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Health in the hands of the people.



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Health in the Hands of the Filipino People: Framework and Action

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Preface

When it comes to health, everyone is at a crossroads on this very day.

Health sector advocates – from the DOH to hospital administrators – are constantly challenged to provide service to the Filipino population. But how will they do it?

Nurses graduate by the thousands every year, but how many of them will stay?

Similarly, new doctors number thousands every year. Will the Filipino people and nation benefit from their knowledge, skills and attitudes? Will we see them practicing in the many doctorless communities of Mindanao, Samar, Palawan and the Cordilleras? Will they eventually practice overseas?

Filipinos – of every age, gender, religion, political preference, and location – are faced with the challenge to stay healthy and free of disease. What should they do? Where should they go? How will they pay for it?

Our nation is at a crossroads itself. Will the malaise of the economy, the disease of too much politics, and the ischemia of our culture be solved by a coup d'etat? Or will these problems be resolved with democracy and genuine political will from our leaders in government, business and civil society? Will we ever have good governance – that is, results-oriented, accountable and transparent to its constituents?

This book arises from my being at the crossroads many years ago. Let me share with you a story from the grassroots that may help us respond to the questions at the crossroads of our lives today.

Right after internship at UP-PGH and the medical board examinations, I went to Eastern Visayas to fulfill my desire to work in the rural areas. My first chosen assignment was the doctorless island municipality of Maripipi in Biliran province, which is located between the islands of Samar and Leyte. Maripipi was often called the *island of no return*. Because I was single then, I initially thought that the name referred to their beautiful barrio lasses – the assumption was that I would be swept off my feet to marry one, stay in the island and never return to Manila. I eventually found out that it referred to the *walo-walo* (*walo* being the local word for the number eight), an eight-day cycle of furious and angry waves stirred up by the *habagat* (northwest winds) during the monsoon season, which typically starts in July and ends in October. Thus, if you enter Maripipi before the monsoon season, you will not be able to get out of the island until the season ends. I later discovered that you can get out of the island during a few hours' lull in between the eight-day cycles of angry waves, when boats and *bancas* get ready to cross the channel to the island of Biliran. You can eventually return to Maripipi after another eight-day cycle of the *habagat*.

I consider Maripipi as one of the most beautiful islands in the Philippines. All villages are on the coastline; the main occupations of the people are fishing and coconut farming. To know the way of life of the people and to better understand their concepts of life, health and illness, I joined the fishers every now and then in their variety of fishing expeditions. Being a former U.P. Varsity

swimming team member as well as a scuba diver and an avid snorkeler, I easily managed to join in their activities. In one of these expeditions, I joined a group of ten small fishers in their *barotos* (hand-paddled boats). They were the poorest since they could not afford to buy a motor to run their boats. Fishing is usually in the evening, particularly on the new or waning moon, since their nets would not be as visible to the fishes. It was during full moons that they rested; I took these monthly days of rest to meet them and plan health programs with them.

As the ten little *barotos* set out into the deep sea, the fishers in their *barotos* formed a circle. Without anyone giving a signal, all of the fishers brought out small candles, lit them, placed them on top of cut banana leaves and floated these into the sea. They then brought out flowers and threw them lightly onto the waters. Finally, they brought out cooked rice and vegetables, placed these on cut banana leaves and gently let them float. I was taken by complete surprise by these rituals.

Being a Manila boy throughout my life, I was totally ignorant of this practice by our fisherfolk. I asked my companion fisher, Mang Celso, what all these rituals meant. He explained that the candles were their way of asking forgiveness for disturbing the spirit of the sea with their nets. The flowers, on the other hand, symbolized their love and care for the spirit of the sea. Finally, the rice and vegetables were their offerings of thanksgiving to the spirit of the sea that gives them life, their paying back for the catch and the food that they would harvest that evening. What great respect they had for the spirit that interconnects us all, the spirit that eventually brings us to the One and Almighty Supreme Being! What a grand celebration of life and love!

I was overwhelmed by this deep spirituality, this innate wisdom and basic philosophy of the fisherfolk of Maripipi. Such spirituality and virtue I also found when I worked in the mountains of Samar, in the towns and villages of Gandara, San Jorge and Matuginao, and in many other places.

Thanksgiving, love, and forgiveness. These are the virtues and values that continue to preoccupy my consciousness as a doctor. The fishers of Maripipi and the farmers of Gandara and Matuginao, in a sense, are also communicating the message of humaneness, compassion and dignity.

These are the virtues and values that challenge us as we approach the decisions we have to make at our crossroads.

Because of their service to patients in the clinics, hospitals, medical centers, and communities, physicians are able to fulfill their goals, hopes and aspirations of helping humanity while fulfilling their need to earn comfortably. However, more importance is given to the concept that doctors are the lords of the health system. Unfortunately, patients are at the bottom of this semi-feudal health system. Consequently, patients' rights are oftentimes not given as much importance as physicians' rights.

How can we show our love for our patients? We can inform and explain to them what their disease is, what its possible complications are, how the disease and its complications can be prevented, and what the ways and means to restore their health and well-being are. Our love can

also be expressed when we educate them on their prescribed medicines: their names, whether generic or branded, when and how often to take them, the possible adverse reactions and side effects, their interactions with other drugs or food. And if there are any procedures to be done to their bodies, we explain how the procedure will be done, the possible consequences of the procedure, and the value of the procedure to them. We can also provide them with advice on what they need to do when at home and how they can involve their family in the healing process.

Currently, globalization and poverty have removed the control of health from the hands of the people and the state, and placed it in the hands of corporations. As the 21st century is foreseen to engender pluralism of ideas, interconnectedness, people and community empowerment, mutual understanding and tolerance and beneficial actions for all, it must be a century of optimism, robust goodwill, and hope to attain health and peace. The triangle of the societal forces of state, market and civil society will hopefully be transformed into the triangle of love, compassion and humaneness, continuously interacting dynamically to produce a civil society without borders, caring corporations and governance with accountability to attain the healthy and peaceful world of the new century and the new millennium.

The 21st century and the 3rd millennium is an era for changing the culture of subservience to a culture of empowerment.

This book is a summation of many years of experience as a doctor to communities, from the fields and mountains and coasts to the hearts of cities. This is a product of years of discussion and study with colleagues, friends, and most especially patients, who, more than anyone, have a

lot to say about health, sickness and wellness. This is an attempt to bring together thoughts and ideas about our health care system, about what we have, what is lacking, and what we can do about it.

The first part of this book encompasses the concepts of primary health care, community-based health programs, and traditional medicine as a framework for change. The second part addresses current issues such as migration and medical education and suggests concrete action. This book is written in the hope that it will inspire the Filipino to care more, to change the system for the better.

We are, indeed, at a crossroads, which may lead us into two paths: a road spiraling down into an abyss of apathy and injustice, or a road to a revolution that will forever change the health sector as we know it.

It is time to be active. It is time to fight. It is time to make a change.

May the force of love, compassion and humanity be with you all.

Part I. A Framework for Change

Chapter 1. The Philippine Health Situation: A Primer

The health situation in the Philippines has come a long way. From the rituals of the *babaylans* to the formal training of the first students of the Philippine Medical School, through various health programs from the Spanish, American, Japanese and the postcolonial days, through radical system changes and cutting-edge innovations brought about by the modern age of society, health care in the Philippines is a story that has proven to be interesting and unpredictable, but up to now, still in progress.

Health care in the Philippines can still be considered as an unfinished agenda. We may have achieved admirable advances in the modernization of health care, but we still need to face the unsettling truth: despite more than a thousand years of documented health programs and countless generations of Filipino doctors and health professionals, up to now, many Filipinos die of preventable diseases. People in the mountains of Luzon, the coasts of Visayas and the forests of Mindanao still do not get proper health care. Basic aspects of health such as sanitation, nutrition and health education are in dismal condition. Old problems of ten, twenty years ago were never resolved, even as new problems continually crop up.

What hope do we have? Do we, in the first place, still have hope?

If we care at all about attaining the dream of having the health care we all deserve to have, we first have to understand what problems are at hand.

A Perennial Victim

Health care has always been a victim of our socio-political milieu. For example, because we have always been under foreign rule, Philippine medical education and the practice of medicine in the Philippines remains mostly westernized. This is not entirely unfavorable. As a case in point, we have always easily kept up with global advances in medicine and hygiene, even as early as in the 1930s. We have a wealth of competent and compassionate health professionals in health services, health sciences education and health research, and we have a network of public and private hospitals, health facilities and health sciences universities available nationwide.

However, because of the progressive westernization of medicine, we retained only a few of our traditional forms of medicine. Currently, most medical professionals continue to advocate the Western approach to diagnosis and treatment, despite recent surveys showing that most Filipinos still prefer traditional healing methods. Most Filipinos, especially in the provinces, still consult traditional healers first before consulting a doctor. Even in the cities, there is a growing interest in alternative modalities of medicine. Such a disparity presents a problem in the provision of holistic health care.

We saw a downward trend in our economy starting from the '60s and '70s. As people progressively became poorer, access to medical care also became harder. There have been many attempts to address this problem, but to this day, acceptable, accessible, and effective health care for all remains to be a problem.

Inadequate Solutions

Despite efforts to mitigate health care problems, the fact remains that there is chronic under-investment in health by both public and private sectors. As a case in point, only 3.2% of the gross national product (GNP) was invested in health care in 2007 due to threatened financial viabilities of providers, although the global standard is 5%.

Another long-standing concern is the implementation of the National Health Insurance Act of 1995 or Republic Act No. 7875. In terms of health policy and programs, this is the most important historic health milestone for changing the face and shape of health care in the Philippines. It is visionary in its goal for all Filipinos to have financial access to quality, acceptable, integrated health care by the year 2010. What has become of the National Health Insurance Program (NHIP) nearly two decades past the law's passage and signing? Does the ordinary Filipino know it, feel it, much less savor its fruits and benefits? How has the Philippine Health Insurance Corporation (PhilHealth) fared in administering the program? Will it fulfill its potential for engendering outstanding and significant changes in health?

Despite reform initiatives such as the Health Sector Reform Agenda and FOURmula ONE for Health, we have yet to see a concerted, harmonious working system for the implementation of health programs. What is going on in our health system? Why is it not working? Will the current emphasis on financial risk protection, health facilities enhancement, and attainment of health-related Millennium Development Goals (MDGs) make a difference?

In the quest for greener pastures, “push” factors of out-migration have been moving great numbers of health professionals to other countries. Even in the face of urgent and persistent appeals to stay and serve the country, why do our doctors, nurses, and health professionals still choose to leave? What are we doing to meet the rising demand for health professionals in the country and the unnerving decline in the quality of nursing education resulting from proliferation and weak regulation?

A New Approach

As noted earlier, health care delivery in the Philippines has been traditionally Western. This in itself is not a problem, but in the face of current issues, it does not suffice. Also, Filipinos are progressively becoming aware that alternative modes of medicine also have benefits and may answer whatever is lacking in the old traditional model.

We need a new approach to health care, one that can adequately answer our needs and be empowering to the people. We need an effective framework, one that is based on principles that can sufficiently answer the current public health challenges that we face.

We need to shift to a primary health care approach, with focus on traditional and integrative medicine. We need to go back to the grassroots, to our communities; as an old adage goes, we need to go back, in order to go forward.

Chapter 2. A Revolutionary Way: The Primary Health Care Approach

The health problems of our country are not mere technical problems that can be solved through improved techniques developed in isolation from the other aspects of the Filipino's social life. The solutions to the country's health problems will always have to take into consideration the economic, political and cultural problems of society. The present health care delivery system in the Philippines functions as an element within a larger social system, and its role is defined by the structure of that system.

Let us delve into the health care – socioeconomic system relationship more deeply. The health care delivery system closely parallels our economic situation wherein the urban areas receive more benefits than the rural areas. The rural areas are the suppliers of raw materials, food and industrial crops, and cheap manpower to the cities. There is uneven development. The urban areas become more developed and the rural areas more depressed.

On a larger scale, the health care situation of our country is analogous to the role we play in the world scene. Our economy is greatly dependent on global market forces. We supply the industrialized nations and the multinational corporations with raw materials and cheap labor. We become the dumping ground of surplus finished products of these countries. Parallel to the urban-rural area scenario, industrialized countries become more developed while developing nations become more depressed.

We are dependent on Western drugs and instruments that are products of multinational corporations. Drugs increase in cost every year; their prices are getting more and more out of people's reach. Medicine as a profession has also become profit-oriented instead of being service-oriented. Medical treatment in hospitals and clinics has been made into a scarce and expensive commodity prejudiced against the poor.

Our health care system also mirrors the political scene. In the Philippines, decision-making is centralized in the hands of a few. The vast majority remains powerless to participate in decision-making on the different aspects of their lives. In a similar way, the doctor controls the know-how of health care, leaving the patients in the role of submissive supplicants and uncritical followers of the medicine man. It is the doctor that defines health. It is the doctor who decides on the techniques and medicines to be used. And the patients are only too happy to follow and leave the doctor to make the decisions about their health. It is a structure that promotes dependency.

Culture is one of the key factors that shape our collective definition of health and illness. The prevailing concept of health care in the Philippines is Western and cure-oriented; the health care delivery system promotes the myth that good health means being treated by a doctor, being confined in a plush medical center and using the latest in Western drugs, techniques and instruments. It is only through the doctor, western drugs and medical intervention that the well-being of the people can be promoted.

The educational system for nurses and doctors perpetuates this Western concept of health care. Medical and nursing graduates become so accustomed to using hospital-based, sophisticated health care during their training that they end up getting frustrated by the lack of resources in the barrios. Their desire to work abroad or in the urban area is further reinforced. The brain drain thus continues.

As long as these socioeconomic conditions prevail, such will be the culture of our health care delivery system. The Philippines will continue to be confronted with the problem of how to meet the basic health needs of its people, the majority of whom are in the rural areas and economically deprived.

The health crisis is real. Existing health services fail to answer the expectations of the people. Widespread dissatisfaction is becoming more evident since such services have not kept pace with the population's changing needs in quantity or in quality. The application of new knowledge and technology did not bring about its expected results and may actually have brought more hardships and untoward consequences to the people it intended to serve. The Western concept of health care delivery has proven inadequate for a developing country like the Philippines.

There is a growing realization that a different approach is essential, an alternative approach which would focus more on rural areas instead of urban and would be directed at serving the neediest population; a health system where the prevention of diseases becomes a priority and where appropriate health technologies are propagated and applied.

What is called for, therefore, is a total re-structuring of the economic, political and cultural aspects of the health care delivery system as part of the concerted effort for the restructuring of the whole social order. The general health care delivery system will not see lasting change as long as the social structures that undergird it remain the same.

A re-structuring of the health care delivery system in specific small communities is the underlying ideology of a community-based health program. The Primary Health Care Approach therefore represents a total attack on the existing health care delivery system in all its aspects: economic, political and cultural.

The Primary Health Care Approach: Health in the Hands of the People

In 1978, more than 100 heads of state and Ministers of Health gathered in Alma Ata, U.S.S.R. (now Almaty, Kazakhstan) to declare their commitment to Primary Health Care (PHC) as the major global and country strategy in achieving “Health for All’ by the Year 2000”. The call for “Health for All” aimed to ensure that the poorest of the poor and the marginalized would be provided with essential health services via the Primary Health Care Strategy.

The most advanced concept to describe Primary Health Care is “Health in the Hands of the People.” It signifies empowerment of the people in managing their health, not just the delivery of health services to them.

Primary Health Care is different from the term “primary level of health care”, as it is used in the health referral system. Primary Health Care is an approach, a strategy, and not a program. Nor is it a project, a component, or an activity.

Let us review some of the core principles of Primary Health Care and how they are commonly applied in the community setting:

1. Accessibility, Acceptability, Availability, Affordability of Health Services

Health services are delivered where the people live and work. Indigenous/ resident volunteer health workers are developed as health care providers; with an ideal ratio of one community health worker (CHW) per 10-20 households. Low-cost, appropriate technologies sustainable by the community are used and combined with the use of traditional medicine modalities (herbs, massage, ventosa, etc.).

2. Partnership between the community and health agencies in the provision of quality, basic and essential health services

Health services and activities are based on community needs and priorities. Community Health Workers (CHWs) are given competency-based training, which includes aspects of promotive, preventive, curative and rehabilitative health care, community health problems, and task analysis. Regular supervision and periodic evaluation of CHWs’ performance are done by the health staff and the community. The roles of traditional healers in the delivery of health services are also recognized.

3. Community Participation

The community is encouraged to build awareness on health and development issues. The members of the community participate in community building and community organizing and in the planning, implementation, monitoring and evaluation of health programs. Community discussions are done through small group discussions or via 10-20 household clusters. The community also selects CHWs and forms health committees. CHW organizations are established at the municipal and provincial levels. Mass health campaigns and community mobilizations are organized to combat health and development problems.

4. Self-Reliance

The community generates the resources needed (cash, materials, labor) for health care programs. It is also responsible for the mobilization of the said human and material resources. Community leaders are trained in leadership and management skills. Income-generating projects, cooperatives, family food production and small-scale industries are also launched.

5. Recognition of Interrelation between Health and Development

Health, food, nutrition, water, sanitation and population services are coordinated. Primary health care is integrated into national regional, provincial, and municipal plans. Health activities are coordinated with economic planning, education, agriculture, trade and industry housing, public works, communication and social services.

6. Social Mobilization

An effective health referral system is established. Multisectoral and interdisciplinary linkages, information, education and communication support using multi-media channels are utilized, as well as collaboration among government agencies, non-government organizations and community groups.

7. Decentralization

There should be advocacy for political will and support from the national leadership to the barangay level. Funding for health programs should also be allotted at all levels as well.

The Three Models of People's Participation in Health Care

To further elucidate the difference in the various ways of health care delivery in our country, the following matrix contrasts three models of people's participation in health care: The Hospital/Clinic-Centered Model, The Community-Oriented Model, and the Community-Based Model. This matrix provided as Table 1 can serve as a basic framework for analyzing the current status of PHC in the Philippines.

Table 1. Models of People's Participation in Health Care

<u>Category</u>	<u>Hospital/Clinic-Centered</u>	<u>Community-Oriented</u>	<u>Community-Based</u>
Locus	Hospitals/Clinics	Community	Community
Type of health services given	Predominantly curative	Generally curative with some prevention	A balance of promotive,

			preventive, curative, and rehabilitative care
Who delivers health services	Mainly doctors	Health professionals	Community health workers
Objectives	Rigid/Statistics-oriented	Closed/Pre-determined	Open-ended/Flexible
Level of People's Participation	None	Token	Active
How people are viewed	As recipients	As beneficiaries	As partners
Value given to community organizing	Community not capable of organizing	As a means of community exposure	As a means for empowerment of the people
Main character	Authoritarian	Paternalistic	Democratic
General Impact	No change; Status quo maintained	Behavioural change	Social change

Self-reliance, self-government and self-determination are the key features of a community-based model of health care delivery, making it the model that most embodies the spirit and principles of Primary Health Care as envisioned by the Alma Ata Declaration. The people take responsibility for their health needs. Through organization, the people form a collective political will and gain a common awareness of the need to do something about their situation. Through a

change of attitudes, values and aspirations, the people achieve self-identify and self-appreciation of their own resources. The myth of the poor man's inferiority is destroyed.

The present health care delivery system, unfortunately, mostly resembles a hospital/clinic-centered model. There is a concentration of health services in urban areas, generally catering only to those who can afford to pay, with heavy emphasis on the use of Western drugs and medicine as well as on sophisticated, expensive technology. Access to drugs continues to be a problem despite enactment of the Cheaper Medicines Law and implementation of the DOH Complete Treatment Pack program. Medical knowledge is sacrosanct and well-guarded. Health measures are doctor-dependent, and health programs thus cannot move without a doctor.

Traditional healers are frowned upon. The focus is on the health of the individual, and medicine as a profession is disease-oriented and profit-oriented. More emphasis is placed on the curative and on the use of crisis-prevention methods. Health needs are taken care of only by health professionals like midwives, nurses and doctors, and health programs are generally imposed on the people. Decisions and policies on health are formulated by a few people at the top with little or no consultation with people concerned. The health staff handpicks health workers, with the organization comprising mainly those close or related to barrio officials. Health leadership thus comes from the rural elite.

In community-based health programs, the distribution and nature of health services are according to the needs of the majority of the people, and thus are directed more to the rural areas.

Traditional practices and herbal drugs and medicines are used. Medical knowledge and skills are shared; the community can handle simple medical concerns independent of a doctor, but knows

when it should call on the doctor's expertise. The focus is on the health of the community. Medical practice is people-oriented and service-oriented. Emphasis is placed on prevention and systematic elimination of the causes of diseases. There is use of appropriate, intermediate, barrier technology; self-help and self-support systems are encouraged. Primary health care needs are taken care of by properly trained community health workers, but decision-making resides in the people; they participate in the analysis of the community's health problems and collectively decide on and implement the solutions. People choose their own health workers.

The approach of a community-based health program is therefore holistic. Health is seen as one component of the community, affected by, and in turn, also affects other components. The basic attitude is **working with** the community to improve health and not merely **giving to** the community. The final aim is to have health **by** the people rather than giving health **to** the people. Communities, therefore, should be on their way to becoming truly self-reliant, self-governing and self-sustaining.

This is a radical departure from the conventional strategies of delivering health services. Instead of waiting for people to come to fixed health centers and hospitals, the Primary Health Care strategy states that doctors, nurses and midwives should involve the community to participate in the identification and prioritization of their health problems and from there, plan, design and manage their own community health programs that respond to their needs. Learning from the experiences of the "barefoot doctors" of China, the "feldshars" in the U.S.S.R and volunteer community health workers in the Philippines, PHC encourages the training of village health workers to deliver basic health care, preventive and promotive health services to their own

people. PHC also advocates for the integration of traditional medicine and traditional healers in conventional health care. In the delivery of essential health services such as maternal and child care, family planning, disease control, water and sanitation and provision of essential drugs, the Primary Health Care strategy pushes for an intersectoral and multidisciplinary approach involving resources from education, social services, agriculture, agrarian reform, environment and public works.

A CBHP experience: Samar, 1976

Samar-Leyte is just one of the regions in the Philippines where a community-based health program has been initiated. The concept of a community-based health program in the Philippines had its beginnings during the middle part of 1975 when three pilot areas spread over the three main regions of the Philippines (Luzon, Visayas and Mindanao) were opened. Originally conceived as a training program for developing grassroots community health workers, the program broadened its thrust and scope. The Samar Community-Based Health Program is a take-off from the gains the pilot area – Leyte – has made. The program was formally launched under the auspices of the Social Action Center of the Diocese of Calbayog, Samar, in October 1976. The two parishes of San Jorge and St. Michael in the town of Gandara, Samar were chosen to be the initial areas for its implementation.

In general, the objective of the Samar community-based health program is to build Christian communities among farmers for total human development through (1) increasing awareness of their situations in which structures are preventing the attainment of basic human needs; (2) organized community action to solve their own problems; (3) self-reliance to the extent of their

personal and local resources; and (4) participation in decision-making which affects their lives. Specifically, it aims to: (1) train farmers who will be leader-teacher-health workers; (2) form small working groups which will confront farmers' problems like usury, land tenancy, etc.; (3) mobilize farmers to solve their own problems and the problems of the community; (4) document the real situation of farmers; (5) maximize the utilization of existing agencies, both government and private; (6) research, utilize and propagate community resources like medicinal plants, use of intermediate technology, etc.; (7) find and develop ways and means which will help in their means of livelihood like labor-exchange, cooperatives, agri-nutrition, etc.; (8) train farmers to live the democratic and scientific way of life in their respective groups; and (9) provide opportunities for interested students and professionals who request exposure to community-based programs.

The program staff consists of the following: four community organizers (CO) and one physician, who all live in the barrios, and one parish priest. Each community organizer is assigned to one barrio. The community organizers act as change-agents who together with the people discover and analyze root causes of problems. They help the people develop their own resources to gradually change the conditions causing their problems. They may be from the barrio or from outside the barrio. What is vital, however, is that they relate with the people thoroughly so that they are accepted as members of the community. The physician acts as a trainer and coordinator while the parish priest monitors the program. The staff is directly responsible to the Bishop of the Diocese of Calbayog and the Social Action Director.

Establishment and operation of the CBCP is an intricate and comprehensive process. An Advisory Board was created to help the Bishop towards the implementation of the program and the integration of health and other related services of the government, private and religious sectors. Composing the Advisory Board are the following: the acting Provincial Health Officer of Samar, the past president of the Samar Medical Society, a prominent businessman and civic leader of the capital town, a district supervisor of the Department of Education and Culture, the principal of the Gandara Right River District, and a lawyer and the Bishop of the Diocese of Calbayog.

Groundwork preparation was done before implementing the program. The staff was given an orientation workshop seminar regarding the principles, philosophy, objectives, strategies and methods of a CBHP. The program was explained to the people and their support was elicited.

Through a process of dialogue and observation, the CO gathered data on the health, economic, political and cultural situation in the barrio. This was usually done by home visits, small group meetings and conversations with farmers, with the CO joining them in their work in the fields. Basic issues were allowed to surface and were then discussed.

The seasonal pattern of the community was also plotted. This included harvest and planting seasons, fiestas, weather patterns, slack periods and disease patterns. This would later help in developing timetables for community activities and mobilizations. A spot map was also prepared, showing the location of houses and the distribution of leaders and resources.

Community health workers were conventionally called “paramedics” or “barangay health aides”. However, because of the title they carried, their work was mainly confined to health services that were mainly curative in nature. It was just like transposing the “health center mentality” to the barrios instead of emphasizing organization for community health, health education and sharing ideas on the prevention of diseases. The holistic view of health was neglected.

In Samar, the health workers were called “Lider-Magturutdo-Parabulong” (Leader-Teacher-Health Worker). A health worker is, primarily, a leader who will organize his community towards better health. He is also a teacher, for he shares whatever he learns from the training seminar, emphasizing the prevention of diseases through health education. Then he is a health worker attending to the immediate health needs of his community.

Based on the concept of a “leader-teacher-health worker”, some of the qualities needed by a health worker were as follows: (1) must be respected by members of the community; (2) as much as possible, should not be an official of the barrio (although some officials might be exceptional enough to qualify, this policy is followed in order to spread the function of decision-making to as many people as possible and to avoid conflict in their duties and functions as local officials); (3) preferably middle-aged, or a permanent resident of the barrio (previous experiences have shown that young people are usually of the marriageable age and may leave the barrio as they marry; those with higher educational attainment tend to leave the barrio and look for better economic opportunities. This creates a “brain drain” or leadership loss at the barrio level and discourages the community); (4) a traditional healer (they have already gained the respect of the community, and an increase in knowledge through CBHP could further improve

their service to the people); and (5) must come from the oppressed class, if possible, or from the lower stratum of society (too often, rural development programs cater their services to the rural elite rather than to the rural marginal groups or to those who most need help. In this CBHP, priority is given to those coming from the depressed sector of the barrio).

In turn, the tasks of the Leader-Teacher-Health Workers were to: (1) achieve productive person-to-person relationships; (2) elicit aspirations, problems and feelings from the groups; (3) conduct meetings in a manner that expressed problems are analyzed and decisions for transforming action are reached; (4) investigate community problems; (5) mobilize community interest community for the common good; (6) document the health situation and related conditions in the barrio; (7) record his own activities in his capacity as leader-teacher-health worker (i.e. keep log book, meaningful records); (8) conduct with own group every previous experiences of the training program (immediate praxis of every new input); and (9) become alert to immediate community needs and be able to confront them realistically.

The Samar CBHP also employed small group (*hugpo*) building. A *hugpo* consisted of 8-15 families depending on the location and distance of the houses from each other. In some of the barrios, the *hugpo* followed the original political division of the barrio.

Each *hugpo* had a leader who was chosen by its members. The program did not decide the criteria by which the leaders were chosen. It was the people who were to decide what criteria they wanted. Formal educational attainment was de-emphasized; the individual's life experiences were more valuable. Illiteracy was also not an issue; some illiterate members of the

community, two of whom were indigenous workers, had been trained as health workers. It was very interesting to note that during their training, they brought with them someone (wife, niece) to act as their “secretary”. One of the leaders who had been assessed to be advanced in terms of critical consciousness was illiterate.

A total of 40 leaders were elected, coming from the four barrios. Twenty-nine were males and eleven were females. The age range was from 22 to 73 years old, with most of the leaders belonging to the 26 to 35-year-old bracket. Thirty-six were married, three were single and one was a widow. Out of the 40, 25 reached the grade school level, 11 reached high school and two reached college while two were illiterate. There were five traditional healers. All were farmers.

Leadership training was also instituted. Local health professionals were invited to give lectures during the seminar. The COs handled the sessions on leadership and organizing. The Bishop, Social Action Director and parish priest were responsible for the pastoral aspect of training. The Advisory Board members were also tapped to share whatever skills they had.

The *hugpo* was expected to: (1) work for the solutions of the problems of the community; (2) support mobilizations regarding farmers’ problems; (3) engage in decision-making regarding issues that affect them; (4) plan, implement and evaluate programs that will benefit them; (5) share with and help members of the *hugpo*; (6) have regular teaching-learning meetings; and (7) know how to take care of their health problems, both in the preventive and curative aspects.

Periodic evaluation of the leader-teacher-health worker was done by the *hugpo*, the leaders themselves and the program staff. The criteria used were the ones made by the *hugpos* and the leaders themselves. Such evaluations made both the leaders and the *hugpos* conscious of their corresponding responsibilities as the main implementers of the program. This also helped them towards the development of their own community-oriented value system and decision-making.

The leaders-teacher-health workers met once or twice a month to share experiences and work on problems encountered in their work. They also decided on what topics they wanted for their continuing education. If they wanted a deepening of the knowledge and skills that they had learned during the seminar, they then invited to the barrio the necessary resource person who had the expertise or experience.

The program physician did not hold clinics in the barrio. This was to de-emphasize the curative aspect of health care. If the health leaders found cases that need referral to the doctor, they invited the physician to visit the barrio to answer their referral.

During occurrences of extreme or emergency cases which they could not handle – and if the program doctor was not available – they made use of the emergency hospital in the town. They also had the option to make referrals to the two midwives and sanitary inspectors of the Rural Health Unit in the town.

The program physician was to make every answered referral a teaching-learning session for the concerned health leader. This gave the health leader additional knowledge and skills and

enhanced his self-confidence in doing primary health care work. The physician also had to see to it that every patient who sought consultation with him had also been seen and examined by the health leader of the *hugpo*. This was for the people to rely and to develop trust in their own health workers and become less doctor-oriented especially for their primary health care needs.

All of the barrios mass-produced drug preparations from medicinal plants. Cough syrup preparations and dried leaves, bark, roots, flowers, and seeds for different ailments were all prepared at the *hugpo* level. Each *hugpo* also had their own herbal gardens facilitating easy collection of needed plants.

For needs still not answered by medicinal plants, the people made use of resources from the Rural Health Unit. In some instances, they would raise funds to buy the necessary medicines such as antibiotics as the need arose.

Health-related issues surfaced and the *hugpos* responded by mobilizing the whole community to help them. As a result, the people of Barrio San Jose de Panaogan were able to petition the Department of Education for an additional teacher in their elementary school; another barrio was able to build a water pump, and yet another was able to build a pipeline from a mountain spring reservoir in order to have potable water. All the barrios were able to get assistance from the Alay Kapwa Funds of the National Secretariat for Social Action, and one barrio, La Paz, was able to take advantage of the rice seed loans given by the Bureau of Plant Industries, after a typhoon destroyed the crops. The whole town was also able to obtain a written pledge from the DAR, DLGCD, and the Mayor of Gandara to meet their 7 basic demands (stop the unjust practices of

the landlords with regard to partition of harvest goods; declare Gandara a land reform area; stop usurious practices in loans; investigate unfair pricing of goods by middlemen; look into anomalous activities of the administrators of land-holdings; implement the minimum wage for agricultural workers from 3 to 8 pesos; and give land titles to homestead agricultural farms).

