, "Health For All by the year 2000 through Primary Care." Country reports were read and concepts of Primary Health Care, its operationalization, input to existing health system and problems encountered were discussed.

The succeeding days, February 4 to 7, were spent on field visits to the primary health care sites. Discussions on field observations were held in the afternoons. In the afternoon of the fifth day, the participants developed a framework for primary health care in participating countries. They also discussed the role that international organizations, like SEAMIC and WHO, can play in contributing to the improvement of primary health care.

The draft report was discussed and approved on the last day.

IV. CONFERENCE REPORT AND RECOMMENDATIONS

Twenty-nine delegates from eight different countries met in Manila from 3 February to 9 February 1981. They observed Primary Health Care (PHC) projects in four different sites in the country and the lessons learned from them were summarized by the group as follows:

1. PHC project in Sorsogon, Sorsogon, which utilizes Extension of Basic Health Services as its approach: a) Effective community participation influences the successful use of the Barangay Health Workers (BHWs); b) BHWs should be from the community;

c) Incentives of BHWs should come from the community itself.

2. PHC project in Carigara, Leyte, which utilizes Community Partnership in Health Development as its approach: a) There should be more utilization of trained community organizers/workers at the initial stage of the project; b) The University of the Philippines-Ministry of Health (UP-MOH) approach is useful in the development of PHC; c) Hospitals can play a new role in comprehensive and integrated health care.
3. PHC project in Consolacion, Cebu, which utilizes the Integrated Area Development approach: a) There is a need for continuing, dynamic leadership; b) The total integrated area development approach is effective in bringing about community development; c) There is a need to strengthen leadership at the Barangay level; d) It is necessary to define responsibilities in the complicated organizational set-up to attain development.
4. PHC project in Sudtonggan, Cebu, which utilizes the Comprehensive Socio-Economic Development approach: a) It is possible with the comprehensive three-pronged approach to get community involvement in health even if there is no initial manifestation of health needs; b) The project is an ideal model for the development of other socio-economic projects; c) An effective decision-making mechanism at the grass-roots level is necessary to attain community participation; d) The project demonstrates how international organizations can assist in community development; e) Health development is possible through economic approach; f) Community organization is effective in promoting the socio-economic development of the community.

Since the participants come from different countries, their perceptions of the implications for their own country of the PHC projects they have observed also vary. These are summarized for the delegation of each participating country as follows:

A. *Sorsogon Project:*

1. *Guam*—The delegate feels that this approach is not applicable to the present health care system of Guam.
2. *Indonesia*—The delegation thinks this approach could be applied in some parts of their country, particularly in communities with low socio-economic status and low educational level, provided there is intensification of the process of community involvement.
3. *Japan*—The delegation feels there is a need to increase the number of personnel engaged in public health activities who are stationed in the community.
4. *Korea*—The delegate opined that to remedy the maldistribution of health resources, his government had already experimented with health workers similar to the BHW, namely Village Health Agent. The results were not as successful as expected, but he feels they can share the experiences gained in Sorsogon which would be very useful for future trial and planning.
5. *Malaysia*—The delegation thinks the concept is applicable to Malaysia with slight modifications. The matter of incentives, however, is not applicable.
6. *Singapore*—As Singapore is a small urbanized site, comprehensive basic health services are already well established and easily accessible to people in urban and rural areas through a comprehensive network of polyclinics, out-patient dispensaries providing curative care, and maternal and child clinics providing preventive care. The policy now is to build more polyclinics in new towns, thereby integrating the existing curative and preventive services under one roof and providing a more specialized health care program.
7. *Thailand*—The delegation stated that the extension of basic health services has already been implemented throughout Thailand. The constraints encountered are similar to those in the Sorsogon project and they need more community partnership.

B. *Carigara Project*

1. *Guam*—The delegate feels that the health issues in Guam could be best addressed through this approach. Its implications include: a) The need to strengthen coordination between private and public health care providers in the planning, implementing,

and monitoring of health development activities; b) The need to initiate community participation and strengthen linkages with community organizations involved in health care activities; c) The need to incorporate socio-economic elements into the health program; d) The need to mobilize all community resources for health; e) The need to expand or modify the present government primary health care facility. Integration of all existing activities will ensure provision of comprehensive primary health care; f) The need to educate the community in the preventive aspects of health care inasmuch as the community is more concerned with curative services; and g) The need to train or orient key personnel in the concept of PHC.

2. *Indonesia*—The approach in this project is in line with the PHC/Village Community Health Development approach in Indonesia. It is already in a developing stage in several provinces.
3. *Japan*—The delegation thinks that medical (curative) and health (preventive) care should be coordinated more closely. It also feels there is a need to establish some kind of mechanism whereby each family could be made to participate actively in making decisions for health planning.
4. *Korea*—The government had already adopted three strategies for primary health care, one of which is health research strategy, to help discover knowledge and relevant indicators needed to develop models of effective partnership or community participation. Since the Carigara project has progressed so much along this line, the delegate feels his government can greatly benefit from the information generated by it.
5. *Malaysia*—The delegation thinks that the role of hospitals in their country with respect to community involvement is minimal, for Rural Health Services are very well developed.
6. *Singapore*—The Constituency Consultative Committees and Resident Committees, which are headed by Members of Parliament (MP), link the people and the government. The MPs hold weekly "Meet the People" sessions at which their needs are known; these needs are met through information fed back to government departments and other agencies. The Committees encourage community contributions for government health education campaigns and health surveys; these also promote individual awareness in health. Family participation is also encouraged through activities of the nursing staff and the Home Nursing Foundation scheme.
7. *Thailand*—Selected areas in Thailand have been implementing PHC programs through this approach. Current information indicates that more than 25 percent of all villages in Thailand are in those areas. The process is time-consuming; hence, results have not yet been obtained.

C. *Consolacion Project*

1. *Guam*—This approach is not applicable.
2. *Indonesia*—This approach cannot be applied except in certain particular instances where there is very low socio-economic development. However, the process of community involvement must be intensified.
3. *Japan*—This type of approach is popular in Japan.
4. *Korea*—Since 1970, the government has initiated SAEMAUL Movement, which is acknowledged as a successful program. However, PHC has not yet been fully integrated in the movement. From the Consolacion project, local leaders in Korea can learn how to integrate the health component in their area-wide development efforts.
5. *Malaysia*—Intersectoral involvement and coordination between government agencies and the community are functioning satisfactorily.
6. *Singapore*—Urbanization of rural areas and urban renewal are accomplished through the Ministry of National Development. Facilities for comprehensive health care services are an essential provision in any new housing project.
7. *Thailand*—The approach is applied only in pilot studies, which has brought it to the

attention of other sectors. It is expected that a country-wide program will be launched in the next 5-year plan period (1982–1986).

D. *Sudtonggan Project*

1. *Guam*—This approach is not applicable.
2. *Indonesia*—This approach is in line with the implementation of PHC and could be further developed with the use of Community Health Workers as internal agents of change.
3. *Japan*—The implications are the same as those for the Carigara project.
4. *Korea*—While this project is the most impressive of the four PHC projects, it needs very careful analysis as to its technical, economic, and administrative feasibility. Once it is done and found satisfactory, it has a good chance of implementation in Korea whose next 5-year economic and social development plan will be implemented from 1982.
5. *Malaysia*—There is community participation in the socio-economic activities in the rural areas, which are also now geared towards promotion of health.
6. *Singapore*—Socio-economic development runs parallel to health development and they complement each other in the process. Preventive services for school children, immunization, prenatal care for the first two pregnancies, post-natal care, and family planning services are provided free, but a nominal charge is levied for curative services.
7. *Thailand*—The delegation feels the approach may be appropriate for Thailand. The only thing that may be difficult is the marketing of local products, not only because of the location of the communities but also because of strong middlemen intervening in their economic system.

