

Health Devolution, Civil Society Participation and Volunteerism: Political Opportunities and Constraints in the Philippines

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Paralleling the general decentralization trend in recent decades, health sector decentralization policies have been implemented on a broad scale throughout the developing world since the 1980s. Often in combination with health finance reform, decentralization has been touted as a key means of improving health sector performance and promoting social and economic development. (World Bank 1993) However, some preliminary empirical data indicate that results of health sector decentralization have been mixed, at best (Bossert, Beauvais and Bowser 2000: 1). In the case of the Philippines since 1992, health services began to be devolved under the 1991 Local Government Code (LGC) or Republic Act No. 7160. Some case studies have shown that beyond decentralization reform itself, civil society participation and volunteerism are crucial in improving health service delivery in the Philippines (Atienza 2003 & 2004). Moreover, civil society organizations have been instrumental in enhancing community participation in health service delivery. Non-government organizations (NGOs), people's organizations (POs) and socio-civic groups have the "capacity to mobilize communities for health-related activities" and social action, "generate resources", "and organize communities around health and development issues" (Batangan 2006: 105). As shown in several case studies in health service delivery, civil society groups and volunteers in the area of health are in the process of performing some of the democratizing roles mentioned by Diamond (1999: 218-260): effecting transition from clientelism to citizenship at the local level; recruiting and

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training new political leaders; disseminating information and therefore empowering people in the collective pursuit and defense of their interests and values; and strengthening the social foundations of democracy even when their activities focus on community development.

This paper discusses civil society participation and volunteerism in the context of health devolution in the Philippines. The author uses the concept of political opportunity (sometimes referred to as opportunity structure), which refers to consistent, though not necessarily formal or permanent, dimensions of the political environment that provide incentives for collective action by affecting people's expectations for success or failure (Gamson and Meyer 1996). The opposite situation would refer to political constraint. These dimensions are resources external to interest groups and movements. Most political opportunities and constraints are also situational, and cannot compensate for weaknesses in internal resources of the group (Tarrow 1998: 77). Thus, using the frame of political opportunity structures and constraints, this paper argues that the institutional environment, the public health system in general, as well as the current devolved set up themselves provide opportunities for civil society participation and volunteerism to thrive in health service delivery. However, there are also remaining constraints for civil society participation and volunteerism to fully grow in a devolved health system and contribute in the process of democratization and development. There may also be other opportunities available but for the time being, the paper will simply focus on the institutional environment, the public health system and the devolved set up as the immediate sources of opportunities and constraints.

The paper first traces the political opportunities and constraints for civil society participation and volunteerism before devolution in 1992. Then, there is an

analysis of the enabling factors for greater civil society participation and volunteerism at the national and local levels in the area of health service delivery since 1992. Embedded in the discussion are two examples of civil society participation and volunteerism in health service delivery at the local level. These are cases at the municipal level, the level of local government without much experience with direct health service delivery prior to devolution but now tasked to deliver primary health care. The two cases are areas where the author has done extensive field work as part of her dissertation which was finished in 2003. Also included are insights based on other cases she has come across in recent years. This empirical data will hopefully show the contributions and potentials of civil society and voluntary participation in health service delivery and development, if sufficient opportunities are available. Finally, the constraints for full civil society participation and higher volunteerism in the health sector since 1992 will also be discussed.

Opportunities and Constraints for Civil Society Participation in Health Service Delivery before Devolution

Community-based health programs (CBHPs) and participation of non-government sectors in health service delivery started way before devolution. This supports available literature worldwide showing that civil society has a long history of involvement in public health (Loewenson 2003). CBHP in the Philippines began to be implemented in the early sixties by independent practitioners affiliated with hospitals and clinics. These even included initiatives of the Philippine Rural Reconstruction Movement (PRRM), the oldest Philippine NGO and the largest rural development NGO in the country to date. But these efforts were limited in scope and did not reach national scale until CBHP was introduced in many parts of country by the Rural Missionaries of the Philippines in 1975. Afterwards, other church-based and secular

groups eventually adopted these early CBHP pilot programs. (Bautista 1999: 3) Other NGOs and POs also engaged in the primary health care approach using community organizing and empowerment. As of 2005, the CBHP has an organized network of 60 programs in different parts of the country. (Rebullida 2006: 128-129)