Leadership was not confined to the leader-teacher-health workers. New leaders in each hugpo were elected to take on other needed tasks. The hugpos also chose a leader-evangelizer to take care of Bible services and other religious-related activities, a cultural leader to take care of community theater activities (the problems of the farmers and the community have been presented in drama form during social occasions like the graduation of health leaders, fiestas, etc.), and committee leaders to handle specific farmers' problems like land titling and working towards land reform.

The Samar CBHP, sadly, eventually faded out. Other CBHPs, however, are still existing, both at the national scale and at the communities where they were started. In Maripipi – the very first CBHP I served in – the health workers I trained are still there and are still working. The community has thrived and has grown because of additional input from other sectors. CBHPs ranging from in North Cotabato to Malibay, Pasay, have also persisted. A new generation of health leaders have taken over – though some of the original proponents still remained, the new generation assures the continuation of the program.

There is always a dynamic interaction between the communities and support. No health community is an island; interaction with other sectors gives it the vital support it needs. This

was one of the pitfalls of the Samar CBHP. Most if not all of the support systems in the original Samar CBHP are no longer there. Leadership in the parish and the community have changed and priorities have changed. CBHPs in Agusan, Surigao, North Cotabato, however, are still flourishing because they have discovered the secret of survival – they have preserved continuity even as leadership and memberships changed, and they used inputs from institutions that believe in the same philosophy of the community-based health program.

Patient Rights as Part of the Primary Health Care Approach

The realization of every person's human rights is an indirect, unspoken, but vital goal of the Primary Health Care approach. Health is a human right as enshrined in our Constitution. A very important element of this constitutional right to health is patients' rights. But how much attention and action have physicians, nurses, dentists, physical and occupational therapists and other health professionals given to patients' rights? How much investment and energy has government given to safeguard patients' rights?

The core principles of the Primary Health Care approach aim to enforce patient rights, the most basic of which is access to health care services. When universal access to health care services has been achieved, the right to quality health care then assumes prime importance. The various elements of quality health care consist of comprehensive health benefits from universal health insurance, patient safety, effectiveness and efficiency, patient-centered care, timeliness, accountability, patient protection, and patient empowerment.

Comprehensive health benefits refer to health care that includes health promotion, preventive medicine, curative care, and rehabilitative care. It also means adequacy of health care wherein a multidisciplinary team coordinates in providing patient care. Continuity of health services is guaranteed by an effective referral system from communities to health centers to secondary and tertiary levels of hospital care and vice versa – something we have yet to witness in the Philippines.

Patient-centered care, as defined by the Institute of Medicine in the USA in 2001, refers to providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions. This is in contrast to the disease-centered model where physicians make almost all treatment decisions based largely on clinical experience and data from various medical tests. The patient-centered model allows patients to become active participants in their own care.

How can medical doctors practice patient-centered care? Physicians can teach patients about their disease and self-management so they can carry out their responsibilities. They can also help patients reflect on their own situation so they can be prepared to make informed choices. They can counsel patients to develop a realistic management plan that fits their individual needs and support their patients' attainment of self-selected behavior change.

Patient safety is also an important issue. The National Patient Foundation in the United States defines patient safety as the avoidance, prevention and amelioration of adverse outcomes or injuries stemming from the processes of health care. In the landmark study from the Committee

of the Quality of Health Care in America entitled “To Err is Human: Building a Safer Health System”, hospital deaths resulting from preventable adverse events were estimated to range from 44,000 to 98,000 annually, which exceed deaths due to motor vehicle accidents, breast cancer or AIDS (Kohn et al., 2000, p.26). In the Philippines, there has been no similar study done. The role of such evidence in guiding policy and practice cannot be overstated, so I continue challenging researchers in my own institution, the National Institutes of Health through the Institute of Clinical Epidemiology, to do such a study no matter how limited the scope. The Department of Health and PhilHealth will do the public a great service should it decide to finance such a study.

Effective health care means avoiding overuse and underuse of care. One significant example of inappropriate use of health care in the Philippines is the proportion of caesarian sections. The World Health Organization (WHO) has stated that caesarian section rates exceeding 15% indicate overutilization, whereas rates below 5% indicate underutilization (WHO, 1994, p.20). In the Philippines, the caesarian section rate is estimated to be 9.5% (2008 NDHS, p.113); however, disaggregation of data shows inequitable use by wealth quintile. In women belonging to the richest quintile, births from caesarian sections constitute 27.7% of births; in women belonging to the poorest wealth quintile, it is only 1.3% (2008 NDHS, p.113). Underuse of health care is also clearly manifested in patients’ lack of access to even the most essential medicines. This may mean the partial filling-up or non-compliance to prescriptions by patients due to the high cost of drugs.

Efficiency of health care refers to reducing waste and maximizing resource use. This can be achieved by using evidence-based medicine as found in clinical practice guidelines, which are

supported by research findings. It implies that health care providers and patients should have better access to evidence through credible sources. Our government should finally set up a Technology Assessment Expert Panel to assist the Bureau of Health Devices and Technology in governing the use of increasingly complex medical technologies and diagnostics.

Other elements of quality health care – as deserved by the people – include timeliness, accountability, patient protection and patient empowerment. Timeliness means reducing delays and less waiting for both patients and health care providers. Accountability implies that health systems are supportive of open discussions and learn from errors without fear of punishment, but at the same time accepting responsibility for the health care that is given.

Patient protection is manifested by the giving of informed consent of the patient as a prerequisite before any medical, surgical or diagnostic procedures are done. Informed consent forms can be standardized to cover around 300 common procedures. It should be available in the patients' mother language. A copy goes to the chart and one goes to the patient. Informed consent, however, should not be a substitute for patient-physician discussion. To guarantee further patient protection, evidenced-based clinical practice guidelines (CPGs) and medical algorithms must be developed and used constantly. Risk management should also be practiced with official avenues for complaints and grievances.

Patient empowerment allows patients to know about their illnesses, the various ways to avoid getting sick again, the interventions and medications and their possible side-effects and adverse reactions, and the ways to best to quickly recover and restore health. All these can be part of the

patient-health care provider dialogues. Patients' health education should also center on health promotion and the practice of healthy lifestyles.

One of the now popular ways of promoting patient empowerment is the formation of patient support groups or self-help associations. These are usually disease-oriented like diabetes clubs, cerebral palsy or autism association, post-stroke care organizations, etc. My own advocacy with patient support groups is to name themselves in a positive manner. For example, instead of asthma club, their name should be "healthy lungs" club; "normal blood pressure" association for those with hypertension; "breast cancer-free" networks instead of breast cancer organization. The name becomes inspirational and motivational, such promoting better health and wellness.

So how can we support the promotion, advocacy and safeguarding of patients' rights? First we have to analyze the different characteristics of relationships that govern the various stakeholders: from policy makers, legislators, physicians and health care providers, the advocates and social activists, and patients themselves and their families. We have to understand the nature of advocacy, particularly for policy and legislation.

This requires an examination of the existing spectrum of relationships between government/policy makers and health NGO advocates. These relationships can range from disengagement to engagement; from adversarial to critical collaboration; from "No to Partnerships" to developmental partners; from closed doors to open lines of communication; from having individual agenda to having a larger common national health agenda. The key is to define which relationships to keep and which ones to let go.

Second is understanding advocacy for patients' rights with physicians and other health care providers. Again, this requires an analysis of the different dimensions and paradigms of physician-patient relationships and health care provider-patient relationships: from paternalism to patient autonomy; from dominance to partnerships; from self-interest and corporate interests to altruism and patients' well-being; from deception and lies to truth telling and disclosure; from detachment to friendship and from mechanistic to humanistic. What is important is that these paradigms are assessed and the extent of their existence determined.

Third is a common understanding, a leveling-off and unity of universal values and virtues in ethics and health care among three major stakeholders – government, physicians/health care providers and health NGOs/patients. There should be unity of values and virtues among the stakeholders, placing importance on humane health care providers; health as a human right; access to health care, quality and equity; justice and fairness; democratic participation; and compassion, benevolence and sensitivity.

All major and minor stakeholders in the promotion of patients' rights should be identified. Analyze who are for the cause, against it or apathetic to it. There should be a selective and focused meeting with key organizations to plan a joint campaign for patients' rights. Strategic allies within government, among physicians and health care providers, and in media should be recognized; actions for advocacy and promotion of patients' rights should be mapped out. A time-bound campaign period with achievable milestones and tools for monitoring and evaluation should be planned. A series of dialogues may be held with various partners and stakeholders.

Research and surveys may be conducted among patients and health care providers to find out their views and experiences on patients' rights. Strategy planning with key allies and outlining of short, intermediate and long term goals and objectives should also be done. Through these actions, cooperative and collaborative approaches are more likely to succeed.

The ultimate goals in promoting and safeguarding patients' rights are as follows: the development of Codes of Ethics for Physicians and Other Health Professionals; procurement of financial support for the networks of patients' groups, consumer associations and health NGOs from government and private resources; legislation of a Magna Carta or Charter of Patients' Rights; integration of patients' rights in the school curricula of elementary, high school and medical/health sciences education; and continuous operations research on how best to implement patients' rights and the impact they have on health.

In conclusion, the Primary Health Care strategy can be the start of a restructuring of the health system that enables and empowers the people and communities to take health into their hands and transform their situation of poverty to a situation of prosperity. This has been proven time and again by organizations since 1975. Although transformations have occurred only at the community level, such transformations have laid the foundation towards genuine national recovery. When rural and urban poor communities begin to actively participate in matters affecting their destiny and in issues that will liberate them from poverty and ignorance; when such communities are able to sustain their efforts in an organized manner; when such actions are further nurtured and fully supported by other community and sectoral organizations, then we can say that Primary Health Care has done its job for national recovery.

Primary Health Care is an imperative. However, it cannot be the answer to all the illnesses of our country. Let us not have the illusion that self-sustaining/self-financing community health is achievable without having a redistribution of economic resources. Let us not be misled that we can have “Health for All” without freedom from foreign domination, genuine land reform, Filipino industrialization, and the full restoration of our political rights and freedom.

Primary Health Care has not been given its rightful attention and importance in health sector reforms of our country. Let there be a serious reflection and assessment on the ways and means to ensure the vibrancy and vitality of Primary Health Care. Political will and commitment to Primary Health Care still hold the key to achieving “Health for, by and with All”.

Chapter 3. In Focus: Community-Based Health Programs in Building Transformative Healthy Communities

Individual health and wellness are very much affected by the health and wellness situation of our community. Whether this is the community where we live or the community where we work, the collective behavior of community members eventually determines the direction and tempo of our personal health and wellness. Thus, it is also imperative that we give importance to community health and wellness.

CBHP 101

In the previous chapter, the Samar CBHP was studied as an example of a program using the Primary Health Care approach in the delivery of health care in the community. The Samar CBHP is one of the earliest non-government CBHPs in the country, which has existed in the Philippines since 1975.

In general, the broad objective of NGO-CBHPs is the creation of basic organizations for total human development through increasing awareness, people's participation, organized action and self-reliance in health and development activities. Such an objective, however, demands meticulous planning and implementation to ensure its accomplishment.

A. Establishing Community Rapport

One of the initial steps in establishing a CBHP is organizing Community Dialogical Encounters. This consists of the following activities: entry into the village, integration and immersion with

the people, conducting social investigation (an informal data gathering done by the community organizer that forms the baseline database), spot mapping of the village, leader spotting, and contact building. This process takes 2-3 months. During this time, the CO lives in the village. The CBHP then formally enters an area only when social preparation and community processes have already been done, usually by other Church and non-government groups.

Organizing the community involves leadership identification and development, community resources inventory, formation of community working or interest groups, launching of community health campaigns, establishment of a formal structure with constitution and by-laws, and continuing organizational development and financial sustainability of the organization. If a community already has these processes in order, community organizing processes are used to further strengthen the existing organizations.

An organizing group is formed from the leaders who have been spotted and the contacts made by the CO. This group is then given leadership and organizing skills. After this training, they organize the village into any of the following sectoral groups: farmers' youth, women, or small family groupings or clusters of 10-15 households. Each group elects its own leader. This process takes another 2-3 months.

Through these basic community groups, community and class issues are discussed. A community issue is a problem that affects all economic classes – e.g., water supply, transportation, education. On the other hand, a class issue is a problem that affects a specific economic class of the community, e.g., land issues affecting small and landless farmers. These

groups provide the main venue for people's decision-making, planning, implementation, and evaluation of any action, project or mobilization initiated in the village.

Each sectoral group or small family group chooses its own community health worker.

Traditional healers who are not chosen as CHWs are encouraged to participate in the program.

The CHWs eventually constitute the health committee of the community.

B. CHW training

The chosen CHWs are given a pre-training seminar, facilitated by a staff member. The CHWs choose the schedule and place of training. They consider the time most convenient for them, e.g., weekends, not during the harvest or planting season, climate and village feasts are also considered. Logistics are also discussed. The community is mobilized to support the training and expenses of the CHWs. This is usually done through contributions in kind or through a fund raising activity. Possible problems that may crop up during the training are also taken into consideration. The CHWs are asked about their expectations in terms of what they want to learn from the training seminar and what skills they would need to fulfill their role as CHWs. Through group dynamics sessions, the CHWs undergo a process of self-awareness raising. The aim is to bring out the individual's strengths and weaknesses as they relate to his role as health worker.

The community health needs and resources are determined through a community survey. The formulation of questions is done during the pre-training seminar. The CHWs are asked, "What data would you need in order to know and understand the health problems in your community?" Basic questions about the health, economic, political, cultural, and educational situation are

eventually framed. The CHWs are then given time to analyze, criticize, and simplify the survey questions that have been put forward. The questions are written in the local language. If there are too many questions formed, they are then prioritized as to what data are most urgently needed to make a community diagnosis, which, essentially, refers to identifying the most pressing problem of the community.

This initial survey should be kept short – around one to two pages or 10-15 questions at a time – so as not to overburden the CHWs and the community. Other survey questions can then be asked later in another survey. This method of staggering the survey has been found to be most practical for the CHWs.

Before conducting the survey, the CHWs role-play a sample interview. They place themselves in a situation as if they are actually doing the survey in their village.

The community health workers themselves do the survey and community diagnosis. The collated questions are then reproduced and the survey forms distributed to each CHW. The CHWs are given 2-3 weeks to conduct the survey. Since each health worker is assigned to 10-15 households, a minimum of one house per day to survey becomes achievable. If the CHW cannot read or write, he may request a relative or a neighbor to assist him in writing in the survey form while the CHW does the interview.

Once the survey is accomplished, the CHWs together with the staff collate and analyze the data. The community problems are then identified. The results, which is a list of priority health

problems is fed back to the community. These are then presented to the small family groupings or sectoral groups for reflection and feedback. A list of priority health problems in the community is formulated. This is the most important result of this process of community survey. The community, CHWs, and the staff therefore become more aware of what the actual health needs and problems of the community are. This activity aims to stimulate the community groups into mobilization on the issues that came out from the survey.

As discussed in the previous chapter, three broad categories of CHW functions are usually expressed by the community: leader, teacher and health worker (though not necessarily always in this order).

The CHW functions as a leader when he organizes his community towards better health. His task as a leader would include organizing mass campaigns on sanitation and immunization, initiating communal food production, and encouraging the people to participate in other development activities.

The CHW is a teacher when he shares whatever he learns from the training seminar to his small family grouping. This way, his newly acquired knowledge and skills are also taught to the community. Conducting health education sessions becomes one of his tasks.

The CHW acts as a health worker by attending to the immediate health needs of his community. His tasks therefore also cover curative and preventive activities on the common health problems identified in the community survey.

The tasks and functions described above thus are not limited to health but also require leadership, organizational, teaching, and communication skills.

The community survey results as well as the CHWs' expectations and tasks are considered in curriculum formation. Important attitudes, knowledge, and skills are made into learning objectives. The result is a curriculum design, which also includes the content, teaching/learning methods, media and materials needed, time allotted, and evaluation tools for the learning objectives.

It has been noted that certain features make community health workers' training effective. Training should be based on local needs and demands. It should be competency-based and problem-oriented. A staggered training course is also better, with plenty of practicum and application of knowledge, attitude, and skills. Rather than lectures, more active learning modules should be utilized. A trainer should act like a facilitator and motivator of learning.

Topics for training are outlined. For each topic, the corresponding attitudes, knowledge, and skills that the CHWs should acquire are listed. These attitudes, knowledge, and skills are then analyzed and classified into the following categories: must learn, useful to learn, and nice to learn (see Appendix 1).

The attitudes, knowledge, and skills that every CHW needs to be competent in his work are considered to be "must-learn". These are the things that training staff must stress the most.

These are also the things that will be evaluated after the training. The attitudes, knowledge, and skills that have been marked “must learn” become the basis for the formulation of learning objectives. These objectives should relate to the tasks the CHW is expected to perform after the training period. As an example, Appendix 2 shows the “must learn” attitudes, knowledge, and skills transformed into learning objectives for the topic of diarrhea.

Once the learning objectives have been written, appropriate teaching and learning methods are chosen. Teaching methods should involve active learning and stimulate maximum participation of CHWs in the learning process. Examples of these include practical work, simulation exercises, role-playing, demonstration-return demonstration, and group dynamics games.

The corresponding training media and materials are then listed. Efforts are made to have as many reference materials and handouts in the local language as well as available visual aids and other graphics that would make learning easier for the CHWs.

The time needed to attain each learning objective is apportioned. This would depend on the total number of hours available for a specific topic.

Finally, the training staff formulates ways on how each of the learning objectives will be evaluated. Usually, for the evaluation of the cognitive aspect, a multiple choice question examination or an essay question is prepared. Attitudes are evaluated through a Likert scale or semantic differential scale. For the psychomotor aspect, a checklist is made for each skill to be acquired and the CHW’s performance of the tasks is observed. These evaluation methods

constitute the pre-test and post-test given at the start and end of each topic during the training seminar.

All the above information is written in a table format and becomes the curriculum design. The curriculum design is used by the staff as a guide to keep the training seminar well-organized. Appendix 3 shows an example of a curriculum design for the topic of diarrhea.

The training is usually held either in the village or in the town. The training period is staggered. It is either done every Saturday and Sunday or 5-7 consecutive days once a month. The days chosen are the time when the CHWs are free from their farm work or other occupations.

The training process used in CBHP is dialogical, evocative, experiential, practical, and participative; it is mainly patterned after Paolo Freire's methodologies. Dialogical means that there is constant communication between trainees and trainers wherein each one learns from each other. The teacher and the student constantly interchange roles. Evocative and experiential suggest a process of questions and answers wherein the trainer first evokes the trainees' experiences, perceptions, and beliefs regarding the topic being discussed. For example, before any input on diarrhea is given, the CHWs are first asked what their ideas and beliefs about diarrhea are – its definition, causes, traditional treatment, etc. This allows the trainer to start from where the CHWs are and build on that base. Emphasis is placed on what they have encountered in real-life situations. Practical means that the training is adapted to the level of the CHWs with the local language as the medium of instruction. Should there be scientific terms introduced, these are painstakingly explained until they are well understood. Appropriate visual

aids are regularly used to further explain concepts. Participative means that the CHWs are asked to do more rather than just look and listen. The principle followed is: “Hear and Forget; See and Remember; Do and Understand.”

A typical training seminar may evolve in the following manner. It can start with a lively action song or an icebreaker. Then, the expectations of the CHWs on the topic to be discussed are solicited. The staff members also give their own expectations. The learning objectives are explained. A pre-test on the topic is given. An evocative discussion on the subject matter then follows. Input is given as needed. Afterwards, depending on whether it is knowledge, skills, or attitude that needs to be reinforced, role-playing, small group discussions, simulation games, return demonstrations, and other learning activities are performed. Should there be boredom or some waning of interest, an action song, a group dynamics game, or a short break would be a good intervention.

Thus the training seminar is a cycle of evocative discussions, inputs, learning activities, action songs, and group dynamic games. The evenings are usually reserved for socialization and individual study.

When all learning activities for the topic have been performed, the post-test is given to see if the learning objectives have been accomplished. Discussions on the post-test follow. Pre-test and post-test results are given individually. Finally, at the end of each training session, an evaluation of the training itself is done. The CHWs and staff reflect and write down the strengths and weaknesses of the training content and process.

Comments are also made on the quality of participation of each CHW, community-building or camaraderie, food, and accommodations. Recommendations and suggestions for improvement are given.

Since the training seminars are staggered, the attitudes, knowledge, and skills acquired are applied in between them. These periods also provide time for the CHWs to internalize what they have learned.

C. Community Activities

The following are the usual activities done by the CHWs in the community:

1. Sharing Sessions with the Community Groups

The CHWs are encouraged to hold regular meetings with their small family or sectoral groups to share whatever they have learned from the training seminars. This is one area where health education and preventive medicine are put into practice. CHWs also teach simple home remedies like oral rehydration, medicinal plants, and traditional massage. This is to encourage community members to rely more on themselves for their simple health needs.

2. Provision of Curative Services to the Community

Curative care is provided either through home visits or when community members actively seek the CHW's help when someone is sick. A combination of traditional and Western medicine is used. Referrals, when necessary, are sent to the government's rural health unit or to local

hospitals with which CBHP has established linkages. The CHWs keep a record of patients who come under their care.

3. Community Health Mobilization

During the teaching-sharing sessions with the community, urgent health issues are eventually brought out by the community. This facilitates mobilization of the community on specific health issues like environmental sanitation, food production, etc. The community may petition the local Rural Health Unit or the Department of Health to provide them with services that the CBHP cannot provide, e.g., immunization for their children or diagnosis and treatment of malaria and schistosomiasis.

The CHWs in a village are visited at least once a month by a staff member. The CHWs keep a record book that becomes the basis for sharing with the staff whatever problems they have met or situations which they could not handle.

The achievement of these results can now be assessed by the monitoring system.

Since the training of CHWs is one of the major health activities, a valid concern is whether the skills of the CHWs are sufficient to successfully perform health activities. A monitoring system – one that is relevant, participatory, feasible, useful, valid, and reliable – is needed. The monitoring system will assess the efficiency of the program as a partnership among the community, CHWs and the staff.

D. Performance Monitoring

Knowing now the process and results to be monitored, the design of the monitoring system consists of the following steps:

1. Determination of the Management Questions. These should reflect the program's priority targets: Does the process achieve its goals? Does it lead to increasing awareness? Does the result lead to organized action and foster self-reliance?
2. Identification of parties involved in each step of the process and affected by each result, whether from the community, the CHWs or the staff.
3. Determination of the Decision Options. These are actions to be taken if management questions are answered in the negative.
4. Selection of Criteria. What parameters will determine whether the process and results are achieved?
5. Selection of Key Indicators. Key indicators should be valid and reliable to measure the level of fulfillment of the criteria.
6. Selection of Standards. These are trigger points which the decision makers will take action.

7. Determination of Information Needs. These will be based on the criteria and indicators selected.

The next action to take after designing the monitoring system is its implementation, which involves the following steps:

1. Selection of Information Sources from Existing Ones. The current information tools are reviewed and new ones are created as needed.
2. Collection of Data. This is done together with the community, CHWs and staff.
3. Analysis and Interpretation of Data
4. Decision for Action. The decision options are considered, which may include changing or modifying the monitored process.
5. Action and Continuation of Monitoring. The rectifying action is implemented and monitoring starts all over again.

Finally, a proposal for testing and evaluating the monitoring system is given. It will be tested in the program areas using the following criteria for evaluation: participation, feasibility, relevance, usefulness, reliability, and validity. A proposed questionnaire will be answered by the community, CHWs, and staff.

The Doctor as a Community Leader

The doctor working in the community, at one time or another, will serve as a community leader – albeit transitionally, that is, only until the members of the community have finally obtained the knowledge, skills, and attitude needed to lead their own communities. It is imperative that the doctor should employ community and sector participation, involving the barangay captain and council, parish priest and council, school principal and PTC, other physicians, youth, and students in all aspects of the mobilization.

The community doctor should enlist the support of the business sector, civil society groups, cooperatives and other professionals, community organizations, city/municipal level agencies, federations and advocacy groups, relevant national institutions, technical agencies, and donors. All community resources – both material and non-material – should be tapped.

He/she should know the issues of the community well. The issues confronting the doctor as a community leader are diverse, ranging from the spread of communicable diseases such as TB, typhoid, hepatitis and dengue, poor environmental sanitation, substance abuse, crime, violence, kidnappings, domestic violence and child abuse, occupational health and safety in markets, barangay constructions, neighborhood industries, and school health and nutrition issues. He/she can do a SWOT – strengths, weaknesses, opportunities and threats – analysis of these issues. At the same time, he/she should determine who are allies and who are adversaries.

Visits and meetings with the barangay captain and *kagawads*, parish priest, and key lay leaders are beneficial. Through these meetings or other venues, the community doctor may find out the views of other members of the community.

Committees or task forces can then be organized to work on the issues. Together, strategic action plans can be formulated and implemented. Regular assessment and evaluation will help to make sure that the targeted issues will be addressed.

Victories should be celebrated and lessons learned from mistakes and failures should be outlined. The community doctor can also share his/her experiences with other physicians, higher authorities like the mayor, city/municipal council, local congress representative, and members of the community by writing for a local publication or inviting a journalist to cover community events for publication in the dailies or weeklies. Though being a community leader is but temporary, it is nevertheless an important role of a doctor, and is something that will prove to be edifying not only for the community but for the doctor as well.

A Note on the Role of Filipino Attitudes and Values, and the Use of Developmental

Terminologies

The cultural milieu should also be taken under consideration in community organizing. Filipino culture, in particular, has certain characteristics that must be understood in order to make any health program a success.

Philippine society, as F.L. Jocano has noted, is more group-oriented than individualistic.

Pakikisama, or maintaining harmonious relations with one another, is paramount. Filipinos tend to be more concerned with what others say than what their actions would merit. Filipino group-orientation also causes a tendency for the Filipinos to be sensitive to the hierarchy of authority. Authority is associated with the organizational status and the age of the ranking official.

The family is the core and most important unit of the Filipino social system. The family is the source of economic, social, and psychological support. The *barkada* or the peer group is the Filipinos' outside – non-family/kin – psychological and economic support system. The family and the *barkada* are two discernible causes of the intricate networking in Philippine business and politics.

Filipinos are characteristically sensitive people. Feelings are valued more than logical reason. Logical reasoning is used, but is focused more on establishing harmony with – rather than mastery of – natural and social events. *Asal* is the internal code of conduct governing Filipino behavior that provides moral substance to the Filipino system of recognition, expression and evaluation. It functions as the inner source of the moral and ethical rules governing desirable behavior, referring to what is really important. This would encompass such concepts as *pakikipagkapwa* – “being part of,” or “being in equal terms with others”; *pakikisama*, the desire or demand to “get along” with someone; *pakikitungo*, being civil, acting humbly, relating to others in the most appropriate way; and *pakikiramay*, an expression of voluntary concern and support.

Damdamin, in turn, refers to the emphasis Filipinos place on feelings and emotions. Emotional imperative/standard are placed on norms such as *hiya* (politeness or compassion, a norm defining both private and public behavior), *delicadeza* (refinement, or sensitivity to ethical rules governing propriety of a social behavior), and *amor proprio* (self-esteem). Other values include *awa*, which usually refers to crisis-oriented compassion, going out of one's way to offer assistance; *dangal* or personal honor and dignity, which characterizes one's identity and pride; *pagbabahala*, responsibility and accountability; *galang* or respect; and *utang na loob* or a debt of gratitude that requires reciprocation.

Filipino culture can be made to work towards team building. One must accept the centrality of the family in each Filipino's life and that it is the family that provides context and meaning to Filipino community life. The ties of kinship help the dynamics of interactions at the highest levels of politics and business. Family and peer group dynamics must be recognized and used to get support and involvement in important corporate undertakings. One must be sensitive to the authority structure and consider seeking group approval instead of immediate enforcement of one's decision. Specifically, two values may prove to be extremely important in team building: *pakikisama*, which refers to being supportive of, being concerned about, and going along with someone, if necessary, to achieve something for the individual or the group and *pakikitungo*, which is a way of handling situations when the consequence of an action is not within one's immediate control, humbling oneself, if necessary, to avoid conflict and to achieve what one wishes to accomplish.

In communicating, *pagsasangguni*, *paghihikayat* and *pagkakasundo* should also be considered. *Pagsasangguni* (consultation) involves sharing responsibility by getting people to participate in planning and in implementing group activities. It links the members of the group and motivates them, since they are not considered subordinates but partners in decision-making. *Paghihikayat* (persuasion) is also vital; Filipinos expect to be shown and convinced how and why certain things ought to be done. In Filipino traditional psychology, it is the most important method of “winning friends and influencing people”. In arriving at a decision, *pagkakasundo* (consensus) is essential. One abides by the judgment of the group because it is what everybody in the group accepts as logical and better than the other alternatives available. When the consensus is reached, it is easier to communicate with team members and to direct team activities toward the accomplishment of group goals.

Motivating can be a balancing act, as *hiya*, *delicadeza*, *amor propio*, and *awa* may be in play. *Hiya* or politeness serves as a means of social control. It tempers tendencies to be confrontational or adversarial. *Delicadeza* requires sensitivity to transgressions of social propriety. *Amor propio* may be used to create self-discipline by appealing to each person’s sense of self-importance.

Aside from taking into consideration local value systems, the terminologies used in training sessions should be thought about. Many commonly used terminologies may be hindrances to the promotion of true development.

Development refers to the empowerment of the poor and deprived, such that they can participate in decision-making that will affect their lives. This implies that the poor should be allowed to (1) identify and prioritize their own problems; (2) assess their needs; (3) formulate their visions and goals; and (4) plan, implement, monitor, and evaluate their own programs and projects or participate in planning, implementing, monitoring, and evaluating projects and programs of government agencies and non-government organizations.

Development should be for self-reliance. This means that development workers and their agencies should strive to cut the dependency of the poor. In a way, development workers should be self-destructing – that is, they are committed to phase out their presence in the community, lessen their importance over time in the eyes of those whom they have decided to help. They may want to consider themselves to eventually be just a resource person to be tapped by the community, and not as the benefactors, heroes, or legends they may subconsciously want to be.

Some examples of terminologies that merit a change include names we give to the poor (Table 2).

Table 2. Examples of terms commonly used to refer to the poor and proposed alternatives

<u>Commonly Used Terms</u>	<u>Alternative Terms</u>
Beneficiaries	Partners
Clientele	Counterparts
Targets	Colleagues
Recipients	Co-workers
End-users	Associates

The terms “beneficiaries”, “clientele”, “targets”, “recipients”, and “end-users” imply that the poor are viewed as **objects** rather than **subjects** of development; that the poor are always on the receiving end, rather than active participants in planning and implementation of programs; and that the poor have nothing to share and only development agencies have the means, the resources, and the services. The alternative terms “partners”, “counterparts”, “co-workers”, “associates”, and “colleagues” view the poor as co-equals of agency workers in development work.

Problem statements may also need revision (Table 3).

Table 3. Examples of problem statements and proposed alternatives

<u>How Problems are More Often Stated</u>	<u>Alternative Ways of Stating Problems</u>
– mothers not interested in immunization	– lack of efforts of agencies to disseminate information on immunization
– mothers lazy to bring their children to be weighed	– inadequate outreach services to the community for growth monitoring
– the poor are generally lazy	– lack of opportunities for the poor to get jobs; if ever the poor have jobs, they are not given just compensation for their labor inputs
– ignorance of poor mothers on basic hygiene, health, and nutrition	– lack of access of poor mothers to informal education, health, and social services

– child prostitution/child prostitutes	– sexual exploitation of children/sexually abused or exploited children
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Problem statements usually put the blame more on the poor rather than point out the inadequacy of the delivery system of agencies mandated to provide services to the people. This is not to say that the fault is only on the side of development agencies. The point is to go into self-reflection first – reviewing our system, approaches, and methodologies as well as our motivation and commitment before blaming our partners. An analysis of the root causes of the problems will help in focusing on systems and structures that create situations of inequality and injustice. Let there be sensitivity in the formulation of problems so that the poor do not always get the blame.

A special note on the terms “child prostitution/child prostitute” versus the terms “sexual exploitation of children/sexually abused or exploited children”: the former terms put the blame on the child, while the latter terms put the blame on adults and society. Children would never want to be prostituted. They have been forced into sexual abuse!