E. *Consolidated Philippine Perspectives*

Since the four projects visited are all being implemented in the Philippines, the implications for the country are summarized collectively. Implementation should give top consideration to the following factors in order to insure the successful attainment of goals, especially in subsequent projects: 1) Review of the different programs of the sectoral agencies related to PHC; 2) Strengthening of the coordination and communication network among all partner sectors and all levels; 3) Survey of community needs, problems, and resources (participatory); 4) Built-in monitoring and evaluation schemes; 5) Support of international agencies and other external assistance; however, provision of withdrawal of assistance should be incorporated; and 6) Tapping of local resources for community development be worked up together by the community, the government, and other agencies concerned so that availability and sustenance may be maintained.

Role of International Agencies in PHC

In the perception of the group, international organizations like SEAMIC and WHO can play vital roles in contributing to the improvement of primary health care. These are summarized as follows:

Role of WHO

Generally WHO holds a coordinating function in PHC in relation to HFA and this includes: 1) Facilitating political support for concept of HFA and PHC; 2) Facilitating economic support for PHC leading to HFA; 3) Facilitating technical cooperation with individual countries or exchange of experiences and information among countries; 4) Helping to strengthen concepts of HFA and strategy for HFA; 5) Facilitating development of an information system among countries; 6) Disseminating information on experiences in the implementation of HFA; 7) Evaluating progress in the implementation of HFA; and 8) Coordinating functions so that concept of HFA in PHC would facilitate implementation of HFA.

Role of SEAMIC

1. Primary role will be to arrange convenient forums to provide each participating country with useful information for its health planning. Essential aim should be to draw up

a complete policy for implementation. SEAMIC's original role does not extend to implementation but it could do so by collaboration with other international aid organizations on a lateral basis.

2. Technical assistance can be very wide. It is not spelt out in SEAMIC's function, but it can be done with limited activity by: a) Arranging for close collaboration between key medical bodies; b) Organizing seminars where there is need for technical assistance to train for better skills, and c) Arranging for data exchange programmes and standardizing laboratory data, for which seminars could be organized by SEAMIC.
3. Communication: SEAMIC can assist in the provision of a more efficient publishing business. Its aim is to unearth the valuable medical works written by participating countries for the benefit of all. Special committees set up in participating countries could be charged with recommending worthy books which could be published through SEAMIC.
4. Aid: This is categorically not a function of SEAMIC. However, occasions may arise in which some extra funds, which are available, could be used locally in each country for domestic purposes to carry out SEAMIC activities. But so far it is not foreseen that financial aid could be made possible.
5. Official recognition of a National SEAMIC body could be made possible with proper representation at higher levels by influential and interested parties.

Suggestion for Future SEAMIC Workshops

SEAMIC workshops should continue to focus on the subjects of Primary Health Care.

In the past three years, the subjects of SEAMIC workshops were "Concept of PHC," "Health Indices," and "Role of Health Centers." On the basis of these experiences and this workshop, "Monitoring and Evaluation of PHC" may be one of the subjects for future SEAMIC workshops.

PHILIPPINES

Problems

Organization and Management

1. Need for coordinated planning at all levels in line with broad policies.
2. Need for effective presentation of health programs to all concerned decision makers, including other related sectors at various levels.
3. Fragmentation of some health services into separate special projects within government health and health-related systems.
4. Need for an improved distribution network for supplies and equipment.
5. Rapid turnover of health staff in rural areas.

Training

1. Insufficient existing orientation of some health staff towards communities.
2. Inadequate information/education/communication materials and methods relevant to existing rural and urban depressed community problem and processes.

Monitoring

1. Limited mechanism to utilize appropriate information regarding community needs, priorities, and decision-making processes.
2. Need for organized mechanisms for promotions and sharing information in PHC among involved workers.

Participation

1. How to maintain and sustain PHC at the barangay level because of certain cultural characteristics while people are busy with the business of making a living.

Collaboration

1. Sectoral-loyalties. Every sector has its goals, objectives, and strategies in the pursuance of its particular mission and therefore tend to hesitate in engaging in activities that do not directly contribute to them. There is also loyalty to agency heads (rivalry).

Recommendations

1. Human Resource Development: a) Strengthening and expanding of training of trainers at all levels; and b) Development/strengthening of team building of personnel of health and other agencies and the community.
2. Organized network system at the central and peripheral levels.
3. Periodic dialogues and workshops of all sectors (government, private, and community) at all levels. Development of PHC councils (national, regional, provincial, municipal, barangay and other agencies).
4. Linkages with learning institutions and other agencies for research and documentation of experiences.
5. Development and monitoring (regular and closer) of all PHC activities through MOH officers.

REPORT ON SORSOGON VISIT

The introductory session started at the Mayon Imperial Hotel at 11:30 a.m., February 3, with Dr. Daguinsin, Director, RHO No. V, as chairman. Legaspi Mayor Gregorio Imperial welcomed the participants to the beautiful city of Legaspi, which is famous for its Mayon Volcano. It was followed by the speeches of Mr. Ohta, Dr. Noordin and Mrs. Torres, thanking the people of Legaspi for their hospitality, representing SEAMIC, WHO, and the participants, respectively.

Dr. Galvez then introduced all the participants. Dr. Daguinsin, after introducing the people of RHO No. V, gave the briefing on the project of Barangay Health Workers (BHW) in Sorsogon province.

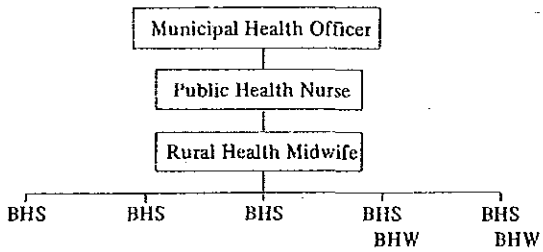
The group left the hotel by bus, arrived at Sorsogon at about 2:00 p.m., and visited Barangay Health Station, Bulabog, Sorsogon; Barangay Health Station, Basud, Sorsogon; Provincial Health Office, and Sorsogon Provincial Hospital.

At the barangay health stations, the group interviewed the BHWs who were actively participating in MCH programs. They demonstrated emergency medical care for a small boy with bone fracture or burn. At Sorsogon Provincial Hospital, Dr. Saturnino Lopez, Director, showed the group around the hospital.

After taking lunch at "Armedo Guebara," the group assembled at the Provincial Health Office and had a discussion on what they observed. The discussion continued after the group went back to Legaspi.

The discussion concentrated on BHW projects. The items discussed were as follows:

1. Structure of PHC delivery in relation to BHW



2. Coverage and number: The number of BHSs with BHWs in Sorsogon is 21, which is six percent of the total personnel working in all the BHSs. Since this is still a pilot project, they do not cover all the BHSs.
3. Functions of BHW: Twelve functions are listed: a) Reporting and recording; b) Health Education campaign; c) Environmental sanitation campaign; d) Medical care; e) MCH campaign; f) Control of communicable diseases; g) Family planning; h) Nutritional campaign; i) Coordination of health sector with others; j) Development of projects; k) Referral and follow up of cases; l) Assisting, leading, and supporting the community in the income-generating potentials of the area for self-sufficiency towards the development of the Barangay through self-reliance.

   In relation to these functions, there were discussions on how to coordinate the functions of BHWs and midwives. In fact there have been no problems, since most of the deliveries have been taken care of by "hilots."

   As far as medical care is concerned, BHWs only treat emergency cases or symptomatic problems. They are taught when they should send patients to hospitals, and there has been no interference with the provision of medical care of the hospitals.
4. Recruitment: To recruit BHWs, MOH has the following requirements: high school

graduate, understands English, resident of the community, has good relations with the community, 18 to 40 years of age, and others. Sometimes traditional "hilots" are also recruited. MOH has meetings with Barangay captains to choose from among the candidates.

