Health Devolution and Central-Local Relations in the Philippines:
The Tripartite Partnership of the Department of Health, Local Government Units and Civil Society Organizations

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Paralleling the general decentralization trend in recent decades, health sector decentralization policies have been implemented on a broad scale throughout the developing world since the 1980s. Often in combination with health finance reform, decentralization has been touted as a key means of improving health sector performance and promoting social and economic development. (World Bank 1993)

Technical impetus for health sector decentralization was provided by the promotion of cost-effective investment in primary health care and outreach services, beginning with the Alma Ata Conference on Primary Health Care in 1978 and reinforced by the World Bank’s 1993 World Development Report. (Bossert, Beauvais and Bowser 2000: 2)

However, some of the preliminary empirical data indicate that results of health sector decentralization have been mixed, at best. Furthermore, in a few cases, limitations of this decentralization have resulted in a backlash against the reforms and an initiative for recentralization. But according to Bossert, et al., this rejection is often premature or misplaced; the issue at hand is “how to better adapt decentralization policies to achieve national policy objectives”. In such a context, it is increasingly
important “to adequately understand the dynamics of health sector reform processes in diverse contexts” in order to draw lessons and formulate effective strategies for future research and policy-making. (Bossert, Beauvais and Bowser 2000: 1)

In the case of the Philippines since 1992, health services began to be devolved under the 1991 Local Government Code (LGC) or Republic Act (RA) No. 7160. Some case studies (See for instance Atienza 2003 & 2004) have shown that civil society participation is crucial in improving devolved health service delivery in the Philippines. Moreover, civil society organizations (CSOs) have been instrumental in enhancing community participation in health service delivery. As will be shown in the case studies in health service delivery in the following pages, civil society in the area of health is in the process of performing some of the democratizing roles mentioned by Diamond (1999: 218-260). These are by effecting transition from clientelism to citizenship at the local level; recruiting and training new political leaders; disseminating information and therefore empowering people in the collective pursuit and defense of their interests and values; and strengthening the social foundations of democracy even when its activities focus on community development.

However, this paper goes a step further by arguing that partnership involving the major national health agency concerned (in this case the Department of Health or DOH), local government units (LGUs), and CSOs leads to improved health service delivery and democratization. This tripartite partnership is crucial in devolution. This paper is premised on the assumption that successful devolution of health services depends on better coordination between central and local levels of government as well as greater state-civil society partnerships.

This paper is organized into three parts. First, there will be a brief discussion of civil society participation in health service delivery before devolution. Second,
there will be an analysis of the enabling factors for greater civil society participation and increased state-civil society partnership at the national and local levels in the area of health service delivery since 1992. These factors include the legal enabling environment, DOH policies and programs that are participatory in nature, and constraints being faced by the formal public health system at both national and local levels. Finally, there will be two examples of the working tripartite partnership in health service delivery at the local level. These are cases at the municipal level, the level of local government without much experience with direct health service delivery prior to devolution but now tasked to deliver primary health care. The two cases are also considered “model” local governments, having been cited by various sectors as exemplary LGUs in health service delivery. Field work for these cases was done in the period of 2000 to 2003. The author used focus group discussions, key informant interviews and review of primary written data as research methods.

Civil Society Participation in Health Service Delivery
Before Devolution

Community-based health programs (CBHPs) and participation of non-government sectors in health service delivery started way before devolution in 1991. This supports available literature worldwide showing that civil society has a long history of involvement in public health (Loewenson 2003). CBHPs in the Philippines began to be implemented in the early sixties by independent practitioners affiliated with hospitals and clinics. These even included initiatives of the Philippine Rural Reconstruction Movement (PRRM). But these efforts were limited in scope and did not reach national scale until CBHP was introduced in many parts of country by the Rural Missionaries of the Philippines in 1975. Afterwards, other church-based and
secular groups eventually adopted these early CBHP pilot programs. (Bautista 1999: 3)

It was in the late seventies that the innovative strategy of CBHP, renamed primary health care (PHC), attained national significance. The Philippine government adopted PHC as its overall health management strategy in consonance with its commitment when it joined the Alma Ata Conference in 1978. In the conference, PHC was declared as essential health care made universally accessible to individuals and families in the community through means acceptable to them, through their full participation and at a cost that both the community and the country can afford (Bautista 1999: 1). PHC forms an integral part of the country’s health system as well as overall social and economic development of the community.

