

## THE TRAINING OF THE *KATIWALA* (VOLUNTEER HEALTH WORKER)\*

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### Introduction

In the Philippines, 70% of practicing physicians are found in urban centers where 30% of the population live. Only 30% elect to put up their practice in the rural areas, where 70% of the population reside.<sup>1</sup> This maldistribution of health professionals, the escalating costs of health services and medicines, and the emphasis on high technology and show case physical plants have led to a situation where the majority of Filipinos do not have access to medical care.

Church-oriented and church-initiated health projects responded to the need of making medical services accessible and available to the underserved and underprivileged in order for them to attain a better quality of life. Many of the ideas which were later to become principles of Primary Health Care were pioneered by these projects. The *Katiwala* Program in Davao City began as one such project.

The *Katiwala* program originated in a free medical clinic established in 1967, by a unit of the Christian Family Movement, (a lay Roman Catholic Organization) to render health services to the residents of squatter areas in the vicinity of the Redemptorist Church in Bajada district, Davao City. The clinic was supported by regular donations from commercial establishments and private citizens. It was manned by volunteer health personnel.

After two years of a dole-out approach, the clinic staff came to the realization that there was no demonstrable change in the health of the clientele served and that the free-clinic was detrimental to human dignity, making mendicants of the people served. The clinic was closed, and a series of meetings were held among the clinic staff, the families served, and a professional social worker. These meetings resulted in the reorganization of the free clinic into a medical cooperative. The members agreed to pay minimal dues and to buy the medicines prescribed at wholesale or subsidized prices. They assumed some duties

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<sup>1</sup> *Ibon: Facts and Figures* Vol. 3, 1980 Issue No. 56.

in the management of the clinic, assisting in clinic work, helping the health personnel, and maintaining discipline among the patients. They had a voice in policy-making and the day to day operations.

General meetings of member families were held every three months or when the need arose. Eventually, area leaders were chosen by the families to represent them at the meetings and serve as liaison between the members and the clinic staff. The need for income augmentation which surfaced at one of these meetings was answered by the establishment of the sewing workshop. Volunteers initially trained member housewives in sewing and later, the Development of People's Foundation (DPF) employed them in quilting and bag-making.

In 1972, after lengthy consultations between the community members, the staff, and the donors of the DPF, a non-stock, non-profit foundation was formed. Its main purpose was to manage the medical cooperative and the sewing workshop. At that time, the medical cooperative consisted of 500 families from 31 depressed communities near the clinic. However, the volunteer health staff was static and could not cope with the number of patients who came for consultation on clinic days, held two afternoons a week. At a general meeting, the members and the staff decided to hold the first volunteer health worker training in order to decongest the clinic and to render better service. Because the health workers would be living in the same communities, the health workers would bring the services closer to the people who most needed them — people who did not have enough money for jeepney fare, or who had no one to leave at home to care for their children and their possessions. The volunteer health workers who called themselves *Kaunaunahang Katiwala ng Kalusugan* (Primary Trustee of Health) later shortened to *Katiwala*, were to render simple curative services to people in their homes. The first group of *Katiwala* were trained by DPF in 1972.

In 1978, the DPF and the Institute of Primary Health Care (IPHC) agreed that the former would continue to serve the urban areas, while the IPHC would train *Katiwala* for the urban areas not served by DPF and for the rural underserved areas in Region XI. Requests from urban *Katiwala* for assistance in mobilizing the community and meeting other perceived needs like income generation and credit resulted in a modification of area coverage so that from 1981 IPHC and DPF were working together in the same urban areas. DPF *Katiwala* based in the *barangay* facilitated the entry of IPHC workers and served as a linkage to the residents.

### Selection and Recruitment

The first group of *Katiwala* were the leaders elected by the members of the cooperative. For the second training course, the *Katiwala* was asked to choose someone she could work with harmoniously from among her members. Each area would then be served by two *Katiwala* ensuring that services would be available in the community at all times. This process of selection did not work out. When personal problems intervened, one or the other *Katiwala* stopped

rendering service. The *Katiwala* selected in this manner was often not credible and did not have the trust of the members.

Requests for expansion of the *Katiwala* Program to other depressed communities resulted in more training courses. By 1975, DPF had employed a full-time project coordinator who also served as training officer, and a community organizer who conducted home visits, family interviews, small group meetings, and assemblies for orientation into the project. He was assisted by volunteers from the community in conducting a baseline survey to identify their health problems and to make a list of possible *Katiwala* activities. Selection of the *Katiwala* trainee was done at a general assembly. Willingness to be trained and to serve, functional literacy, and the confidence of the members were the only criteria for selection.

Similarly, the IPHC employed assemblies after a three-month community preparation as the strategy for the selection of the trainee. The staff soon perceived that strong, articulate leaders and a docile population could result in the manipulation of the assembly to favor a relative or a friend. It was also realized that community assemblies did not give the residents enough time to understand the program nor the criteria for selection of trainees. The Project Officers (PO's) who were the *Katiwala* trainers felt that three months were not enough for a thorough program orientation — they had to make allowances for the family's schedule and availability. Community preparation for orientation and selection of the trainee was extended to six months.

Before the training, the prospective *Katiwala* with the help of some residents, conducted a survey of her community to gather socio-economic, health, nutrition and environmental sanitation information. The trainee was involved in the survey to bring the health problems of her community to her awareness and to test her willingness to do volunteer work.

### Criteria for Selection

The trainee should be:

- 1) a resident of the community to be served. This requirement ensures that the Volunteer Health Worker (VHW) will be available when the need arises. Ideally, two *Katiwala* are trained in each *barangay*.
- 2) willing to be trained and to serve. Family responsibilities may pressure the candidate to refuse training and service even though selected by the residents, so a prior agreement is made. Usually a married woman is selected. The consent of the spouse is sought.
- 3) credible and acceptable to the community. The candidate selected may have served the community in other capacities and in the process, earned the respect and confidence of the villagers. This is expressed by being chosen as candidate for training. When the community in general did not participate in the selection and they allowed some pressure groups to put up their candidate, the

choice did not necessarily reflect the confidence of the village and sometimes, this resulted in an ineffective *Katiwala*.