Our terminologies concerning processes and methodologies may also be modified (Table 4).

Table 4. Examples of commonly used process/methodology terms and proposed alternatives

<u>Commonly Used Terminologies</u>	<u>Alternative Terminologies</u>
Social Preparation	Community Dialogical Encounters
Community Preparation	Establishing Community Rapport Building Community Reciprocity

Awareness Building	Mutual Awareness Building
Consciousness Raising	Mutual Consciousness Raising
Government-NGO Collaboration/Partnership	Government-NGO-Community Partnership
Use of Community Volunteers	Development of Community Volunteers

The terms “social preparation” implies that the community is not ready, that only the development agency is prepared and knows better. From the point of view of the community, it has a condescending effect. The alternative terminologies “community dialogical encounters”, “establishing community rapport”, and “building community reciprocity” connote a sense of give and take and equity between communities and development workers.

The terms “awareness building” and “consciousness raising” imply that only development workers are aware and have a higher level of consciousness. These terms do not take into consideration that the poor are aware and conscious of their problems and situation. The other implication is that the development worker does not allow himself/herself to be made conscious and more aware of the true situation of the poor in the process of his/her interaction with the community.

“Mutual awareness building” and “mutual consciousness raising” are improvements on the abovementioned terminologies. These terms recognize that through exchanges between the

community and development workers, both parties are made more aware and their levels of consciousness raised. Awareness building and consciousness raising are therefore not the exclusive domain of development workers alone. The community participates as well in making the development workers more conscious.

As for the terms “government-NGO collaboration”, the community should always come into the partnership since they are the subject and center of development.

Regarding the term “the use of community volunteers”, the question is who “uses” whom. The term as written implies that the development agency uses the community volunteers for the agency’s benefit, usually to implement their self-designed projects. The term “development of community volunteers” is more neutral.

The Goal: Transformative Healthy Communities

Having worked with community-based health programs for the past thirty years, I made a review of effective strategies and actions to ensure the health and wellness of communities, whether urban or rural:

1. Community participation and involvement. The majority of community members should participate in the identification and prioritization of their health. They should also actively participate in planning, designing, implementing, monitoring, and evaluating solutions and programs to respond to these health problems. This is essential for all the phases of community

health management cycle. Without this, most community health programs will not succeed since the support of the community will be difficult to sustain.

2. Community organizing. This strategy has been used in two circumstances – when a community is unorganized and when a community is already organized but needs strengthening using the primary health care approach. Community organizing results in the establishment of community-based organizations, people’s organizations or sectoral organizations.

3. Building trust groups. This is a modified form of community organizing wherein members of the community who trust each other form community caring clusters. However, existing community trust groups – informal networks of families that regularly assist each other – may need to be unraveled in order for their mechanisms to be tapped to help other families in need that are outside their network. The different levels of trust relationships are established using a sociogram and validated by a series of community workshops. The health caring mechanisms are first used within the trust groups and can be eventually expanded to include additional community members. Community trust groups have been tapped in the health referral system across all levels from community to health center to hospitals.

4. Building Community Capacities. Efforts should go beyond starting community-based health programs. Skills in community leadership and management, community organizational development, good governance, community financial and resource management, negotiation and conflict resolution skills, advocacy, and social mobilization must also be developed among community members with equal intensity.

5. Election of health leaders and workers by the community. If the selection is done by the barangay captain or the program manager, community health workers do not last long in their volunteer work. Volunteer community health leader-teacher-health workers are elected by the community members and provided moral and material support by the community. They eventually compose the community health committee. The community selection process guarantees a partnership and a pledge of commitment and support between the chosen community health workers/leaders and the community members.

6. Community Linkages and Networking. The community health committee is linked with the Barangay Development Council. It is vital that networks be established with other health committees of other barangays, other people's organizations, non-government organizations (NGOs), national and local government agencies, and the private sector for mutual support and coordination. A federation of barangay or community health workers at the municipal level further facilitates the networking process. Liaisons are also made with the local chief executive and local health officers. If moribund, the Local Health Board is revived.

7. Community Health Systems Development. Communities also need to build on systems to produce results and achieve objectives. Examples of these include: community health information systems (like the community health data boards and community health maps); water and environmental sanitation systems (with a community water and sanitation management team); community health financing (with community social health insurance as a main component); community health care delivery systems (with an integration of conventional health

care services and traditional indigenous medicine); food production systems (with family food gardens as component); and a community health human resource development system (with focus on volunteer community health workers, traditional healers, traditional birth attendants and mothers as family care givers).

8. Liaison with the Local Chief Executive and Local Health Officer. In the era of decentralization and devolution, effective working relationships with the mayor, governor and barangay captain have become indispensable. The internal revenue allocation of local governments can be tapped for health and wellness programs and activities.

9. Re-activation of the Municipal Health Board. While this is mandated by the Local Government Code, around 30% of all municipal health boards are not working well. An active and effective Municipal Health Board ensures actions are taken on health policy issues and resources that will strengthen community health and wellness are mobilized.

10. Integration of Primary Health Care Programs. Ministries and Departments of Health generally work using a top-to-down planning and programming approach. Thus, through the years, there has been a proliferation of “vertical” programs like immunization, tuberculosis control, maternal and child health, growth monitoring and promotion, family planning, and malaria, to name a few. Each “vertical” program would have its own planning guidelines, training modules, monitoring and reporting systems, etc. All this leads to an overburdened staff at the local government unit level filling up various reporting forms and attending all kinds of trainings.

However, at the community level, a horizontal, integrated and participative approach works best. Community health care is needs-based and responsive to day-to-day health illnesses of its members. “Vertical” health programs have had their heyday. The Primary Health Care approach has shown that integration or “horizontalization” is possible. Examples of these are the integrated approaches to health, nutrition and population programs; the integrated management of childhood illnesses (which combines the services of breastfeeding promotion, immunization, growth monitoring and promotion, complementary feeding, micronutrient supplementation, treatment of acute respiratory infections, control of diarrheal diseases, malaria and intestinal parasitism control); integrated women’s health and reproductive health services (that combines maternal health and nutrition, family planning, reproductive tract infections including sexually transmitted diseases and HIV-AIDS management, violence against women, post-abortion care management, infertility management, human sexuality education, and adolescent reproductive health promotion); and integration of vector-borne diseases control programs (includes malaria, lymphatic filariasis or elephantiasis, and dengue fever).

Such strategies are still viable in the context of decentralization, devolution, and empowerment of communities. While family and household health production is influenced by local, national, and global issues, the task of national and local health leaders is to facilitate health production in partnership with families, households, and communities.

With years of practice in empowerment, people power, and participation, can community-based organizations work together in partnership to define their own agenda for development of their

communities based on their individual advocacies and issues? Can they select leaders that will promote and implement their formulated agenda? And once the leaders are elected to positions of power, can the communities hold them accountable for their action and for promoting their agenda for development?

The answer is **yes**: poor rural and urban communities can transform and become truly healthy communities. They can be healthy in the six dimensions of health and wellness, namely, body (economics), mind (politics), soul (spiritual), heart (histo-cultural), hands (social), and feet (environmental).

So what is a truly transformative and healthy community? It is a community of people of common history and interests, shared values, practicing progressive politics, and with goals and aspirations for the overall good. Decisions are reached through participatory processes and consensus building. And the members are able to engage the power structures operating in their community and manage the change process.

They have human rights-based objectives such as the rights to access productive resources, social services, and social protection. There is principled partnership between civil society, government, and the business sector. Community-managed enterprises abound where communities control technologies and culture. They have culture-based development and a community-determined standard of service and leadership. The focus is the total human development of disadvantaged and marginalized sectors. Social inclusion rather than exclusion pervades. The community members have the courage to trailblaze; are able to agree to disagree;

have a system of communication with each other and with others; and foster networking and international solidarity.

They have experienced continuous struggles, always meeting them with action-reflection-action. They use popular culture to convey values of peace, sharing, and respect. They continue to rediscover their arts and cultural heritage. There is capacity building, training, and convergence of enablers and leaders with abilities for management, mentoring, and resource mobilization. There is multi-sectoral, multi-disciplinary, and multi-stakeholder participation in the planning, implementation, monitoring, and evaluation of community actions, programs, and projects. They practice nurturing and caring processes.

The indicators of a transformative and healthy community are summarized in the acronym: “cocobread”, to wit: Critical, creative, and collective consciousness; Organizational development; Coalition advocacy; Overcoming gender and other biases; Basic services delivery; Resource upgrading and improvement; Economic self-reliance; Agricultural development; and Democratic participation in governance.

Is it utopia? No, it is real in the current Philippine context. While there are still greater challenges to be faced by these communities, their members are motivated to commit themselves to advance the development of transformative and healthy communities. In such communities, hope is renewed; optimism strengthened; joy is rejuvenated.

Chapter 4. A Radical Change of Perspective: Traditional and Integrative Medicine

Let me just state at the start, that as a physician, I have a very positive attitude towards folk medical practices, traditional medical beliefs, *hilots*, and *herbolarios*.

For many years now, I have been involved in community-based health programs. I have come to realize that to be truly effective in working with communities as a health worker, one needs to have a good grasp of the culture of our people, especially the culture of the rural areas – the culture of the poor. One therefore needs to undergo a radical change of values. The health worker who has been mainly educated in the cities would have to acculturate himself first before entering into any planning schemes with the community he will be working with. He must keep in mind that he is dealing with people who have been brought up in a different way and have a different cultural orientation.

I have also come to learn to accept the fact that certain practices have positive values in the lives of the people I have been working with. In the realities of the rural areas, traditional, or folk medicine has been a valid means of coping with the local health problems; its effectiveness in overcoming illnesses even matches comparable scientific applications.

Aside from reading the latest scientific medical journals relevant to my practice, I have had to review and read a lot more on our history, on sociology, anthropology, psychology, and philosophy. Modern medicine, I believe, is more of a social science than a natural science. We

are mainly dealing with people and not just with diseases per se. Moreover, we are dealing not only with a single person as a patient but his family and community as well.

The doctor therefore assumes a multi-faceted role – as healer, teacher, organizer, social worker, and community development worker. I don't consider these roles as extra tasks. In fact, I consider them part and parcel of being of true service to our people. It is about time that we bring back medicine as a truly service-oriented profession and not what it is becoming now – a profit-oriented enterprise.

Our approach to medical care should be holistic; meaning, we take care of the person as an individual in his entirety; we see not only his disease, but the impact of the disease to his person. We also consider his environment – all of the things that encompass his life: his family, his livelihood, his community – his entire world, in effect. We believe that until we have done this, we are only touching his health problems very superficially.

Integrative Medicine: Definitions and History

There are different definitions of complementary medicine, alternative medicine, and integrative medicine, as made by different institutions.

The National Center for Complementary and Alternative Medicine in the US defines complementary and alternative medicine (CAM) as a group of diverse medical and health care systems, practices, and products that are not currently considered to be part of conventional medicine. Integrative medicine, in turn, combines treatments for which there is evidence of

safety and effectiveness from conventional medicine and CAM. The Cochrane Complementary Medicine Field characterizes complementary medicine as “all such practices and ideas that are outside the domain of conventional medicine in several countries and defined by its users as preventing or treating illness, or promoting health and well-being. These practices complement mainstream medicine by 1) contributing to a common whole; 2) satisfying a demand not met by conventional practices; and 3) diversifying the conceptual framework of medicine.” In the Philippines, R.A. 8423, which mandated the creation of the Philippine Institute of Traditional and Alternative Health Care (PITAHC) defines "traditional and alternative health care" as the sum total of knowledge, skills, and practices on health care other than those embodied in biomedicine, used in the prevention, diagnosis, and elimination of physical or mental disorder.

However, these definitions and even the names “complementary medicine” and “alternative medicine” are somewhat inaccurate and prejudiced. By classifying modalities as “complementary”, “alternative”, and “not part of mainstream medicine”, these terms effectively label CAM modalities as second-rate to Western medicine, which is not and should not be the case. The term “complementary and alternative medicine” nevertheless has more or less been ingrained in medical and lay communities alike, and is used in this discussion for the sake of convenience and clarity.

In this light, I would like to propose a definition of integrative medicine. Integrative medicine views health as having six dimensions: spiritual, physical, mental, environmental, social, emotional, and social, promoting harmony among these dimensions in order to produce wellness.

Integrative or holistic medicine thus involves modalities commonly ascribed to complementary and alternative medicine, including traditional medicine, in addition to Western medicine.

The recognition of traditional medicine was started by the WHO, when in 1978, the Alma Ata Declaration on Primary Health Care (PHC) ruled the integration of traditional medicine with PHC. In 1999, the US Congress established the National Center for Complementary and Alternative Medicine (NCCAM) in the National Institutes of Health (NIH) Bethesda, Maryland. CAM derives its modalities from great traditions of medicine such as Chinese Traditional Medicine from China, Korea, Japan, and Vietnam; Buddhist traditions from Mongolia; Ayurveda from India, Pakistan, Sri Lanka, and South Asia; Yunani-Tibb from Iran, Iraq, Turkey, and Arabian states; and traditional medicine from North America and Europe. Examples of CAM include:

- the concepts of yin-yang; 5 element law; acupuncture, acupressure, moxibustion, tuina, medicinal plants, chi-gong, tai chi, animal, and mineral medicine from Traditional Chinese Medicine;
- humours (vata-pita-kapha), yoga, meditation, fasting, purification, medicinal plants, and aromatic oils from Ayurvedic tradition;
- homeopathy, iridology, health spa, psychic healing, Swedish massage, orthomolecular, anthroposophy, and macrobiotics popularized in Europe;
- chiropractic, osteopathy, prayer healing, nutraceuticals, music therapy, color therapy, chelation, and biofeedback from North America;

- Asian modalities such as reiki, shiatzu, Kampo medicine, reflexology, Zen meditation, Buddhist meditation, Thai massage, Tibetan medicine, and kalimasada;
- as well as distinctly Filipino healing modalities such as herbal medicines, hilot sa pilay, hilot sa panganganak, psychic surgery, biomagnetic healing, pasma, usog, babaylan, mumbaki, spiritual healing, bentosa, tawas, and hiyang.

Traditional Medicine and CAM in the Philippines

R.A. 8423 defines “traditional medicine” as the sum total of knowledge, skills, and practice on health care, not necessarily explicable in the context of modern, scientific philosophical framework, but recognized by the people to help maintain and improve their health towards the wholeness of their being, the community and society, and their interrelations based on culture, history, heritage, and consciousness. In turn, Filipino Traditional Medicine defines health and wellness as the state of harmony, balance, and synergy between humankind and the universe, between humankind and the environment, between and among humankind, and within the human body itself. This is the view shared by hundreds of Filipino traditional healers.

Filipino Traditional Medicine has been in practice for more than a thousand years as recorded in the annals of Asian travelers starting circa 8th century A.D. Even before the Spanish colonial era in the Philippines (1521–1898), traders from China, India, and Persia were visiting the islands of Southeast Asia. Thus, Filipino Traditional Medicine as it exists today is an eclectic mix of indigenous healing knowledge, attitudes, skills, and practices that has included a blend of great

traditions of medicine of China, India, and Greek-Persia with the conventional medicine of Europe and North America while basically retaining its distinct socio-cultural characteristics.

The Spanish chroniclers and friars also documented in full detail accounts of indigenous healing as practiced in the different islands of the country. Foremost in the Hispanic literature in the Philippines are botanical descriptions of medicinal plants and trees and their uses by various types of traditional healers. However, Catholic Christianity suppressed traditional healing practices, which were labeled as pagan and “works of the devil”. The medical and health system of Spain during its early colonial era in the Philippines was not yet the modern scientific medicine as practiced in Europe in the late 19th century but was also a mix of European traditional medicine mainly using natural substances such as herbs and minerals. Hispanic medicine was also greatly influenced by *Yunani-Tibb* (Greek-Persian) medicine since Spain was under the Moors of Persia and Arabia during the first centuries of the Second Millennium. Thus, when scholars examine present day Filipino Traditional Medicine, elements of pre-modern Hispanic medicine and *Yunani-Tibb* can be appreciated.

Modern European medicine, as a product of the industrial revolution and advancements in science, came to the Philippines with the establishment of a College of Medicine in the University of Sto. Tomas in the latter part of the 17th century. However, education was only available to the children of Spanish colonizers and a few Filipino *mestizo* elite. Modern European medicine was not accessible and available to the ordinary Filipino then.

It was only during the American Colonial Era (1898–1946) when universal education was made available to all Filipinos. North American medicine was inevitably introduced with the establishment of the Philippine Medical School in 1905, now the University of the Philippines College of Medicine. With North American health and medical systems embedded in government and society, Filipino Traditional Medicine was sidelined and ignored. With North American medicine dominating the culture of health, invariably, elements of the new colonizer's medicine made inroads also in the practice of Filipino Traditional Healing. These included the use of synthetic medicines especially in the urban and peri-urban areas.

Interviews with thousands of Filipino traditional healers and a review of literature reveal a unity of purpose and reasons-for-being of their indigenous healing practices:

- **Theory of Macrocosm and Microcosm** (*Kalawakan at Sangkatauhan*).
Filipino Traditional Healers believe that the universe (macrocosm/*kalawakan*) and humankind (microcosm/*sangkatauhan*) are interlinked and intertwined. Whatever happens in the universe has an effect on humankind and vice versa. Humankind must thus respect the environment, be it the far vast universe of stars and planets or the near, immediate surroundings of forests, mountains, fields, rivers, oceans, the atmosphere, animals, and other living creatures as well as communities of people. All of nature, whether living or non-living, seen and unseen, should be in harmony and peace. Any disrespect or disruption of this basic positive relationship will lead to destruction and death.

- **Theory of Elements (*Kalikasan*).** All things on earth and the universe, living and non-living, are composed of four basic elements: earth (*kalikasan ng lupa*), wind (*kalikasan ng hangin*), fire (*kalikasan ng init*), and water (*kalikasan ng tubig*). Each of these four basic elements has its own characteristics and manifestations in every object on earth that expresses their uses and effects. Each element is interrelated with the other elements and must remain in harmony and balance to achieve peace (*kapayapaan*), calm (*katahimikan*), and serenity (*kaginhawahan*) in the world. The four elements are also applied to health and illnesses; an imbalance of these four elements in the human body spells wellness or disease.

In contrast with the four elements of Filipino Traditional Medicine, in Traditional Chinese Medicine there are five elements: earth, fire, water, wood, and metal; the last two – wood and metal – are different from two of the four elements of Filipino Traditional Medicine. *Ayurvedic* Indian Medicine also has five elements with the addition of ether: earth, fire, water, wind, and ether.

- **The Theory of Humours - Hot and Cold (*Init at Lamig*).** Every object on earth, living and non-living, is also labeled as either hot (*init*) or cold (*lamig*). In Traditional Chinese Medicine this is the *yin* (cold) and the *yang* (hot). Balance and harmony must also be achieved between hot and cold within the human body and in the environment. A dominance of one humour will lead to a disease state (*pasma/pasmo, pilay/pi-ang*). Hot and cold labels are applied to

medicinal plants, food, aroma, daily life activities, and diseases. A disease labeled hot would be treated by a medicinal plant labeled as cold to achieve balance, thus restoring good health.

- **The Theory of Energy and Balance** (*Kisig at Patas*). Energy (*kisig*) is created by the interaction of opposite forces e.g. macrocosm versus microcosm and hot versus cold, and by the interaction of the elements of earth, wind, fire, and water. However, all of these opposite forces must achieve a state of balance and harmony (*patas-patas*). And in the human body, the interaction of humankind and the environment, the hot and the cold, and the four elements must also be in balance and harmony to achieve health and wellness.

In Filipino Traditional Medicine, causes of illnesses include the concept of *hangin* – whether present in food, the environment, or within the body; *bara* or blockage of energy; *pilay*; *pasma*; *hilo*; or poison. Illnesses may also be effects of seasons, habitat, diet, way of life, or days of the week.

Proponents of Filipino Traditional Medicine make use of pulse diagnosis (*pamulso*) as well as external diagnostic tools. These may include *tawas*, eggs, bottles, *dahon ng saging*, *papel*, animal sacrifices, use of *hilot*, laying of the hands, and reading of aura.

Therapies in Filipino Traditional Medicine include the use of herbal medicine; animal medicine; mineral medicine; *hilot* or massage; *bentosa* or cupping; food or animal offerings; prayers and *oracion*; *oslob* or fumigation or steam inhalation, bathing practices, pinching; *laway*; skin abrasions through coins or wood sticks; psychic healing; and angel healing.

Filipino Traditional Medicine also have measures for prevention of disease through *anting-anting* or amulets, *habak* tied around the waist or wrist, various *panagang sa buyag*, the use of garlic (*bawang*) or coconut oil (*lana*), and prayers and offerings.

With the increasing intensity of globalization starting in the late 20th century to the present, Europeans and North Americans also became open to accepting and absorbing the best of the great and little traditions of medicine of Asia into their conventional medical and health practices. Asia, on the other hand, has also embraced the European and North American models of health and medical care. We in the Philippines have also joined this trend and are now a curious, but all the same, a good example – we are an Asian country whose medical practitioners were primarily trained in Western medicine, and then eventually recognized and studied the Asian traditions of healing.

Private Filipino physicians started training in acupuncture in China as early as the 1970s. In the 1980s, DOH physicians also trained in acupuncture in China. Herbal medicine production also started.

As a response to the clamor for a quality health care system for the Filipino people on December 8, 1997, the Traditional and Alternative Medicine Act (R.A. 8423) was signed into law establishing the Philippine Institute for Traditional and Complementary Health Care as an attached agency of the DOH. It aims to develop effective, accessible, and affordable traditional and alternative health care modalities and integrate it into the present national health care delivery system. This law also embraces the possibility of overcoming the barriers on the convergence of Western medicine with alternative medicine. Furthermore, it encourages scientific research and promotes and advocates the use of traditional health care modalities proven to be safe and effective. It also develops and coordinates skills training courses, formulates standard guidelines and codes of ethical practice appropriate for integrative medical health care, and formulates policies to strengthen the role of integrative medical health care system in the Philippines. Filipino physicians have also since then organized the Philippine Association of Medical Acupuncturists Inc. (PAMAI) and the Philippine College for the Advancement of Medicine (PCAM) to promote the practice of CAM.

A new paradigm called the Integrative Medicine Paradigm is now emerging in our health care system, which aims for all to have better quality of life with good health using health options from both conventional medicine and alternative medicine.

Traditional and Integrative Medicine as a Solution to the Inadequacies of Western Medicine

The health care system in the Philippines and other countries is now slowly evolving into the paradigm where the mind, body, and spirit are integrated to fully heal an individual. The dictum of only treating the disease now belongs to the past. Healing does not involve only the body but

the different aspects of the individual as well. People are continuously seeking more options to maximize their health potentials and subsequently improve their quality of life.

Traditional Medicine modalities have been a part of Filipino culture for as long as we can remember. They are being used until now not only for curative purposes but for prevention and health promotion as well. In a study done by Madamba et al., entitled “The Current Practice of Acupuncture and its Perspective in the Philippines”, it was noted that in the past, people had several reasons for the pursuit of Traditional Medicine in the Philippines. These reasons include limitations of a Western-oriented and dominated health care delivery system to adequately respond to the health needs of Filipinos, particularly, in terms of human resources; health seeking behaviors of Filipino households, which included traditional health practitioners among the choices for health practitioners consulted; the WHO endorsement to study the use of Traditional Medicine, particularly, acupuncture and herbal medicine for primary health care purposes; and the need to understand the contextual and cultural aspects of health care delivery in order for legislation and policy to provide an environment in which people can make appropriate, safe, and effective choices for health care.

There are similarities between the practice of traditional and conventional medicine. Both modalities employ specialists trained in healing. Both modalities are effective, though some practices in both modalities may also be harmful. However, there are also differences between traditional and conventional medicine. Traditional medicine treats the whole person – body, mind, spirit – and also includes his family, community, and social relations. Treatment is thus individualized and personalized, leading to an involved and familiar relationship between patient

and healer. Traditional Medicine is more often readily available and affordable, and its methods fit with customs and traditions of Filipinos, especially those in the provinces. In contrast, conventional Western medicine simply treats the disease, leading to a formulaic or *de cahon* treatment. There is an impersonal and detached relationship between the patient and the healer. It is usually also expensive and not within the reach of many Filipinos. Furthermore, it is strange for some Filipinos in the provinces who find it contrary to customs and traditions to be dependent on doctors and hospitals.

This does not mean that traditional medicine does not have disadvantages. Some practices in traditional medicine lack precision and standardization in dosage, preparation, and technique, and are fraught with superstition. Some are also wanting in sterile precautions. Thus, there is also a need for refinement of some methods in traditional medicine.

With our present medical system being Western-oriented and with our doctors trained in the Biomedical Model of health, integrating traditional health modalities into the system is not easy. However, the benefits of acceptance of Integrative Medicine would be worth the difficulties. Integrative Medicine would involve the patient in his/her own recovery via mindfulness-based stress reduction, lifestyle changes, and other techniques designed to unite the mind, the body, and the spirit in the healing process; it is through this integration that options for attaining the best quality of health care will be made accessible to all.

The Doctor and Integrative Medicine

In his paper called “Understanding Filipino Patients and their Relationship with Medical Doctors”, Professor Ned Roberto of the Asian Institute of Management found that “more and more doctors are becoming impersonal in their handling and processing of patients.” Filipino patients have expressed specific complaints about doctors such as “*walang concern, nung nakapagpaliwanag na, ayaw sumagot sa tanong ko*”; “*parang walang malasakit sa pasyente, parang nagtatanong lang sa estudyante niya na nangangailangan ng tamang sagot*”; “*ang daming tinanong, hindi muna ako binigyan ng lunas*”. In the quest to find the kind of care they need, patients say that “we’ve found the TLC (“tender loving care”) treatment we’re looking for from alternative therapy sources like healers, chiropractors, reflexologists, and physical therapists.”

Patients go to Complementary and Alternative Medicine (CAM) therapists for various reasons, which include:

1. For first-line therapy (“*Nakagisnan namin na pag may sakit kami, hilot muna bago ipakita sa doctor*”; For post-operation therapy, *kailangan ng hilot para maigalaw-galaw.*)
2. Strong belief in effectiveness of alternative medicine; accustomed to alternative medicine (“*paniwala na duon tayo gagaling; kanya-kanyang belief*”)

3. Belief that some illnesses are better cured by alternative medicine (*“May mga doktor na hindi kayang pagalingin (ang ibang sakit); may time na kailangan ang doktor, may time na hilot lang; depende kung ano ang hilig ng katawan”*)

4. Value-added treatment (*“Parang mas concerned sila (CAM healers) sa ‘yo hindi puro medical terms; pwedeng mag home service; magaling mag-advise para gumaling agad and hindi ka na pipila”*)

5. Frustrated/exasperated with MDs (*“pagod na kaiinom ng gamot kaya nagta-try ng alternative healing; mahal sa doctor/magbabayad ng P500”*)

6. Fear of/aversion to chemical medicines (*“gagaling ka agad sa herbal medicine”*)

7. The absence of MDs/don’t know which MD to go to, especially in the provinces

Doctors thus should be able to demonstrate their ability to empathize with their patients. They should provide personalized, friendly reception and diagnosis. Waiting time for consultation should be reasonable. Competence should be shown by explaining the diagnosis adequately as well as explaining the treatment, which includes what each prescribed medication is expected to do. Treatment should minimize pain and discomfort. Doctors should address the disappointments patients feel about the fee charged by addressing the patients’ perceived value for money of the service rendered.

Thus it is a challenge – an advocacy – “to bring back the healing relationship between doctor and patient... for doctors to treat with the heart as well as the mind... to bring life back to medicine.”

Taking into consideration the principles of holistic healing that is paramount in integrative medicine, perhaps it would be wise for doctors to consider bringing in aspects of integrative medicine into their practice.

Use of CAM by patients raises multiple questions and challenges for the physician. CAM therapies, by definition, do not have the same level of evidence of many conventional therapies. They exist at the interface of science and healing. However, it cannot be denied that many patients use many forms of CAM, whether or not their physicians advise them to do so.

Doctors often believe that scientific and evidence-based medicine are fundamental; because of standardized treatment, sometimes – or most of the time – they cannot adapt to the individual needs of the patient. They fail to communicate effectively with patients on CAM and fail to recognize that patients do not reason the way doctors do. Patients, in turn, would like control over their health, including control over side effects of drugs such as organ toxicity. They recognize the need to stimulate immunity and prevent recurrence of disease, and aspire for an overall increase in quality of life. To achieve these, they voluntarily make use of CAM modalities, but they do not report the use of CAM to their doctors due to perception that doctors are indifferent and negative to CAM.

Because of these dissonances in Physician–Patient Interaction, the unspoken needs of patients are not addressed and there is a loss of trust within the therapeutic relationship. Patients are also

at risk for choosing harmful, useless, ineffective, and costly non-conventional therapies, interfering with self-healing responses.

Physicians dealing with patients using CAM should be patient-centered, honest, open-minded, rational but compassionate, and above all, respectful. There should be systematic knowledge acquisition, open discussions, and explaining of options and risks in a non-threatening manner. Skepticism is most assuredly not needed.

Doctors should open discussions with patients about their needs and aspirations. When physicians use a patient-centered approach, they can promote informed decision-making by the patient in collaboration with the physician. This combined effort can provide a base for an improved patient/physician relationship and can empower patients in their own health care.

A review of current literature is often not sufficient to answer questions about CAM therapies with a high level of certainty from the perspective of evidence-based medicine. These data cannot be considered proof of efficacy, but they do offer clinical clues that support the use or avoidance of specific therapies.

All available scientific data about the safety and efficacy of CAM modalities should be used. If a high level of uncertainty is present, the doctor should involve the patient in decision-making, clarifying risks and benefits. A frank, non-judgmental discussion is necessary to inform the patient effectively about the known risks and benefits of CAM therapies. Arguing with patients who are convinced that an unproven therapy would be helpful is not productive. It is likely to

damage the therapeutic relationship and drive the communication process underground. It may even be considered cruel if no better conventional therapy is available. Note that many therapies, including a number of plant-based agents, chemotherapy, and radiotherapy were once considered “alternative” before they were accepted standard care.

A Case in Point: Profile of the Traditional and Integrative Medicine Clinic, UP-PGH

The government created the Traditional Medicine Unit (TMU) of DOH to continue the efforts in propagating integrative medicine. In accordance with this and in continued pursuit of excellence and quality health service for the Filipinos, the University of the Philippines through its then-Chancellor Dr. Nemenzo initiated the creation of this unit in the Philippine General Hospital where services for alternative health care modalities would be offered to employees, students, and other staff. The Traditional and Integrative Medicine Clinic (TIMC) was conceptualized and developed and was inaugurated in 2001, opening its doors to those interested in availing its services for holistic healing.

The Traditional and Integrative Medicine Clinic is a healing venue with 3 treatment and consultation rooms initially located at the right side of the UP Health Service of the Philippine General Hospital. The TIMC was renovated with the interiors purposely designed for the proper ambiance of healing using the different alternative modalities offered, which include acupuncture, massage, aroma therapy, reiki healing, pranic healing, yoga, and herbal medicine. It envisions to be a center accessible and affordable to all especially the marginalized population and where the best of both conventional and complementary/alternative medicine are integrated for service, training, research, and development. It aims to provide a venue where scientific and

evidence-based complementary/alternative medical services are integrated with conventional medicine that can be made accessible and affordable initially to UP-PGH employees and students, and eventually to the general public; a place where tools of scientific analysis can be applied to traditional as well as complementary/alternative medicine in documenting evidence for further development of the practice of Integrative Medicine. The TIMC will then provide a basis for evidence-based traditional and integrative medical practice and will serve as a training center for traditional and integrative medicine for students and faculty members in the health sciences and all health professionals. It also aims to promote the value of traditional and integrative medicine among medical and allied health students and practitioners in both community and hospital settings and to develop a network of resources and referral systems among traditional and integrative medicine practitioners and organizations for service, training, and research development.