In the late seventies, the innovative strategy of CBHP, renamed primary health care (PHC), attained formal national significance. The Philippine government adopted PHC as its overall health management strategy in consonance with its commitment when it joined the Alma Ata Conference in 1978. In the conference, PHC was declared as essential health care made universally accessible to individuals and families in the community through means acceptable to them, through their full participation and at a cost that both the community and the country can afford (Bautista 1999: 1). PHC forms an integral part of the country's health system as well as overall social and economic development of the community. The adoption of the PHC as a national policy revolutionized the health delivery system and the government bureaucracy in general. This is because of the application of two major strategies. First, the participatory approach implies that community residents are active participants in the different phases of the management cycle. This was adopted under an administrative system that was still centralist and top-down in perspective. Second, inter-sectoral collaboration as an approach requires various institutions in health and other socioeconomic spheres to work together as a team for an integrated and consolidated perspective of development. At that time, this was an innovative strategy since the dominant mode was unitary, that is, services were delivered by field office staff of a sectoral department that catered to a particular area of specialization. With the PHC, the Department of Health (DOH) was the first national agency to propagate a participatory strategy nation-wide. (Bautista 1999: 2)

However, prior to devolution, the real essence of PHC had not been fully achieved, especially during the years of the strategy under the Marcos dictatorship (1972-1986). Prior to 1986, there was still very limited community involvement in the planning stage and project assessment. Nevertheless, there had been some progress. PHC was able to shift from a doctor-centered type to a community-oriented type with the harnessing of the involvement of voluntary workers, who came to be known as *barangay*² health workers (BHWs). Community residents also began to provide free labor and share resources for activities aimed at local development.

At the national level, after the downfall of Marcos in 1986, a major victory for health workers was the inclusion of health as a right in the 1987 Constitution. Through its Article XIII (Social Justice and Human Rights), sections 11 to 13, the 1987 Constitution became the first Philippine law to recognize health as a right. Hence, it is a significant legal landmark for health in the Philippines. In addition, Article II (Declaration of Principles and State Policies), Section 23 says that it is the policy of the state to encourage “non-governmental, community-based, or sectoral organizations that promote the welfare of the nation.” Thus, civil society participation is already enshrined in the fundamental law of the land.

With the assumption of Secretary Alfredo Bengzon of the leadership of the DOH in 1986, the department forged further partnerships with civil society. Under the Partnership for Community Health Development, the idea was not to change the role of government health workers but to upgrade the capabilities as well as mobilize other people, groups or sectors to partner with the DOH (Bautista 1999: 30-31). Some of the strategies include partnership building at the local government levels to support community-based efforts and initiatives of POs and the community as a whole, and

² The community or village level, known as *barangay*, is the smallest political unit in the Philippines.

building up the capacities of local government units (LGUs), the DOH, NGOs and POs for their various roles in partnership (Bautista 1999: 31).

Opportunities for Increased Participation of Civil Society and Volunteers in Health Service Delivery since Devolution in 1991

Legal Enabling Environment

While the 1987 Constitution formally recognizes the role of civil society, the biggest boost to formal civil society participation was the enactment of the 1991 LGC. The Code has features that set it apart from previous decentralization attempts in the country. It devolves the responsibility to deliver various basic services like health to local governments; transfers certain regulatory and licensing powers to local governments; increases the financial resources available to LGUs by broadening their taxing powers, providing them with a specific share from the national wealth exploited in their area, and increasing their automatic share from national taxes from 11% to 40%; encourages LGUs to be entrepreneurial; and most significantly, lays down the policy framework for the direct involvement of civil society, most especially NGOs and POs in the process of local governance. Civil society participation in local governance is done in several ways: (1) sectoral representation in local legislative councils; (2) the allocation of specific seats for NGO and PO representations in local special bodies like the local development council, the local health board, and the local school board; (3) participation in political exercises like plebiscite, referendum, and recall; and (4) involvement in the planning and implementation of development programs. These openings for civil society are meant to promote not only popular participation but also local accountability.

The public health system is the most affected sector within the national government. The LGC has triggered unprecedented far-reaching structural and

functional transformation. In terms of facilities, personnel and resources transferred from the national level to LGUs, the DOH has the biggest transfer in all these areas. In terms of the scope of facilities, health services and personnel involved (See Brillantes 1998: 44; Perez, et al.1995), the number of local governments participating and the high degree of authority being decentralized, the World Bank (1994: i) says that the Philippine experience stands out as one of the most ambitious health decentralization initiatives ever undertaken in Asia. In Bossert, Beauvais and Bowser's study (2000) comparing the Philippines with Ghana, Uganda and Zambia, the Philippine health reform gives the widest range of choice or decision space over many functions that were devolved to LGUs.