4) functionally literate. Many of the residents of the urban poor communities have not completed even elementary education, and if a minimum educational requirement is enforced, numerous capable, and well motivated candidates could be excluded. When the villagers select a barely literate trainee, often an herbalist or a traditional birth attendant with long years of service, the staff makes provisions for a tutorial training and for assistance in future record keeping. Usually, a child or neighbor is enlisted to help in keeping records. We have found a number of trainees with less education who are more highly motivated and more dedicated to their duties than some with a higher educational attainment.

5) physically fit.

6) one who has the time to serve the community — does not have full-time employment which would render her incapable of performing her tasks.

Preferably, the trainee should be above 20 years of age and married; not too young to be without stability and experience and not too old to have difficulty understanding and absorbing the lessons being taught. Young unmarried VHW's have proven to be more likely to change residence, to be on the lookout for job opportunities, or to go back to school and therefore cease to function as VHW.

Although no preference as to sex is expressed, the candidates have been mostly women. This may be due to the fact that men are usually away from home; the women are more concerned with health problems or have an inclination to extend a helping hand to others.

The first *Katiwala* Training lasted 6 months. Classes were held every Saturday afternoon. Subsequent courses were one-day-a-week sessions for three months. This was later changed to daily sessions for one month with practicum on clinic days.

The first 3 courses of *Katiwala* training used the one-afternoon-a-week for six months format. Availability of staff and the distance between the communities made it necessary to test the possibility of a live-in training with a break for practicum and which, at the same time enabled the participants to go home for a visit. Presently, the regular course schedule is two weeks live, two weeks practicum in their villages, and another two weeks live. Apprehensions on the part of the staff regarding reluctance of trainees to attend a live-in training were unfounded. If intensive follow-up is expected, IPHC may conduct three weeks live-in training to adjust to resources and/or constraints of the agency requesting the training.

Urban *Katiwala* are trained at the Davao Medical School Foundation (DMSF) building, while rural *Katiwala* are trained as close as possible to their villages — at a multipurpose center, a public school, or a *barangay* hall. This way, the trainees are in an environment that is similar to the conditions in which they will be working. IPHC staff go to different provinces where VHW training is requested. The venue for such training is chosen by the requesting agency.

## Training Methodology

The training was unique in that it did not have a fixed course content. The topics discussed were decided by the trainees themselves based on their observations and experiences in the community. Training was dialogic, an approach that was greatly influenced by Paulo Freire's *Pedagogy of the Oppressed*. As the training progressed, two representatives from the class met once a week with two of the training staff to evaluate the previous session and to plan for the next.

In 1975 DPF was assisted by Asia Foundation. The training officer received a study grant at the University of Hawaii. On his return, he oriented the training to the tasks the *Katiwala* performed in the community and the clinic so that, without losing its dialogic aspects, the training assumed its competency-based, task-oriented features.

The community survey done by the *Katiwala* trainee is collated and analyzed and an assessment of training needs is done by the IPHC staff. The training content is focused on community needs vis-a-vis the tasks the *Katiwala* is expected to perform. Tasks are analyzed, while knowledge, attitudes, and skills needed are categorized before proceeding to the finalization of the course content. Training is conducted in the vernacular. Visual aids and teaching materials are prepared to suit local conditions. Trainees are put at ease in the course by structured learning episodes like, "getting to know you" sessions and "ice breakers". The pace is adjusted to the group. Participatory teaching methods are used. The staff makes a conscious effort to get to know each trainee, draws out the shy ones; responds to their needs, listens to their problems. The PO's look after the trainees from their target areas in every possible way to make the learning process easy. Skills are taught, gradually proceeding to more complex ones like blood pressure-taking and filling up of growth charts. Questions are encouraged, so that feedback is quickly obtained.

Entry skills are determined by simple pre-training evaluation tasks. Methodology used depends on the topic — when suitable demonstration and return demonstration are employed, as in the preparation of ORS, herbal medicines, or giving of sponge bath. Small group discussion, brain storming, and role-playing are used whenever applicable. Flow charts have been tested for continuing education. The *Katiwala* found this method easy to follow, interesting and clear. Lectures are the least used method of teaching; they are kept short and followed by discussion. The trainees' own knowledge is explored in a non-threatening evocative manner. No one is allowed to dominate a session. Repeated testing is done in order to find out if the trainees are keeping up. Testing is done using the same participatory methodology. A daily recapitulation of the previous day's topics is made — this served as a review and provides an occasion for clarification or correction. Reflection sessions are held as part of the course. Action

areas for the trainees are clearly specified. These action areas are embodied in the *Katiwala* Action Plan (KAP) which serves as her manual of instruction on her return to the village.

## Training Staff

The training staff was made up of volunteer physicians and nurses. A process of selection from among the volunteer training staff weeded out those who clung to the didactic method and used too many technical terms. A training officer who had previous teaching experience and was trained in competency-based paramedic training later joined the staff.

The DPH and IPHC shared the services of the training staff in 1978-1979. As the project officers acquired facilitating skills, they became more confident in their ability to conduct training using participatory teaching methods; more and more of the training was conducted by the Project Officer and the technical staff of the IPHC. Reliance on visiting resource diminished, and uniformity in training methodology was assured. Practice teaching and critiquing were resorted to in preparation for the actual training. Health professionals are presently a small minority.

## Training Materials

A loose leaf Visayan primer incorporating many topics from *Where there is no Doctor* by David Werner was prepared by the staff for the *Katiwala*. An IPHC *Katiwala* primer was first printed in 1979. It is now on its fourth edition. It also draws heavily from Werner's book. Handouts prepared by the staff are given. Visual aids which the staff developed, are used. They help in comprehension and in arousing interest. Initially, the graduation kit given to the *Katiwala* contained first aid medicines and supplies and a weighing scale. Today, the graduation kit includes visual aids, teaching materials, and/or minimal amount of first aid supplies. This change was brought about by the emphasis on herbal medicine since 1980.

## Course Content

The course consisted of:

- 1) classroom instruction on the essentials of PHC,
- 2) practicum at the DDF clinic, and
- 3) recapitulation and evaluation.<sup>2</sup>

<sup>2</sup> Teresita N. Angeles and Nonita S. Relatado, "Katiwala in Davao del Sur." A research study conducted by the Social Research Office of the Ateneo de Davao University in December 1980.