According to Bautista (1999: 2), the adoption of the PHC as a national policy revolutionized the health delivery system and the government bureaucracy in general. This is because of the application of two major strategies. First, the participatory approach implies that community residents are active participants in the different phases of the management cycle. This was adopted under an administrative system that was still centralist and top-down in perspective. Second, inter-sectoral collaboration as an approach requires various institutions in health and other socioeconomic spheres to work together as a team for an integrated and consolidated perspective of development. At that time, this was an innovative strategy since the dominant mode was unitary, that is, services were delivered by field office staff of a sectoral department that catered to a particular area of specialization. With the PHC, the DOH which was then called the Ministry of Health (MOH) was the first national agency to propagate a participatory strategy nation-wide.
However, prior to devolution, the real essence of PHC had not been fully achieved, especially during the years of the strategy under Marcos. Prior to the Aquino administration, there was still very limited community involvement in the planning stage and project assessment. Nevertheless, there had been some progress. PHC was able to shift from a doctor-centered type to a community-oriented type with the harnessing of the involvement of voluntary workers, who came to be known as barangay health workers (BHWs). Community residents also began to provide free labor and share resources for activities aimed at local development.

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

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

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2 The community or village level, known as barangay, is the smallest political unit in the Philippines.
organizations (POs) and the community as a whole, and building up the capacities of
LGUs, the DOH, NGOs and POs for their various roles in partnership (Bautista 1999: 31).

**Enabling Factors in Increased Civil Society Participation and State-Civil Society Partnership in Health Service Delivery**

**Legal Enabling Environment**

As mentioned above, after the 1986 EDSA people power, the resulting 1987 Constitution formally recognizes the role of civil society. However, the biggest boost to formal civil society participation was the enactment of the 1991 LGC or RA 7160. The Code has features that set it apart from previous decentralization attempts in the country. It devolves the responsibility to deliver various basic services to local governments (health included); transfers certain regulatory and licensing powers to local governments; increases the financial resources available to LGUs by broadening their taxing powers, providing them with a specific share from the national wealth exploited in their area, and increasing their automatic share from national taxes by increasing the Internal Revenue Allotment (IRA) shares from 11% to 40%; encourages LGUs to be entrepreneurial; and most significantly, lays down the policy framework for the direct involvement of civil society, most especially NGOs and POs in the process of local governance.

Civil society participation in local governance is done through several ways. One is through sectoral representation in local legislative councils, particularly representing women, workers, and other sectors as determined by the specific sanggunian (local legislative council). Another way is the allocation of specific seats for NGO and PO representations in local special bodies (LSBs) like the local development council (LDC), local health board (LHB), and the local school board.
Still another way is participation in political exercises like plebiscite, referendum, and recall. Finally, civil society can be involved in the planning and implementation of development programs. These openings for civil society are meant to promote not only popular participation but also local accountability.

The public health system is the most affected sector within the national government. This can be seen by contrasting the pre- and post-devolution public health systems.

The pre-devolution public health system had both central and local dimensions. At the central level, the DOH presided over a national service delivery structure operating from basic health and hospital facilities located at the barangay level and up to the municipal, provincial, regional and national levels. (See Figure 1) The notable exception was found in the chartered cities possessing direct authority over their health delivery systems, subject only to DOH supervision and regulation. In 1982, the Provincial Health Officer was allocated expanded authority over budgetary actions, personnel actions and operational decision-making. Although this earlier effort fell short of the fully devolved structure now in place, such effort nonetheless builds a substantial local capacity to manage health facilities and services at the provincial level.

