COUNCIL FOR
HEALTH AND DEVELOPMENT, INC.

Deepening Our Commitment to People's Health to Face the Challenges of the 1990's

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Proceedings of the Second General Assembly

January 10–16, 1991
De Meester Residence, St. Theresa's College
Quezon City

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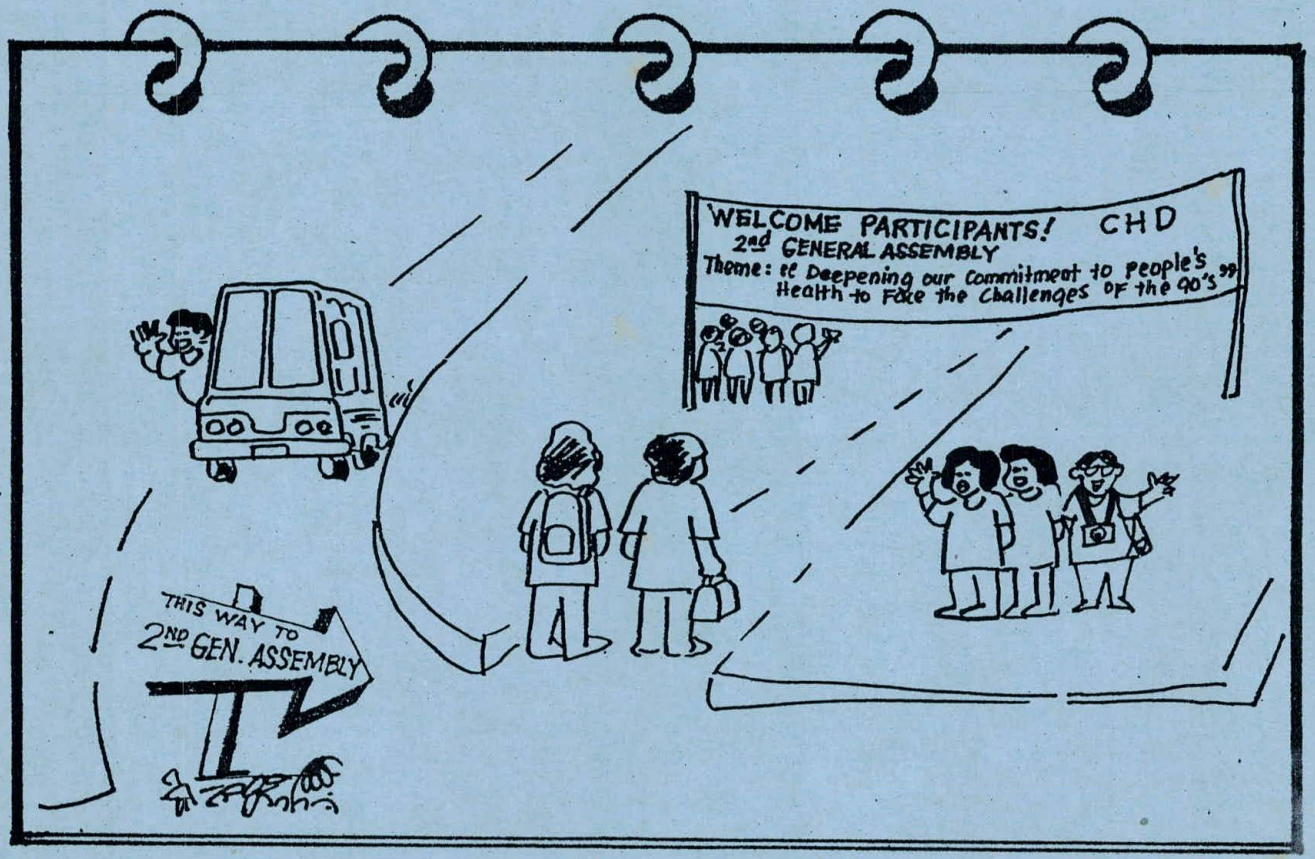
DAY 1

10 January 1991
Thursday



DAY 1

Over-all facilitator - Dr. Jojo Carabeo

SCHEDULE

2:00 PM	Arrival	
4:50 PM	National Anthem	Dr. Tess Umipig
	Invocation	Sr. Eva Varon, SCMM
5:00 PM	Welcome Remarks	Dr. Ruben Caragay
	Introduction of Participants	
	Orientation to the Conference	
	Presentation of Collated Expectations	
	Committee Formation	
6:50 PM	Orientation on Regional Caucus	

WELCOME REMARKS

Ruben Caragay, M.D
Chairperson, Board of Trustees
Council for Health and Development (CHD)

I would like to thank all of you who came to the 2nd General Assembly despite the crisis we have had and the present crisis we are being confronted with. In the past, we experienced the killer quake and presently we are apprehensive of the effects of possible outbreak of the Gulf War. Despite all of these, we have made a quorum for the General Assembly.

It is notable that many of the delegates are women.

We hope that despite our heavy schedules this year, we can still hold inter-regional hopping to share and look into the results of the CBHP evaluation and to unite on the implementation schemes.

Based on the theme of our assembly, we will be facing the challenges of the 1990 decade so we will need to know the national situation and the results of the CBHP evaluation.

I am extending a very warm welcome to all of you, participants, observers and guests of the 2nd CHD General Assembly and we hope that this will be a success.

PRESENTATION OF PARTICIPANTS

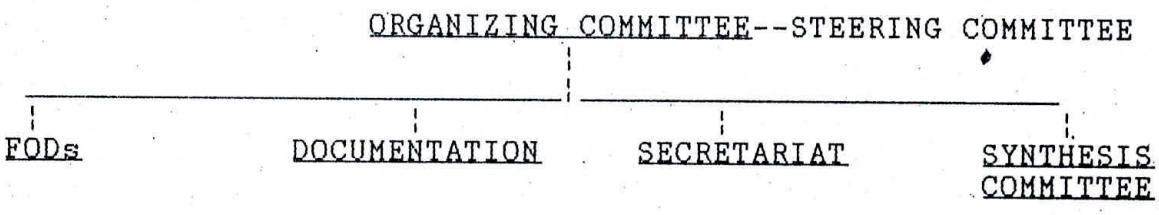
The facilitator of the day (FOD) explained that the participants will introduce themselves according to their position in the program/organization, their strengths, weaknesses and their expectations.

OBJECTIVES OF THE CONFERENCE

The Facilitator of the Day presented and explained each of the objectives of the General Assembly:

1. To have an overview of the current status of CBHP's based on regional updates and results of the summing up and impact evaluation.
2. To discuss current national issues and their implication to people and their health situation.
3. To contextualize CBHP work with development work in in general.
4. To understand the principles and strategies for health work in the current context.
5. To formulate resolutions on organizational matters and elect a new set of members for the Board of Trustees.
6. To draw up stresses and plans of the consortium for the next two years.

PRESENTATION OF THE CONFERENCE PROPER



I. STEERING COMMITTEE
- Over all Coordinator — Yayen Barcelon
- Over all Facilitator — Jojo Carabeo
- Regional representatives
  - Visayas - Tess Umipig
  - Mindanao - Ann Kadile
  - Luzon:
    - NCR - Cel
    - SL - Vicky
    - CL/NL - Patrick

II. DOCUMENTATION
Marivic
Teth
Helia
Nelson
Flora
Coralyn
Grace
Nene
Glenda

III. SECRETARIAT
Gemma
Nitz
Efren
Del
Sr. Ester
Teng

IV. SYNTHESIS COMMITTEE
Lyn
Mel
Leni J.
Stella

The Facilitator of the Day explained the committees of the conference. Changes were made as the body decided to have one representative from each region: Visayas, Mindanao, National Capital Region (NCR), Southern Luzon (SL), Central Luzon (CL) and Northern Luzon (NL).

ORIENTATION TO THE CONFERENCE

The Facilitator of the Day explained that the CHD has invited also non-members to the General Assembly. CHD members will participate and attend the whole conference. Non-members will be listed as observers and may participate in the workshops and discussions but will have no voting powers. Only CHD members will participate in the organizational part of the General Assembly (Days 6 and 7).

PRESENTATION OF HOUSE RULES

The facilitator of the day explained the do's and dont's for the 7 days live-in General Assembly. He also reminded them to settle their reimbursements with the Secretariat and to pay their membership dues.

COMMITTEE FORMATION

The participants were grouped into committees to help in the smooth flow of the conference:

a. Socials committee
   Day 2 - NL
   Day 3 - CL
   Day 4 - NCR
   Day 5 - SL 1) ST
           2) Bicol
   Day 6 - Vis
   Day 7 - Minda

b. Buzz Session Groupings

NL	NCR	VIS
CL	SL	MINDA

c. Regional Caucuses Groups
   Same group as in Socials Committee

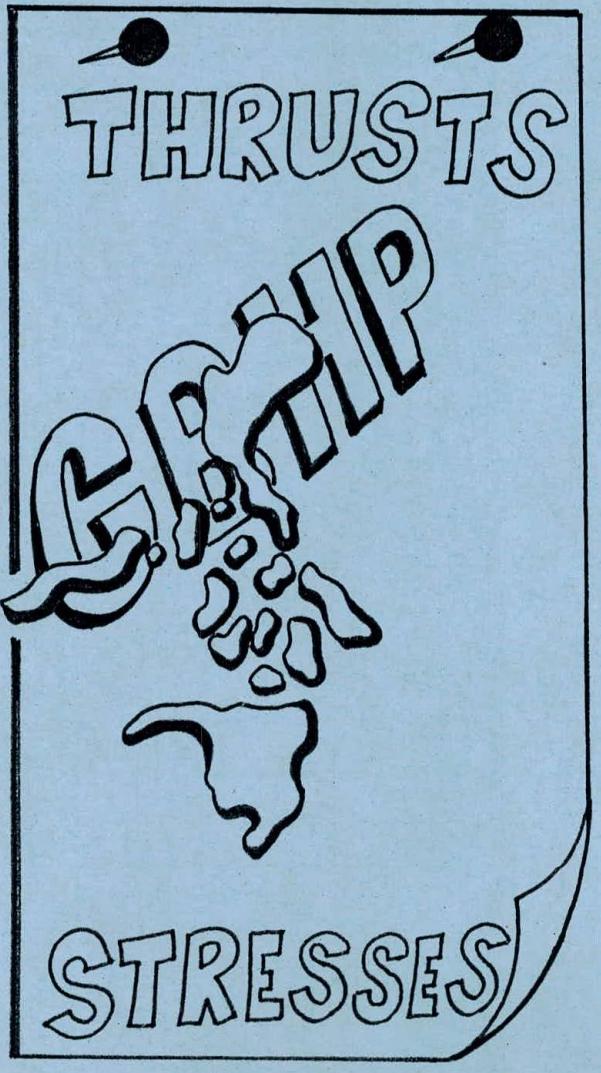
ORIENTATION ON REGIONAL CAUCUSES

The groupings for Regional Caucuses were made per region.

The facilitator presented the guide questions for Regional Reports which includes the status of the program, the stresses and summing up (See Appendix B). The said questionnaire would help them assess the program in terms of the quantity and the quality of their work.

DAY 2

11 January 1991
Friday



DAY 2

Facilitator Of the Day: Teth Guevarra

SCHEDULE

8:10	8:25	Morning Praise
8:25	9:00	Announcements: Change in Schedule Update on Gulf Crisis
9:00	12:00	Continuation of Regional Caucuses
12:00	2:00	Lunch
2:00	7:00	Regional Reports
7:00	8:00	Supper
8:00	9:00	Continuation of Regional Reports
9:00	9:30	Buzz Session

OBJECTIVE OF THE DAY

- To have an overview of the current status of CBHP's based on regional updates .

The facilitator of the day welcomed the other late participants who arrived this morning from Kalinga Apayao, Bicol and Quezon Province.

The participants requested for extension of time regarding regional caucuses so it was agreed upon that the regional reports would be presented in the afternoon.

GUIDE QUESTIONS:

ACTION TAKEN ON THE CONSORTIUM'S STRESSES AND CALLS TWO YEARS (1989-1990)

1. Did you conduct consultations with local leaders/ people's organizations? If yes, how many times within the 2 years? What were the resolutions reached? If no, why?.

2. Have you directed program efforts to community organizing? If yes, how did you do it? What are the problems you encountered?

No. of program areas	old		expansion	
	org'd	unorg'd	org'd	unorg'd

3. Have you conducted a program summing-up within the last 2 years? If yes, when (inclusive dates)? Format used (CHD or otherwise please indicate). What were the significant lessons learned (summary statements)?(If possib[illegible] per component). If no, cite reasons why not done.

4. Have you conducted a comprehensive community diagnosis within the past two years? If yes, how many barangays were covered? What instrument was used? Problems encountered? How did you utilize the results?

   If no CDx was done, what were the bases for your program planning?

5. Have you conducted SDS focused on value and attitudinal formation? What topics were discussed?

   Was there an echo session of the 1988 consultation (staff level, CHW level, board level)? If yes, what are the feedback from them? If no, cite reasons why not done?

6. Have you developed a continuing development education for CHWs? What topics were discussed and what were the results? % of CHWs benefitting from the dev-ed.

7. Did you have a Staff Development Seminar on program management? Were there any significant changes introduced towards improving program management? Problems encountered?

8. Specific people's health issues addressed by the program?
Specific campaigns participated in:

issue	inclusive date	forms	lead agency

What were the results and significant gains for the people?
How did you prepare the staff and community for the campaigns?
What were the problems met in projecting the people's health issues?

9. What health services were given by your program in the past 2 years? What were the bases for such services? Were criteria set? What methods were used in unorganized and organized communitties?

10. Have you identified and prioritized contact groups and individuals in the local and international levels? What were the basis of your relationship? What are the significant gains for the program and the people? Problems encountered?

REGIONAL REPORTS

A. CORDILLERA
Reporter: Dr. Chandu Claver

There are four health programs in Cordillera namely:
a. CHESTCORE - Community Health Evaluation, Services and Training for the Cordillera Region.
b. MCDC - Mining Communities Development Center
c. IMHES - Integrated Medical Health Services
d. CHECK- Community Health Concerns for Kalinga Apayao

These health programs provide health services in five provinces composed of Kalinga, Apayao, Abra, Benguet which includes Baguio, Ifugao and Mt. Province.

I. Quantitative Data

Completed BHST	Active	Inactive	Drop-outs
321	197 (61%)	85 (26%)	47 (14.6%)

- From 1988-1990 the number of CHWs trained in BHST totaled 321. 197(61%) active CHW's, 85(26%) inactive CHW's, 47(14.6%) drop outs due to military harassment.
- The four health programs are presently handling 50 program areas (50 barrios).

II. Qualitative Data

A. Significant Developments

1. Training
   - expansion was not the stress for the last two years, mostly consolidation work and follow-up training.
   - focus was on improvement of existing modules. A significant development is the participation of CHWs as trainers.

2. Services
   - Have started giving regular and sustained health services focused on immunization, goiter and control program, botica, nutrition instead of barangay clinics, medical and surgical missions.
   There is active involvement in rehabilitation and relief work.

3. Research
   - Community diagnosis(CDx) was developed and conducted. The programs were also able to update Community diagnosis in old areas. One program was able to update the community diagnosis of its 13 old areas.
   - Research on herbal medicines is still going on. For the last two years, focus was on the subject of domesticating the plants and propagating them for mass distribution.
   - launched province and region wide SIs

4. Organizing
   - After July 16, organizing efforts (CO & HSO) were greatly accelerated by NGO participation in rehabilitation work.
   - Of the four programs, MCDC has an organizing component.

Action Taken on Stress and Calls

1. Consultations with People Organizations have always been an integral part of implementation. Cordillera health programs have always stressed that health programs must only be set up in organized areas. They are not comfortable with the idea of using the health program as entry point for organizing.

2. Organized areas are prioritized but coordination problems exist between organizers and health programs.

3. Three-year summing-up ('87-89) was conducted in one health program.

4. CDx was used but collated results, although used were not formally written up. The programs were also able to update Community diagnosis in old areas.

5. Exposures were used widely as a form of value and attitude formation. There is a call for stress on value and attitude formation among the staff. The program used the exposure technique wherein staff will be exposed to other advance program or the program will be exposed to well organized areas.

6. Continuing Education for CHWs such as leadership trainings were given.

7. The staff recognizes the importance of program management. However, the staff as well as the CHWs encounter difficulty in its actual application.

8. Projection of particular health issues. The Baguio-based programs launched campaigns on health and pollution, logging and mining.

9. Health services include surgical missions, dental services, laboratory, acupuncture, referrals, goiter control, immunization and medical relief. The programs have started giving regular and sustained health services focused on immunization, goiter control program, botica, and nutrition instead of launching barangay clinics, medical and surgical mission. There is active involvement in rehabilitation and relief work.

10. Linkages were forged but mostly on individual basis. Follow-up was not systematic nor organized.

B. CAGAYAN VALLEY

Reporter: Tita Rillorta, R.N.

The Cagayan Valley programs cover 3 provinces. These programs are the following:
1. Community Based Health Development Program (CBHDP) - Isabela
2. CBHDP - Nueva Viscaya and Quirino.

Action Taken on Stress and Calls

1. After the first general assembly, the programs held consultations with the peasants and church workers for the formation of a health program structure within the parish and vicariate. Inter-regional program consultations were held once a year.

2. CBHPs gave program orientation to barangays. The whole community as well as the leaders requested for the CBHP orientation. So the programs conducted community general assemblys. The topics discussed were:

   > national situation
   > health situation
   > program orientation
   > criteria for selection of CHW's

3. The programs conducted regular quarterly evaluation and annual evaluation. They also conducted a summing up in 1989 and were able to identify the strengths and weaknesses, problems and came up with recommendations.

4. Before the CDx training, the programs used PSI forms. But there was a weakness in collation and in documenting the results. That is why the survey results were not fully maximized. The data were not analyzed.

   In 1989, after the CDx seminar, the programs used the Cdx form drafted by CHD- National Secretariat. They conducted CDx in late 1990 to update their records. Ten barangays have been surveyed. Collation is on-going.

5. The following trainings were given: theobiblical study, community organizing/leadership trainings (qualities of a good leader and errors to be avoided), Rational Drug Use (RDU), Minor surgery, Community Diagnosis (CDx), Medical Neutrality, Acupuncture, Under Fives Clinic (UFC), Disaster Preparedness, TLS, Program Management, Course on Community Development (CCD) towards total

human development. The staff coordinated with the Center for Nationalist Studies for their seminar on Philippine History.

6. CHWs were also given continuing development education which also covered the above topics. SDS also included attendance to/participation in campaigns and symposia.

7. Trainings on program management were conducted.

8. The following campaigns were launched:

ISSUE	FORM	DATE	SPONSOR
Medical Neutrality	Sympo	Dec. 1989	CBHDP
NDP	Sympo	Jan. 27, 1990	CBHDP
US Bases	Sympo	July 1988	CBHDP/SARANAY
PCAP	Campaign	Jan - July 1989	Peasants Orgs.
CAWA	Campaign	Nov. 30, 1990	TFD/Isabela
Human Rights Day	Campaign	Dec. 10, '88-'90	TFD

Significant Gains:

Medical Neutrality - strengthened staff and CHW's commitment
National Drug Policy
- recognition of banned drugs
- there are initiatives among the CHW's to have botica hopping and prescriptions collection.

US Bases - People in the community are not aware of the effects of US military bases.

Campaign against warrantless arrest - sharing about warrantless arrests.

9. Barrio clinics were held upon the request of the community. Medical and surgical missions were conducted for indigent patients from CBHP areas. The programs also conducted fact finding missions, medical missions (Cayapa) for disaster victims. There is a Referral Center in Isabela with subcenters which continue to

serve Viscaya and Quirino. Under Fives Clinics (UFCs) have been set up in 4 areas. Other services: TB/Malaria case finding, Immunization Campaign and Safe water supply project.

10. The programs have many contacts. These health professionals provided services but do not necessarily accept the CBHP orientation.

Gains: free service
resources
financial support
moral support

C. NATIONAL CAPITAL REGION (NCR)
Reporter: Isay Villayuan

The NCR has the following programs:

1. Tuason Community Center Foundation, Inc.
2. Programa sa Pag-oorganisa at Pangkalusugan sa Sitio Ruhat (Popsir)
3. Kaisahan ng mga Programa sa Pagpapaunlad ng Kabuuang-Pagkatao (KAPPAG-BULONG)
4. Paranaque Development Foundation, Inc. (PDFI)

All are urban base ranging 6-8 years. Program component is education, training, organizing, linkages and Income Generating Programs. Their main problem is the rapid turnover of staff.

Action Taken on Stress and Calls

1. All programs were able to launch a consultation with local leaders, people organizations and the community. Consultation were launched monthly and quarterly when necessary.

> Formation of coordinating body
- there was coordination on issues and program implementation

2. In the program areas, the stress was on organizing. This was attained by setting-up a health committee, levelling off with CHWs, conducting consultations with the POs.

No. of program areas	old		expansion	
	org'd	unorg'd	org'd	unorg'd
NCR areas	0	13 9	0	3
Total		14		

3. Summing-up was done. Some used their own format, others used the guidelines sent by the National Secretariat, but these were not completed because of other priority tasks.

Lesson: Multiple tasks and rapid turn-over of staff are some of the causes of delays in work.

4. All were able to conduct CDx but one program did not adopt the CHD guidelines. CDx became the basis for planning of each program. The CDx covered 20 areas.

Problem: Lack of Technical Manpower

5. All the programs conducted SDS like
   > process retreat
   > spiritual upliftment
   > self awareness
   > inter-personal relationship
   > team building

6. The programs conducted continuing education for the CHWs. This included updates on the national situation, health situation, political issues, oil price increase, and US bases. These helped in the awareness raising of at least 20-30% of CHWs.

7. Program management was given little attention due to the July earthquake disaster, wherein the attention or focus of work was on relief operations.

8. The programs launched a campaign on environmental sanitation and also joined campaigns of other institutions.

9. Health services rendered for the last two years were acupressure, acupuncture, nutrition education, referral/K.B., Community Clinic, Medical/Dental, Immunization, MCH/Well baby/ Growth Monitoring, Pre-Natal, Post Partum Care, and Health Awareness Building.

Basis: This is the actual need of the Community.

Methods Used:
> health education
> home visits
> referral procedures
> community clinic
> health campaign - small scale

10. Local contacts - facilitated services/smooth coordination and mutual support. Venue for awareness raising of individuals and other groups.

Gains - provided free service
- sustained relationship with the GO's

International financial support
- maximization of resources within the area.

Problems: > There is difficulty in linkage work if contacts have a different orientation.
> GO's tend to regard and use the CBHPs as extension programs.

D. CENTRAL LUZON
Reporter: Patrick Chuidian

Programs:
1. HODS - Nueva Ecija started in 1987
2. Pampanga - started 1983
3. Bacolor - started 1986
CL - is a support program which started in 1990
4. MCBHP-Munoz NE, started in 1982

Action Taken on Stresses and Calls

1. Regional

Consultations were made with local leaders, PO's, and sectoral groups. But as a whole the resolutions reached were about the cooperation in launching special projects. Some barangays in N.E. agreed to implement a comprehensive program but these plans were hampered by problems like militarization surfaced.

Problems encountered:
> Health work is not a priority of P.O's

2. There were efforts in community organizing but the CBHPs were not able to form a program for organization. Of 37 barangays, only one fits the criteria of an organized area.

3. Program Summing-up

In the program summing-up conducted the following strengths were identified:

a. provided services for the basic health needs of the community.
b. able to tap health professionals to render services in the areas.
c. some CHWs were able to give training and services.
d. in organizing, there are 21 advanced CHWs who can function as members of Barangay Health Commitee in some areas in Nueva Ecija. Core group were formed among women and youth particularly in Bacolor.
e. linkages were established and there is now an extensive referral network.

In the program summing-up conducted the following weaknesses were identified:

CBHP work is not systematic:

a. Training - Consultation with trainees was not implemented. Training modules were not updated, as well as the visual aids and kits. There was no evaluation of trainees and the staff's training capacity were not evaluated.
b. Services - Delivery of health services is not enough. There is a need to develop services in order to respond to the needs of the community. Types of services were basically barrio clinics and individual consultation.
c. Organizing - There is no comprehensive program for organizing.
d. Staff - Skills and knowledge are not broad enough. There is a need to develop skills in program management and health.
e. Program Management - There are weaknesses in systematization and professionalization of program management.

4. Community Diagnosis

The programs were able to start the process of CDx but were not able to finish it. The problems they identified was the lack of personnel who will attend to it. The planning was based on the condition of the area.

5. As a whole, CL programs were able to launch staff development sessions on value and attitudinal formation through the training on ways of giving feed-backs, leadership training, CBHP orientation, recollection, retreat and situationers.

The 1988 CBHP Conference results were echoed to the staff in the Pampanga and Bacolor projects and also to the staff and CHWs in Nueva Ecija.

Feedback: It boosted the staff's & CHWs' morale and provided motivation ''Marami palang dapat gawin ang bigat ng trabaho''.

6. There is continuing development education which focused on the advancement of CHW's in terms of knowledge, attitude and skills. This helped deepen their commitment that is why they spend more time and are more active in the program. Particularly in Munoz, the families of CHWs not only understood their work but also got involved in the program.

7. Staff of the three programs of HIDS attended the SDS on program management and from this they realized that there is a need to systematize the program. In the latter part of 1990, HIDS was able to take some steps towards systematization and sought outside help.

8. Health campaigns were launched but the problem was how to sustain them and the lack of funds in non-health campaign issues. The participation was only through attendance but this was not included in the planning because the programs prioritized program work.

9. There are similarities in services although there are some particularities based on the health needs.

Problems:

The program could not cope with the health service needs like minor surgery and disaster management.

10. There is no programmed networking activities. Networking is usually conducted at the local levels. The HIDS-Bacolor has international contact groups aside from FA's who were able to support the program in other needs. The basis of relationship is services, finances and resources.

GAIN:

Promotion of program, conscientization of health professionals and contacts and understanding of the conditions of the country.

PROBLEMS:
- no program for networking
- unable to prioritize networking due to lack of staff.

For clarification and levelling of of teh participants, the OF reviewed the definition of terms concerning Organized Communities (as agreed upon in the 1988 CBHP Conference).

E. SOUTHERN TAGALOG
Reporter: Rocky Agyapac

There are 8 Health Programs namely:
1. MAI Welfare Development Foundation
2. Mindoro Institute for Development, Inc
3. UCCP - United Council of Churches in the Philippines (HAND)- Palawan
4. AUSCULTA - Ambagang Udyok ng Sandiwaan ng mga Congregasyong may Ugnayang Lingkod para sa Taong Aba
5. FMT - Formation Mission Team
6. Rural Missionaries (ST)- Cavite
7. CDCI- Caysasay Development Center, Inc.
8. KSK - Kilusang Sambayanan sa Kalusugan,

Action Taken on Stress and Calls

1. One to 3 consultations with the POs were done within two years.
   The Resolutions/agreements were:
   > legalities - the program should be registered with the Securities and Exchange Commission and should issue identification cards to its staff.
   > endorsement of program
   > support assistance
   > establish good relationship with respected persons in the community
   > coordination with Peoples Organization in setting up health programs

2. Courtesy calls with GO's and NGO's, community meetings to introduce the programs, trainings for awareness building, services and formation of CHWs were all done by the programs.

Problems:

> Lack of skills (organizer)
> Difficulty in sustaining a program w/o PO's
> Slow organizing work
> Harassment of health workers
> If the area is militarized it is hard to get the trust of the people

No. of program areas	old		expansion	
	org'd	unorg'd	org'd	unorg'd
Southern Tagalog areas	8 1	5 1	1	9 2
Total	9	6	1	11

3. Three programs conducted summing up: CDCI, HAND, and AUSCULTA but they still need to use the guide formulated by the National Secretariat.