Since its opening, the clinic has been spearheaded by the Department of Family and Community Medicine (DFCM). The consultants, residents, and staff of DFCM have treated patients with acupuncture, herbal medicine, massage, and stress management programs. Gradually, the awareness and knowledge of people on Integrative Medicine has been increasing steadily. More and more people are now informed and updated that they have control of their health and that many options are offered for them to achieve it. Several research works on traditional health modalities have also been done by students and residents rotating in the department.

The Traditional Medicine Clinic – from initially providing only acupuncture services and herbal medicine – now offers more modalities such as *hilot*, pranic healing, other forms of energy

healing, qi gong, meditation, and body-mind-spirit exercises. Despite having been closed down twice due to lack of support, the TIMC now continues to flourish and address the needs of the public for quality integrative medicine. It is now located at the Out Patient Department of the Philippine General Hospital. In the future, the TIMC envisions establishing an electronic record system for its patients; presenting more teaching opportunities for UP students and resident doctors (currently, it holds elective classes for students and residents); and sustaining a stronger research agenda for the improvement of integrative medicine.

Further Challenges for the Advancement of Integrative Medicine in the Philippines

CAM needs more research. Research challenges includes identifying an appropriate research framework, among other technical problems that scientific research in general faces (e.g., randomization not culturally acceptable to patient or provider, problems with generalizing results across populations due to different environments, ethical and cultural issues, etc.)

There is a need for culturally competent physicians, with knowledge of patients' health care belief systems and how these can affect medical care. Enough ethnolinguistic and cultural competence should be developed for the physician to communicate sensitivity, understand the patients' perspective, and formulate culturally sensitive treatment plans. Doctors should develop attitudes that demonstrate empathy and respect for other views regarding health and illness.

There are also regulatory issues concerning CAM. The roles of BFAD, PITAHC, DOH, and the academe should be more clearly defined. There should be harmonization of policies and standards among public, private, and academic communities. Will BFAD, PITAHC, DOH, and

the academic and science laboratories rise up to the challenge? PITAHC, specifically, should take the lead in the promotion of Filipino traditional medicine and in the regulation balanced with facilitation of the practice of traditional and alternative medicine. There should be a directory of Filipino traditional healers and a National Research Agenda in Filipino traditional medicine.

A more comprehensive reform would include curricular changes in health and science in basic education and higher education, in residency training and postgraduate courses. There should be patient education on holistic medicine in the context of patients' rights and policy reforms in health insurance (PhilHealth), hospital, and clinical care guidelines. Moreover, there should be a change in perspective towards traditional and integrative medicine not just in the medical sector, but in Philippine society in general – from one of distrust, indifference, and skepticism into one of open-mindedness and awareness.

In conclusion, a health innovator cannot be effective in the planning and implementation of a health program unless an understanding of how traditional beliefs and practices function in meeting the medical needs of the people. Our Western form of education has isolated the professional more and more from truly understanding the culture of his people.

I must say that nowadays, more often than not, doctors and other health professionals have lost that personalized touch – that so-called tender loving care for our patients, whether they be in the hospital or in the clinic. Patient–physician relationship is not what it used to be.

Blame it on the medical system and training which has placed so much emphasis on the use of sophisticated instruments and laboratory aids to make a diagnosis; blame it on the ever increasing patient load of government doctors in the rural health units or government hospitals that they hardly have the time to talk or give advice on prevention to their patients. But let us also admit that our Western type of medical education has isolated health professionals more and more from the people. Let us also admit that we have made health care services into very expensive and scarce commodities that only a few benefit from. Because of these, doctors, nurses, and other health professionals prefer working in the cities rather than in the rural areas. Truly, modern medicine has depersonalized itself and has detached itself from the majority who cannot afford its services.

Professional health workers need to re-orient themselves to the Filipino culture and psychology. They need to have a radical change of values, shed elitist and Western attitudes, and meet the people on their cultural level, irrespective of the biases and prejudices the medical profession has about peasant folk medical practices. All these are needed in order to succeed in truly serving the people.

The question I therefore ask is this: in our struggle to have a change in society for the betterment of our people, what should our attitude be towards traditional and integrative practices? Should we integrate and learn from the people or should we impose what we want them to believe?

We always declare that we are for people's participation in decision-making. But how much involvement do we really allow them in planning, implementing, and evaluating programs

intended for them? How often do we consult them in an open and honest manner? How much feedback and ideas do we receive from them? Too often, people's participation is practiced only in the implementation stage and very rarely in the planning and evaluation phases.

Planning with the people is a painstaking task, as we have found out. It means being creative, being flexible, and effectively communicating with them. Our project staff used to meet people in big village assemblies, but we soon discovered that only a few people talked in these large assemblies and they were usually the rich peasants, the storeowners, and the moneylenders. These people wielded power in their villages. We would meet groups of 10 to 15 families, following the village pattern of houses in clusters. In these small group meetings, the villagers were more open; the discussion, livelier. Everybody got a chance to voice his or her opinions and sentiments.

Planning with the people demands perseverance in facilitating the small group meeting, carefully explaining the issues, and encouraging responses that are not usually spontaneous. After a question is thrown into a meeting, there is long period of silence. The silence can be discouraging if one is not patient and hopeful enough to wait, to give time for the people to think and formulate their ideas. The silence of a few minutes can seem like hours, but one must manage to take a deep breath and say to oneself, "Relax, don't hurry." Soon enough, the responses come in.

To impose on these people, long accustomed to domination, is the easy way out. But it is not necessarily the most effective way. As a concrete example, consider what happened in one of

the villages in Leyte where we were working. The sanitary inspector of the town health center had scheduled an immunization for typhoid and cholera. Upon his arrival in the villages, only a few people showed up for vaccination. The sanitary inspector cursed the people for being uncooperative and not being interested in taking care of their health. What he did not know was that it was the rice harvest season in the village. The villagers had to choose between food and a cholera-typhoid vaccination. Had the sanitary inspector consulted the people and involved them in the planning of the vaccinations, they would have advised him to come after the harvest. Had he done this, the delivery of a health service would have been more effective and the people would not have been blamed for being uncooperative.

Doctors, if they only listened and observed more often, would also learn more. While working among the indigenous people of Kalinga in Northern Philippines, I had an experience for which my education and training as a Manila doctor did not quite prepare me. Upon reaching a village that took four hours of hiking over two mountains and two rivers, a fellow community-based physician and I were called by our volunteer health worker to see a 14-year-old girl with high fever. After preparing a decoction of medicinal plants we noticed that her fever subsided rapidly. After ensuring it was just influenza and not malaria, we gave some advice on continuing care in case the fever returned.

Our job done, we prepared to leave. It was already dusk and as we were going down the stairs of this one-room elevated dwelling, we saw a large crowd of village people seated around the house in several rows. Having heard about the sick girl, they had come, as was their custom, to pray in

silence for the girl's quick recovery, showing their solidarity with their neighbor in crisis. And then, without ceremony, they slowly and quietly began to get up and leave.

It was an amazing demonstration of an admirable aspect of Kalinga indigenous healing – the expression of goodwill, of being one with the afflicted individual and her family. It was a gesture and sentiment that one would hardly see in urban areas, much less in Metro Manila hospitals. One had to travel all the way to a far-flung village to find once again the humaneness and compassion that should be expected in healing the sick.

Part II. Effecting Change: Actions and Reactions

Chapter 5. Advancing or Retreating? An Analysis of Health Programs in the Philippines

Health is a right, as affirmed by national and international decrees. Article 25 of the Universal Declaration on Human Rights states that every person has “the right to a standard of living adequate for the health and well-being of him/herself and of his/her family, including food clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or the other lack of livelihood in circumstances beyond his control”. Similarly, the International Covenant on Economic, Social and Cultural Rights acknowledges “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health”.

The right to health is also enshrined in the Philippine Constitution. Article II Sec. 15 states that “the State shall protect and promote the right to health of the people and instill health consciousness among them”; Article XIII Sec. 11 states that “the State shall adopt an integrated and comprehensive approach to health development, which shall endeavor to make essential goods, health and other social services available to all the people at affordable cost. There shall be priority for the needs of the underprivileged, sick, elderly, disabled, women and children”. Another part of Article XIII asserts that it is the duty of the government “to undertake appropriate health, manpower (human resources) development and research responsive to the country’s health needs and problems”.

It is imperative then, that health system reforms be always in order such that accessible, effective, efficient, equitable, and quality health care is made available for the population.

Reforms should continually take place in a myriad of aspects: in public health services delivery, health planning, health management information, health policy development, health financing, health human resource development, health standards and regulatory systems, hospital management, health referral systems, community health programs, procurement and logistics systems, health research, district health systems, and traditional medicine.

A Closer Look at Philippine Health Systems

Let us again take a look at our health systems today.

Concerning the delivery of public health services, the statistics are dismal. Minimal gains were made in reducing the proportion of children who have not received any vaccination from 2008 to 2011. Tuberculosis remains to be one of the leading causes of morbidity and mortality in the country. Logistics and supplies for these programs still remain in the DOH national office and CHD offices. There are only slight improvements in antenatal care and birth delivery by health professionals.

Health planning systems are still top-down, with the DOH setting national programs ahead of locally designed programs. There is lack of interconnectedness with the health management information system.

The National Field Health Services Information System (NFHSIS) is suffering from under-reporting and delay in reporting. There is lack of administrative machinery, and though the national system (as manifested by the national surveys by the NSO) seems to be working, the

health management information systems at the local government unit (LGU) level are problematic. There is also no interaction among various levels of reporting systems.

There is minimal information systems planning below the national level; we have poor communication systems that are unable to facilitate information flow. There is a need for information systems that capture local health situations, enlist participation of the community, assist in identification of problems and service delivery monitoring, and impact evaluation.

To date, there is no unified national policy for human health resource development (HHRD). The Human Resources for Health Master Plan 2005-2030 has, however, led to the creation of the Human Resources for Health Network in 2006. This body, which includes government agencies involved in HHRD as its members, has been tasked to coordinate various stakeholders' responses to health human resource issues in the country. Whether recent progress would result to eventual policy coherence still remains to be seen.

Within the DOH, the Health Human Resource Development Bureau is involved in planning the professional growth of health personnel. However, funds for continuing education, scholarships, and training are minimal; most training is provided by Centers of Health Development. These mainly touch on the technical side of public health and rarely on planning, management, and other aspects of health systems development. Rural health units are inadequately staffed.

There is a need to develop a National Agenda for Health Policy Development. The health care system suffers due to lack of synchrony between legislative and executive departments and lack of coordination between local and national government policy development.

The Food and Drugs Administration is severely underfunctioning and underfunded vis-à-vis the demands. There is a lack of harmony between licensing and regulation of health facilities, no national health agency in charge of standardization and licensing of private health clinics. While generics use has reached up to 40% in recent years, access to medicines continues to be a problem, particularly in rural areas and for the poorest.

The Cheaper Medicines Act is but a stopgap in the whole process of bringing down the prices of medicines. The real root cause of escalating drug prices is that we do not have a real national drug industry. Philippine pharmaceutical corporations are still essentially importing, compounding, repacking companies. Nowhere on the horizon is the day when we can manufacture our own medicine like Thailand, Indonesia, and Malaysia do. Even more unlikely is the day when through our own research we can discover, manufacture and market our own indigenous medicinal products as China, Korea, and India do. Until we have these kinds of drug industries, we will never be able to permanently bring down the prices of medicines. We will always be beholden to the dictates of the multinational drug companies.

Most of the hospital systems we employ are obsolete. The majority of our district hospitals are not fully functional. There is a need to create and employ effective and efficient management systems and to review government hospital leadership and management.

We have a virtually non-existent health referral system. Our procurement and logistics systems are still a major source of corruption, with a sore lack of professionalism.

The National Policy on Primary Health Care and Community Involvement is in the doldrums. Health Research Systems Assessment has the lowest priority in the health and science budget. Even with the low budget plus foreign funding, health research bodies have come out with numerous outputs, but these rarely create significant impact on health care in the country.

Concerning health financing, notable gains in increasing PhilHealth membership have only been made in the recent years. It reported having 27.92 million members as of 2011, 32% of which were privately employed, 7% government employed, 16% individually paying, 34% indigents/sponsored and 9% OFWs.

Contrary to claims that the DOH budget for health has gone up beyond its pre-devolution levels, it has steadily gone down since 1992. There was, however, a modest increase in the recent years. Most of DOH budget, however, is still allocated to retained hospitals. There is a current trend towards more creative and expansive methods of revenue generation and resource management, but the PhilHealth Information Systems are still inadequate. Aside from the need to harness community-based organizations and existing health insurance schemes to further hasten the expansion of coverage, there is also a need to strengthen PhilHealth's management structure and information system. There is a need to hasten the decentralization of claims processing to avoid delays. This requires adequate plantilla positions as well as an efficient information system to

replace the current manual procedures in the processing of status of payments, membership database management and other operations. Lastly, there is a need to quickly put in place mechanisms for effectively controlling the processing of fraudulent claims and to intensify the expansion of the indigent program.

LGUs are responsible for health services delivery, but resource and systems development support for health is inadequate to fulfill the mandate. Efficiency and effectiveness in utilization of health resources are hampered by weak local health support systems.

What would make our health systems work more effectively? Our country needs dynamic and responsive leadership, strategic planning and thinking, better resource mobilization and management, well trained and capable health managers and staff, and enhanced policy and research development.

We have to tap opportunities to enhance our strengths and make our weaknesses irrelevant. We need to have enabling policies, negotiating for equity to support the development of the local health care system; out-of-the-box thinking for the medical sector and government policy makers; strong cooperative linkages of private sector, national and local government and communities; responsive research and development support; active health professional registries; and relevant reforms in health sciences education.

Many health programs have been instituted as attempts to address these needs. But years after their inception, what have they contributed to lessen the problems of our health care systems?

The Story of Devolution

The Local Government Code of 1991 signaled the legal basis for the decentralization of central political and economic powers to local chief executives. In 1993, health care was “devolved”, meaning all local health programs were no longer under the supervision of the Department of Health but were placed under the jurisdiction of local officials.

When then-Secretary of Health Juan M. Flavier and I, as his Chief of Staff and Undersecretary, entered the DOH in July 1992, we were faced with a hostile environment wherein nearly all of the government health sector personnel were against devolution. We requested the President that we be allowed to defer its implementation for six months since we needed time to formulate a well-thought-out strategic plan.

Secretary Flavier and our team designed a 10-year strategic plan for the devolution of health services. It consisted of three phases: the Change-Over Phase (1993), followed by the Transition Phase (1994-95) and the Stabilization Phase (1996-2002). We had to create a totally new unit, the Local Government Advisory and Monitoring Services (LGAMS) headed by a manager and chief of health devolution, Dr. Juan Antonio Perez.

The Change-Over Phase consisted of the following: (1) transfer of 42,000 national DOH personnel (out of 60,000) to the all local governments in the country, which also meant ensuring that the personnel plantilla would be properly absorbed by their respective municipalities, cities, and provinces without hitches; (2) transfer of all assets of health facilities and hospitals, e.g. land

titles, buildings, vehicles, equipment, etc., to provinces, cities, and municipal governments; and (3) formal turn-over ceremonies to every mayor and governor, ensuring that all these were done in a manner as smooth as possible with the least burden on both sides. Left behind in the DOH were the 52 specialty, national, and regional hospitals and medical centers, the 16 regional health offices, and the personnel of the central office in Manila.

The Transition Phase focused on the transfer of software, operational guidelines, programs, and projects, and capacity building of key personnel on both sides. An example of this is the establishment of a Comprehensive Health Care Agreement (CHICA) with each mayor and governor. This was meant for more than 1,600 local government executives to commit to health goals and objectives as well as the necessary support services and budget for health programs and projects. Capacity building centered on the development of new skills like negotiating skills, partnership building, management of change, and process oriented technologies especially for DOH officials.

The Stabilization Phase consisted of three further sub-phases: (a) the decentralization sub-phase, (b) the empowerment sub-phase, and (c) the sustainable development sub-phase. The decentralization sub-phase involved LGU strategic planning; combination of bottom-up and top-down decision-making; and capacity building in health systems development and DOH streamlining. By the time of the empowerment sub-phase, all health systems (health planning; health management information; health human resource development; health promotion; health care delivery; district health; hospital development; referral systems; logistics and procurement; health financing; health research; community health; local and international health networking;

traditional and alternative medicine) should have been installed and functioning. In the sustainable development sub-phase, LGUs should be working autonomously; there should have been transformation of Regional Centers for Health and Development into an LGU Health Advisory; universal health insurance coverage for all LGUs; and a unified voice and a single lobby for health with the DBCC, ICC and Congress, DOH, PhilHealth, PITAHC, LGUs, civil society, business sector, and national government agencies.

The Stabilization Phase, however, was never implemented after Secretary Flavio and I left the DOH in 1995. The next two Secretaries of Health were not in favor of devolution and were in fact vocal about being in favor of the re-nationalization of health services. There were efforts since 1999 to proceed with the Strategic Plan, but there was no political will to do it. Even the Health Sector Reform Agenda launched in 1999 provided only small efforts to advance the cause of health devolution.

Compared with other countries that have decentralized their health systems, the Philippine experience is the most encompassing so far in terms of scope of devolved functions, degree of autonomy, levels affected, and rate of change. The devolution, however, served to accentuate inherent weaknesses in the public health system at the national and local government levels. The nature of resource distribution in our country perpetuates the primacy of traditionally resource-rich population centers, thus reinforcing inequity. We have undeveloped systems that have weak absorptive capacity for change. Health financing is also characterized by weak allocative efficiency and poor equity. Health care planning still operates under a superior (Central Office/Regional Office)-subordinate (Provincial/City/Municipal Health Office) paradigm.

Up to now, full transition to the devolved ideal is not yet complete. DOH has a clear framework and identified strategies to deal with devolution, but seems to have weakened in mobilizing resources needed for hastening stabilization by problems attendant to devolution itself. It was estimated that the transition phase should have been completed by the year 1998. However, the frequent changes in the political and administrative setup at the national and local levels coupled with calls for the re-nationalization of health services have made capability building and institutional development efforts ineffective. The development of LGU capabilities and setting-up of local health systems responsive to local situations have yet to gain momentum.

Currently, DOH-LGU relationships involve “firefighting” response mechanisms (versus proactive and strategic responses); centrally-led health decision-making; and minimal bottom-up processes (versus LGU led and/or LGU-DOH joint decision-making). Added to this, the LGU Health Planning Guidelines 2001 Memo #02 dated July 17, 2000 dictated national health priorities for LGUs (versus local health needs planning and consideration of national priorities only when appropriate for the LGU).

The clarion call for change and innovation remains unheeded, or heeded but decisive action still lacking. Though the die is cast on the issue of decentralization, DOH is still working in a centralized and exclusive mode (e.g., procurement, standard-setting, projects that are single-focused, not cutting edge). There is promise, though, in projects like the Integrated Community Health Services Project and the UNICEF Convergence Project.

The health sector has the logical and moral responsibility to foster and harness convergence and synergy between other sectors and between LGUs. This lack of convergence and synergy results in blind spots in investment planning at the local (across sectors) and national (across sectors and geographic boundaries) levels; inadequate response to major health problems like malnutrition; and missed opportunities for networking resources and social solidarity among LGUs. If the health sector steps up to this responsibility, our health systems may finally evolve into something better after the disappointments we experienced in the process of devolution.

Our priority concern should be towards responding to the inequity in health. First, we should re-think the DOH budget; poor provinces should get more while rich provinces should give more. The technical capacities of the Centers for Health Development should be strengthened in the following areas: public health care services; planning; information system; human resource development; health financing; hospital operations and management; community and NGOs; intersectoral synergy; and inter-LGU collaboration and quality assurance.

There are also strategies on funds generation that can be employed. Strategic health investment plans can be formulated, bilateral and multilateral governance funds can be tapped, and LGU resources can be merged. Income can be gained through establishment of a professionally-managed provincial/city health corporation, local taxation of cigarettes and alcohol, and mobilization of government financing institutions for health resource generation. Proper debt financing and public-private sector financing may also be implemented.

LGUs should be supported in improving their efficiency in the use of resources. Linkages should be re-established between the different levels of the health delivery system through expansion of the inter-LGU collaboration through the Inter-Local Health Zones.

Mechanisms should be instituted to support HRD development in LGUs through establishment of a replacement pool for health personnel undergoing training and support for the establishment of distance education learning centers in the regions.

LGUs should be seen as co-equals; DOH as servicer of servicers. It should be recognized that LGUs are heterogeneous in terms of economic, political, historical, cultural, and geo-ecological situations. National and regional budgets should further be decentralized to LGUs with equity as a major factor.

All these would lead to a more definite division of roles between the DOH and the LGUs. DOH would be in charge of health policy development: standards, regulations, licensing, health promotion, and advocacy. Tertiary hospitals would serve as major service frontliners. DOH should also head national health information systems, epidemiological surveillance, disease registries, and health human resource development.

DOH programs should be national but planned with and by LGUs. To use an analogy, DOH should be more of an orchestra conductor rather than a musician trying to play all the instruments. DOH effectiveness should be redefined in the context of devolution towards stabilization. A Strategic Health Devolution Stabilization Plan should be formulated.

The Local Government Units, in turn, would be in charge of management of local health systems; direct health service delivery; management of hospitals and public health in provinces and cities; and management of public health, community health and water, environmental health, sanitation, food, and nutrition in municipalities and barangays.

LGU chief executives should be health-oriented with great political will. They should build on the strengths and opportunities available at the LGU and Inter-LGU levels. They should accept autonomy and practice it.

Most of all, there should be a strong and unwavering advocacy for devolution. Mitigating measures should be instituted and existing ones should be strengthened to cushion the impact of economic slowdown. There should be advocacy towards sensitizing the Internal Revenue Allotment (IRA) allocation process through a real, thorough, multi-agency study of the IRA, taking into account the lessons from the field and the “unfunded mandates” of the DOH. COA rules and regulations that impinge on efficiency should be recast. We should learn from best practices and scale them up.

Health Sector Reform Agenda

To be a true advocate of Primary Health Care, one must always be vigilant to ensure that the key elements of PHC are being applied or integrated into any new policy, programs, or projects of the DOH, the LGUs, or by non-government organizations (NGOs). It requires a level of social activism to guarantee that the following key PHC elements are always considered: (1)

community participation and involvement, (2) community representation in decision-making, (3) intersectoral linkages, and (4) health promotion and prevention of diseases to ensure the availability, accessibility, acceptability, and affordability of quality, effective, efficient, and equitable health care, most especially to the poor, deprived, and marginalized.

Since 1999, the Philippines has been implementing the Health Sector Reform Agenda (HSRA) as its major strategy in improving health care delivery in the country. HSRA consists of five pillars, namely, health financing reforms, hospital reforms, inter-local health zone reforms, standards and regulatory reforms, and public health service delivery reforms.

How is the Health Sector Reform Agenda faring now? Does it ensure that the principles of Primary Health Care are being applied?

1. Social Health Insurance and Health Financing.

Evidence of community participation and involvement will be manifested by the extent to which PhilHealth members and cardholders know the privileges and benefit packages they are entitled to. The PhilHealth law states that PhilHealth members must have a voice in the organization of PhilHealth.

If PhilHealth members are indeed represented in the Board of Directors of PhilHealth, was the process of representation done through a nomination or election process across all members of PhilHealth? Currently, the representative of PhilHealth members in the board comes from the formal labor sector (organized labor unions). How about the informal labor sector, the self-

employed and the sponsored (indigent) members? Were they consulted or asked to nominate whom they want to be their representative in the PhilHealth Board of Directors?

In health financing reforms, attention is given to sponsoring indigents' enrolment in the Philippine Health Insurance Program by PhilHealth. While there is participation of the local government units in identifying and enrolling the poor, there is no activity that encourages the active participation of the poor who are enrolled. There have been no meetings of PhilHealth cardholders nor are there attempts to form a PhilHealth members organization. Partnerships have only been established with LGUs and agrarian reform communities, but beyond that other sectors have not been involved in the planning, implementation, and evaluation of the health insurance program.

2. Intersectoral Linkages.

One good example of effective intersectoral linkages concerns the Provincial Health Insurance Program of Bukidnon (1994-2001). Under the leadership of then Governor Fortich, various sectors of society – the municipal mayors, the Diocese of Malaybalay and the various parishes, the cooperatives, farmers' organizations, indigenous people's organizations, and other community based organizations including the private hospitals and private health care providers, business companies – were all involved in the planning, implementation, and evaluation of the Bukidnon Provincial Health Insurance Program (BPHIP).

It was unfortunate that PhilHealth did not provide the proper support to Bukidnon. PhilHealth considered BPHIP as a competitor rather than a partner in social health insurance. The PhilHealth law specifies the establishment of a Local Health Insurance Organization (LHIO); the BPHIP, in fact, is a manifestation of the LHIO. With the election of a new governor of Bukidnon in 2001 (upon the expiration of the 9-year term of Governor Fortich) and with the encouragement of PhilHealth, the Bukidnon Provincial Health Insurance Program was, with great regret, abolished.

Community Based Initiatives in Health Financing must also be recognized by PhilHealth if the champions of Primary Health Care are to be listened to. But historically, PhilHealth has a way of wiping out the gains made by community-based organizations in community health financing. Clear examples of this are the community-based health financing programs, integrated into the community-based health programs in Abra from 1995 to 1998. Abra is one of the poorest provinces in the Philippines and is one of the Social Reform Agenda priority provinces of then President Fidel V. Ramos (1992-1998). PhilHealth supported the Social Reform Agenda and started the sponsored (indigent) program in Abra. Instead of recognizing the community health financing programs in Abra, PhilHealth just proceeded with its sponsorship for indigents with counterpart funding from the local government of Abra. This obliterated the initiative of the community's self-contribution of one peso a day for community-based health financing. PhilHealth played the role of a benevolent almighty government agency ready to dole-out its funds for premium payments of the poor, and wittingly destroyed the self-reliance and self-determination of the communities of Abra.

The PhilHealth management circa 2001-2005 at least has shown flexibility with its partnership with the Department of Agrarian Reform (DAR) and Agrarian Reform Communities (ARCs) in ensuring that contributions of the members of ARCs will be integrated with their premium payments alongside counterparts from DAR, the local government and PhilHealth.

To further ensure PHC in social health insurance and health financing, PhilHealth must have a PHC expert and advocate within their organization.

3. Hospital Reforms and Corporatization of Hospitals.

Community involvement and participation can be manifested by hospital officials encouraging the establishment of Patient Support Groups. These are usually patients with a particular disease, together with their families and friends, who self-organize to help themselves have access to information, essential medicines, and psychosocial support. Examples are Breast Cancer Support Network, Asthma Club, and Diabetes Club (Note: recommended, however, are affirming or aspirational names like Cancer-Free Support Network, Healthy Lungs Club, Normal Blood Sugar Club). Non-disease-based health promotion groups care should also be encouraged (e.g., Breastfeeding Support Groups, Family Planning Support Networks, Having Healthy Bright Child Club).

Hospitals can also organize an Advisory Council composed of various stakeholders of hospital services. This is an arena where community-based organizations and people's organizations can be represented. Even the functional committees in the hospitals can have lay people as members. For instance, the therapeutic committee and the infection control committee can consider the viewpoints of community members side by side with the technical issues being discussed. A

higher order would be the organization of a Board of Trustees of the hospital where again community members get representation in decision-making.

Hospitals launched their programs on Hospitals as Centers of Wellness in 1994. This is one example where Primary Health Care intersects with tertiary levels of health care. Hospitals have outreach programs, but it would be better for hospitals themselves to establish partnership with several communities for hospital-community health care interface for at least 5 years, rather than just having on-and-off medical missions. Other innovative hospital programs include labor exchange for unpaid hospital bills wherein relatives of poor patients can give a day or two of their labor (e.g., laundry work, cooking, or cleaning up) to pay their bills and hospitals offering routine immunization, family planning, women's desks, and child protection units.

According to the 2001 survey of the Social Weather Station for the Filipino Pro-Poor Report Card of the World Bank (p.12), government hospital services were used by the poor 39% of the time, while barangay health stations and health centers combined were used 51% of the time. Traditional healers were consulted 27% of the time. Hospitals therefore need to make their services more pro-poor. There has been no community participation in hospital affairs and very little intersectoral partnerships and coordination. I would like to commend, however, the Balingasag District Hospital and Initao District Hospital in Misamis Oriental for having strong intersectoral linkages to make their hospitals work better for the people. Let us hope there will be more of their kind.

4. Local Health Systems Development Reform through the Inter Local Health Zones (ILHZ).

Community participation and involvement is manifested if the barangays that are part of an ILHZ are considered major stakeholders in the planning of programs and projects of the ILHZ. Barangays need not just be represented by the Barangay Captain or Barangay Council but by people's organizations and community-based organizations.

The ILHZ must recognize that health is not just the job of the health sector. To achieve good health, the health sector must also reach out to other sectors of society. Food production, food security, food safety, and nutrition governmentally belong to the Department of Agriculture and the Department of Agrarian Reform; environmental health and safety, zero waste management, pollution control from mining, factories, geothermal plants, and motor vehicles governmentally belong to the Department of Environment and Natural Resources; occupational health and safety, employees' compensation due to work accidents, and social security are governmentally under the Department of Labor and Employment; peace and order, violence against women and children, crimes against persons, and devolved local health governance are governmentally under the Department of Interior and Local Governments, the Philippine National Police, the Department of Justice, and the Armed Forces of the Philippines-Department of National Defense; literacy, health education, healthy habits and behaviors are within the domain of the Department of Education; health research and development are under the Department of Science and Technology. To truly attain the goals of Primary Health Care, all these agencies must work with the health sector via the ILHZ at the district level. Such orchestration of health and health-related efforts must also be manifested at the provincial and national levels. PHC requires

effective health leadership at all these levels for the people and communities to have access to health and health services.

In the inter-local health zone reforms, several municipalities must come together to form a District Health Board to plan and manage a health district system together. This is a form of intersectoral coordination, though limited only to local chief executives and the health sector. There can still be room to involve the education, environment, transportation, and trade and industry sectors. Representation of community-based organizations and people's organizations still has to be realized. The poor are still nowhere on the horizon of the inter-local health zone reforms.

5. Public Health Reforms.

The basic question to ask in public health reforms is: what is the extent of community participation and involvement in disease control programs and health promotion campaigns? For example, in the National Tuberculosis Programs, are patients with tuberculosis part of the decision-making processes on policies, plans, and programs? A positive step forward is the partnership of the Department of Health with the Philippine Coalition Against Tuberculosis (PhilCAT). However, patients with tuberculosis are still not represented in PhilCAT. And in every local government unit implementing the TB Control Program or in every Directly Observed Treatment Short Course (DOTS) Center, are tuberculosis patients involved in the planning, implementation, monitoring, and evaluation of the program? These questions could very well also be asked in the Malaria Control Program, the Integrated Management of Childhood Illnesses (IMCI), and the Filariasis Elimination Program. In the HIV-AIDS

Prevention and Control Program, the participation of People Living with HIV-AIDS is already an affirmation action for Primary Health Care. But this has been mainly a victory for the People Living with HIV-AIDS due to their strong advocacy and social mobilization.

The same questions can be asked in health promotion campaigns in family planning, maternal care, reproductive health, healthy lifestyle, tobacco free society, national exercise program, and the national expanded program on immunization, to name a few. If mothers, families, and communities are involved in these programs, then Primary Health Care is indeed alive and well in the public health sector reform agenda.

An important aspect of Public Health Reforms is the participation and involvement of Filipino Indigenous Healers and Traditional Medicine Practitioners. The Philippine Institute of Traditional and Alternative Health Care (PITAHC) was established in 1997, but Filipino Indigenous Healers are still not represented in any decision-making bodies at the local government unit level or in any public health programs.