A large part of the devolved health services is borne by provinces and municipalities, the latter having no prior experience with health decentralization. Provincial governments are responsible for medical, hospital and support services. Municipal governments are mainly responsible for the administration of primary health care and other national programs' field services through the municipal health offices and corresponding rural health units (RHUs) and *barangay* health stations (BHSs). They are also responsible for ensuring constituents' access to secondary and tertiary care through vertical referrals. City governments are responsible for city health offices, city hospitals in highly urbanized cities (except the National Capitol Region), and corresponding RHUs and BHSs. In a sense, the involvement of cities in the devolution process is minimal due to the low level of DOH assets and staff devolved to them. Large highly urbanized cities in the Philippines are chartered and have administered and financed their own health systems for many years. *Barangay* governments are responsible for the maintenance of the facilities of the RHUs and the BHSs. As for the regional health offices, they continue to be an integral part of the

DOH structure, now with a focus on monitoring health policy implementation and LGU performance. Meanwhile, the DOH retained a number of key functions best carried out at the central level.

DOH Programs and Policies in Relation to Civil Society

In a study made by Clark (1998: 92-93), the DOH, together with the Department of Natural Resources and the Department of Agrarian Reform, was able to forge close links with NGOs since 1986. The first year of implementation of the Code coincided with a “new management” in DOH (Perez 1998:2). Then newly elected President Fidel Ramos signaled his support for devolution of health services in 1992 by appointing Juan Flavio, a rural physician who was very active in local countryside development, as Secretary of Health. He would be one of the prominent NGO leaders to be appointed to the Ramos cabinet, in keeping with the President’s strategy to establish formal links with the NGO community. Flavio was a former president of the PRRM and its sister organization, the International Institute for Rural Reconstruction. The DOH Secretary would then appoint as chief-of-staff Jaime Galvez Tan, a well-known advocate of CBHPs and then working with the United Nations Children’s Fund. Flavio also created a “kitchen cabinet” to help him devise policies on how to implement the LGC (Perez 1998: 2). This informal cabinet would be composed of the Secretary’s colleagues in the PRMM who had been involved in local development and were severe critics of the centralization besetting Filipino politics and bureaucracy. With the DOH, the “kitchen cabinet” formulated the DOH Reorganization Plan to make it more ready for devolution.

In the area of collaboration with NGOs, like other national departments, the DOH took advantage of the upsurge in the number of NGOs since 1986 by collaborating with the latter in order to implement government programs. In general,

the DOH had to rely on NGOs in the provision of health services. The DOH under Flavio Reyes and in alliance with LGUs, has sub-contracted the provisions of services such as training to NGOs. The reason for this is explained in the following sub-section.

Then, under the leadership of Secretary Alberto Romualdez, Jr., another doctor sympathetic to devolution, the DOH in 1999 introduced the Health Sector Reform Agenda on the premise that with devolution already a reality, the DOH had no choice but to assure its success. Health management had to be reformed and the approach had to be comprehensive. The thrust of the reform agenda is to establish *Sentrong Sigla* or DOH-certified “vitality centers” for health, and further, to progress into developing a locality that could acquire a *Health Passport* or *Sentrong Sigla Plus* status.

In addition, the *Tulong Sulong sa Kalusugan* (literally “helping move health forward”) which began in 2001 is a new strategy intended to support the reform agenda. The idea is to set up inter-local health zones (ILHZ) where the reforms in the agenda converge. The overall concept is the creation of an inter-local health system by clustering municipalities. Each ILHZ has a defined population with a defined geographical area comprising a central or core referral hospital and a number of primary level facilities such as the RHUs and the BHSs. The concept is inclusive of all stakeholders and sectors involved in the delivery of health services or health promotion. (DOH 2002: v) Through the ILHZ, NGOs and POs can become members of the health boards that are the policy-making bodies of the local health systems. In addition, community health workers (volunteers included) and community members are also key players in the ILHZ. NGOs and church-based groups, together with various government health institutions, can train these volunteer health workers and community people.

The above data coincide with the *Rapid Field Appraisal* (RFA), a program pioneered by the United States Agency for International Development to track the pace and direction of the Philippine government's decentralization agenda. The RFA singled out the DOH together with the Department of Agriculture as examples of national government agencies that have introduced participatory modes of planning in their programs. In particular, both of the agencies were cited for their efforts to strengthen and restructure their respective regional offices to become more facilitative rather than supervisory of local objectives—signs of a strong commitment to the decentralization process. (RFA 1999: 4-6)

Financial and Human Resource Constraints of the Formal National and Local Health System

The DOH has to rely on civil society, NGOs especially, in the provision of health services because of serious resource constraints of the public health system. The first constraint is in the area of financial resources. The DOH gets its budget from the financial allocation from the national budget, possibly supplemented by congressional allocations and foreign funding. Based on Department of Budget and Management data, the total national budgetary allocation for health increased through the years but the allocation as percentage of the total national budget declined slowly during the devolution years. The average for 1989 to 1991 was 3.4% but the average for 1992 to 2001 was 2.6% (Bautista et al. 2002: 14). Public health expenditure as percentage of GDP in 2002 was only 1.1%, low when compared with other Asian countries (UNDP 2005).

