of the people. This has been more evident in Tagum than in Davao. Tagum has incorporated the thrust for social justice more so than Davao has.

It is important that the local Church realize that the GKK cannot remain only on the spiritual level but must take into account the social reality the people are living in. The different programs attempting to promote integral evangelization can and should learn from the experiences and insights of other programs which have experienced success and failure in their efforts to grow. Thus, the pastoral plans of the local Churches can be strengthened by the involvement of trained personnel from other institutions and groups that could make possible a significant program of integral evangelization.

The following two studies by Sony Chin and Rey Tusoy will examine two types of community outreach programs that the Ateneo de Davao University is involved in.

THE CHANGING ROLE OF THE *KATIWALA* PROGRAM IN THE DAVAO REGION[7]

SONY J. CHIN

The *Katiwala* Program is essentially a community based health program. *Katiwala,* in Pilipino, means a person to whom one entrusts care over something. There are four specific activities of the *Katiwala* Program:

1. The training of community selected and community based health workers on curative, preventive, and promotive aspects of health care;
2. The *Katiwala's* sharing and disseminating health nutrition information through mothers or family classes;
3. The evolution of a mechanism which will lead to the continuous identification of the community's changing needs and the mobilization of local resources for meeting these needs;

[7]This article is a shortened version of a case study prepared for the workshop on "Community Participation in Family Planning" organized by the Institute of Population Studies of the Exeter University, Exeter, England. October 18-20, 1983. This study was prepared with data from project documents available at the Institute of Primary Health Care of the Davao Medical School Foundation.

4. The determination of local social services which are not utilized by the community because of its non-awareness of the availability of these services.[8]

As of 1983, there were more than seven hundred *Katiwala* in the Southern Mindanao Region. Two sister organizations have helped in conceptualizing, supporting, and implementing the program: the Development of People's Foundation (DPF), a non-stock, non-profit medical cooperative established in 1972, and the Institute of Primary Health Care (IPHC) of the Davao Medical School Foundation (DMSF), which the Ateneo de Davao University is in consortium with. This paper describes the experience of increasing community participation in the *Katiwala* Program.

Organizations Involved in the Katiwala Program

The various stages in the *Katiwala* program were initiated and implemented by the Christian Family Movement (CFM), 1967-69; the Development of People's Foundation (DPF), 1969- present, and the Institute of Primary Health Care (IPHC) of the Davao Medical School Foundation (DMSF), 1978 - present.

The Christian Family Movement is an organization of Christian couples who conduct programs designed to improve family life among its married couples. This is a national organization with chapters located in the major cities of the Philippines. Although the CFM continues to exist, it ceased to directly participate in the *Katiwala* program after 1969. Its ongoing involvement is now through its members who formed the DPF and the DMSF-IPHC.

The Development of People's Foundation was organized in 1969 as a result of the consultative meetings between the community and the CFM, regarding the need to review the operations of the charity clinic operated by the CFM in the Bajada district of the city. Fom 1969 to the present, the DPF has managed the Bajada Medical Cooperative, the Bajada Workshop which employs 80 to 200 women from the urban poor, and the initial stages of the *Katiwala* training. The DPF was responsible for training the initial group which formed the IPHC. At present, the DPF continues to serve as a referral point for cases requiring the attention of doctors or nurses within the City of Davao. The DPF is one of the five organizations which manages the Davao Medical School Foundation.

The Institute of Primary Health Care (IPHC) is one of the three operating units of the Davao Medical School Foundation (DMSF). The IPHC had been the training center for the *Katiwala* working in three regions in Mindanao. The IPHC has also assisted these

[8]Ma. Concepcion P. Afiler, "The Katiwala in the Philippines: Program Transformation for Increasing Social Access to Basic Services. A Case Study prepared for the Workshop on "Increasing Social Access to Basic Services," Co-sponsored by the Asian Pacific Development Center and UNICEF, Kuala Lumpur, Malaysia, December 2-13, p. 4.

communities in the selection of community volunteers, providing training for these volunteers, and monitoring them in the conduct of linkage – building activities. Today, IPHC is helping communities build their capabilities to plan, implement, monitor, and evaluate their own programs designed to meet community needs. As a result of these interventions, community credit groups were formed. These groups are now serving as channels for production credit: training on micro-business and production technology, and other technical, managerial and group building inputs. After reviewing its operations at the end of 1982, the Institute has re-written its organizational objectives to focus not only on health care but also on community building and development towards a better quality of life. The restatement of the IPHC's objectives was necessitated by their perception of the evolving roles of the different program components.