Significant Lessons Learned/Highlights
> found out the needs for proper endorsement of work
> lack of staff slowed down program implementation
> importance of CDx and PO's
> criteria for CHW selection should be set to prevent drop-outs
> need to strenghten org. component
> need for health prof.
> focus should be on the quality of CHW's not on the quantity
> need to re-emphasize the preventive aspect
> need for Rapid Rural Assessment

4. Six programs conducted CDx, while 2 have not.

No. of barangays covered - 17

Problems encountered during CDx:
1. the questionnaires for the beneficiaries are too long
2. expensive - on the part of program
3. lack of skills in analysis and presentation
4. lack of proper orientation and trainings
5. health programs were already established before the conduct of CDx

CDx was used
1. Project proposal making
2. Result of Cdx - not utilized
3. as basis to come up with the situation of the area

Those programs that did not conduct CDx based their plans on
1. consultation with the POs
2. requests of the community

5. Focus on value and attitudinal formation was done thru
> psychological tests
> retreats
> informal CSC accomplished thru activity
Only one program was able to echo the 1988 and 1989 CBHP Conference results; the rest did not.

6. In some areas, CHWs were able to complete the BHST
Topics taken:
> case conferences (method)
> leadership training
> dental prophylaxis and extraction
> disaster preparedness
> IGP trainings like soap making, biscuit making
> advance herbal medicine
> Rational Drug Use
> feminism
> growth monitoring - UFC

7. The staff of two programs were given training on program management. Job descriptions were clarified.

8. Campaigns participated

ISSUES	DATES	FORMS	LEAD AGENCY
Pollution	Nov. '90	MPT	PO
Oil Price - up	Oct. '90	Kampong Bayan	PO
Calabarzon	Oct. '90	Mobilization	PO
Preservation of Forest	April '90	Rally	Haribon - PAL
US Bases	June '90	Protest-rally	

9. Services given are:
   > mental feeding
   > Operation Timbang
   > Acupressure/Shiatzu
   > IV insertion of in - pt.
   > Maternal Child Health
   > Medical Mission
   > Dental prophylaxis and extraction
   > Laboratory examination

   Emergency Care of Patients
   - trauma
   - minor surgery

   Services given were based on the health needs of the area.

10. The bases of relationship of local and international contacts are orientation and services.

    Gains:
    > support
    > security
    > moral
    > financial
    > resources
    > assistance/technical/Personnel

F. BICOL REGION

Reporter: Minda Cortez

Bicol Region is composed of 4 health programs namely:
BIHS - Bicol Integrated Health Services.
TABI - covers two provinces Sorsogon and Albay and three towns Daraga, Legaspi City and Densol
BP - Bagong Paglaom
SIPAGKO - Sentro ng Inisyatibong Pagsasarili ng Kmunidad

TABI and BIHS are members of CHD and the other two are observers. From 1986 - 1990 period of reviving PO's through health.

Action Taken on Stress and Calls

1. Consultations with POs were launched twice a year with special consultations if needed.

Resolutions reached:

- endorsement of program by community leaders
- adhoc committee building after the assembly
- assertion of legality in times of military harassment
- to revive the People's Organization

2. Community Organizing Process:

a) without People's Organization - organizing the Community Health Committee
b) with People's Organization - coordinate with People's Organization

No. of program areas	old		expansion	
	org'd	unorg'd	org'd	unorg'd
Bicol Region areas	36	10	1	1

Problem encountered:

- People are passive and apathetic to CBHP.

The eve ts of 1986 has considerably weakened a lot of our organized areas. Areas have expressed the need for services but have remained apathetic to the concept of CBHP. There is a need to strengthen our organizing work in order to answer the challenge of reviving these weak POs.

3. On CBHP Components
   a. Health services: Mainly medical/dental services plus referral based on felt needs. Services are used as entry point for organizing.

   b. Training - based on the needs of the community or upon request.

      Trainer's capacity - can handle BHOS/BHST.

   c. Organizing to define specific program and direction toward health sector organizing.

   d. Linkage building - breakthrough in consolidating a network of health NGO's in the region.

4. In CDx, there is conscious efforts to implement CDx.

Form used: Survey

Level: Period of Social Investigation
- there has been an attempt to advance into comprehensive CDx.

Problem: Passive response from the area.

5. Staff development focused not only on attitudinal aspect but also on the skills that are needed by the staff.

   The result of the first GA was shared with the program staff.

6. The Continuing Development Education for CHWs has been included in the programs' plans but these plans have not yet been implemented.

7. On program management, on the job training has been the norm supplemented with consultancy with other agencies; formal trainings were not given to the staff.

8. On the projection of health issues
   - no health issue projected
   - participated in the multi-sectoral campaign e.g. signature campaign, march-rallies.

Results: Clearly defined stand of CBHP on burning issues and ensures active participation of PO's and health workers.

9. On Health Care Services: rendered basic medical/dental services in community clinics.

Bases: - felt needs in the community
- upon the request, conduct medical mission

Method used:
Organized - direct to PO/partnership
- health as a support service to PO

Unorganized: - Health programs started from organizing towards PO building

10. Networking:
Basis: Program orientation

Significant Gains - mutual support and coordination
- consultancy

Non CBHP - basis of unity is issue oriented e.g. Provincial disaster management team.

Problems encountered:

Weak in network expansion due to lack of systematization and clear programming of networking work.

G. VISAYAS
Reporter: Hersie Mitaran

Eastern Visayas - Samar and Leyte
Central Visayas - Bohol and Cebu
Western Visayas - Iloilo, Panay, Negros Occidental
Eastern Visayas - Negros Oriental

General Problems met in the last two years:
- economic crisis
- demolition issue particularly in Cebu
- disasters, man-made and natural
- militarization

Health problems are measles, hepatitis and communicable diseases.

Action Taken on Stress and Calls

1. On consultation with P.O.s:
   - all programs consulted with the leaders of PO's, socio-economic groups and other NGO's as well as with parishes and bishops.

   In other areas, the agenda set were:
   - clarify roles and programs or organization
   - review orientation and philosophy
   - consider programs in the next activities

Problem: The programs cannot enter the areas because of militarization.

Resolutions:
- lines of coordination were cleared
- to have a continuous activity in the area even without staff
- need to observe protocols in organized and unorganized area.

2. On directing program efforts to Community Organizing:
   -all the programs are trying their best to direct efforts to community organizing.

   In some areas, the programs held consultations with POs and clarify roles of program and POs.

Problems:
- Lack of staff to focus on Community Organizing. Also, available personnel still need to develop their organizing skills.

3. All programs conducted summing up.

   Samar - 3rd quarter 1990 (August, 1984 - June, 1990)
   Central Visayas - 1st quarter 1989
   Iloilo - midyear 1990
   Leyte - last quarter of 1989

Significant lessons learned:
- realized mistakes in the area selection and corrected these in 1986
- lack of staff development and CHW value formation
- re-orientation and re-direction at all levels (management, staff, community) towards the realization of its vision and philosophy
- areas for improvement: time and program management
- realized the importance of defining short term and long term plans
- need for leveling-off of the staff on knowledge, skills and attitude.

4. All conducted CDx.

Out of 31 barangays covered by the CDx, only 9 were finished. CDx results were used as basis for regional health situation and services.

Problem: Lack of manpower to conduct the survey
- difficulty in entering the area due to militarization
- lack of staff to conduct analysis and interpretation

CDx result was used for program implementation, planning of program activities, and as a means for organizing.

5. All programs conducted value formative SDS except in some areas where there were problems like militarization. Topics: renewal and deepening one's commitment, realizing the kind of work, knowing one's self and knowing others, and reflection sessions.

6. All programs were able to conduct continuing development education. Topics included immunization, disaster preparedness refresher courses, CDx, para-legal training, food survival technology and some reflection sessions.

7. On staff level management scheme: majority of the programs recognized the importance of program management.

Some programs were able to finish the program management training, while for others, only selected topics were finished.

Gains:
- lines of authority and coordination of desks and departments were clarified
- more systematic planning and evaluation method
- more systematic monitoring of activities

8. On the projection of Health Services: campaigns concentrated on medical neutrality, rational drug use, US bases and primary health care, in the form of symposium, forum, radio hopping and informal discussions.

Gains: - helped in the promotion of program
- helped in the consolidation of the program with the local organization.

Problems:
- lack of a folow-up mechanism
- lack of sustaining activities

Professionals and students benefited from the campaign. There was minimal community involvement.

9. On Health Care Services, majority conducted basic health services. The health services given are:
- health awareness
- nutrition
- safe water supply
- mobile clinics particularly in Negros
- immunization
- management of common diseases

Basis: - felt need of the areas and request of PO's
- area assessment conducted by staff and CHW

10. On all programs identified contact groups especially in the local level. International networking was not done.

Problem: Poor communication lines with the national secretariat especially during typhoons.

H. MINDANAO
Reporter: Ann Kadile

Programs:

1. CBHS - Butuan
2. BSMS - Butuan City
3. CBHS - Lanao/Iligan
4. Interfaith Program for Health Cocnerns Cotabato
5. CBHS - Marbel (data not included)

Area Report:

1. Situation:

a. Economy
- the products of the farmers were cheap like copra, banana, corn, palay, abaca and others
- basic commodities like rice, oil and soap are expensive
- many are unemployed
- usury is rampant; mostly affected are farmers

b. Politics
Militarization
- "Silent Military Operations" - 5 barrios affected. Soldiers borne helicopters to identify organized barrios.
- creation of Bantay Bayan, Barangay Brigade
- immersion of soldiers with the people (they live in the community area)
- they gather people in one place and project them as " rebel surrenderees"
  * Encounter between the military and the rebel forces (MNLF, NPA)
  * Massive evacuation
    - Lanao del Norte
    - Agusan Sur/Norte (Noble Coup)
    - Pikit North Cotabato (MNLF vs. Military)
  * There was a coup in Butuan City, Cagayan de Oro and Iligan City last October 4 and 5 1990.
  * Increased in crimes

Socio - Cultural
- many Born Again groups (Fundamentalist), preaching in the bus and market
- rampart gambling ("last two", pyramid)
- drug addiction

c. Health Situation
- upper respiratory tract infection
- typhoid fever
- measles
- parasitism
- dengue fever
- bronchitis
- amebiasis
- pneumonia
- APD
- malaria
- PTB
- schistosomiasis

2. Stresses and Calls:

1. Consultations were conducted with local leaders, (traditional leaders, religious, barangay officials, community people, and Pos).
   - consultations were held once or twice a week especially if the program and activity is newly formed.

Resolutions:
- services used as entry point in reactivating people's organizations in the areas
- services directed to organized areas with GO surgeon
- develop CBHP in the Moro/TF communities and since the communities are still unorganized the CBHP will help to initiate.

2. There are concerted attempts and efforts in community organizing.
- consultations
- contact building
- services

Problems:
- At first, there are difficulties in entering former areas pushing the organizations to use services, linkages, and coordination with COGs (programs)
- Language barriers: resolutions
- integrate with the people (Moro)
- conduct studies regarding Moro

No. of program areas	old		expansion	
	org'd	unorg'd	org'd	unorg'd
4	63 * 15 towns	8 * 3 towns	2 *	25 * 6 towns

Note: * communities

4. CDx was conducted in thirty communities.

Problems encountered:
- take a long time to analyze
- you still have to talk to many people before you can conduct a survey
- during the survey, the military is still doubting your presence.

5. On value and attitudinal formation: conducted from staff to trainers level

6. CHWs' knowledge, skills and commitment were upgraded. Most of those who were able to get advance training were able to continue with their work.

7. On program management: these studies helped the staff to systematize their work

8. On the projection of issues: programs joined campaigns launched by other sector. Issues involved were human rights violations, US bases, Ecology (Earth Day), transport strike, WB, HR day.

9. Services were used as entry point in areas where POs need to be revived.

Method used:

Unorganized area: referrals

Organized: Most of the services are focused here.

Methods:
1. Request coming from POs.
2. Survey/preparation in area.
3. Organize health teams.

10. Most of the contacts are religious people, (RC, PIC, UCCP, slam) health professionals and other health concerns. (Individual)

Basics: Coordination and Networking

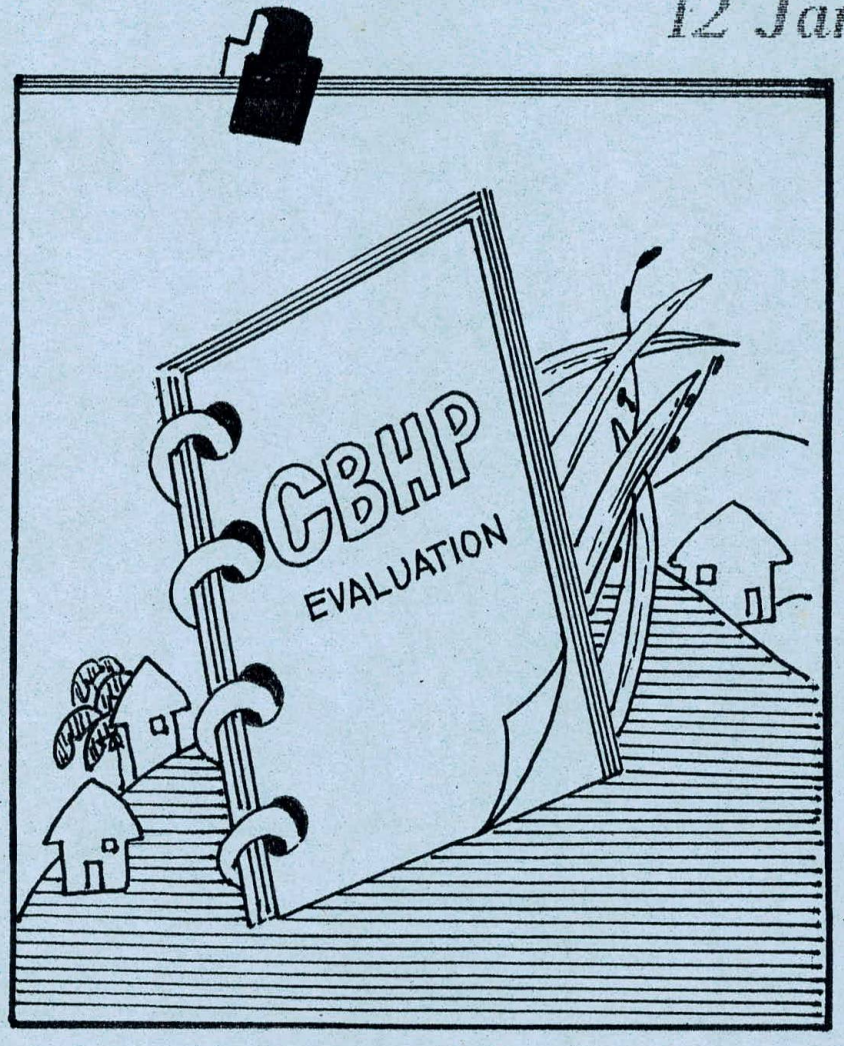
Gains: It helped in the delivery of services and in the promotion of program.

It also boosted the morale of the workers.

Problems:
- how to sustain contacts in order to sustain their active participation
- lack of consolidation

DAY 3

12 January 1991
Saturday



DAY 3

Facilitator of the Day: Dr. Tess Burgos

SCHEDULE

8:00 - 8:15	Morning Praise	
8:15 - 10:00	Executive Committee Report	Dr. Len Barcelon
10:00 - 10:30	Break	
10:30 - 12:00	Synthesis of Regional Reports	Dr. Leni Jara
12:00 - 2:00	Lunch	
2:00 - 4:00	Continuation of Synthesis	
4:00 - 4:30	Break	
4:30 - 7:00	Medical Ethics, International Codes and Humanitarian Laws (Protocol 2)	Dr. Au Parong
7:00 - 8:00	Supper	
8:00 - 9:30	CBHP Impact Evaluation	Mel Garcia
9:30 - 10:00	Buzz Session	

EXECUTIVE COMMITTEE REPORT

Len Barcelon, M.D.
Executive Director
CHD National Secretariat

INTRODUCTION

The past two years have been marked by major events in the history of the development of Community-Based Health Programs in the Philippines. As the programs have consistently maintained, their development has always been intertwined with societal events, especially the development of the popular movement for social transformation. So, as the people's organizations continued to evolve in the midst of a deepening social crisis, the process gave rise to ever-burgeoning needs. Cause-oriented groups and people-based programs like the CBHPs have tried to face the challenges of more refined visions and directions, advance skills, new strategies, higher levels of services and technical expertise, more comprehensive concerns and integrated intersectoral approaches with long term perspectives.

For the CBHPs in the network, the process of gearing ourselves to face these challenges involved several forms of reflecting and evaluating what we have done so far. After which we had to ask the question: Where do we go from here?

The process was started in a consultation late in 1987 among some regional and national CBHP coordinating bodies

and major programs which recommended a comprehensive review and evaluation of then existing strategies, approaches orientation.

As an initial step in this evaluation, the programs gathered in December 1988 for an assessment of the most recent period of the CBHPs' 15-year history -- from 1984 to 1988. Apart from the results of the program assessments synthesized into a national picture of the CBHP status, the conference output included several important resolutions. These were the resolutions for all the programs to conduct summing-up evaluations from the start of the program to the current period, to review and re-orient the programs towards focusing their services to organized areas and people's organizations, and the resolution to set up a national body for coordination and common concerns of the different programs.

This step was in recognition of the need for us to close ranks and accelerate the development of our programs to keep up with the pace of the growing needs of the people's organizations and other efforts towards social transformation. These were the beginnings of the CHD. The consortium was later formed in July 1989 through an organizational conference with representatives from the programs and regional bodies.

During the same period, the major partner agencies of the CBHPs initiated the process of an impact evaluation of their partner programs and institutions to be done by external evaluators. There was thus at this time ongoing summing up evaluation being conducted internally by program personnel and the impact evaluation by an external team of evaluators which would be able to validate and supplement each other's data and findings.

Thus, for the network, the past two years may be characterized as a period of transition. The member programs were undergoing a period of evaluation and working towards new directions after the period of setback in the development of CBHPs as identified in December 1988. At the national and regional coordinating centers, the setting up of the national center which would be staffed by the secretariat was a priority concern. Negotiations and consultations with the existing coordinating centers resulted in the composition of a team of personnel from at least 3 major agencies involved with CBHPs to staff the national secretariat.

THE CHD NATIONAL SECRETARIAT - PRESENT CONCERNS AND ORGANIZATION

The fields of work and concerns of the CHD fall into five clusters which have been delegated to the departments of the national secretariat. These are the following:

1. **Management Training and Consultancy** which holds the key to the vision of community-managed programs through its work in local capacity-building in management, and assistance in the project development cycle from needs assessment to conceptualization and evaluation;

2. **Health Education and Training** for further skills, attitudes and knowledge for improved health services, leadership and organizational growth of the programs communities we serve;

3. **Health Care Services** which assists member programs in improving strategies and methods in rendering health care and supplements the services currently offered by the programs through its missions and projects;

4. **Research, Documentation and Information** which facilitates the exchange of positive experiences and insights in health work and its dissemination to others; and

5. **Special Projects** for pilot experiences in new fields work such as urban CBHP, health work in minority groups, community-based approaches to major infectious diseases such as malaria, health financing schemes.

Networking, linkage-building and coordination are built-in components in all fields of work and are undertaken by the secretariat as a whole with the members of the executive committee taking the lead role. In addition, the executive committee also supervises the national secretariat and particularizes decisions, plans and policies set by the Board of Trustees.

During the last 18 months since the CHD's formation, the national secretariat strove to implement the tasks and functions designated by the CHD general assembly and at the same time undertake the requirements of the transition stage. The process has been difficult and complicated with many learnings for the staff members and the network as well.

Initially the transition process was slow and prolonged as the secretariat tried to meet the requirements of the old agency partners and the new demands and needs of the network, resulting in backlogs in the general work of each department. There was also initial difficulty in maintaining a balance between external services and center-based work, between work in the capital region and in the other regions, and between internal secretariat concerns (i.e. staff upgrading and development) and assistance / services to the regional member programs among the different departments.

The BOT met during the designated schedules (4x) to help guide the consortium operations during the past one and a half years while the executive committee was convened five times between these meetings to further concretize plans and programs.

HIGHLIGHTS AND OBSERVATIONS

A. Management Training and Consultancy (MTC)

* Assistance in the summing up evaluation of nine out of 13 member programs that conducted summing up (35% of members). (This data was based on summing up reports received by the NS as of January 10, 1990. So those submitted after this date were not included.)

* Series of area visits, consultations with people's organizations and sectoral groups that requested for assistance in program conceptualization and setting up;

* Assistance in setting up of 5 programs in 4 areas; mainly in Southern Luzon, Cavite, Mindoro, Quezon, as requested by the POs in the areas;

* Facilitation of CBHP Evaluation and participation in the national coordinating committee for this activity;

* Deployment of community health volunteers (5) in priority areas for assistance - Negros, Bicol, Quezon;

* Assistance in program services and management through temporary staff deployment to assist the programs in different aspects of PIME in Negros, Panay and consultations with POs in Samar and Southern Tagalog;

* Drafting of Implementation Scheme for CBHPs and Program Management Manual up to discussion of framework and topic outline;

* Projects development and proposal making - 2 proposals for community volunteers, facilitated proposals for Training programs for Bicol (3) and AUSCULTA, Health relief projects (2) for earthquake victims;

In general, the MTC functions were focused during the past 18 months on assistance and consultancy to member programs, people's organizations, sectoral organizations and other agencies in program conceptualization, development and PIME. No management training activities were conducted yet, which may be one of the projections of MTC for the coming period. Also, the special assembly on the implementation guidelines for CBHPs had to be deferred.

B. Health Education and Training (HET)

* Total number of trainings conducted: 28
  - Mainly as per request by regions although a breakthrough experience in terms of launching or initiating a course on Trainer's Training was done.

* Scope of Training:
  - Nationally coordinated: 2 (CDx and Immunization)
  - Regional CB's: 4 (RDU, TLS and DDx)

* Levels of Training:

Level	Total	Requesting Organization	
		Member Program	New Contacts/Affiliates
BHST	11	----	11
AHST	8	2 (Regional CB)	----
BHOS	9	2	7
Total	28	4	18

- Trainings were availed mainly by new contacts / affiliates rather than by our member programs, and most trainings conducted for the latter were AHST and BHOS. However, two (2) out of four (4) AHST were also participated in by a number of member programs. We still would like to pose questions to this assembly regarding the trend of our training work which will have implications on our projections:

  Does this mean that our member programs can already handle the BHST conducted, and that the assistance needed from the national secretariat is in other forms or levels in our training and education work?

* Level of Participants

Note: The level of training participants may vary in one training. Program staff, CHWs and health professionals/students may all be participants in one training.

Level	Community/P.O.	CHW	Staff	Health Professionals/ Students
BHOS	----	6	----	5
BHST	1	6	6	----
AHST	----	2	7	----

- Many AHST were for staff level, BHST were conducted for both staff and CHWs. As expected, BHOS were for outside groups specifically health professionals and students who requested these seminars;

* Other Observations:

- Training activities were directed to organized groups and were in line with CHD consortium stresses.

- Training services for members were mainly from areas in Luzon with SL, CL and CV sending the most requests.

- Training resource development (manuals, visual aids) are presently under review based on revision of curricula, training designs and concepts in relation to CBHP transition/re-orientation.

- Training personnel: no new trainers were mobilized but the concepts of the National Pool of Trainers (NPT) / Regional Pool of Trainers (RPT) were reviewed and guidelines were drawn up.

- Implementation of training process and guidelines continued to be problematic even in conducting training needs assessment. Some pre-training consultations and identification of needs of participants did not push through.

* Major weak points in our training work:
  - Irregular HET Department meetings.
  - Inadequate turnover/endorsements of work assignments when staff were out of town for trainings.
  - Delay in production of manuals and kits.
  - Proper operationalization of systems of work and guidelines as agreed upon in the past as a consortium.

* Factors affecting implementation of HET plans and activities.
  - Simultaneous field deployment of three (3) trainers for a duration ranging from 1-2 months.
  - Failure to review and make adjustments in department plans after the earthquake and disaster relief operations actively participated in by the HET staff.

C. Health Care Services Department (HCS)

1. Clinic services were operationalized by the first quarter of 1990.
   - Emphasis was on referral services for patients referred by member programs/beneficiary organizations (POs, etc.) from the region needing specialty care.

a. Number of Patient Consultations:
   (January to November 1990)

New Patients	- 158	Male	- 95
Old Patients	- 123	Female	- 186
Total	- 281		281

b. Referrals coming from programs from the regions:
Patients from Regions - 58
Patients from NCR - 223
- Of these, six (6) were surgical cases and 275 were medical cases.

c. Sources of Referrals:
1. POs - 50
2. CBHPs - 108
3. Other Agencies/Institutions - 94
4. Individuals - 33
- Majority of our patients came from CBHPs (beneficiaries)
- Patients from other agencies/institutions were usually their staff and members of POs.
- A consultation with other NGOs and POs was conducted in June 1990 to discuss guidelines for the referral system.
- There is still room for improvement of our system and the utilization of our referral services.

d. Common Diseases:
1. Upper Respiratory Tract Infections (URTI) - 24
2. Pulmonary Tuberculosis (PTB) - 14
3. Obstetrics and Gynecological cases (OB-Gyne) - 7
4. Asthma - 6
5. Neuralgia - 5
6. Heart Diseases - 5
7. Urinary Tract Infections (UTI) - 2
8. Dermatitis - 2
9. Hyperacidity - 2
10. Errors of Refraction (EOR) - 2
- Some illnesses were still treatable at the community level.

e. Patient Referrals:
1. To Out-Patient Department (OPD) clinics - 57
2. Tertiary Hospitals - 6
3. Admissions to tertiary Hospitals - 6

- Many patients were referred to OPD clinics but there were also admissions to tertiary hospitals. While cases of URTI, PTB, etc. were seen, most patients also needed specialty treatment.

2. Mobile Health Services:

A. Missions and Community Clinics:

* Community Clinics - 5
  Medical Missions - 3
  Internal Refugee Clinics - 2
  (Services provided to IRs in NCR.)
  - Regions reached were ST (Laguna), CL (Tarlac), and NCR (Antipolo, Sta. Mesa and Quezon City).

* Total number of Medical Patients - 883
  Total Number of Dental Patients - 67

* Total number of Volunteers Mobilized - 28
  MD - 5
  DMD - 6
  RN - 5
  PT - 1
  Medical Students - 10
  Nursing Students - 1

* Preparatory stage for Medical/Surgical/Dental missions to Panay and Bicol this 1991 is ongoing.

B. Health Relief/Disaster Response and Management:

* Organized and mobilized relief teams to NL/CL during the July 16 earthquake.

* Resource generation both locally and with international friends/partners.

* Cooperated with other NGOs through Inter-Agency Network for Disaster Response (IANDR).

* Observed that initiatives for assistance came from the national secretariat and the member programs tended to work things out on their own. On one hand, we have the tendency to be self-reliant but on the other hand, we also have to realize that we can also tap other resources and this is but one essence of being a consortium - mutual assistance and sharing of resources.

3. HCS Projects

(Presented for the information of our member programs that are interested in launching their own services component.)

* Projects currently being implemented:
  1. Immunization campaign (1990-1992)
  2. Disaster management training (1990)
     - c/o HET Department
  3. Health Relief and Medical Assistance to Disaster Victims (1990)

* Conducted 2 Immunization Campaign Training/ Consultations (Cebu and Manila) and came up with a module on Immunization Campaign which can be used/availed of by member programs.

4. Assistance to member programs through temporary deployment of 1 physician, 2 nurses and 4 volunteers to program areas in Negros, Panay and Quezon. Deployment ranged from one to six months. The deployed personnel also helped the programs in networking and referral system building, conceptualization of services components, health services for evacuees on IRs.