The LGC has triggered unprecedented far-reaching structural and functional transformation (See Figure 2). In terms of facilities, personnel and resources transferred from the national level to LGUs, the DOH has the biggest transfer in all these areas. In terms of the scope of facilities, health services and personnel involved (See Brillantes 1998: 44; Perez, et al.1995), the number of local governments participating and the high degree of authority being decentralized, the Word Bank (1994: i) says that the Philippine experience stands out as one of the most ambitious
health decentralization initiatives ever undertaken in Asia. In Bossert, Beauvais and Bowser’s study (2000) comparing the Philippines with Ghana, Uganda and Zambia, the Philippine health reform gives the widest range of choice or decision space over many functions that were devolved to LGUs.

A large part of the devolved health services are borne by provinces and municipalities, the latter having no prior experience with health decentralization. Provincial governments are responsible for medical, hospital and support services. These include the provincial health offices; provincial hospitals and hospitals of component cities; and district, Medicare, and municipal hospitals. Municipal governments, for their part, are mainly responsible for the administration of primary health care and other national programs’ field services through the municipal health offices and corresponding rural health units (RHUs) and barangay health stations (BHSs). Municipal governments are also responsible for ensuring constituents’ access to secondary and tertiary care through vertical referrals. City governments are responsible for city health offices, city hospitals in highly urbanized cities (except the National Capitol Region), and corresponding RHUs and BHSs. In a sense, the involvement of cities in the devolution process is minimal due to the low level of DOH assets and staff devolved to them. As mentioned earlier, large cities, or the highly urbanized ones, in the Philippines are chartered and have administered and financed their own health systems for many years. Barangay governments are responsible for the maintenance of the facilities of the RHUs and the BHSs. As for the regional health offices, renamed Centers for Health Development, they continue to be an integral part of the DOH structure, now with a focus on monitoring health policy
implementation and LGU performance. Meanwhile, the DOH retained a number of key functions best carried out at the central level.  

DOH Programs and Policies in Relation to Civil Society

In a study made by Clark (1998: 92-93), the DOH, together with the Department of Natural Resources (DENR) and the Department of Agrarian Reform (DAR), was able to forge close links with NGOs since the Aquino and Ramos administrations.

The first year of implementation of the Code coincided with a “new management” in DOH (Perez 1998:2). Then newly elected President Fidel V. Ramos signaled his support for devolution of health services in 1992 by appointing Juan Flavier, a rural physician who was very active in local countryside development, as Secretary of Health. He would be one of the prominent NGO leaders to be appointed to the Ramos cabinet, in keeping with the President’s strategy to establish formal links with the NGO community. Flavier was a former president of the PRRM (the oldest NGO as well as the largest rural development NGO in the Philippines) and its sister organization, the International Institute for Rural Reconstruction (IIRR).

The DOH Secretary would then appoint as chief-of-staff Jaime Galvez Tan, a well-known advocate of CBHPs and then working with the United Children’s Fund (UNICEF). Flavier also created a “kitchen cabinet” to help him devise policies on how to implement the LGC (Perez 1998: 2). This informal cabinet would be composed of the Secretary’s colleagues in the PRMM who had been involved in local development and were severe critics of the centralization besetting Filipino politics.

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3 The DOH-retained functions are training and technical assistance for medical professionals; all foreign-funded programs; all national experimental and pilot programs; health service and disease control programs associated with international agreements; management of technical and financial assistance to local governments; regulation, licensing and accreditation of health professionals; regulation and monitoring of health facilities and food service establishments; regulation of drugs; and administration of regional hospitals, medical centers, and specialized health facilities.
and bureaucracy. With the DOH, the “kitchen cabinet” led by Horacio Morales of PRMM formulated the DOH Reorganization Plan to make it more ready for devolution.