Financial support for the LGUs originates from the Internal Revenue Allotment (IRA) but LGUs can raise revenues through local taxes, fees and other schemes enumerated in the 1991 LGC. But there are complaints that the IRA allocation formula leaves provinces and municipalities at the losing end. Both levels

of LGUs combined received 57% of the revenue transfers but shoulder 92.5% of the cost of devolved functions, including health, while cities and *barangays* bear only 7.5% of the cost of devolution but receive 43% of IRA. Thus, provinces and municipalities complain that their budget is inadequate to fulfill health and other responsibilities devolved to them.

Several important localized facts must be considered in the discussion of adequacy of budget for health. First, there are LGUs, particularly municipalities, that are simply too poor to assume all its health responsibilities even if they wanted to. Second, even if an LGU has sufficient budget, local chief executives and officials may not prioritize health. Finally, there may be a large allocation for health but people in the locality may be too many for the budget to be adequate. For example, a poor rural municipality like Irosin noted for its successful participatory health programs only spent roughly P90.31 (about US\$2) per constituent based on its 2000 health budget and population. Meanwhile, a high-income, heavily-populated municipality like Baliuag with *Sentrong Sigla*-certified health facilities, roughly spent P83.93 per constituent based on its 2000 budget and population. (Atienza 2003: 201-240)

The second set of constraints refers to human resources. In 2002, the most number of personnel devolved to LGUs was the midwife; the ratio to the population is 1:4,808, close to the benchmark ratio of 1:5,000. The ratio of nurses to population in 2002 was 1:16,844, better than the benchmark of 1:20,000. (DOH 2002a) But public doctors and dentists are few. They are burdened with an average of 1:26,317 and 1:42,493, respectively, in 2002. The benchmark ratio is 1:20,000. (DOH 2002a) According to World Health Organization statistics, the ratios of doctors and nurses per 1,000 population in the country are 0.58 and 1.69 respectively, which are much lower than the world's average figures of 1.23 and 2.56 (WHO 2007: 60, 62). Carlos

and Sato (2008: 28) also cited some newspaper accounts that reported the closing of several hospitals due to shortage of health workers.

In particular, the DOH has problems recruiting young doctors to serve in the rural areas. This is because of very low government pay and the fact that doctors, mostly from urban areas and educated at great cost, usually opt for lucrative private practice in urban areas or even abroad. In 1993, Secretary Flavio offered incentives for young doctors to go to the *barrios* (local communities) through the Doctors to the Barrios Program with a salary roughly equivalent to the salary of an urban-based professional. But the DOH experienced further problems despite the new policy with the decentralization of its budget. Thus, most doctors in rural areas received only a quarter of the original amount (Clark 1998: 92). With devolution, doctors had additional apprehensions—possible interventions of local chief executives in appointments and promotions, lower chances of being promoted to regional and national offices, and non-payment of benefits under the Magna Carta for Health Workers as a result of the non-prioritization of health or lack of adequate budget for health personnel. With the remaining doctors serving in rural areas overburdened, NGOs have supplemented doctors' salaries by as much as 300% of the government salary (Clark 1998: 93) or provided equipment and medicine.

Another worrying trend for the public health care system is the exodus of health professionals abroad. The Philippines is considered a major supplier of health professionals, particularly nurses, abroad. It has been estimated that from 1992 to 2003, Filipino health human resources working abroad are close to being 97,000 of which more than 86,000 are nurses. Deployment of Filipino nurses has also experienced rapid increase in recent years. According to the World Health Organization, the country is the largest global exporter of registered nurses. (Kraft

2006: 30-31) Tigno's sources (2006: 69-70) say that more than 70 percent of the 7,000 nursing graduates every year leave the Philippines despite the existence of an estimated 30,000 unfulfilled nursing positions in the country.

While there are numerous adverse effects of out-migration of health professionals, let us zero in on its impact on the public health system. According to Kraft (2006: 31), outflows of health professionals may lead to (1) a reduction in the pool of skilled health workers, (2) a depletion of trained medical staff, and (3) increased turnover of personnel. In turn, these effects can affect health service delivery at the frontline and "may have implications on the sustainability and quality of health programs in the community". Of course, the real impact of migration on the health system is dependent on whether the exodus of health professionals results in real shortages. According to labor officials, enough medical professionals are being produced by the educational system to supply local needs despite labor exports to richer countries. However, data on health human resources in the country is "sadly inadequate" to actually gauge the net impacts of migration on the health system (Kraft 2006: 31, 32).