The course is a mixture of theory and practice. Every opportunity for practice is given, under close supervision, until particular skills are learned satisfactorily. The opportunity to practice in a clinic setting is given when they return to their villages and assist the midwife at the health center. Some of the topics the courses cover are:

- community organization,
- voluntarism,
- analysis of community health situation,
- human relations and communications,
- prevention and treatment of common injuries,
- prevention and treatment of communicable diseases,
- nutritional deficiencies and promotion of better nutrition,
- maternal and child health including family planning,
- environmental sanitation, personal hygiene, parasitism,
- herbal medicine,
- teaching skills, preparation of visual aids, and
- for rural areas, vegetable gardening is included.

Practical skills are polished in the community and in the health station under the supervision of a health personnel. Although the core curriculum remains the same, whenever indicated changes are made, topics are added or deleted based on specific needs. Stress is on the process by which the trainee is encouraged to participate and contribute her own insights and experience. The same teaching techniques are employed by the *Katiwala* when conducting family health classes. After every topic, post-evaluation is done to assess the trainee's comprehension and skills.

### Continuing Education

Monthly meetings are held among the *Katiwala* so they could share their experiences, problems encountered, and their solutions. New inputs based on their needs are given by the staff. The first group of *Katiwala* emphasized curative care. Gradually, preventive and promotion activities were included in their tasks. As the *Katiwala* became more skillful, continuing education meetings were held every three months.

When the training design is made, the less urgent topics and skills are scheduled for the monthly continuing education sessions, which are whole day meetings among the *Katiwala* facilitated by a IPHC staff. The *Katiwala* report on their performance, the problems they encountered in carrying out their tasks, and whether or not they solved the problem. Eventually, the scheduling, planning, and the conduct of the continuing education (Katiwala Development Plan - KDP) is done by the *Katiwala* with the IPHC staff playing a minor supportive role.

### The *Katiwala* Action Plan

This is an innovation introduced at IPHC before the end of the basic training. Barangay officials and representatives of service agencies working in the barangays join the *Katiwala*. They explain the services offered by the office they represent. Together with the *Katiwala*, they draw up a plan of activities, based on the community survey. This *Katiwala* Action Plan (KAP) enables the villagers to assume more responsibilities in the health activities of the *Katiwala* and prepares them for the eventual phase-out of IPHC staff. Upon her return, the *Katiwala* presents the plan to the community, and together, they agree on how best to implement it. When the *Katiwala's* plan calls for activities already being done by other agencies, the *Katiwala* cooperates with them as in the nutrition surveillance done by the Nutrition Workers, or the Nutrition education classes conducted by the extension workers of the Ministry of Agriculture. She also assists the government health personnel in campaigns for immunization by informing the mothers in her *barangay* about the schedule, by gathering them on the specific date, and helping keep order during the actual immunization days.

### The *Katiwala* At Work

The *Katiwala* is responsible for 30-50 families in her *barangay*. Some *Katiwala* can attend to more than 50 families. Others, because of family responsibilities and the need to provide for her family, can not attend to more than 30 families. Experience has shown that the *Katiwala* devotes 1-2 hours, 2-3 times a week to her volunteer work.

Credibility and acceptance of the *Katiwala* is enhanced by the simple curative skills she has acquired. Her campaigns for environmental sanitation and immunization have earned the cooperation of the community because the *Katiwala* explains the relationship between parasitism and filthy surroundings, between the incidence of diseases like measles and whooping cough and the failure to have the 0-6 years old children immunized. Through the years the *Katiwala*, although primarily a health worker, is gradually drawn into activities like income-generating activities.

The sick either go to her house or call her to visit them. When necessary, she accompanies the sick to the health center or hospital. Sometimes she is requested to remain with the sick person throughout the latter's stay in the hospital. Her presence is reassuring, and she can explain the needs of the patient to the health personnel.

In the village, one of her main activities is the Family Health Class. She gathers one member per family, usually the mother, (it could be an older child or occasionally the father) so that she may echo the health lessons she learned during the training. The project officer by her presence, boosts the morale of the *Katiwala* especially at the beginning. Sometimes, two *Katiwala* may join

forces to conduct these classes. Graduation is a festive occasion, to which local officials, members of the family and community, and IPHC-DPF staff are invited. When other agencies conduct health classes, she may be called on as organizer or resource person. Occasionally, she is requested to conduct family health classes in other communities.

The *Katiwala* is often requested to look after the needs of the mothers and children. She advises the pregnant or lactating mother regarding low cost nutritious foods. She refers the pregnant woman to the health center for pre-natal care including tetanus toxoid injection. She motivates the mother to breastfeed her baby. She may assist the traditional birth attendant during the delivery, and uses the knowledge she acquired regarding personal hygiene and proper care of the umbilical cord. She visits the mother and baby after delivery. She teaches the mother when to start supplementary feeding, what foods to give, and how much to feed the baby. She accompanies the mother and the baby to the center for check-up, immunization, and family planning. She occasionally requests the midwife to come to her village to give immunization in her area.

### Growth Monitoring and Nutrition Surveillance

The *Katiwala* cooperates with other workers in attending to the nutritional problems of her villagers. The government nutrition survey conducted in 1978 revealed extensive malnutrition among the 0-6 years population. In 1983, agencies engaged in feeding programs, conducted weighing activities in some depressed areas in Davao City.<sup>3</sup>

The *Katiwala* supplements this weighing activity by involving the mothers in growth monitoring through the use of home-base-growth charts. She explains the significance of the growth curves and what events should be recorded. She encourages the mother and compliments her when the curve shows an upward trend. She gives nutritional advice when the curve levels off. She refers the child with a downward curve to the health center for food, assistance, and treatment. The use of the home-based growth chart is a very recent innovation. Even though the *Katiwala* has long been familiar with its use, the chart is clinic- or center-based.