5. Networking

* 11 MD's reached for referral services and community clinics
* 1 Social Worker
* 3 Institutions for referral
* 1 Institution for training facilities

D. Research, Documentation and Information (RDI)

1. Assistance to Programs in conducting community diagnosis (CDx):

* Finalization and use of module and instruments for CDx;

* National training and consultation on CDx (1989);

* 50% of programs who attended the 1989 training / consultation are conducting CDx;

* Implementation of CDx has been intensified through the national CDx training and other trainings / consultation visits to regional and local programs. However, its conduct has been hampered by such factors as lack of staff and resources as well as other urgent program activities or priorities.

2. The department has actively assisted in documentation and publication of other CHD national secretariat activities, information dissemination and media linkages. An example was the Samar experience wherein RDI actively disseminated information to media and helped launch a press conference re: harassment of medical teams that conducted medical missions during a measles epidemic in KAPPS areas.

3. The library set-up and inventory has been systematized, and continues to provide reference materials and takes charge of publication exchange which added resources to our library.

4. Databanking of CHD and program operations is still in the initial stages. We are in the process of getting the updated regional program profile for consortium area.

5. Current projects include video production on CBHP historical development and slides production on CBHP orientation.

E. Special Projects (SP)

1. NCR coordination and linkage:

* NCR CBHP conference was launched in 1989 to discuss CBHP conference results of 1989;

* NCR Secretariat/Coordinating Body was set up with 7 participating programs;

* Services consultation re: basic services at community level, referrals and mobilization of community members for health services;

* Current network includes:
  8 people's organizations (Pasig, Paco, Novaliches and Quezon City)
  11 health programs and institutions
  5 parishes (Caloocan, Tondo, Sta. Ana).

2. Assistance in program building and re-orientation to 4 POs and 3 parishes.

3. Education and Training activities. As a regional network, the Special Projects Department was able to conduct:

- standardization of selected curriculum designs
- 17 training and education activities as follows:

CDx	- 3
BHO	- 3
BHO-ST	- 7
RDU	- 1
Awareness Building Issues	- 2
Disaster Preparedness	- 3

4. Health Services of the local unit consisted of referrals, dental community clinics, supplementary feeding, first aid for people's mobilizations, QRTs and formation of disaster response teams in several areas.

5. CHW organizing was focused on strengthening local level structures of Health Committees or CHW organizing. Thus NCR-wide activities were limited to 1-2 times/year sharing and discussion of vital issues.

6. There was a re-focusing of NCR desk work from local area operations to NCR-wide activities.

In general, the NCR desk was able to respond to needs and requests of POs and programs for health education and training but there is a need to launch more community level health education.

For other special projects on Leprosy, Malaria and Moro CBHP, draft concept papers have been presented to the Executive Committee for comments. Preparatory activities such as program area consultation and visit, initial discussions and coordination with other agencies have been started with the Philippine Leprosy Mission, and Research Institute for Tropical Medicines.

F. National Secretariat Administration and Management

1. Office management systems have been developed and are currently implemented but not fully operationalized.

Staff development plans have not been implemented regularly especially during the late half of the year due to other urgent activities (i.e. disaster relief).

The organizational structure has functioned moderately well with regular meetings of the BOT, Executive Committee and National Secretariat staff. However, status for the different management concerns of the departments varied.

2. Finance Management

The secretariat is currently operating on funds from old projects turned over by the 3 agencies and we are right now in the process of developing new projects. Other desks have submitted new project proposals for implementation.

	PARTNERS	DURATION
Training	- BW/NCOS	- 1991
Center for Urban PHC	- SCLF	- 1992
CBHP Consultancy Services	- MISEREOR	- 1990
Immunization	- Third World Relief	- 1992
Disaster Preparedness Training	- Caritas	- 1991
CBHP Evaluation Results Dissemination	- CEBEMO	- 1991
AIDS Education	- APHEDA	- 1992

3. Coordination and Networking

A. External Linkages:

1. Local linkages and guidelines for relations with sectoral organizations were worked out during the first General Assembly. Based on this, the BOT has come up with decisions on some inter-organizational relations.

a. On BUKAS invitation for membership. The BOT decided not to involve the consortium as a whole because it is the GA's mandate to decide. However, this can still be changed based on the decision of this assembly. But the BOT thinks member programs can join the BUKAS network and continue our support to setting-up their regional counterpart;

b. Membership invitations from BUNSO and LAMBATLAYA which came in recently will be decided upon by this GA or the incoming Board of Trustees so this will be part of our discussion later;

2. Intersectoral Linkages

CHD's major linkage is with the Council for People's Development (CPD), in which RMP and CPHC were members, representing the health sector in development work. and the BOT decided to continue

our membership as a consortium. Again it will be up to the GA whether or not to change this decision.

CPD is also a consortium of NGOs' network from different regions and sectors involved in the Caucus of Development NGOs. This involves broad coalition promotion with other NGOs of varied affiliations and approaches, which we think is a new challenge in working with other NGOs.

3. International Linkages

Continued affiliation with the following organizations/agencies:

- Asian Community Health Action Network (ACHAN) the previous agencies were part of this network. This includes: AHI or Asian Health Institute which sent us invitations for training which some of the member programs have availed. We received invitations from them which we can discuss during our organizational meeting.

- Volunteer Health Association of India (VHAI) invited us for a conference on Community Financing Scheme and we sent a staff of the national secretariat.

- Catholic Hospital Association of India (CHAI) RMP is engaged in an exchange program with CHAI and invited participation from other members of CHD.

- International Breastfeeding Action Network (IBFAN) other programs are also involved here. One concrete result was the establishment of linkages with Latin American Community Health Groups with similar orientation as ours. There is a standing invitation for an exchange program but this is still pending due to funding constraints. Some regions are already aware of this.

- We attended the International Women and Health Meeting (IWHM) where we met advocates of other alternative health programs including those from countries with similar to our with conflict situations; and others with liberation movements.

- New links, more on people to people level:

  * Research group based in Holland, an Inter-University/Inter-Country Research Group.

  * Third World Health Group in Australia.

  * Other Foreign Volunteers Organizations in the Philippines that expressed interest in coordinating with CHD and fielding volunteers to our programs. This can be discussed later, as to the needs of our programs on this.

B. Internal Coordination within the CHD:

- Despite the implementing guidelines drawn up by the first GA, we have had problems in coordination within the consortium itself.

Re: - Relationship with other organizations both sectoral/non-sectoral;

- Utilization/availing of services of the national secretariat; services do not reach other members;

- Relationship with some CB's and member programs.

Problem:

The agreed system of sending through the Regional Bodies (RBs) all communications intended for the local programs did not work as expected. There is a need to review this during the organizational meeting.

OPEN FORUM

Important Points Raised:

A. What were significant events that happened in the National Secretariat for the past 2 years?

1. In terms of regular workings as a national secretariat
   > established different desks and formed into different working teams. Considering that the staff were from different institutions with different approaches to CBHP components, it took us some time to get together as a working team.

2. In terms of highlights
   > launched a campaign for Samar in which KAPPS areas were the beneficiaries - first major activity of CHD (Waray Bugas an Samar: A Campaign Against Poverty, Hunger and Disease, Sept.-Dec. '89)
   > provided relief services to earthquake victims (CL, CV, NL and Cordillera July 16-August '90)
   > these were big undertakings since majority of the planning to actual implementation was participated in/initiated by the national secretariat. It entailed generation and mobilization of resources (both personnel and material/financial) within Metro Manila, to be sent to the regions.

3. In terms of networking and promotions
   > established identity as CHD by introducing the consortium to other sectors/NGOs/Networks
   > launched a book on CBHP evaluation results (November '90)
   > earthquake relief efforts helped us get in touch with other NGO's/agencies involved in relief, services and development work
   > conducted consultation with different PO's/ sectors to explain/discuss health work in relation to the whole context of development work
      * the ongoing development work is seen as a process towards change. What then is the role of health in this process?
      * it was observed that most health programs/ CBHPs concentrated on the services component of the program.
      * other sectors/POs recognized health only in terms of its traditional role as mere providers of services not as a sector with issues and concerns, with goals and directions, similar to theirs. So that every time health problems/ needs arise these groups would call on the program to respond to such situation
      * it was recognized that the POs, with their potentials as groups/sectors, carry an important role in health care by integrating/including
      health services/ work in their program so they can address health needs/problems within their ranks and not always rely on the health sector to do so.

> Collation of experiences of different CBHPs, so we can discuss it in this General Assembly, was also considered a big gain.
  * collated experiences will enable the GA to situate itself in the present context
  * it can help the body to discuss/decide on future thrusts and stresses, to address questions and concepts and to make adjustments to old concepts.

B. Problems/Difficulties

1. Communication and coordination with member programs
   > consultations were conducted to discuss some projects requiring comments/decisions of member programs involved and/or targetted for the project, but attendance is poor. In some instances, discussion as to concepts, etc., of the project was approved, however, during the mid-implementation phase, it turned out that the requirements were not met, and what has been agreed upon by the secretariat and the member programs was not implemented.

2. The National Secretariat had difficulty in really functioning as a "secretariat" of the consortium
   > member programs tend to always go back to dealings with previous institutions (CPHC, RM, UM) which made the transition phase somewhat difficult for both the National Secretariat and member programs

   > it seemed that for some member programs, CHD is not clearly seen/identified as a consortium

C. Recommendations:

1. Update member programs re: revisions of training materials
2. Send staff of HET to other member program
3. Clearly define the roles and responsibilites of the national secretariat and the member programs of the consortium

All points raised were well taken.

SYNTHESIS: STRESS AND CALLS

Eleanor Jara, M.D.
Member, Synthesis Committee

(Refer to Table No. 1: Total Number of Participants and Observers & Table No. 2: Total Number of CBHPs' Human Resources)

1. Consultation with P.O.

- all programs had conducted consultations with PO's
- Frequency - 2 to 4 consultations/year
  - 2 programs did not have regular consultations due to militarization

Results of Consultations:
- coordination was systematized
- the roles of the program were defined:
  * assist people's organizations
  * revive PO's
  * provide direct services

2. Direct Program Efforts To Community Organizing

- all programs directed their efforts in organizing the community except for 2 regions. The 2 regions had limited staff to do linkage work with different programs which have different organizing work;
- 3 regions stated that majority of their areas are unorganized;
- Problems encountered in organizing:
  * militarization/harassment - 3 regions
  * coordination with organizations
  * lack of staff
  * weakening of PO's
  * staff's lack of experience in organizing
- How to direct the programs

In Unorganized Communities - community assembly started with courtesy call and with training formation of BHC (Barangay Health Committee)
In Organized Communities - consultation with P.O.

3. Conduct Program Summing-Up

CV	CORDI	CL	NCR	ST	BKL.	VIS	MINDA	TOTAL
Isabela								
1/2	1/4	4/4	1/1 + 3 observers	3/4	2/2	4/4	2/2	17/21

Summing-up Observations:

a. Training
   - no systematic training modules, kits
   - no evaluation of training capacity of staff and CHW's
   - recognized the importance of CDx
   - trainings given were based on the needs of the community

b. Services
   - rendered assistance in answering the needs
   - health professionals tapped for services
   - CHW's were able to give services
   - inadequate services based on the needs of the community

c. Organizing
   - Barangay Health Committees are functional
   - recognized the importance of linkage with the P.O.'s
   - there is a need to define the specific program and direction of Health Sector Organizing
   - recognized the poor selection of areas.

d. Program Management
   - lack of systematization and professionalization
   - staff and CHWs lack the attitudinal development
   - recognized the importance of short and long term plans
   - areas for improvement were recognized.

4. Community Diagnosis

- 2 regions were not able to write the results of the CDx
- 4 regions have not completed the process of CDx
- 2 islands, Visayas and Mindanao have partially completed the CDx

PROBLEMS:
- lack of writing skills
- lack of staff
- lack of skills in analysis
- long questionnaire
- militarization

RESULTS OF CDx

- results of CDx were used as entry point in the community and in planning data obtained from CDx fulfilled partner agency requirements

5. SDS on value and attitudinal formation

Top 3 forms - orientation seminar
recollections
CSC

- all programs had conducted SDS

6. Continuing Development Education For CHW's

- all programs had their continuing education for CHWs except for Bicol.
Generally, SDS were not programmed and systematized.

TOPICS:

HEALTH
- Under-Five Clinic (UFC), Acupuncture(AQ), TB Microscopy, Rational Drug Use(RDU), Dental Prophylaxis and Extraction, Immunization, Goiter Control, Herbal Medicine Preparation, Minor Surgery

HEALTH RELATED
- Disaster Preparedness, CDx, TLS, Appropriate Technology, Soap and Biscuit-Making

NON-HEALTH
- Oil price hike, food survival, paralegal training updates; situationers, feminism, leadership training, community building, organic farming, reflection sessions, value formation.

Effects on Continuing Education
- deepening of CHW commitment
- understanding of the work of the health worker by the members of the family

7. Development of Appropriate Staff Level Program

- all programs except NCR had conducted program management training
- there is difficulty in applying program management principles
- the training made the staff realize the need to systematize the program
- it clarified the training on program management made job descriptions clearer
- it clarified also the lines of authority, coordination of different desks and departments and resulted in the systematization of planning and evaluation methods.
- there was some systematization of their management work but this still needs further refinement

8. Projection of People's Health Issues

- All programs had projected health issues
- 5 programs conducted Health Campaigns in Mindoro, Southern Tagalog, Central Luzon, Cagayan Valley and Visayas
  * Advancement of Drug Policy
  * Medical Neutrality
  * National Drug Policy
  * Primary Health Care
  * Anti-Pollution
  * Preservation of forests
  * Demand immunization services from the government
- Most of the programs participated in multi-sectoral campaigns
  * US Bases
  * Human Rights
  * Oil Price HIke

In general, programs participated in multisectoral campaigns on national issues but only 4 out of 8 regions were able to initiate campaigns on people's health issues.

9. Services given by the Program

- Clarified basis for delivery of services
  * mosquito control
  * barrio clinic (10 barangays/year)
  * fact-finding missions
  * under-five clinics
  * TB-Malaria control
  * safe water supply
  * medical and surgical missions
  * health awareness building
  * environmental sanitation
  * referral during Klinikang Bayan
  * Health Education
  * Immunization
  * medical/dental

- Upgraded the level of services on
  * minor surgery
  * Disaster preparedness and management
  * mental feeding
  * operation timbang
  * acupressure/acupuncture
  * training on minor surgery
  * first aid
  * mobile clinics
  * blood typing
  * herbal preparation

* laboratory examination
* klinikang bayan
* relief and medical missions

10. Identification and prioritization of contact groups and individuals

* provided orientation
* others gave services

In general, programs lack systematic programming for contact building and networking

SIGNIFICANT DEVELOPMENTS

Mindanao - through CBHPs, areas that were left behind were recovered and POs were reactivated
National Capital Region - standardized curriculum design
- conducted NCR wide conference
Central Luzon - provided relief and rehabilitation service during the calamities
- reactivated good working relationship through inter-provincial regional and national activities
- provided a venue for PO to recognize that the program is not only for services

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ADDITIONAL SIGNIFICANT DEVELOPMENTS

VISAYAS - conducted Visayas-wide Immunization Campaign Training
- relief and rehabilitation services
- assistance of CHW's during mobilization

ISABELA - development of cooperatives
- self reliance of CHW organization

RURAL MISSIONARIES - Socio-Eco, health, relief and rehabilitation assistance to different regions

CORDILLERA - active participation in environmental health issues
- CHW as trainer

1. On consultation with PO's
   Content: - many programs presented did not have consultation with PO's and entered areas with no PO's
   Effect: - served as a venue to orient PO regarding CBHP
   Lessons: - be conscious about consultation with PO because we do not intend to own the community
   - CBHP is only a part of the development work and consultation is the key in order to define our work in the over-all development work
   - in consultation, we clarify concepts and role of CBHP in the over-all development work on different types and level of the area.

2. On Organizing
   Question: Are we going to enter in unorganized areas?
   Answer : Yes, but we have requirements such as:
   1. The area must have the potential to become an organized area
   2. We must have an organizer
   3. We must link up with different organizing efforts in the area.

3. Summing-up

   Reasons Why Some Programs Were Not Able To Conduct Summing-up:

   1. It was scheduled but was postponed of the calamity that happened.
   2. There were problems in data gathering especially when previous staff resigned.
   3. There is difficulty in joining together 2 different areas with the same management.

   RESOLUTION: CHESTCORE and KSK will conduct summing-up on the first quarter of 1991.

4. Community Diagnosis:

   Problems Encountered in Community Diagnosis
   1. There were problems in the implementing guidelines in CDx
   2. The staff lack the skills and knowledge in collation and analysis of data.

   Feedback:
   1. CDx was the first major research project
   2. CDx stopped program operations and took too much time
   3. The tool must be examined again

4. The primary objective of CDx (whether for program planning or for national data) was not clarified
5. Program staff dislike paperwork
6. The community participated in collation of data but not in analysis

5. Staff Development Seminar

RECOMMENDATIONS:

1. Request for a module on value and attitudinal formation because the module used by all the programs is from the church.
2. It is not enough to show/teach the importance of sacrifice but the meaning of sacrifice, the commitment to serve the poorest of the poor. Process retreat was introduced ; it is a liberating form of staff development.
3. Basic trust in staff as well as teamwork are important and helps minimize competition.

6. Continuing Development Education

OBSTACLE: It is not yet systematized.

RECOMMENDATION: Formulate a tool for CHW skills assessment
- develop continuing development education for CHW's.

7. Program Management

The scheduled national training on Program Management did not push through because only a few programs submitted their summing up results.

8. Campaigns

All programs had initiated health campaigns and joined campaigns on other issues of different sectors.

There was a weakness in monitoring and reporting during the medical neutrality campaign. Cases of harassment of CHWs in the regions were not reported to the National Secretariat.

RECOMMENDATION: Cases should be reported right away to the National Secretariat so that we can project these issues.

9. Services

The concept/recommendations of health care services will be tackled and discussed comprehensively during the regional sharing of the results of the summing-ups and impact evaluation.

10. Relationship with Contacts

Linkages with contacts was not prioritized and systematized.

RECOMMENDATIONS ON THE RELATIONSHIP WITH GOVERNMENT AGENCIES:

* It is the responsibility of the government to give health services so it is right to avail of their resources.
* We must be conscious on the line and extent of coordination with government organizations.

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MEDICAL ETHICS, INTERNATIONAL CODES AND HUMANITARIAN LAWS

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I. Definitions

A. Medical Ethics - a body of norms, values, principles and perspectives of the medical profession

B. International Medical Codes - covenants, codes and guidelines embodying medical ethics approved, accepted and implemented by international bodies or groups encompassing generations, peoples and nations of varying cultures

Examples: Declaration of Geneva
International Code of Medical Ethics
International Code for Nurses

C. International Humanitarian Laws - laws for the protection of victims of armed conflicts and the personnel responsible for taking care of them; approved by international bodies where various governments are represented; during times of conflicts, whether internal or international

Examples: Geneva Conventions (1949) - respect and protection in time of armed conflict without discrimination of all persons who do not or no longer take active part in the hostilities

Protocol I - international armed conflict

Protocol II- internal armed conflict

Protocol Additional to the Geneva Conventions of 12 August 1949, and Relating to the Protection of Victims of Non-International Armed Conflicts (Protocol II)

Article 7 - Protection and Care

1. All the wounded, sick and shipwrecked, whether or not they have taken part in the armed conflict, shall be respected and protected.

2. In all circumstances they shall be treated humanely and shall receive, to the fullest extent practicable and with the least possible delay, the medical care and attention required by their condition. There shall be no distinction among them founded on any grounds other than medical ones.

Article 9 - Protection of Medical and Religious Personnel

1. Medical and religious personnel shall be respected and protected and shall be granted all available help for the performance of their duties. They shall not be compelled to carry out tasks which are not compatible with their humanitarian mission.

2. In the performance of their duties medical personnel may not be required to give priority to any person except on medical grounds.

Article 10 - General Protection of medical duties

1. Under no circumstances shall any person be punished for having carried out medical activities compatible with medical ethics, regardless of the person benefitting therefrom.

Article 11 - Protection of medical units and transports

1. Medical units and transports shall be respected and protected at all times and shall not be the object of attack.

2. The protection to which medical units and transports are entitled shall not cease unless they are used to commit hostile acts, outside their humanitarian function.

Article 13 - Protection of the Civilian Population

1. The civilian population as such, as well as individual civilians, shall not be the object of attack. Acts or threats of violence the primary purpose of which is to spread terror among the civilian population are prohibited.

II. Principles embodied in International Medical Codes and Humanitarian Laws

A. International Medical Codes

1. health and life of the patient is foremost consideration
2. service of humanity
3. non-consideration of race, party politics, religion, sex, socio-economic status, nationality
4. confidentiality
5. non-profit
6. respect for colleagues and mentors

B. International Humanitarian Laws particularly Protocol II

1. respect for the human person especially of groups including:
   a. wounded, sick and shipwrecked (incl. hors d' combat)
   b. medical personnel
   c. religious personnel
   d. civilian population
      - children
      - women
   e. detainees

2. 1 - 4 principles reiterated

III. Importance of International Code of Ethics (ICE) and International Humanitarian Laws (IHL)

A. ICE and IHL respect and assert principles of humanity and civilization which are embraced, promoted and defended by peoples and nations of various cultures and generations. Any individual or group upholding such principles attains a high moral ground even as any individual or group disregarding and violating such principles is discredited.

B. ICE and IHL render protection to the sick and wounded without considerations of race, party politics, religion, sex, nationality and eco-social standing.

C. ICE and IHL uphold principles of confidentiality.

D. IHL protects special groups not involved in the hostilities and also those rendered incapacitated in the course of war. Medical personnel, facilities and transport are included.

IV. Limitations of International Codes and Humanitarian Laws

A. Subject to national law which may mean disregard or watering down of the principles upheld in the codes and laws.
- different interpretations of governments though monitored by ICRC
- disregard or violation by governments (PD 169, EO 212)

B. Control or strong influence of world superpowers of international bodies such that their positions greatly affect the outcome of any deliberations.

example: draft made by ICRC of Protocol II was subjected to so many amendments by the US ("subject to national law")

C. Seeming disregard (?) of important social and political considerations: need to further study these issues for objectivity

1. liberation movements -- IHL (specifically Protocol II) provides for the protection of some special groups as long as they have not taken part or have ceased to take part in hostilities which brings to question the right even of civilians who are part of the people "to reform, alter and abolish government" which becomes unresponsive to the needs and wishes of the people. Abraham Lincoln/Thomas Jefferson/Patrick Henry/Justice Black; Declaration of Independence/ Declaration of the Causes and Necessity of Taking Up Arms/ Universal Declaration of Human Rights

2. reproductive rights and responsible parenthood-abortion vis-a-vis "respect for human life from the time of its inception"

V. Application in Community Health in the Philippine Context

A. Characteristics of Community Health Workers

1. committed to serve
2. interested and committed to health work
3. with empathy and concern for the sick/patient and the needy

4. with self-confidence and bearing but recognizes capacities and limitations
5. conscientious to raise level of knowledge and skills for better health work
6. with initiative, patience and industry to implement work

B. Relations with Patients

1. treat and assist the sick to the best of one's ability without considering material rewards
2. ensure actual needs of patients and manage in the most effective way and as soon as possible
3. do not harm patients: refer to more capable health workers if in doubt
4. do not violate confidences to discredit the patient, however, information to protect the health of the majority should be reported to proper authorities for appropriate action
5. must show concern for the patient when relating to gain confidence and trust of the patient and show willingness to assist in some other ways

C. Relations with Co-Health Workers

1. relate to them with equal respect
2. relate to them without arrogance
3. assist each other: strengthen unity for the sake of the patient

D. Relations with Enemies

1. enemy patients are considered just like any other patient who deserve treatment and health services to the best of one's ability
2. do not use health knowledge to change normal mental functions just to extract information
3. do not use health knowledge to weaken or kill
4. do not experiment
5. torture is absolutely prohibited.

VI. Need to Assert the International Medical Codes and Humanitarian Laws BUT MAY GO BEYOND THEM IF THERE ARE MORE HUMANE PRINCIPLES NOT CONSIDERED.

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Important points raised:

1. Regarding the limitation of these laws and codes

   a. On the issue of being sexist

      - Oath of Hippocrates refers to his colleagues as his brothers

   b. On the issue of conception

      - the controversial issue of life beginning at conception as opposed to the issues of plight of the child especially with the present economic difficulties and the need of the child for proper upbringing (considering the emotional and psychological needs of a child)

* We are not saying that we must change these laws and codes now but there is a need to openly discuss these controversial issues.

2. Regarding the status of Executive Order 212

E.O. 212 is still being enforced. Government officials in the Department of Health have admitted that it violates the international law but they say that because it is in place it must be implemented.

In Congress, a law repealing E.O. 212 is still pending.

3. Recommendation:

   a. The conceptualization of an urgent action network
      - to include the mechanisms on cooperation, role of the CHD national secretariat and CBHPs

A basic need of this quick action network is proper / prompt documentation and reporting of these incidents to the National Secretariat (also to MAG). Reporting of HRVs can cover incidents which affected the implementation of the health program as well as incidents of individual cases.

Foreign friends (delegates in the IFFM Conference held last February 1990) have signified their willingness to support issues concerning Human Rights Violations (HRVs) involving the health workers. Support of these foreign friends can be in the form of letters of appeal to government officials or the sending of international fact finding teams. But there are disadvantages to the inclusion of foreigners in the fact finding team like the added difficulty of entering the target areas.

b. Formulation of resolutions/statement of the continuing HRVs in the CBHP areas

The seeming trend that HRVs of health workers have lessened is deceptive. This trend is due to non-reporting of HRVs and military actions that affect the implementation of CBHPs.

c. Draft of the Community Health Worker Code of Ethics

There is a need to draft a code of ethics for the community health workers. The existing code of ethics (e.g. Oath of Hippocrates for doctors) is elitist although it can also cover the health workers. Protocol II protects all health workers including the ambulance drivers.

But a code of ethics drafted for community health workers is still necessary to better define their rights and responsibilities.

EVALUATION OF CBHP INSTITUTIONS AND SOME CBHPs IN THE PHILIPPINES

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Outline:

I. Objectives of the Evaluation

Focus: A. CBHP impact at the community
B. Institutional Capability
C. Community Health Worker's knowledge, skills and attitude (KSA)

II. Methodology

A. Household Survey
B. CHW KSA Test
C. Case Study

III. Results of the Evaluation

A. Household
1. Socio-economic conditions in the CBHP areas
2. Implications to CBHPs

B. CHW TEST
1. Knowledge
2. Skills
3. Attitude

C. Institutional Capability

IV. Recommendations

A. On the program content
B. On the organization

I. Objectives of the evaluation

The objectives of the evaluation have three areas as focus: program impact on the community, institutional capability, and CHW knowledge and skills. The objectives were:

A. To determine the impact of CBHP on the community:

1. to determine the socio-cultural and health impact of the program on the health status of the community;
2. to determine the extent of community participation and involvement of the people in the whole process;
3. to determine how CBHP facilitated community self-reliance;
4. to determine the current level of implementation of CBHPs at the communities.

B. To determine the capability of the RMP, CPHC and CBHS Mindanao in implementing CBHP:

1. to determine the efficiency of service delivery by the service institutions as well as their representatives at the regional and community levels;
2. to find out the extent of linkages and coordination between institutions tapped and maximized existing resources (of both GOs and NGOs) in support of CBHP.

