In 2010, the whole INAM staff was able to identify the organization's three year (2011-2013) direction based on the highlights, accomplishments and significant developments of the departments and the organization as a whole. The INAM's general direction for the next project cycle was already included in the project proposals submitted to the different funding agencies.

From **2007 to 2010**, the following are the main thrusts of INAM: Enhancement of Philippine Integrative Medicine (PIM), Sustainability and Collective Leadership.

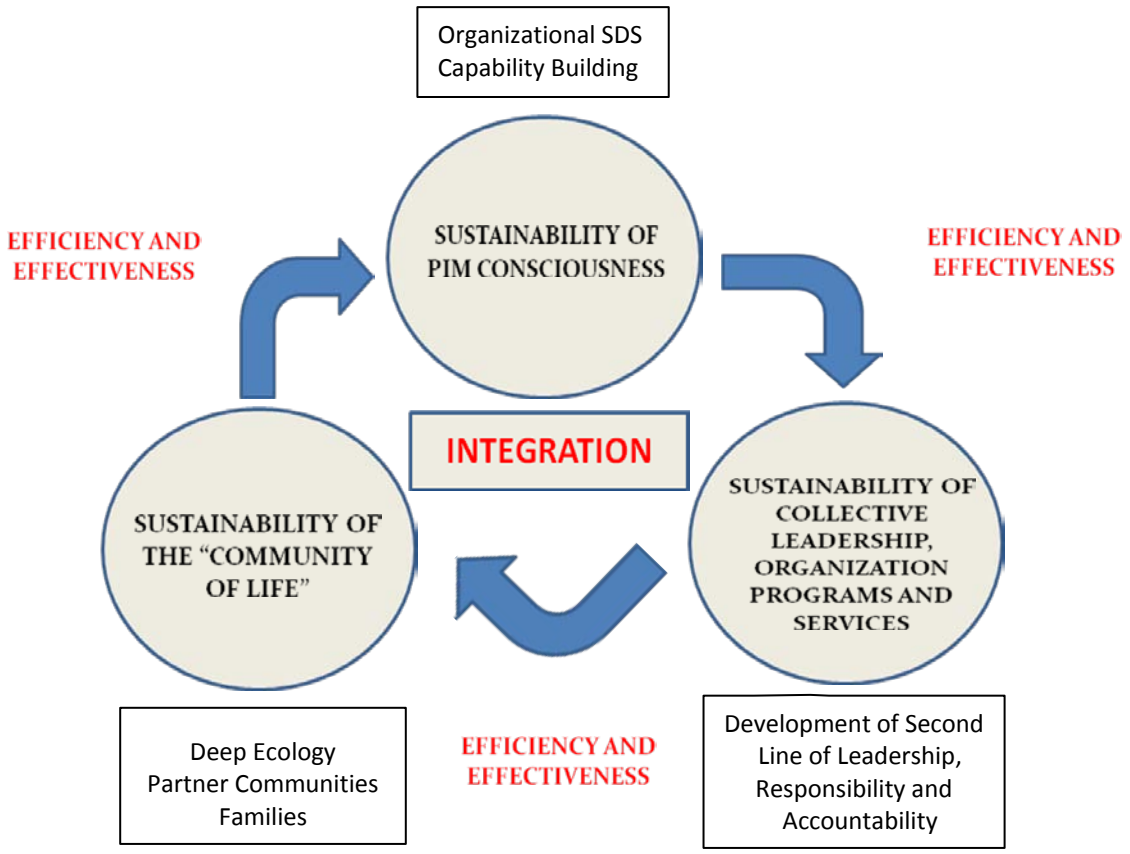
Enhancement of PIM was achieved through trainings using PIM curriculum to the partner communities in different provinces of the country. This was also evident in the clinic services where integration of other health systems was used in various conditions of patients who consulted for treatment. All INAM staff underwent different PIM trainings which prepared them to improve their skills for conducting PIM trainings, provide appropriate integrated health services to the target groups, and improved program management and information system which served as basis for sound decision making process of the organization.