Insistence of each agency involved in nutrition surveillance on the use of

<sup>3</sup> Out of a total 2,220 pre-schoolers targeted in Agdao, Davao City, 2,190 were weighed — 70 or 3.6% were severely underweight, 391 or 17.85% were moderately underweight and 820 or 37.4% were mildly underweight. In 1984, out of a total of 2,120 pre-schoolers targeted 2,113 were weight and 54 or 2.5% were severely underweight, 364 or 17.2% were moderately underweight and 925 or 43.7% were mildly underweight. The pre-schoolers targeted by these agencies were those previously identified as suffering from varying degrees of malnutrition — given feeding assistance and followed up for a period of eighteen months to monitor the result of the intervention. Since no other weighing program is being carried out in Agdao, no other figures are available.

their own charts or tables has led to some confusion in the field. Growth monitoring is supplemented by cooking demonstrations of nutritious supplemental foods using locally available inexpensive materials. The *Katiwala* helps the extension workers who have been very active in conducting sessions on food processing and cooking. Weighing sessions are utilized by the *Katiwala* to explain to each mother the importance of breastfeeding, immunization, child spacing, and proper weaning foods. The campaign against malnutrition in urban areas is handicapped by the fact that most of the food has to be bought at higher prices than in rural areas.

Because of overcrowding, the makeshift nature of the houses, and the constant threat of demolition or relocation of the urban squatter areas, sanitation remains a serious problem. The *Katiwala* through the Family Health Classes motivates her neighbors to dispose of their garbage properly, to keep the ditches clean and construct sanitary toilets. The Ministry of Health is presently donating toilet bowls to those families who are willing to give a counterpart in the form of labor and materials for installing the bowls and building outhouses. In Lanang, the *Katiwala* was able to obtain a donation of more than 150 toilet bowls from the Ministry of Health for her community. A few *Katiwala* have succeeded in getting all the families under their care to install sanitary toilets. This is possible when the community give their wholehearted support and even help each other in putting up the toilets.

Water has long been a problem especially its availability and potability. Many houses have galvanized iron rain collectors attached to roofs for collecting rain water. The urban poor buy from delivery trucks which sell water by container or from homes that have rain collectors. Water for washing or bathing comes from shallow wells. The Davao City Water District (DCWD) is now serving many of the depressed urban areas, but financial constraints prevent a more widespread distribution of safe water. One *Katiwala* obtained the installation of a deep well in her barangay because her area is far from the main road, and connecting to the main pipes of the Davao City Water District is too costly for the villagers. In other barangays, the *Katiwala* invited the manager of the water works to a dialogue with villagers resulting in the extension of the water system to their villages. Some villagers have had water installed and sell this water to their neighbors. One of them, a member of a community credit group organized with the help of IPHC, is now able to gross about P3000.00/month.

A few *Katiwala* were specially trained as sputum micropists in a TB case finding project. An acupuncture course was conducted for the *Katiwala*. Although everyone was invited and many attended, only a few showed the perseverance and interest to complete the course. Those who became skillful now have their own clientele and are occasionally called on as trainers for other groups — nurses, church workers, and others.

The *Katiwala* has been called on to train volunteer health workers of other organizations like the Rotary Club and Zonta International. In communities where medical students are assigned for their community medicine course, the *Katiwala* assists in making them accepted and trusted by the residents. She helps

orient them to the customs, the culture and health practices as well as the prevalent health problems.

Some *Katiwala* have been employed as part-time health aides in the clinics of factories near Agdao. In communities with Health Scouts, 8-15 year old children have been trained to look after the physical, mental, and spiritual needs of their pre-school siblings (Child-to-Child Program). The *Katiwala* serves as adviser, helps their trainers (Child Trainers) during the classes, helps the Health Scouts to mobilize the community, and assists them in their health activities.

Some *Katiwala* are exceptionally dedicated and hard working. Not all of them however, have the time nor the inclination to engage in all the activities mentioned. As they gain the confidence of the community and become more sure of their capability, they tend to gravitate to activities they are comfortable with — attending deliveries, giving herbal treatment for common diseases or giving acupuncture treatment, and the rest of the tasks become a secondary priority.

Those with leadership potential have been developed. They usually are in the thick of many community activities like credit groups, income generation, church organizations, and local government. In *Putting Lupa*, the *Katiwala* and the community residents were able to obtain a promise from the City Government to put up street lights along the path that goes through the *purok*.

In 1984, the Archdiocese of Davao assisted by UNICEF started a campaign for Growth Monitoring (using home based growth chart) Oral rehydration, Breastfeeding and Immunization (GOBI). The program was ultimately projected to reach every home in the diocese. The training team was made up of MOH, IPHC, and Diocesan Staff. *Katiwala* help in the chapel meetings for information dissemination and for actual training. A quick survey using a format recommended by WHO, UNICEF to measure impact is presently being tested by IPHC field staff.

### Support Systems

The members of the medical cooperative, the medical and volunteer staff, and DPF with its financial resources serve as a back-up to the *Katiwala*. The *Katiwala* expressed a need for community support especially for her activities in the community like campaigns for environmental sanitation, motivation for immunization, and attendance at family health classes. The community organizer visits homes and holds meetings to encourage community participation in the various *Katiwala* activities.

The DPF encouraged the *Katiwala* to accept non-monetary and monetary incentives. *Botica sa Barangay* (Village Drug Store) was established, and the *Katiwala* was given a percentage of the profit made on sales. The opportunity to go to other towns (and countries like Indonesia) was another strong incentive. DPF gave minimal monetary incentives to the *Katiwala* for water-sealed toilets

installed and for recruitment of vasectomy and tubectomy acceptors until the funds earmarked for the purpose were consumed. The DPF *Katiwala* were invited to the annual *Katiwala* Convention organized by the IPHC *Katiwala*. They continue to serve at the DPF clinic and mobilize their communities for outreach services.

While the *Katiwala* needs the cooperation of the community in her campaigns for garbage disposal and sanitary toilets, immunization, family planning, or gathering people to attend the family health classes, the villagers have to perceive themselves not as recipients of dole outs but as active participants.

At the very start, the temporary and catalyst role of IPHC was already emphasized — it made clear that the institution would only continue to stay in the area until such a time that the community is ready to assume its responsibilities in managing its health problems. Aside from home visits, small group meetings and assemblies, IPHC has tested other strategies for generating community participation and involvement.

