Hello … Goodbye! Developing Inclusive Community Health and Development Programs

Maria Tuklaslakas, a new faculty member of the department of speech pathology, was assigned to be a supervisor of the community based rehabilitation (CBR) program. She had just graduated in May and had been teaching third-year students for a semester. She was set to work with a retiring faculty member in the community setting who, due to health reasons, resigned a week ago from the program. Tuklaslakas was now tasked with presenting a disability inclusive development program to the mayor and the municipal council on Tuesday.

Dean Alejandro Makulit personally chose her since he considered Tuklaslakas to be the type of individual who thought "out-of-the-box," but was grounded in the social realities of rural life. The CBR program needed to be reframed since its interns were confused about what they could contribute to the program. It was also noted that not a lot of graduates went into this program.

The administration staff had kept records and were told to bring to Tuklaslakas five boxes worth of three decades of CBR program documents. She knew she had to review all this information so that she could make a plan and present it to the college by Monday and then present it to the community officials the next day.

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Tuklaslakas had a lot of questions running through her mind, foremost of which were: how should community programs start? How should they target specific populations? What activities can we use to promote disability-inclusive development? How can we improve participation of persons with disabilities?

Background

The CBR program of the university had been existence since 1989. It involved the fielding of three disciplines — occupational therapy, physical therapy, and speech pathology. The program had partnered with at least three communities and had recently transferred to a new community.[1]

Comprehensive Community Health Program (CCHP): Medicine Alighting From the Ivory Tower

In the 1960s, the University of the Philippines decided to create a comprehensive community health program (CCHP). Various colleges sent students representing the fields of medicine, agriculture, dentistry, public health, social work, nursing, pharmacy, anthropology, and occupational and physical therapy at Bai, Laguna. It was initially meant to influence medical students to experience real life conflicts in health care so that they would consider practicing within their own communities. Before the ratification of the Primary Health Care Approach, an approach agreed to by United Nations member states in 1978 and promoted by the World Health Organization (WHO),[2] the university used the interdisciplinary and multisector approach of managing health care at the community level. With the support of the Rockefeller Foundation and Department of Health (DOH), the program expanded from educating medical students to educating other students in the university to training residents of the community to sustain the work of the professionals. This later became a model for the country. They also undertook research and explored models to improve the delivery of health services. As work continued to expand, other institutions pledged their support. The United Nations Children's Fund (UNICEF) was able to promote training of traditional birth attendants or *hilots* to address the needs of pregnant mothers in the community.[3]

Originally, the placement of the students was to be at Bay, Laguna but by 1969, DOH allowed the university to engage with the municipalities of Calauan, Los Baños, and Victoria. The objectives of CCHP was to develop a community health system that was decentralized and equipped to handle community health affairs.

In the town that was chosen by the university, health problems abounded. **Table 1** shows the most prevalent diseases, which were primarily infections or preventive in nature.

The Republic of the Philippines was a developing economy in the late 1960s. The Filipino population was increasing fast, and the government invested in infrastructure to promote rapid urbanization and industrialization within Metro Manila. Filipino medical practitioners were very much open to migrating to greener pastures such as the U.S. or other first world countries as they were highly skilled in teaching and adjusting to various cultures. The diaspora of health service providers was so great that it left a big gap in valuable human health practitioners who could have served as trainers for public health (i.e. maternal and child health) and direct service providers across Asia and all over the world. Graduates of the university who were successful in other countries encouraged others to also go out of the country, perpetuating the brain drain of the nation. More medical practitioners took resident and fellowship medical sub specialties making them highly skilled in managing specific conditions, but decreasing the need for consult through general medical practitioners, who were more accessible to the majority of the population.[4]

Despite the growth, multiple pockets of underserved areas existed. Health care was costly and unaffordable to the masses. Another complicating factor was the declaration of martial law for health care practice. The Philippine government in 1969 passed Republic Act No. 6111, an act that established the Philippine Medical Care Plan. The act was said to be revolutionary since it would extend the government mandate to provide medical care to all residents within the country's economic means and capability. Having a medical care plan would also help Filipinos by gathering funds to pay for adequate medical care. The act also established the Medical Care Commission, which was the precursor to the Philippine Health Insurance Corporation.[5]

Table 1

The Most Prevalent Diseases in the Philippines and Rates per 100,000 People

Influenza	936.1
Bronchitis	805.5
Gastro-enteritis and colitis	499.2
PTB (pulmonary tuberculosis)	340.7
Pneumonia	217.0
Malaria	79.1
Whooping cough	62.0
Measles	54.5
Dysentery (all forms)	52.2
Beri-beri	46.1

Source: Campos, Paulo C. Comprehensive Community Health. 1975.