Despite the absence of more accurate data about demand and supply for health professionals at all levels of the public health care system, it is clear that with possible staffing problems particularly in rural areas (most health professionals are concentrated in urban areas), utilization of substitute health care providers for tasks usually performed by health care professionals who usually migrate is necessary. Some options include: (1) training low-level workers like *barangay* and community health workers in the provision of basic preventive and curative services; (2) expanding training of certain health professionals to substitute for doctors especially in underserved areas; and (3) utilizing nursing aides and assistants for some tasks

performed by registered nurses (Kraft 2006: 34; Tigno 2006: 74). These proposals are actually being carried out by many civil society organizations as well as academic institutions that not only perform substantive health services to various communities but are also training non-professional health workers and volunteers in the provision of basic preventive and curative services.

A Story of Two Municipalities

NGOs represent one sector that has contributed much in implementing health programs in the different LGUs. Unfortunately, there is no systematic compilation of NGOs involved in all health programs undertaken around the Philippines. According to the National Economic and Development Authority, there were 145 NGOs engaged in reproductive health programs in 1999, with many of them concentrated in Metro Manila. In 1997, there were about 485 NGOs engaged in primary health care in different parts of the country with majority of them in Luzon. (Bautista, et al. 2002: 50) Given the absence of a comprehensive compilation of all NGOs involved in health programs in the country, perhaps we can see the importance of civil society groups and volunteers in health service delivery by looking at some of the LGUs that were awarded for best practices in the area of health. Most of them had active civil society involvement in their award-winning health programs. The paper will focus on the cases of Baliuag in Bulacan and Irosin in Sorsogon, two municipalities that were the subject of extensive research in the author's previous work from 2000 to 2003 (Atienza 2003).

Creating *Sentrong Sigla* Facilities in Baliuag

The municipality of Baliuag is a first class³ municipality in the first class province of Bulacan. As of 2003, RHUs (4) and BHSs (23) are present in all *barangays* of the municipality. The DOH certified all RHUs and 15 of the BHSs as *Senrong Sigla* facilities. The municipality had the most number of *Senrong Sigla* facilities in Region III in 2001. In addition, the municipality is part of one ILHZ, known as the Baliuag Unified Local Health System. This ILHZ has been hailed as one of the model cooperative schemes among municipalities in the Philippines. Devolution has also significantly altered the pattern of health service in Baliuag. It has brought about certain openings for greater innovations at the local government level, more partnerships between government and nongovernmental sectors, closer interaction between health personnel and the people, and greater grassroots participation in governance.

However, the case of Baliuag shows that even a first class municipality with significant resources that is not very much dependent on the IRA (52.41% as percentage of total income in 2000) also experiences some of the concerns and problems of many LGUs meeting the challenges of devolution (Atienza 2003: 231-263). The public resources for health, not the biggest priority but nevertheless still getting a big amount in the annual budget, are not enough. While there were four municipal doctors, a dentist, nurses, numerous midwives, and sanitary inspectors, i.e. all the required health workers present in Baliuag at least in the early part of this decade, more personnel are still necessary to meet the needs of the big and still growing urban population. Medicines and other supplies are not sufficient to give to constituents seeking medical assistance. There are also problems in personnel benefits

³ Based on Philippine government standards, there are six classes of local government units based primarily on income and population.

as well as strained relations of some midwives with their *barangay* chairpersons (official community heads).

But civil society plays an important role in the improving health situation in the municipality since devolution. Before devolution, while medicines were plenty, not all *barangays* had a health facility, doctors rarely visited the communities, and midwives and volunteer workers were also very few. However, even before devolution, the Baliuag University's (BU) College of Nursing, established in 1974, had already began an outreach community service program involving professors and students in the town and other nearby localities. The College already had a partnership with the RHUs and the BHSs in terms of health programs even before devolution.

Today, Baliuag also has plenty of socio-civic organizations that conduct regular medical missions, nutrition programs, and other health-related activities in coordination with the RHUs and BHSs. In addition, the Roman Catholic Church, other church-based organizations, private and public schools in the town, and business establishments like pharmacies have health programs usually done in coordination with specific *barangays*.

But the BU has become the constant partner of the LGU and the DOH in health service delivery. Through the College of Nursing, the BU has a number of important outreach health programs, including a nutrition program in one *barangay*, organizing of senior citizens, training programs for volunteer health workers, a home-based nursing program, community organizing programs, health education for mothers, and health counseling. For the home-based nursing program, instead of patients being required to stay in the hospital for five days, for example, he or she can stay only for three days and the treatment can be continued at home through regular visits of the BU's nursing staff and students. In the nutrition program, an important

component is the training of mothers because the nutrition of children begins with proper food at home. In the community-organizing project in Barangay Paitan, the College trains local leaders to be in charge of health. As a result, there is now a Paitan Health and Development Organization, a PO composed of volunteer health workers and some *barangay* officials. Because the assigned midwife in the *barangay* comes only twice a week in the area, the trained volunteers are the ones staffing the health center daily and are also assigned to specific zones in the area. As an academic institution, the College of Nursing also has a research component in order to trace the causes of health problems as well as to document the features and results of its various community programs.