Sustainability during this project cycle was reflected as popularization and acceptance of PIM to the different stakeholders such as partner communities, partnership with the local government units and partnership with the academe. INAM continues to implement its sustainability plan for the clinic and laboratory services and periodically conducts assessment on its effectiveness. Program and financial sustainability of the organization also means supporting and sustaining the well-being of all INAM staff.

Collective Leadership developed the decision-making capacity of all INAM staff and prepared them to be accountable and responsible for their respective tasks and participate actively in department meetings, assessments as well as organizational assessment and planning. During this period, synchronization of the programs and services of the different departments was initiated. Collective leadership was also reflected in the partner communities' decision making process and program management.

INAM's **Ecological Perspective** started when the organization engaged in a tree planting activity in partnership with the CARE Foundation. Staff development sessions (SDS) on Deep Ecology were provided to all INAM staff for almost one year. The SDS increased the awareness of all INAM staff on how to take care of the environment and determine its important relationship to health. It also opened a wider perspective for the organization to seriously consider in its direction the aspect of "Sustaining the Community of Life"

In the next page is the organizational direction for the next project cycle which was approved by all INAM staff:



Sustainability of PIM Consciousness

PIM consciousness shall be sustained through the continuous conduct of staff development sessions or trainings to INAM staff to further deepen their understanding of PIM and its relationship to other factors such as health and environment. This shall also be realized through the conduct of PIM trainings to the different communities as well as establishment of community health programs using the PIM approach and/or framework.

Sustainability of Collective Leadership, Programs, Services and Organization

Knowledge, skills and attitude of all INAM staff shall be enhanced through the PIM trainings and staff development sessions which can be used in effectively and efficiently implement the different programs and services for INAM's target groups.

Accountability and responsibility of all INAM staff as well as the community leaders is highlighted in this goal. This shall eventually assure the organization's second line leadership because the staff are already prepared to take on greater roles and challenges.

Sustainability of programs and services shall also mean sustainability of the whole organization and ensuring the well-being of all INAM staff through provision of additional personnel benefits and a more conducive working environment.

In the communities, this shall mean development of appropriate services to the people and continued provision of such services based on the needs of the communities. Trainings on Community Health Care Financing shall be introduced to the established community health programs.

Sustainability of the Community of Life

Embracing PIM framework and consciousness to our individual life, families and reflecting it on the different services based on the needs of the community and taking into consideration the "care and continuous nurturing" for our Mother Earth shall mean sustaining our community of life.

The three major aspects of INAM's goal/ direction for the next project cycle are related to one another. If one aspect is not fully realized the others will be affected and the process of "integration" shall not take place.

INAM shall ensure that all aspects shall be effectively and efficiently implemented by developing measures or indicators of effectiveness and efficiency. The indicators shall also be the basis for periodic assessments if the direction will be achieved for the next three years.

In August 2010, INAM was visited by staff and Board of Directors of Asian Health Institute (AHI), a non-government organization in Aichi Prefecture, Nisshin City, Japan. AHI provides International Leadership and Development Courses (ILDC) for qualified representatives of non-government organizations in Asia. Four INAM staff are alumni of AHI on its ILDC course. AHI staff and board members were able to get some updates on the accomplishments of INAM and its new organizational direction. They were able to visit one partner organization of INAM at Tanay, Rizal. AHI is interested to support INAM trainings on community health care financing.

INAM's 2008-2010 Highlights and Significant Developments

- Acquisition of property for INAM

  One of the many accomplishments of INAM in its 25 years of existence is having its own place which is a symbol of the organization's identity and existence and also an expression of sustainability.

  It was a consensus decision of all INAM staff and Board of Trustees to purchase the property which is currently being rented by INAM. The owner then offered to sell its property to INAM being a long time leasee for about 20 years already. To realize this dream, INAM sought the financial assistance from Women's Rural Bank. They were the only bank who understood INAM's financial situation and provided the loan which the organization needed. A sustainability plan was developed in order to further sustain the payment for the said loan and also to sustain some aspects of the administrative cost.