C. To determine the type and level of skills of CHWs.

D. To determine main strengths and weaknessess; failure and success factors in the implementation of the CBHPs.

E. To come up with recommendations on which to base the future implementation of CBHP.

II. Methodology

In line with the above-mentioned objectives and with the intention of doing the evaluation participative, the following methodologies were identified:

A. Household Survey -- for the Community Impact
B. Case Study - for the institutional capability
C. CHWs Skills, Knowledge and Attitude Test

Respondents of the Evaluation Study

A. Households					B. CHW's		C. Institutions
	Total # of Barangays	Total # of sample Barangays	Actual Respondents/ Total Number of		Total	Sample	Case Studies
			Served	Unserved			
Luzon	29	5 (1*)	84/100	51/70		14	CPHC - Cavite and HIDS-Pampanga
Visayas	15	5(1*)	105/100	63/70		14	RM-CBHDP Isabela
Mindanao	590	20(12*)	398/400	254/260		54	CBHS-Kidapawan
TOTAL	634	30 (14*)	587/600	378/400		82	
			Total = 965/1000				

Note: * - substitution

III. The Results of the Evaluation

A. Household

1. Socio-economic conditions in the CBHP areas

1.1. Socio-economic and Health Related Background of Household (HH)

a. Socio-economic conditions of households

> large families (5-6)
> engage in multiple kinds of livelihood that hardly give livable wage
> Luzon and Mindanao - economic earnings less than 5 years ago
> P 10.5 T to 14 T per annum income
> Water - Luzon 4/5 access to piped or pumped water; Mindanao 20% spring /rain sources
> Toilet - Visayas - 30-40% with no toilet
> Garbage disposal --- burning and dumping

Visayas - 36- 40 % increase in earnings than 5 years ago

Conclusion: Economic Stagnation

b. Household Diets and Nutrition

> Luzon and Mindanao - rice but Luzon shifting to rootcrops during certain periods of the year
Visayas - 80% buy rice
> 70% grow vegetables (gabi, malunggay, Kangkong)
grow food to supplement their food intake
50% raise chicken and pigs
> Luzon and Mindanao - buy bagoong (50%)
coffee/sugar (90%)
fish (88%)

Conclusion: Below Nutritional Standard

c. Health facilities

> Luzon: RHU - over 5 km.
Hospital - 40 km. average

> Visayas: Hospital - 4 km.
> Mindanao: Hospital - 7-8 km.
RHU - within 4 Km.

Observation: No private clinics or doctors in surveyed barangays

1) RHUs more common facility in survey areas

- Government hospitals and private clinics are less common and therefore their services are less frequently availed of by households

2) Utilization of health facilities

- Mindanao : 75 % of HH availed of the RHU services
- Luzon and Visayas : HH patronize hospitals more than the RHUs

3) Considerable number of households are not reached by RHUs

4) Households do not fully utililize the services of existing health facilities

1.2. Prevalence of Illnesses, Deaths and Disabilities
(Note: No standard procedures for estimating these from surveys)

a. Serious illnesses (on preceding year)

> relatively high incidence
Luzon - 41-51%
Visayas - > 20%
Mindanao - 34-41%
> afflict older family members
- 17 year old has increased and above
Visayas - < 6 year old
> Nature: Luzon -- respiratory (asthma/pneumonia) gastroenteritis, malnutrition, malaria, Flu, TB

Visayas - Flu, asthma, diarrhea, pneumonia
Mindanao - Malaria, diarrhea, flu, and wounds/injuries (6%) - related to counter - insurgency

b. Minor illnesses

> more incidence of minor illnesses
> afflicts more young children - Gastroenteritis and respiratory diseases

c. Child deaths

> Luzon - 26 %
Visayas - 30 %
Mindanao - 28 %

> Causes: Pneumonia, Diarrhea (for Visayas and Mindanao), tetanus (Luzon), starvation (Luzon)

d. Perception of Health Status 5 years ago

> Improvement of health status
- Luzon and Visayas - 46 - 58 %
- Mindanao - 43- 45 %

1.3. Health Indicators and Practices

a. Patterns of Health Consultations:

> More likely to seek advise/assistance in times of serious illness, during childbirth, for family planning
> less likely to go for medical assistance in minor cases and Pre-post natal care
> Households increasingly turning to CHWs

b. Maternal Health

> number of pregnancies and living children

	pregnancies	living children
- Luzon	4 - 6	4 - 5
- Visayas and Mindanao:	4 - 5	3 - 4

> Miscarriage - 7 - 30 % : at least 1 miscarriage

> Pre-natal consultation:
Visayas: 9 - 14%
Luzon and Mindanao: 20 - 30 %

Luzon and Mindanao : consult doctors

Observation: low average in pre- and post-natal consultations
* Mothers unable to follow advice

> Delivery
- majority give birth at home; hilots assist 47 - 75%
- less than 15% give birth in clinics and hospitals
- in cutting the umbilical cord
  Luzon : more than 80% use scissors
  Visayas : 32 - 34% use blade, bamboo and banana fronds
  Mindanao

> family planning (FP)
- 44 - 79 % : No longer wish to have children
- 50 % : Never tried family planning
  * 3 - 9 % - strongly object to FP
  * 2 - 11% - do not need FP
  * 21 - 50 % - the FP methods they used failed

> Breast Feeding
- Practice of Breastfeeding in CBHP areas is at 63 -77 % and shifted towards mixed feeding
- Below the National percentage which is 80 - 83 %

1.4. CHW Services and Relationship with Households

a. CHW services

> % HH visited by CHW
  Luzon: 90%
  Visayas and Mindanao: 80%

> % HH which consulted the CHWs: 72 - 81 %
  * Treatment of common illness: use of herbal medicine
    Luzon: 87% - taught herbal
    10% - taught sanitation, immunization, nutrition
    Mindanao: 2/3 - herbal medicine
    1/3 - sanitation

> % of household who receives reading materials
  Luzon: 20 %
  Visayas: 9 %
  Mindanao: 25 %

b. Relationship

> minority participated in the selection of CHWs
  Luzon: 7 %
  Visayas: 40 %
  Mindanao: 28%

> % HH which contributed to the maintenance of CHWs
>
> Luzon : 55 %
> Visayas : 43 %
> Mindanao: 59%

c. Community Problems and Health Needs

> Most families identified these problems:
> economic - lack of employment
> lack of land, capital and food
>
> Fewer families consider lack of social services (incl. HEALTH) and education and criminality as urgent social problems

1.5. Summary of the socio-economic conditions in CBHP areas

The study shows that the areas reached by the CBHPs consists of poor communities which suffer from different forms of deprivation:

- households in the areas engage in various unrenumerative on farm and off-farm activities that hardly give them livable wages and income;
- families in the program areas must endure the inadequacy of basic facilities as roads, electricity, water and irrigation;
- government social and technical or extension services rarely reach communities.

Problems of low income, poor harvest, inadequate nutrition, inadequacy of basic facilities, and lack/ absence of government services adversely affect the health condition of the people and also impede the growth and the general progress of the communities.

The LUZON communities are the most cash-strapped and economically disadvantaged:

- low household incomes
- low agricultural yields (sometimes only rootcrops and bananas)
- suffering from starvation due to lack of food

The MINDANAO households have slight advantage they have:

- more land to grow food (more varied diets)
- greater access to government health services
- but, least serviced by basic infrastructures like water and electricity: and
- the already precarious economic and health conditions is aggravated by continuing insurgency conflict

The VISAYAS households are less dependent on subsistence agri-cultural activities:

- they lived in more urbanized places
- better reached by infrastructural amenities except for water
- not better off economically or socially

2. Observations and the implications of the socio-economic conditions to the CBHPs:

2.1. Uplifting and improving the health of communities with a continuing poor economic base is doubly formidable.

2.2. Findings show that because of these conditions, the preventive aspect of CBHPs is very low. Also, this may be a result of the following:

a. CHWs tend to be overworked. Due to lack of public health facilities, it is the CHWs who perform: 1) organizing tasks 2) caring the sick 3) initiating various kinds of health-related activities. Because of this, they neglect other areas of preventive health care, their health assistance has been largely curative.

b. Training/curriculum design is partial to the curative rather than preventive aspect of health care.

c. Reality remains that the need for curative health in the communities is high. In practice, the CHWs have no choice but to respond to the immediate needs of the beneficiaries in the communities.

2.3. Some CHWs tend to relate and identify health problems as results of the societal structure, always broad problems. They fail to see the immediate, short range problems in the communities. They are fixated at long term goals

like social transformation (ultimate preventive solution to our health problems). CHWs should be able to balance both the long term and immediate needs of the communities.

2.4. There is a neglect of the maternal care/family planning aspect of the health program. Decrease in breastfeeding of served communities is alarming. Breastfeeding is actually one of the best preventive measures to maintain health communities.

In the main, despite its many limitations and problems, the study points out that CBHPs have existed in far flung poor, marginalized communities where these services are most needed.

B. CHW EVALUATION (KNOWLEDGE, SKILLS & ATTITUDE)

1. Profile of the CHWs evaluated

A total of 82 CHWs were evaluated for the study. The profile of the CHWs evaluated:

1. Occupation - 70% housewives & farmers
2. Sex - 83% female
3. Status - 86% married
4. Age - 18 yr. old to 63 yrs. old
5. No. of yrs. as CHW - 1 yr. to 13 yrs. (average 3 yrs.)

2. Results of the tests

a. Knowledge portion

There were 50 questions asked. These were based on the major health problems confronting the general population.

- range of scores were from 26 to 49; majority got scores ranging from 41 to 45.
- the result shows that:
  * 74% still believe that TB is inherited
  * 68% think that BCG cures TB
  * 51% do not recognize the multifactorial causes of malnutrition
  * 46% do not know the drug of choice for pneumonia
  * 34% could not distinguish a low grade fever
  * 31% do not know the right time to give measles immunization

The results indicate that:

- Knowledge of the CHWs on rational drug use is still weak. This may be explained that CBHPs have given more emphasis to herbal medicines.

- CHWs are very strong in the following knowledge: home remedies for cough and fever; transmission and complications of measles; duration of TB therapy; oral rehydration; signs and symptoms of dehydration; treatment of minor wounds; use of tourniquet and need for butterfly bandages; and the predisposing factors in causing pneumonia.

b. Attitude Portion

The main values and attitude seen among CHWs were: perseverance and determination; compassion and sense of duty; dedication and commitment; honesty and humility.

Values and attitudes are best evaluated in concrete and actual situations.

c. Skills Portion

There were 3 skills tested on the following topics: Maternal and Child Health; Oral rehydration; and Herbal Medicine.

On MCH, CBHPs have been weak in areas of breastfeeding, family planning, preparing for delivery, knowing danger signals of pregnancy and the rational use of drugs in pregnancy.

Trainers should concentrate their efforts on the proper steps in ORS preparation. It would be good to review if CBHPs have indeed adopted a standard formula for the sugar-salt solution.

Herbal medicine has been one of the major strengths of CBHPs.

3. Conclusions

The results provide insights on what areas need strengthening particularly in the training and services components of CBHPs.

The results coincide with the result of the household survey that the preventive aspect of the program needs improvement.

C. CASE STUDIES OF 3 CBHP INSTITUTIONS:

1. RURAL MISSIONARIES - COMMUNITY BASED HEALTH DEVELOPMENT PROGRAM (RM-CBHDP)

The RM-CBHDP had made a mark in the history of CBHPs since its inception 13 years ago:

a. Quantitatively, there is a growth in the number of areas:
   - from 27 to 432 villages
   - from 15 to 79 towns
   - from 3 to 15 dioceses

   In addition to these, more and more medical and health professionals have become involved in CBHPs at the barrio level.

b. Qualitatively,
   1) it has been responsible for propagating and popularizing the use of alternative treatment methods particularly herbal medicine and acupressure.

   2) it has made possible accessible and low cost health services to villagers through the services of the CHWs and through parish medical consultations

   3) the program's approach in relating the health problemsto societal conditions has contributed greatly in raising the consciousness particularly among the health sector.

   4) leaders for health and non-health organizations emerged from among the village health workers.

After more than a decade of operation, RM-CBHDP must now address a number of issues to ensure its growth and continuity. The CBHDP must now deal with the task of strengthening the managerial and technical capability of the program -- data recording and reporting should be improved, CHWs skills should be assessed and evaluated, management methods should be improved.

2. COUNCIL FOR PRIMARY HEALTH CARE (CPHC)

The CPHC's decade-long history has been characterized by continuous efforts to learn from accumulated positive and negative experiences in the promotion of the community-based approach to PHC.

CPHC is distinguished from other CBHP institutions in its unique mandate to primarily coordinate the different agencies, programs and groups committed to the cause of PHC.

It has no direct health delivery services but instead offers more technical services such as training, publication and dissemination of materials and networking.

In its early years, it had difficulty in enforcing the idea of a coordinating body ("coordinating' still other coordinating bodies) and assuming its primary function of coordinating all efforts for PHC. But through the years it has developed/contributed the following:

a) New structures have been established in CPHC's services in pursuit of its principal mandate. CPHC carries out its coordinating and networking role in three levels:

1) it links CBHPs around the country with each other through island-wide, regional and sub-regional coordinating bodies which meet periodically in various conferences and consultations sponsored by CPHC.

2) CBHPs are also linked with each other through CPHC publication and the newly created National Pool of Trainers.

3) indirectly, CPHC linked CBHPs by gathering individual program information on which can come up with a comprehensive view of CBHP in the country.

b) CPHC links CBHP with health professional and other sectors so that possible areas of exchange and assistance can be explored and developed.

The possibility of reviving the "Friends of PHC" (1984) to gather a group of physicians and other health professionals sympathetic to the CBHP philosophy.

c) CPHC links CBHPs with international groups and networks mainly through exposure visits, referrals and information exchange.

PROBLEMS:

(1) One of the basic problems of CPHC is that it is unable to monitor on a sustained basis the developments of the programs it helps to set up.

(2) Many good resolutions or plans made during conferences and consultations remain on paper for lack of follow-up.

(3) Though there has been marked improvement in its content and form, the publication continues to be delayed.

3. COMMUNITY BASED HEALTH SERVICES (CBHS - Mindanao)

After more than seven years of existence, the CBHS has gone a long way with these achievements:

a) the quantitative growth of the number of areas and the number of CHW's trained
- from a single diocese in 1975
- now (1989) 11 dioceses covering 911 remote baranggays
- 2,309 active CHWs

b) the program has contributed in raising the people's awareness of the root causes of the health and other societal problems.

c) it has encouraged health and other intermediate sectors to share their resources, knowledge and skills in the services of the people.

d) through the development of local and international linkages, the program has drawn support for the people's desire for social transformation.

Despite these achievements, the study reveals that CBHS must now respond to a number of issues/weaknesses.

a) Organizational weaknesses have been observed like functions of the various organizational units have not been clearly distinguished; there are units included in the organizational chart which do not actually operate while there are positions

(like Program Coordinator) that have given important functions but are not included in the organizational chart; and, the functions of the organizational units are confused with those of positions within those organizational units.

b) Diocesan programs must clarify their organizational relationship with the church.

c) Relationships of the Diocesan Program with CBHS Central office and the Diocesan programs with those of the Parish programs need to be clarified.

d) Inadequacy of progress reports. Activities reported were consistently similar through the years. Progress reports do not clearly show the program's growth and the extent to which plans for a given period has been realized and therefore have not been helpful in evaluating performance and in planning directions.

e) Weakness of the reporting system is related to weakness in the planning system

- Measurable targets could not be set resulting in weak monitoring and evaluation procedures.

f) Problems of high rate ofpersonnel and CHW turn-over.

IV. Summary of Recommendations

A. On the Program Content

1. From the Household Survey

a. Reassessment of the role of CHWs towards defining their services and functions more realistically and conserving their energies and talents for longer-term service to communities;

b. CBHPs should review their activities and prioritize the kinds of services they wish to bring to communities;

Prioritize program goals and services and align these better with implementing strategies and the resources that the programs have at hand;

c. CHWs should make health of mothers and women their special concern;

d. CHWs can devote their attention to encouraging mothers to breastfeed, to have their children immunized, bring their babies to health clinics for periodic check-up;

e. They can further educate mothers on the nutritional needs of babies and growing childrenand inform them not only on use of herbal for treating common children's illnesses but on the use of simple and inexpensive treatments like ORT;

f. CHWs can also conduct health education sessions on household hygiene and on the value of teaching children clean habits from early on;

g. Health education classes can further be supplemented with related reading materials;

h. CHWs can help identify which crops must be grown in the communities to meet household consumption requirements and improve diets and nutrition of families.

2. From the CHW Skills, Knowledge and Attitude Test

a. Develop parameters for evaluating training outcome.

b. CBHPs should improve their standards of training CHWs.

c. Fine tune evaluation instruments to measure CHWs' Skills, Knowledge and Attitude and make them relevant and attuned to the Philosophy and objectives of CBHP.

3. From the Case Studies

a. for CPHC

1) A catalogue of training materials, modules, etc. currently available should be made and sent to CBHPs for easy accessing.

2) A complete directory of all CBHPs in the Philippines should be made containing updated basic information about each of them.

3) Stricter measures in editing, production work and meeting deadlines should be enforced on TAMBALAN and other CBHP publications.

4) Standardized format for the CPHC Progress Report should be developed to facilitate future evaluations.

5) Improve the traditional health care component of CBHPs by developing conveniently located herbal gardens.

6) Intensify local and regional initiatives in research on herbal medicines and home nursing practices.

7) Set up cooperative pharmacies in the communities.

b. for RM-CBHDP

1) A comprehensive study of CHWs to arrive at a profile of socio-economic background, health skills levels and the number of years they stay with the program.

2) Data recording must be improved and include indicators which should help assess program achievements and/or failures.

3) Reassess the amount of time given to direct organizing work.

4) Document experience in the different areas and popularize them nationwide.

B. On the Organization

1. From the Household Survey

a. CBHPs should take stock of the number of their program areas and CHWs and arrive at a more judicious ratio for the area assignment and/or household coverage of CHWs.

b. CBHPs should cultivate and not only develop working linkages with those groups engaged in delivering Community Organizing, livelihood, skills training and other forms of assistance to communities.

c. Have a ready directory of nearby or alternative health facilities to which CHWs can refer their cases or clients.

d. Other health facilities and personnel who are obligated to provide health services must be pressured further to respond to the health needs or demands of households.

e. Pursue linkages with other government and non-government groups engaged in the larger scale production of herbal medicines to ensure the wider use of herbal.

f. Linkages with agencies/organizations engaged in assisting rural households with agricultural production should be done.

2. From the CHW Skills, Knowledge, Attitude Test

a. For those in government to legitimize and formally recognize the work done by CHWs to give them protection from harassments.

b. Provide CHWs with avenues for welfare opportunities.

3. From the Case Studies

a. for CPHC

1) The CBHP Coordinating Body should make regular short, medium and long-term planning targets on the local, provincial, regional and national levels on points such as CBHP expansion areas.

2) For greater efficiency, a clearer delineation between direct and indirect services of the four secretariats can be made.

3) Find some solutions to alleviate the economic aspect of the staff's and CHWs' salaries.

4) GO-NGO cooperation and exchange should be explored and work for the sustenance of such a link by pressuring for a PHC officer/desk/unit within the DOH.

b. for RM-CBHDP

1) Set up a CHW desk to concentrate on CHW training, development and retention needs.

2) More realistic programming should be done in terms of setting-up new health programs or answering requests to assist health programs of other Church groups and need to consolidate existing network of RM.

3) Records and reports should be consolidated and systematized to provide the basis of new plans and the future monitoring and evaluation of the program.

4) Bring in technical assistance to upgrade internal managerial and administrative capacities in running the program.

c. for CBHS

1) Review of CBHS organizational structure must be done and must lead to the preparation of a functional chart which shows the summary of functions per organizational unit and an organizational structure showing the position titles and incumbents per organizational unit.

2) Relationship with Bishops and Parish Priests must be clarified.

3) Diocesan health programs should clarify their relationship with the church.

4) Clarify relationship of Diocesan Health Programs with the CBHS central office and Diocesan Health Programs with those of the Parish Health Programs.

5) Reporting system should be improved with a suggestion that reporting by objective be done.

6) Planning system should be improved.

7) Review staff selection process and new strategies for keeping personnel must be considered.

8) CBHS must broaden its financial support base.

Reference:

Virginia Miralao, An Evaluation of Selected Community Based Health Programs and Institutions in the Philippines 1990. A report on CBHPs in the Philippines.

DAY 4

13 January 1991
Sunday

Day 4

Facilitator of the Day: Patrick Chuidian

SCHEDULE

8:00	-	8:15	Morning Praise
8:15	-	8:30	RECAP
8:30	-	9:30	Regional Workshop: Results of Summing-Up and CBHP Impact Evaluation
9:30	-	12:00	Current National Trends and Issues and their Implication to NGO's and PO's - Liddy Nakpil-Alejandro
12:00	-	1:00	Lunch
1:00	-	2:30	Continuation of Regional Workshops
2:30	-	5:30	National Health Situation - Dr. Mike Tan
5:30	-	6:00	Supper
6:00	-	10:00	Cultural Night: "Kahapon, Ngayon at Bukas" (PETA Play)
10:00	-	10:30	Buzz Session

NATIONAL SITUATION

CURRENT NATIONAL TRENDS AND ISSUES AND THEIR IMPLICATIONS TO NGO's AND PO's

Liddy Nakpil-Alejandro
Secretary General
Bagong Alyansang Makabayan (BAYAN)

Objectives:

1. To present a framework for understanding the national crisis situation and to appreciate the data presented in daily newspapers
2. To present an update of the current trends in the strategic aspects of the situation

A. ECONOMIC SITUATION

1. The Gulf Crisis and its implication to our economic crisis

Presently, the Gulf crisis and the imminence of war in the Gulf region is the object of attention of the whole nation especially the government, the curious bystanders and the increasingly apprehensive Filipino people.

However, a great number also say that the war is not likely to happen since both parties do not want the War

and that they will not benefit from it. The issue is being exaggeratedly projected in our country and overshadows the real and decisive issues and problems in our own country. In fact, the Gulf Crisis was the best event that could happen to the Cory Aquino Government (CAG). The government is exploiting the issue to explain our economic crisis situation, particularly, on the oil price increase.

2. The Real Effects of the Gulf Crisis in our Economy

Actually, the Gulf Crisis has some effects on our economy. Clearly, these are the following:

a. Massive dislocation of Filipino overseas workers.

This has grave effects on individual migrant workers. In the national level, there is the slowing down of dollar remittances, thus depleting the country's much needed dollar reserves.

b. The increase in oil price.

The continuous fluctuation of crude oil price and the possible outbreak of war will create higher crude oil price and reduction of oil supply.

Principally, the Philippines uses oil for its energy supply, but only a small percentage of it comes from Kuwait.

c. Other effects on the economy.

The Gulf crisis gave the government a convenient excuse to lay the blame of the present economic problems particularly on the oil price increase. Actually, the three successive increases from September 21, to December 5, 1990 that reached up to 100% was not precipitated by the market price of crude oil import. Rather, it was precipitated by the IMF dictates to reduce our national budget deficit. And one way to reduce this was to increase the prices of oil which was done through the Oil Price Stabilization Fund (OPSF) reimbursements to the oil companies in our country. OPSF is part of our budget. Therefore, the Gulf Crisis is not the real reason for the oil price increase in our country.

3. The Real Causes of our Crisis in the Philippines

When we talk about the crisis the Filipino people face; we are talking of two things:

a. poverty of the vast majority
b. Philippine economy in crisis

The Philippine Economy is characterized by:

1. import-dependency
2. foreign-dominated capital
3. elite-owned economy

The Implications

1. import-dependency

Since we are import dependent, we need dollars to finance our economy and problems arise when dollar reserves are depleted.

2. import-orientation is also debt dependent

3. foreign capitalists do not invest when they are unsure of getting profits.

4. foreign capitalists repatriate their profits and wealth generated in the country. This means that for every $1 capital they bring in, they still borrow $2 from our banks. Whatever profits they earn are being repatriated to their mother country. These are not really foreign investments because they deplete our much needed capital.

Artificial Gross National Product (GNP) growth rate

The year 1986-1988 registered GNP growth rates but they were not the result of increased productivity but was only due to a consumer-led growth. It did not sustain the GNP growth.

4. The Crisis Situation the Government Faces

- there was an increase in the export earnings by 15% but there was a 120% increase in importation resulting in a negative trade balance
- debt servicing
- capital flight

Such factors contribute to the severe and continuous depletion of the economy so much so that we have

large budget deficits. Definitely, we have no money to buy oil and other imports.

Furthermore, the policy of import liberalization will bring about closures of many business firms and companies.

Adding gravity to the economic crisis is the International Monetary Fund's (IMF) dictated conditions on how the government will be able to pay the $700-$750M foreign debt.

Some of the conditions set by the IMF were:
1. reduction of the national budget deficit and
2. import liberalization

In general, the IMF orientation requires us to sacrifice more so that we can pay our debts so that we can get more loans.

With this orientation, the people in government have to institute measures that will further aggravate the already suffering Filipino people.

B. POLITICAL SITUATION

1. Trends in the Cory Aquino Government (CAG)

a. The Gulf War

The hysteria of the Gulf War created by the government itself among the people further aggravated the political and economic situations.

b. Crisis of governance

The present government does not only govern ineffectively, it is also notorious for aggravating the situation thus creating mass unrest.

c. Rise in political forces seeking solutions and change in governance

Because of the crisis in governance, political forces, legal and underground, are formed and strengthened.

General Effects of these Trends:

The effects of these trends are either GOOD or BAD.

It is BAD because:

- it will have immediate and serious effects on the people as a whole
- political instability brings about repression, though this is a natural consequence in the process of change
- such situation offers opportunities to other political forces whose intentions are not really pro-people.

It is GOOD for people who want change and who want to hasten the process of change.

2. Political Forces

a. The Cory Aquino Government (CAG)
Trends:

1) A broken up coalition of:
   - PDP with Pimentel
   - LP with Salonga
   - LDP with Mitra
   - Laurel
   - Cardinal Sin and the
   - Big Businessmen

What is left of the coalition is the Council of Trent led by Estanislao and Cuisia though it is now becoming isolated in Makati.

Such broken coalition is manifested by:
   - the sympathetic attitude by businessmen to rallies and such other activities staged by the mass organizations
   - the Philippine Chamber of Commerce and Industry (PCCI) of Periquet
   - the distancing of Cardinal Sin and his being critical to the CAG with his pro-people statements. However, he remains supportive of the status quo
   - Mitra, Ramos and Salonga are making their ways for the presidency while Pimentel is hoping to be Cory's running mate
   - Laurel has an uneasy position among the four presidential aspirants

2) Massive disenchantment among the people

3) Probable "melt down" of the CAG

There is a probability that the CAG will just "melt down" naturally, instead of a forcible removal of those in power because presidential aspirants would like to reach 1992 for the elections.

Meanwhile, Laurel has his Cory Aquino Resign Movement Agad or CARMA, a mass movement carrying the line of "Cory resign, Laurel take over". But this can still wait for the 1992 election.

Cojuangco on the other hand is for "snap elections".

Estrada, though sincere in many nationalist issues, has some limits.

b. The Rebel Military Forces

The rebel military forces is a coalition of several factions - RAM, YOU and SFP - which are not consolidated in terms of principles, visions, ties with the U.S. and its strength of influence.

RAM - tries to assert itself as an entity
- works out and clarifies its own vision and program
- carries a general platform to overthrow the government, turn power over to a new government and return to the barracks. But while its vision is not yet so articulated, they can still stage another coup if they will not agree with the new government they helped institute.
- to understand this group/coalition better, we must also study the nature of the Coups that happened in other countries.

It must be known that they are still part of the military. So, we should be more critical and a little more open to other people's organizations.

c. Other Armed Groups

Other armed groups like the New People's Army (NPA) which is under the National Democratic Front (NDF) are waging a peace process.

The NDF and its member organizations have interests in participating in this peace process.

The NPA is not just for a ceasefire, the agenda which is always being pursued by the Cory Aquino Government (CAG). It is for the discussion on the real causes of the mass unrest with the government and other forces, to arrive at a political settlement.

However, the CAG viewed the insurgency as the biggest threat to government and therefore has to be resolved immediately. The CAG would like to compromise but carries a different agenda. It uses the ceasefire agenda to diffuse the attention of the people to enable itself to give attention to political-military factions within its ranks.

d. The Mass Movements

The political upsurge on the streets of the growing mass movements heightens the political crisis situation.