Evolution of Roles

The Community

At first, the community characteristically had no defined role in the program except to serve as its passive, although willing, beneficiary. Community participation was something that was indicated from its attendance or absence from the clinics. The community's responses were gauged by its assistance to the *Katiwala* in matters of clerical and housekeeping chores, membership in the medical cooperative, and the payment of membership dues. Then, sometime in the seventies, the community began to assume a more active role by choosing their *Katiwala* and by participating in the training of potential community leaders. While continuing to provide earlier forms of assistance to the *Katiwala*, the community became responsible for compensating the volunteers' services. Presently, the community has taken over the initiative in the program. It defines its priorities, objectives, and aspirations. Furthermore, it identifies the work plan by which its goals are to be realized, monitors *Katiwala* services and other ongoing projects in the community, and decides on the agencies it wishes to link up.

The *Katiwala*

The *Katiwala* serve as the link between the DPF and the community. In this capacity, the *Katiwala* perform the tasks assigned to them by the clinic staff such as bringing patients to clinics or hospitals, providing assistance to medical personnel in works such as deworming, campaigning for the Family Planning Program, and other health education campaigns. At the end of the 1970's, the *Katiwala* began to prepare their own action plans based on the health needs of the community. In addition, they organized projects

for their respective communities without abandoning their earlier role of providing assistance as health workers to the Ministry of Health (MOH) personnel. Today, *Katiwala* share with the community leaders the responsibility for their community projects.

Program Proponents

As program proponents, the CFM, DPF, and the DMSF-IPHC have provided free services, free medicine, and studied community problems in consultation with the community members. Towards the end of the 1960's, the CFM initiated the formation of the DPF. In the 1970's, the DPF continued to guide the community in the choice of *Katiwala* as well as in the identification of community health problems while at the same time initiating program activities and securing rewards for outstanding volunteers.

More recently, linkages have been built between the *Katiwala* and service agencies mainly through the efforts of the DPF and IPHC. The *Katiwala* training has been improved by skills other than health skills. Income generating know-how such as soap-making and basket-weaving have been important projects developed in the community. The proponents have broadened the *Katiwala's* role by initiating family dialogues and household surveys. Information dissemination has been made possible through the printing of the *Lanog*, the *Source Book*, and various primers. The proponents continue to provide loans and other forms of material assistance for community planned projects when requested.

Problems and Issues

As the program and participants evolved, problems and issues associated with growth took new forms. When the program started, the problems were those that were usually found in many growing communities. Most of these were financial problems for which solutions were sought by means of loans. Many people went to the Refemptorist Fathers for medical assistance. Many mothers wanted to have supplementary income but lacked the skills to engage in any livelihood undertaking. Those who had been trained in the Bajada Workshop did not posses organizational or any other management skills. Characteristically, the community was falling into a pattern of dependence on those able to provide help.

Meetings were held between the Redemptorist Fathers and the CFM which resulted in the clarification and identification of the more pressing problems of the community. Observation visits to households provided information which resulted in certain steps being taken to remedy the situation. The CFM suggested that given a short vocational training, mothers could learn handicraft skills. Meetings between the CFM and the community were soon arranged and held through the help of a religious social worker. A survey of possible recruits proved to be disappointing -- the findings revealed that (a) some were too ill (presumably unable to undergo training), (b) some had no money for transportation, and (c) others were unwilling to leave their households for work. In spite of the discouraging results of the survey, the Bajada Workshop was started with some volunteer trainees. The charity clinic was closed and instead a medical cooperative was organized where members had specific obligations and responsibilities such as payment of membership dues, payment for all medicines taken from the cooperative, clerical and housekeeping tasks, and collection of clinic dues. Using a dialogic method, the first volunteers were trained as community health workers and became the first *Katiwala*.