In relation to recruitment, the use of unemployed nurses was discussed. At present there is a substantial number of unemployed nurses who are engaged in jobs not related to health care. But the group had to admit the difficulty of sending these nurses to rural areas where they are not paid as much as in the urban areas.

5. Training: The initial training period of BHWs is six weeks, divided into three phases: lectures, practice, and training in hospitals. Although six weeks of training is short, there is a continuing mechanism for training and the BHWs can brush up on the skills they acquire.
6. Incentives: In principle, barrio health work is a voluntary activity of the community. BHWs do not get any salary, but they receive an incentive of P150 a month. This money comes from the provincial and municipal funds of Sorsogon. Community people do not have to pay for their services, but sometimes they show their gratitude in informal ways such as giving eggs, chickens, and even a cow.
7. Turnover: There is no formal mechanism of turnover. Out of the 29 BHWs trained five years ago, 23 have remained. When necessary, training is started for new groups to fill the vacancies.
8. Intersectoral activities: BHWs get involved in community development programs such as income generation. In fact, the group observed the BHWs teaching the local people how to make ropes or mats.

   During the discussion, the question of coordination with the activities of the community social workers who belonged to the Ministry of Social Services and Development was raised. The answer was that coordination existed although not in full scale.

   There was also a suggestion from the group that school teachers may be utilized to promote the concept of PHC. This kind of education is already being implemented in some countries.
9. Impact of BHWs: It seems to be too early to say anything about the impact of BHWs. It was reported that no change in the organization structure of the Provincial Health Office has taken place.
10. Problems encountered in the BHW project
    It was reported that there were three problems: a) Resistance from the community as well as other sectors; b) Inadequate supplies of medicine and equipment; and c) Lack of a support system. But these problems appeared only during the initial stage of implementation and they disappeared gradually.
11. Community participation: Since this is a project initiated by MOH, the question of whether this was community participation in the real sense was raised. There were different views to this question; these will be discussed after observing all the projects.
12. In summary, the people of Sorsogon believed that the BHW approach is one way to achieve "health for all by the year 2000." The group agreed.

Criteria to Evaluate PHC Project

Dr. Noordin proposed the following criteria for reviewing PHC projects and suggested that the results of observation of the projects be summarized in the same format.

The criteria are: 1) Coverage—potentiality of universal coverage; 2) Technology is appropriate; 3) Continuity; 4) Content of the activity—how much it covers the PHC activities; 5) Community participation; 6) Intersectoral approach; 7) Support; 8) Impact to health.

The group agreed to these criteria and the general rapporteur was asked to arrange the final discussion in this format.

REPORT ON CEBU VISIT

The briefing session at Cebu by the Honorable Mayor Florentino Solon was held on February 5, 1981 at 5:00 p.m. at the Regional Training Center, RHO No. 5.

In his comments the Mayor pointed out that: 1) His administration was development oriented; 2) Cebu is the only province where the health budget is enormous; 3) There is a step-ladder approach so that one graduates from nutrition work to a feature of gradual training for a village that would tantalize community participation and form a core for PHC; 4) Only principles could be copied but not the real practice. One needs to modify models according to economical, biological, social, and educational situations; 5) Health and nutrition are part and parcel of politics.

During the field visit to the Sudtonggan Human Development Project, we were briefed by: Mr. Stephen Leenhouts—ICA Project Director; Ms. Herminia Banayo—ICA Staff; Mr. Ben Putot—Sudtonggan Administrator; Ms. Punta Limpangog—Health Caretaker.

The Institute of Cultural Affairs

It is concerned with the human factor in world development and the uniqueness in its approach to human community development is that: a) It takes specific comprehensive approach to the task of development; b) It has specific methods which are concerned with motivation of local people; c) Special care has been taken to work side by side with villagers and to motivate tha ICA staff to the same process.

The ICA is made up of 1500 volunteers who work for specified periods of one to forty years. They are prepared to go anywhere and live in villages with ICA projects. The ICA is interested in historical changes towards a more human society; i.e., development of self-reliance, self-confidence, and self-sustenance of groups and individuals. The village is a catalytic place to work in. There are at present more than 200 community village projects spread evenly over the world and placed according to the 24 time zones.

The main objectives of the ICA can be presented as:

Economic	Human	Social
1. Cooperative Agriculture	1. Living Environment	1. Preventive Health
2. Appropriate Industry	2. Community Patterns	2. Functional Education
3. Commercial Services	3. Identify Systems	3. Community Welfare

Its aim is to make the village its own company and think of itself as an independent economic entity in order to create its own Social Service Programme so that it could take care of its underprivileged and form its own political system for decision making.

Methods used are useful for training others and themselves. It is a 5-step method:

1. A way to awareness by. a) Showing them other places; b) Bringing outsiders in.
2. Demonstrate: Do the most important thing for the most insignificant.
3. Engage the village
4. Sustain: The ICA would move to the background and the villagers would move to the foreground after a period of time.
5. Sharing: Village expands to other villages and they awaken others. The original number of villages was four, and now there are 24 villages involved.

At the Sudtonggan Project the following comments were made by the staff involved in the project:

1. Every village must have its own garden.

2. Every child between 0–6 years of age must be weighed.
3. There are feeding schemes with supplements from various agencies.
4. Classes for mothers have been held since January 1980.
5. There is a Purok Parents Association (PPA).
6. Sport events were undertaken in February 1980.
7. There was an Agro-Industrial Fair.
8. There was encouragement to improve the environment, housing, and water supply, among others.
9. The aim was to have people go through their own experience; i.e., to manage resources and income and stand on their own. The project looks forward to villagers handling and managing their own project.
10. Within two years of implementation, the villages were able to contribute towards a community fund.
11. The Health Guild has 48 members, young ladies who were the first outside contact. These workers had nine months of training in first aid, common pediatric problems, family planning, and stool and sputum microscopy. There are two health workers working full time at the Health Center. Family records are kept and the work done is evenly distributed over the week and month.

    The visit to the Health Center was very brief due to the bad weather, and no further group discussions were held on the Sudtonggan Project.

Highlights of the briefing session on the Consolacion Project:

1. Health is a component of any development program. The Mayor has his own development plans and one section is on health.
2. The total approach to local administration (TALA) is adopted.
3. Since the Area Development approach was most effective, an Action Plan was developed. It was identified that 70 percent of the land was agricultural and this was composed of eight Barangays. The land was divided into agricultural, residential, and commercial areas, and the IBAD scheme was developed. The Municipal Development Council was the planning advisory body.
4. There was a need to strengthen the line agency situation. The Consolacion Line Agency Association was formed.
5. The project failed in developing a strong structure because the barangay captains had been in office for a long time and were not willing to work. A change in leadership was needed.
6. Upper echelons were duplicated in the lower echelon.
7. Development has to be in all areas—political, economic, social, and others.
8. Malnutrition stems from the family and environment. The whole family was taken into consideration by: a) Keeping the father in a job; b) Training the mothers on family budgeting, home management, and nutrition; and c) Placing the pre-school children under the Day Care Services of the Ministry of Social Services and Development. Those of school age were first cared for by the Ministry of Education and Culture, and subsequently the Ministry of Local Government and Community Development followed up the progress of the whole family.
9. The programme was divided into two phases: Phase I—Total approach to family; Phase II—Intervention programmes to increase production
10. To improve the economy there are a number of projects, such as the Self-Employment Assistance Project, Livelihood Center, and Consolacion Information Farming Aid System.
11. PHC was the point of entry for the development of plans in order to make the people aware that: a) Good health increases productivity; b) Education is needed to upgrade skills for equal output.
12. Selection of agencies was by the Barangay. The line agencies used were the RHU and the Family Health Association (FHA), and the programme was integrated into the

private sector. The aim was to go forward with or without support.