This situation makes it timely to raise and popularize the issue of an alternative government. There is a need to unite with the broad progressive front to pursue this alternative government.

For instance, BAYAN carries the slogan, "Oust the CAG". But what is the alternative? How shall we do it? What must be done? Now people want to know what is the alternative and how will it be done.

The broad front tries to do the same but they are not ready to face the challenge.

CARMA must be given some basis to recognize their movement to heighten the issue of an alternative government.

It will be the organized groups that will lead the people to change the situation in an organized and systematic, not in a chaotic process.

In view of the recent developments brought about by the Gulf crisis, the People's Caucus organized a People's Crises Conference with the following objectives:

1. To critique the Gulf War with NGO's and GO's and take position on this,
2. To establish alternative economic measures for governance,
3. To define and clarify what can be done now, and
4. To discuss other issues relating to the present problem.

C. THE CRISIS SITUATION AND ITS IMPLICATIONS TO HEALTH

The present economic and political crises have grave implications on the general health conditions of the people. There will be severe deterioration of the state of health of the people, especially the poor in urban and rural areas who are already living in poor health conditions.

In case of shortage of medicine we must be ready with alternative medicine.

NATIONAL HEALTH SITUATION

Dr. Michael Tan, DVM, PH.D.
Executive Director
Health Action Information Network

It seems that there are no significant changes in the health situation since the first time we looked at it in 1974.

MORBIDITY FIGURES (see Table 1)

The latest available figures from the DOH are still those of 1987.

The top ten diseases for 1987 were generally the same as in the previous five years; only their ranks changed.

Although it is believed that the cases were underreported, it would be still be useful to look at these figures. This underreporting is quite apparent in the number of cases of influenza and tuberculosis shown.

For 1987, there was an increase in the figures and this had been going on since 1985.

The report shows that about one out of every 100 people had bronchitis, the no. 1 morbidity cause, and this figure could still be very much higher considering the underreporting of cases.

The no. 2 cause covered a wide range of diarrheal diseases, which did not only include the ordinary diarrheal diseases but notably the many serious cases which were admitted in hospitals.

No. 7 was accidents, which included injuries due to war/civil strife/LIC--injuries that were not really accidental.

MORTALITY FIGURES (see Table 2)

For the past years it seemed that pneumonia being the no. 1 cause of death was becoming a "normal" fact. But in reality it is very much possible to control pneumonia as in China where it is no longer the leading cause of death. This is attributed to their control of environmental sanitation and other factors.

The diseases of the heart and the vascular system, nos. 2 and 3 respectively in the leading causes of death, were mentioned in some DOH reports as a sign of development in the Philippines. But this is very deceptive since

TABLE 1

Morbidity: Ten (10) Leading Causes

Number & Rate/100,000 Population
PHILIPPINES
5-Year Average (1982–1986) & 1987

Cause		5-Year Average (1982-1986)		1987	
		Number	Rate	Number	Rate
1. Bronchitis	(466)	485807	911.0	642777	1120.6
2. Diarrheal Diseases	(004-009)	465159	872.3	607148	1058.5
3. Influenza	(487)	356212	668.0	495161	863.3
4. Pneumonias	(480-486)	163834	307.2	183143	319.3
5. Tuberculosis, All forms	(010-018;137)	134314	251.9	163740	285.5
6. Malaria	(084)	89826	168.5	121097	211.1
7. Accident*	(800-999;E800-E949)	75574	141.7	114445	199.5
8. Measles	(055)	55459	104.0	81896	142.8
9. Diseases of the Heart*	(390-398;402-402;410-429)	72442	135.9	79214	138.1
10. Malignant Neoplasms	(140-239)	25630	48.1	27195	47.4

* Declared Notifiable Diseases in 1984.

Source: Computed from Department of Health's Philippine Health Statistics 1987.

Mortality: Ten (10) Leading Causes

Number & Rate/100,000 Population

PHILIPPINES

5-Year Average (1982–1986) & 1987

Cause	5-Year Average (1982–1986)			1987		
	Number	Rate	% of Total Deaths	Number	Rate	% of Total Deaths
1. Pneumonias (480-486)	48701	91.3	15.1	52700	91.9	15.7
2. Diseases of the Heart (390-398;402-404;410-429)	35178	66.0	10.9	38840	67.7	11.6
3. Diseases of the Vascular System (401;403;405;430-438; 440-448;451-459)	26438	49.6	8.2	29905	52.1	8.9
4. Tuberculosis, All forms (010-018;137)	29428	55.2	9.1	28697	50.0	8.6
5. Malignant Neoplasms (140-239)	17813	33.4	5.5	20367	35.5	6.1
6. Measles (055)	7340	13.8	2.3	12431	21.7	3.7
7. Accidents (800-999;E800-E949)	10162	19.1	3.2	11630	20.3	3.5
8. Diarrheal Diseases (001-009)	12347	23.2	3.8	10589	18.5	3.2
9. Chronic Obstructive Pulmonary Diseases (COPD) (490-496)	6316	11.8	2.0	7343	12.8	2.2
10. Avitaminoses and other Nutritional Deficiency (260-269)	6642	12.5	2.1	5229	9.1	1.6

Source: Computed from Department of Health's Philippine Health Statistics 1987.

cardiovascular diseases are not necessarily signs of affluence. Heart diseases here were in fact different from the heart diseases of Western nations; many of the cases here were rheumatic heart disease which is infectious in etiology. Likewise, hypertension cases here were not exclusive to businessmen as any kind of stress could cause them. And with the increase of hypertension cases in males between 20 to 30 years old especially in the rural areas, we would look into the linkage between hypertension and pesticide poisoning.

It is also intriguing to know that there was a very very big difference between the mortality rate of rheumatic heart disease between the women and the men. Was it possible that the higher death rate in women was because women were not getting the necessary treatment as compared to male members of the family?

Tuberculosis went down from no. 2 to 4. Could this be a sign of development or just that something else came up? However, visits to the rural areas revealing many untreated cases would point to the underreporting of cases. Even then it had still a very high death rate and we still had the highest death rate for TB among the ASEAN countries and in the Western Pacific region.

With the worsening financial crisis, this death rate is expected to rise some more since treatment will also become more expensive. For although the DOH says that the medicines are free, it is very hard to avail of them because of the bureaucratic process required.

Cancers have also been on the rise and again it would be wrong to attribute this to a more modern society since the pattern here would point to agrarian/underdeveloped society factors like for instance its linkage to pesticides.

There was an increase in the percentage of total deaths of measles from 2.3 to 3.7. This notably was already after the EDSA revolution. There could have been an increase in immunization coverage as the government claims, but the problem was that they concentrated on the infants and we saw that deaths due to measles were mostly among the 2 to 6 years old. According to UNICEF, all vulnerable children were supposed to be immunized.

Avitaminoses and other nutritional deficiencies were still in the top ten and although there was a decrease in the cases from 2.1 % to 1.6%, we should be careful in its interpretation. This would have meant only that it was not just malnutrition itself that killed the person but some other disease like measles.

The government itself admits that the nutritional status of children did not improve--it worsened in 1985, improved a little in 1986-87, deteriorated in 1988 and most probably will continue to deteriorate. Thirty percent of Filipino pre-school children are moderately to severely undernourished; if we count the mildly undernourished the figure may reach 80%.

In 1987 when there was an improvement of the nutritional status of pre-school children, it was observed that undernutrition cases were high among the 7-10 years old. These were the survivors of the 1984-86 crisis; they were then the pre-schoolers. So whatever happens in 1991 we will be seeing the consequences of that as late as 1995 and in some instances maybe in a longer time. Like when we talk about the problem of goiter which is endemic in the Cordilleras and other areas, we will also talk about cretin children which is a lifelong problem.

Looking at the pattern of disease in the Philippines, we could keep on reporting that most of the causes of death are preventable and curable.

DEATHS BY OCCUPATION AND AGE (see Table 3)

It is time if possible, to also use our community diagnosis for figures from our communities and to take a more critical look at national figures and find some important differences.

The infant mortality rate in the Philippines was abqut 55/1,000 live births (and we know that this is underrated). This means that 5 out of 100 died before the age of one year. Further another two died before reaching the age of five years. The mortality rate continues to be quite high until the age of around 10 to 15 years.

The first row in table 3 shows that at a certain age it seems that it would be a continuous survival up to the age of life expectancy but as we will see there are differences according to the occupational groups.

For the professionals, they tended to die at an older age but not quite at the range of >65 (24% for the professionals and 30% for all) which may be due to their being prone to cardiovascular diseases. The average however represented the extremes for those going beyond 65 years. As seen, a very high percentage of elementary teachers died between the ages of 20-49 and very few reached beyond 65. And we know how hard the life of teachers is and that they are paid very low wages, comparatively speaking.

For clerical workers, it is notable that many died at an early age and perhaps this could be attributed to poor

TABLE 3

Deaths 1987 by Usual Occupation and Age of Death

	All	20-30	30-39	40-49	50-59	60-65	>65
Gainful	75091	10721	11250	11263	13150	6171	22536
Percent		14.28	14.98	15.00	17.51	8.22	30.01
PROF	3000	258	427	550	725	308	722
Percent		8.60	14.23	18.33	24.17	10.27	24.07
Physicians	150	5	8	13	31	18	75
Percent		3.33	5.33	8.67	20.67	12.00	50.00
Lawyers	190	1	12	19	59	30	118
Percent		0.53	6.32	10.00	31.05	15.79	62.11
Elem teac	468	33	60	138	128	53	56
Percent		7.05	12.82	29.49	27.35	11.32	11.97
CLERICAL	581	124	129	101	116	40	71
Percent		21.34	22.20	17.38	19.97	6.88	12.22
SALES	4306	521	645	763	840	406	1131
Percent		12.10	14.98	17.72	19.51	9.43	26.27
SERVICE	2797	740	668	508	431	122	328
Percent		26.46	23.88	18.16	15.41	4.36	11.73
AGRIC	39820	4103	4312	5034	6638	3588	16145
Percent		10.30	10.83	12.64	16.67	9.01	40.54
PROD	18407	3559	3653	3264	3259	1270	3402
Percent		19.34	19.85	17.73	17.71	6.90	18.48
Miners	188	78	61	18	14	3	14
Percent		41.49	32.45	9.57	7.45	1.60	7.45
Electr	283	57	79	50	53	20	24
Percent		20.14	27.92	17.67	18.73	7.07	8.48
Transport	3457	601	957	748	637	210	304
Percent		17.39	27.68	21.64	18.43	6.07	8.79
AFP	1614	744	532	161	76	25	76
Percent		46.10	32.96	9.98	4.71	1.55	4.71

working conditions. A relatively high percentage of sales workers, which may include sales workers of big companies like the medical representatives, died beyond the age of 65.

Notable in agricultural workers is that >20% of them died before reaching the age of 40 years. A research in Nueva Ecija revealed that there was an increase of deaths of males due to cardiovascular diseases since the advent of the green revolution leading to the speculation that those may have not been only cardiovascular disease cases but may have been cases of pesticide poisoning.

Almost half of the production workers died before the age 40. This could be attributed to occupational hazards.

It is very apparent from the figures that working with the AFP was the most dangerous occupation. More than a thousand died in 1987 and most of these were enlisted men belonging to poor and peasant families. Almost 1/2 died before the age of 30 and about 1/3 before the age of 40; many of these deaths occured in encounters. Around 5% were more than 65 years old and almost all of these were officers.

It is shown here that age range of deaths differed in the different occupations. The factors that could be cited here are the occupational hazards and perhaps the type of diseases associated with the respective occupations. Political factors could also be contributory, such as the low intensity conflict (LIC), where the peasants were affected, forcing their children to join the AFP for economic reasons and to die at very early ages. These young soldiers were victims themselves.

INFANT MORTALITY RATE (IMR) BY CAUSE OF DEATH AND OCCUPATION OF FATHER (see Table 4)

This table shows that socio-economic status or the class factor already had a bearing even in the cause of death of infants.

It is seen that more infants died due to intestinal infection, nutritional deficiencies, pneumonia and influenza, and other respiratory diseases in the agricultural workers than in the professional and technical workers. The dramatic difference in the nutritional deficiencies (around three-fold) points out that the kind of family an infant is born to makes a difference on the infant's nutritional status.

Congenital anomalies were higher in the professional and technical workers than in the agricultural workers. This could be possibly because in the former, mothers had more access to drugs. Another theory is that fetuses with

TABLE 4. PERCENTAGE DISTRIBUTION OF INFANT MORTALITY BY CAUSE OF DEATH AND OCCUPATION OF FATHER: PHILIPPINES, 1983

CAUSE OF DEATH	PROFESSIONAL & TECHNICAL WORKERS & OTHERS IN GROUP 1	CLERICAL & RELATED WORKERS & OTHERS IN GROUP 2	AGRICULTURAL WORKERS & OTHERS IN GROUP 3	OTHER WORKERS IN GROUP 4	ALL GROUPS
INTESTINAL INFECTION	6.06	7.21	7.91	5.55	7.19
NUTRITIONAL DEFICIENCIES	1.30	2.37	3.74	1.73	2.80
VIRAL DISEASES	2.60	1.70	1.41	1.36	1.56
PNEUMONIA & INFLUENZA	9.52	20.21	20.68	13.28	18.94
OTHER RESPIRATORY DISEASES	3.46	2.40	4.24	2.37	3.19
CONGENITAL ANOMALIES	13.85	7.24	5.40	6.46	6.58
CONDITIONS ORIGINATING IN PERINATAL PERIOD	49.78	46.05	44.19	56.78	47.12
Disorders relating to short gestations	39.13	38.84	29.79	41.99	35.96
Intrauterine hypoxia & birth asphyxia	9.57	8.51	13.10	6.09	9.85
Respiratory distress syndrome	12.17	12.68	6.55	13.78	10.50
Other respiratory conditions of fetus & newborn	10.43	9.07	7.83	8.49	8.53
Infections specific to the perinatal period	9.57	13.96	11.98	12.02	12.67
Other conditions originating in perinatal period	19.13	16.93	30.75	17.63	22.49
ALL OTHER CAUSES OF DEATH	13.42	12.62	12.42	12.47	12.62
T O T A L	100	100	100	100	100

congenital anomalies in mothers of farmers' families usually were not delivered alive at all; as we see in the community diagnosis of CBHPs, the rates of abortion and miscarriage in the communities are quite high.

LOW BIRTH WEIGHT (LBW) INFANTS (see Figures 1 and 2)

Low birth weight infants are those born weighing less than 2.5 kilograms (5.5 pounds).

In Figure 1, we see a U-shaped configuration. The high incidence of LBWs in first born children (21.12%) could be due to the fact that the mothers still had no experience, hence still lack the education about child bearing. This may stress the need for CBHPs to give more effort in educating women who are in their first pregnancy. The start of increase of LBWs in the fourth children may suggest that the ideal number of children is two to three.

Child bearing at a very young age does not only increase the possibility of a LBW infant, as shown in Figure 2, but also the risk of maternal death. The maternal mortality rate for women <15 years of age is around 50% as compared to the national average which is <1%.

Figure 2 also shows that based on the risk of LBW infants, the ideal age to give birth was between 25 to 35 years of age and that giving birth after the age of 35 was much safer than giving birth before the age of 20.

There is a need for the CBHPs to address this problem of child mothers. This birthing before the age of 15 years still constitutes around 2,000 deliveries/year in our country.

THE INTERNATIONAL MONETARY FUND (IMF) CONDITIONALITIES

There are economic, political and economic factors leading to this health situation.

For the Philippine government to get more loans, the IMF is imposing the following conditionalities:

1. Reduce government budget by P30B. The budget for 1991 was reduced by P25B but surely the P5B will be made up in the other conditionalities.

2. Reduce/eliminate government subsidies on oil, rice, etc. (deregulation). This will mean that the government will no longer set prices for the commodities concerned. As for oil for instance, this would mean that the pricing will be left to the oil companies to determine. This would definitely

FIGURE 1. Percentage Distribution of Infants Below Standard Birth Weight By Birth Order.

BIRTH ORDER	% OF INFANTS W/ LOW BWGT
1	21.12
2	17.18
3	15.72
4	16.22
5	16.92
6	18.59
7	18.72
8	19.19
9	19.31
10	21.70

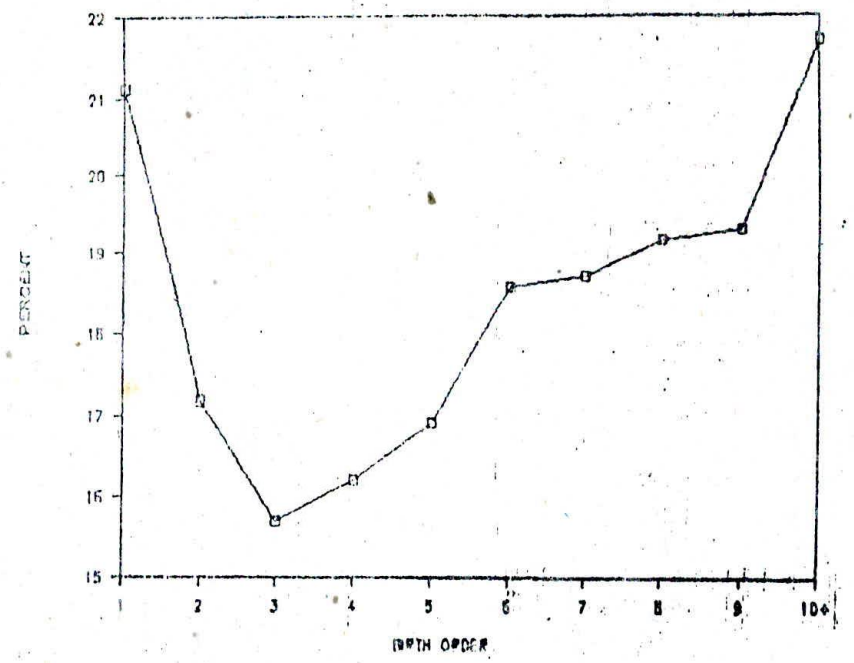
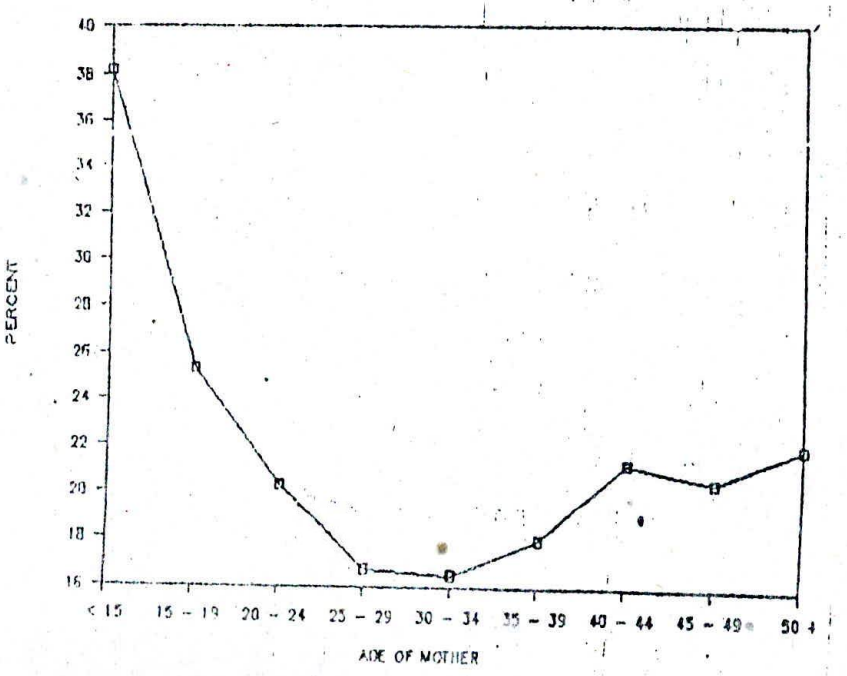


FIGURE 2. Percentage Distribution of Infants Below Standard Birth Weight By Age of Mother

AGE OF MOTHER	% OF INFANTS W/ LOW BWGT
<15	38.18
15 - 19	25.35
20 - 24	20.23
25 - 29	16.76
30 - 34	16.50
35 - 39	17.93
40 - 44	21.20
45 - 49	20.39
50 +	21.90



result in higher prices; we will expect a series of price increases in the near future. As a matter of fact even today, our oil prices here are already higher than in Canada and America, that in absolute terms.

3. Raise government revenues.

Examples:

* 9% import tax - This is a reversal of the import liberalization policy but although it may seem that it is based on nationalist reasons, it is not, because it is being done simply because the government is in need of money. This could even be dangerous since we do not have self-reliance programs making us very dependent on imported raw materials as in the manufacture of drugs. This tax increase will be passed on to the consumers through the higher prices and high inflation rates that will result.

* increase in income taxes - In Metro Manila the minimum wage has been increased to P118/day from P89 or equal to about P2,596/month. However, there has been an observation that this increase in wage has resulted to a lower take home pay because it also raised the income brackets of your taxes -- consequently you have to pay higher income taxes. What is needed here is to reform the income tax system wherein the rich will be made to pay higher taxes and the poor given more tax exemptions.

* increase in SSS and Medicare premiums - We may opt to give more non-wage benefits and maximize reimbursements, which are non-taxable, than outright salaries.

These IMF conditionalities are supposed to reform the government's economic system for a more efficient government -- a solution to our economic problems. But we very well know that these have been used since the time of Marcos and we know that these are not the solution.

The government can raise taxes through other means like real estate taxes especially on idle lands; in Metro Manila for instance an aerial survey revealed that 15% of the lands is still idle. However, it seems the increase of taxes for idle lands cannot be done because the people in Congress, who owns them, will be the ones to be affected.

There are also the controversial sin taxes (increased taxes for cigarettes, hard and soft drinks). The increase in the taxes of cigarettes and hard drinks some argued, only affected the consumption of the poor. Does that mean that they are going to be healthier?

TREASURY BILLS (T-BILLS)

Presently half of the debt servicing goes to payment of domestic debt. To finance this, the government floated T-bills wherein you may put money in (minimum is P100,000) and in turn get high interest of 27-32%. So that if you put P1M in T-bills, your interest would reach P32,000/year. So people are lured to put their money here instead of investing it in some business which can generate productive employment but which has risks. This may be tempting to those who have money but with these T-bills, the economy does not move and the government debt gets higher and higher because it has to pay the monthly interests.

BLOATED AND EMACIATED BUDGETS (see Tables 5 and 6)

The national budget reflects the political will of the government. Because the government lacks funds, the budget for 1991 is the same as that for 1990 minus P25B.

According to the DOH national office, to a certain extent the department is affected by the P25B cutback. (A participant shared that according to the regional director of Central Luzon, their regional hospital was made to slash expenses for 1991 by 30%.)

Looking at Tables 5 and 6, let us compare some items of the bloated and emaciated budgets and see for ourselves the distorted priorities of the government.

1. The health services for the the AFP General Headquarters has a budget of P43M for 20,000 personnel or that would be P2,063.31/person/year. The four main services of the AFP have the following budgets for their health services (per person/year): Air Force P2,400; Army 1,668; Navy P1,863.33; and PC P1,028.39. Further, the AFP Medical Center and Veterans Memorial Hospital have separate budgets of P130M and P126M respectively. Compare these with the budget of DOH of P7B to take care of the health of 60M Filipinos or that would translate to P127/person/year or P0.30/person/day. Also compare those bloated budgets with that of the Research and Promotion of School Health and Nutrition under DECS which is P11M for 10M schoolchildren or that would be approximately P1/year for each child. Included in this P11M budget is the 2.3M or P0.20/child/year for medical and dental services of the schoolchildren.

2. The Office of the Press Secretary under the Office of the President has P401M. Compare this with the P2M for the Public Information and Health Education Services of the DOH which is in-charge of keeping the 60M Filipinos informed on

TABLE 5

Bloated Budgets (1990)
Figures in millions of pesos

Department of National Defense	**P22,962**
AFP General Headquarters	2,618
Intelligence Services	214
Civil Military Operations	108
Health Services	43
(Staff 21,102. Per capita health: 2063.31)	
Philippine Air Force	2,298
Intelligence Services	49
Health Services	46
Civil Relations	6
(Staff 19,117. Per capita health: 2391.43)	
Philippine Army	5,179
Intelligence Services	72
Health Services	153
Civil Relations	29
(Staff 91497. Per capita health: 1668.13)	
Philippine Constabulary	3,399
Intelligence	57
Health Services	47
Civil Relations	22
(Staff 45226. Per capita health: 1028.39)	
Philippine Navy	3,193
Intelligence	37
Health Services	52
Civil Relations	14
(Staff 27657. Per capita health: 1863.33)	
Integrated National Police	4,745
(Staff 73798)	
Presidential Security Group	39
AFP Medical Center	130
(Staff 1173)	
Veterans Memorial Medical Center	126
(Staff 1534)	
CAFGU	523
(Staff 72000)	
Philippine Military Academy	221
(Staff 2009)	
Government Arsenal	130

Manufacture of Arms (Staff 1131)	91
Office of Civil Defense (Staff 306)	16
Office of the President	**2,145**
National Intelligence Coordinating Agency	106
Presidential Commission on Good Government	85
Presidential Committee on the Philippine Nuclear Power Plant	244
Other Executive Offices	
Office of the Press Secretary	**401**
Games and Amusement Boards	**10**
National Police Commission	186
National Stud Farm	8
Philippine Gamefowl Commission	9
Philippine Racing Commission	19

TABLE 6

Emaciated Budgets
Figures in millions of pesos

Department of Health	7.655.
National TB Control Program	150
Subsidies to indigent patients	9
(excluding subsidy of P37 million for indigent patients at Heart Center)	
Assistance to PTS	8
Purchase of drugs and medicines	363
Community health services	2
Public information and health education services	2
Health intelligence services	4
Dangerous Drugs Board	30
Bureau of Food and Drugs	19
(Staff 73,124)	
DOH annual budget per Filipino: 127.58)	
Department of Labor	578
Appropriate Working Conditions and standards	7
Rural Workers' Welfare	7
Appropriate working conditions and welfare of women and minors and family planning	5
Department of Science and Technology	920
Food and Nutrition Research Institute	54
Philippine Science High School	38
Philippine Council for Health Research and Development	17
Department of Social Welfare	836
Commission on Population	60
Council for Welfare of Children and Youth	4
National Council for the Welfare of Disabled Persons	9
Department of Agriculture	
National Nutrition Council	26
Pertilizer and Pesticide Authority	14
Department of Trade and Industry	
Product Standards	10
Consumer protection and regulation of domestic trade	5

Department of Education, Culture and Sports	26,894
Research and Promotion of School Health and Nutrition	11
(Including 2.3 milion for field operations of medical/dental health services)	
(Total staff: 435,590, excluding Institute of Philippine Languages, National Library, National Museum, National Historical Institute)	
State Universities and Colleges	4,600
Philippine Normal College	79
(Staff 604)	
Polytechnic University of the Phil	309
(Staff 2051)	
University of the Philippines	1,170
Health services and training of medical students at PGH	203
(Staff 12811)	
Department of Agrarian Reform	904
Department of Environment & Natural Resources	6,868
National Power Corporation	995
Office of the President	
Presidential Commission for the Urban Poor	19
Other Executive Offices	
Commission on Filipinos Overseas	12
Energy Regulatory Board	24
National Commission on the Role of Women	8

how to handle respiratory diseases, diarrhea, etc. The P401M of the Press Secretary is very high to the P578M of the Department of Labor and Employment which is in-charge of taking care of the labor problems of the country.

3. The National Stud Farm has P8M while the DOH Community Health Services has only P2M.

4. The Philippine Gamefowl Commission has P9M while the Council for the Welfare of Children and Youth of the DSWD gets P4M. The welfare of children gets <50% of what goes to cockfighting.