- The assessment done by each department is according to the direction identified by the general assembly

  The content and process of the department assessments were aligned with the direction agreed upon during the general assembly. The growing PIM consciousness of all INAM staff was the major factor in pursuing the identified direction. From this experience, it was realized that the progress of an organization towards the pursuit of the direction depends on the degree of internalization by every member.

- Development of systems in each department for effectiveness and efficiency towards sustainability

  All departments were able to develop their own systems to ensure efficient and effective use of the organization's resources. This was reflected in the updated department inventories for office supplies, health shoppe supplies, clinic and training supplies. Each department was able to use the information from the inventories and incorporate the costing necessary for training and clinic services. Monitoring systems appropriate to the department needs were also developed during this period.

- There is an initial glimpse of developing a "**new type**" of personnel (embodying PIM)

  The staff development sessions became opportunities for all INAM staff to further understand their role and contribution in the organization. The application of the different types of learnings especially the adult learning process and the willingness of the staff to take on new challenges are significant factors which led to this organizational development.

- Community Clinics in Typhoon Stricken Areas

  Around 1,500 families were provided with integrated health service to victims of calamity in the areas of: Quezon City, Taytay and San Mateo, Rizal and Pandacan, Manila.

- INAM's 25th Anniversary

  INAM celebrated its 25th Anniversary last September 12, 2009 at Bahay ng Alumni, University of the Philippines, Diliman, Quezon City. The jubilee mass became the center of celebration. The event was participated in by the different partner organizations, BOT members, former ATRC/ INAM staff, patients and friends of INAM. Plaques of recognition were given to ATRC founders, BOT members and staff who rendered more than ten years of service to the organization.

- 1st National Community Health Workers' Assembly

  A gathering of community health workers who finished PIM Levels 1 and 2 was organized by INAM during the last quarter of 2009. The gathering became the venue for sharing the different experiences of the community health workers in applying what they learned in the PIM trainings and how they use their skills in managing the common health conditions in their respective communities.

- 1st National Conference of Acupuncture Practitioners in the Philippines

  Non-medical and medical acupuncturists trained by ATRC and INAM attended the first National Conference of Acupuncture Practitioners in the Philippines. The Philippine Institute of Traditional and Alternative Health Care (PITAHC) of the Department of Health in partnership with INAM Philippines organized this conference. PITAHC accredited acupuncturists from INAM and its partner organizations were the major participants in this event. There was an election for Board of Trustees for the Philippine Academy of Acupuncturists wherein 2 INAM staff were elected as members of the Board. Other acupuncture practitioners trained by ATRC/ INAM are still awaiting for their acupuncture certification.

- INAM assumes a lead role in promoting PIM to its patients and partner organizations through its integrated health services, trainings and networking with other groups. PIM is a major contribution in developing the alternative health care system of our country.

- Decisions made are based on information and actual experience. Process of decision making is done collectively ensuring the participation of all INAM staff.

- Increased PIM consciousness and a better grasp of PIM framework was seen among the staff. This was seen through:
  - the manner of work and relating with colleagues, patients and partner organizations
  - openness and objectiveness during discussions in meetings and assessments
  - values of responsibility and accountability are reflected in daily activities
  - concern for the environment and how it affects health and the issue of climate change

- Unified approach to the communities shall be the PIM framework and perspective

- Enhancement of the monitoring tool for accountability and responsibility shall be done per department

- Admin Department shall develop a Community Health Care Financing scheme for all INAM staff. Policies and procedures shall be presented to all staff for approval.

- Admin Department shall also develop the system and policies for the gratuity and retirement pay as mandatory and additional personnel benefits for all INAM staff.

- Community Based Recovery Department shall be dissolved and ear acupuncture detoxification training and services shall be integrated with the ART department's trainings and IHSD's integrated health services.

- Re-visit of INAM's Vision, Mission and Goals shall be done every eight years.

- INAM was accredited by the Department of Health's Philippine Institute of Traditional and Alternative Health Care (PITAHC) as an acupuncture training center.