13. There is intersectoral approach to the programme and close collaboration and coordination of line agencies.
14. Community participation is in the form of a streamlined approach and there is: a) Approval and selection of health workers from the indigenous population; b) The Barangay assembly; c) Training of contact teachers; d) Self-reliant herbal leaders; and e) A series of Barangay meetings wherein the problems brought up would be fed back to the Barangay. These identified problems would then be tackled in coordination with other relevant agencies.
15. The main aim is to allow the people to come out with their own problems, their specific solutions, and give them support. The reciprocation from the masses makes them self-reliant.
16. Tambal Ya Yang is a system of managing patients with the cooperative effort of the hospital staff, family and community. The *hospital staff* provides the scientific guidance; *the family* the comfort of the home; and the *community* the much-needed moral support. This system is a departure from the western approach of confining patients in the ward, separated from friends and relatives, and handled mechanically by nurses and physicians who are mainly concerned with routine hospital procedures rather than the actual needs of patients.

The briefing continued with details of the Consolacion Project as outlined in the reports handed to participants.

Discussions on the drafting of the framework of PHC centered on the following points:

1. A framework for PHC in participating countries was decided upon.
2. Specific problems and measures for improvement should be presented as a result of the exposure to the different approaches in PHC as observed in Legaspi, Cebu, and Tacloban.
3. Common factors for comparison could be taken and discussed.
4. The main aim is to identify common lessons learned and devise a framework for PHC. Countries could be grouped according to approaches and each approach has different problems.
5. The countries could be divided according to type of suggested framework so that the output of this workshop may be the models with issues and recommendations. The end product will be generalized and not specific, for each country must develop PHC according to its own needs and resources.

The participants then went into a discussion of the role of WHO and SEAMIC as international organizations that can contribute to the improvement of PHC.

Role of WHO

Generally WHO holds a coordinating function in PHC in relation to Health for All, and this includes:

1. Trying to obtain political support for the concept of HFA and PHC.
2. Trying to get economic support for PHC leading to HFA.
3. Arranging for technical cooperation with individual countries or exchange of experiences and information among countries.
4. Helping to strengthen concepts of HFA and strategy for HFA.
5. Facilitating and developing an Information System among countries.
6. Disseminating information on experiences in implementation of HFA.
7. Evaluating progress in implementation of HFA.
8. Coordinating functions so that the concept of HFA in PHC would facilitate implementation of HFA.

Role of SEAMIC

1. Primary role will be to arrange useful forums to provide each participating country

with useful information for its health planning. Essential aim should be to draw up a complete policy for implementing. SEAMIC's original role does not extend up to implementation but it can do so by collaboration with other international aid organizations on a lateral basis.

2. Technical assistance can be very wide. It is not spelt out in SEAMIC's act, but it can be done with limited activity by: a) Arranging for close collaboration between key medical bodies; b) Organizing seminars where there is need for technical assistance to train for better skills; and c) Arranging for data exchange programmes among participating countries; to standardize laboratory data, seminars could be called for by SEAMIC.
3. Communication: SEAMIC can assist in the provision of a more efficient publishing business. Its aim is to unearth the valuable medical works written by participating countries for the benefit of all. Special committees set up in participating countries could be charged with recommending worthy books which could be published through SEAMIC.
4. Aid: This is categorically not a function of SEAMIC, especially as Finance SEAMIC Tokyo has realized that when amounts are not big, occasions may arise where some extra funds, which are available, could be used locally in each country for domestic purposes, to carry out SEAMIC activities. But so far it is not forseen that financial aid could be made possible.
5. Official recognition of a National SEAMIC could be made possible with proper representation at higher levels by influential and interested parties.

REPORT ON DISCUSSIONS IN TACLOBAN
February 7, 1981

Project	Approach	Advantages/ Strengths	Disadvantages/ Weaknesses	Lessons Learned
1. Sorsogon	Extension of Basic Health Services	* Implementation of PHC faster * Wider coverage	* Danger of too much responsibility of BHW * Insufficient incentive to sustain BHW in this set up * Community participation doubtful * No mechanism to solve turnover * Insufficient time for training of BHW	* BHW could be utilized effectively if there were community participation. * BHW should be from the the community * If possible, the incentive of BHW should come from the community
2. Carigara	Community Partnership in health development	* More effective implementation of PHC * Commendable training program * Promotes better utilization of basic health services * Better community involvement * More effective coordination and integration of health and medical services	* Preparation for community involvement is a long process * Risk of delay of utilizing community workers at the initial stage * Risk of a program not being accepted by the community	* There should be more utilization of trained community workers at the initial stage * The UP-MOH approach may be useful in this type of PHC * New role of hospitals in comprehensive and integrated care
3. Consolacion	Integrated Area Development	* Intersectoral involvement and coordination in government and private sector * Full backing of local officials * Dynamic leadership	* Role of PHC worker not clearly defined such as Barangay Health Brigade * Too heavy program; not enough linkage in lower echelons	* The program may not function as well if the dynamic leadership which sustains it changes. * Total integrated area development approach with the community is very effective.

REPORT ON DISCUSSIONS IN TACLOBAN (Continued)

Project	Approach	Advantages/ Strengths	Disadvantages/ Weaknesses	Lessons Learned
				* Need to strengthen leadership at the Barangay level * The organizational set-up is complicated.
4. Sudtonggan	Comprehensive Socioeconomic development	* Improve partially the economic situation of the community * More community participation * Social preparation more or less comprehensive * Develops self-confidence, self-reliance and self-sustenance of community * Favorable effects were felt by the community	* Costs much * If outside assistance ceases, project might collapse. * It might not be replicable * If the remuneration system remains static, community participation may fail.	* Because of comprehensive 3-pronged approach, it is possible to get community involvement in health even if there is no initial manifestation of health needs * It is a good show window or model for others to follow as a scheme for development of projects. * For effective community participation, it is necessary to organize effective decision-making mechanism at grass-roots level * It shows how international organizations can effectively help in community development * Entry point of the project is economic, not health. Community organization is effective in promoting the socio-economic development in the community.

ASSESSMENT OF THE WORKSHOP

Apart from the lively discussions engendered and the technical conclusions drawn up during the workshop, a more reflective assessment of the week-long activity points up various other positive achievements. While these have not been well emphasized by the participants, they were mentioned by the resource persons, and the Organizing Committee is of the concensus that the participants themselves realize and appreciate them.

They may be summarized as follows:

1. The field visits afforded the participants with ample opportunities to observe firsthand on-going PHC activities. Instead of lecture-type orientation, they were able to see the actual organization and mechanics of PHC implementation and to understand the problems and difficulties met in the field. There were plenty of chances to engage in a dialogue with those who implement the PHC projects and those who benefit from them, and for both observers and implementors these were excellent learning experiences.
2. Since several areas visited showed varying approaches, strategies, and methodology in achieving primary health care for the whole population involved, the participants were enabled to compare the strengths and weaknesses of each. They were made aware also of the evolutionary processes which the different PHC programs had undergone, including the lessons that were made along the way. Transposing such experiences to his own home situations may be useful and beneficial for the participant and his country.
3. From the standpoint of organization, the workshop stressed the utility of a strong body at the national level, which maintains close liaison with the SEAMIC Secretariat in Tokyo, to plan, organize, and conduct a workshop of such nature. Without an active organizing committee to facilitate arrangements with the regional and peripheral health and health-related agencies, this workshop or any similar activity could not have been conducted as smoothly and as well.
4. The workshop demonstrated also the feasibility and value of multilateral involvement in the preparation for the workshop. The arrangement, whereby a participant from another country was given the responsibility of visiting the PHC project sites and preparing a background paper on them, constituted an invaluable help in the subsequent discussions during the workshop.
5. The expanding linkages generated by the workshop and its theme augur well not only for PHC per se, but also, and more importantly, for SEAMIC and its future activities.