In the area of collaboration with NGOs, like other national departments, the DOH took advantage of the upsurge in the number of NGOs since 1986 by collaborating with the latter in order to implement government programs. In general, the DOH had to rely on NGOs in the provision of health services. The reason for this is explained in the following sub-section. Under the PCHD, the DOH under Flavier and in alliance with LGUs, has sub-contracted the provisions of services such as training to NGOs.

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

In addition, the Tulong Sulong sa Kalusugan (literally “helping move health forward”) is a new strategy intended to support the Health Sector Reform Agenda. The DOH has selected 64 convergence sites from 2001 to 2004. The idea is to set up inter-local health zones (ILHZ) where the reforms in the HSRA converge. The ILHZ is actually inspired by the previous district health system (DHS) concept, a generic term developed by the World Health Organization (WHO) to describe an integrated health management and delivery system based on defined administrative and
geographic areas known as health districts (DOH 2002: v). The overall concept is the creation of an inter-local health system by clustering municipalities. Each ILHZ has a defined population with a defined geographical area comprising a central or core referral hospital and a number of primary level facilities such as the RHUs and the BHSs. The concept is inclusive of all stakeholders and sectors involved in the delivery of health services or health promotion.

Through the ILHZ, NGOs and POs can become members of the health boards that are the policy-making bodies of the local health systems. In addition, community health workers (volunteers like the BHWs, barangay nutrition scholars [BNSs], community volunteer health workers [CVHWs], traditional healers, etc.) and community members are also key players in the ILHZ. NGO and church-based groups, together with various government health institutions, can train these volunteer health workers and community people.

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

**Constraints of the Formal National and Local Health System**

The DOH has to rely on civil society, NGOs especially, in the provision of health services. This is because of serious resource constraints of the public health
system. The first constraint is in the area of financial resources. The DOH gets its budget from the financial allocation from the national budget, possibly supplemented by congressional allocations and foreign funding. Based on Department of Budget and Management data, the total budgetary allocation for health increased through the years (from P6.5 million in 1989 to P14.7 billion in 2000). However, the allocation as percentage of the total national budget declined slowly, during the devolution years. The average for 1989 to 1991 was 3.4% but the average for 1992 to 2001 was 2.6% (Bautista et al. 2002: 14). Public health expenditure as percentage of GDP in 2002 was only 1.1%, low when compared with other Asian countries (UNDP 2005).

Financial support for the LGUs originates from the IRA but LGUs can raise revenues through local taxes, fees and other schemes enumerated in the 1991 LGC. But there are complaints that the IRA allocation formula leaves provinces and municipalities at the losing end. Both levels of LGUs combined received 57% of the revenue transfers but shoulder 92.5% of the cost of devolved functions, including health, while cities and barangays bear only 7.5% if the cost of devolution but receive 43% of IRA. Thus, provinces and municipalities complain that their budget is inadequate to fulfill health and other responsibilities devolved to them.

Several important facts must be considered in the discussion of adequacy of budget for health. First, there are LGUs, particularly municipalities, that are simply too poor to assume all its health responsibilities even if they wanted to. Second, even if an LGU has sufficient budget, local chief executives and officials may not prioritize health. Finally, there may be a large allocation for health but people in the locality may be too many for the budget to be adequate. These different considerations can be made clearer with a couple of examples. Irosin, a fourth income class municipality in Sorsogon noted for its successful participatory health programs only spent P90.31
(less than US$2) per constituent based on its 2000 health budget and population. Meanwhile, Baliuag, a first class heavily-populated municipality in Bulacan with Sentrong Sigla-certified health facilities, spent P83.93 per constituent based on its 2000 budget and population. (Atienza 2003: 201-240)

The second set of constraints refers to human resources. In 2002, the most number of personnel devolved to LGUs was the midwife who served 1:4,808 persons, close to the benchmark standard of 1:5,000. This shows the DOH’s emphasis on promotive and preventive health where midwives are crucial. The ratio of nurses to population in 2002 was 1:16,844, better than the benchmark of 1:20,000. (DOH 2002a) But public doctors and dentists are few. They are burdened with an average of 1:26,317 and 1:42,493, respectively, in 2002. The benchmark ratio is 1:20,000. (DOH 2002a)