To answer this, an inventory and directory of all Traditional Medicine Practitioners and Filipino Indigenous Healers can be instituted in every barangay, municipality, province, and city. The PITAHC can then come out with a National Directory of Traditional Healers and Complementary and Alternative Medicine Practitioners based on these local directories. A Code of Ethics and Code of Good Practice can be formulated, using a bottom-up approach and self-regulatory framework for every type of traditional healer and CAM practitioner. Traditional healers and CAM practitioners can be asked to draw up a Code of Ethics and Code of Good

Practice, which they will all agree to adopt. PITAHC can then collate all these Codes at the national level and come up with a National Code of Ethics and National Code of Practice for traditional birth attendants or *hilot sa panganganak*, traditional bone setters or *hilot sa pilay*, traditional herbalists or *albolaryos*, spiritual healers or *espiritistas*, and Complementary and Alternative Medicine Practitioners like acupuncturists, therapeutic massage practitioners, pranic and reiki healers, iridologists, homeopathic doctors, and chiropractors. All these actions are further expressions and full manifestation of PHC in public health reforms.

In the health sector, health regulatory reforms are mainly in the realm of food and drug safety; licensing of hospitals, clinical laboratories, diagnostic centers, and radiation technologies; and health technology assessments. The *Sentrong Sigla* (Vibrant Centers) is the current accreditation system for public health outpatient clinics, e.g. rural health units and city health centers.

However, there is still no equivalent accreditation and licensing system for private medical clinics from the Department of Health or from PhilHealth, except for off-hospital cataract clinics, stand-alone dialysis centers, clinics offering voluntary permanent sterilizations, and DOTS tuberculosis centers, or from the Philippine Institute of Traditional and Alternative Health Care when it concerns clinics practicing Complementary and Alternative Health Care.

How can Primary Health Care be manifested in health regulatory reforms?

Communities should be empowered in the understanding of health regulations such that their members can assess the quality of health services they are receiving. This is one way of

achieving consumer responsibility wherein the people themselves provide government regulatory bodies feedback for any lack of quality or violation of any regulatory code. Patient satisfaction surveys and patient feedback mechanisms are strategies to make Primary Health Care effective. Likewise, there should be representation of the people and communities in regulatory bodies especially at the local government levels. This can also be achieved at the regional and national levels — at the Water and Sanitation Councils and Sanitation and Hygiene Councils involved in inspection of food, hotel, and entertainment commercial establishments. People’s representatives should be welcome at the Food and Drug Regulatory Board, the *Sentrong Sigla* National Committee, the National Health Facility Licensing Committee, the PhilHealth Accreditation Committee, and the PITAHC Accreditation Committee.

In the public health delivery system, the aim is to integrate all the public health programs in a horizontal manner versus the vertical way. If truly integrated, the poor will benefit in receiving services in a more convergent manner; for example, a family can be treated for tuberculosis and malaria but at the same time can be advised concerning maternal and child health, family planning, and nutrition needs. Again, there have hardly been any community consultations or participation of the poor in the planning and management of public health programs.

Can health regulation and standards be decentralized? This is a controversial area of discussion. But a true passionate advocate of PHC will answer “yes” to this question. How can the standards and regulations of Metro Manila apply to Tawi-Tawi or Batanes or Camiguin? While there can be minimum basic standards and regulatory rules, there should be room for adjustments and flexibility when considering geographical locations (hard to reach mountain municipalities or

island municipalities); economic classification of municipalities (4th class to 6th class as compared to 1st class and to 2nd and 3rd class municipalities); appropriate technologies applicable to areas with no electricity or irregular electrical power; and lack of transportation and communication facilities. Communities and people's organizations must again be represented in the formulation of such adjusted health standards and regulations and its decentralized manner of implementation.

FOURmula One For Health

The goals of the DOH program FOURmula ONE for Health include better health outcomes, a more responsive health system, and equitable health care financing. It aims to achieve these via a four-fold thrust: financing (increased, better and sustained), regulation (assured quality and affordability), service delivery (ensured access and availability), and governance (improved performance).

Building upon gains and lessons from major reform initiatives, FOURmula ONE for Health intends to implement critical interventions as a single package backed by effective management infrastructure and financing arrangements. Each implementation thrust will be managed by offices with clear mandates, performance targets, and support, all within well-defined time frames.

More importantly, the four implementation components will be managed and financed following a sector-wide approach. This implies that the management perspective covers the entire health

sector, and that financing portfolio management encompasses all sources. The NHIP is its primary instrument.

The NHIP supports each of the FOURmula ONE elements by reducing the financial burden of Filipinos; first as prudent purchaser of health care, thereby influencing the health care market and related institutions; second by providing accreditations and payments based on quality as incentive for improved performance in the health sector; and last by fair compensation for cost of care directed at providing essential goods and services in health.

Improved health regulation is to be enacted through assuring the quality and affordability of health goods and services. This will be jointly implemented by PhilHealth and the Health Regulation cluster of DOH. Key strategies include: strengthening of accreditation systems to ensure quality care; implementation of initiatives such as Clinical Practice Guidelines and other guides to promote quality care; harmonizing & streamlining of systems; enacting processes for licensing, accreditation and certification; development of a seal of approval for institutions; pursuing cost recovery with income retention for health regulatory agencies and other revenue generating mechanisms; and ensuring access of the poor to essential health products.

The program also sets its sights on quality health service delivery, to be led jointly by the Health Program Development cluster and the field operations clusters, with support from PhilHealth. This would include harmonization of hospital and public health services with a financing scheme for each, to be marketed to interlocal health zones or the local government for appropriate provision; reduction of public health threats (disease elimination, reduction in morbidity and

mortality of preventable diseases); increased involvement and expansion of critical stakeholders and reforming budgets based on priorities; and development of a health facilities investment plan, which would include rationalizing services in DOH-retained facilities and local government by maximizing the structures brought about by decentralization.

Good governance in health can be attained by enhancing the performance of the health system. This will be implemented jointly by the External Affairs cluster through the Bureau of Local Health Development and Bureau of International Health Cooperation and the Sectoral Support cluster particularly by the Health Policy and Development Planning Bureau. These would include: Sectoral Development Approach for Health, Health Human Resource Masterplan, Establishment of 4-in-1 Convergence Sites, Philippine Health Information System, Procurement and Logistics Management System, and Public Finance Management System.

A health program can be deemed effective only if it lessens the inequities in access, availability, and affordability of health care. If each one of these interventions – health sector devolution, HSRA, FOURmula ONE for Health – has made health care more equal or equitable, then it has done its part. However, as of now, the disparities have not changed. The same poverty-stricken regions – ARMM, Zamboanga, Bicol, Samar-Leyte, Mimaropa, and Soccsksargen – are still in dire need of health services. It is the CBHPs and the NGOs, small as they are, who provide services in places where there are inequities.

Primary Health Care should always be integral to any National and Local Health Policy. There are still numerous areas in the Health Sector Reform Agenda where Primary Health Care is not at

all evident. Affirmative action for Primary Health Care must be manifested relentlessly when such policies are translated into health plans, health programs, and projects for the poor and the marginalized.

Let the core of Primary Health Care remain steadfast among policy makers, health care providers, patients, and communities, especially the poorest. Community participation and involvement, intersectoral linkages, health promotion, and prevention of diseases to ensure availability, accessibility, acceptability, and affordability of quality health programs and quality health services are the keys to the success of any effective, efficient, and equitable national policy, plan, or program.

Chapter 6. When the Budgets Don't Budge: Health Care Financing

Health care financing is defined as the spending required for a health system to undertake health care or health actions. It is manifested in three spheres: first, in the financing of health system **capacities**, which refers to spending in order to establish, acquire, or create desired health care projects or health actions; financing of health system **operations**, which refers to spending on existing health systems; and financing of **use** of health capacities, which basically refers to health insurance coverage.

What are the problems we face concerning health care financing?

Problems arise when there are inadequate resources to fund essential health system capacities and operations. Most health officials cannot agree about which health provisions are essential and should be subsidized for all Filipinos. Mostly, there are also “dis-economies” of scale and scope in the investment policy framework for local health systems. Following devolution, inequities and inefficiencies of health system operations were merely absorbed by LGUs. Adjustments to local needs and priorities, to date, have not been completed.

Double financing burden, which refers to capital funding for new capacities and operational funding for existing capacities, also occurs. The current manner of spending for health capacities is hard to change due to a more or less “fixed” budget; annual spending is hard to re-focus quickly due to limited headroom in total spending.

A more evident dilemma, with implications acutely felt by virtually every Filipino, concerns social health insurance. More than ever, problems arise with the availability and ability of health care providers to provide quality health care services to covered constituents with health insurance.

A Devolved Health System with a Diminishing Budget

National health plans do not ensure provision of budgets, resulting in a perceived irrelevance of planning. There is high dependence of LGUs for resource support from DOH for TB, Nutrition, and Maternal and Child Health services. There is no standard approach to planning, and public health planning is not integrated with hospital planning. There is a need to review current local planning systems and develop alternative planning methodologies that are simple, needs-oriented, and reflect the vision for health of localities. Systems for determining the appropriate levels of resource support needed to attain certain health goals should be developed and advocated to LGUs.

Provisions for local health financing reforms were specified in the FOURmula ONE for Health to address these issues. These provisions include allocation of funds and prioritization of health services; social marketing/advocacy to LGUs, NGOs, and the private sector to earmark funds for priority health programs; identifying tools for prioritizing health services (e.g., segmentation and targeting the poor); and rationalizing pricing/costing policies for priority programs.

There are also provisions for management/coordination of LGU health funds. These would entail integration of the national and local investment plan, national and local coordination of funds (i.e., counterparting arrangements), cost-sharing arrangements among LGUs, and rapid estimation of local health accounts.

A related issue is the high cost of hospital operations, which poses a financial burden to many provinces. There are inefficiencies in utilization of financial resources, resulting in an increase in referrals to higher level hospitals because lower level hospitals are incapable of providing services. The increase in public sector proportion is due to the implementation of the Salary Standardization Law and the Magna Carta for Public Health Workers. The fact that budgets do not meet the increased requirements for the public sector adds more gravity to the problem. Instead, maintenance and other operating expenses are reduced to cope with increases in public sector requirements.

Often, too-centralized and circuitous procurement systems result in delays in acquisition of essential drugs and supplies. Restrictive COA regulations do not encourage revenue retention/setting up of revolving fund systems. There is also low DOH technical support for hospitals in areas of finance management, public-private mix, quality assurance, among others.

FOURmula ONE for Health, again, aims to answer these by institutionalization of revenue-enhancement measures, resulting in full retention of income and better asset management. There should also be development of efficient and equitable allocation mechanics factoring in priority health programs, geographic distribution of the population, national and local income, and

specific needs of population groups. A performance based-budgeting system was initiated by DOH in 2005, but it has yet to maximize utilization of available funds. In addition to improving the implementation of its hospital models, it needs to develop and implement models for public health and regulatory agencies. It should also reform financial management and procurement systems and develop/implement performance audit and review system.

It remains to be seen, however, how all these plans will translate to actual progress.

The Insurance Problem

Republic Act 7875 or The National Health Insurance Act of 1995 was signed into law in February 14, 1995. The National Health Insurance Program effectively consolidated the separate Medicare components of the Social Security System (SSS), Government Service Insurance System (GSIS), and Overseas Workers Welfare Administration (OWWA). It was envisioned to provide health insurance coverage and ensure affordable, acceptable, available, and accessible health care services for all citizens of the Philippines.

The NHIP – implemented by the Philippine Health Insurance Corporation or Philhealth – provides health benefits for employees, individually paying members, and indigents through its subsidized indigent program. These benefits include financial assistance for outpatient and in-patient expenses, including room and board fees and operating room fee; drug expenses; x-ray and laboratory fees; and professional fees for the attending physician, surgeon, and anesthesiologist.

In terms of health policy and programs, this is the historic health milestone that should have changed the face and shape of health care in the Philippines. However, nearly two decades after the passage and signing of the law, where is the National Health Insurance Program? Does the ordinary Filipino know it or feel it, much less savor its benefits?

Let us take a closer look at the major features of the National Health Insurance Program (NHIP) and determine where it is now.

In the era of devolution, one would expect LGUs to be the major foci of the application of universal coverage. However, up to this day, there is not a single local government that can say that their whole population has been covered by the National Health Insurance Program. The province of Bukidnon was the demonstration LGU for health insurance since 1994. With the leadership of Governor Fortich, it was shown that universal coverage was possible. However, PhilHealth did not consider the LGU strategy as the way to reach universal coverage and almost totally ignored the relatively successful elements of the Bukidnon Health Insurance Program. With no support from PhilHealth and with the end of the maximum three-year term of Governor Fortich, the Bukidnon Health Insurance Program was scrapped by the leadership that followed.

Right now the focus of PhilHealth is the enrolment of indigents in the National Health Insurance Program. Based on the 2009 Family Income and Expenditure Survey, prevalence of poverty now is 26.5%. This means that over 23 million Filipinos are living below the poverty threshold. How many of them have been enrolled in health insurance?

Just go to any slum and squatter area or any poor rural barangay and ask the first poor person you meet whether she/he has a PhilHealth Passport Card. It is not likely that you will find someone who has one. As of 2011, only a third of the 27.92 million PhilHealth members are indigents enrolled in the NHIP through its sponsored membership program. The rate of enrolment, albeit increasing in the recent years, has not been able to catch up with the speed of the growth of the number of Filipinos joining the ranks of the poor. Furthermore, implementation of strategies to increase indigents' utilization rates should be strengthened to close the inequitable gap in benefit payments received by its rich and poor members.

While targeting the poor for health insurance is a worthy strategy, concentrating efforts only on them will be risky in the management of any insurance. Social solidarity is one of the hallmarks of social health insurance. This basically means that the rich subsidize the poor, the healthy subsidize the sick, and the young subsidize the old. Therefore, greater efforts must be exerted to enroll the informal sector and the self-employed. PhilHealth reported that it has enrolled 4.34 million individually paying members in 2011. However, according to the Department of Labor and Employment, there are over 16 million workers in the informal sector. There is a long way to go in reaching the workers in informal economies such as market vendors, small transport workers, street hawkers, small construction workers, and home based industry workers. And they truly need health security.

In the formal sector, how many establishments with more than 10 employees are rightfully paying the PhilHealth premiums of their workers? One of the most popular malls, which has a

total workforce of more than 20,000, has not been paying any social security and health insurance. PhilHealth should exert its muscle in getting such industries to comply with the law.

The Philippine Health Insurance Act guarantees both in-patient care and outpatient care services as well as the continuum from health promotion, prevention of illnesses, curative, and rehabilitative health services. However, PhilHealth still has no strategic design on how it intends to provide integrated health care to all its members. Even in-patient hospitalization services are still very much wanting in terms of support value. The out-of-pocket contributions of its members are still high compared to the reimbursements it provides.

In the trial runs of supporting outpatient care services by PhilHealth, private health sector providers were not part of the design. Yet, health seeking behavior studies have shown that patients, whether poor, middle class, or rich, prefer to go to private health practitioners rather than use government health facilities.

PhilHealth is currently sitting on a gold mine with its Health Insurance Fund of more than PhP98 billion, which continues to grow annually just from the maturation of investments. With these reserves, it can very well increase its support value for benefit claims by 100 percent. PhilHealth can very well introduce outpatient care services given by private health practitioners, and include support for the essential drug requirements of its members. It should place mechanisms to control the inflationary effect of increases in benefits payments, which counterbalances expected improvements in financial risk protection (i.e., increase in benefits matched by increase in prices charged by providers diminishes, if not negates, any gains). Inefficiencies should also be

addressed (e.g., over 40% of diarrhea and community-acquired pneumonia cases were treated in tertiary hospitals in 2006).

How can the unfinished agenda of the Philippine Health Insurance Act be fully realized?

There is a need for strong political will and full commitment on the part of the President, the economic cluster of the Cabinet, the Department of Health, and the Board of Directors and Executive Officers of PhilHealth to fast track the implementation of the law.

A two-pronged strategy can be adopted to achieve universal coverage. The first strategy that can be adopted is an area-based approach through the local governments. Two hundred LGUs should immediately be chosen, which will implement universal enrolment not just of the indigents but also the informal sector, the self-employed, and the formally employed. There are more than 1700 LGUs, and if 200 LGUs a year implement this strategy, universal coverage can be achieved in less than a decade. The other strategy is through a sectoral approach. Universal coverage should be implemented among all teachers and students of public and private schools, then all members and families of the military, the agrarian reform communities, all small transport workers, etc.

An integrated health benefit package should also be implemented in these LGUs and sectoral groups. This package should comprise outpatient care with essential drugs and in-patient services with higher support value, and utilization of both the public and the private health care

providers, through a combination of global and area budgets and capitation and fee for service reimbursements.

A massive information, education and communication campaign should be launched in these LGUs and sectoral groups to ensure citizen, community, and PhilHealth member participation in the implementation and evaluation of the program. Barangays, people's organizations, or non-government organizations should encourage the formation of community-based health insurance schemes. Technical assistance should be provided as well. A social re-insurance strategy is also needed for these community-based efforts to be sustainable.

Private individuals can also write to PhilHealth and their local government executives to encourage them to partner and ensure the full implementation of the Philippine Health Insurance Act.

Another Use of Health Financing: Increase the Reimbursement, Decrease the Migration

Innovatively, PhilHealth may also help curtail the migration of health professionals by considering increasing reimbursements for health care professionals in the rural areas.

Philhealth has the funds to execute such a proposition. PhilHealth's premium collection has increased steadily over the years. To illustrate, premium collections totaled to PhP 25.6 billion in 2008, PhP 27.5 billion in 2009, and PhP 29 billion in 2010. Meanwhile, benefit payments were at PhP 18.2 billion in 2008 and PhP 24.3 billion in 2009; it was only in 2010 when benefit payments, which totaled to PhP 30.5 billion, first exceeded premium collections (whether this

increasing trend translated into actual gains in financial risk protection is arguable, if inflationary effect and inefficiencies are considered). By law, PhilHealth is allowed to keep reserves equivalent to two years' worth of projected benefit payments. Its reserves were equivalent to about PhP 98 billion in 2010. In the same year, accredited PhilHealth physicians totaled to 20,804; professional fees constituted only 24% of benefit payments. As only 40% of PhilHealth-accredited hospitals are government-owned, increasing rural payments would, theoretically, not severely strain reserve funds. It is a small price to pay in exchange for encouraging our rural public health professionals not to jump on the diaspora bandwagon.

At present, the majority of health professionals are in Metro Manila, Metro Cebu, and Metro Davao. However, less than 20% of the Philippine population resides in these areas. Health care professionals in the rural areas receive the same standards for reimbursements as their city counterparts even though their working conditions are more adverse. An Ease/Difficulty index, similar to the DOH Doctors to the Barrios 1993-1995 payment scheme, can be developed. In this index, factors such as accessibility, municipality class (average annual income of municipality), peace and order situation, presence of water, electricity, and other basic necessities, and the patient-to-doctor ratio would be considered. This index would be factored in when it comes to reimbursements. Thus, health professionals working in underserved municipalities would receive double or triple the amount received by their urban counterparts. This initiative would hopefully tame the health professional diaspora affecting these underserved areas and encourage health professionals to consider working in rural areas.

In the spirit of national solidarity, PhilHealth is called upon to take concrete actions in offering positive incentives to our unsung heroes – the Filipino health professionals who choose to remain in rural areas and serve their countrymen.

A Matter of Redirection and Redistribution

For more efficient use of funds, the financing directions of LGUs should be made clear.

Clarifying and asserting the authority, stake, role, and function of LGUs is central in improving local health system capacities and operations.

Health financing directions should go towards acquisition, enhancement, or expansion of health system service capacities, maintenance of existing health service operations, and extension of health insurance coverage for local beneficiaries.

LGUs should define and sustain a long-term capital investment strategy for an adequate local health system. They should continually adjust annual operational expenditures to progressively get the best outcomes possible from the existing local health system.

The Filipino people deserve better health care than what they have now. This is the time for all stakeholders to act for the health of the Filipino.

Chapter 7. A Brain Hemorrhage

The Philippines has traditionally been a major source of health professionals for many countries. Because of Filipinos' fluency in English – this language being the major language of instruction in our health sciences education – and because of our world-renowned people skills in practicing compassion, humaneness, and patience in caring, Filipino nurses and doctors have been in great demand globally for the past four decades.

Vital Signs

The country is reputedly the acknowledged major exporter of nurses to the world and the second major exporter of physicians, with India being the first. During the mid-seventies, 68% of Filipino doctors were working outside the Philippines. Recent studies show that 70 percent of all Filipino nursing graduates are working overseas. During the peak period of recruitment of overseas-trained nurses, Filipino nurses constituted the major ethno-linguistic group of migrant nurses in the United Kingdom and Ireland.

In 2001, the Philippine Overseas Employment Administration (POEA), reported the departure of 13,536 Filipino nurses to 31 countries. The majority went to the U.K. (5,383 nurses), Saudi Arabia (5,045), and Ireland (1,529). The POEA reported only 304 nurses going to the USA. This is definitely gross underreporting since the International Union of Nurses reported that close to 10,000 Filipino nurses were directly hired by US-based hospitals in 2001 through nursing job fairs held in various parts of the Philippines.

In 2002, the POEA further reported that a total of 11,867 Filipino nurses left for 35 countries, again with underreporting of those who left for the USA. This outflow of Filipino nurses was almost three times greater than the production of licensed nurses of that year. The country exported roughly 50,000 nurses from 1999-2003, but the Professional Regulation Commission (PRC), through the Board of Nursing, gave only 27,343 nursing licenses during the same period. This is despite the increase of nursing schools from 170 in the 1990s to over 250 by 2003. The Philippines faced the threat of being bled dry of nurses – a threat that would more aptly be called as a “brain hemorrhage” rather than a “brain drain” of our Filipino nurses.

With the high demand for nurses mainly in the United States, United Kingdom, and Ireland, Filipino doctors also started to enroll in droves in abbreviated nursing courses specially designed for physicians who want to become nurses.

At one time in Pasay City alone, out of 16 public health doctors employed, 6 had just finished their nursing course. While nursing used to be a pre-med course, now medicine has become a pre-nursing course. I called the Association of Deans of Colleges and School of Nursing (ADCSN) to find out the number of student nurses from the existing 232 nursing schools at that time and how many of these nursing schools accepted doctors. They said they had no statistics. I also asked the Board of Nursing of the Professional Regulations Commission, but they also did not have updated data. It seemed that no one was monitoring this unusual development.

These MD-RNs were not only from highly urbanized cities teeming with private hospitals and doctors. According to key informant surveys, these MD-RNs came from all regions of the

country. An estimated 80% of public health physicians, including 90% of Municipal Health Officers (MHOs), were taking up nursing and were expected to leave the country. These were the doctors who are supposedly safeguarding the health of the mass majority of the Filipino people, the managers of the health care delivery system catering to the poorest of the poor.

At a rate of 1,200 per year, at least 9,000 Doctors were trained as MDs-RNs or “Nursing Medics”. In a move triggered by the USA granting migrant visas for nurses and their family members, at least 6,000 doctors worked in the US as nurses – this is a sizable amount considering that the Philippine College of Physicians reported 6,318 members in 2007. Imagine having as many MD-RNs in the US as we have internists all over the country!

Based on our baseline survey of nursing-medics in the Philippines (2004), more than 3,500 Filipino medical doctors have left as nurses since the year 2000. A little more than 1,500 have just passed the national nurse licensure examinations in 2003 and early 2004. An estimated 4,000 doctors were enrolled in nursing schools all over the country at that time.

In a Nursing Medics Nationwide Survey done in Batangas, Cotabato, General Santos, Caraga, Ilocos, Palawan, Western Visayas (Iloilo, Capiz, Romblon), Quezon, Laguna, Cavite, and NCR, it was found that most doctor-nurses are female, married, with an age range from 25 years old to 62 years old, and with an income bracket below PhP 120,000 to PhP 480,000 annually. The nursing medics come from all kinds of specialties – pediatrics, general medicine, family medicine, surgery, pathology, internal medicine – with years of practice as a physician ranging from 0 to 35 years. Around 80% of public health physicians have taken up or were enrolled in

nursing. Sixty-six percent of the respondents planned to leave the country in 6 months to 2 years time, while 60% planned to leave for the US.

They explained their situation quite succinctly. A 45 year-old male surgeon, married to an OB-GYN with 3 children, currently a Training Officer in a private hospital and a municipal health officer (MHO), said: “I belong to a batch of 534 medical doctors taking up nursing way back in 2001. We’re the third batch. The first batch (around the same number) already went abroad.

And we hear good news from them. Their life now is much, much better. Those remaining here are still in medical practice. But, ALL are prepared and ready to leave anytime, if the country situation gets worst (sic).”

Another nursing medic – a 36 year-old female OB-GYN, married with 2 children, in private practice – said, “It seems that there is no hope for the country – graft and corruption situation is really at its WORST! And life is really very difficult. There’s a part of me wanting to stay and practice here but I can see that there is no hope for me and my family. I just want to live a decent life and my income cannot afford to give me even the ‘simple’ life I dream for my family.”

The message sent by this sad reality is heard by our youth loud and clear. Once hailed as the most noble and sought-after profession, being a doctor is no longer a dream of young Filipinos. There was a decrease in medical school enrolment – by as much as 50% – since 2000; the number of National Medical Admission Test (NMAT) examinees also steadily declined from 6,245 in 2000 to only 2,912 in 2005. Out of these aspiring medical students, only around 2,500

students would finish medical school and 1,500 would pass the physician board exams. And yet still how many of them will stay?

At the rate we were losing our highly skilled nurses and doctors, and with the Philippine government, via the Department of Health, raising its hands in helplessness, offering no strategic solutions in sight, we could have only expected a worsening of the health crisis already plaguing our country.

The looming crisis forced us confront the complacency of our society. Will the Philippine government just tolerate this trend of health human resource outflows to other countries? Will we, as Filipinos, just wait, stand by and not do anything about this threatening situation? Will the Department of Health act only when the catastrophe is already beyond resuscitation?

Push and Pull

What are the factors pushing and pulling away our doctors and nurses?

The major driving force that motivated Filipino doctors to become nurses stemmed from the enormous demand for nurses especially in the northern countries, a demand which started at the turn of the century and has persisted since then. The United States became the most attractive market when foreign graduate nurses and their families were given migrant visas after the year 2000.

People in the northern countries of the world are experiencing longer lifespans; for these countries, there is a graying of their populations. These factors create increased pressure on their health systems to provide greater response mechanisms to the health problems of a growing proportion of the elderly. Their young population no longer takes interest in the nursing profession due to relatively more difficult and riskier working conditions, such as evening duties, care of the chronically ill, and exposure to HIV/AIDS. This creates a great demand for foreign graduate nurses who are willing to undertake the work.

There is an acute shortage of nurses in the countries mentioned above which became palpable at the entry of the 21st century – a need that persisted not just for a year or two but continues on to this very day. So it is no longer the roller coaster demand for foreign graduate nurses by developed countries that characterized the outflow of nurses from developing countries in the previous decades; instead, a persistent, chronic need has grown.

The Philippines will never be able to compete with the salary scales of nurses in these northern countries. The basic monthly pay there is USD 3,000 to USD 4,000 a month compared to the USD 150 to USD 250 that nurses receive in the Philippines. Yes, our Filipino nurses are globally competitive in professional nursing care and practice but our Filipino salaries will never be competitive. The current income of doctors in the Philippines of USD 300 to USD 800 a month, which is still a pittance compared to the monthly salary of US or European-based nurses.

At the peak of recruitment of overseas-trained nurses, the United States and the United Kingdom offered the best working conditions for Filipino nurses. Filipino nurses need to take the

Commission of Graduates of Foreign Nursing Schools (CGFNS) and the National Council Licensure Examination (NCLEX) examinations to qualify entry in the United States. However upon passing, Filipino nurses, along with their spouses and children, were given migrant visa status. These nurses were offered a work contract with remuneration of at least USD 4,000 a month. Some hospitals even offered subsidized housing grants.

In the United Kingdom, only an English proficiency examination or TOEFL (Test of English as a Foreign Language) was required. A work contract usually corresponds to a USD 3,000 salary. Clearly, these “pull” factors have been very attractive.

Based on key informant survey results, the top five reasons pushing a career shift from medicine to nursing include: (1) political instability in the country; (2) poor working conditions; (3) threat of malpractice law; (4) low salary and compensation; and (5) the peace and order problem in the country. The socio-politico-economic security in other countries, attractive salaries and compensation packages, and opportunities for career growth prove to be too attractive for doctors.

This is further compounded by the fact that there is little investment of our budget on health, a measly 1.4 % of the total national budget in 2004. This is puny compared to the 49% allocated to debt servicing, and the estimated 13% lost to corruption according to a United Nations Development Program 2004 study. Thus, migration of health professionals is not a root problem; it is a consequence of the problems of corruption, poor resource allocation, poor social service provision, and lack of long-term health human resource development programs.

The research findings of Hazel Pascual of the Philippine Health Social Science Association (PHSSA) reveal that doctors become nurses essentially because of a desire for eventual immigration to other countries – for a higher standard of living, a better future for the family, reunion with loved ones, and eventually the opportunity to petition relatives from home. Some also leave due to work-related reasons. It has been more difficult to get into hospitals as stockholders, as only the rich can own hospitals or be stockholders. Most doctors also aspire for better working conditions, better training, better assurance of work, no *palakasan/padrino* system, and enforcement of better work ethics in the workplace. Even socio-cultural factors come into play: doctors express frustration over poor infrastructure and lack of patient resources, threat of malpractice law, diminishing “doctor prestige”, and the relative ease of passing the nursing boards compared to passing the US Medical Licensure Exam (MLE).

Policy Gaps

Sanchez and Batangan in 1995 identified three major policy gaps in the health human resource development environment in the Philippines. The two physicians were commissioned by the Department of Health in 1992 to formulate a 25-year health human resources development plan for 1995-2020. Their recommendations, however, remain unheeded to this day and the master plan still has to see the light of day in its implementation.

The major policy gaps are:

1. There is no official unified government policy in health human resource development. The Department of Labor and Employment (DOLE), Philippine Overseas Employment Administration (POEA), Department of Finance (DOF), and the Department of Trade and Industry (DTI) all say to our health professionals and our other skilled workers, “go abroad,” while the Department of Health (DOH), the Commission on Higher Education (CHED), and the Professional Regulatory Commission (PRC) say, “stay and serve the country”. There is no unifying stand from the government concerning the issue and the two viewpoints that it does express are contradictory and irreconcilable with each other. Definitely, something is wrong with the Philippine policy on health human resource development.

The reason for this dissonance is mainly due to our economic policy makers who have been promoting overseas employment as a way of generating inflow of foreign currencies to preserve economic growth. The Philippines received an average of USD 13.4 billion in foreign currency remittances mainly from overseas Filipino workers (OFWs) in the past decade. This is over five times the total foreign investments received in the same period, which is a meager USD 2.4 billion. In 2004 alone, it was nearly 12 times the amount of foreign investments received.

On the other hand, the health sector has remained chronically underfunded since the 1970s. The health budget was consistently less than 2% of the total national budget from 2000 to 2010 – a meager 1.1% in 2005. Total health expenditures have been in the level of 3% of the GNP, way

below the 5% recommended by the World Health Organization. This indirectly affects the capabilities of health sector policy makers to convince health professionals to stay in the country.

2. There is no single government agency responsible for concerted health human resource development planning and management. There are 14 government agencies involved in health human resources development policy, planning, and management. These are the following: (1) Department of Health (DOH), (2) Department of Science and Technology (DOST), (3) Professional Regulatory Commission (PRC), (4) Commission on Higher Education (CHED), (5) Technical Education and Skills Development Authority (TESDA), (6) Department of Labor (DOLE), (7) Philippine Overseas Employment Administration (POEA), (8) Overseas Workers Welfare Administration (OWWA), (9) Philippine Health Insurance Corporation (PhilHealth), (10) Philippine Institute of Traditional and Alternative Health Care (PITAHC), (11) Department of Trade and Industry (DTI), (12) Department of Finance (DOF), (13) National Economic and Development Authority (NEDA), and the (14) Department of Foreign Affairs (DFA). There is a dire need for one of these 14 government agencies to take the lead in the national health human resources development.