- INAM's 26th Anniversary

  INAM celebrated its 26th Anniversary last September 8, 2010 by providing community clinic and health education to the poor residents of Barangay Pinyahan, Quezon City. INAM coordinated with the East Triangle Neighborhood Association (ETNA) for the said activity. The community clinic was able to provide integrated health service to 285 community members. Health education on respiratory diseases, cardiovascular diseases, dengue and sore eyes were also provided. All INAM staff, volunteers and supporters participated in the meaningful celebration of INAM's 26th anniversary.

- 1st National Partners Conference

  The conference brought together INAM Partners who shared experiences in organizing the PIM trainings and initial impact of the PIM trainings on the communities and the organizations. The workshops and discussion in the plenary helped clarify the role of the partners in the preparation of the training, during the actual training and after the training as well as the initial impact of the training on the communities and the organizations.

- Intensive Acupuncture Training

  INAM staff participated in the Philippine Academy of Acupuncturists (PAA) Intensive Course on Acupuncture and Trainers' Training which aimed to generate consensus on a common language for a PAA core curriculum that will not only enable participants to conduct acupuncture training more effectively but also lead to better research opportunities and eventually to PhilHealth accreditation.

In the background of these actual developments in the country and as an organization, INAM finds its mission of propagating Philippine Integrative Medicine (PIM) all the more relevant and urgent. INAM through its programs and services needs to reach to more poor and marginalized communities who will have the most difficulty in accessing and affording

essential health services. Hence, INAM evaluates its programs and services periodically to ensure its continued relevance to the poor and marginalized.

II. ACCOMPLISHMENTS FOR THE PERIOD[1]

TRAINING

Component 1: Training of Partners on PIM Courses

Objectives:

- *Functioning community managed health programs (CMHP) among current and prospective partner NGOs/ POs*
- *Progression of a partner's community based recovery program (CBRP) to become a component of the Community Health Program*
- *Systematic documentation of CMHP experiences towards development of best practice.*

A. Philippine Integrative Medicine (PIM) Trainings

During the period being reported, INAM facilitated two (2) PIM Level 1, three (3) PIM Level 2, four (4) PIM Level 3, 4 PIM Orientation, 1 Training on Health Education Facilitation and 1 Training on Organizational Management. For PIM Level 1 trainings, a total of 85 participants from 23 barangays in 9 municipalities/cities in the National Capital Region and Lanao del Norte completed the course on PIM Level 1.

For PIM Level 2 trainings, 113 CHWs included 37 CHWs from urban poor communities in the NCR. 37 Dumagat CHWs from Tanay in Rizal Province are able to serve 401 households. 39 mothers in Quezon Province completed the course and can provide health services through 11 CHPs to 626 households organized into family groups in 36 barangays in 10 municipalities.

As a result of PIM Level 3, 62 CHWs became CHP Managers of 19 Community Health Programs in the provinces of Mizamis Occidental, Sulu and North Cotabato in Mindana and Sorsogon in Luzon, taking care of the health of approximately 2,700 households or 16,200 persons.

Details of the aforementioned activities are presented below describing particularities in the experiences of each group including outcomes and insights.

[1] See Annex A for Summary Matrix of the Advocacy, Research and Training Department accomplishments for the period. This includes the lessons and effects and cumulative effect for the period of July 2010 To Mar 2011.

1. **TANAY PIM LEVEL 2 Training, Rizal Province**
   July 26-30, 2010

After five days of PIM Level 2, a Community Health Program was set-up in each of the nine (9) upland communities of Dumagats/Remontados in Tanay, Rizal Province and are presently providing health services to 401 households (approximately 2,406 persons) or 24% of the total Dumagat population of 1, 650 households. These CHPs are being implemented by the 37 Dumagats who became Community Health Workers after completing the course on PIM Level 2.

Dumagat CHWs graduate from PIM Level 2 training

The Dumagat CHWs previously trained in PIM Level 1, enabling them to formulate a survey form which they used later to conduct the survey of 401 households and ascertain the real situation of their indigenous communities. The information generated from the survey served as baseline information on the Dumagat households and were useful in monitoring the health of the Dumagat families. The survey also initiated the organizing of the households in preparation for the setting up of the Community Health Program in the next PIM Level training.