In particular, the DOH has problems recruiting young doctors to serve in the rural areas. This is because of very low government pay and the fact that doctors, mostly from urban areas and educated at great cost, usually opt for lucrative private practice in urban areas or even abroad. In 1993, Secretary Flavier offered incentives for young doctors to go to the barrios (communities) with a salary roughly equivalent to the salary of an urban-based professional (P24,000 at that time). But the DOH experienced further problems despite the new policy with the decentralization of its budget. Thus, most doctors in rural areas received only P6,800 a month in 1993 under the Salary Standardization Law (Clark 1998: 92). With devolution, doctors had additional apprehensions—possible interventions of local chief executives in appointments and promotions, lower chances of being promoted to regional and national offices, and non-payment of benefits under the Magna Carta for Health
Workers as a result of the non-prioritization of health or lack of adequate budget for health personnel.

With the remaining doctors serving in rural areas overburdened, NGOs have supplemented doctors’ salaries by as much as 300% of the government salary (Clark 1998: 93) or provided equipment and medicine.

Thus, in this section, we have seen enabling factors for increased civil society participation and state-civil society partnership in health service delivery in the Philippines. This is not a unique situation. As Loewenson (2003: 8) compared various literature on civil society and health worldwide, he observed that “[W]hen legal, institutional and procedural mechanisms support the synergy between state and civil society,” there are positive health outcomes reported.

State-Civil Society Relations in Local Health Service Delivery since Devolution

NGOs represent one sector that has contributed much in implementing health programs in the different LGUs. Unfortunately, there is no systematic compilation of NGOs involved in all health programs undertaken around the Philippines. According to the National Economic and Development Authority (NEDA), there were 145 NGOs engaged in reproductive health programs in 1999, with many of them concentrated in Metro Manila. In 1997, there were about 485 NGOs engaged in primary health care in different parts of the country with majority of them in Luzon. (Bautista, et al. 2002: 50)

Given the absence of a comprehensive compilation of all NGOs involved in health programs in the country, perhaps we can see the importance of civil society groups in health service delivery by having a look at some of the LGUs that were awarded for best practices in the area of health. Most of them had active civil society
involvement in their award-winning health programs. Due to limited space, the paper will focus on the cases of Baliuag in Bulacan and Irosin in Sorsogon, two municipalities that were the subject of extensive research in the author’s previous work from 2000 to 2003 (Atienza 2003 & 2004).

Creating *Sentrong Sigla* Facilities in Baliuag, Bulacan

The municipality of Baliuag is a first class municipality in a first class province. RHUs (4) and BHSs (23) are present in all barangays of the municipality. The DOH has certified all four RHUs and 15 of the BHSs as *Sentrong Sigla* facilities. The municipality had the most number of *Sentrong Sigla* facilities in Region III in 2001. In addition, the municipality is part of one DOH-initiated ILHZ, known as the Baliuag Unified Local Health System (BULHS). This ILHZ composed of five municipalities and the District Hospital located in Baliuag has been hailed as one of the model cooperative schemes among municipalities in the Philippines.

Devolution has significantly altered the pattern of health service in Baliuag. It has brought about certain openings for greater innovations at the local government level, more partnerships between government and nongovernmental sectors, closer interaction between health personnel and the people, and greater grassroots participation in governance. But even a first class municipality with significant resources that is not very much dependent on the IRA (52.41% as percentage of total income in 2000) also experiences some of the concerns and problems of many LGUs meeting the challenges of devolution. (Atienza 2003: 231-263 & 2004: 42-47) The public resources for health, not the biggest priority but nevertheless still getting a big amount in the annual budget, are not enough. While there are four municipal doctors, a dentist, nurses, numerous midwives, and sanitary inspectors, i.e. all the required health workers being present in Baliuag, more personnel are still necessary to meet
the needs of the big and still growing urban population. Medicines and other supplies are not sufficient to give to constituents seeking medical assistance. There are also problems in personnel benefits as well as strained relations of some midwives with their barangay captains.