Feedback from *Katiwala* already trained indicated that community support was sporadic and short-lived. A deeper and sustained involvement was needed. One strategy used in 1981-1982 was the Community Leaders Training. Local Officials, Church Leaders, Members of Womens' and Youth Groups and other interested residents were invited by the PO to attend a series of meetings. The schedule was suited to the participants' wishes. The topics discussed included *Katiwala* program orientation, role clarification, health situation analysis, leadership training, problem-solving, and communication skills.

The community leader's training was meant to form a core group that would assist in information dissemination, selection of the *Katiwala* and help her in the performance of her activities in the barangay. These core groups were able to help in the selection of the trainee and were active in assisting the *Katiwala* right after her graduation. They helped present the *Katiwala* Action Plan to the community.

The strategy used presently for stimulating community involvement is the Team-Building Workshop. Meetings are held at provincial, municipal, and barangay levels. Representatives from all government agencies, barangay officials and identified barangay leaders including the *Katiwala* attend the district and municipal workshop for program orientation, presentation of services of each agency, and presentation of problems by the barangay residents. An action plan utilizing the resources of the agencies represented is drawn up. Scheduling of activities culminates the workshop.

*Barangay* meetings follow the municipal meetings. These are attended by barangay officials, all formal and non-formal leaders and representatives of agencies who have made a commitment at the municipal level. Vision setting, problem identification, planning and evaluation of barangay projects are worked on by the group. Follow-up meetings are scheduled. The *Katiwala* is one of the leaders who attends the municipal and barangay level team building sessions. As such, she brings the health problems of her barangay to the attention of the other leaders and obtains the support of the rest.

The initiative for Team-Building comes from IPHC, but follow-up, planning,

implementation, and evaluation come from the *barangay*. IPHC is only invited to succeeding meetings in order to give guidance in conducting the meetings.

In the urban slum area of Agdao, the *Katiwala* have been functioning for almost ten years. Participation of the community consisted in the initial acceptance of the program, selection of the *Katiwala*, attendance during meetings or classes called by the *Katiwala*, and other *Katiwala* activities. However, this involvement was not sustained. For these communities, the IPHC devised a strategy of mobilizing the community and developing its capability to work towards its total development. Focused Family Dialogues (FFD) were held by the PO. There were meetings between the Project Officer and individual families to discuss their aspirations in life, the obstacles in attaining these aspirations, and possible solutions to overcome them. After these dialogues, the whole community was gathered to validate the individual aspirations, obstacles, and solutions to discuss these and to create an awareness of the common problems of the community. Each family was asked who they could work with harmoniously in order to form small working groups or clusters.

The clusters furthered their plans and activities further and devised schemes for implementation and monitoring. The cluster has a narrower focus: the obstacles identified are often economic and the solutions are activities to generate capital/income or to obtain small loans to finance small businesses. The IPHC realizes that health problems cannot be dissociated from the other realities of daily life that once the community learns how to cope with its economic difficulties it can attend to its other needs. For this reason, IPHC has helped the communities in economic activities. At present, the clusters are doing well. Many have engaged in microbusiness like selling firewood, repacking commodities for sale, sewing, and setting up small stores. There are plans for the clusters to meet regularly in order to ascertain if they have been able to overcome the obstacles that they earlier perceived as hindrances in attaining their aspirations in life. The clusters are active, not only in their income generating activities but in assisting the *Katiwala* perform her tasks.

In general, there is rapport between the Ministry of Health personnel and the *Katiwala*. The midwife or nurse in the health center provides technical supervision of the *Katiwala*, just as the community support group supervises her community activities. When necessary, the *Katiwala* brings villagers to the health center for referral. The midwife or nurse in turn enlists the help of the *Katiwala* for informing the villagers regarding schedules for immunization or weighing of 0-6 years old children.

A unique support group of the *Katiwala* is the Health Scouts. These are school children from 8-15 years of age who have been trained to help their pre-school siblings in their physical, mental and spiritual development. Trainers are called Child Trainers — volunteer workers who have received special training from IPHC. The Health Scouts are taught how to use the growth chart. They are also taught personal hygiene, environmental sanitation, and character education. The *Katiwala* is their adviser and together they plan their activities. The Health Scouts help the *Katiwala* in information dissemination, mobilizing the community, and in various other ways.

The *Katiwala* is a volunteer; she does not demand payment for services rendered, but she is free to accept tokens of gratitude given in cash or in kind. It is customary for the family to give fruits, other foodstuff or money, the amount ranging from P0.50—P50.00 — what the family can afford, for services rendered. Yet many more can only say "thank you." The community realizes that the *Katiwala* is in the same financial bind as the families she serves. The residents have tried several strategies for raising funds for the *Katiwala* and her activities through benefit dances, raffles, bingo socials, etc.

All the strategies mentioned constitute a mobilization of community resources but have been on an ad-hoc basis. Making the incentive of the *Katiwala* dependent on the sale of medicines from the village drug store creates an association between curative care and compensation of the *Katiwala*, which may result in de-emphasizing her preventive and promotive activities. This is discouraged by IPHC. The IPHC is promoting the use of herbal medicine and encouraging herbal gardens.

Income generating activities financed through small community credit groups are presently being tried. Preference is given to communities served by *Katiwala*; she herself is eligible to join the group. Various non-monetary incentives have also served to motivate her to continue her volunteer work. The opportunity to attend continuing education meetings and the annual convention at which outstanding *Katiwala* are given awards of recognition, the possibility of being sent as participant to seminars on Primary Health Care in other towns or provinces, the respect and recognition she receives from her community are all the factors that help to motivate her. A newsletter in the vernacular, *Lanog*, and a weekly radio program serve as a link between the *Katiwala* and the IPHC. *Lanog* contains articles about and by the *Katiwala*.

Intersectoral cooperation was limited to the use of the MOH building for the first *Katiwala* training. MOH personnel donated their services as resource persons during the training of *Katiwala* and provided vaccines for immunization activities in the communities served.