After conducting the survey for a month, they gathered for the PIM Level 2 training, bringing with them the results of the household survey for analysis. INAM facilitators walked them through the analysis of the data by establishing the relationships which gave meaning to the data. The three (3) major problems in each of the community were identified. How they saw themselves responding to these problems became one of their bases in determining their responsibilities as Community Health Workers and consequently their Community Health Programs. A common problem among these communities was the lack of knowledge on healthcare by the Dumagats. Their training as Community Health Workers contributed towards addressing this problem.

Hence, INAM facilitated basic health skills training on the top common conditions identified from the survey. The BHST built on their indigenous health practices, giving them scientific explanation so that they would be more confident to apply them or recommend its use to other Dumagats. Giving value to their indigenous practices helped uplift their self-worth as an indigenous group.

A more systematic approach to health education is emphasized. As mentioned, diseases studied were based on the results of the survey. Hence, CHWs can appropriately respond to

the health needs of the Dumagat families. However, because the analysis of the survey took time to finish to give time to the Dumagats to be able to gain confidence in speaking in front of the people, only gastroenteritis and influenza were discussed.

Dr. R. Luce, Tanay MHO, listens to results of survey being presented by Dumagat CHWs.

Nonetheless, this became also an opportunity for the staff of the Rural Health Unit of Tanay to be able to assist the Dumagats by training them in basic health skills. To prepare the RHU staff for this task, INAM conducted a Facilitation of Health Education training for the RHU staff. In December 2010, Tanay RHU conducted a basic health skills training with the Dumagat CHWs and discussed the remaining diseases not covered during PIM Level 2.

With the major problems identified, the basic health knowledge and skills gained, the Dumagats have identified their responsibilities as CHWs to include: 1) conducting health education among family groups; 2) treatment of the sick, 3) referral to RHUs of the sick who cannot be treated at home, 4) environmental sanitation, 5) coordination with the RHU forn various health programs that can be accessed by the Dumagats, 6) coordination with other government agencies for livelihood opportunities. These served as the main components of their Community Health Program (CHP) and became the basis for crafting a one-year plan to implement their CHP.

Organizing of households they surveyed was refined in PIM level 2 by introducing family clustering with a CHW being responsible for the health of 15-20 families of Dumagats. This ensured that every Dumagat household will have access to the services of CHPs.

The conduct of PIM trainings and eventual setting-up of CHPs in the Dumagat communities was particularly significant because it addressed their long time problem of lack of access to health services. As mentioned, the Dumagats live in the remote parts of the municipality, hence limiting their access to health care. Also, because of the marginalization of the Dumagats, their indigenous heath practices were frowned upon despite experiences that demonstrated the effectiveness of some of their practices thus, limiting further their options for health care.

The rich indigenous health practices of the Dumagats were very evident during the training. The use of herbal medicine to treat sick members of their families/communities is a common practice. The PIM trainings gave them the opportunity to rediscover their

indigenous health practices and integrate these to the management of common conditions identified from the household survey they conducted.

The training also provided information to the Dumagats on the services that are available in the RHU. Knowing the RHU staff assigned to their barangays facilitated access to RHU health services. The RHU staff coordinated with the Dumagat CHWs for the schedule of immunization, pre-natal check-up, family planning and others. They also learned that a vehicle for emergency is stationed in one of the barangays in Sto. Nino for transporting their patients with an emergency condition.

During the INAM Partners' Conference in November 2010, Dr. Rene Luce, Tanay Municipal Health Officer (MHO) shared how the PIM trainings have enhanced the health-seeking behaviour of the Dumagats. Access to health services offered through their Rural Health Units has improved with more pregnant Dumagat women having pre-natal check-up, mothers having their children immunized and the use of herbal medicine before treatment with modern medicine to treat common diseases. The MHO himself prescribes the use of herbal medicine to treat common illnesses.