While the updated 25-year health human resources master plan for 2005-2030 has led to the creation of the Health Human Resources for Health Network, the DOH still has no regular or official ties with the PRC, or the POEA, or CHED, or TESDA. The PRC has no regular meetings with the DTI or the DOF regarding the plight of health professionals. The DOLE rarely discusses the issues of health human resources deployment, retention, and development with the DOH or PRC or CHED. Clearly, there is no leadership and coordination among the

government agencies involved in the planning, production, placement, and maintenance of health professionals, whether in the short term or in the long term. The private health sector, the health professions associations, faculties of medicine, nursing and other health sciences education institutions, and the various civil society organizations in health are also in a quandary on whom among the government agencies to approach regarding solving the current issues and concerns of human health resource development (HHRD).

3. There is no official information database of health human resources in the country. No government or private organization is analyzing the trends in health human resource production and deployment from a national perspective. There was a National Health Accounts established in 1995, but expenditures for HHRD have not been integrated into such accounts systems. This is the tragedy of HHRD in our country. The end result is that there are no reliable and accurate data on many aspects of HHRD that could serve as the basis for an evidence-based national health policy development and national planning for health human resources development.

For example, the Philippine Medical Association (PMA), the Philippine Nurses Association (PNA), Integrated Midwives Association of the Philippines (IMAP), and the Philippine Dental Association (PDA), have different figures on the total number of doctors, nurses, midwives, and dentists in the country today compared to the data from the PRC and CHED. The PRC can give figures of the total number who passed the different licensure examinations annually but they cannot account for the number of nurses who have become medical representatives or the number of doctors who have become full-time business entrepreneurs. They also cannot say how many have gone abroad. There is disparity of data among major government agencies (i.e., PRC,

CHED, DOH, POEA, DOLE) and the different national associations of health professionals; associations of medical and nursing schools also have different figures. There have been no formal, official systematic studies on the health workforce in the Philippines.

The Side-Effects of the Brain Hemorrhage

While the Philippines has traditionally produced a surplus of nurses for export since the 1960s, the large exodus of nurses in the past decade has been unparalleled in nurse migration history. As a result, the number of nursing schools has increased by leaps and bounds. In the 1970s, there were only 40 nursing schools. By the 1990s, there were 170. By June 2003, there were 251 nursing schools and by April 2004, a total of 370 nursing schools had sprouted all over the country based on data from the Association of Deans of Philippine Colleges of Nursing (ADPCN). In less than a year, the number of nursing schools increased by 47% nationwide and 84% in Metro Manila.

A specialized nursing program has also been developed for doctors and other health professionals taking up nursing as a second course. The abbreviated course usually covered 98 to 128 units to be taken in 1 to 3 years, with some classes offered on a flexible schedule. During its peak, course fees range from PhP 500 to PhP 1,000 per unit. Classes were often held during weekends in the campus or in affiliated hospitals. Students also underwent nurse-capping ceremonies and nursing duties.

Equally disturbing was the deteriorating quality of nursing education. The increase in nursing schools has not led to an increase in the number of qualified nurses who pass the national nurse

licensure examinations. In the 1970s and 1980s, the proportion of nursing graduates passing the national nursing licensure examinations was somewhere between 80% to 90%. However since 1994, the passing mark has been below 61%. In 2010, proportion of passing reached a low of 38%. Unlike before, when the number of nurse licensure passers reached 22,000 to 25,000 a year, only an average of 5,400 nursing graduates passed the nurse licensure examinations in 1999-2003. Thus, the number of nurses that left within the same period (approximately 50,000) far exceeded the production of licensed nurses of only 27,000.

While there is still the perception that the Philippines will remain a potent producer of nurses to supply the world due to the very real surpluses of the past decades, the current situation is showing otherwise. Despite the reported lull in deployment of nurses in 2004 to 2006, on average, over 10,000 newly hired nurses left the country every year in 2000 to 2010.

Furthermore, although the demand for overseas-trained nurses has reportedly stabilized in a few northern countries, over 38,000 Filipino nurses were deployed in 2008 to 2010 – again, not accounting for re-hires. These trends may be explained, in part, by the diversification of importing countries as a consequence of population ageing – a phenomenon that is now occurring on a global scale. If these circumstances continue, the “surplus” will cease to exist, and a severe health care crisis is bound to happen.

In 2005, at least three hospitals in Mindanao (i.e., Surigao del Norte, Lanao del Sur, and Sulu) and two hospitals in Isabela province came to a point where they had no more nurses in their staff. Two hospitals in Zamboanga del Sur could not operate their new wards due to lack of nurses. The southernmost island of Mindanao has always been deficient in health human

resources in all aspects, whether in numbers, ratios, and distribution, and the mass migration has severely strained this underserved part of the country. All rural areas in the Philippines have also been vulnerable to these health human resources deficiencies.

Hospitals all over the country – both public and private – have been lamenting the loss of their senior and more experienced nurses. Their nurse-patient ratios are now less than ideal and new nurse entrants are no longer as efficient and effective as before.

The University of the Philippines-Philippine General Hospital (UP-PGH) in Manila, which is the largest hospital in the country and the major training hospital for doctors and nurses in the Philippines, used to employ only the top ten percent of graduates of nursing schools. It had to lower its standards by hiring nurses who just made the minimum passing mark. This is not for lack of applicants, but because the top nursing graduates who used to apply for training or work were already leaving for abroad. At the height of migration, the PGH lost 300 to 500 nurses of its health workforce every year.

There are currently 38 medical schools in the country. Two regions, both in Mindanao, still have no medical schools. In the 1970's, there were only seven medical schools – one public and six private. In the early 2000s, the total cost of a five-year medical education based on school tuition fees alone was USD 10,000 per student. Total cost of textbooks, uniforms, board and lodging, and other miscellaneous expenses ranged from a low of USD 10,000 to a high of USD 20,000. These costs have only risen since then. The total number of graduates in the '70s was in

the vicinity of 1,000. In the past five years, an annual average of 2,400 medical graduates passed the medical licensure examinations.

The medical education data at the height of recruitment of overseas-trained nurses was alarming. There was a decrease in the number of NMAT examinees by 53% from 2000 to 2005. This has resulted in a decrease in the number of applicants entering medical schools. There has been a decrease in first year medical school enrolment that has ranged from 10% to 70%, with an average of 47%. Three medical schools have already closed down, while two private medical schools located in the rural areas were contemplating on closing down due to a severely low enrolment rate of less than 20. A random sampling of ten large training hospitals has shown also a decrease in applications in residency training positions for 2005. All these data show that the medical profession in the Philippines was under severe threat of decimation.

The same hospitals in Mindanao and Isabela that were mentioned earlier also had no doctors to serve them anymore. The Philippines as a whole has been suffering from severe maldistribution of doctors, with those who do not migrate mainly practicing in large urban areas, leaving the rural areas and towns unattended by medical services.

With chronic underfunding of the health system for the last four decades, the Philippines is bound to experience an impending health disaster if nothing drastic is done.

But is there really no way out?

Ten Strategic Solutions

A comprehensive compromise between the Philippines and the nursing importing countries must be the ultimate goal in resolving the crisis in nursing and medical human resources and services.

There is no longer room for piece-meal approaches to this issue. But first, the President, the Cabinet, and Congress leaders must accept that this is indeed a serious national problem deserving urgent attention and action.

Ten strategic solutions are proposed to resolve the current crisis in health human resource development. These strategies do not aim to prevent nurses, doctors, doctors who have become nurses, or other health professionals from leaving the country. The goal is to tame the mass exodus to the northern countries, achieve a rational programmed departure of our health professionals, and secure a win-win situation for the Philippines and the importing countries. Four of these need to be acted upon by cooperative global action; the others are unified national actions at the Philippine level of decision and policy makers.

The strategies demanding action at the international level are as follows:

1. The initiation of high-level bilateral negotiations with the major northern countries importing health human resources. The top five importing countries are the United States of America, the United Kingdom, Saudi Arabia, Ireland, and Singapore. The 14 government agencies – DFA, NEDA, DOLE, CHED, DOH, PRC, POEA, OWWA, DOF, PhilHealth, PITAHC, DOST, TESDA, and the DTI – should all speak with one voice in these negotiations. The bilateral agreements can lead to (1) an annual official development assistance that will fund investment

packages for HHRD particularly for health professions scholarships, improvement of training/education and working conditions, and salary incentives; (2) compensation for every health professional transfer by the receiving country wherein the Philippines will establish a National Trust Fund for HHRD to be used for scholarships of nurses and doctors, continuing education, and improvement of working conditions (the bilateral agreements on health human resources between South Africa and the United Kingdom and the one between Poland and the Netherlands are models that the Philippines could emulate); and (3) an ethical framework that will guide recruitment policies and procedures applicable to importing countries.

The current approach to the importation of Filipino nurses by these rich countries has been lopsided and advantageous only to such countries. The Philippines, meanwhile, continues to wallow in poverty, underdevelopment, and inadequate health care. In the negotiations, these rich countries must be made to realize that the agenda and interests of their Departments/Ministries of Health and their Development Agencies can coincide. Thus for example, USAID, in behalf of the US government, and DFID, in behalf of the United Kingdom, can include in their aid package to the Philippines financial assistance to continuously train globally competitive nurses, constantly upgrading nursing education, nursing health services, and nurse remuneration and offering nursing scholarships. Such aid will eventually benefit both countries: the US and UK will have a regular pool of nurses to serve their needs, but the Philippines will also be ensured of a regular production and supply of nurses for its own health care system.

The Philippine Cabinet Bilateral Negotiation Team must be able to come up with concrete investment packages for nursing development, up for discussions with these countries at the soonest possible time.

2. The North-South health facility partnership agreements. This would entail creation of a high-caliber negotiating team in each hospital or a group of hospitals/nursing schools and identification of key partner health facilities in importing countries. A health facility can be a hospital, academic institution, or even a clinic that is in a position for bilateral negotiations. The partnership agreements aim to have a specified amount of US dollars given to the exporting health facility for every nurse, doctor, or health professional that the US hospitals will acquire from that particular partner hospital. Such funds will go to a health facility-based Health Human Resource Development Trust Fund which can be used to increase doctor and nurse training and practice, upgrade hospital and educational facilities, provide for nursing and medicine scholarships, and improve working conditions in the health facility.

For example, the Philippine General Hospital (PGH) can enter into a partnership agreement with the Johns Hopkins University Hospital (JHUH) in Maryland, USA. JHUH will then donate a negotiated amount to the PGH Nursing Development Trust Fund for every nurse that it recruits from the PGH. The Ateneo de Zamboanga College of Medicine and Hospital, a Jesuit college and hospital, can negotiate with the Jesuit-run Hospital of Georgetown University in Washington D.C. The Mindanao Sanitarium or Manila Sanitarium of the Seventh-Day Adventist can negotiate with Loma Linda Medical Center in California, which is also an Adventist Hospital. It

may be easier if the negotiation is between Adventist to Adventist, Jesuit to Jesuit, or state hospital to state hospital.

This is only fair and just since hospitals from foreign countries do not spend a single centavo in the production, development, education, and licensure of Filipino nurses. At the very least, they should be able to pay partially, if not fully, the cost of nursing development since they are going to benefit from the services of that nurse for at least 25 years.

3. Convene the health human resources development agenda of the General Agreement on Trade and Services (GATS) of the World Trade Organization (WTO). The GATS of the WTO identifies health services and health professional services as commercial goods and services that can be traded across and among countries in need of additional health care services. The Philippine panel led by the NEDA, DTI, and DFA must align with other countries similarly affected by the migration of health professionals to the northern countries in order to create pressure to include this in the agenda in the next WTO meeting. The Philippine panel currently does not have a health profession sub-panel to discuss issues attendant to the WTO agenda on health service commodity trading. It is in the interests of health professionals to be represented in the WTO negotiations. The World Health Organization must act as a catalyst to bring this issue to the attention of the WTO.

There should be global representation of Filipino nurses' concerns. The Global Health Workforce Alliance under WHO, which was created in 2006, serves as a mutual platform for dealing with health human resource concerns at a global scale; however, its concerns are not

specific to the issue on nurse migration. The country should lobby with the Director General of WHO Geneva for the creation of a WHO Global Commission on Nurse Migration. A Filipino nurse representative should be sent with the Philippine Panel to the World Trade Organization, specifically, to the GATS meetings. There should be creation of a PNA Task Force on Global Representation to WHO and WTO-GATS.

4. Forge a joint or multi-country research agenda and action program on health human resources development between and among importing countries and the exporting countries. At the very least, there should be a partnership in the regular sharing of health human resources data and policies among these countries. It would be valuable for the Philippines to know regularly the changing policies on migration of health professionals of the United States or the United Kingdom. The Philippines also is currently unable to secure vital information on the deployment, placement, and retention of their health professionals who have migrated to the northern countries.

The strategies demanding action at the national level are as follows:

5. Creation of a National Commission on Health Human Resource Development (NCHHRD). The creation of a NCHHRD is imperative to oversee the overall situation of the planning, production, deployment, retention, and development of all health professionals and health workers in the country. This can be a Presidential Executive Order, and later on, a legislative act by Congress. The NCHHRD will have members from the executive agencies, the Congress, the private sector, various health profession associations, health sciences educators, and civil society

organizations. With budgetary support and a lifespan of 3 to 5 years, the major tasks of this National Commission will include: (1) review of past and current situation analysis of health human resources; (2) completion of the national health human resource database; (3) implementation of the updated the 25-year National Health Human Resource Plan (2005-2030); (4) formulation of a National Health Human Resource Development Research Agenda; and (5) development of evidence-based national health human resource development policies. The council's tasks will also include face-to-face meetings with the Executive Secretary, Senate President, Speaker of the House, and Chair of the Senate and Lower House Committees on Health, as well as meetings with their respective Chiefs of Staff for follow-up actions.

6. Enactment of a National Health Service Act. This is a compulsory requirement for all licensed health professionals to serve anywhere within the country for a number of years. While in the past there were attempts to have such a law passed, major objections centered on the individual human rights to move freely and practice their profession where each individual wants, even in another country. However, with the globalization and active trading of health human resources and the inevitability of the severest brain drain to hit the Philippines, the country's collective interest and collective rights should now prevail.

The Philippines is the only country in Southeast Asia without a National Health Service Act. In Indonesia, every year of medical studies and specialist training is to be matched by a year of national health service. The Indonesian model is pragmatic and humane. If a medical graduate goes to far flung rural areas like Kalimantan or Irian Jaya, the national health service is reduced to only two years. If one serves in urban areas like Jakarta or Bali, the national health service will

require the full five years. Malaysia requires all medical graduates, local or foreign, to serve the government health service for a period of three years.

At best, health professionals graduating from state universities, schools, and colleges must be covered by the National Health Service Act. Their education has been heavily subsidized with taxes paid by the Filipino people. It is but right that they repay the country with their services equivalent to the number of years under subsidy. The Philippine National Health Service Act will require health sciences education graduates of state colleges and universities like the University of the Philippines, the Mindanao State University, or the West Visayas State University who benefit from subsidized medical and nursing education to serve the equivalent number of years of study in the country. A compulsory, instead of a voluntary, service is called for since the situation now is critical and entirely of a different nature from the past decades of health professional migration. If the Philippine Military Academy (PMA) has been doing this since its foundation, government health sciences schools should no longer be exempted.

In the Philippines, there are more private schools than public schools of nursing and medicine. Graduates from private health sciences schools can employ a modified scheme in complying with the Act, but nevertheless should be covered by it as well. The requirements for private institutions of health education can be subject to negotiations and public hearings before any policies are made. For example, a two-year compulsory service, whether in public or private health facilities, can be the requirement for the National Health Service. The Philippine government, being cash-strapped, and the DOH, being chronically under-funded, will not be able to absorb all nursing and medical graduates as public sector employees.

Enactment of the National Health Service Act will involve: (1) consensus meetings of heads of State Colleges and Universities offering health sciences education; (2) consultations with stakeholders such as students, parents, LGUs, faculty; (3) formulation of a Draft Bill based on consensus meetings; and (4) face-to-face meetings with the Senate President, Speaker of the House, and the Chairs of the Health Committees of both Houses of Congress.

With the National Health Service Act, the country will be able to scientifically program the exit of our health professionals, thus ensuring a steady maintenance of health human resources in all health facilities, whether rural or urban.

The return of service programs of UP and PLM are steps in the right direction, ways to provide a long-lasting solution. For example, UP produces 160 graduates every year; if these 160 are sent to areas where there are disparities in health care, then the UPCM would have done its part to lessen the inequities in the regions. Of course, the contribution of this program remains to be seen by 2014 – when the first batch of students covered by the return of service contract will finish their studies. If the rest of the state universities in the country – for example, Cagayan State University, West Visayas State University, Mindanao State University, UP School of Health Sciences in Palo, Leyte – will follow suit with their own return of service programs, we may have a good number of doctors that may make a difference in the underserved areas. Hopefully, return of service programs may serve as models for a National Health Service Act.

7. Establishment of Health Professionals Registry (a national registry of doctors, nurses, midwives, and other health professionals). A Health Professionals Registry, as maintained in other countries, is a management tool that locates and monitors health human resources availability for deployment or transfer. It is usually run by the private sector, and can negotiate for better remuneration, better benefits, and better working conditions for health professionals. It is usually geographical in scope like a Health Human Resource Registry per province and per city. It can start within a local government unit (LGU) – whether a city, a province, or a municipality – or a district health system (DHS), covering a network of health facilities in various LGUs. The registry can also center around a tertiary hospital and cover its referral units and catchment areas. If implemented nationwide, city and provincial registries will be a tool for efficient tracking and monitoring of movement of health professionals and health workers.

This may expand into the creation of Area-Based Alliances of Nursing Schools/Public and Private Hospitals/Nurse Recruitment Agencies/CGFNS/NCLEX Reviewers. Consensus building on Terms of References of the Nurse Registries with Nursing Welfare should be a primary goal. This can lead to the creation of a corporation to negotiate with importing hospitals and facilities.

8. Create Civil Society Organizations-led National Councils for Nursing and Medical Concerns. A Philippine National Council for Health Professional Concerns can also be established. This will be composed of all the major national organizations involved in nursing and medicine. There should first be an agreement on the Terms of Reference of the Philippine Council, with a common goal of establishing a civil society movement of, for, and by nurses/doctors/allied health professionals. Its functions will include developing a 10-year strategic plan for

nurse/physician/allied health professional development in the Philippines; acting as an oversight body for the implementation of all medical and nursing policies; being the locus for the national data bank on health professionals; being the national sounding board for all health professions' (medical and nursing) issues and concerns; coordinating all efforts to uplift and upgrade the health professions; and ensuring funds for its operations.

The major medical and nursing organizations and associations have not been gathering together on a regular basis to discuss common concerns. A National Council for Nursing Concerns and a National Council for Medical Concerns would be able to elicit active participation of civil society organizations in regular forums to analyze the current state of health professionals' development and to formulate recommendations for policies and action for the betterment of the various health professions. The Councils will also promote solidarity and collegiality in the face of the current threats to the health care delivery system and health professions.

9. Development of New Learning and Career Opportunities. This can be any of the following: (1) new residency and fellowship training programs; (2) new postgraduate courses; and (3) new career tracks for doctors, dentists, nurses, and midwives. A variety of well-designed postgraduate programs and scholarships are attractions to retain health human resources. Medical doctors can have new careers in health economics, health financing, health communications, health entrepreneurship, health advocacy, and health informatics. Nursing residency programs can be initiated and expanded in all training-based and university-based hospitals, like residencies in Intensive Care Nursing, Operating Room Nursing, and Emergency Room Nursing, to name a few. New career tracks like nurse counselors, nurse practitioners, midwife and nurse wellness

advisory, community nursing, complementary and alternative medicine, and health research can be developed and implemented.

Nurse specialty associations can formulate respective training curricula for adoption of training hospitals/nursing schools. This can be aided by technical assistance from the Commission on Higher Education, the UP National Teacher Training Center for the Health Professions, and the Board of Nursing. There should be official recognition from the CHED and Board of Nursing with regulatory provisions. This will be regulated by the Board of Nursing or a new Board of Nursing Specialties. The Filipino public can also benefit from direct nursing care from stand-alone nurse clinics, nurse wellness centers, and other modalities of nurse practitioners' facilities.

10. Initiate reforms in health financing and management of medical education in the country. There should be more scholarships for medical students in underserved areas. In underserved areas where there are only private medical schools, the high-performing medical schools can be rewarded with these scholarships.

There are still two regions in the Philippines with no medical schools: the Caraga (East Mindanao) Region and the Autonomous Region of Muslim Mindanao (ARMM). The stepladder curriculum started by the University of the Philippines School of Health Sciences in Palo, Leyte can be initiated and established in these two regions. Other public medical schools can also adapt this stepladder curriculum.

The stepladder curriculum recruits students from rural high schools. They are trained first to be village health workers for six months; then they go on service leave in their places of origin. They return to study for midwifery degrees for another year, and then go again for service leaves. They can then return to study for nursing degrees for another three years and go for service leaves after their licensure exams. In areas in need of physicians, nurses re-enroll to obtain a degree of Doctor of Medicine. The stepladder curriculum has been evaluated internationally and nationally, and has been found to be an effective educational strategy to fill the need for health human resources in underserved rural communities.

For private medical schools, a rethinking of the four-year baccalaureate degree requirement before entering medical school can be done. Instead, schools can consider a requirement of two-year basic science education. This will decrease the cost of and increase access to medical education.

In addition, Filipino physicians, on their own, can also do something to reverse the threats. They can organize a concerted lobby to support the 10 strategic solutions to resolve the mass exodus of health professionals. They can support the self-regulation of physicians with an organized medical grievance system; they can also adopt a province or municipality for 5 years and make their health systems work.

At least 8 bills with different authors have been filed in the Senate and Lower House concerning medical malpractice. The first of which was filed in 2002, namely, House Bill No. 4955, also known as the Medical Malpractice Act of 2002. In the Senate and Lower House Hearings,

passions are either extremely “pro” versus extremely “anti”. The National Institutes of Health Philippines of UP Manila is proposing a middle ground: self-regulation with an organized medical grievance system involving 12 major stakeholders. In particular, Senator Pia Cayetano, Chair of the Senate Committee on Health, and Congressman Dodong Pinggoy, Vice Chair of the Lower House Committee on Health, vow not to pass any law that will penalize or criminalize medical malfeasance. Senator Cayetano and Congressman Pinggoy are open to a self-regulatory medical grievance system in lieu of a malpractice law.

A medical grievance system would involve the following major stakeholders: PRC, PMA, DOH, APMC, UP Manila, specialty organizations, IBP, DOJ, the Supreme Court, social workers, LGUs, NGOs, and patient support groups. The Senate and Lower House Committees on Health should serve as oversight.

Two medical grievance system tracks have been suggested. Track 1 involves first ensuring access to a “complaints desk”; a primary mediation and triaging/referral to appropriate authority; secondary mediation and review of merit of the case; resolution and recommendation of sanction(s); and establishment of a clearinghouse of cases and institution of rules on compensation.

As a case scenario, a medical grievance case is set against a local government hospital surgeon in Palawan. The complaint will be received at a “Patient Complaints Desk”, which may be located at the DOH offices at the Provincial/City/Municipal Levels; PHIC Regional/Field Offices; or Social Welfare Offices at the Provincial/City/Municipal Levels. The duly signed complaint

forms are filled up, and upon receipt of the complaint, the social welfare officer and the DOH representative in the municipality, or nearby municipality, initiates a first level mediation between the complainant and respondent. The social worker should send notices for first level mediation to both parties within three days from receipt of complaint.

The first level mediation is deemed a success if the parties reach a settlement agreement. Duly signed mediation forms are filled up stipulating the details of the settlement. First level mediation is deemed a failure if: (1) the parties do not reach an agreement; (2) either or both parties fail to appear at the first level mediation within 15 working days from notice.

If mediation fails, the social welfare officer and the DOH representative facilitate the preparation of position papers of both parties and ensure that proper forms are filled out. Mediation forms also stipulate that the complainant will not file any legal action against the respondent until after the opportunity for a second mediation has failed. All pertinent documents are sent to the Office of the Regional Director of the DOH CHD and have to be postmarked not more than three days after failed mediation.

A Committee Review must establish prima facie evidence for the case to be given further consideration. Once received at DOH CHD, the Office of the Regional Director will convene a review committee to establish merit of the case, composed of 7 members, namely: (1) DOH Assistant Regional Director – Chair; (2) IBP representative; (3) PhilHealth representative; (4) PRC Regional Office representative; (5) Professional society representative (PMA, PNA, IMAP, etc.); (6) Academe representative; and (7) PHA representative.

Pertinent documents (i.e., complaint, position papers) are reviewed by the committee. The complainant and respondent are then brought together for a second opportunity mediation. The complainant may be assisted by the social welfare officer and the DOH representative that assisted him at the first mediation.

If second mediation fails, the review committee will conduct a fact-finding investigation. Pertinent documents should preferably be volunteered by the respondent and/or his organization with the assurance of confidentiality that the documents used for fact-finding will not be used for any other purpose, particularly, legal action from the courts.

If the merit of the case is established, the review committee will arrive at a resolution and can recommend sanctions. The committee is expected to arrive at a resolution within 60 days from receipt of documents. Findings and recommendations are formally endorsed to the concerned agencies.

If no merit is seen, a letter will be sent to the complainant to explain the course of action. Only a qualified and authorized spokesperson, assigned by the review committee, will be allowed to report the results of the proceedings.

“Forum-shopping” of the complainant should be avoided. This can be negotiated with the Supreme Court that complaints will not be entertained unless it has passed through the mediation

procedures of this grievance system. The courts can require a “certification to file action” for cases that have failed a second mediation.

The NIH will maintain a national database of the cases heard and resolved. The Office of the Regional Director will keep the NIH informed of the results of mediation and report on the compliance to resolutions. Reports of compliance to resolutions will be required every 6 months for 2 years.

A no-fault compensation is a system of addressing medical grievance by not assigning blame or fault on any provider but ensuring a way in which disability or death is compensated for by a fixed rate per case basis. This, however, might take some time to develop.

In a meeting held in June 2005, which was attended by the various chairs of the respective representatives of the various medical specialties including the nursing profession, the APMC, the office of Senator Pia Cayetano, the DOH, NIH, and the H4H Foundation, it was agreed that a parallel process or structure – Track 2 – be set up at the institutional or hospital level and that the PHA should encourage the setting up of ethics committees in the respective hospitals in order to address issues concerning patients within their jurisdiction. Likewise, the various specialties shall create a pool of independent and credible expert witnesses who would be mobilized to objectively handle or scrutinize the respective cases. This parallel movement shall operate complementarily with the above proposed system and is hoped to decongest an anticipated influx of complaints at the regional level. However, should the case remain unresolved after going through Track 2 after a considerable period of time has elapsed, the case may then be filed and

processed through Track 1. Cases involving free-standing clinics and other non-hospital-based facilities may be filed directly through Track 1.

For Track 2, each hospital shall create an ethics committee composed of a multidisciplinary team whose members are eminent, credible, and objective. The ethics committee shall thoroughly and objectively review the merits and particulars of the case. It shall, after a fair review process within a reasonable period of time, recommend the appropriate course of action to be enacted by the hospital or institution.

Features of the Adopt a Province/Municipality Action Program, on the other hand, would include provision of technical assistance and capacity building on health care management tools and health systems development; a public-private sector partnership approach to health planning and development; an out-of-the-box health financing solution to increase access to essential drugs by the people.

To avert the health crisis arising out of the health human resource development crisis, there is a need for concrete action. We should foster solidarity with the importing countries. However, such global and bilateral actions must be matched by national political will to institute the strategic solutions at the country level. The long-term and short-term solutions have been laid out. The situation is just waiting for political will and action.

As William Esposito said, “We are a nation adrift because we have lost our moorings and we failed to set the right standards for ourselves. We tolerate corruption in the highest public offices. We allow popularity rather than qualifications to select nominations for public office...

“History proved that even a known divided society like ours can be galvanized into greatness – and even inspire the world like our People Power events did – if there is a leadership that can raise the right standard every Filipino will rally to.”

Filipino doctors of medicine, in particular, have a significant role to play in this national condition. Physicians can either enlighten and uplift society or allow the oppressive structures to continue by not exposing and challenging them. Doctors of medicine can opt to promote a national consensus that in turn will foster unity or they can allow themselves to be tools of the ruling class who want to divide, rule, and exploit the people. Physicians, therefore, are part of the Philippine problem but can also be the key to providing the solution.

As doctors we are trained to be thinkers, doers, and innovators – not bystanders. The mass migration of Filipino health professionals brought about by gross inequities in the Philippine health situation is one disease we cannot allow to progress. In the spirit of national solidarity, we must take concrete actions to give our colleagues reasons to stay and allow the Philippine health system to benefit from those who do go.

The time to act was yesterday.

Chapter 8. Hope for the Future: Investing in Medical Education

The physicians of today are seen as highly competent medical technicians who are hospital, laboratory, and instrument dependent, and lacking in patient rapport and bedside manners. Many are observed to have become arrogant, uncaring, and materialistic. Society has gradually become dissatisfied with the health system and disenchanted with doctors.

As a template that shapes medical practice, medical education has been identified as a major cause of this situation.

- Association of Philippine Medical Colleges Foundation, Inc., 1997

Philippine medical education has made significant strides in the past decades. We have produced a bumper crop of doctors who know their craft and contribute, one way or the other, to good health in this nation where 75% of the population are living in poverty. But this statement, of course, is just one side of the coin. The other side is that despite all the good contributions of doctors all over the country, there are still many Filipinos who are still suffering ill health because of the lack of means to afford medication or a consultation with a doctor.

We now have 38 medical schools producing an average of 2,400 new doctors a year. From 1991 to 1996 alone, we produced 10,956 medicine graduates. At the rate we are producing doctors, the Philippines should now be a healthy nation, beaming with energy, hope, and vitality. But

since health does not exist in a vacuum and is interdependent with the bigger socioeconomic and political realities, the health of our people has remained in a miserable state.

We have seen how bad governance, inequitable policies, and inopportune economic events have affected our health care system. For the sake of the future generations, we have to work to make Philippine medical education responsive to the realities and exigencies in our midst.

Gaps between reality and what is learned

Let me just cite the dissonances I observed between what is learned from medical schools and what exists outside the four walls of the academe. These cannot be attributed to medical schools alone, but it is worth taking a look at them in order for us to appreciate the real challenges to Philippine medical education.

The 2011 Family Health Survey shows that reliance on traditional birth attendants or TBAs as health human resource during childbirth remains high, with 27% of births attended by them. For poor Filipino families, TBAs are a cheaper alternative to professional midwives and doctors; in some instances, they will accept payments in kind. While most maternal deaths occur in the hospital, in most instances, these are due to late referral. At the first referral level, late referral can be aggravated by inadequate medical management due to lack of emergency obstetrics supplies and equipment or incompetence of health staff to manage obstetrical emergencies. An obstetrician–gynecologist is available only at the secondary and tertiary levels (Provincial Hospital and Regional Hospitals); the first level referral facility (District Hospital) is staffed only by a general practitioner who may have had training on first level referral doctor (FLRD), a

special 6-month course on obstetrics for general practitioners, or have not received any training on basic obstetrics at all.

The question now is: What are medical schools doing to respond to the challenge of high maternal mortality in the Philippines, in terms of curriculum, program development, and research?

Diarrhea is still among the top causes of illness among children and adults. It is more an exemption than a rule that doctors give proper and complete advice on preventive measures. For example, a patient is told that water should be boiled, but is not told how long it should be boiled. Handwashing is advised but the proper manner and duration of handwashing are left out. In a country where the patterns of prevalence of malnutrition (i.e., early onset of stunting and being underweight before six months of age) suggest that faltering breastfeeding behavior is one of the major culprits, what do medical students know about the benefits of breastfeeding, the properties of breastmilk, or the methods of inducing lactation or relactation should a mother stop breastfeeding before six months?

The public's familiarity with traditional herbal medicines is high, as evidenced by the National Demographic and Health Survey. We are rich in botanical resources, with 12,000 species of plants, of which 1,500 species are used by traditional healers in providing primary care in the communities. Barangay Health Workers as well as many members of the local communities use traditional herbal medicine, but are our medical students adept and knowledgeable about the use of herbal remedies?