Support for the *Katiwala* Program was expressed by the local government in a resolution (September 1, 1979) passed by the Regional Development Council adopting the *Katiwala* approach as a component of the region's development strategy. The Inter-Agency Advisory Council's main function is the planning for PHC activities for all levels. The council is supplemented by Inter-Agency Committees at provincial, municipal, and *barangay* levels. They serve as resource persons during the training and participate in the preparation of the *Katiwala* Action Plan. The MOH — the lead agency in health activities calls on the *Katiwala* to help in different campaigns like immunization, nutrition, and the like. IPHC staff and *Katiwala* are called on as resource persons for the MOH training of BHW (*Barangay* Health Workers). MOH in turn provides resource speakers to IPHC on request.

## Case Studies

The effectiveness of the *Katiwala* depends to a large degree on her commitment and dedication to volunteer work. The following case studies are personal experiences of *Katiwala* whose successful work have been possible only through persistence and unremitting effort. Each case or personal experience shows as well the different kinds of problems peculiar to each locality or community.

### I. Experiences of a *Katiwala* in Puting Lupa

I am LUCITA CAITUM, a *Katiwala* in *sitio* Puting Lupa, District of Agdao, Davao City. I am married and I have six children. Before I became a *Katiwala*, I was a dressmaker. My husband is a carpenter. Before, I was very ignorant about the problems in the area. I was only concerned with my family. I was shy. I could not even face or stand in front of other people to talk. Puting Lupa is 873 meters from Agdao Barangay Hall and 973 meters from Agdao Health Center. Tuba gathering is the main occupation in this area. Puting Lupa used to be about five hectares. It had six houses and sixteen families with a population of 200. At that time, we called it a *sitio*. Before, the houses were scattered and not well-formed. Formerly, this area was muddy during the rainy season. In 1976, the sanitation was very poor. We only had two Antipolo type toilets. Most people left their wastes in their backyards. Some children are malnourished, and every year, death comes to 20 or more children and adults.

In 1976, a Project Officer of a private agency called the Development of People's Foundation (DPF) came to our *sitio*. He talked to our chapel president and offered help. The chapel president called a community meeting, and in that meeting problems were discussed. The first problem discussed was the lack of medical care. The Project Officer said that the DPF can help us. All we had to do was to send a representative to the foundation for training. The representative to be sent:

1. must be recommended by the community;
2. must be at least 30 years old;
3. willing to serve the community without any compensation.

It happened that the wife of the chapel president was recommended but she needed a companion or teammate, so I volunteered. The Training Officer refused to accept me because I was underaged. He said I was too young to handle the responsibilities in the area since the training is more on medical care, and it is very risky for the community. However, I was very interested in the training, so I talked to the late Dr. Jesus dela Paz, who was the founder of the *Katiwala* Project. I promised him that I could handle the responsibilities of a *Katiwala*. So, the father of the *Katiwala* agreed, and I was one of the 37 selected to be trained for the third group.

When the training was over, I went back to my community ready to handle responsibilities. I thought being a *Katiwala* was easy. I thought it was just giving

health care. I did not know there were many problems. The first problem that I met was environmental sanitation which included construction of water-sealed toilets and blind drainage. The construction of the water-sealed toilets bothered me so much because the people in the community wanted to get nails and lumber for free. I taught them to use low cost materials.

I found out also that there were many who died from diarrhea in the area due to the unsafe drinking water. People got drinking water from the open well and did not boil it. So, I asked for help from the MSSD because I was told they could give loans for artesian wells, if we agree that the manpower is our responsibility. By the end of 1978, we were able to use our artesian well. We learned how to use ORS, and the number who died from dehydration went down from eight persons in 1978 to four in 1979 then one in 1980. There have been no deaths from diarrhea since 1981.

The mothers in the area were ignorant about immunization. They refused to bring their children for immunization. They did not believe that immunization could help. They knew it caused fever or sickness. I told them that when the children have fever, it is a result of the vaccine taking effect. Then some mothers became worried when their children did not get fever. So, I held a Family Health Class to tell them more about immunization. This Family Health Class covered nutrition, how to handle emergencies, herbal garden, growth chart, and attending to mild cases of sickness. It turned out that I re-echoed what I learned in my training. The family health class members helped me a lot.

Family Planning was my biggest problem. The implementation of the Family Planning is quite hard when a method fails. The husband of a family planning acceptor who got pregnant chased me with a *bolo*. There were many problems, but later on they noticed that the couples who accepted Family Planning completely, seldom had financial problems. Now they come to me and ask about Family Planning methods.

In 1979, when the medical situation in my area became better, my main problem was malnutrition. I had noticed that while we were teaching nutrition, there were many malnourished children. The mothers said it was because the income of the family was not enough to give them a balanced diet. With the help of my Family Health Class members we looked for loans. It was known that the MSSD would give loans. We applied, but after two years, and several seminars, the loan was still being processed. We were quite discouraged.

In 1982, Florenda Sango, a Project Officer from the Davao Medical School Foundation (a sister organization of DPF) visited our community. Flor and I conducted household interviews and held Focus Family Dialogues. We asked the families about their aspirations, problems, and what they wanted to do about these problems. We also asked them if there were community members they wanted to work with to solve their problems. The results of these dialogues showed that their main problem was lack of income for food and education of their family. This was the start of the Community Credit Group among the family health class members.

In 1982, the Davao Medical School Foundation (DMSF) also tested the Child-to-Child Program in my area. Luz Canave, the DMSF Training Officer taught children how to care for their younger brothers or sisters. After they graduated, two of them trained other children so that they could help develop the health of their younger brothers or sisters. The project covers physical, mental, and spiritual aspects of growth. At present, the health scouts are also engaged in income generating projects so they can help their parents pay for their schooling.

I also tried to put up a day care center which was made into nursery class in a nearby *purok*. It is self-sustaining. Mothers paid the salaries of the teacher.

### Conclusion

When I started working as a *Katiwala*, I thought I could easily do the job. I thought it was simple to use the skills I learned. Later on, I learned I had to prove to my community that I could really do a good job inspite of all the problems I had. Then, many trusted me so much that they became dependent. Today, Puting Lupa has organizations which help in developing the community. I still provide health services but in these organizations, I am only an adviser. They are able to implement their own plans with very little help from me.