5. The Philippine Racing Commission and the Bureau of Food and Drugs of the DOH has a budget of P19M each. The same budget but try to look at the functions of the two agencies. The two agencies have the same budgets, but not the same importance and functions. This could be the reason why we have so many problems with the National Drug Policy and the Generics Law. There is only one inspector per province to check all the drugstores.

6. The Philippine Military Academy has P221M to train the future right-wing soldiers who keep on launching coups d'etat while the Philippine Science High School gets P38M to train our future scientists. Compare also the P221M of Philippine Military Academy (PMA) to the P203M of the Philippine General Hospital.

7. The Department of National Defense which has a total personnel of 250,000 gets P23B almost the same as that of the P27B of the Department of Education, Culture and Sports which however has a total personnel of almost half a million.

The government budget is very problematic in terms of priority. We are fighting for the increase of the DOH budget but in the DOH itself there are already mispriorities -- their organization is quite top heavy with so many under- and assistant secretaries. A lot of the DOH budget goes to the top while in the fields they are made to cut back in their expenses.

THE GULF CRISIS

The government is now inflating the threat of the Gulf crisis to hide its own defects, when in fact we have so many domestic problems. Of course the Filipinos are affected since there are many Filipinos in the Middle East. But precisely they are there in the Middle East because of our current economic situation.

THE HEALTH CARE SYSTEM (HCS)

Talking about sustainable development, as they would say in Western countries, let us keep what we have right now and pass it on to our children. But in the Philippines what we are leaving to our children is not what we can keep but problems that would emerge out of the problems that we are creating today.

It is still being said that our problems are due to Marcos but we must also think of the problems created in 1986-91 that aggravated those Marcos problems. The present government started some good things but its intensification of the total war policy aggravated the economic crisis. If we look at health services, for all that rhetoric on the Rational Drug Policy and the Generics Law, that is only the peak, the bottom is still the same situation. There is no change.

Over-all the present situation will affect the health care system. The decrease in government budget will result in a decrease in the delivery of services. The economic crisis will also have its toll even on CBHPs. We are already feeling the crunch of the higher transportation rates and increased prices of other commodities.

It is the role of the state to deliver health care services to the people. But despite the increase in Medicare premiums, subsidy for medical expenses is still not enough. The inability of the state to do its role paves the way for more involvement of the private sector. We already hear plans for the sale of the Heart, Kidney and Lung Centers. Indeed privatization brings in modern technology but the services that it could provide are still inaccessible to the majority of the people.

DOH educational materials are usually either not distributed or are inappropriate. The production of Astra Pharmaceuticals of a First Aid Manual using relatively high cost materials shows that private companies still have a lot of money despite the crisis.

Could we still accomplish an alternative Health Care System given this direction of the government?

OPEN FORUM

The following points were made regarding the question raised on what alternative measures can our sector formulate, still in the direction of an alternative HCS, to answer the health needs of our beneficiaries in the light of the present crisis:

1. Present pressure on the government is concentrated on the wage issue; but this should not be all. The body may pass and publish a resolution to express opposition to the IMF conditionalities and to express its stand regarding the dipyrone issue which has been sitting in the DOH for a long time now.

2. Regarding RDU, we could discuss how to meet the crisis in terms of providing medicines, which is one of the biggest expenses of CBHPs. For a short term measure, there has been a request for a national procurement body that could purchase drugs on a wholesale basis for more bargaining leverage; and a long term measure moves for self reliant industries. We could also make political moves to decrease the profit of drug companies. There is a need for the continuous promotion of the essential drugs concept.

3. On the vision of a nationalist HCS, BUKAS is presently working on a material based on a framework--Model of a Nationalist HCS by the World Health Organization (WHO). If endorsed it will be shared with CBHPs for comment of its contents especially on the aspect of what the components of a nationalist HCS should be and how to attain that system. It is intended to be popularized in the communities. They expect to finish it next month.

4. Even though we have already been promoting herbal medicines, it is known that it is yet not that well accepted in the communities. One of the reasons for this is the inconvenience in preparing and using them. In response to the present crisis, there is a need to further study and adapt measures to continue the promotion and development of the use of herbal medicines.

5. The impact evaluation showed that CBHPs are really identified with herbal medicines. It should be emphasized that CBHP also includes nutrition, education, empowerment, among many others. The use of capsules in herbal medicines reinforces the fixation of the people that health comes from tablets or capsules. There may be a need to find other ways to prepare herbal medicines; the use of tea bags as in the now commercialized pito-pito could be more appropriate.

6. The recommendation of a revolving drug fund, i.e. to sell drugs with the proceeds going to the CBHP creates some fear. This could be counterproductive since if you tie fund raising to the sale of drugs there will be a tendency to sell more drugs for more money. You cannot use drugs to receive funds because it penalizes the sick.

7. Regarding health insurance system, there is an idea to set-up our own health maintenance system for all the cause-oriented groups. It is not only the health sector that needs it there are also the women's group, peasants' group, etc.

DAY 5

14 January 1991
Monday

DAY 5

Facilitator of the Day: Dr. Tess Umipig

SCHEDULE

8:00	8:15	Morning Praise
8:15	8:30	RECAP
8:30	12:00	Continuation of Regional Workshops
12:00	2:00	Lunch
2:00	4:00	People's Development Work - Bimboy Penaranda
4:00	4:30	Break
4:30	7:00	The Situation of Women in the Philippines - GABRIELA
7:00	8:00	Supper
8:00	9:00	Continuation of Regional Workshop on Results of Summing-ups of CBHPs

DEVELOPMENT WORK CONCEPTS

Bimboy Penaranda
Director General
Council for People's
Development (CPD)

DEFINITION of Development Work

Development work is all efforts to answer the immediate needs of the people and at the same time raise their awareness to demand their rights for basic services.

CONCEPTS of Development Work

Framework

In this concept, there is one very important question that we need to answer: What is the relationship of organizing to development work?

Organizing and development work are closely linked together. During organizing, we must answer the immediate needs of the people by providing services. We cannot provide services effectively if we don't organize. We look at it as a process. When you organize, education is an essential component. In organizing and education work, the first thing is to launch a project or activity that answers the immediate needs of the people and at the same time, not to neglect working or fighting for their rights.

Process -------> Immediate needs
Organizing ---------->
Education --------> Demand for basic rights

1. Development Work must answer the immediate needs.

If we talk about development work, we need to answer the immediate needs of the people.

2. Development work involves demanding for people's basic rights through advocacy, promotion and mobilization.

In answering the immediate needs of the people, advocacy is also important. Advocacy work is fighting for your rights as citizens of this country. For instance on the question of literacy, there are available schools but what you are fighting for is the right of your children to free education. What you are fighting for is your right to basic services to answer your basic needs.

Government Cannot Answer All Our Basic Needs

Most of the time, you demand basic services from the government but the government cannot give these basic services. And so we in the non-government agencies offer alternatives by forming organizations like CBHP. You are giving alternative health care services.

We fight for our basic rights because GOVERNMENT IS INEFFECTIVE. This means that a government cannot afford to provide the basic needs or services. Or these basic services are not the priority of the government.

For example, in the community the ratio of midwife to population is 1:5,000; health center to population is 1:28,000. The ratio of nurses to population being served is lower and the ratio of doctors to population is even much lower. If that is the case, delivery of health care services is not effective.

It is the responsibility of the government to provide all of these basic services but if we look back at the 1940's and 1950's, the government did not deliver basic services, especially health care services, effectively. During those times there were civic clubs like Rotary, Lions etc. They were the ones providing medicines.

The GOVERNMENT CANNOT AFFORD to provide these basic services that is why ever since the government's call was to

mobilize the private sector and citizenry in order to do its job for them, because the government cannot do its role of providing services.

So it is justified to form alternative organizations or mechanisms for effective delivery of health care services. Sometimes we ask why we still need to form health programs or organizations when we already have the government to provide health care services. For instance, if you are an employee of the government, you do not encourage your clients to fight for their rights to demand health care services from DOH. But if you're with the NGO's or PO's you will encourage them. **People's autonomy and independence is important in development work.**

Development Work Must Be a Coordinated Effort

Services in development work such as health, agricultural production, marketing, ecological management, small scale industry, livelihood, literacy and numeracy and also relief and rehabilitation should be closely coordinated. You will notice that NGO's have sectoral services. In the peasants' sector, for example, there is an organization that deals only with agricultural production.

For others, ecological development is their focus. They are not multi-purpose that is why sometimes, there is good production in agriculture but the rate of malnutrition is high. The point here is, these basic services must be closely coordinated. They must work hand in hand. There will be no impact in the community if for example agri-business and health services work are not coordinated.

In terms of impact, we cannot measure the effect in the community if there is only one NGO providing services. It is important that the advocacy work should be closely coordinated with the integrated approach of answering the basic needs. If we have difficulty in coordination, there is no impact. If there is no impact, we will not be able to answer the people's basic needs effectively.

The Concept of Integrated Area Development

An example of an integrated area development plan is that of 10 nearby barrios that formulate a plan; this plan must be well represented by different types of advocacy work such as health, literacy, livelihood etc. If it is not possible to plan these together, a memo of agreement can be utilized. This can also be done through coordinated advocacy work, formulation of plans and the creation of a management committee. In setting up a cooperative, it is

not necessary that all sectors have a cooperative. If 10 barrios will set up 10 cooperatives it will lead to confusion unless close coordination is done. Then there will be no effective development in that area.

The Concept of Process and System

If we talk about process and system, we talk about organizing. In organizing we must have the right attitude and virtues or ability to persevere, and of course we must have commitment. Here we have to undergo a process. It is not advisable to make short-cuts in this process.

You must have an education component because it is difficult to relate the problems of the community to the national problem. If you undergo a process, you must have a system.

You systematize the operation of health workers. Example: Paramedics somehow in the system become veterinarians. This system aims to empower the People's Organization. A systematic training activity coupled with good coordination will help upgrade the ability/capability of the people's organization.

For example, putting up cooperatives is not easy for the people's organization especially if they lack the capability or skills. For instance, one problem in health work is the difficulty in sustaining the training of paramedics, usually because of financial constraints in the project. So we must build a social capital. However, this is not the issue of additional income. The role of the cooperative of the people's organization is to generate more resources for the organization. Without a cooperative, the organization will weaken. It should not depend only on NGO's. Some organizations avail of credit from institutions.

The Concept of Empowerment

In simple words, empowerment means a shift of power or political decision from one group to another group. For example, from oppressor to oppressed, from elite to the poor. Development work is not neutral. It is always biased for the poor. The bias here is in transferring skills: to help them fight for their rights: developing alternatives towards the transfer of political decision making to the people's organization.

For example, **an organized community has always the** right to say no to any project or program. This is the

first right of the people's organization. Through experience, the NGO's and the GO's introduced many program interventions especially in agricultural production. For the NGO's, usually it is a demonstration of a particular technology, but for the people's organization or the poor community, it is a matter of life and death because if the project or program is not successful, the community will suffer.

It is really hard to introduce new technology, that is why demonstration farming is a practice in agricultural production projects. But the point here is they will not gamble their lives for such innovations. There is also a need to do this because we really need to try new technology. As they say, if there is no investigation, their is no right to speak! So respect their right to say no. They know very well their situation because it is their own life. Respect their integrity while correcting their situation. That is the work of a development worker and organizer. Organizing work and service delivery must go hand in hand. As a development worker you must also have skills in organizing.

Therefore shifting power from one group to another is itself part of development work. This is what we call empowerment. If there is no change in the relationship in production of one group to another group, there is no development. What is the use of development work if one is subordinated?

Empowerment has to do with changing relations in society. That means the shift of power from one group to another and the bias is for the poor. Always the process should be empowering. If the process is not empowering, there is a problem there.

It is necessary for the people's organization and even the development worker to undergo a process. People's organizations have developed paramedics, parateachers etc. and this is empowering. In simple words, they now have what they did not have before.

The Need to Assess (Document Experiences)

Part of being systematic is being able to assess. Here, problems arise. For instance, people find it difficult to document. When there is no documentation, it will be difficult to produce an educational curriculum for others to learn or to propagate or popularize experiences. Basically, if you want to sustain training until the people's organization has gained skills or capability, you

need documentation. If you want clear policy, you need policy research. One important thing in documentation has something to do with international relations or cooperation.

There is a spiritual dimension effect in development work. It is controversial because the connotation here is you have to be religious in institutional terms.

The arts is included in development concerns. Somehow, it is important for people to express themselves whether the experience is one of hardship or success. They have to express it in other terms. Not only in terms of service or doing something for material good, but to express themselves as individuals or as a group. This is what you call leap in consciousness or "diwa" in Tagalog. There will be a need for other formulations that separate arts from education and the usual cultural works.

Creativity in Development Work

Lastly, creativeness is part of development work especially in an environment where there is not much resources. Appropriate technology is applicable. It is important that the project is based on the situation and that requires a certain degree of creativity. Without this, the project will not survive in the community. There is always a bias towards the rural environment but this should also apply to both rural and urban.

Considerations:

* It is important to consider social groups like in the case of women because of role transformation; the tribal groups because of their different situation and culture-transformation of socio-cultural structures; and then the youth because they are the first ones to be affected by the many problems being experienced.

* The importance of ecology is also to be considered. the environment is the material basis of the people's lives which the next generation will inherit.

* Child care and responsible parenthood is also another consideration. This involves a concept of the family and its importance.

OPEN FORUM

Main Points Raised in the Open Forum:

1. The relationship of non-government organizations and people's organizations.
   * need to build-up relationships and closer coordination.
     Criteria:
     a. level of organization/method in selecting leaders
     b. what are the strengths/capacities
     c. members' level of participation in decision making

2. Social movements - there is a relationship with the historical development of the people.

   Social Movement is composed of people's organizations.
   Example: religious, nationalist, individual movements with political- economic issues.

   Social institutions - influence the awareness building of the people.
   Example: church, educational institution, mass media

3. Development projects are parts of the system undertaken usually to expand constituency.
   Example: Cooperatives

4. The Stand of CPD on the Present Gulf Crisis:

* The contingency to the current crisis in terms of emergency is to have lucid minds and deliberate action. What the coalition notices is the growing climate of anxiety surrounding us. The atmosphere is almost panicky.

Now there are ways that NGO's and PO's can agree to work out in times of the crisis:

a. education - can be in the form of group discussion or symposium
b. systematic information dissemination and exchange
c. there should be a public coordinating center
d. launch a program with survival tactics and techniques

DAY 5

THE SITUATION OF WOMEN IN THE PHILIPPINES

Wilma Balistoy
Lilet Usoy
Lina Anastacio
Education Department -- GABRIELA

Outline:

I. Introduction
II. The Plight of Filipino women in the field of:
    A. Economics
    B. Politics
    C. Reproduction
    C. Violence
III. General Perspective on Women's Development

I. Introduction

Community Based Health Work is an approach by which health services can be accessible to the people and the community. The important point, however, is not only the effort to serve them but also the effectivity of the services we render in relation to their needs.

As we look at the health workers and beneficiaries of health services in the community, we notice half of them are women. If we could only understand their present situations and conditions only then can we respond effectively to their health needs through services. Women can even participate in improving their health.

II. The Plight of Filipino Women

> Slide presentation on the roles and issues of Filipino women in the present context of society.

> It is a concrete reality in our present society that women as a distinct social group are facing various problems and dilemmas.

Factors Showing the Condition of Women in Society:

a. Multiple Burden of Women

The women sector is largely composed of workers, students, teachers and peasants who suffer oppression, exploitation and hardship. They are seen as weak, plain housewives, objects of sexual pleasure, and are considered second class citizens of society.

b. Additional burden as a result of being a woman

The problem of class oppression and difficulties in the case of a woman-farmer landlord relationship

A. ECONOMY

The present economic crisis in our country brought by poverty to the majority of the Filipinos is further aggravated by unemployment. The women is one of the sectors affected when it comes to employment priorities because companies see them as weak. To big business, they entail additional expenses, especially the married women, like the benefits of maternity leave. This situation has prompted women to seek other means of earning money like going into prostitution. As of 1989, we have an estimate number of 100,000 adult prostitutes and 20,000 child prostitutes.

There is also discrimination in the types of jobs. For example, most women work as secretaries, nurses or in jobs which require menial tasks. Women also occupy lower positions in their field of work and have less oppurtunity for promotion than men. They are usually sexually exploited by their employers in order to be hired or to keep their jobs.

B. POLITICS

In our society in general, the women do not have a voice in decision-making processes. In the government ,for example, majority of those who are in control are men. If we use the gender classification in our government, only a small portion are women.

Also, our present law does not deal equally with both men and women. For example, the Penal Code states that adultery is punishable. Women who commit adultery will be imprisoned from 6 months - 12 years while men who commit the same will only be imprisoned from 6 months to 2 years.

C. REPRODUCTION

Reproduction is defined in the context of production and reproduction as determining factors in development of society.

In the field of labor we define reproduction as the production and maintenance of labor power. We can relate this also to human reproduction as to the propagation of the species and to childbirth and rearing.

Issues of Reproduction and Its Implications:

1. Reproduction was relegated by society as a primary responsibility of the women.
   Implications:
   a. Undernutrition among mothers especially when breastfeeding. This is also due to inadequate income and the preference given to the child and the husband.
   b. Mothers are confined to household chores which hinder their comprehensive human development.
   c. Reproduction is not given equal value in our society. For example, pre- and postnatal care are very limited to lower income bracket mothers compared to affluent ones who can afford it. The woman has also less authority especially in decision making within the household.

Factors That Control Reproduction

- State ------:
- Church :---- direct bearing on family
- Men ------: planning

IMPLICATION:
- not recognizing the reproductive rights of women.
- women are mere objects of pleasure to their husbands and private property of men.
- adverse effects of contraceptives among women.

Issues on Reproductive Rights:

1. The right of women to bear children: maternal and child care
2. The right to bear: Prevention and termination of pregnancy
   - reproductive technology issue related to both and made available for both.
   - maternal care:
     - inadequate
     - curative approach

D. VIOLENCE AGAINST WOMEN

Scope of Violence:

1. Individual Violence

2. Institutionalized Violence
   - Example: prostitution, mail order bride and other forms of commodification.
   - Causes : Economic crisis and general decay
   - Effects:
     - dehumanization
     - numbing sensibilities
     - warped cultural value
     - diseases

3. State Violence
   - ongoing militarization
   - Cause: state repression vs. peoples resistance

Types Of Individual Violence (see Table)

1. Sexual abuse, rape and harassment.
2. In highly militarized zones like Negros, women are left behind to take care of the children.
3. Vulnerable in cases of wanted men.
   example: hostaging
4. Women suffer gender question oppression.

III. General Perspective in Women's Development

General Perspective	Task
1. Based on the analysis of the present condition of women in society in recognition of the importance of societal transformation towards women's emancipation.	1. AOM women for emancipation
Issues:	
a. eco. field - to have a productive and progressive economy to support the class demands of peasants, students and other sectors.	
2. Real representation in the government as to ensure lower class participation and substantial representation of women.	2. Advance the struggle for the interest of women in all the fields.This involves mass action and activities towards tactical gains in relation to women's right.
3. Real independence from foreign domination.	3. participation in the over-all struggle for social transformation.
4. Ensure equal right to both men and women in all fields.	4. to make sure of the democratization of women within the family
	5. International Solidarity among women.

General Points in the Women's Movement

1. The women's movement firmly believes in the importance of determination and struggle for women's emancipation.
2. Advantages of solidarity of women in addressing major issues.
3. There is an inadequacy of women in leadership and social responsibility in the lower strata and women's movement is towards leadership and social responsibility in the lower strata.

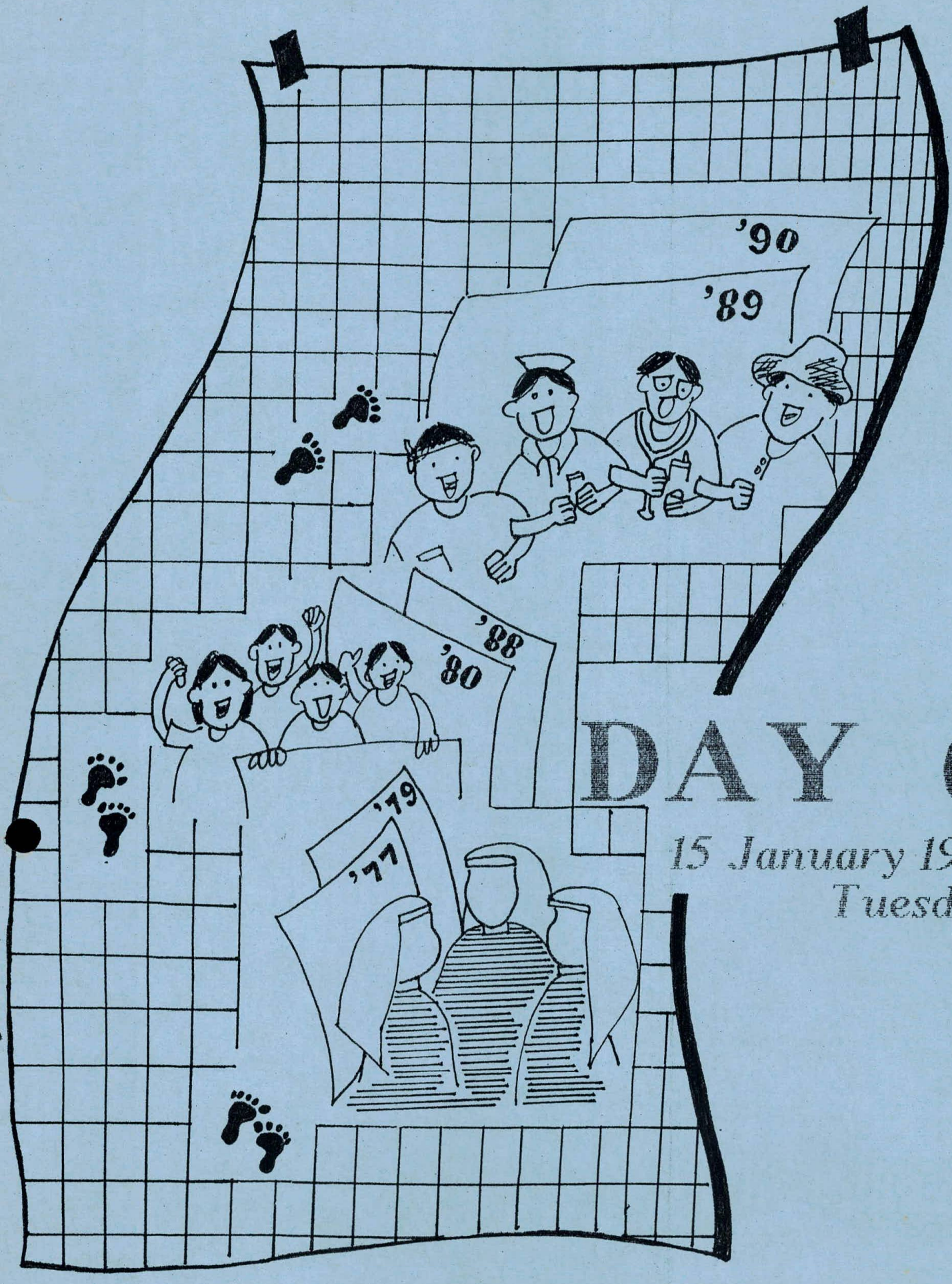
OPEN FORUM

Main Points Raised in the Open Forum:

1. Probable disparity of opinion between single and married women in view of equality between men and women.
2. Most men are still conservative on issues regarding:
   - reproductive rights as a basic human rights issues
   - women's liberation is not basically a gender question but more so on societal structure.
   - patriarchal culture plays an influential factors on the issue of women orientation on the different aspect like among health workers.
   - recognized that one major step in liberating women is through national liberation. However, social transformation does not guarantee women's emancipation. It is a continous process and it goes beyond social change.

Recommendations:

1. Raise the level of awareness on women's orientation through education.
2. Health workers doing social investigation in the community must be sensitive to gender issue.
3. On the contraceptive issue, women need to be informed and that information has to be accessible to be able to make an intelligent choice.



DAY 6

15 January 1991
Tuesday

DAY 6

Facilitator of the Day: Dr. Jojo Carabeo

SCHEDULE

8:00 - 8:15	Morning Praise
8:15 - 8:30	RECAP
8:30 - 8:30	Plenum: Synthesis of Regional Workshop on Summing-Up and CBHP Impact Evaluation
12:00 - 2:00	Lunch
2:00 - 4:00	Organizational Meeting
4:00 - 4:30	Break
4:30 - 7:00	Workshop on Health Work
7:00 - 8:00	Supper
8:00 - 9:00	Continuation of Workshop on Health Work

PRESENTATION OF COLLATED COMMENTS ON THE SUMMING-UP RESULTS

Lyn de la Cruz, RN
Deputy Executive Director
Council for Health and Development (CHD)

Lyn presented the synthesis in the framework of how the body validated the results, points for clarification, reactions, realizations or learnings and recommendations.

II. Summing-up Results (Qualitative)

A. Project Concept and Orientation

1973 to 1976

1. The general orientation was to develop a health program responsive to the needs of the poor in the rural areas.

2. Analysis of the health situation was based on awareness of social injustices.

3. Setting-up of 3 pilot areas and the first pilot area evaluation was launched. The term CBHP was introduced.

1977 to 1979

1. The orientation was to help in Community Organizing.

2. The CBHPs were maximized in Social Investigation work, formation of liaison groups and organizing groups, but these also had negative effects on the security of the program and staff.

The programs began to recognize its limitations for Community Organizing work (up to Consolidation) and realized that:

- there should be good coordination with staff doing consolidation work (COs)
- there should be definite timeframe for turn-over of formed groups (organizing group will turn-over to core group handling the community organizing)
- the health component and organizing component of the program should be balanced.

Also, the programs provided a venue for involving the middle classes in the struggles of the basic sectors.

3. Structural analysis was used as a framework in presenting the health situation, but seminars conducted tended to equate CBHPs as a solution to national problems.

4. The second pilot area evaluation was conducted. A national conference was launched and CBHP concepts and methods were formulated and popularized.

1980 to 1982

1. CBHPs started shifting to support group building among the middle class while some areas continued with its orientation as entry point to organizing.

2. The health conditions were used as starting point for discussing general political issues and health issues in raising the social consciousness of the middle classes; health professionals (HPs), bishops, nuns and priests.

3. Structural analysis was no longer utilized as framework. Discussion of the problems of the Philippine society was used instead. CBHPs were cited as one way of contributing to laying the foundations for a relevant health care system.

4. The Council for Primary Health Care (CPHC) was set up with the objectives of national coordination of CBHPs and to serve as resource center.

1983 to 1984

1. The orientation: Entry point for organizing (in unorganized areas), linking the middle classes to the basic sectors, and building international support groups.

2. The concept promoted was that health programs are part of the comprehensive people's response.

3. Setting-up and strengthening of regional or island-wide CBHPs and agencies to coordinate and answer the needs of local CBHPs.

4. Unity on CBHP objectives and components attained a nationwide level.

1985 to 1988

1. Orientation - help lay the foundation of a relevant health care system.

Community Organizing (CO):
- Entry point for organizing and help in the consolidation of people's organizations

Health Sector Organizing (HSO):
- Contact building for referral network
- Facilitate in the setting up of organizations and alliances
- Allocate personnel and materials for HSO

2. Started the popularization of progressive health mass movement concept.

3. In general, CBHPs were not able to adapt to the level of development of community organizing and to the increasing and heightening health needs of the people's popular movement for social transformation.

4. Launched first national CBHP assessment/evaluation and agreed to set up a national consortium of CBHPs.

5. The orientation and functions of health committees were defined. Criteria for membership to CBHPs and relationships with existing CHW Organizations and other Health Programs and Institutions were clarified. Also clarified were the methods and approaches that CBHPs use.