In terms of health service management, studies have shown that Filipinos, especially women, have mixed feelings toward the health system, having heard rumors or personally experienced any of the following weaknesses: (1) a health system that is complex and alien to the ordinary person, who is not readily given the information that would assuage her fears or lighten up his or her load; (2) arrogant and overbearing doctors who are intolerant and uncomfortable when patients doubt or question their opinions, findings, or prescriptions; (3) government health services that are free or cheap but of low quality, unreliable, and brusquely delivered; and (4) private medical care that is more inspiring of confidence but expensive.

In medical schools, are equity, cost-effectiveness, and cost-efficiency of health care interventions critically discussed? Is health care financing and social health insurance a part of the curriculum? How about its application to PhilHealth guidelines?

If day-to-day physician practice is 90% outpatient care, how come medical education spends more time in hospital care? Of the 1,816 licensed hospitals in the country, only 64 (3.5%) have 250 beds or more. How come our hospital exposure for medical students is mainly conducted in large hospitals? There are 15,000 barangay health stations, 2,000 rural health units, and more than 25,000 private clinics in the country. How come our venues for outpatient experiences are, for the most part, in hospital settings?

What has Philippine medical education done to engender a caring, compassionate, and friendly attitude towards patients among would-be doctors?

Another educational concern is in the area of clinical information systems. Many Filipino practitioners give very low priority to health records management even with the advent of the information age. This is despite the fact that medical errors arise from poor records management of health strategies such as the Directly-Observed Treatment Short Course (DOTS) for the treatment of tuberculosis, which require a good level of recording and reporting among practitioners. How many of our medical students are trained in clinical information systems?

Last but not least, medical students are not made to understand the bigger environment wherein they will practice their profession. How many of our graduates, much less senior medical students, are aware of the implications of the devolution of health services delivery and the Health Sector Reform Agenda to private practice? How many have studied and practiced the Integrated Management of Childhood Illnesses? Or understand the rudiments of health care financing and PhilHealth? The Philippines has an overall physician-to-population ratio that is comparable to that in Taiwan, and exceeds the ratios in Thailand and Indonesia. Yet how many of our medical students are made aware that 4 out of 10 Filipinos die without seeing a doctor for their illness, while 20% of Filipinos have never seen a doctor in their entire life?

Two Standards

Philippine medical colleges have shown in the past a willingness to bring about change for the country and for the young people who will be a part of the future Philippine health workforce. To initiate reforms in medical education, Philippine medical colleges have to accept that two standards now dictate the practice of medicine.

The healing profession has always been regarded as a humanitarian service. Doctors of medicine are expected to render health care above self and family. At times, public expectations go so high, calling for physicians to be patriotic in the service of the nation. This is particularly true in socialist countries, whether the ideology and political spectrum is from Christian democratic, to Christian socialist, to Communist.

However with the crumbling of the Berlin wall, the break-up of the Soviet Union, and the rise of a pragmatic open market China, the economic and political make-up of the world has changed. The ascension of the World Trade Organization (WTO) with its General Agreement on Trade and Services (GATS) has been defining the economic, political, and social agenda of countries when it comes to the marketing and trading of goods and services, including health services and goods.

The medical profession is also greatly affected and influenced by these global forces of change and development. Market forces now dictate the behavior of physicians in the promotion of pharmaceuticals and medical devices. Doctors of medicine can no longer escape the influences of national social health insurance programs and health maintenance organizations (HMOs) using the principles of managed care. Hospitals and polyclinics are run like business corporations rather than healing humanitarian institutions. Even malpractice laws succumb to the dictates of commerce and markets.

In a world where market forces dominate conscience, thinking, and action, the physicians of today will have to accept these overwhelming changes in their health care behavior and practice. Doctors of medicine have no other choice to survive in this modern-day world but to integrate with the world of capitalism, commercialism, and profit-making. These developments have altered the relationship between physicians and patients. While doctors of medicine behave as capitalists and entrepreneurs, their patients still expect them to be humanitarian, compassionate, and caring.

Can these two contradicting behaviors still co-exist in peaceful ways? Yes, if physicians will allow medical ethics or bioethics to guide their behaviors. Medical ethics is the single saving grace in the face of these overwhelming market forces as doctors of medicine enter the world of entrepreneurship and corporate health care management.

This will be the unique character of medical entrepreneurship and medical health care corporations – a merger of medical ethics with medical trade, industry, and commerce. Yes, doctors can have five-star clinics providing compassionate, competent care with a one-star price. Hospitals and medical centers can engage HMOs and social health insurance programs in tie-ups that will serve the poor and underprivileged so that patients of all socio-economic classes can be given access to quality health care. Prescriptions of essential drugs and use of laboratory diagnostics and medical procedures can be tempered with principles of rationalization as manifested in clinical practice guidelines, medical algorithms, and technology assessments. Even recruitment and exportation of health professionals, as a business, can be guided by ethical guidelines in the trading of doctors and nurses between and among countries.

So for physicians of the 21st century, as long as medical ethics become the standard of medical entrepreneurship and health corporate management, doctors of medicine will be able to balance their humanitarian concerns with their acquisition of material and monetary wealth.

These are the realities that face the graduates of Philippine medical colleges. Thus, reality-based curriculum is the present and future challenge in order to bring about a new, more humane era of medicine in our country.

In Perspective: The UP College of Medicine

The UP College of Medicine (UPCM), founded in 1907, has lofty principles guiding its students. It envisions “A community of scholars highly competent in the field of medicine with a heightened social consciousness; imbued with moral, ethical and spiritual vigor; dedicated to a life of learning; committed to the development of Philippine society; inspired by love, compassion and respect for the dignity of human life; and anchored on the principles of Truth, Freedom, Justice, Love of country and the Democratic way of life.”

It sums up its mission in an ideal: “Guided by moral, ethical and spiritual values, we commit ourselves to excellence and leadership in community-oriented medical education, research and service, using the primary health care approach, intended especially for the underserved.”

An average of 750 college graduates aspire to enter the UP College of Medicine each year – in 2012, there were 760 applicants. Only 120 are accepted to start Year level 3 (i.e., first year medicine proper) at the UPCM. However, where have all its graduates gone?

Statistics from the UP Medical Alumni Society (UPMAS) show that from 1954 to 1989, an average of 50.9% chose to practice abroad; according to the UP Medical Alumni Society in America (UPMASA), an average of 20% left local shores from 1990 to 2004. These numbers are underestimates, since some have passed away or did not register. These numbers also did not take into consideration those who are still taking the US MLE, those who are practicing as nurses, or those engaged in other non-medical careers.

On the other hand, what have become of those who remained in the country? Earlier data from UPMAS showed that about three-fourths of UPCM graduates practice in Metro Manila, leaving only a fourth practicing in the provinces. Having one-fifth of its medical graduates practicing in other lands in the recent decade while only a fourth serve in the provinces is undoubtedly a disturbing trend, given the bigger backdrop where health resources are lacking in many parts of the country and where a crisis of proportions has developed in terms of local health human resource. In the recent years, UPCM placed greater emphasis on serving the underserved through the Regionalization Program and Return of Service agreement, but the impact of these programs still remains to be seen.

A study on UP medical students' perception and values on being physicians was done in 2004. Entitled "From Idealism to Pragmatism: A Longitudinal Study of the Perception and Values on

Being Physicians Among Medical Students in UP College of Medicine”, the study followed the cohort of Class 2005 whose answers to a yearly survey initiated by the UP College of Medicine, through the Community Oriented Medical Education (COME) in 1999, were analyzed.

The study aimed (1) to describe the course of self-appraisal as future doctors among medical students from Class 2005; (2) to analyze the changes in students’ perceptions about their future selves as doctors and their future medical practice; (3) to describe the changes in students’ self-ratings vis-à-vis the UPCM vision; (4) to determine the factors that affect the change or non-change in perceptions/self-ratings.

The main methods used were the survey and the focus group discussion. The progression of attitudes was measured during the whole course of the training of the students to help clarify when attitude changes are detectable. Out of the initial pool of 160 students, 158 responded to the baseline assessment during their first year (YL3), yielding a response rate of 98.7%. Only 145 responded during the second year (YL4); 153 during the fourth year (YL6); and 138 during the fifth year (YL7). Unfortunately, for some reason, the survey was not administered during this cohort’s third year (YL5). A total of 117 students responded on all four occasions (74% of the original cohort).

The survey questionnaire used was a tool developed in 1999 (see Appendix 4). It consisted of three sentence-completion type of questions about a student’s perception of himself/herself as a future doctor and his/her medical practice. The rest of the questions were Likert-type items that tried to assess how far the students have gone vis-à-vis the UPCM vision.

The focus group discussion (FGD) participants consisted of both students from batch 2005 and the UPCM faculty. The students were selected based on those who retained their values throughout medical school and those who completely reversed their values by their last year. The faculty consisted of Chairs of the different departments and a sampling of senior and junior faculty members.

The FGD guides used consisted of questions that probed the respondents' insights into the changes that occur among students as they progress through medical school (see Appendix 5).

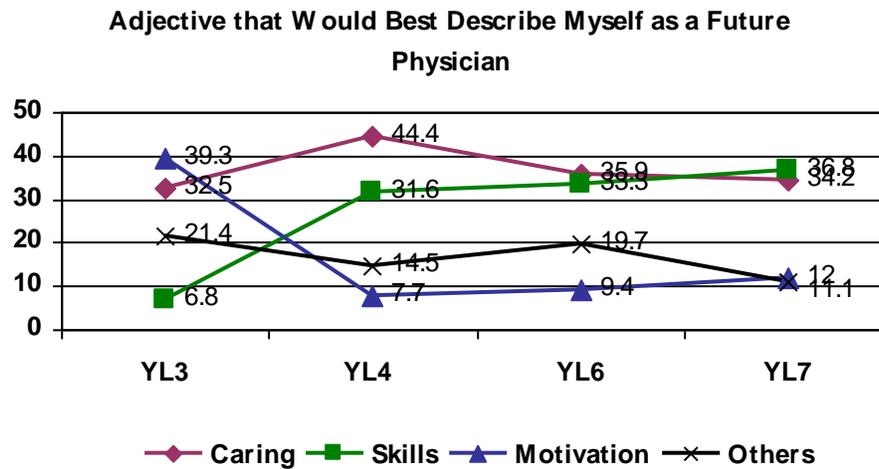
When asked what adjective to describe themselves as future physicians, the respondents came up with a diverse lot. Three major themes surfaced, namely, caring-related adjectives, skills-related adjectives, and motivation or drive-related descriptions. All the other answers that did not fit these three were classified as "others".

Upon re-classification of the individual answers based on these themes, findings reveal that motivation-related adjectives were the most-mentioned among the first-year students (39.3%), which then took a big dip in the second year and then increased steadily after (see Figure 1). Caring-related adjectives had a high percentage among the first-year students too (32.5%), but these reached their peak during their second year (44.4%) and then went downhill after that. Skills-related adjectives, on the other hand, were at its lowest during the first year (6.8%), which then jumped during the second year (31.6%) and steadily increased after. It was at its highest during their last year (38.8%).

However, univariate tests reveal that there is no significant difference among the year levels in terms of the caring-related adjectives. On the other hand, there is a significant effect among the year levels in the skills-related ($F [3, 453] = 12.852, p < .01$) and motivation-related adjectives ($F [3, 453] = 19.709, p < 0.1$). The Tukey follow-up test showed that the significant change in skills-related adjectives occurred between the first year (YL3) and the upper years. This suggests that as soon as the students finish their first year of medical training, they tend to place increasing importance on skills than when they did in their first year.

Analysis also showed that motivation-related adjectives were significantly different between the first-year students and the rest of the year levels, but this time the mean scores were highest during their first year. The mean score during YL3 was significantly higher than the mean scores in YL4, YL6, and YL7. Although the trend has been increasing slightly after the second year, the difference of the YL3 scores from the rest is too stark not to be noticed. This suggests that the value placed on being driven, dedicated, hardworking, and passionate during the first year is very high, but the succeeding years no longer find this value high on their list.

Figure 1. Adjective Describing Oneself as a Future Physician (Percentage of Students by Year Level)



As for future medical practice, students have shown a preference for being specialists. This is true across all year levels, with percentages increasing steadily from first year to fifth year (see Figure 2). Preference for super-specialists has taken a more roller-coaster trend. The percentage of those who want to be community doctors, however, was very small compared to those who want to be specialists and super-specialists. It is interesting to note that preference for community medicine was at its highest in the first year and lowest in the fifth year.

Univariate tests showed that the difference in mean scores in all types of medical practice, except specialists, is not significant. The significance across year levels occurs mainly for those who answered specialists ($F [3, 461], p < .05$). Using Tukey's post-hoc comparison, the significant difference has been identified between YL3 and YL7 students. Students in their last year tend to show a preference for specialization more than students who are just starting in medical schools.

Figure 2. Future Medical Practice (Percentage of Students by Year Level)

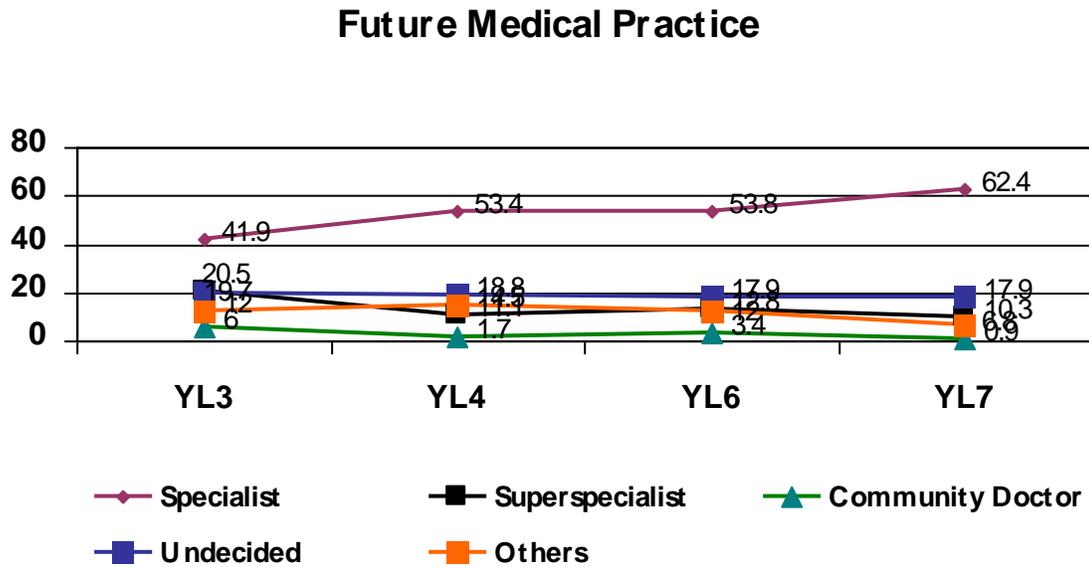
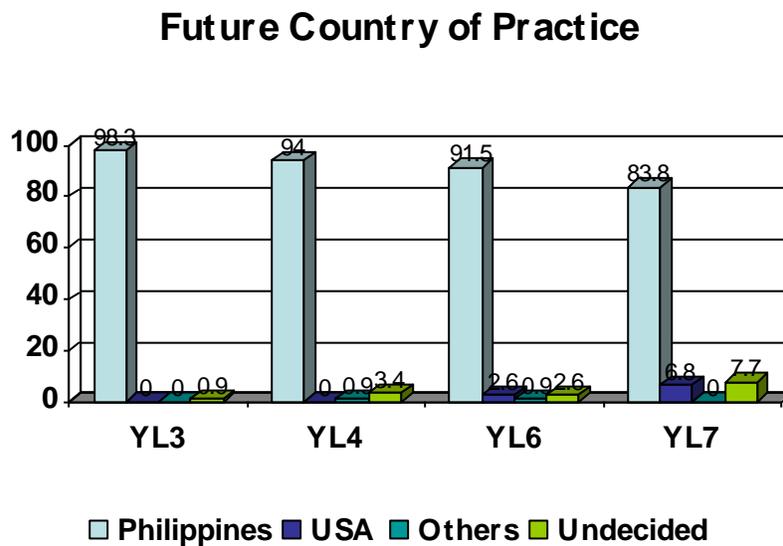


Figure 3 shows that the majority of the students across year levels still prefer to stay and work in the Philippines. However, the number has declined across the year levels. Univariate tests show that the difference in mean scores across year levels is significant ($F [3, 456] = 6.868, p < .01$), while post-hoc analysis show that the difference lies mainly between the lower year levels and YL7. This means that the mean scores of YL7 students were significantly lower compared to the mean scores of those in the lower years. This finding suggests that the passion of the few students who desire to stay in the Philippines tends to decrease considerably by their last year in medical school.

Figure 3 also shows that the number of those who want to practice in the USA ($F [3, 456] = 5.462, p < .01$) and those who were undecided ($F [3, 456] = 2.864, p < .05$) increased significantly during YL7. For those who want to practice in the USA, the difference is significant between YL3 and YL7 as well as YL4 and YL7. Among the undecided, the

difference is significant between YL3 and YL7 only. It would seem that many of those who initially favored Philippines as the country of practice during their first year or second year eventually chose the USA or has become undecided as they reached their last year in medical school.

Figure 3. Future Country of Practice (Percentage of Students by Year Level)



During the FGDs, students in their last year in medical school expectedly mentioned technical skills as something they gained that would put them in good stead as they practice medicine. In particular, this technical skill meant having gained the diagnostic ability or the clinical eye. Interpersonal skills or people skills, such as knowing how to deal with different kinds of people, were also cited as a gain. The value of constant learning and adopting a certain mindset to cope with stress were also deemed important.

The faculty, on the other hand, perceived the attitudes of the students differently. While they agree that the students are intelligent and competent, they also felt that the current generation of students was too grade-conscious. Gathering as many points as one can and earning the highest grade is foremost in many students' minds. In addition, students seem not to know the meaning of the word "sacrifice". They seem unwilling to go beyond their usual tasks. There was also an observation that students can no longer relate well with patients. They also think they are in a position to negotiate with their professors about many things. These behaviors may be a reflection of the assertive and confident way the current generation goes about things. Some faculty also felt that there is already a breakdown in basic courtesies. Some students show impoliteness in how they relate to their professors.

These responses reveal the divergence in the perspectives of students and faculty about the former's attitudes. Not surprisingly, students have emphasized the positive aspects while faculty members have emphasized the negative side more. Perhaps, this is due to a generational difference. Perhaps, it's a manifestation of self-serving bias.

So whereas there is an agreement among all respondents – students and faculty alike – about the students' competence, the faculty additionally perceives the students' seeming fixation on grades. Whereas students think that they have developed people skills, the faculty additionally perceives the inability of students to connect well with their patients. Whereas students felt they have learned to be dedicated to a life of learning, the faculty additionally perceives the unwillingness of the students to sacrifice and learn more by going beyond what are expected from them as medical students. And whereas, some students are clamoring for a return of

service, the faculty noted that some students are of the thinking that clerkship and internship in UP are enough service to the country already.

These reasons indicate that prior to entering college, students may already be carrying a certain mindset or personal context that predispose them for these changes in values.

Looking at the students' main reasons for choosing medicine as a course gives us an insight into factors that may be contributing to the change in values among medical students. These reasons may be categorized as external and internal in nature. It is interesting to note that some of these reasons had to do with personal circumstances like having parents who put on the pressure to go into medicine, or with statements that revolve around one's self such as wanting personal growth, economic security, or the prestige that goes along with being a doctor. While some mentioned the desire to be of service to others, it was uncertain whether this desire is directed towards the underserved sectors of Philippine society, the moneyed sector, or people from other countries.

Some factors may be described as external in nature, meaning, the influence was mainly external to the person. One of these is parental pressure. Others believe that "destiny" played a role. The service-orientedness of the course was also a factor for choosing the medical course. Through the profession, they know that they could be of service to the people. It was also seen as a way where they could take care of their own families as well. A person's willingness to help and be of service to others is something that cannot be easily taken away.

Other factors can be described as internal, that is, the decision was a personal choice and no outside force has explicitly influenced them. Professional goals such as personal growth and economic development fall into this category.

For some, personal growth was the driving force. They perceived medicine as a multi-faceted and dynamic field where many choices exist for those who want to pursue it. One may do private or public practice, or go into teaching or research. For some, medicine will also open up better opportunities for them.

For others, medicine is also a career that could bring them economic development. It is a widely sought-after profession, since finding a job in any place or self-employment would not pose much difficulties.

The prestige or high status associated with being a doctor is also an important drive for others. For instance, being a doctor means being the boss or taking charge. A respondent shared that she used to dream of being a nurse. But since she is the type who likes to be in-charge, she felt that pursuing a medical career would give her that satisfaction.

Answering one's "calling" was also how others saw it. When they were asked as kids as to what they want to be when they grow up, they would automatically answer "doctor" for no reason at all. It was what they really wanted to be ever since; they could not think of themselves being in any other profession.

The students may also be bringing with them characteristics inherent in their generation. Their attitudes toward their studies may merely be a subset of this generation's tendencies and attitudes.

For the current generation of young people, everything seems to be handed down to them on a silver platter. One participant added, *“Because if times were hard, they were not as hard as the pre-martial law and the martial law period. They did not know what that was... Ngayon nagreklamo sila na may konting baha. Dati nilalakad namin yan dahil wala naman. Ni walang aircon nun. Ni walang computer, cellphone...”* According to another participant, this generation does *“not understand permanence because they grew up in a throwaway consumer society where everything is instant... and disposable”*. As a consequence, they do not know postponement of gratification the way the previous generations did.

Therefore, proposed policies such as cutting back the 24-hour duties may worsen the situation, according to a faculty participant. Declaring 24-hour duties as “student-unfriendly” may be coddling and spoiling the students, thereby reinforcing their tendency to shun hardships and self-sacrifices.

The current generation seems to be particularly strong on “rights” too. They are very much aware of what they have a right to say “no” to, as taught to them in schools. *“Nasobrahan ang rights”*, as one faculty put it. Some faculty felt that current students think nothing of asking their professors for a copy of their lectures on Powerpoint. They also think they are in a position to

negotiate with their professors about many things. These behaviors may be a reflection of the assertive and confident way the current generation goes about things.

The most significant factor that may be affecting students' attitudes is the stressful environment in which they work and study. With a low budget to work with, the hospital is lacking in facilities and supplies. There are also many encounters with patients who cannot afford to pay their bills and medicines. Majority of the patients come from a low socio-economic class. And there is just too much work. The students have particularly complained about the workload or the numerous patients they had to attend to. They think that the quality of patient care suffers as a result. This also became a frustration for some, because in as much as they want to give more of their time to explain to the patient or the relatives what the illness is, they simply cannot because of the other responsibilities they are burdened with.

Another effect of the heavy workload, according to the students, is the loss of values that were taught to them during their early years in medical school. Values like compassion and respect were lost along the way. Some said they became bad and brutal. Others said they were dehumanized along the process. For one respondent, it came to a point where he wished his patient would die so that he would not have to monitor anymore. Such a stressful environment may be setting-off the ill-tempered attitude of the students as they relate to their patients.

For others, the lack of emotion, a possible manifestation of being less compassionate, is a defense mechanism from all the sufferings around them. Long years of study can also make one tired and *masungit*. Too much work and patients combined with the limitations of time can make

one forget how to be compassionate. Compassion takes time, which, unfortunately, doctors do not have the luxury of. As one respondent put it, *“Compassion also is not a priority for one’s learning because one is too busy being competent”*.

The lack of role models in community education could also account for these attitudes. There is a dearth of community role models that the students can look up to for inspiration. One participant surmised that this could be because COME is a relatively recent development.

There were criticisms that the curriculum is reactive and wanting in its commitment to the community. The College has not been giving its students the opportunity to actually see the situation at the community level. The training provided by the College is still highly specialized and tertiary in nature.

This is related to another issue about the College’s dilemma between the need for generalists and the need for specialists. The College seems to be caught in a bind between the community’s needs at the local level and the challenge of keeping up with the advancements at the global level. This has eventually generated an identity crisis in medical students.

Students have also voiced their dissatisfaction with the undervaluing of their skills in some departments. Others said that they were tasked to do menial jobs like answering the phone or doing the charts. The undervaluing led to dehumanization. For one respondent, the undervaluing made her feel like she is a “scum of the earth”. For another, she was like a

“charting machine”. Another felt that he wasn’t really able to help the patient since he just had to follow the orders of someone else and couldn’t do things or decide things by himself.

There was also the issue of the 24-hour duties, days wherein they had no breaks and no relievers. They were really pulled out of their comfort zones. They had to bypass meals and even the call of nature. A respondent said that he sees his internship as a “*payment of obligation to UP for their low tuition fee*”.

Others felt dissatisfied with the “bad pedagogy”. Their dissatisfaction is with the preceptors who gave boring lectures or who came to class unprepared; with the departments who implemented poor curricula and which assigned students scutwork; and with those who gave them too much work that did not translate to substantial learning in the end.

There were several factors which shaped their plans after graduating from medicine. These factors may be classified as pull and push – push factors being those that drive or force them to practice outside PGH or outside the country, while pull factors are those which make them or attract them to stay in PGH or in the country in general.

Among the push factors cited were the heavy workload, the presence of better economic opportunities elsewhere, and the lack of exposure to non-mainstream practice. One respondent initially planned to take his residency in PGH. However, upon being exposed in the clinics – to Surgery in particular – he has observed that the training has the tendency to overwork the

residents. “*Kung okay lang sana yung surgery dito. Wala kasing way na mag-train ka ng surgery dito na hindi ka nilalaspag.*”

The country’s current economic condition is also a push factor for respondents who were not planning to pursue their practice in PGH or in the Philippines. They have to address their financial needs as well. A respondent said that there is the need for her to earn bigger since she plans to have a family of her own before finishing her residency. Another said that the salary in PGH is not commensurate to the workload that one will be doing. Opportunities here are also not as abundant compared to those outside the country.

The lack of exposure to other avenues is also a push factor. As UPCM students, they were only exposed to either residency, MLE, or community practice. Had they been exposed to the other non-mainstream practices of a doctor besides the usual MLE and residency, they probably would have planned to stay.

It has also been observed that contemporary society tends to put value not so much on work but on winning lotteries and getting money the quick way. Everything is fast-paced and instant. There is much premium on convenience and comfort. This could have had influenced students to adopt attitudes that would lead to instant personal gratification.

For others, the quality of education abroad entices them to study there during their residency. For one respondent, she plans to study in the US just for “*nakaw talino*”. She just hopes to learn from there but plans to eventually come back to the country.

Some parents could also be a reason for their children's decisions and plans. The parents' examples and teachings may overtly or covertly influence these plans.

On the other hand, the quality of training that can be acquired at PGH is also a reason why some chose to stay in the country. As one respondent has stated, "*Sa dami ng pasyenteng titingnan mo, kung di ka pa naman gagaling*". PGH serves as a good training ground since a variety of cases can be seen here. Another respondent added that its Pediatrics Department has a good program hence she intends to take her residency in PGH.

A respondent has another view on why he intends to stay. For him, being accepted in PGH for residency is a natural opportunity that comes along from having graduated in UPCM.

"Andaming nagkukumahog na pumasok ng PGH, ikaw na andiyan na bakit ayaw mo pa."

Results confirm what many other previous studies have found: that there develops increasing pragmatism and waning idealism and empathy among the students as they progress through the five years of medical education. By the last year in medical school, students have put more emphasis on skills-related values or on competence. The last year in medical school has also witnessed a considerable number of students aspiring to be future specialists as compared to when they started studying medicine. And while a majority of students claim that staying in the Philippines remains to be their future plan, it is significant to note that less and less students desire to do so, while more and more students are planning to practice in the USA.

It seems evident from these findings that medical education in UPCM has not been completely true to its vision of community-oriented education directed to the underserved. While it stays true to its aspiration of excellence as reflected in the students' increased emphasis on skills-related values, it has not been entirely successful in encouraging career specialty choice and practice location that would benefit the greater majority of poor and underserved people in the country. As the World Health Organization pronounced in 1993, which was later affirmed in the Edinburgh Declaration of the World Medical Association of 1998, medical students must be educated considering the health needs of the population in which they live. They declared that the purpose of medical education is to train doctors to be capable of improving communities' health standards; towards this end, medical school curriculum should be restructured according to the health requirements of the community. If the majority of medical graduates would aspire to work as specialists or super-specialists and an increasing number would plan to work abroad either as physicians or as nurses, then medical schools are not being true to what their mandate should be; therefore, the health needs of the local population would not be addressed adequately. Those whose health plight has been in the fringes would mostly remain stuck in the fringes.

The study results also suggest that the first year of medical training seems to be very crucial since some value changes appear to occur after the first year. The difference in the emphasis on skills and the de-emphasis on motivation was considerable between the first year and the higher years. While caring-related values were not found to be significantly different across year levels, it still posed a downward trend after the initial two years. In the US, it has been found that the first clinical year is considered especially important in the socialization process. Similarly, the first year in the undergraduate level of Philippine medical education seems to be a critical time

for the students to value skills without losing sight of the other equally important characteristics of empathy, compassion, and motivation. Thus, it is clearly important to nurture the idealism of medical students at the outset. In order to do this, there should be more effort in striking a balance between competence, compassion, and motivation.

It is also worthy to note that the significant increase in the number of medical students aspiring for specialization and for US practice occurs in the last year. This is related to the finding of Dambisya (2003) wherein rural practice was preferred more by the freshmen in a university in South Africa, while graduating students signified more interest in urban practice. The current study implies that the experiences during YL7 could be contributing significantly to the increase in interest in specialization and migration. As some of the FGD participants admitted, the stressful experiences they had during their internship, which include the heavy workload and the appalling conditions in the hospitals, could be undermining the compassion and empathy that have been taught to them during their early years in medical school, and could be pushing them to consider specialist pathways and greener pastures abroad, more and more. There should be a re-examination of the curriculum – both official and hidden – such that changes in values not consistent with the UPCM vision would be minimal, if at all, during the last year.

The self-ratings of the students on how far they have gone in terms of the UPCM vision reveal a highly optimistic appraisal of one's current self as a medical student. And this optimism is most significant during the final year. The ratings seemingly imply the success of the College in instilling its ideals in its students, including commitment to the development of Philippine society and compassion for others. These students' assessments of their achievement of certain

attributes may successfully reflect the influences and values expressed in their learning environment. This, however, seems to clash with the tendency of the students to value competence and specialization more in their future selves as physicians. This implies a certain disharmony in the self-identity of medical students.

This disharmony could, in fact, be a reflection of the bigger context at the UPCM level. While the College has tried to reaffirm its commitment to community-orientedness time and time again, the reality is that the highly specialized and tertiary-oriented nature of their training has given a “schizophrenic” bent to the implementation of the vision and mission. As Sanchez (1988) has observed about medical education in the Philippines, it has always emphasized knowledge, skills, and technology, thus leading to increased specialization. In addition, more and more medical students are being socialized towards career choices in hospital settings. Such extensive exposures would then predispose students to choose hospital-based specialties. Conversely, increased exposure to primary and community care can also significantly alter career intentions in undergraduates. This then supports the view that as community-based learning increases, so should the students who make general practice and community practice as their own choice. Unfortunately, the community aspect of the UPCM curriculum remains to be weak, as was lamented by some participants of the FGD.

The UPCM Curriculum, in particular, seems to be geared towards attracting the graduates to specialization. The exposure students get often lead them to specialization and/or to take the MLE, and only minimally influences graduates to choose or retain community practice. The

curriculum diminishes the graduates' personal characteristics of caring, compassion, motivation, and dedication.

Given these findings, the following recommendations are offered. First, a more scholarly and nurturing environment should be created; exposure to various fields should be increased; the 24-hour duty may be modified; career talks should be conducted; and the subjects Introduction to Patient Care (IPC) and Perspectives and Values in Medicine should be sustained throughout all years.

The mentoring program should be institutionalized in the medical curriculum. There should be monthly mentoring sessions during the school year, one-on-one dialogue assessment with the mentors every end of the academic year, and final exit interviews with graduating students.

Selection of faculty members should be values-based instead of being based purely on competency. There should be continuous faculty development; positive role-modeling should be promoted.