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

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

But definitely, the BU has become the constant partner of the LGU and the DOH in health service delivery. Through the College of Nursing, the BU has a number of important outreach health programs, including a nutrition program in one barangay, organizing of senior citizens, training programs for volunteer health workers, a home-based nursing program, community organizing programs, health education for mothers, and health counseling.
For the home-based nursing program, instead of patients being required to stay in the hospital for five days, for example, he or she can stay only for three days and the treatment can be continued at home through regular visits of the BU’s nursing staff and students. In the nutrition program, an important component is the training of mothers because the nutrition of children begins with proper food at home. In the community-organizing project in Barangay Paitan, the College trains local leaders to be in charge of health. As a result, there is now a Paitan Health and Development Organization, a PO composed of volunteer health workers and some barangay officials. Because the assigned midwife in the barangay comes only twice a week in the area, the trained volunteers are the ones staffing the health center daily and are also assigned to specific zones in the area. As an academic institution, the College of Nursing also has a research component in order to trace the causes of health problems as well as to document the features and results of its various community programs.

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

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

As far as the local chief executive is concerned, Baliuag may not have mayors who made health their priority programs but its succession of mayors since devolution have not been major obstacles to health programs either. In fact, the creation of an additional RHU and more BHSs, more financial resources poured to health compared to pre-devolution years, and the hiring of additional health workers would not have been possible without the consent of the political leadership. The mayor may prioritize infrastructure development over health service but he is supportive of the health programs in the municipality. In particular, nutrition was given emphasis as the mayor designated his wife to be in charge of this area.
More significantly, Baliuag by extension benefited from two succeeding provincial leaderships (Pagdanganan and de la Cruz) who are known innovators and strong supporters of devolution. They have encouraged and set examples for component LGUs to innovate despite limited resources in order to fulfill the responsibilities devolved by the LGC and to improve overall public service. In particular, present Governor de la Cruz has been very supportive of health services by encouraging health volunteers in service delivery, protecting the positions of devolved personnel against barangay captains abusing their authority, and strengthening the BULHS.

In terms of networks of cooperation, the network of cooperation among different actors in the municipality and with the outside existing even before devolution has proved valuable in the improvement of health service delivery. On one level, within the municipality, there is a network involving the RHUs, BHSs, other volunteer health workers, the BU, and other socio-civic organizations that can coordinate in terms of health planning and programs. At another level, even before devolution, Baliuag has working relations with other municipalities in the health district, thereby making the formation of the BULHS possible after devolution. Today, the BULHS is a substantial boost to health service delivery in terms of resources, equipment and personnel. Still at another level of coordination, Baliuag and other members of the BULHS continue close coordination with the provincial, regional and national DOH offices as well as NGO networks and foreign funders, thereby strengthening both local and national health programs. The DOH Regional Office takes a very active role in coordinating downward and upward linkages.

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

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

But despite the above-cited problems, accompanying the improvements in health service delivery in the town is the increasing health awareness and consciousness among the people in the communities. These can probably be attributed to the increased vibrancy of health facilities and personnel as a result of devolution, the personnel’s more hand-on role in the communities, increasing understanding and closeness of health personnel and constituents, the increasing presence of volunteer health workers, the tireless work of the BU, and finally, the existence of formal and informal links among LGUs, civil society, and the DOH at various levels.

**The Community-Based Health Program in Irosin**

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

Devolution has brought about certain openings for greater innovations, more partnerships between government and non-government sectors and greater grassroots participation. However, devolution also brought several concerns or problems that can also be found in most other LGUs since devolution (Atienza 2003: 178-230 & 2004: 35-42). While health has become a priority since 1992 and Irosin’s income classification rose to fourth class, the town is still heavily dependent on the IRA (84.46% as percentage of total income in 2000) and available public funds are not always enough to meet all health needs. While there were nine midwives in 2000, there were only one doctor and two nurses available. Medicines and supplies are not sufficient for the growing population. Like in Baliuag, health personnel also complain about low pay, limited professional growth prospects and occasional politicking. In this case, the Mayor who was elected in 2001 was the one who removed the municipal doctor on allegations of disloyalty.