Later, it became apparent that some of the proponents, in particular the IPHC, did not have the resources for an indefinite support of the *Katiwala*. At the same time, it was realized that there was the danger of the community becoming dependent on an external agency which could hinder community self-reliance and development. The program continuity was threatened in areas where *Katiwala* was phased out. At around this time, primary health care was adapted as a matter of national policy. The National Economic and Development Authority (NEDA) and the United Nations International Children Emergency Fund (UNICEF) took the initiatives of forging links with the Ministry of Health. With the infusion of new resources from these agencies, more time and effort were poured into the program. This time the emphasis was given to education. The training of *Katiwala* came to include organizational and communication skills. Likewise, the training of community based support group was made an integral part of the program. The project timetable was increased to two years.

The continuing inventory and review of the program proved very fruitful and regarding in terms of self-reassessment. The program noted that problems have a "repetitive" nature and seemed to recur in a cyclical pattern. In particular, problems such as poor sanitary conditions and poor child-spacing practices appeared to be the cause of many health problems. Most, if not all, available health facilities are found in the cities while the majority of the population live in the rural areas. To compound the situation, many health professionals are not trained to work with health volunteers. However, not all health needs require the services of the medical professionals. The question the program needed to confront was, "Should the *Katiwala* program be expanded to cover the rural areas?"

Fortunately, the DPF together with other institutions in Davao were willing to share the burden of alleviating the problems of the rural poor. They formed a medical school with a rural orientation. The organizers also felt that a close teamwork between the *Katiwala* and health professionals was necessary. The DMSF was thus the answer to the need for an institution that would provide quality medical and dental education for community-oriented practitioners. To bring about the teamwork between health professionals and the *Katiwala*, it was decided that the DMSF will take charge of their training. The IPHC was established for this purpose.

Today, the program has taken a wider view of rural health problems. It has realized

that health problems tend to recur unless there is an improvement in the socioeconomic conditions of rural families. Low income and high prices continue to be the main obstacles to improve the health conditions of the people. The IPHC does not limit its programs to training health volunteers. It has sought ways of getting the *Katiwala* integrated into the health program of the MOH. Other government agencies are willing to extend their assistance and services. UNICEF has also made funds available for self-help community projects.

Program Continuity

What happens when the IPHC leaves the community? Between 1980 and 1983, the IPHC revisited many of the communities where it had stopped its monitoring activities. Many of the *Katiwala* interviewed continued to work as the need arose. Several *Katiwala* interviewed had integrated their volunteer health activities into their daily routines so that they no longer saw these as *Katiwala* tasks. For example, a *Katiwala* in Barangay San Isidro of Sta. Maria, Davao del Sur, told an IPHC project officer that she had stopped doing health volunteer work since the IPHC project officer stopped visiting them. The project officer asked more questions and in the process found out that the *Katiwala* was using skills gained during training to enable her to care for her own sick father. Furthermore, the *Katiwala* regularly conducted weighing of children who were below 6 years old, provided advice on nutrition to the mothers of children who were malnourished, motivated mothers to have their children immunized against measles, assisted the midwife in gathering the mothers and children when it was time for the immunization to be given, and gave treatment and advice for common ailments to her neighbors. After discussing all these activities, the *Katiwala* realized that she was keeping up her health volunteer activities.

Today, the *Katiwala* program has trained other mothers for family health care. Many of these trained mothers have formed organizations which have planned and implemented their own projects. Every year, the *Katiwala* from all over Mindanao are invited to attend a three-day continuing education seminar. This Convention started in 1979 and is also an occasion for recognizing the outstanding activities of the *Katiwala*. Several categories of awards are given. The *Katiwala* are also invited to send letters and articles to the IPHC. These letters or articles are featured in the IPHC newsletter called the *Lanog*, published in Visayan and distributed to the *Katiwala* in various communities whether or not they are being monitored by IPHC. The purpose of the *Lanog* is to provide a venue for sharing *Katiwala*-initiated activities. This is a means of recognizing the work done, and it also provides a means of knowing what else could be done for the community.