Clinical competency should be balanced with caring skills and compassion. Incentives may be given for these qualities. Modules should consistently reflect attitudinal development and curricular impact on both caring and competency skills should be evaluated.

Admission policies should be reviewed. The background, civic-mindedness, and community involvement of the student should be balanced with GWAG & NMAT results. Regionalization slots should be increased to ensure nationwide coverage.

The mandate of a country's medical schools is to produce the highest quality of compassionate, humane, and competent physicians who will serve the basic health needs of its citizens. In developing countries, medical schools are expected to produce such physicians to practice in underserved geographical areas in need of medical services and provide basic health care to disadvantaged population groups. Medical education should focus on the terminal competencies of the Filipino medical graduate but without losing sight of for whom and why the medical graduate is studying.

Guiding principles should include acquisition of knowledge, skills, and attitudes to produce humane and globally competitive physicians. This includes the concept of the 5-star physician developed by the WHO and adapted by the DOH, APMC, and CHED; that is, the concept of a physician as a health care provider, educator, counselor, researcher, and social mobilizer.

The bureaucratic and conservative nature of medical schools can prevent them from moving faster than the ever-changing health care environment. Medical school officials should accept the nature of conservatism of a medical school within a bigger college and university. They should self-rank their medical schools as to where they are in the spectrum of conservative to progressive. They should search for creative ways of minimizing the school bureaucracy and for

the various means to catch up with health care realities, and have the political will to initiate reforms.

There should be more public involvement in curriculum development. How many medical schools have a consultative public panel as a listening and sounding board to touch base with reality changes? Are there public representatives in the curriculum committee? A public panel of eminent persons from the community (urban and rural), local government, civil society organizations, Department of Health, PhilHealth, and PITAHC should be organized to advise medical schools. Specific panels of similar memberships may be created on an as-needed basis for management of problem-oriented areas (e.g., cardiovascular diseases, TB).

Social accountability of medical schools should be further actualized. Let there be less lip service concerning social accountability, and more action; monitoring and evaluation tools should be put in place to assess performance. Annual reports to APMC concerning these may be submitted.

Policies that will institute social accountability and unity for health should be initiated, for example, a university national health service policy. Projects and activities that demonstrate the medical school's social accountability and operationalize "All for Health, Health for All" should be expanded and promoted.

Community Medicine as a Training Program

Community Medicine is the branch of medical science that is concerned with the health needs and conditions of population groups of known size and composition, and in dealing with these it uses appropriate methods and interventions. It is recognized as a specialty by the Philippine Medical Association (PMA); the DOH, DILG, PITAHC, and PhilHealth all likewise recognize the specialty. Community medicine, however, is usually offered as a Masters of Science in Community Medicine or as a combined degree of M.D. and M.Sc. in Community Medicine, but not as a residency training program.

Requisites for a training program include the following: (1) faculty in practice or with experience in community medicine; (2) an academic program in community medicine approved by the university council and its board; (3) participation of vibrant communities, municipalities, and local governments; (4) medical doctors committed to a career in community medicine; and (5) Philippine textbooks and databases on community medicine.

This is a proposal for a possible Community Medicine Curriculum:

Year 1 (12 Subjects)

- Community Diagnosis
- Community Organizing and Leadership
- Community Development
- Medical Anthropology
- Medical Sociology

- Community Epidemiology and Biostatistics
- Community Psychology
- Filipino Traditional Medicine
- Community Health Education
- Community Health Research (CO-PAR)
- Community Health Information System
- Community Doctor's Health, Fitness, and Well-being 1

Year 2 (12 Subjects)

- Community Obstetrics
- Community Pediatrics
- Community Psychiatry
- Community Adult Medicine
- Community Surgery and Orthopedics
- Community Rehabilitation Medicine
- Preventive Medicine
- Social Medicine (Human Rights, Ethics, etc.)
- Complementary and Alternative Medicine
- Community Nutrition and Food Production
- Water and Sanitation
- Community Doctor's Health, Fitness, and Well-being 2

Year 3 (12 Subjects)

- Principles of Community Medicine Management
- Community Advocacy and Social Mobilization
- Community Health Team Management
- Intersectoral Linkages and Multidisciplinary networking
- Community Health Financing
- Social Health Insurance
- Environmental Health
- Teaching, Learning, Communication Skills
- Local Government Health Policy Development
- Community Disaster Prevention and Management
- Community Medicine Thesis
- Community Doctor's Health, Fitness, and Well-being 3

Proposed Community Medicine Curriculum - Electives

- Community Medicine and Globalization
- Community Health Surveillance
- Occupational Health
- The Community Physician as Leader and Social Catalyst
- District Health Management
- Community Clinics Network Management
- Community Health Human Resources Management

- Issues in Access, Quality, Effectiveness, Efficiency, and Equity in Health Care
- Best Practices in Community Medicine

It is hoped that after comprehensive training in community medicine, it may now be defined as the branch of medical science that empowers communities, municipalities, and local governments to achieve health, wellness, well-being, and total human development, together with community-based physicians who are fully enabled as social catalysts in the transformation processes of a country.

Shall we see the day when Community Medicine is recognized as a discipline?

Will the critical mass of Community Medicine champions stand united to ensure that Community Medicine is acclaimed as a health science?

Will Filipino community medicine physicians be working amongst the underprivileged and marginalized communities and municipalities of the Philippines as manifestations of mainstream medicine?

All reforms to be undertaken in medical education add up to one thing: the molding of doctors who not only have the knowledge and skill to practice their profession, but the heart and soul to enable them to become compassionate, humane, and caring. For too long, doctors and medical students have been made to forget the true purpose of their profession. The notion of the medical profession as a form of service has been neglected, scoffed at, and dismissed as impractical and

unreal. On the other hand, profit and personal advancement have been acknowledged as the useful goals of the smart doctor. No wonder that the words most often used to describe our culture and society are the same words frequently encountered in our profession: damaged, sick.

The road back to recovering our memory as professionals in the service of our disadvantaged countrymen will be long and difficult. But the number of those who are choosing to travel it is increasing. One day, it will not be such a lonely road. And the rewards of traveling it will be felt not just by doctors, but by a country that has long been in need of healing.

Afterword: Portrait of the Doctor as Filipino

I end this book by leaving my thoughts to the young Filipino doctor.

We are like matchsticks in the box called life, we are created for a purpose and destined for fulfillment. You can come out from the box, albeit painful or stay inside till you rot. The choice is always yours to make.

Many years back, I was also in the same boat as you are. I had to make a decision and in doing so I made a list on who will benefit from my decision, the pros and cons, the advantages and disadvantages.

Having stayed in the cities for most of my life, the shift to the rural areas brought feelings of fear and inadequacy.

“There is no electricity. The people go to bed early. What will I do in the evenings?”

“There are no movies, disco houses, or theaters. What will be my form of leisure?”

“There are no soft beds. Will I be able to sleep on the floor and manage with just one room for my family?”

“There is no regular transportation. Can I make it hiking along trails on hills, mountains, and rivers?”

“There are no toilets, tap water, showers, newspapers, televisions, or telephones. How am I going to cope without all these?”

When I was about to start my work in the community, I was asked how long I intended to stay in the rural areas. I said I would give it a year. I was not sure I could cope with life in the boondocks. At the same time, there was the threat of separation from my family, my friends, and the comforts of city life that I had grown used to.

Soon, I found out that there were a lot more things that could take the place of movies, disco houses, showers, television, electricity, and other luxuries. The hospitality and warmth of the rural people were a far cry from the impersonal behavior of city dwellers.

The seas, rivers, waterfalls, and springs could rival any bathroom shower. The sunrise, sunset, native music, dances, and other village festivities offered a totally different form of recreation. The cool breeze, fresh air, colorful butterflies, chirping birds, and majestic scenery along the trails and tracks made the hikes not just bearable but even pleasurable. Life in the rural areas was not as bad and lonely as I had feared.

Gastronomical Adjustments

We learned many lessons while adjusting to the food and meal schedules in rural areas. City lifestyle offers three meals and two or three snacks a day. In rural areas, there are seasons of plenty and seasons of hunger. During seasons of hunger, the people eat only one or two meals a day, with a “meal” consisting of rice or root crops and dried fish or salt. It shocked me to discover that the majority of our people did not have enough food to eat.

This brings to mind an experience in one of the Samar villages. A meal of wood potatoes and salt was served at the breakfast table. I thought it was just an appetizer. After finishing the food, I asked whether there was more to come. How I regretted the question! I was told that it was the hunger season and there was no other food except wood potatoes and salt. I was filled with embarrassment and sadness as I nibbled the remaining precious bits of salt.

It is easy to say we want to adjust to the lifestyle of the people but often it is the people who feel obliged to adjust to our chosen “simple” lifestyle. Out of their inherent hospitality and as victims of advertising, they tend to serve us food that is actually a big drain on their meager incomes. I told them I would eat whatever they were eating – camote leaves, watercress, and edible ferns. I noticed, however, that these were never served to me. People would say, “Doctor, those vegetables are only good for the pigs.”

So every time a doctor entered a village, it seemed like chickens were being hit by an “epidemic”. The doctor would find himself being served chicken for breakfast, lunch, and

dinner. One would think doctors carried a virus that killed the chickens every time they visited the villages! And when the doctor left, the people would go back to eating rice, root crops, and salt.

One morning, in a Leyte village, I was given instant coffee in a jar. When I removed the cap, I found out that the contents were still sealed by aluminum foil. The coffee had not yet been used. I learned that it had just been bought from the store. The villagers did not regularly drink instant coffee because it was expensive, but instead prepared the cheaper kind made from corn or rice, or ginger tea.

So the doctors had to explain to the people that they need not be served anything special. We said if such practices went on, the village would go bankrupt. Instead of helping the village, we would become a burden.

Hard Choices

Our families have great expectations of us, having sent us to medical school. They expect us to comply with the conventional roles of doctors and health professionals. Becoming a community physician does not fall within their expectation of their idea of one who has “made it”.

My parents were initially disappointed with my decision to go to the rural areas. Their vision was for me to work in a big city hospital, specialize abroad, and become a big-time doctor. I had to keep on communicating and relating to them the joys and wonders of my activities in the

community. It took some time before they could accept the work I was doing. Now what is important to them is that I am happy and fulfilled in my work. They have since become very supportive of what I do.

A few of my colleagues have not been as fortunate as I am with regard to their families. The greatest pressure was economic – the need to augment the family income, to support brothers and sisters who were still studying. Their parents often reminded them about the money spent for their education and the expectations from them. Emotional appeals were frequently made. Families would usually say, “You are the only doctor in the family. We need you to take care of us.”

One of our doctors was the victim of a ruse by her mother who pleaded with her to go to the United States. The mother said she was going to have a heart operation and therefore needed her daughter by her side. So the daughter accepted the pre-paid plane ticket and went to the US, only to find out that her mother was not really very sick. But the young doctor could not come back to the Philippines; she only had a one-way ticket. For this doctor and others like her who would have wanted to stay in our country, other means of making themselves relevant to their people have to be found.

What do you know?

Another issue that needs to be dealt with is knowledge and skills. Should medical workers use only North American and European ideas and techniques or should they be open to traditional

practices and beliefs? Should they concentrate on curative means or emphasize prevention? What about the new roles demanded of them? Should they fear professional and intellectual stagnation and isolation?

I remember a time in school when I, along with my classmates, was fined for speaking in Tagalog. We always had to speak in English. It was a stark reflection of just how Americanized the Philippine educational system was.

And then, as medical students, we were taught more about North American diseases rather than those afflicting Filipinos. We were also taught how to pass the United States board examinations. The not-so-secret dream of most Filipino medical and nursing students was to go abroad and make a comfortable living. The trend was to specialize in cardiovascular and degenerative diseases, usually the ailments of the rich. Communicable diseases – those that usually afflict the poor – were neglected. We were taught to rely on laboratory tools and sophisticated instruments for diagnosis so much that we failed to develop and trust our five senses. We became dependent on the hospital setting and on expensive curative techniques and interventions. We learned to belittle traditional healers and dismiss them as quacks.

With this type of educational background, working in the rural areas initially caused a culture shock. There were no laboratory tools, sophisticated instruments, or hospitals. People were dying of pneumonia, tuberculosis, and gastroenteritis, not of coronary heart diseases and diabetes. Disease prevention, rather than curative skills, was crucial. The rural people regarded

their traditional healers highly. It was only after spending some time in the rural areas that we realized how inappropriate our training had been, how irrelevant we were to most of our people!

Pain and frustration accompanied our de-schooling and re-schooling process. We had to undo practically everything we had learned. We were not at all prepared to answer the health needs of our people in the rural areas. We had to review and study more about tuberculosis, schistosomiasis, malaria, and other communicable diseases. We realized that our work must emphasize health education, sanitation and hygiene, maternal and child health care, the use of medicinal plants, and traditional massage. We had to conduct research on and document our indigenous forms of medicine. To make our communication and training methods effective, we had to translate scientific, medical jargon into a language more understandable to the people. We had to learn from the people, especially from the traditional healers. We had to be humble. Indeed, we are still continually humbled by the people.

Learning from the People

The temptation to remain locked into curative work can be very great since most of our training time has been devoted to clinical medicine. Aside from this, curative measures give immediate, tangible results, while disease prevention takes a longer time before their effects are felt. Concentration on curing is ego-boosting. This not only gives personal satisfaction, it also reinforces the god-like status and role of doctors.

Rural health needs, however, center on primary health care. Prevention should therefore take precedence over curative care. Good water supply, sanitary disposal of waste, health education, immunization, and control of communicable diseases should receive priority over big hospitals, sophisticated instruments, and expensive medicines.

Working in the rural areas brings with it the fear of being “left behind” intellectually, of being out of touch with the latest developments in the medical profession. Intellectual stagnation, however, is a matter of outlook. The rural areas offer a wide range of intellectual pursuits and activities. Initially, most doctors do not have the academic skill to do research in rural areas. But through observation and participation, they can learn how to document the patterns and determinants of certain diseases in the villages, the scientific practices of traditional healers, and the people’s concepts and responses to health and diseases. All these are useful guides in improving our service to the people.

In relation to community health, I can say that I have learned more from the people than I did at medical school. The field is open for community-based research on relevant subjects. More documentation has to be done on the pharmacology of medicinal plants, the systematization of indigenous theories on health and healing, the development of appropriate medical technology, the production of teaching aids for illiterate groups, and analysis of prevalent health problems in the rural areas.

We did not anticipate that working among the masses would require new roles for us. We were trained in medical practice. The situation demanded that we take on the role of agents for change, with special skills in health care.

To be a change agent, we also needed to be a community organizer, catalyst, teacher, learner, researcher, coordinator, supervisor, and health worker, all at the same time. We had to learn how to motivate and organize the people, and understand their experiences, their feelings, their skills and actions as well as their dreams so they could mobilize themselves and move out of their dehumanized conditions. At first, these multifaceted roles often evoked strong feelings of insecurity and inadequacy within us. However, when we realized that these roles were necessary to be of total service to the people, these initial doubts were superseded by hope, enthusiasm, and optimism.

Many years back, I decided to stay and serve my community. I became a doctor, a teacher, a friend and confidant to my patients. In my own right I became a leader. I don't have the monetary wealth, when I can easily have it, I don't have the latest models in cars. But I have the strength, the strength I gained from the people I worked with. I have the wealth that no one in this world could take away from me. I am successful because I was able to do what I most desire. That is to be a doctor, a doctor for others, a doctor for the community.

To the doctors of today, I appeal to you all to take the challenge. Stay, serve your community first, be a doctor for the people. At least give it a chance, especially now that our country is at the turning point of progress, we need human resources to sustain our development.

The whole world stands before you. Your future as young doctors is filled with limitless possibilities on what you can become – as a person and as a citizen of this country and this world. While there is now again a wellspring of hope for progress, peace, and social justice, there is a caveat that we now have to get our acts together, muster our collective strength, and make that one great push towards sustainable progress because history will not be that gentle next time.

It is in the context I mentioned that I am exhorting each and everyone of you to make a difference in terms of improving access to quality health care. I am challenging you to give at least two years of your life in the service of those who need medical care the most. They are the unwashed, the exploited, and the marginalized in the remote rural areas and the blighted urban poor communities.

This option will not bring financial reward that you will reap when you go abroad or serve in a private hospital in the metropolis, but I can guarantee you that this will give you a sense of fulfillment that no amount of money or recognition can equal.

You shall have given sense of security to a community that there is now a doctor they can run to when someone gets ill.

You shall have brought back a people's sense of humanity by nurturing their health.

You shall have bestowed respect on the profession that, all too often, is thought of as biased to those who have possessions.

You shall have empowered people by caring for them.

You shall have been, and perhaps will always be, a doctor of the people.

Then you will know in your heart that “A poor man’s tear of gratitude is more precious than gold.”

But working in service of the poor is not exactly without benefit of career advancements and monetary rewards. You may choose later on to become public health sector or primary health care experts for development agencies and be paid handsomely without you asking for it. So the formula is simple – do good to your oath and the rewards will come.

You must proudly stand and bravely wave the banner for quality health in the Philippines. There are no alternatives for this. Caregivers are expected to play the role of culture-bearers, bringing hope and patiently sowing seeds of innovation until the roots gain ground and respect for humanity becomes embedded in all our dealings, including what we call the patient-caregiver relationship.

Maintaining excellence in quality health care and services is essential to improving the overall health and quality of life of populations. It also has a direct link in improving capacities related to access to health care.

Intellectual humility and social responsibility dictates that doctors, whether in unity with experts from other disciplines or other sectors of society, make their voices be heard in terms of making policy and decision – makers understand the implications of their actions or inactions. Being doctors puts us in a distinct place to express what we think of the issues that puts health at the receiving end. As men and women of science, we should stand indignant and not tolerant of these misdeeds.

The writing on the wall is clear: we will remain a weak and vulnerable nation unless we recognize that selfless dedication to the country is expected from each and everyone, especially from whom much is given in terms of education or material possession.

Through your caring, remind the people of their humanity – so that their humanity will remind them of their strength.

Appendix

Appendix 1. Examples of Attitudes, Knowledge and Skills CHWs Should Acquire in Tackling the Problem of Diarrhea, Classified into Must Learn (ML), Useful to Learn (UTL), and Nice to Learn (NTL)

Attitudes:

- ML – patience in explaining prevention and treatment of diarrhea to community members
- ML – perseverance in teaching how to make and use oral rehydration fluids
- ML – empathy with the patient or mother of child with diarrhea and/or dehydration.

Knowledge:

- ML – anatomy and physiology of the digestive tract
- ML – signs and symptoms of the different types of diarrhea
- UTL – changes undergone by the digestive tract as a result of diarrhea and malnutrition
- ML – relationship of diarrhea to malnutrition and infection
- NTL – mechanism of lactose intolerance

Skills:

- ML – preparation of oral rehydration fluids
- UTL – microscopic examination of stools
- ML – recognition of the signs and symptoms of dehydration
- NTL – nasogastric rehydration
- NTL – intravenous rehydration

Appendix 2. Examples of Learning Objectives as Derived from “Must Learn” Attitudes, Knowledge, and Skills in Tackling the Problem of Diarrhea

At the end of the learning period, the CHW should:

1. Identify correctly all the parts of the digestive system;
2. Describe accurately the functions of the main organs of the digestive system;
3. Differentiate the different types of diarrhea by their signs and symptoms;
4. Identify the different factors causing diarrhea;
5. Discuss the different measures taken in preventing diarrhea;
6. Discuss clearly the relationship between malnutrition and diarrhea;
7. Demonstrate correctly how to prepare a home made oral rehydration solution;
8. Show empathy, patience, and perseverance in teaching the preparation and use of home made oral rehydration solution to a mother whose child has diarrhea, through role playing; and
9. Recognize the signs and symptoms of dehydration.

Appendix 3. Sample Curriculum Design for a Training Session on Diarrhea

<u>Learning Objectives</u>	<u>Content</u>	<u>Teaching/Learning Methods</u>	<u>Media/Material Needed</u>	<u>Time Alloted</u>	<u>Methods of Evaluation</u>
1. Identify correctly all the parts of the digestive system	Simple anatomy and physiology of the digestive system	Evocative questions: What do you think happens to food when it is chewed and swallowed?	Posters/Charts of Digestive System Jigsaw Puzzle: of the Digestive System	15 minutes	Actual drawing by each CHW of the digestive system MCQ (Multiple choice question)
2. Describe accurately the functions of the main organs of the digestive system		Input on parts of the digestive system and their functions: Ask CHWs to explain anatomy and physiology back.	Blackboard/Colored chalk Books: Our Health Our Lives Where There Is No Doctor		

3. Differentiate the different types of diarrhoea by their signs and symptoms	Signs and symptoms of the different types of diarrhoea: Factors causing diarrhoea	Evocative questions: What is diarrhoea? What are its signs and symptoms? Input-discussion of the different types of diarrhea	Flash cards of signs and symptoms of the different types of diarrhea	30 minutes	Problems solving
4. Identify the different factors causing diarrhea		What do you think are the causes of diarrhoea?	Blackboard/Colored Chalk		MCQ
5. Discuss the different measures taken in preventing diarrhea	Preventive measures in diarrhoea	Small group discussion on how the community can prevent diarrhoea	Handouts on prevention of diarrhea	15 minutes	MCQ

6. Discuss clearly the relationship between malnutrition and diarrhea	Cycle of diarrhoea and malnutrition	Discussions on personal experiences with malnutrition and diarrhoea; input	Chart on the cycle malnutrition and diarrhea	15 minutes	MCQ
7. Demonstrate correctly how to prepare a home made oral rehydration solution	Ways of preparing home made oral rehydration solutions	Demonstration-Return Demonstration	Sugar, salt, measuring spoons, containers, samples of factory prepared oresol, medicinal plants for diarrhea	30 minutes	Checklist for Skill in preparing home made oral re-hydration solution
8. Show empathy, patience and perseverance in teaching the preparation and use of home made oral	Value of empathy, patience and perseverance in the work of the CHW	Role-playing	Instruction on Role playing	30 minutes	Likert scale

rehydration solution to a mother whose child has diarrhea					
9. Recognize the signs and symptoms of dehydration	Signs and symptoms of dehydration	Demonstration-Return demonstration on an actual patient	Chart illustrating the signs and symptoms of dehydration Slides of patients with Dehydration	30 minutes	Checklist in Examination of a patient with dehydration
			Total:	2 hours 45 minutes	

Appendix 4. Survey Questionnaire (From Idealism to Pragmatism: A Longitudinal Study of the Perception and Values on Being Physicians Among Medical Students in UP College of Medicine)

STUDENT NO.: _____

YEAR LEVEL: _____

CLASS NO.: _____

CLASS SURVEY: Please answer the following as faithfully as possible.

1) The best single **adjective** that would best describe myself when I become a full-pledged physician is: _____

2) In terms of my **future medical practice**, I would most likely be a:

(Name your most likely medical profession: faculty, researcher, general practitioner, community doctor, specialist (specify), NGO physician, MHO, DOH secretary, WHO/UNICEF Health Officer, legislator, governor/mayor, hospital director, health business manager, public health specialist, etc.)

3) The most likely **country** where I will practice my medical profession is:

4) Rate yourself by encircling the number that best represents where you are in achieving the vision of the UP College of Medicine, which states: “A community of scholars in.....

	Rating					
a. highly competent in the field of medicine	1	2	3	4	5	6
b. with a heightened social consciousness	1	2	3	4	5	6
c. imbued with moral, ethical and spiritual vigor	1	2	3	4	5	6
d. dedicated to a life of learning	1	2	3	4	5	6
e. committed to the development of Philippine society	1	2	3	4	5	6
f. inspired by love, compassion and respect for the dignity of human life	1	2	3	4	5	6
g. anchored on the principles of truth, freedom, justice, love of country and the democratic way of life”	1	2	3	4	5	6

Legend: 1 – not there at all

2 – far from there

3 – nearly there

4 – almost there

5 – already there

6 – fully achieved

Appendix 5. FGD Interview Guide (From Idealism to Pragmatism: A Longitudinal Study of the Perception and Values on Being Physicians Among Medical Students in UP College of Medicine)

For the Students

1. Bakit kayo nasa medisina ngayon?
2. Bakit UPCM ang kolehiyo/eskwelahan nyo?

Probe:

- a. Ano ang meron sa eskwelahan na ito at ito ang pinili nyo?
- b. Bakit ito ang basehan ng inyong pagpili ng kolehiyo ng medisina? (hal., excellence ng UP para matanggap agad ako abroad)
- c. Masasabi ba ninyong bentahe ito ng UP sa ibang eskwelahan? May iba pa ba siyang bentahe? Ano ang mga ito?
- d. Meron bang “disadvantage” sa pag-aaral dito?
- e. Gamit ang mga basehan na nabanggit nyo kanina, gaano kayo kakuntento ngayon:
Bakit o bakit hindi kuntento?
 - i. sa kolehiyo nyo sa pangkalahatan?
 - ii. sa mga propesor nyo? (**Probe:** positive role models & negative models; i.e., those people who you don’t want to be like)
 - iii. sa curriculum ninyo? (**Probe:** What do you want to see retained? What changes do you want to see? Bakit ito ang nabanggit nyo? Ano ang makakamit o maa-achieve nito para sa kolehiyo at sa bansa?)

3. Sa 5 taon nyo dito, ano ang nadagdag sa inyong kaalaman o kasanayan dala ng pag-aaral nyo dito na maituturing nyo na napakaimportante sa pagiging doktor nyo sa hinaharap? Bakit ito?
4. Kung ikukumpara nyo ang sarili nyo ngayon sa kung sino kayo nung freshman kayo sa UPCM, ano ang pinakamalaking pagbabago sa inyo, kung meron? Ano ang hindi nagbago? (**Probe:** self-description) Tingin nyo, bakit kayo nagbago? Bakit hindi?
5. Ano ang plano nyo pagkagraduate nyo dito sa UPCM? Saan nyo gustong magtrabaho?

Probe:

- a. Ganito na ba ang plano sa umpisa pa lang ng pag-aaral nyo ng medisina? Bakit/ bakit hindi na? (**Probe:** i) the change from community doctor to specialist or vice versa & ii) the change from Philippines to USA or vice-versa)
 - b. Paano nyo narating ang desisyon na ito? Ano sa tingin nyo ang nakaapekto/ nakaimpluwensya sa desisyon nyong ito?
 - c. **Probe** factors: 1) personal level; 2) family; 3) school-related like teachers & curriculum; 4) societal; 5) global
6. Dalawampung taon mula ngayon, paano nyo nakikita ang sarili nyo bilang doktor? Bakit?
 7. Ngayong nasa huling taon na kayo ng medisina, paano nyo tinitingnan ang mga doktor ngayon sa Pilipinas? Bakit?

Probe:

- a. Ganito ba yung pagtingin nyo dati?
- b. Kung hindi, ano ang nagbago? Bakit siya nagbago?

8. Anong mga importanteng katangian meron dapat ang isang doktor sa Pilipinas? Bakit ito?
Mula sa mga ito, ano sa tingin ninyo ang pinakaimportante? Bakit? **Probe:** relevance ng katangiang ito sa – a) buhay nila, b) sa pamilya nila, k) sa propesyon, d) sa lipunan
9. Paano nyo tinitingnan ngayon ang propesyon ng medisina? Bakit?
Probe:
 - a. Ganito ba yung pagtingin nyo dati?
 - b. Kung hindi, ano ang nagbago? Bakit siya nagbago?
10. Ano ang kalakasan ng propesyon nyo? Kahinaan?

For the Department Chairs

1. In general, how would you describe UPCM in terms of:
 - a. Vision
 - What is UPCM's vision?
 - How does the vision relate to the present situation in the Philippines? (Probe: relevance or outdatedness)
 - What is your department's vision? How does this vision relate to the overall vision of UPCM?
 - Do you have a personal vision of how the College should be? Of how the medical profession should be? Of how doctors should be? How can these be achieved?
 - How successful is the College in achieving its vision? How successful is your department in achieving its vision?

b. Curriculum

- How does the old curriculum work?
- What are the strengths of the old curriculum? Weaknesses?
- Why is the curriculum going to be changed?
- What is Organ System Instruction (OSI)? What changes are we going to see in OSI? (i.e., what is/are different from the old curriculum?)
- How is the OSI going to address the weaknesses in the old curriculum?
- Do you agree with the introduction of these changes? Why or why not?
- How are these changes going to impact the students & teachers?
- How else do we avoid the weaknesses of the old curriculum?

c. Teachers

- Do they differ from the teachers during your time? If yes, how? If no, how are they the same?
- What should a model teacher possess?
- Do you think there are role models in your department? In the whole of college?
- If yes, in what ways are they role models?
- Is there a need for role models? If yes, how do we ensure that there are role models?

d. The current batch of UPCM students using the following areas

- performance in academics
- attitude towards their studies/ requirements
- attitude towards their professors
- attitude towards patients
- motivation to become a doctor
- future plans/ aspirations (self-image; medical practice & place of practice)

▪ Aside from the increase in knowledge, do you observe any fundamental differences in the students across the year levels? (e.g, are the freshmen fundamentally different from the seniors?)

- If yes, what are these?
- To what would you attribute this change/ non-change? (probe: curriculum, internship, community involvement, social environment, role models, etc.)
- How do you feel towards this change or non-change? Why?

▪ How are the recent batches different from the ones during your time?

- In what ways are they different? In what ways are they the same?
- To what would you attribute this change/ non-change? (probe: curriculum, internship, community involvement, social environment, role models, etc.)
- How do you feel towards this change or non-change? Why?

2. What kind of doctors is the UPCM producing right now? How different or similar are these doctors to the kind the Philippines is producing right now as a whole? How do you feel towards this?

3. What does UPCM pride itself in? (advantages) What isn't it proud of? (disadvantages)

4. Do you have any other specific recommendations that would help improve the College and the doctors it is producing?
 - The best single adjective that would best describe myself when I become a full-pledged physician is:
 - In terms of my future medical practice, I would most likely be a:
 - The most likely country where I will practice my medical profession is:
 - Self-rating as to the attainment of UPCM's Vision & Mission

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About the book

Health in the Hands of the Filipino People: Framework and Action is a collection of Dr. Jaime Z. Galvez Tan's essays, reflecting over three decades of his work in the field of medicine and public health. Drawing from his experience as far back as 1970s in the doctorless island municipality of Maripipi in Biliran, the book tackles a wide range of issues that plague the Philippine health system to this very day. It touches on the predominance of Western approach to diagnosis and treatment, economic, political and cultural factors that shape service delivery, the myriad of health system reforms implemented to diminish health disparities, among many others. It is a visionary piece that looks forward to the day when development of national and local policies, programs and services are more participative and responsive to the needs of the people, a time when grassroots leadership in health is the norm rather than the exception.

About the Author

Professor Jaime Z. Galvez Tan, MD, MPH, or 'Dok Jimmy' to many of his friends, found his vocation in a small island in Palawan in 1968. The image of health inequity inspired him in his study of Medicine. Graduating in 1974 from the University of the Philippines, he started heeding the challenge of ensuring health as an unalienable and inviolable right, especially to the most marginalized and disenfranchised.

Dok Jimmy, the doctor to the masses, has been faithful to this vision in many facets of his life— his work at the Department of Health where set the foundations for universal health; his local and international advocacies in primary health care and public health; his career as a teacher, as a researcher, as a leader. Up to this day, his eyes reflect the same glint of fiery dedication that went against conventional concepts of what a physician should be. As he juggles his time between educating both lay public and professionals and his consultancies, he advances his cause and remains steadfast to the faith for a more health-equitable nation.

Through *Alay sa Ginhawa at Kalusugan*, a project that aims to set up a barangay health center that caters to the best interest of the poorest and strengthening the public health services of communities, he reaffirms his beliefs that each of us can be partners for change and actors for social justice.

History evinces to Dok Jimmy's outstanding dedication, efforts and heroism to his country and his countrymen. Indeed, in 2012, he has been hailed as one of the Eminent Filipino Physician by the Philippine Jaycees, testifying to his sacrifice for the millions of our countrymen that remain uncared, unheard and unhealed.