But like Baliuag, CSOs play an important role in improving the health situation in Irosin. Actually, the experience of Irosin surpasses that of Baliuag in terms of the importance of civil society in health service delivery. The intervention actually began even before devolution. Lingap para sa Kalusugan ng Sambayanan (LIKAS) or Caring for the Health of the People was an NGO founded by Eddie Dorotan (a native of Irosin) with other medical students, paramedics, and young
professionals mostly from the University of the Philippines’ College of Medicine in 1979. LIKAS aims to find and develop appropriate health alternatives to what it considered as “fundamentally ineffective, western-oriented and elitist health care delivery system” (Penunia, Casanova-Dorotan and Dorotan 1999: 5).

LIKAS was initially integrated with the Center for Community Services (CCS) of the Ateneo de Manila University. In 1994, LIKAS became an autonomous organization with a separate legal personality. Today, it continues to be an organization of students and professionals in the health-related field. It also evolved to include three social development offices: LIKAS in Bicol, Health Alternatives for Total Human Development (HEALTHDEV) Institute in Quezon City, and Nutrition and Livelihood Resource Center (Nutrilinc) in Pampanga.

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

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

From 1988 to 1992, PHP had spread out over the whole municipality. The LIKAS-trained and -organized CHWs merged with the DOH-trained BHWs to form the Community Volunteer Health Workers of Irosin (CVHW). By 1992, in partnership with the DOH and the Dutch-based NGO CEBEMO, LIKAS established the Irosin Partnership for Community Health Development. This partnership is aimed at strengthening functional relationships among the local government through the RHU, LIKAS, the CVHW, and the communities for more efficient and equitable delivery of basic health services. This project institutionalized tripartism in the area of health, enabling the creation of barangay health committees and the LHB. LIKAS also helped the CVHW form a PO, the Community Health Workers’ Association, which got accredited in 1995. Aside from capability-building and health issues’ advocacy, the PO is concerned with livelihood promotion and health financing for the
members. This last concern is due to the realization of LIKAS and the volunteers that in a devolved set-up, the LGU couldn’t do these concerns for the volunteers. Thus, the PO gives incentives to participate more actively in health service delivery.

To make the health service delivery system in Irosin more community-based, traditional medicine has also been comprehensively incorporated. LIKAS’ traditional medicine program is concentrated not only in Irosin but in the whole second district of Sorsogon. The setting up of the Center for Traditional Medicine and the organization and training of traditional healers are meant to address the immediate needs of the people in the rural communities who have more access to traditional healers than to the RHU or the secondary hospitals. At the same time, this is meant to complement the Western medicine-focus of the regular volunteers.

In the political front, LIKAS started vigorous voters’ education and urged farmer leaders to run for posts in the barangay councils in 1989. Many of them won seats not only in Irosin but in neighboring municipalities. This focus continues today as several LIKAS-trained CHWs and traditional healers have become councilors in their barangays. But LIKAS and API’s biggest victory was in 1992, coinciding with the first year of implementation of the LGC, when Dorotan won as mayor and almost all the other candidates they supported for elected town officials won.

Under Dorotan, many LIKAS community organizers also assumed key municipal positions. The LGU held a multisectoral planning that produced the Irosin Integrated Area Development Program (IIADP). This was mean to address poverty, powerlessness and inaccessibility of basic services using livelihood promotion, people empowerment, and improvement of basic services. These have to be carried out by different stakeholders (the government, the private sector, and the grassroots sector).
This tripartite approach was adopted in almost all of the municipality’s undertakings as its new developmental model.