In all the activities of the College, the people of Baliuag and that of other municipalities of the Baliuag health district benefit but the LGUs are not spending money. This is because the BU has its own source of funds through its different networks. BU is also part of the Luzon NGO Network, Inc., a network of NGOs working for community-based empowerment that the Japan International Cooperation Agency (JICA) helped initiate under the DOH-JICA Family Planning/Maternal and Child Health Care Project. The network was an offshoot of a JICA-organized training program on capacity-building of local NGOs and POs for health development. Through this network, member NGOs can access further training as well as funding from Japanese sources for particular health-related activities. In the case of BU, it was able to access JICA funds for the 2002 feeding program in one *barangay*. Incidentally, Dean Elizabeth Roxas of BU's College of Nursing was the lone Outstanding NGO Health Partner Awardee during the thirty-second year anniversary of the Baliuag District Hospital and the third year anniversary of the ILHZ in July 2002.

The presence of volunteer health workers in Baliuag has also increased after devolution (Atienza 2003: 255-256). The regular volunteer BHWs coexist with the *Lingkod Lingap sa Nayon* and the Mother Leaders who were organized by the Provincial Governor's Office. In some *barangays*, the distinctions among these different sets of volunteers are blurred. All of them have been indispensable partners of the midwives in health service delivery. Despite the presence of many well-equipped BHSs all over the municipality, actual health services and even physical improvements of the facilities cannot be carried out without the volunteers' work. They get only meager allowance, depending on the budget allocation of the *barangays*, and most of them work only out of desire to help their neighbors.

However, it must be observed that these volunteers are not well-organized and well-informed of the overall health situation beyond their *barangays*. There is also no well-integrated traditional medicine program, and no accredited traditional healers among the volunteers. In addition, not all *barangays* in Baliuag receive assistance from NGOs and other organizations in their health programs. *Barangays* far from the center of the town do not receive much outside assistance. Thus, many of the *barangays*, even those that are currently recipients of JICA and BU's assistance, prefer achieving self-reliance in dealing with health concerns. Some of the *barangay* leaders and volunteers understand that they cannot always count on the assistance to be provided by the municipal government and other external help. (Atienza 2003: 256-257)

Another important observation in Baliuag is that its health board is not working properly as mandated by the Code. The NGO representative is the Dean of BU's College of Nursing. But meetings are not held regularly and the LHB does not play a big hand in influencing the passage of health ordinances.

But despite the above-cited problems, accompanying the improvements in health service delivery in the town is the increasing health awareness and consciousness among the people in the communities. These can probably be attributed to the increased vibrancy of health facilities and personnel as a result of devolution, the personnel's more hands-on role in the communities, increasing understanding and closeness of health personnel and constituents, the increasing presence of volunteer health workers, and finally, the tireless work of the BU.

The Community-Based Health Program in Irosin

The municipality of Irosin is a fourth class agricultural community situated in one of the poorest provinces in the country. As of 2003, the town has one certified *Sentrong Sigla* RHU and 9 BHSs servicing the 28 *barangays*. In the 1980s, it was a sixth class municipality, a typical Filipino town where majority were poor while much of the economic resources were in the hands of a few families. It was a depressed area with very poor basic services and also a staging area for communist insurgents. But since the 1990s, the municipality is getting accolades not only from government agencies but also from private national and international agencies for innovations in local governance, including health services.

Devolution has brought about certain openings for greater innovations, more partnerships between government and non-government sectors, and greater grassroots participation. However, devolution also brought several concerns or problems that can also be found in most other LGUs since devolution (Atienza 2003: 178-230). While health has become a priority since 1992 and Irosin's income classification rose to fourth class, the town is still heavily dependent on the IRA (84.46% as percentage of total income in 2000) and available public funds are not always enough to meet all health needs. While there were nine midwives in 2000, there were only one doctor

and two nurses available. Medicines and supplies are not sufficient for the growing population. Like in Baliuag, health personnel also complain about low pay, limited professional growth prospects and occasional politicking. In this case, the Mayor who was elected in 2001 was the one who removed the municipal doctor on allegations of disloyalty.

But like Baliuag, civil society organizations play an important role in improving the health situation in Irosin. Actually, the experience of Irosin surpasses that of Baliuag in terms of the importance of civil society in health service delivery. The intervention actually began even before devolution. *Lingap para sa Kalusugan ng Sambayanan* (LIKAS) was an NGO founded by Eddie Dorotan (a native of Irosin) with other medical students, paramedics, and young professionals mostly from the University of the Philippines' College of Medicine in 1979. LIKAS aims to find and develop appropriate health alternatives to the western-oriented and still-elitist health care delivery system.