During the same year, CCHP was awarded by the National Science Development Board a study grant to conduct a research on developing a new health care system that was tailored to the socio-economic conditions of the Philippines.[6]

However, it was only after President Ferdinand E. Marcos declared Martial law in 1972 that intense efforts to reform the health department were seen. Renewed interest was seen as the government took it upon itself to provide comprehensive medical services for the Filipino people.[7]

In its first 24 years of existence, the program had produced research and training programs. Leading health professionals devoted to promoting the welfare and development of communities would always look back on their CCHP experience as the foundation for current practice.

CCHP also was a pilot program of the Ministry of Health, the provincial government of Laguna, and the university that integrated curative, rehabilitative, and promotive care. The system of employing trained barangay (smallest administrative division in the Philippines) health workers was first seen in this program. The program also increased access to health services since there were no clinics, hospitals, and limited private practitioners to tend to the health needs of the people when the program started. Communities became aware of the need to implement health education, health data collection and monitoring, community nutrition improvement, school health program development, environmental sanitation, communicable disease control, and preventive measures such as immunization.[8]

Because of the program, resources flowed into the town of Bay, and the university shouldered the cost of personal services, maintenance, and program operating services. Donations were gathered from

civil society and professional organizations to supplement resources. Non-governmental organizations such as the Christian Children's Fund, which had beneficiaries in the area were also able to contribute funds. Institutions, such as the Canadian International Development Agency, the Philippine Center for Health Research and Development, and the Japanese Society for the Promotion of Science also made significant contributions to initiate research projects related to CCHP.[9]

In 1988, at the 1, 012th meeting of the University of the Philippines Board of Regents, the board decided to terminate CCHP since they deemed that it had fulfilled its mandate. There were protests, however, the decision was final. All involved colleges were then asked to learn from the CCHP experience and duplicate such efforts of integrating community concerns into the individual academic units.[10]

CBR Montalban: Promoting Character Building and Transdisciplinary Practice

After the CCHP program ended, two of the former CCHP faculty, Luningning Ginto, a physical therapist and Christina Solis, an occupational therapist, went back to their home college to establish a CBR program.

Ginto was part of the thesis team that looked into establishing a physical therapy service program in Bay. Prior to engaging with the municipality of Montalban, two feasibility studies were conducted. Because it was a rural area near Manila that was accessible by land transport with a high disability prevalence (11%) and had a supportive culture, this area was selected as the next site of the CBR program. She was very passionate about conducting preparatory activities as she would go to the site to collect information about the distribution of persons with disabilities, people's attitudes toward disability, interested foster families, and conduct inter-agency meetings among local leaders.

In one of the meetings, the vision was that communities would include persons with disabilities as dignified members of society who could contribute to community development and this could be done through empowerment training, service, and research (See **Appendix A**).[11]

From May 28, 1988 to November 2007, students, faculty, and caregivers used a transdisciplinary approach to provide the rehabilitation and habilitation needs of persons with disabilities. The transdisciplinary approach was viewed as the solution to having limited numbers of therapists who provided community level services. Students and therapists were exposed to persons with disabilities to encourage these stakeholders to have a changed mindset toward persons with disabilities. As the students and faculty grew professionally when they shared their knowledge and expertise, they became valuable resources not only for health information and skills development, but also for contributing time, money, and energy since they were assigned to areas that were geographically inaccessible for most people. The program was recognized by various bodies such as the Civil Service Commission when it were given the Pag-Asa ng Bayan Award (Hope of the Country Award) and the DOH with its HAMIS award.