In additional to the Convention, the *Katiwala* Development Program (KDP), a continuing education program, is also conducted in each area. This is done in small groups. The IPHC and the DPF continue to be available for consultancy, training, and linkage building activities on request from the *Katiwala* or her community. The IPHC has also

continuously conducted staff development programs for its own staff. This is done through in-house programs as well as participation in training workshops and meetings conducted by local and international organizations. Every year, the IPHC also conducts at least one two-day sessions for the review of its own operations and to plan future directions of the Institute. In some cases, this is done right after recollection sessions wherein the groups reflect on their own motivation for service and how they have developed during the year.

Insights Gained

From the 1967 to 1983, there were many significant insights gained by the IPHC. One important insight gained was that if the IPHC listened to the community, it could draw from them the direction how to help them grow independently. More often that not, it will find itself as facilitator rather than as director of the peoples' development.

Second, past experiences have shown that unless provisions are made, those who are most in need are the last to avail of services designed to help them. It is important to bring this problem to the attention of the community being served.

Third, the IPHC recognizes that it is important that the government organizations be involved in the program. This will enable the community to improve its own capability for working with these agencies which have the technical and material resources designed to provide the community with various types of services. For program continuity, it is important that the community have the capability to utilize existing referral systems. In the process of working together, the IPHC had grown to respect the capabilities and intentions of many people working in government organizations. It also has a better picture of the problems within the government structure which limits the capabilities of many well-intentioned government workers for providing services needed.

Fourth, the IPHC recognizes that due to the variety of needs within communities, the capabilities of field workers or project officers, have to be assessed regularly. Capability gaps have to be remedied either through training or non-training interventions. If the capability required is not available within the organization, it is necessary to tap the resources of other organizations. A team of multi-skilled workers have evolved from this process. In addition, the IPHC experiences have shown that constant reflection and team-building and sharing sessions are needed to enable each worker to assess his or her own motivations, attitudes, and skills.

Fifth, unless the program fulfills a need perceived by the community, the program will die as soon as the external agency stops its assistance, even if the community members were trained to do the task. On the other hand, even if the program responds to a need perceived by the community, it will cease to continue if the community is not confident about their own skills in the performance of the task. An external agency must help the community experience the actual planning, implementations, and evaluation of a

program or project before the agency withdraws their assistance from the community.

Sixth, the IPHC recognizes that without financial assistance from various funding organizations, it would not have grown the way it did. It would not have been possible to assist as many communities as it did. However, organizations like UNICEF have done more than just provide funds. The visits of UNICEF program officers have enabled the IPHC to know of other methods used by similar programs. The UNICEF staff also facilitated the building of linkages between IPHC, government organizations, and other service or funding organizations. UNICEF has also encouraged the IPHC to test new ways of building capabilities within the community. It was the first agency to provide IPHC with funds to support community-planned projects. It was also instrumental in getting the IPHC to focus on the importance of continuing staff development programs.

Seventh, the formation and leadership of groups within the community must be determined by the community itself. The groupings of community members according to the geographical location of their residence is not always consistent with the groups which emerge when people are given the opportunity to choose their own members. The IPHC has also used sociometric analysis in order to help the community determine the membership of groups they work with and to help them decide on the leaders who are sent to training programs and/or sent as their representatives to meeting or workshops. In cases where this is not done, there is a high risk of training isolates who cannot and will not share what he/she has learned. Finally, community development work is never finished. There are always many needs which need to be responded to, and each method used could always be improved further.

These insights indicate the changing role of the *Katiwala* Program in the Davao Region. Through the years, as the Program has grown, it has become aware that it must be flexible and continually receptive to the peoples' changing needs and aspirations.

A CRITIQUE OF THE AGRICULTURAL EXTENSION PROJECTS OFF THE ATENEO DE DAVAO UNIVERSITY

REY TUSOY

The Ateneo de Davao University Outreach Projects

The Ateneo de Davao University in relating to the local community is concerned about where it could be of service. Representative of the University's outreach efforts are the Davao del Sur Agricultural Extension Program, the Agricultural Extension and