* On CHW organization
  - island wide in Mindanao, 8 provinces
  - regional organization in the Visayas
  - provincial level in NL (Saranay)
* Role of CHW organization (refer to 1988 proceedings handout)

6. Concepts regarding organizing work, levels of organizing and definitions of terms such as organized areas, unorganized area and genuine people's organiztions were also clarified.

7. A call to conduct a series of consultation and dialogue with groups and organizations working in the communities.

1989 to 1990

1. Orientation:
   - assist in areas of reactivation of peoples organization
   - assistance to consolidation work of peoples organization
   - network building/organizing among health professionals for referral services
   - technical, material and financial assistance for organizing efforts

2. Refocusing of CBHP efforts towards organized groups and communities for maximization and effectivity

3. Review of orientation of CHW Organizations and focusing their activities to health within the direction in helping organized areas.

4. A call to develop services work at all levels and upgrading of skills and leadership capabilites of staff and community health workers

5. Training, Education and Services work were given stress.

6. Working towards area integrated approach.

SUMMARY:

The concept and orientation of CBHPs developed starting from the purpose of responding to health needs at the rural poor. CBHP has proven its potential in organizing people to respond to their needs and problems. Hand in hand with the development of people's concerted efforts towards social change is the CBHP's response to their health needs. All these resulted from various sectors', the broad unity and movement towards social transformation.

CBHPs contributed greatly to the people's movement by helping plant the seeds of a people-oriented and relevant health care system. In general, the development of CBHPs is closely linked with the development of the people's popular movement towards social transformation.

Over-all Realizations:

* lack of internalization of organizing work and efforts
* there are calls for organizing but still the program lacks efforts in this work
* lack of grasp of the CBHP orientation and there's always a recommendation to review the CBHP orientation in order to adapt it to the present condition
* the difficulty of adapting the orientation to the concrete situation
* programs are united to follow the proposal of the National Secretariat regarding basic services.

Recommendations:

* do not separate organizing work from CBHP work
* equip the people with organizing skills because it is the role of the P.O.
* develop proper orientation based on concrete conditions
* staff should write the orientation paper adapting the program orientation to concrete conditions
* program staff must have an orientation manual

B. Components and Activities (levels attained)

1. SERVICES

a. CBHPs' health services have remained at the basic level. Not all the aspects or components of each basic service are implemented. CBHPs have not yet united on what basic health services to set up in the community.

Recommendation: to unite on the level of services based on the level of community development.

b. The bases for delivering services are the following: the needs of the community, assistance to organizing and promotion of CBHPs in the areas.

c. The scope of CBHP services is still generally at the barangay level.

d. Services given to organized areas or groups are not programmed (irregular and unsystematic); they merely respond to requests.

e. Services given became dole-out because most programs directed these to unorganized communities. Added to this was the mechanical implementation and the lack or absence of the active participation of the community members which starts from identification of problem conceptualization, program implementation, management and evaluation aspect(Program staff are the ones directly giving services).

Qualify: more on input of services rather than on developing a process of empowering the people.

Also, the method of service delivery is not applicable to the level of organizing reached in those areas. In effect, the services given by the programs in these areas tend to make up for or support the government's inefficiency in delivering services.

We are in the process of empowering the people and building their capacity to respond to their own health needs.

f. Most of the time, CHWs were mobilized in giving services, while health professionals outside the CBHPs were not maximized.

Recommendation: Review role of CHW in the delivery of services and come up with methods and approaches in HSO.

g. Health sevices given focused on curative or symptomatic care, based on 2 separate evaluators, the trend of health care given was more on the curative aspect.

Recommendation: focus also on referral system.

SUMMARY:

Through their services work, CBHPs were able to respond to the immediate health needs of their areas. However, CBHP services work is still at the basic level. These services are generally curative and dole-out. There is a need to lay down and develop comprehensive health care services (basic and advanced) in priority CBHP areas (see proposed Health Care System), and bringing our work to the forefront of the struggle. We should be able to assert and bring our health agenda to the people's agenda.

Realizations:

* focus on technical skills
* training approaches are mechanical and are not based on the level of CHW
* trainings given was not commensurate to the output of services
* there is a need to stress on practicum (70-30)
* staff and CHWs do not have the right attitude in giving trainings, lacking in value and attitudinal aspect
* still lacking in monitoring and follow-up
* training content lacks awareness raising component both on staff and CHW level

2. TRAINING

a. CBHPs have already trained quite a large number of CHWs, but these are still not enough compared to the vast areas covered by the CBHPs. Also, the level of services that CHWs are now able to deliver is still not equal to the level of trainings that they have reached. this is because of the following factors:

- most of the trainings given to the CHWs are theoretical; there is a lack of constant practice of skills
- CHWs lack guidance monitoring and supervision from the program staff
- there is a lack of systematic program to develop the capabilities of CHWs
- CHWs perform too many tasks
- there is a lack of support from the people's organizations and level by level development of CHWs.

b. The content of trainings launched was based on community needs as perceived by the staff or verbalized by community leaders. Most of the time these do not go through the process of comprehensive community diagnosis. there is still a need to adapt the types of training to the CDx results and to the services needed by the people.

c. Several training modules and manuals have already been developed, but most of these are for program staff level. there is still a great need to develop popular forms that could be used not only by the CHWs but by other community members as well.

d. CBHP trainings have already reached the advanced level, but still seriously need to systematize the basic health skills training (BHST) to be able to develop the ability to give basic services while developing their advance skills.

Recommendations:

1. Immersion of trainer in the community to monitor the impact.
2. Develop monitoring scheme.

SUMMARY

CBHP training work was able to help respond to the health needs of the community by developing CHWs. However, this has had minimal impact if compared to the level of services given to the community. Also, training work has not helped much in the strengthening and consolidation of GPOs towards people's empowerment because most of the trainings were focused on technical skills.

3. ORGANIZING

a. Health Sector Organizing (HSO)

There was an effort to help in organizing health professionals in the form of launching fora, symposia, and inviting them to the activities of the program, but the bulk of the resources of the sectors for the people and the community have not yet been harnessed due to:

- lack of capacity of the staff and correct methods of organizing at varying degrees of community organizing
- absence of programmed education and training and follow-up of contacts in the health sector to encourage them to give continuous assistance.

Program staff lack grasp of the importance of HSO and its relationship to and implications on CBHP work. In

general there is a lack of understanding of the characteristics, issue and role of the health sector in the overall people's efforts for social transformation.

b. Community Organizing

Majority of the programs cannot cope with the organizing requirements in their covered areas.

In unorganized areas: During the period 1975-1983, CBHP was used as an entry point to organizing in several communities.

However, in 1984-1988, 80% of the CBHPs concentrated on health services work and gave less attention to setting up groups and organizations. There was a noticeable lack of consultation/coordination with the groups and sectors doing organizing work or focusing on organized areas. Although they had organizing work among CHWs and health committees, using training, services and support network building for the programs, there was a lack or absence of conscious recognition that these should help in consolidating the GPO.

There were also identified CBHPs in areas where organizing work has not yet been started by the people or other agencies.

By 1989, some CBHPs launched consultations with GPOs regarding coordination.

In general, there is still a need to systematize integration of health work in the program and the work of the GPO in the area as part of the overall thrust of the POs.

Realization: Organizing in the community level was done by the PO because there is a lack of staff to concentrate on organizing.

c. CHW Organizing

CHW organizations continue to increase and have started to function as an alternative health machinery at the barrio level. Some of these have the capacity to stand as a separate machinery, but majority are still part of the program. For some, the level of organizing has reached island-wide, provincial and municipal or parish levels. However, most of these are still under the health program.

In general, CHWs of CBHPs have performed several tasks at different levels of organization. A need to clarify the focus and direction of their work was seen.

On skills: In general, majority of the CHWs are not capable of giving the basic level training and services, while some CHWs have the capacity to render some topics of the basic level training and provide basic health services.

On attitude: Dominant attitudes seen were sense of duty, dependability, commitment, honesty and humility, perseverance, courage and determination. But some use their skills and knowledge for personal advancement. They became elitist due to the following reasons:

- concentration of skills and knowledge
- awareness-raising was neglected
- weakness in clarifying area of responsibility in terms of organizing and ensuring transfer of knowledge to co-workers and development of second liners

SUMMARY

Despite the programs' organizing efforts, these failed to adapt to the organizing requirements of the area and sectors concerned. This is due to the lack of unity and grasp of CBHP orientation and direction of organizing work, lack of staff with organizing skills, the absence of clear coordination with the GPOs, and the lack of integrated area development plan.

C. PROGRAM MANAGEMENT AND ORGANIZATIONAL SET-UP

1. Organizational structure

a. Most of the programs are within the Church structure, although not directly under their supervision, while 8 out of 30 programs were set up by non-sectarian organizations. As long as church-based or church initiated program accepts concepts, orientation and principles of CBHP and will not hinder in its program of work, the organizational structure will not be a negative factor.

b. All CBHP structures have a board of directors, but usually these are not functional or their role is advisory in nature. Most of the time, the program staff make major decisions with minimal consultation with the board and the CHWs/beneficiaries.

Recommendation: Board of Directors should be functional and should understand the program.

c. There is a need to improve management and organizational set up from program level to community level.

d. One trend seen is that most of the health professionals tend to concentrate a large part of their time on managerial and administrative work. We must consider where the services of our health professionals can be most maximized.

2. Program Planning, Monitoring and Evaluation

a. Planning was done regularly, usually quarterly, semi-annually and annually. Inspite of being able to line up the tasks/activities every period, there is a weakness in adapting these activities to the philosophy, objectives and stresses. In effect, planning for each program component becomes mechanical, lacks clear and specific targets and a programmed raising of the level of implementation towards achieving its mission, vision and goals (MVG).

b. Assessments conducted were based on the periods planned (quarterly, semi-annually and annually). There is a tendency to focus only on the qualitative assessment and there is a lack of deepening or analysis of the points or data gathered. Also, assessment results and recommendations are seldom used to answer the seen weaknesses/problems. One serious weakness is the failure to draft implementing guidelines for every recommendation agreed upon leading to the observation that the same errors and weaknesses have been cropping up over a long period of time.

Lesson Learned: Assessments done were too mechanical. Staff lack analytical and facilitation skills.

c. Regarding monitoring of work, plans and tasks are followed up or checked during meetings, but there is still a lack of close monitoring up to the CHW and community levels.

3. Management of Resources

a. The community has greatly contributed its counterpart to CBHPs, especially in the form of material and human resources. Initial efforts have been made in raising funds through income-generating projects (IGPs).

b. Almost all programs have depended on external sources of funds.

Recommendation: Study local sources of funding.

4. Staff Building and Development

a. CBHPs have developed committed staff who are willing to serve despite difficult situations and problems

of personal safety. CBHPs have also developed a considerable number of CHWs.

b. Inspite of the presence of committed staff to run the program, they are not enough when compared to the vast needs of the program. Another observation is the quick turn-over of staff because of the lack of internalization, and because of security, economic and personal problems

c. Most of the program staff were developed in the course of doing their work; no comprehensive program was done to raise their knowledge, skills and attitudes (KSA). There is also a lack of regular staff performance evaluation.

GENERAL STRENGTH

CBHPs have continued to grow and are now able to adapt to various situations brought about by the present political climate in the country. These have greatly contributed to answering the primary health services in the community, and have been able to develop committed staff and CHWs through training and services delivery.

Other Strengths

1. CBHPs have propagated and popularized the use of alternative treatment methods, particularly herbal medicine, acupressure and acupuncture.

2. CBHPs were able to provide low cost health services to villagers through the services of CHWs and parish medical consultations.

3. CBHPs created a venue for raising the consciousness of the middle classes, particularly the members of the health sector, as well as for involving health professionals in community work.

WEAKNESSES

1. CBHPs have not sufficiently directed most of its efforts to its primary target groups (organized PODE).

2. Continuous health sector organizing was neglected.

3. International relations work (IRW) as part of CBHP work has lagged behind.

4. There has been no unity on the concept of comprehensive services.

5. CBHPs are still weak in promotion, information and advocacy work.

6. Program management

Main Trends:

* Institutionalization of CBHPs
* Alienation from the dynamics and direction of genuine people's organizations (GPOs)
* Weak preventive aspect of CBHPs
* Move towards health committee (HC) building
* Moving towards institutionalization

POINTS FOR REFLECTION:

1. Ensuring availability of primary, secondary and tertiary services in our area of responsibility.

2. Distribution of health personnel in relation to the number of population in our areas of responsibility.

3. Appropriate health structure for effective delivery of care and its interrelationship.
   - What basic health unit will be built by CBHP?
   - Is it on a Municipal, Provincial level?
   - How?

4. Appropriate drugs and medical equipment needed in the program at the different levels of health structure.
   - centralized procurement; other

5. Full participation of the citizenry in health.

6. HSO -- towards what direction and how to maximize their skills and potential?

7. Integration of health work with other development programs.

8. Clarifying and defining our relationship with counterpart health and development agencies in the international scene.

9. Relationship with GO and other social agencies working for change but using other approaches to the development perspective.

10. Working out all concepts of alternative health care services.
- Unity on how to attain - content
- components

11. Financing scheme to sustain our program and projects.

RECOMMENDATIONS

1. Always review program orientation and formulate stresses and implementing guidelines after every program assessment/ evaluation.

2. Prepare specific guidelines and concept papers needed for implementation of projects/activities to ensure concrete program output.

3. Conduct community diagnosis (CDx) and use this as a basis for planning and adapting to community conditions.

4. Review the role and functions of community health workers (CHWs) in the program. CHW skills should be assessed and evaluated .

5. Review the orientation and functions of CHW organizations.

6. Integrate and stress on preventive and promotive health care in all aspects of program activities and planning.

7. Review curriculum designs based on the levels of health care services.

8. Study and develop health services work at different levels and define the types of services needed for each level.

9. Study existing curriculum module and prepare separate curriculum and training modules for staff, CHWs and health professionals.

10. Develop health committee building concept as part of health organization building in CBHP areas.

11. Improve managerial and technical capability

- data gathering
- reporting must be improved
- develop management methods applicable to CBHPs

- improve follow-up of implementation of conference/consultation resolutions and plans

12. Develop popular education materials and ensure distribution up to community level.

13. Ensure that health work and GPO work are both smoothly implemented. Study the applicable orientation and methods in implementing health programs in unorganized areas.

14. Give attention to health sector organizing work and define role of HSO and apply this together with other aspects of CBHP work to be able to heighten other health professionals' involvement in CBHPs.

ORGANIZATIONAL MEETING

FLOW

I. Roll Call of New Members
II. Health Work
    A. Workshop
    B. Unity on Health Work
        1. Definition of HW
            - Principles of HW
            - Scope of HW
        2. Role of CBHP's
III. Resolutions
    A. Identification of Stresses and Priorities
    B. Plans
IV. Amendments
V. Elections

ROLL CALL OF NEW MEMBERS

Sr. Eva Varon announced the new member programs and individuals, as approved by the Board and affirmed by the General Assembly. She as well announced those whose applications for membership are still pending for deliveration by the BOT. They are as follows:

A. New members and affiliates of the CHD as approved by the Board of Trustees on January 10, 1991:

    1. Mining Community Development Center (MCDC), affiliate member

    2. Kaisahan Ng Mga Programa Sa Pagpapaunlad Ng Kabuuang-Pagkatao (KAPPAG), affiliate member

3. Paranaque Development Foundation, Inc. (PDFI), affiliate member

4. Saluri at Ayat Ragsak, Anus Naanep nga Agserbi Iti Iyawat ti Ken Maysa (SARANAY) - (Health, Love, Joy, Patience and Perseverance), regular member

5. Programa sa Pag-oorganisa at Pangkalusugan sa Sitio Ruhat (POPSIR), regular member

6. Butuan Socio-Medical Services (BSMS), regular member

7. Formation Mission Team (FMT), regular member

B. Programs endorsed by the Board but membership approval are still pending for processing.

1. MAI Welfare and Development Foundation

2. Mindoro Institute for Development (MIND)

3. Agustinian Missionaries of the Philippines Health Integrated Response (AMPHIRE)

C. Individual Members

1. Marie Therese Burgos
2. Sr. Gloria Coquia, FMM
3. Pearl Domingo
4. Sr. Mary Grenough, MM
5. Luz Pambid Dones

WORKSHOP: HEALTH WORK

Group I	Sr. Eva	Tess A.
	Violy	Patrick
	Adette	Bro. Recto
	Vicky	Gemma
	Petty	Sr. Vene
	Angie	
Group II	Sr. Mayang	Emy
	Tess B.	Janet
	Tita	Tata
	Tess U.	Glo N.
	Paz	Sr. Eliza
	Lina O.	

Group III	Sr. Oyie	Rocky
	Chandu	Neneng
	Cora	Dennis
	Elena	Yam
	Hershie	Sr. Willy
	Glo V.	
Group IV	Jessie	Emmaline
	Doms	Badette
	Anne	Isay
	Cel	Gina
	Lina M.	Vangie
	Nitz	

WORKSHOP GUIDE QUESTIONS ON HEALTH WORK:

1. In the context of the national situation and over-all development work, describe the over-all health work.

   a. What are the guiding principles?
   b. Define its coverage scope.
   c. How will it be implemented?

2. What is the role of CBHP's in the over-all health work?

Workshop Results by Groups (see Appendix C)

PLENARY OF WORKSHOP

Each group presented their workshop result. Only clarifications, as to meanings of statements and the like, were allowed. No critique on the content of each report was made to avoid the other groups from presenting their own outputs.

Important points raised in the plenary regarding setting-up of an alternative health care system (AHCS):

1. Details on how to set-up an AHCS should be tabled as a separate major agenda.

2. A bigger body should discuss and conceptualize AHCS in another venue.

3. Setting-up of AHCS is not part of HW and by experience, CBHP is also part of assisting in its setting-up.

ORGANIZATIONAL MATTERS

DAY 7

16 January 1991
Wednesday

DAY 7

Facilitator of the Day - Dr. Jojo Carabeo

SCHEDULE:

8:00	-	8:15	Morning Praise
8:15	-	12:00	Workshop Synthesis: Health Work
12:00	-	1:30	Lunch
1:30	-	4:00	Continuation of Workshop Synthesis
4:30	-	5:45	Resolutions
5:45	-	6:00	Organizational Structure
6:00	-	6:30	Implementing Guidelines
6:30	-	6:45	Amendments to the Constitutions
6:45	-	7:15	Elections

SYNTHESIS: WORKSHOP ON HEALTH WORK

Tess Umipig, M.D.
Member, Steering Committee

HEALTH WORK IN THE CONTEXT OF THE PRESENT SITUATION AND DEVELOPMENT WORK

DEFINITION:

Health work (HW) is the process of setting up structures and systems to empower the PDOE to answer their health needs in their struggle for genuine people's development. This entails provision of services and mobilization of the sector and people.

PRINCIPLES:

1. HW is an integral of development work because health and development are interrelated. A healthy citizenry is attainable only in a developed society where people can realize their productive capacity.

2. HW is biased towards the PDOE, working people's empowerment towards social transformation.
   - democratic
   - in close coordination with POs
   - with full people's participation

3. HW should be creative, innovative, scientific (theory-practice-theory), and at the same time, culturally sound, with appropriate technology, e.g., traditional medicine.

4. HW is a responsibility of all sectors, as health is a basic human right.

PREMISES:

1. Nature and extent of HW based on the level of organization of the area.

2. The health sector (HS) plays a key role in HW.

3. The health sector is done in close coordination with other social institution/NGOs and POs working towards social transformation.

MAIN CONCERN:

To assist in developing, strengthening and popularizing the AHCS (qualities: democratic, active people's participation, nationalistic, relevant to present situation) in the present context of people's popular struggle.

SCOPE/AREAS OF HEALTH WORK:

1. HEALTH HUMAN RESOURCE DEVELOPMENT (HHRD)
   - Holistic development (SKA, programmed) of:
     a. formal health sector:
        i health professionals
        ii allied professionals/institutions workers
        iii students
     b. CHWs includes workers or trained by other organizations/groups
     c. Traditional healers

   Strategies/Methods:
   - exposures
   - exchange programs
   - programmed training / education (Community-based, learner-centered, reality - oriented, dialogical in process)
   - reflection sessions
   - direct involvement in HW (OJT)

   * The priority group for HHRD is the health sector because it plays a major/key role in AHCS

2. PROVISIONS OF COMPREHENSIVE HEALTH SERVICES

   - nature: promotive, preventive, curative, rehabilitative
   - level: basic, advanced (please, refer to prepared comprehensive health services handout included in kits)
   - type: health and health-related

Strategies/Methods:
- actual delivery
- facilitation and referral
- networking
- health education
- health campaigns

* The level of organizing/organization determine the nature, level and type of services provided.

3. SETTING UP OF APPROPRIATE STRUCTURES
   a. Organizational: HC building
      CHW organizing
      CBHP building
      HS organizing
   b. Physical: health center, field clinics, hospitals, offices
   c. Educational Structure/Resource Center

   Strategies/Methods: setting-up/accessing

4. FINANCE AND RESOURCE GENERATION
   a. Local:
      - IGP's/fund raising project
      - Community health insurance scheme (for further study)
      - Coordination with other NGO's
   b. Foreign:
      - "twinning" - people to people relation, similar to sponsor-approach example:
        1. an overseas Filipino organization to support to CBHP
        2. School outreach program to be done in CBHP areas
        3. Sister congregation to support it Philippine counterpart/congregation
           - project proposals
           - availing overseas - development assistance (ODA) (still a pending question for various reasons)

Strategies/Methods: Additional insight centralized procurement of material resources (e.g., drugs, supplies, equipments, etc.)

5. ADVOCACY
   - Critique of present HCS and promotion of the AHCS
   - Direction:
     a. services
     b. broad political movement
     c. mobilization on sectoral and subsectoral issues
     d. resource generation

Strategies/Methods:
- fora, symposia
- petition-signing, statements
- exposures
- mass media
- cultural forms

6. INTERNATIONAL RELATIONS WORK (IRW)
- Direction: a. resource generation includes human/material/moral
  b. mutual development and cooperation in all aspects of HW which also includes political support and sharing of relevant experiences

After the big group discussion on the role of CBHP, the synthesis committee has come up with the following 13 points / tasks of CBHP's in the over-all HW:

1. All-sided development of the staff and CHWs to fulfill their tasks in responding to the health needs of the community.

2. Setting-up of a barangay health committee/center.

3. Provision of comprehensive health care services with the barangay as basis level.

4. Setting-up of appropriate health structure for regular and sustained health services, e.g., clinics.

5. Mobilizing the formal health sector to render services to the community.

6. Setting-up of a referral system (primary to tertiary).

7. Conducting systematic CDx and continuous needs analysis as basic for services and trainings.

8. Conducting simple reseraches and documentations of community health experiences to raise them in a higher theory.

9. Critique of present health care system and popularization of the alternative health care system.

10. Supporting people's mobilizations (technical, human, financial, moral)

11. Drawing up systems of financing to sustain the people's program.

12. Fostering international relations work.

13. Coordination of efforts with other NGO's working for social transformation and CBHP's on local, regional, and national levels.

RESOLUTIONS IN THE CHD SECOND GENERAL ASSEMBLY

The following resolutions have been agreed upon by the General Assembly. The first six resolutions plus the 13th resolution have been considered as stresses by the body. The no. 11 resolution will be implemented by the health programs in the National Capital Region.

1. Develop comprehensive Health Care Services (HCS) based on the level of Community Organizing.

   a. level of people's organizing efforts - type of services per level
   b. health organizational structure
   c. methodologies for rendering services

2. Clarify the role of CBHP in community organizing.

3. Develop CHW capacity in terms of:

   a. grasp/understanding of orientation
   b. clarification of roles and functions
   c. Knowledge, Skills and Attitude (KSA) assessment
   d. forms of support: accreditation, welfare and CHW organization
   e. special study: Profile of CHWs - c/o National Secretariat

4. Develop the concept of Barangay Health Committee (BHC)

   a. definition
   b. role/Tasks
   c. formation/setting up BHC

5. Concepts of Health Sector Organizing (HSO)

   a. role of CBHP in HSO
   b. direction, strategies and methodologies of HSO

6. On training

   a. Review curriculum design based on level of HCS organization.
   b. Develop curriculum organizing KSA for staff, CHW, community health education.

c. Develop monitoring scheme for training.
d. Combine/balance curative/preventive, theoretical/practice, technical/comprehensive.
e. Develop tools/guidelines in evaluation of KSA (staff and CHW).
f. Develop popular education materials.

7. Community Diagnosis (CDx)

a. Conduct CDx and utilize result as basis for planning
b. Upgrade skills on CDx - analysis of data form.
c. Review CDx tools and instruments used.

8. Formulate health agenda as part of people's agenda.

a. Clarify and unite critique of present Health Care System.
b. Fully conceptualize the Alternative Health Care System (AHCS).
c. Project health issues.

9. Improve Managerial and technical capability.

a. data gathering
b. reporting
c. management methods applicable to CBHPs
d. follow-up of implementation of conference / consultation resolutions and plans
e. preparation of specific guidelines and concept papers needed for implementation of projects/activities to ensure concrete program output

10. Study the optimum ratio of health personnel to population and levels of Health Care (HC).

11. Sum up the experiences of CBHP implementation in urban areas to identify proper orientation and methods.

12. Economic support system.

a. Study appropriate insurance scheme pilot.
b. Develop a health financing scheme.

13. Coordination

a. Clarify and formulate guidelines in relationship with GO and other NGOs.
b. Strengthen coordination of consortium members.
c. Facilitate close coordination among development groups in a given area towards integrated area development.

The body agreed to assign regions to develop concept papers based on the resolutions stressed. Drafts of the concept papers called for shall be made by regions assigned as follows:

Mindanao	- priority resolution	#1
Cagayan Valley	- " "	#2
Visayas	- " "	#3
Cordillera	- " "	#4
Bicol	- " "	#5
Southern Tagalog	- " "	#6
Central Luzon	- " "	#13
N C R *	- secondary resolution	#11

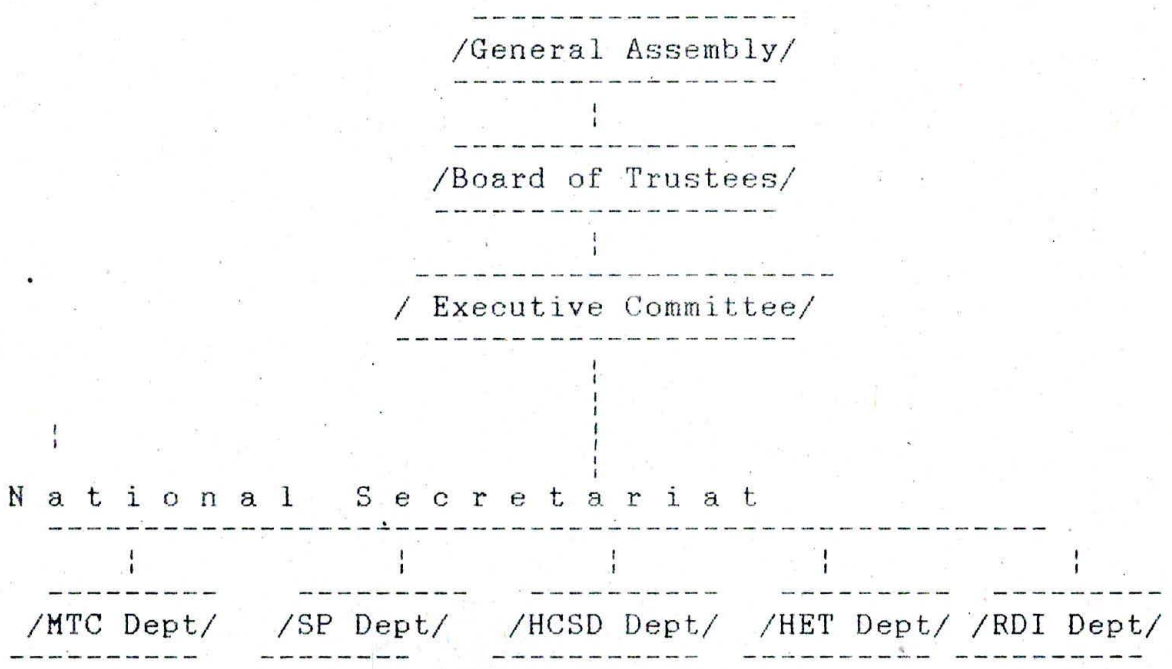
Concept papers shall be submitted to the National Secretariat during the Board of Trustees meeting. These should include implementing guidelines. Regions may contact the National Secretariat for references needed.