   The wide intersectoral involvement manifested during the workshop is a new development in SEAMIC activities.

   In like manner, the increasing participation of WHO and some of its Member-States, that share with SEAMIC countries mutual concerns and interests, is indicative of SEAMIC's growing influence.
6. The travelling nature of the workshop gave the participants from other countries an unusual chance to view several areas in the Philippines and to note the diversity in the scenery and environment and in the culture and customs of their rural populations. At the same time, the participants must have perceived the homogeneity in their aspirations for better health, in their positive responses to proper motivations for self-improvement, their dream of a better life for themselves and their children. Furthermore, each of the areas visited has tourist attractions of its own. Seeing them is a 'fringe benefit' of the travelling workshop.

   While the workshop had its strong points, it was not without some weaknesses.

   The visit of a big group composed mostly of foreigners to small rural communities had created some local stir. The native inhabitants went to great lengths in order to accord their guests the utmost attention and hospitality. While such courtesies were not unwelcome, they sometimes disrupted schedules and shortened the time available

for much needed discussions.

The movement of such a big group to widely separate areas following a tight schedule was potentially subject to hitches that could have dire results for the workshop. It was fortunate that no such thing occurred.

Since the PHC project sites visited were mainly rural, it was possible that some inconveniences were felt by the participants.

SUMMARIZATION OF COUNTRY REPORT ON
PRIMARY HEALTH CARE
Country: PHILIPPINES

1. Concept of Primary Health Care
   Health of the people, for the people, and by the people in partnership with the health and other sectors.
2. Policies on PHC
   a. Intersectoral linkages shall be promoted, established, and maintained.
   b. Human development and leadership training activities shall be pursued in order to bring about self-determination and self-reliance among people.
   c. PHC activities need not be health activities.
3. Strategy
   a. Social investigation, community organization and social preparation.
   b. The satisfaction of community wants and needs shall serve as the entry point for health development.
4. Organization and Management
   a. The existing development councils at all levels shall act as the coordinating body in PHC.
   b. The health sector and other sectors shall act as catalyst, brokers, and consultants to communities.
5. Problems in Implementation of PHC
   a. How to maintain and sustain PHC at barangay level because of certain cultural characteristics and the fact that people are busy with the business of making a living.
   b. Sectoral-loyalties. Every sector has its own goals, objectives, and strategies in the pursuance of its particular mission and therefore tends to hesitate in engaging in activities that do not directly contribute to them. Then there is also loyalty to agency heads (rivalry).
6. Solutions
   a. Health development should conform to the peculiar characteristics of the community.
   b. PHC activities should also include income-generating activities to keep the people interested.
   c. Policies of every sector should be reviewed by an intersectoral group at the highest level and be made to jibe with, and be supportive of, each other.

Partnership through Primary Health Care

The Republic of the Philippines, an archipelago of some 7,000 tropical islands, is home to forty eight million people. As in any developing country, its health problems relate to a rapidly increasing population, poor socio-economic conditions, limited and inequitably distributed health resources with a deprived majority in the rural areas.

To meet the needs of these underserved and unserved areas, the Ministry of Health in the past merely focused on increasing the coverage through peripheral expansion of the health infrastructure.

Despite the improvement of coverage to an estimated 67 percent of the population, the Ministry realized that gaps in services provision will persist in view of the increasing population and the limited resources. The need for an alternative approach to health care led to a series of re-examinations of the Ministry of Health structure, resources, and strategies to meet its health commitments.

From two different processes within the Ministry of Health, two major views evolved as to the form of this alternative approach.

As complimentary strategy to the Restructured Health Care Delivery System, the project management staff proposed a national program on the training and utilization of indigenous health auxiliaries. The other, a product of Country Health Programming, described an organizational strategy which calls for an active partnership among government, private sector, and the communities.

Elements of both approaches provided the bases for the national framework of action on Primary Health Care. Providing the forum for the merger of these approaches, an inter-sectoral group of senior staff officials from health and health-related agencies was created as the PHC Task Force. Chaired by the National PHC Coordinator, a senior Ministry of Health official, the PHC task force serves as the moving force in PHC implementation.

Its first accomplishment was the adoption of the Philippine Policy Paper on PHC by the Social Development Committee of the National Economic and Development Authority, the national planning and coordinating body.

The first year of operations dealt with both the support system, government and private sectors, and the communities. These have resulted in the following: 1) Identification of the existing development councils at various levels of government, from national to barangay, as the coordinating mechanisms for Primary Health Care; 2) Strengthening of training and facilitating capabilities of regional, provincial, and municipal health staff; and 3) Initiation of community in selected barangays throughout the country.

The promotional efforts brought into fore constraints in implementing PHC from these points of view as follows:

1. Government Health Care Service
   a. Misconceptions in Primary Health Care approach
   b. Constraints in central level functions
   c. Deficiencies in training and research capabilities of health staff
2. Intersectoral Collaboration
   a. Fragmentation of sectoral priorities
   b. Ineffective utilization for existing coordinating structures
3. Community Participation
   a. Traditional dependence of local communities on government and private institutions for basic health care services
   b. Limited capabilities for leadership, organization, and management of community activities

Basic to the identified solutions was the need to develop an understanding of the community's perceptions and its dynamics. These interventions will require central level and intersectoral involvement in data generation and utilization. Moreover, this will require information generated by the communities themselves to be shared with government and private agencies.

These are the main areas of concern which form the bases of Primary Health Care developmental activities in the next few years.

PRIMARY HEALTH CARE IN TACLOBAN: AN INNOVATIVE STRATEGY FOR HEALTH MANPOWER DEVELOPMENT AND DISTRIBUTION

Manuel Roxas
Director
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The University of the Philippines Institute of Health Sciences (UPIHS) was established in Tacloban City, Leyte, in 1976 as an experimental medical school to innovate a curriculum which would develop community-oriented health workers.

The Institute seeks to contribute to the development of various levels of health manpower which can be functional in the rural communities. Its objectives are: 1) to produce a broad range of health manpower to serve the depressed and underserved communities in the Eastern Visayas region (Region VIII); 2) to design and test program models for health manpower development that would be replicable in other parts of the country and, it is hoped, in other countries with similar situations as the Philippines; and 3) to monitor the development of rural communities in relation to the effectiveness of the health care system operating in these communities.

The UPIHS is an outcome of an increasingly resonant feeling that the delivery of health care in developing societies needs a large pool of primary health workers. This feeling arises from the understanding of the broader concept of health, which is, that health includes not only the condition of the body but also of the environment. This broader concept focuses on the reality that the delivery of effective health care requires a "team" of health workers supporting each other with different levels of expertise and interest. Included in this team is the community itself, which must play an active role in the promotion and maintenance of health.

The students at the Institute are recruited from target communities in Region VIII which are badly in need of health workers. These students are nominated by their barangays; the selection of nominees is made in an open barangay meeting. Upon nomination, the student, with the consent of his parents, pledges to return to the community to render service as a health worker. This pledge operates like a "social contract" entered into by the student and his barangay.

The barangay, in turn, pledges to provide a measure of support to the student while at the Institute. This support includes transportation money, medical kits, and community participation in the health program the student will set up upon his return to the barangay.

In the larger sense, therefore, the beneficiary of the Institute is not only the student, but the entire barangay. This relationship builds upon the principle of "active partnership" between the Institute and the rural communities. In fact, major decisions in the nomination, as well as the recommendation for a student to go to the higher training modules offered by the Institute, are made solely by the barangays.