LIKAS' regional headquarters in Irosin was established in 1982 with focus on primary health care. Collaborating with international and local religious organizations, LIKAS implemented a People's Health Program initially in six *barangays*, later expanding to other areas including a nearby municipality. Primarily patterned after the primary health care program of the DOH in the 1980s, an essential component of the PHP was the training of community health workers (CHWs) that would serve as leaders as well as teachers. The result was the creation of *Sandigan sa Kalusugan* (Bulwark for Health).

LIKAS also realized that in order for it to sustain and systematize the health program, an economic program was also required. Thus, *Sandigan* became a cooperative, started operating a rice mill, and branched out to other services like

variety stores. The *Kilusan ng Bayan Para sa Kalusugan* (KABAKA or People's Movement for Health) where CHWs and other interested farmers were members was also formed to serve as a structure for program implementation. Furthermore, realizing that the problem of health was related to the general problem of poverty in the countryside, LIKAS, together with *Sandigan* and KABAKA, confronted non-health issues faced by rural communities, including landlessness and the necessity of agrarian reform. *Sandigan* evolved into *Sandigan ng Magsasaka* (Bulwark for Farmers), primarily a provincial farmers' federation but with CHWs being majority of members. SANDIGAN also started the *Botika sa Barangay* which enabled *barangays* to have their own mini-pharmacies that provide cheap medicines and allowed poor people who needed medicines to avail of them without paying immediately. LIKAS also began training and advocacy in a variety of areas like environment, sanitation, and gender sensitivity. Cooperatives set up by LIKAS formed the *Alyansa ng mga Pesante sa Irosin* (Peasants' Alliance in Irosin), a more overt political grouping that led them to be in conflict with the local elites in the late 1980s.

From 1988 to 1992, LIKAS' health program had spread out over the whole municipality. The LIKAS-trained and -organized CHWs merged with the DOH-trained BHWs to form the Community Volunteer Health Workers of Irosin (CVHW). By 1992, in partnership with the DOH and a Dutch-based NGO, LIKAS established the Irosin Partnership for Community Health Development. This partnership was aimed at strengthening functional relationships among the local government through the RHU, LIKAS, the CVHW, and the communities for more efficient and equitable delivery of basic health services. This project institutionalized tripartism in the area of health, enabling the creation of *barangay* health committees and the LHB. LIKAS also helped the CVHW form a PO, the Community Health Workers' Association,

which got accredited in 1995. Aside from capability-building and health advocacy, the PO is concerned with livelihood promotion and health financing for the members. This last concern is due to the realization of LIKAS and the volunteers that in a devolved set-up, the LGU couldn't do these concerns for the volunteers. Thus, the PO gives incentives to participate more actively in health service delivery.

To make the health service delivery system in Irosin more community-based, more accessible and more affordable, traditional medicine has also been comprehensively incorporated. LIKAS' traditional medicine program has spread to nearby municipalities. The setting up of the Center for Traditional Medicine and the organization and training of traditional healers are meant to address the immediate needs of the people in the rural communities who have more access to traditional healers than to the RHU or the secondary hospitals. At the same time, this is meant to complement the Western medicine-focus of the regular volunteers.

In the political front, LIKAS started vigorous voters' education and urged farmer leaders to run for posts in the *barangay* councils in 1989. Many of them won seats not only in Irosin but in neighboring municipalities. This focus continues today as several LIKAS-trained CHWs and traditional healers have become councilors in their *barangays*. But LIKAS and organized farmers' biggest victory was in 1992, coinciding with the first year of implementation of the LGC, when Dorotan won as mayor and almost all the other candidates they supported for elected town officials won. Under Dorotan, many LIKAS community organizers also assumed key municipal positions. The LGU held a multisectoral planning that produced the Irosin Integrated Area Development Program, which was meant to address poverty, powerlessness and inaccessibility of basic services using livelihood promotion, people empowerment, and improvement of basic services through the partnership of three

different stakeholders (the government, the private sector, and the grassroots sector). In the area of health, Dorotan and company launched the Irosin People's Health Program that is meant to promote not only health but also links and working relationship among the LGU, the DOH, NGOs, POs, and the communities in the delivery of services. The health board is open to different NGOs and POs, not just a single representative. Connected to the board is a Municipal Traditional Medicine Coordinating Council.

But in 2001, the newly-elected mayor came from a traditional political clan and she was the opponent of the LIKAS-supported candidate. But despite having a strained relationship with the new mayor, LIKAS is still recognized the undisputed health-based NGO in the town. It still retains its seat in the health board and while continuing some health programs in partnership with the LGU, it also strengthens its own programs as well as focusing more on political education of the people, livelihood promotion, strengthening the communities, and improving the health profile. Many of its activities are done in partnership with national and international agencies. Its two-storey building in Irosin hosts regular meetings, trainings and seminars of different groups. Its resources like medical equipments and the ambulance are often used to assist the needs of constituents.