After three years of implementation, the program was expanded from campaigning disability prevention, rehabilitation, and training the first CBR workers to include a school health program, special education class, and livelihood projects to further enhance the skills of children and working age persons with disabilities. These programs were strengthened in 1994-1996.

When nearby towns heard of the benefits of the program, they invited the university to visit and explore possibilities. Before the program ended, questions arose on mechanisms that would ensure its sustainability. The Montalban CBR council and the Kapisanan ng mga Maykapansanan sa Montalban (KMKM), a persons with disabilities organization was formed to monitor the programs. A municipal therapist was also employed to supervise the CBR workers manning each barangay CBR clinic.[12]

However, a review of the impact of the program's clinical, training, and research and extension services revealed that not all agreed that a CBR program was beneficial. Some expressed concern that it could threaten professionals when replicated since the CBR workers might become pseudo-therapists, who could practice and could do harm if they decided to implement therapy procedures without any supervision. Only a handful of CBR workers were still connected with the local government. They had been raising issues of support in terms of providing transport during their visits and honorarium for their time and effort.

As the CBR program ended in Montalban, Ginto, as chair of the University Committee on Community Health and Development, tried her best to integrate the CBR program since there was a resurgence of interest in having another integrated community health and development program.[13]

San Juan, Batangas: Reintegration of CBR in the Mainstream

The Community Health and Development Program (CHDP) was inaugurated in 2007 as the unit of the university that was mandated to forge partnerships with rural communities. The community-based health programs that were developed would serve both the community needs and the university's training goals. All academic units of the university, namely the Colleges of Medicine, Nursing, Public Health, Dentistry, Pharmacy, Allied Medical Professions (occupational therapy, physical therapy, and speech pathology), and Arts and Sciences were invited to consider San Juan, Batangas as their site of community immersion.[14]

The CHDP site was recommended since it was already a community medicine placement site. The first year was devoted to information gathering by the College of Social Work and Community Development and College of Medicine. Based on the information gathered, CHDP created community-based health programs that served both community needs and the university's training goals. The program had two main objectives:

(1) To provide faculty and students with opportunities to learn the principles and practice of community health and development; and

(2) To assist communities to attain increasing capacities for their health systems, strengthening and community development using the primary health care (PHC) approach.[15]

As the program was evolving, the participating colleges tried to develop a conceptual framework that stressed that genuine improvement in community health and development should be one of the most important outcomes of every university-community partnership. It was the university's vision to become the leader in public service, guided by the PHC approach, which recognized health as a basic human right. The equal partnership of the community and university would lead to mutual benefits including learnings on how to promote healthier, more developed, and empowered communities.[16]

Most of the implemented activities were related to health, environment, and livelihood programs. Most of the students spent their time providing direct health services as they assisted barangay and municipal health workers at health stations or during home visits. Capacity-building activities were completed to update the knowledge and skills of nurses, midwives, barangay health workers, and others.[17]

Other programs that affected health and development were also conducted. Solid waste management campaigns, identification of natural resources, and educational drives on the sustainable

use of natural resources were initiated.[18] Because most persons with disabilities in the area had financial limitations, community-based livelihood programs were also encouraged to fill in the gap.

Most of the faculty involved in the program were new or did not have CCHP experience. Personality clashes were sometimes a deterrent to implementing activities. Coupled with that was the political nature of service provision at the municipal level. When asked to fund the first municipal CBR worker's training, the head of the league of barangay councils, replied, "I understand that what you are doing is important, but it is not our priority."

For two years, the CBR team struggled in gathering information since only three to four supervisors with about 20 interns were asked to conduct persons-with-disability identification in 42 barangays with multiple types of terrain. Frequently, students complained of the cost of their community education because they spent in one week of what they could stretch to two weeks in an urban health facility setting.

Another challenge faced was that people were not keen on having therapy since there were spiritual healers in the area. The people, especially those in the far flung barangays, would mention at times that they were just being "practiced" on.

When the program ended in 2013, not one of the trained CBR workers had practiced what they were taught. Though some ran for barangay positions and won, others preferred to just work in the health center taking blood pressure or weight because they said that no government support was provided for their transport and the people that they visited did not believe in their advice.