The curriculum of the UPIHS is unique. In one complete program it can produce an entire range of medical workers with varying levels of expertise and interest: from barangay health workers to midwives, nurses, and full-fledged medical doctors. The Institute has an evolving ladder-type curriculum structure with various points of exit and entry. (Please see the Ladder Type Curriculum of the IHS)

Students admitted to the program initially go through what is commonly known as paramedic training or formally the *Barangay Health Workers (BHW) Program.* This program consists of 11 weeks of training covering such subjects as Pediatrics, Obstetrics, Nutrition, Community Hygiene, Sanitation, Primary Health Care, Emergency Care, and Rural Sociology.

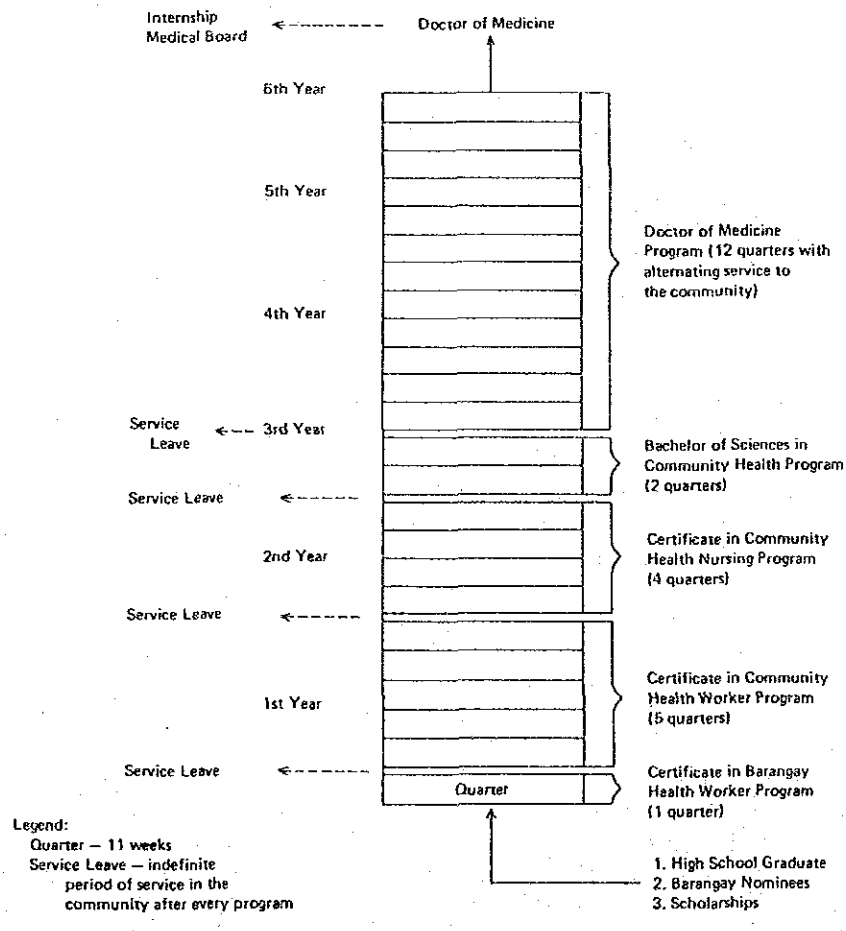
After one quarter, or 11 weeks of training, a student receives a certificate as a Barangay Health Worker (BHW), qualifying him to be a practising paramedic. If his barangay recommends him for further studies, the student can study for an additional five quarters to qualify as a Community Health Worker (CHW). Completion of this program entitles the student to

the University-awarded Certificate in Community Health. This certificate was originally termed a Certificate in Midwifery. What necessitated the change in title was the fact that the male students did not exactly like to be called "midwives." Moreover, the Community Health Workers program is broader than the standard midwifery program, because it includes a variety of health and behavioral subjects such as English, Mathematics, Ethics, Community Development, Fundamentals of Anatomy, Physiology, Microbiology, and Public Health. The courses prescribed for this program are in part determined by government regulations pertaining to the midwifery curriculum.

A total of two-and-a-half years of studies would allow the UPIHS scholar to receive a certificate as a Community Health Nurse (CHN). This program includes instruction in Basic Chemistry, Chronic and Communicable Diseases, Nursing, Pharmacology, Folk Medicine, Anatomy, Physiology, and Community Organization. After becoming a CHN, the student may proceed to a Bachelor of Science in Community Medicine (BSCM) degree after two more quarters, or become a medical doctor (MD) after an additional twelve quarters of study.

After completion of each training level, students go on three-month service leaves during which they practice what they have learned.

The UPIHS Curriculum is innovative in the sense that the social context of its courses is a real Philippine rural community. The programs have been designed with particular attention to community needs arising from sociocultural, economic, and political conditions in rural areas. This system of designing programs assures that the graduates of UPIHS maintain con-



tinuity with the communities they are expected to serve. Their competencies are tailored to fit the context within which they are to apply these competencies. The UPIHS also believes that as persons, the students have roots in the rural areas, which supports the assumption that they would be inclined to go back to serve their home communities.

The Research and Development Component of the IHS

The Institute of Health Sciences features a flexible curriculum and structure which allows for the continuing adjustment and change in course content and teaching methods. Its "ladder" structure is linked to a Research and Development program which essentially serves to test assumption made about the IHS programs. The R & D theory ensures the continued evolution of programs relevant to the changing needs of rural communities.

The Research and Development component is an information Monitoring System with internal and external components to generate data on which changes in the strategy of programs are based.

The internal system deals with methods, techniques, and structures within the Institute itself such as the admissions program, teaching methods, course contents, and alumni follow-up. The R & D analyzes, on a continuous basis, community health needs, perceptions, interactions, and capabilities, using the faculty visits and students' feedback mechanisms. With the information obtained in this process, the directions and methodologies of the UPIHS are adjusted accordingly, so that the Institute may shape what can be considered realistic health care and relevant services for the depressed and underserved communities.

The Research and Development outside the Institute aims at developing an information system which monitors changing community needs. This system will keep the program of the Institute in community health synchronized with the actual community development. Corollary to this, community perspective becomes a major input in determining the content of UPIHS training programs for health manpower.

The Research and Development arm was externally focussed on the evolution and development of the community-based barangay health program which was deemed necessary as an initial step because the development of the information system is based on the perspectives of the recipients of health care. Community-based barangay health programs are those which are designed, planned, implemented, and evaluated by and for the community. Thus, the ideal approach to health development must engrain an integrated, holistic development involving the community (i.e. including socioeconomic, political, cultural, and other developments).

Health is only one facet of life at the individual and community level. Hence, the program envisioned to study and develop the following: 1) To design of health programs with the community (barangay) as the major beneficiary; 2) The process of evolving these program designs and incorporating them in the community; and 3) The establishment of work linkages between the project-proponents and the community to ensure synchronization and to allow a smooth flow of support system.

The general objectives of Research and Development are as follows: 1) To identify and describe domestic factors involved in the development and maintenance of health programs at the community level; 2) To identify design criteria affecting health programs consistent with the level of development of communities particularly the rural areas; 3) To establish an information system at the community level which allows for a continuous adjustment of health programs in response to changing community needs; and 4) To develop training modules for the various categories of health manpower involved in health care in rural communities. These categories of health workers include the village or local health workers of the rural health unit staff and potential members of rural health teams. The training modules will serve as bases for processes evolved in the study.