## II. The *Katiwala* As A Change Agent in Barangay Ipis

Barangay Ipis is part of the municipality of San Vicente, Davao del Norte. The terrain is hilly. Most of the people are engaged in farming. The major crops are cacao, coffee and corn. The population is approximately 1,400. There is no health center, but one midwife who is not residing in the place serves the area. She lives in the neighboring *barangay* with a distance of four kilometers. There is one *herbolario* (faith healer) and two *hilots* (midwives). People usually go to *herbolarios*, for minor illnesses because the midwife can not provide medicine for them and she is often not around when needed.

There is one elementary school with five fulltime teachers. There is one pit-type uncovered toilet on the premises. There is a half-finished Barrio Hall, a multi-purpose barrio hall that the *Katiwala* sometimes uses for holding Family Health Classes. It has one jetmatic pump which the people do not use because water is not potable. They use spring water for drinking and washing. Only a few use rain water for drinking. People who use spring water for drinking have to hike two kilometers from their residence and carry the water in plastic containers.

The *Katiwala* found it difficult to present the action plan to *barangay* officials and also to the community members due to previous experiences with

CCP-NPA infiltrations in the *barangay*. Any group or organization that wished to introduce development programs in the *barangay* are suspected of subversive activities. Besides, the community also had previous experience with other government agencies whose services did not meet their expectations.

With the presence of the P.O. during the *barangay* assembly, the *Katiwala* presented their action plans and explained the objectives of the program, the role of the implementing agency, and the role of *Katiwala*. During the assembly, there were mothers and barrio councilmen who, although, previously were very negative toward the program, later on expressed their willingness to attend the FHC which the *Katiwala* conducted.

On the first day of class, the *Katiwala* drew expectations from the participants. Attendance declined during the course of the Family Health Class. Some of the mothers transferred residence; others were busy in the farm, and others were not interested because they found out that they could not get any material things out of the class and from the *Katiwala*. With the use of essential visual aids, actual demonstrations of herbal medicines preparation, acupressure, and others, the *Katiwala* were able to sustain the interest of the rest of the participants, and eighteen graduated.

The presence of the *Katiwala* at Barangay Ipis, caused some conflict and competition with the Barangay Health Worker (BHW). The BHW felt the *Katiwala* was a threat to her recognition as a health trustee in the *barangay* and the BHW started spreading negative feedback through the *barangay* against the *Katiwala* like:

1. The *Katiwala* is making excessive profits by selling booklets and supplies at a higher price than that of the implementing agency.
2. The *Katiwala* thinks that they are more knowledgeable than the BHW because they have undergone four weeks intensive training under a private health agency.

The BHW even channeled these feedbacks to the municipal health officers. The *Katiwala* consulted the P.O. regarding the problem. They came up with a solution: that of holding a Team-Building Workshop on the municipal level inviting the MOH personnel, the *barangay* captain, and the BHW's of the *barangay*. The BHW and *Katiwala* together with the Municipal Health Personnel and the *barangay* captain were able to set up plans of health activities in their respective *barangays*. BHW and *Katiwala* have specific assignments on the formulated action plans. Presently, there is close coordination between the *Katiwala* and BHW and the health activities are more attainable and realistic.

### Monthly Weighing of 0-6 Children

Surveillance on the nutritional status of 0-6 years old children is a part of *Katiwala* activity in the *barangay*. Weighing of children was done monthly. Mothers of the weighed children expected feeding supply from the *Katiwala* which is not a component of the services and activities. The *Katiwala* tapped

other government agencies for feeding supplements. They also conducted cooking demonstrations and lectures giving emphasis on the nutritional values of locally available raw materials for feeding supply. The *Katiwala* put up the kitchen gardens in their own backyards so that some of the mothers asked seeds for their own kitchen gardens.

### Conclusion

Presently, the *Katiwala* are invited to conduct family health classes in two neighboring *barangays* by the *barangay* officials. All expenses incurred by *Katiwala* are shouldered by these communities. Some extension workers of government agencies also give lectures in these family health classes. The *Katiwala* are now getting more recognition from neighboring *barangays* as well as the municipal health personnel for their capability of delivering basic health services.

### III. Raising The Consciousness of Rural Folk In Barangay Sapa

On entering the municipality of New Bataan, the Project Officer (P.O.) paid a courtesy call on the officials at the municipal *barangay* levels. With the help of other PO's, a pre-test was held in order to check if this process is applicable to both the agency and the community. He then explained to the people both the objectives of the program, the criteria in selecting areas and the methodology utilized in identifying whom to send for the crops, livestock, micro-business, team-building and child-to-child training. Interviewers were hired to do the actual survey using guide questionnaires. Only the heads of the family were to be interviewed. This survey served as a tool in gathering baseline data. Key persons were identified through sociometry.

Two months after the crops and extension training for North Davao farmers, the P.O. went back to this area in Barangay Sapa to follow up the farmers' class. He was eager to talk to the two farmer classes and visit the *barangay* captain who agreed to the action plan presented, and even suggested that the overall *purok* chairman be contacted and enlist his help in communicating with the *purok* leaders to schedule a meeting. During the meeting, only six out of 16 *purok* leaders attended. Orientation of the on-going activity was given by the two farmer leaders. It was agreed that every *purok* leader should bring two or more farmers to attend the Farmer's Class once a week every Friday. On the first day of the Farmer's Class, the P.O. could not go due to a heavy rain. The next day nobody showed up. This happened several times. He went to some people he had met before — leaders, ordinary farmers, teachers, officials in the *barangay* and discussed the problem with them. A few people

who had been positive regarding the program convinced others until informal meetings could be conducted. The purpose of a farmer's class and who it would benefit most was explained.

The efforts to raise the consciousness in the community eventually paid off. The farmer's class began with a good attendance of interested participants who were active and enthusiastic. The P.O. now looks forward to the demonstration farm which the farmer trainees agreed to undertake as their next project.

### IV. A Community Need Is Answered In Barangay Sto. Nino

Barangay Sto. Nino is situated five kilometers from the *Poblacion* of Babak. The terrain is mostly sloping. Due to a rough, poorly maintained road, public utility vehicles hardly ever enter the *barangay*. It has a total household number of 160 with an average household size of seven members. Of the 1,120 population, 98% are engaged in farming.