Breaking Barriers at Bustos

Tuklaslakas decided to pause for a few minutes and reflect on what she just learned. She tried to recall her experience last year while she was a student. She was assigned to Bustos, Bulacan under Professor Anne Sy. Sy told her group that Bustos was the next CBR placement site after San Juan, because it was where she had her master's in community development immersion and she knew the local government was progressive in developing programs for excluded sectors of society.

In their first week, Tuklaslakas and her batch mates took part in workshops given by the faculty to equip them prior to fieldwork. The workshops would orient them on the community and the process of data-gathering that they would employ. They thought it was easy, but when they got to the field site, they were surprised.

They tried to start information gathering, but the list of persons with disabilities and senior citizens given by the barangay secretary and the municipal federations was not updated. When asked when it was last updated, their source admitted that it was done more than five years ago.

Once, they happened to meet the president of the barangay association of persons with disabilities who welcomed them to her home. As they interviewed her, the field workers learned that members seldom attended meetings because they could not afford to pay association dues or even for the transport going to the venue. Health services were a major concern because a lot of their members had multiple conditions needing further diagnostic tests and management. As they were ending their discussion, the president asked them if they could contribute to their programs by buying cake or mobile phone raffle tickets. However, she was unable to state where the gathered funds would be allocated. She just said "para sa aming PWD program" (for us persons with disabilities with a mischievous smile).

Tuklaslakas was snapped back into the present when her phone rang. It was Dean Makulit, asking her if she received the boxes and what her suggested plans for the new disability inclusive CBR program were for the coming year.

Appendix A

CBR Montalban Program and Training Objectives

PROGRAM OBJECTIVES	TRAINING OBJECTIVES
1. To train UPM-CAMP students in CBR. 2. To plan, implement, and evaluate programs and services that address the needs of persons with disabilities in the municipality through the: • Home level care of persons with disabilities. • Training of CBR workers. • School health program. • Livelihood project. • Special education class. • Organization of persons with disabilities. 3. To maximize community participation in all aspects of the CBR program. 4. To ensure an effective transfer of rehabilitation technology to the persons with disabilities, families, and the community. 5. To empower persons with disabilities together with their families and the community. 6. To establish structures that will ensure the sustainability of the program. 7. To train CBR workers and upgrade their skills accordingly.	1. Appreciate the role of the allied health professionals in a community setting. 2. Integrate themselves in the life of their Kaibigang May Kapansanan (KMK) together with the family, and the community. 3. Identify how the condition of persons with disabilities is affected by the following factors: • Biological/medical. • Environmental. • Socio-economic. • Cultural. • Political factors. 4. To provide rehabilitation services to persons with disabilities through: • Identification of the priority problems of persons with disabilities or KMK with the KMK and family. • Preparation, implementation, and evaluation of the Family Care Plan (FCP) with the KMK and family. • Training a family member of every KMK, possibly the KMK and a CBR worker, as primary caregivers. • Preparation of instructional material and/or assistive device with the KMK, family member and a CBR worker. • Conducting a family and/or neighborhood (kapitbahayan) conference. 5. To demonstrate caring and professional attitudes towards KMK, family, CBR workers, and co-interns. 6. Enhance professional skills including time management and documentation of all activities. 7. To appreciate and help develop the strategies used in CBR. 8. Refer problems related with KMK, the family, and activities related to other CBR programs and services through proper channels when necessary. 9. Actively participate in the different programs and services in response to the needs of the KMKs. 10. Work effectively and efficiently with the other members of the team utilizing the transdisciplinary approach.

Source: Magallona & Datangel. The Community Based-Rehabilitation Programme of the University of the Philippines Manila, College of Allied Medical Professions, 2011.

Endnotes

1 Magallona, Ma. Lucia Mirasol and Jeffrey P. Datangel. "The Community Based Rehabilitation Programme of the University of the Philippines Manila, College of Allied Medical Professions." *Disability and Community Inclusive Development Journal*. Vol. 22 No. 3(2011): 39-61. Accessed 23 April 2015. <http://dcidj.org/article/view/110/55>.
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