Specific Objectives of Research and Development: 1) To enter and organize selected barangays in the catchment area and initiate the process of community development, which includes provisions for the evolution of an appropriate health program; 2) To assist selected barangays

in their own community development programs by facilitating access to resources available from external agencies; 3) To provide technical assistance and supervision to selected barangays in the development and implementation of their own health programs; such assistance includes training of local health workers consistent with the program design; 4) To utilize the barangay (community) leaders as health workers and primary links between the barangays and the Institute; they serve as the media for a two-way flow of information and services between the two systems; 5) To utilize the larger study area as a training ground for participants in the required rural government service for underboard nurses and physicians; and 6) To document and record the steps involved in program development. This documentation includes the recording of significant events and creation of parameters/indicators using sociological methods.

The Carigara Catchment Study Area

Initially there were three areas chosen in Region VIII for the study: Gandara in Western Samar, Carigara in Leyte, and Baybay in Leyte. These areas typically represent the region as a depressed community in terms of disease patterns and low socioeconomic conditions.

The Carigara area was finally selected over the two other areas. The decision was made on the basis of its geographical advantage. Carigara's proximity to Tacloban, where the regional office of the Ministry of Health is located, offered closer supervision of the project. This also implied lower cost of operation.

A. *The Carigara Setting*

Carigara is fairly typical of rural Leyte with an economy based on agriculture (rice, coconut, and fishing).

In terms of health problems, Carigara is classified as a socioeconomically depressed area. Infectious diseases, such as tuberculosis, gastro-enteritis, and schistosomiasis, are endemic in the area. These diseases are the main causes of mortality and morbidity. Malnutrition and poor environmental sanitation aggravate these problems.

Carigara has a government hospital, the Carigara Emergency Hospital (CEH). It has a 25-bed capacity, serving a population of approximately 130,000 people in the municipalities of Carigara, Barugo, Capoocan, Jaro, San Miguel, and Tunga.

Aside from the CEH, the government, through the Ministry of Health, also maintains a Rural Health Unit in each of these towns. Five of the RHUs are each headed by a Municipal Health Officer (MHO). The Tunga Rural Health Unit is run by a Public Health Nurse. These government facilities constitute the major portion of the health infrastructure in the area. Only a few private clinics in some of the town centers are existing.

B. *Phases of Research and Development Program Implementation*

1. Social Preparation of the R & D field staff (MHOs and COH).

   To establish a functional base for operation, a rural hospital, specifically the Carigara Emergency Hospital, and the five rural health units and their staff were tapped.

   Familiarization and orientation of the objectives and nature of the project were conducted for the hospital and rural health unit personnel. The social and technical preparation of the field staff included an introduction to the plans of action, the epidemiologic survey of disease patterns of the catchment area, principles of community organization, and the development of an information system.

2. Social Preparation of the Community

   This is the phase where the health officers approached their respective barangays to inform the people of the rationale and objectives of the Research and Development program. Barangay assemblies ensued, whereby the community discussed their problems. This was how rapport was established. Baseline data of each of the six barangays were gathered through the use of the Quick Survey. Information gathered covered not only health but other aspects of community life; e.g., socioeconomic and cultural data. Community maps were also constructed with indicators of health problems to counter-check the data gathered in the Quick Survey.

3. Organization of the Community

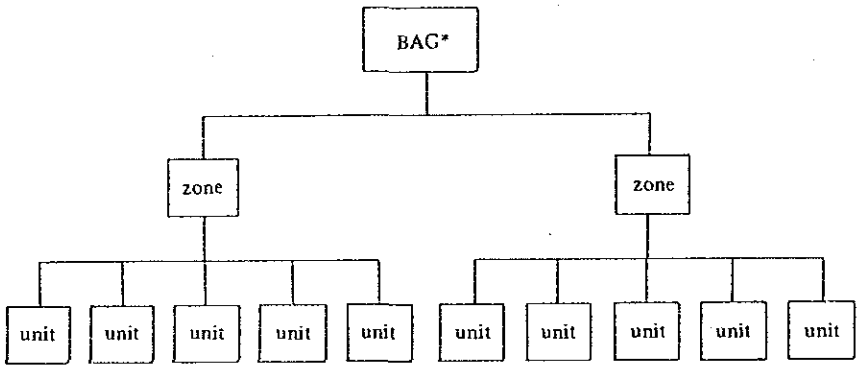
Results of the quick survey showed the pressing health problems of each of the six chosen barangays. Below is the list of the chosen pilot barangays with corresponding medical problems:

Municipality	Pilot Area	Medical Problem
Barugo	Sta. Rosa	Schistosomiasis
Carigara	Jugaban	Pulmonary Tuberculosis
CEH	Barugohay Norte	Gastro-enteritis
San Miguel	Canap	Pulmonary Tuberculosis
Capoocan	Balud	Pulmonary Tuberculosis
Jaro	Hiagsam	Pulmonary Tuberculosis

The results and analyses of the Quick Survey were presented to the community in an assembly for their comments and reactions. It was during this meeting that the community identified its problems and came up with the decision to act on them in close coordination with the RHU. In order for the community to actively participate in the planned activities in the barangay, it decided to establish a community structure known as Barangay Network (BN). Through the BNs the MHOs introduced the idea of evolving a developing program for each community.

The community was divided into zones (each composed of 20–25 families headed by a zone leader) and units (each with 10–15 family members, headed by a unit leader). The entire Barangay Network was coordinated by either a chairman or an advisory board whose members were the representatives of different government agencies assigned in the area. The leaders of the Network and the chairman were all elected by the community. The Barangay Network served as a channel for two-way communication between the health system and the community.

Below is a diagram of the Barangay Network of Hiagsam, Jaro.



(*) Barangay Advisory Group of Hiagsam whose members include the school principal, the Parent-Teacher Association president, Kabataang Barangay Chairman, Barangay Captain, Chairman of the Barangay Brigades, and the Municipal Health Officer.

4. Implementation of Programs and Projects

At this stage, activities, programs and projects were implemented in response to community problems, which included the major health problems identified in the Quick Survey. Gradually, activities such as program planning, implementation, and evaluation were integrated in the community system.

The health and health-related projects initiated in the community were as follows:

Comparative Summary of the R & D

Before R & D	Present Situation
A. *RHU/Doctor's Role*	
1. People relied first on self-medication before going to indigenous healers; consulted rural health unit (RHU) for advance cases.	1. Barangay Network through unit leaders (UL) is able to do surveillance of cases needing referral to RHU or for attention of municipal health officer (MHO). Using simple indicators, each is kept informed of the health status of each member and when to consult UL or RHU.
2. RHU provided primarily curative services, neglecting preventive aspects of health care.	2. Emphasis on prevention and health development by first meeting basic needs without neglecting curative aspects.
3. This fostered dependency on hospital service and medical care for the solution of health problems.	3. Emphasis on meeting basic needs and community efforts to live a healthy life and not only to prevent diseases.
4. Dependence on RHU for external services including dispensing of drugs for minor ailments.	4. Strengthening capability of community to take care of their own problems including simple medical care.
5. All cases came to municipal health officer (MHO) for help, thus overburdening the doctor's service.	5. Development of referral system from community level and up through barangay network. Only serious cases needing MHOs attention are consulted, thus giving him more time for quality services.
6. Consequently, role of MHO limited to that of clinician.	6. Role of MHO has broadened to those of leader, facilitator, trainer, ensuring community participation through development of the BN.
7. People dropped out from treatment regimen (e.g. pulmonary tuberculosis, schistosomiasis) owing to lack of follow-up and unfamiliarity with RHU services.	7. Use of BN to reach every family, explain importance of early diagnosis and continue treatment, perform immediate referral for the necessary health service and follow-up.
B. *Community Organization and Information System*	
1. Generally no feedback mechanism.	1. Established BN with unit leaders (ULs) responsible for a number of families for adequate monitoring and communication.
2. Lack of systematic collection of health data, and depended primarily on reports of accessible patients who consulted RHU or health centers.	2. Feedback is gathered systematically through BN.
3. Compilation of data irrelevant to community needs.	3. More accurate data obtained through the family sheet. Consequently, awareness of health problems and of capability to solve these problems, making people responsible for their own health.
C. *Community Participation*	
1. Concept of health depended on perception of providers.	1. Concept of health/disease is taken from clients' viewpoint and synthesized; few simple indicators agreed upon and understood by community.
2. Planning was centralized from top to bottom.	2. Families confer with ULs, who in turn meet with other BN leaders. Thus, planning is not only top to bottom but also bottom to top.