LIKAS continues its direct interventions at the municipal health board level as well as the Irosin District Health Board that covers four municipalities in Sorsogon. The district board continues to be operational and is credited for being instrumental in the creation of a District Health Plan. The new leadership seems to have acknowledged the improvements in the community as a result of the work of the civil society organizations and has therefore retained many of the innovations introduced by the two previous LIKAS-supported administrations.

Irosin since 1992 has seen plenty of developments. While poverty and livelihood continue to be challenges until today, awards as well as continued national and international assistance continue. Irosin received numerous awards from national agencies, academic institutions, and foreign agencies in the areas of local governance, health, environment, social welfare, agrarian reform, and peace. There also appears to be significant citizens' participation in health service delivery down to the community level. There is quality health information dissemination. Many of the *barangay* health councils are still operational and there are communities that have become more self-reliant in improving health and other conditions in the locality. Despite limited formal health personnel, the spirit of voluntarism is also very high. As of 2002, there were 190 BHWs and 67 *hilots* (traditional midwives). In 1998, there were already 131 accredited traditional healers. (Atienza 2003: 210, 212) These volunteers are considered informal leaders in their communities, taking the lead and mobilizing people for many activities that go beyond health. Many of them are also very much aware of health and other related issues such as the IRA, the role of politicians, lobbying, etc. They are very articulate and their association has been an effective lobby group for health needs at the municipal level.

Continuing Political Constraints for Greater Civil Society Participation and Volunteerism in the Devolved Health Structure

The enabling factors for increased civil society and voluntary participation in health service delivery in the Philippines have been discussed lengthily. But constraints and challenges for greater civil society participation and voluntarism in the current devolved health system are not negligible. The first challenge is the “[l]ack of coherence in the government’s policies and programs for civil society participation in the health sector”. As mentioned earlier, the PHC policy in the 1970s and 1980s

provided a framework for civil society engagement in health programs. However, the successive waves of health reforms created different interpretations of the PHC policy and disrupted its implementation. This lack of a coherent framework for civil society participation and engagement was identified as one of the reasons why civil society participation in health has not been consistently supported by the government (Batangan 2006: 106).

A second challenge is that while the DOH is historically known as one of the national government agencies that consider civil society as partners and had made adjustments in its systems and processes to better accommodate devolution, the DOH can still be considered top-down in approach and its direction is still very much influenced by the persuasions of whoever is the current Secretary. Civil society groups have yet to be considered equal partners of the DOH. As political appointees of the Philippine President, Health Secretaries are also susceptible to the persuasions and leanings of the appointing power. For instance, in the issue of reproductive health, while civil society groups are currently pushing for a stronger reproductive health policy, the DOH has not made any solid directive to encourage LGUs to do so when the sitting President prefers a more conservative stand on the issue.

A third challenge is the uneven growth of the evolving local health systems. Because of devolution, LGUs have assumed greater roles in managing local health systems. However, uneven resources, capacities, and local politicians' attitudes towards health responsibilities, civil society participation and volunteerism definitely result in uneven development of their local health systems, further leading to inequities in the health systems and disparities in the health conditions of the people. Sometimes, unevenness can be seen in whether the more participatory provisions of the Code are actually implemented or not.

Conclusions

The paper shows that there are political opportunities or enabling factors for greater civil society participation and volunteerism in health service delivery, especially since 1992 with the advent of devolution in the Philippines. These include a legal enabling environment, the primary health agency's openness to enter into partnerships with civil society groups, and interestingly, the constraints faced by the formal public health system. This is not a unique situation. As Loewenson (2003: 8) compared various literature on civil society and health worldwide, he observed that "[W]hen legal, institutional and procedural mechanisms support the synergy between state and civil society," there are positive health outcomes reported. However, while there are opportunity structures for greater civil society participation and volunteerism, the constraints and challenges cannot be neglected. These institutional and attitudinal limitations must be addressed by all actors — the national government, LGUs, civil society and volunteers. On the part of civil society groups and volunteers, they must not only take every opportunity available but also break down the constraints that prevent them from fully participating in the improvement of health service delivery, devolution, development, and in the long run, democracy.

As shown by the two contrasting municipalities that both interestingly provided room for greater civil society and volunteers' participation which in turn contributed to the improvement of health service delivery in a devolved set up, there are specific local conditions that civil society groups and volunteers must deal with adequately to have greater roles as well as further improve health service delivery. A closer analysis of how different groups responded to the opportunities and constraints will require another lengthy inquiry.

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