ORGANIZATIONAL STRUCTURE, DEPARTMENTS AND DEPARTMENT FUNCTIONS OF THE NATIONAL SECRETARIAT

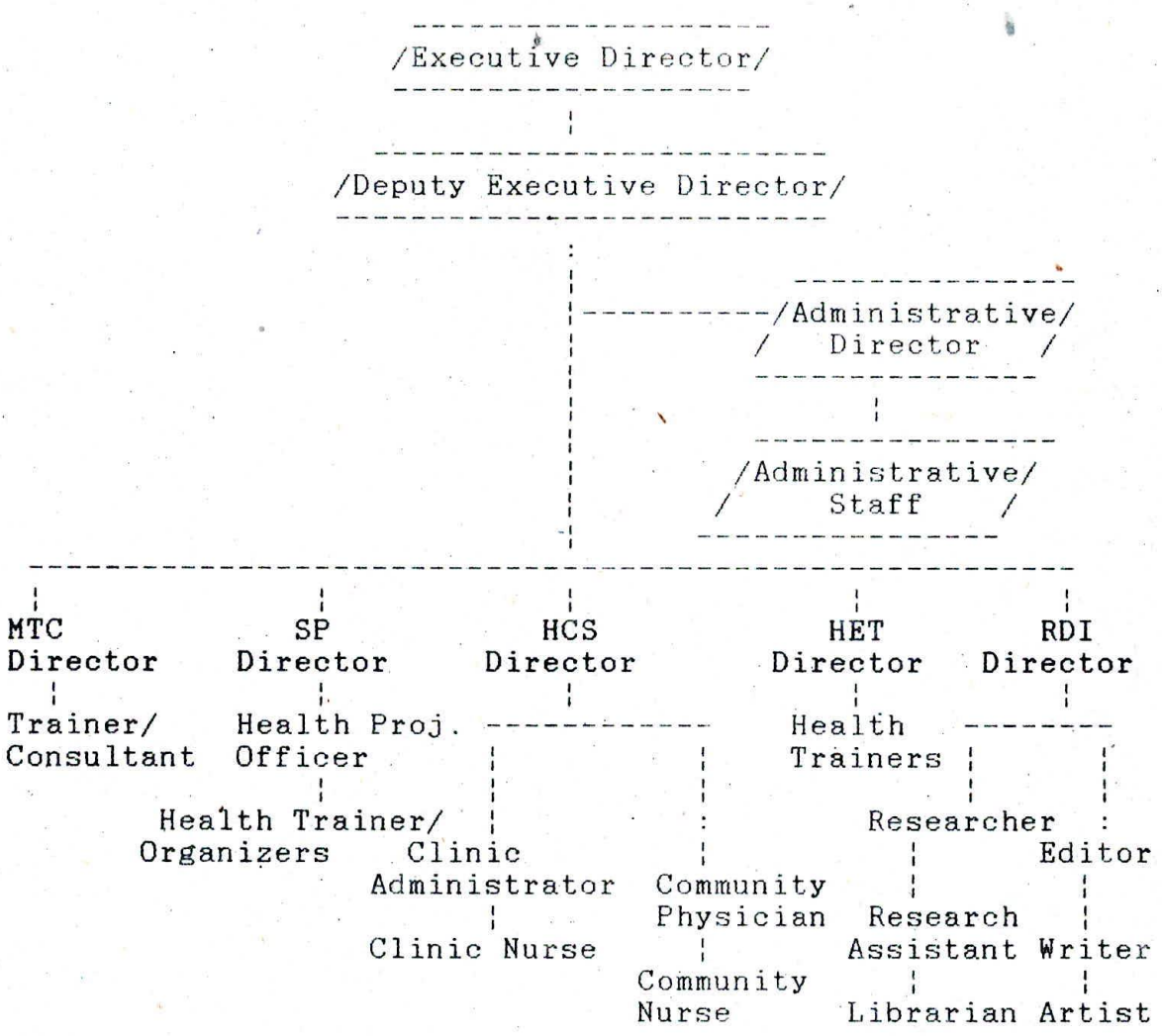
Len Barcelon presented the Board of Trustees' proposed changes in the consortuim, national secretariat departments and functions. The General Assembly ratified these changes:

Organizational Structure

A. Structure of the Consortium



The CHD National Secretariat



B. The Departments of the National Secretariat

1. Management Training and Consultancy (MTC)
2. Special Projects (SP)
3. Health Care Services (HCS)
4. Health Education and Training (HET)
5. Research, Documentation, and Information (RDI)

The Functions of the Different Departments of the National Secretariat

In line with its assistance function, the National Secretariat shall have the following departments with their corresponding functions:

A. Management Training and Consultancy

1. Help upgrade the management and operational capability of the members of the consortium by:
   a. conducting management training
   b. providing assistance regarding program PIME
   c. conducting organizational diagnosis and recommending appropriate interventions.

2. Provide consultancy services to the members and affiliates regarding:
   a. General NGO Management
   b. Health Program Management and Implementation.

3. Assist local programs and people's organizations in the conceptualization of new health programs and projects.

4. Assist in setting the direction of CBHPs (strategy formulation). Help unify programs on the direction and orientation of CBHP Work in relation to the current situation.

5. Hold regular consultations with people's organizations regarding the status of health work.

6. Provide technical assistance in health project development (project analysis and evaluation).

B. Special Projects

1. Plan and supervise implementation of breakthrough programs and/or projects based on needs.
   a. Supervise implementation of the Moro Health Program.
   b. Implement special health projects: Leprosy and Malaria Care Projects.

2. Supervise implementation of the NCR-Urban Health Program.

3. Develop and pilot implementation of a cooperative health insurance scheme for NGOs.

C. Health Care Services

1. Assist in the development of additional relevant and timely health care services of the CBHPs.

2. Maintain a regular clinic to include the following services: Medical Consultation, Pharmacy with the Basic Drugs, Maternal and Child Health, Psychological Rehabilitation, and Referrals.

3. Establish a referral network for patients of CBHPs who need secondary and tertiary levels of care.

4. Provide health relief services to organized groups/sectors during epidemics and natural or manmade calamities.

5. Launch surgical, dental, and medical missions to organized areas covered by the program.

6. Supervise implementation of the Immunization and Tuberculosis Care Programs.

7. Gather necessary resources (human and material resources) for health care services of the CHD.

D. Health Education and Training

1. Develop and upgrade the capacity of CBHP personnel/staff/trainers on the national, interregional, and regional levels by:
   a. conducting Trainers' Training
      - Basic and Special Trainers' Training
   b. conducting Health Skills Training
      - ADHST and Basic HST Trainers' Training

2. Provide continuing education and professional development (SDS/Value Formation) to CBHP staff and advocates.

3. Develop and popularize appropriate and relevant training curricula, methodologies, training aids, and materials.

4. Coordinate CBHP training work and monitor implementation of training thrust and stresses set by the General Assembly.

5. Conduct Basic Health Orientation seminars in schools, institutions, and other groups who are interested in CBHP Work (Advocacy Work).

E. Research, Documentation, and Information

1. Document experiences and breakthroughs in CBHP work.

2. Work out research designs and protocols and conduct research on health and related matters.

3. Take charge of public information regarding CBHP work.

4. Popularize existing studies through a regular publication, manuscripts, manuals, and readings.

5. Publish a regular publication that reflects the experiences and aspirations of the CBHPs and individual members.

6. Publish pertinent and timely statements and declarations on relevant issues in health and development.

7. Take charge of the databank and library.

IMPLEMENTING GUIDELINES of the Council for Health and Development

The body deliberated on the proposed implementing guidelines and after some changes, ratified them.

The following are the ratified CHD implementing guidelines (changes are in bold type).

I. Membership

A. Process, criteria, voting rights, collection of membership fee

1. All convenors will be founding members of the consortium and may exercise full rights as member programs or institutions or individual members.

2. Criteria for New Members
   a. For program or institutional membership, a recommendation from the Regional Body (RB)
   b. For individual membership, recommendation from CBHP or individual member
   c. For affiliate membership, a recommendation from the RB

3. Process
   a. Application for membership has to be recommended by the RB or by two (2) consortium members in good standing.
   b. The RB will forward their positive or negative advice to the Secretary of the Corporation.
   c. The Secretary shall properly submit the same to the BOT for approval and/or confirmation.
   d. The application will become official during the meeting of the GA.

4. Voting rights
   a. Each member program/institution shall be entitled to two (2) votes.
   b. Each individual member shall be entitled to one (1) vote.
   c. Each member of the Board of Trustees (BOT) shall be entitled to one (1) vote during BOT meetings.

5. Collection of membership dues and fees
   a. Upon approval of BOT, new members shall pay the corresponding membership fee:

institution/program	P500.
individual	100.

   b. Members shall pay yearly dues - deadline: end of January.

institution	P500.
programs	200.
individual	50.

   c. Affiliates shall pay the same rates as full members.

B. Termination

C. Registration

II. Conduct of Elections

A. General Assembly

1. The General Assembly mandates the regional representatives to form a caucus and elect their members to the Board of Trustees.

2. Individual members are nominated from the floor and elected at large by secret ballot.

No individual or representative of any regional body, program or institution can be elected to the Board of Trustees unless he/she is present during the elections held in the General Assembly, or unless there are valid reasons for the absence, and the representative has expressed willingness to be elected in absentia.

In succeeding General Assemblies, an individual or representative of any regional body, program, or institution cannot be elected to the Board of Trustees if he/she is not present throughout the period of the General Assembly.

3. Representation to the Board of Trustees

The body approved the following breakdown of regional representation in the Board of Trustees:

Cordillera	- 1 representative
Cagayan Valley	- 1 representative
Central Luzon	- 1 representative
Southern Tagalog	- 1 representative
Bicol	- 1 representative
Visayas	- 2 representatives
Mindanao	- 4 representatives
Individuals	- 3

Executive Director of the National Secretariat

Total of 15 BOT members.

B. Election of Officers of the Board of Trustees

1. Election of BOT officers shall be done during the BOT meeting.

2. Positions in the Board of Trustees are the following:
   * Chairperson
   * Vice-Chairperson
   * Secretary
   * Treasurer
   * PRO

The definition and formulation of the roles and functions of the Board Officers shall be the responsibility of the Board of Trustees.

III. Relationship of the National Secretariat to Programs, Regional Bodies and other Institutions and vice versa.

The General Assembly agreed on the following guidelines:

A. National Secretariat --(to)--> Regional Body --(to)--> CBHP

1. In line with Stress/Calls which have been decided during the General Assembly, the National Secretariat (NS) can communicate directly with the CBHPs but has to inform the RBs regarding these.

2. For major activities such as trainings and services to be launched between Assemblies, the National Secretariat must consult with the Regional Bodies to synchronize these activities.

B. CBHP --(to)--> Regional Body --(to)--> National Secretariat

1. For Normal Operations --

The Regional Body is consulted by the CBHP about the request. The RB has the responsibilities of facilitating and updating the National Secretariat.

2. Emergency Cases: trouble shooting, security matters, administrative matters and relief emergencies --

The CBHP can go directly to the NS but it should still inform the RB.

With the Regional Body properly informed, the National Secretariat can go directly to the local programs with or without an emergency situation.

to
C. Other Institutions ---> National Secretariat -
to
---> CBHP

Other health institutions (such as MAG, CIHC, NEHCC-NCCP, HAIN, PYHP, IACHS, BUKAS, AHW) must coordinate with the National Secretariat who in turn will consult the programs.

AMENDMENT TO THE CONSTITUTION

The following amendment was ratified by the body:

Article V

Section 10: Members of the Board of Trustees may be represented by proxy only by another member of the board and only during meetings of the Board but not during the General Assembly.

BOARD OF TRUSTEES ELECTIONS

A. Roll Call of Voters

The facilitator called the roll of voters and reiterated the rules for voting:
- the vote of each program will be counted as two votes
- each individual member will have one Vote.

The body will break up into regions to select their representatives to the Board of Trustees (BOT). Three individual members to the BOT shall be elected by the body.

B. Elections

The following are the new regional representatives to the Board of Trustees:

1. Cordillera - Chandu Claver, M.D
2. Cagayan Valley - Tita Rillorta, R.N.
3. Central Luzon - Patrick Chuidian
4. Southern Tagalog - Eulalia Utrera, M.D.
5. Bicol - Bernadette Abiso
6. Visayas - Alice Labado, R.N.
7. Mindanao - Ann Kadile, R.N.

The General Assembly elected the following individual members to the Board of Trustees (BOT) who garnered the following number of votes:

CANDIDATE	VOTES
Sr. Mary Ann Grenough, MM	52
Sr. Eva Varon, SCMM	38
Ruben Caragay, M.D	39
Marie Therese Burgos, M.D.	38

Special Resolution

Because of the tie in the number of votes for Sr. Eva Varon and Dr. Therese Burgos, (both third placers), the Assembly passed a special resolution to include both candidates in the Board of Trustees.

The representatives from Mindanao agreed that one of the slots for Mindanao be allotted to an individual member of the consortuim (Mindanao is allowed 4 slots in the BOT).

CLOSING REMARKS

Sr. Mayang, one of the newly elected Board members of the consortium gave a short message to the general assembly. She expressed her happiness in becoming a part again of CBHP. Her encouraging words to the General Assembly were to ORGANIZE... GO BACK TO YOUR AREAS AND ORGANIZE...

APPENDICES

APPENDIX A

LIST OF HANDOUTS

A. Publications/Newsletters

1. Pulso ng Bayan: Educational Series No 43-44, July-August 1990
2. Pulso ng Bayan: Educational Series No 45 September 1990
3. Development Monitor: Issue 3 December 1990 Council for People's Development
4. Agrarian Reform Monitor: December 1990 (CPAR)
5. Agrarian Reform Monitor: October 1990
6. Progress Notes: May - June 1989
7. Progress Notes: July 1989
8. Progress Notes: February 1990
9. Progress Notes: March - April 1990
10. Progress Notes: June - July 1990
11. TAMBALAN: October - December 1989
12. ARI News: August 1990, Issue No. 17

B. Readings on the National/International Situation

1. Batas na Nagtatatag ng Programang Repormang Agraryo ng Sambayanan at nagtatakda ng mekanismo sa pagpapatupad nito - Congress for a People's Agrarian Reform (CPAR)
2. Vital Signs: A Brief Survey of Crisis of 1990 - Newstep
3. Assessment of the Second Year of Republic Act 6657 - CPAR
4. What Arabs know and you don't -Eqbal Ahmad: Philippine Daily Inquirer, January 12, 1991
5. Langis, Bala at ang Krisis sa Gitnang Silangan: Implikasyon sa Pilipinas: Prof. Roland G. Simbulan
6. On the Middle East Situation's Effect on the Philippines: Food for All Coalition (FFAC) January 12, 1991
7. An Open Letter to Our Fellow Members in the Health Sector: BUKAS

C. Readings on Development Work

1. Earth Day Objectives - Foundation Bulletin October 1990
2. Networking: One of the New Directions Transforming our Lives: John Naisbitt
3. Appropriate Technology as Ideology: Michael Tan

4. Strategies and Mechanisms for Empowerment of People in the Rural Sector: Horacio Morales, Jr.
5. The Limits and Possibilities of Philippine NGOs in Development - Karina Constantino-David from: Lambatlaya National Conference on Networking in the 90's: Affirming Commitment to the Decade of Nationalism; November 22-24, 1990, University of the Philippines, Diliman, Quezon City
6. What Ought a Network be? Ponciano L. Bennagen
7. Stepping in the Paddy: Jose F. Bartolome
8. Networking: One of true New Directions Transforming our Lives: John Naisbitt

D. Readings on Protocol 2

1. 1977 Geneva Protocol II Additional to the Geneva Conventions of 12 August 1949, and relating to the Protection of victims of Non-International Armed Conflicts
2. The Human Right to Participate in Armed Revolution and Related Forms of Social Violence; Testing the Limits of Permissibility: Jordan J. Paust
3. Rights and Duties of Medical Personnel in Times of Armed Conflict - Center for International Humanitarian Legal Studies

E. CHD Draft Concept Papers

1. How to conduct a successful medical/surgical mission
2. Managing a Botika ng Barangay
3. Refugee Health Care
4. Concept Paper on Community Clinic
5. Concept Paper on Emergency Services

F. CHD Forms

1. Program Profile Form
2. Council for Health and Development (CHD) General Assembly: January 10-16, 1991 - Guidelines for Reporting
3. Activity Report Form

G. CHD 2nd General Assembly Papers

1. Unities in the 1988 National CBHP Conference - November 26 - December 3, 1988, Baguio City
2. Working Paper No. 2 - Definition of Terms
3. Summary of Recommendations; Chapter 5, Page 2
4. Health Education and Training Department's Library Book List
5. List of CHD Training Materials

H. Readings on CBHPs and Health Work

1. Are we ready for a Disaster? Mercedes B. Apilado
2. Ang Karanasan ng Medical Committee: Jess Fuentes
3. Health in Our Hands: Community Based Health Programs in the Philipppines: Ma. Sophia Lizares-Bodegon

I. Other Materials

1. Some Golden Rules for Good Time Management
2. Seven Basic Habits of Highly Effective People: Stephen R. Covey

APPENDIX B

LIST OF PARTICIPANTS

(Note: Names in bold type are CHD board members)

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(July 1989 - Jan.1990)

Chairperson	Ruben Caragay, M.D. UP College of Public Health
Vice-Chairperson	Sr. Eva Varon, SCMM Community Health Development Program Quirino and Nueva Viscaya (CHDP-QNV)
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APPENDIX C

GROUP REPORTS:
WORKSHOP ON HEALTH WORK

GROUP I

VISION: Change and Social Transformation

I. Health Work in the context of over-all development work and the present national situation:

The nation in crisis rooted in extreme poverty, relate it to the concept of empowerment, we facilitate this and make sure it is related to social transformation. We have to re-orient our approach because when we started as a health program, we did not have much impact so we became an integrated program.

- our health program in Negros started as health but expanded to IGP: mothers: CHW; fathers: IGP
- crises

  HEALTH WORK >
  ----------> -- Immediate needs
  DEVELOPMENT >

- lack of social services
- need for finance work/resourcing

A. Principles

1. Health as a basic human right and responsibility of all
2. Bias for the PDOES
3. People have the potential, they are change agents
4. Empowerment, confidence, participation
5. Geared towards self-reliance
6. Health work is an integral part of over-all development.

B. Scope/Coverage	Methods/Strategies
1. Resourcing - networking - human - material - financial	- IRW, IGP, coordinating, networking, education, training
2. Organizing	- HSO, health committee building, CO and all of above, mobilization and participation in struggle
3. Development and popularization of alternatives	- Research work on traditional medicine, appropriate technology, publication
4. Development of different levels of services based on the level of organizing	- Referrals, network, provision of appropriate facilities and resources
5. Advocacy	- Fora, symposia, petition - signing, statements, etc.

C. Methods/Strategies

1. active and full participation of the people
2. networking/coordinating
3. education

II. The role of the CBHP in Health Work
- initiator, catalyst, facilitator
- CBHP's carry the objectives of HW

GROUP II

I. Health Work in the context of the present national situation and over-all development work.

A. Principles

1. HW is by and for the PDOE; toward people's empowerment for social transformation, i.e. democratic, linked to the PO's, etc.

2. HW is a part of the comprehensive development of the region, nation, and world, taking into consideration the various cultures and levels of organization and development.

3. HW should be innovative/creative and scientific (theory-practice-theory) in process.

B. Scope

1. Health Human Resource Development (HHRD) including staff, CHW, and formal health sector.

2. Develop, strengthen, and popularize alternative health care system.

3. Comprehensive direct services.

4. Develop and ensure appropriate health and health related structures and services.

Example: - services directly related to health such as health centers/facilities.
- services indirectly related to health such as economic, agriculture, housing.

5. Develop and sustain financing scheme and resource generation.

6. Criticize and expose existing HCS particularly, its anti-people policies, priorities, decision-making process and apply pressure on the government (pressure politics)

7. International relations work based on mutual gains.

Note: HSO was not included in the scope, but it was considered as a given premise and can be used as a strategy to attain the scope given above.

C. Strategies/Methodologies
(With consideration of the levels of organizing.)

1. For Health Human Resource Development (HHRD)
- appropriate and relevant training and education (correct theory and practice)

Example: appropriate coordination and training of health and CO skills training and education (varies according to area)

2. For popularizing AHCS

a. Advocacy at all levels and major social institutions (scheme, government, church), including maximization and development of masa media and arts and cultures as forms for popularizing AHCS.

b. Setting-up and ensuring the functional health organizational structure to implement system.

Example: CHW organization and BHC

c. Enlarge coverage of effective and functional CBHP's.

d. Exchange of personnel, i.e., local and international sharing of experiences.

3. For comprehensive health services

a. promotive, preventive, curative and rehabilitation.

b. Basic services package, i.e., balancing or considering the level of organization of the community.

4. For building/setting-up of support structures with defined criteria depending on the level of organization of the community.

There must be indicators to ensure the utilization and maximization of facilities.

Example: Health Center/Clinic:
- stable program
- health committee capable of running the barangay health center
- stable PO

5. For financial scheme and resources generation.

a. Local
- IGPS, community health insurance
- services "fees"/donations
- coordinate with other NGO's

b. Foreign
- overseas development assistance (ODA) (through this in still in question)
- "twinning": exchange of technical know-how
- pledges such as "adopt a CHW"
- project proposals

II. The role of CBHP's in HW

A. Support and complement organizing work at the community level for social transformation (as part of integrated development not by ourselves)

B. Help in laying the foundation of setting-up of AHCS.

C. Serve as catalysts, initiators, change agents, prime movers, and liberating educators.

GROUP III

I. Health Work in the context fo the over-all development work and the present national situation.

A. Principles

1. HW must develop people's empowerment.

2. It must answer effectively the immediate needs of the people towards total human development.

3. It must serve the vast majority of the people, the PDOE and must serve as the venue in raising their level of social consciousness.

B. Scope/Coverage

1. Health services must be based on the capacity of the program.
   - capacity of the area
   - level of struggle

2. Training - continuous and systematic skills training and graded education towards the development (HHRD).

3. Organizing

```
          <Health     >          HSO
HW:--<                >--------CHW
     <Organizing>              People
```

4. Management: - organizational matters
   - financial matters

5. Advocacy: - issues
   - principles of HW
   - health policies

C. Methods/Strategies

1. For health services: primary, secondary and tertiary levels
   - giving emphasis on traditional medicine
   - using appropriate technology towards self-reliance
   - giving relevant services

2. For HHRD
   - needs assessment
   - planning
   - implementation
   - monitoring and evaluation

3. Organizing

   HSO: - referral networking towards services
        - programmed alliance building
        - broad health orientation

   CO - CHW
        - People's organization - make good the programming

* Define within the network the scope and limitation of the level of organizing to: organized and unorganized management must be:

- democratic and representative
- generating finances that do not depend on foreign funding

4. Advocacy
   - advocacy for AHCS

II. The role of CBHP's in HW

CBHP's are part of the over-all health work.

GROUP IV

I. Health Work in the context of the present national situation and over-all development work.

Vision: Health work must respond to the people's issues and must support in building of an alternative health care systems that is integated with community development.

A. Principles

1. Health is a social phenomenon. Therefore, it must be in the context of the people's struggle towards social transformation.

2. Health is a basic human right.

3. Health work must be an empowering undetaking - health in the hands of the people.

4. The principle of coordination/complimentation must be had with other health organizations and health advocates.

B. Scope

1. Services - must respond to the needs of the genuine people's organization (GPO's) and in the context of their struggle.

2. HSO - in two (2) levels (complimentation of HSO was not discussed):
   - community level
   - program level

3. Assistance in setting-up of an alternative health care system, in consultation with other socially oriented advocate NGO's.

C. Implementation

1. Community level
   - facilitation
   - direct services
   - transfer of skills
   - organizing (health sector and CHW)
   - support to people's issues
   - research and transfer of appropriate technology
   - generation of FTMS
   - health committee building as component of PO's organizational structure
   - linkages building

II. The role of CBHPs in HW

A. Research and development of appropriate technology
B. Health services and trainings
C. Venue for networking and HSO
D. Advancement of people's agenda
E. Assist in setting-up of alternative health care system

APPENDIX D

SUMASAATIN ANG ESPIRITU

I. Sumasaatin ang Espiritu ng Panginoon
Tayo'y hinirang niya upang tumugon
Sa daing ng mga aba at ihatid sa mga dukha
Ang magandang balita ng kaligtasan.

II. Sinugo tayo upang ipahayag
Ang kalayaan sa mga bihag
Bigyang paningin ang mga bulag, dalhin
ang nasa dilim sa may liwanag.

REPEAT STANZA I

III. Ang inaapi at mga sinisiil ay hahanguin
sa mga hilahil.
Ipapahayag ang pagsapit ngayon
Ang tanging pagliligtas ng Panginoon.

REPEAT STANZA II

BIBLE READING: Luke 5:17-26

Silent Reflection: 3 mins.

Closing Song: AMA NAMIN

ACTION SONG

Si Uncle Sam 2x namingwit sa Karagatan
nakakuha 2x, malaking kayamanan
Iniuwi 2x sa sariling bayan
ang bansang inaapi 2x
ngayon ay lumalaban.

ST. FRANCIS SONG

1. Lord, make me a channel of Your peace
When there is hatred let me bring Your love
Where there is injury, Your pardon Lord
Where there is doubt, true faith in You.

Refrain: Oh Master grant that I may never seek
So much to be consoled as to console
To be understood as to understand
To be loved as to love with all my soul.

2. Make me a channel of Your peace
Where there is despair in life let me bring hope
Where there is darkness only light
Where there is sadness ever joy.
(repeat refrain)

3. Make me a channel of Your peace
It is in pardoning that we are pardoned
In giving to all men that we receive
And in dying that we're born to eternal life.
(repeat refrain)

BUTTERFLY
(to the tune of Paru-Parong Bukid)

B-U-T-T-E-R-F-L-Y, butterfly

MAG-ISIP-ISIP

Mag-isip-isip, ng 1,2,3 (3x)
Sundan mo ako
ref.: Sundan (3x) ako
Sundan (3x) ako
Sundan (3x) ako
Ikaw naman dito

THE MUSICAL ROOT

Eat camote the musical root
The more you eat, the more you toot,
The more you foot, the better you feel
Eat camote the musical root.

HAGIT SA EBANGHELYO

I. Ang hagit sa ebanghelyo
Alang kanato, bigugwaon to
Ang atong ibig katawa, apan
Kon tinud-on ta ang pagserbisyo
Masubay tag kalbaryo
Sama sa atong Ginoo.

Chorus:
Dili sayon ang pagsunod kang Kristo
Daghang tunok ang dalan
Nga giagian mo
Bug-at ang Krus, nga pas-anon mo
Ug kamatayan, naa naghulat kanimo.

II. Si Kristo mismo nag-ingon
Sa mga tinun-an
Pagbantay kay panakpon
Kamong biay-biayon
Prisohon kamo, ug ang naa sa gahum
Hukman kamog silutan.

FATHER ABRAHAM
(Igorot Translation)

Si Amo'y Abraham
Pito nan anak na
Pito nan anak na
Wada nan an-ando
Wada nan ap-aptik
Makne-makneg de amin
Esa'y Lima, Duay Lima
Esa'y Siki, Duay Siki
Esa'y kimot, Duay Kimot
Esay ulo.