(Continued)

Before R & D	Present Situation
3. RHU set priority health problems; planned programs and expected people to participate without adequate social preparation	3. RHU meets with the community to identify their problems and needs and solutions; people are motivated to sustain programs they helped create.
4. Usually no formal community leaders were involved in orientation on the planned programs.	4. Existing leadership pattern is tapped before actually reaching out to individual families; through the BN, the whole community is informed.
5. People's role was primarily to receive the health service.	5. People participate in the process of problem identification, planning, implementation and evaluation.
6. Since programs were imposed by providers, they usually resulted in unintegrated sectoral programs, thus confusing the people.	6. The community knows its problems. When an agency comes in, the community is in the best position to coordinate or fit in the program and tap the agency as resource for their problems. Since problems are varied and complex their solution has to be intersectoral, thus leading to an interdisciplinary health team.
D. *Approaches to Health Development*	
1. Diseases were regarded as monocausal, treatment of which was the domain of health personnel.	1. Acceptance of concept that a disease is not monocausal (e.g. diarrheal), therefore need for intersectoral approach to solve it.
2. Monosectoral approach to solution of health problem. This led to single-role conventional type of professional manpower development, i.e. doctor, nurse, midwife.	2. Information system leads to the identification of complexity of health problems. This leads to the development of a worker with intersectoral orientation, who is able to work with community and other sectors, e.g. barangay and community health workers (BHW, CHW) trained by IHS.

Status of the IHS Students

	1978	1979	1980
First Batch of 96 Students			
	34 Midwives	3 lateral Entry to Nursing	BSCH
		26 employed by MOH	
		3 unemployed	
		2 out of program	
		34	
73 Students From Region VIII			
	39 Nurses	15 BSCH	10 M.D.
		18 employed as Midwives	
		4 Lateral entry	BSCH
		1 out of program	
		1 delayed in graduating	Board examination
		39	
	13 Midwives	7 employed by MOH	BSCH
		2 Lateral entry to Nursing	
		1 out of program	
		2 volunteer Health workers*	
		1 unemployed	
		13	
23 Students from Outside Region VIII			
	10 Nurses	5 BSCH	2 M.D.
		1 employed	
		1 unemployed	
		1 volunteer worker	
		2 lateral entry	BSCH
		10	
Second Batch of Students			
68 Students	—	19	BSCH
		1	out of program
		48	CHN (in the process of employing themselves)
Third Batch of Students			
63 Students	—		All took the Midwifery Board Examination, November, 1980
Fourth Batch of Students			
63 Students	—		Enrolled in CHW program (2 more quarters to finish in 1981)

(Continued)

	1978	1979	1980
Fifth Batch of Students 63 Students	—		BHW (on service leave)

* Students who are working but not paid by any government agency.

A. *Health Activities*

1. Community-wide weight survey (Operation Timbang, OPT) to determine the nutritional status of pre-school children. This led to the deworming of children and establishment of feeding centers for the malnourished children.
2. Case-finding, treatment, and follow-up of tuberculous patients in Jugaban, Hiagsam, Balud, and Canap by the RHU staff assisted by the zone and unit leaders.
3. Training of the Barangay Network leaders to assist the RHU in dispensing first aid medicines and case-referrals.
4. Botika sa Barangay was established in Sta. Rosa to solve the problem of inaccessibility of drug stores and as an income-generating activity.
5. Establishment of herbal gardens in each RHU and a communal herbal garden in the community.
6. Health education on schistosomiasis conducted in Sta. Rosa.

B. *Other Health-related Community Activities*

1. Water pipes were installed in Jugaban in response to the water problem expressed by the residents of one unit at a community assembly. Subsequently, resources were tapped and each family agreed to contribute annually for their maintenance.
2. Community self-help activities, such as construction of drainage, waste disposal systems, and water-sealed toilets, were undertaken in Canap, with the involvement of the RHU.
3. Beautification was made as an initial activity in all the pilot barangays. This included fencing individual houses, construction of flower boxes, and control of stray animals.
4. Funds were raised through benefit dances and tapping of resources to finance the construction of multi-purpose halls in all pilot barangays.
5. Piggery projects were undertaken to augment the income of the residents in Jugaban and Balud, using a ₱5,000.00 loan from Research and Development. The families held monthly meetings on their own and invited technicians from the Bureau of Animal Industry to lecture on swine raising and management.
6. Inter-project visitations of zone and unit leaders. There were two purposes of these visits: a) As an observation tour of the leaders in other pilot barangays; and b) Leaders acted as resource speakers about the Research and Development program in new or expanded barangays.
7. Establishing a Community Information System in all the pilot barangays.
   This enabled the people to continually assess their own problems and resources and served as basis for decision-making. A system of collecting information and monitoring the community situation was designed to be undertaken by the heads of the families. The information system consisted of three forms to be filled out:
   a. The family sheet
      An information sheet which contains: 1) General information on the family, such as membership, size, ages and sex; 2) Home environment—e.g., housing, water supply system, waste disposal system, and energy sources; 3) Economic status, such as source of livelihood, income, expenditure, and assets.
   b. Health sheet
      The health sheet form reflects the health status of each family, such as mortality, morbidity, health service demands, and reproduction.

c. Growth charts

This chart shows the nutritional status of the children in each family. Mothers are taught how to plot the weight of their children and determine the nutritional conditions of their children.

The sheets provide primary data which would be collated at the higher levels from the barangay level to the municipal (RHU), provincial, and regional health offices, which in turn would be used in designing and planning health programs.

The Role of the Health System in Relation to PHC

Hospital—(CEH)

1) Training base for RHU personnel (sputum microscopy, obstetrics, pediatrics, etc.); 2) Link in chain of health care referrals (BHS, RHU, *Hospital*); 3) Administrative but non-financial support (assessment of CCA needs; e.g., supplies and materials), 4) Community organizing, facilitating; generally has wider outlook than RHUs because of the larger area serviced; and 5) Outreach programs which establish direct links to the barangays within the area serviced.

Rural Health Unit (RHU)

1) Community organizer and facilitator, particularly in introducing intersectoral collaboration and outside resources into the community; 2) Training center for barangay health personnel; RHU personnel also train personnel in the barangay itself; 3) Supervision of preventive health activities by barangay personnel, such as health education and identification of TB suspects; 4) Identification of health problems requiring community attention and action; example: a faulty drinking water supply which causes perennial gastrointestinal problems; and 5) Curative health activities.

Barangay Health Station (BHS)

1) Focal point for health care treatment in the barangay; 2) Manned by midwife with the assistance of community personnel, it has both symbolic and practical value as the community strives to achieve greater self-reliance; 3) As an outpost for the RHU, it provides community health information not otherwise obtained; example: a diseased person requiring attention might not make a trip to a distant RHU, but might stop at the nearby BHS for diagnosis and ultimately referred to the RHU for treatment; 4) Barangay health personnel become involved as facilitators and community organizers concerning health matters; 5) Case follow-up, e.g., treatment of T.B. patients; and 6) The Midwife does mother and child health care through house-to-house visits.

II. National Health Administration