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

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

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

Irosin since 1992 has seen plenty of developments. While poverty and
livelihood continue to be challenges until today, awards as well as continued national
and international assistance continue. Irosin is a Galing Pook hall of famer after
winning three Galing Pook\textsuperscript{4} awards. It received the Konrad Adenauer Foundation
Medal of Excellence for Local Government as well as other awards from national
agencies in the areas of health, environment, social welfare, agrarian reform, and
peace.

There also appears to be significant citizens’ participation in health service
delivery down to the community level. There is quality health information and
trainings. Many of the barangay health councils are still operational and there are
communities that have become more self-reliant in improving health and other
conditions in the locality. Despite limited formal health personnel, the spirit of
voluntarism is also very high. As of 2002, there were 190 BHWs and 67 hilots
(traditional birth attendants). In 1998, there were already 131 accredited traditional
healers. (Atienza 2003: 210, 212) These volunteers are considered informal leaders in
their communities, taking the lead and mobilizing people for many activities that go
beyond health. Many of them are also very much aware of health and other related
issues such as the IRA, the role of politicians, lobbying, etc. They are very articulate
and their association has been an effective lobby group for health needs at the
municipal level.

\textsuperscript{4} The Galing Pook awards is an annual national awards program of the Asian Institute of Management
in Cooperation with the Local Government Academy of the Department of the Interior and Local
Governments (DILG). The award is aimed at promoting excellence and innovations among local
governments.
It can be said that Irosin already has the beginnings of social capital and a web of networks of cooperation among different sectors in the municipality and outside. These networks have been forged and strengthened through the years. While the relationship is not always smooth and sometimes even competitive, since the 1980s a working relationship among various stakeholders (LIKAS, other NGOs and POs, the LGU primarily through the RHU, the BHWs, the barangays, and the DOH) exists. This is evident by the continuing joint projects and partnerships in forging community health plans despite changes in political leaderships and conditions. Thus, social capital or “the features of social organization, such as trust, norms, and networks, that can improve the efficiency of society by facilitating coordinated actions” (Putnam 1993: 167) exists. The change in administration since 2001 is testing the strength of this social capital. But NGOs, POs, and volunteers have not waned in their work and participation even with the leadership change. This set-up also maintains upward governmental links with the District Health Board, Sorsogon’s Provincial Health Office and the DOH. Irosin, through LIKAS and the DOH, continues to receive foreign funding for its projects.

Conclusions

While DOH-civil society partnership continues to evolve, it is noteworthy that the health sector is conducive for civil society participation and inter-collaboration. This may be due to the existence of numerous NGOs focused on social service delivery with health projects already established as early as the 1960s. In addition, even during the period of martial law in the late 1970s, the DOH was the first government agency to propagate a participatory strategy nation-wide through its Primary Health Care program. Thus, DOH-civil society collaboration preceded devolution.
Since devolution, civil society participation becomes even more important because of the legal enabling environment, the financial and personnel constraints of the public health system, and the need for more participatory health service delivery. While the two cases discussed above may be considered exceptional and still in the process of meeting many challenges, there are lessons that can be drawn that emphasize civil society’s importance in establishing multisectoral partnerships and developing greater community participation in health service delivery. Furthermore, the two cases support the argument mentioned at the beginning of this paper that the partnership of an active national government agency (the DOH), local governments placing importance on health service delivery, and CSOs is very crucial in both devolution and democratization. While the three “partners” do not always agree with one another and there are multiple arrangements for collaboration or partnership existing (legal, institutional or informal), this tripartite partnership has been very crucial. It would be worthwhile to test further this hypothesis by using various case studies across countries and across devolved services. Further studies on the dynamics of state-civil society relations, the diversity of CSOs and comparisons of various modes of participation and partnership should also provide interesting insights.

References


FIGURE 1 Pre-Devolution Organizational Structure of the Philippine Health System

FIGURE 2 Post-Devolution Organizational Structure of the Philippine Health System