A survey in the *Barangay* showed that the lack of potable drinking water was one of the main problems of the community. Upon identifying the problem, the community worker (P.O.) referred the matter to the IPHC. Thinking that the Ministry of Health could help, she also consulted the Regional Water Sanitation Engineer. In response, the MOH officer scheduled a meeting with the two Peace Corps water specialists.

Two weeks later, the Peace Corps Volunteers together with the P.O. visited the area. The first visit was an ocular survey. A week later, the Peace Corps Volunteers and P.O. went directly to the water site (wells) to get a sample. Some people in the community were there washing clothes and fetching water. From among the people around, one was asked by the Peace Corps Volunteers to fetch water. The Peace Corps Volunteers explained to them why it was necessary to have a sample. The results were obtained after two weeks. The community, especially those who were around when the sample was taken, kept on asking the Barangay Captain and the P.O. about the result. The result from the laboratory showed that the water was contaminated.

This information was transmitted to the *Barangay* Captain. The *Barangay* Captain, realizing the problem, called for a special session of the council in which he explained the need to do something to solve the water problem. Since everyone was using the same source of water they tried to find ways and finally decided to ask help from the Municipal Mayor.

It was recalled that the *barangay* requested for a jet-matic or a pitcher pump from the Mayor a year ago. The *barangay* captain and councilmen followed up this previous request which was finally granted. The Mayor's office provided the cement while the people provided the labor. The community led by the *barangay* officials cleaned the site and dredged the well. They needed to be deepened. Meanwhile, the wives cooked lunch. The actual work took two days.

The installation was done with the help of personnel from the MPWH and the advice of the two Peace Corps Volunteers. The cementing and other finishing touches were done by the community. Since the end of February, Barrio Sto. Nino has had safe drinking water from the new set-up jet-matic pump.

### V. Hog-Raising Project in Barangay Wines

Barangay Wines of Baguio District is an agricultural area. Farming is the main source of income, and average yearly income is P1,300.00. To provide for other needs, the people raise animals in their backyard. Barangay Wines is a depressed community. The Davao Medical School Foundation Institute of Primary Health Care (DMSF-IPHC) with the assistance of the UNICEF assisted in the development of the community's capability to manage their own development.

In January 1982, a Project Officer and Documentor of DMSF conducted a Focused Family Dialogue with 25 family respondents. The agenda covered family aspirations, barriers to the aspirations, the steps taken to reach the aspirations or minimize the barriers, and the persons they wanted to work with regarding these aspirations.

As a result of these FFD's, the IPHC team found out that the community aspirations were:

1. to send their children to school;
2. to have three square meals a day, and
3. to improve their houses.

Low income and high prices were identified as the main barriers to these aspirations. The FDP's were followed by a Focused Community Dialogue where the result of the FFD were fed back to them. As a result, cluster or small groupings were formed on the basis of their choice (i.e., who they want to work with). The IPHC team worked with these clusters to help them build their capability to take responsibility in initiating community development projects. Planning and prioritization of projects were done by these clusters. They also helped in the identification of possible resources which could respond to their aspirations. After the cluster members were identified, a series of meetings were conducted to plan for effective community development projects. Cluster members identified their needs in relation to aspirations raised and prioritized these according to their urgency and the availability of resources. Prioritized projects were thoroughly discussed by the group until everybody agreed to have it as a community project. In planning, they also considered the market or outlets of their finished projects/products. Identification of resources were made possible in coordination with the P.O. and identified leaders.

The project recipients identified the United Way of Greater Davao Inc. as the agency to be approached for the Hog Dispersal Project. The P.O. made the

initial contact with the agency for project assistance. As a result, cluster members were informed about the procedures in availing of their services. The clusters formed a BRIC organization which was a major requirement of United Way.

Upon completion of the requirements set by the Agency,

1. The Barangay Rural Improvement Corps Organization, Wines Chapter was recognized by the United Way.
2. A one-day seminar on Hog-raising was conducted by the United Way personnel. The assurance of assistance through piglet dispersal was approved provided other project requirements were accomplished (e.g. cemented pigpen, and purchase of required feeds as counterpart).
3. The community asked MLG to provide gravel for pigpens.
4. The completed counterparts such as pigpens and feeds using the gravel given by MLG.
5. The community reported to United Way the completion of requirements.

### Problems Encountered

United Way could not provide the piglets as promised. The long drought affected the hog-dispersal program of the United Way. They had to temporarily suspend dispersal, due to decreased production and repayments of piglets from BRIC recipients of other areas. Some members wanted complete assistance (i.e., loans for pigpen materials purchase foods and medicines, and piglet). When told that such was not within the mandate of the project they dropped out. Drop-out of cluster members was due to the gap between cluster formation and release of assistance.

Meanwhile DMSF-IPHC conducted seminars on local-feed formulation. Formation of a Community Credit Group which discussed and agreed on a system of managing the group and financial assistance for the purchase of piglets. The IPHC project officer also looked into an alternative source of piglets for the community and organized field trips to several pig raises. On the day the piglets were purchased, the P.O. also accompanied the group. A DMSF vehicle was used to transport the piglets and the owners of these piglets. Members were given training in bookkeeping and how to estimate the weight of the pig with the use of a tape measure.

The United Way provided Technical Assistance through:

1. advising the identification of piglets;
2. giving immunization to piglets, and
3. helping monitor project recipients giving continuing education - such as fieldtrips and educational tours.

After the piglet-dispersal, close supervision and monitoring by P.O. was administered. Members who were project recipients also took active part. The spirit of sharing was felt by the group, and sharing made the group more cohe-

sive. This was emphasized through sharing of commercial feeds and medicines. Growth monitoring was done by the group. Individual members were also taught simple bookkeeping, and each member kept records of their project. The United Way personnel also participated in the active monitoring for continuing education and motivated them for proper care of the hogs. The group agreed to extend their services to non-project recipients.

At the end of the project, the education revealed that the effects on the community were the following: the community was influenced to use pigpens for proper sanitation; they came to realize the importance and practice of immunization; they also valued the attitude of being cohesive/close to each other.