Dr J. Taleon giving an inspiring talk to Dumagat CHWs

Dr. Juanito Taleon, DOH Regional Director, continued to support the PIM Trainings being conducted in Tanay and expressed support for PIM Trainings that will be conducted within Region IV-A, which includes the provinces of Cavite, Laguna, Batangas, Rizal and Quezon (CALABARZON).

INAM hopes to conduct PIM Level 3 with the Dumagat CHWs this August 2011 after a year of implementation of their CHPs to enhance their knowledge and skills on managing their CHPs.

2. KUMARE PIM Level 2 Training, Infanta, Quezon
August 23-27, 2010

Five months after PIM Level 1, the women of Quezon Province who are members of *Kilos Unlad ng Mamamayan ng Real* or KUMARE gathered again for PIM Level 2 bringing with them varied experiences in conducting the survey as well as their experiences in attending to the health needs of their own family and members of the community who approached them. Stories of challenges to make the people cooperate in order to finish the survey and

amazement at how the answers to their health problems are just within their reach abound during the training.

Coming from the conduct of household survey, the participants shared varied experiences on approaches to be able to convince their respondents to share information. This became an opportunity to process the following:

- the depth of information that family-respondents were willing to share with them depended on how much they were trusted by the communities, and
- the confidentiality of information that was entrusted to them by families they surveyed.

Bishop Julio Labayen Building in Real, Quezon, venue of the PIM Level 2 training

Personal experiences on the effectiveness of treatment practices INAM shared with them in PIM Level 1 enhanced their interest and determination to pursue the training. A participant confirmed the effectiveness of *camote* juice to manage dengue, a knowledge they brought home with them coming from their training in PIM Level 1. At that time, dengue cases were widespread and the only option people knew was to bring sick family members to the hospital if there was continuous high fever, with a blood test confirming the diagnosis of dengue. A mother shared how her son recovered from dengue despite having visible signs of body rashes and bleeding.

Majority of the participants were mothers in their late 30s and 40s. They shared how they worried whenever their children, especially those below five years old, would get sick. Having knowledge and skills to manage illnesses that commonly afflicted family members, especially the children, gave them a sense of security and composure.

A total of 626 households were surveyed in 20 barangays from 3 municipalities of Quezon Province namely, Real, Infanta, and Polilio in Polilio Island. The training team walked the participants through the analysis of the data and idenitifed the three major problems, which varied across communities surveyed. A common problem was the lack of knowledge on health care by the families, which resulted in death in some cases of diarrhea due to dehydration and which explained the practices of bringing sick family members to a doctor, to a hospital or clinic even if said diseases can be readily managed at home and using antibiotics for common diseases that were viral in etiology.

After PIM Level 1, aside from conducting the survey, the participants also conducted monthly meetings with the families they surveyed to discuss a topic on health. These experiences served as a springboard to conduct a return demonstration (return demo) in facilitating health education. The return demo provided an opportunity for the CHW to

learn from each other and to challenge one another to try a facilitation process that built on the experiences of the people as opposed to just giving a lecture on the diseases.

INAM divided the participants into six groups and each group was assigned a topic to demonstrate facilitation of health education. The groups facilitated health education on five common community conditions namely, 1) pulmonary tuberculosis, 2) gastro-enteritis, 3) ascariasis/pinworm infection, 4) amoebiasis and 5) asthma.

Having gained knowledge and skills on managing the top common conditions in the community and knowing the major problems of their communities, helped the trainees identify their responsibilities as CHWs. These responsibilities provided the bases for determining the major components of their CHPs.

Among the responsibilities of a CHW they identified were: 1) conduct of health education, 2) referral of patients, 3) coordination with the barangay, rural health center, local agencies and other organizations, 3) lead the initiative to protect the environment, 4) cultivation of herbal plants, and 5) continuing study of the situation of the community.

KUMARE CHWs proudly show their Certificates as CHWs

Aside from these responsibilities, they also identified the characteristics a CHW should have. These included: 1) being a role model, 2) having patience and humility, 4) having tender loving care, and 5) creativity. The participants agreed that listing of characteristics of a CHW should remain open and would able to identify additional characteristics to be included with the development of their experiences.

Before the training ended, seven (7) cluster CHPs covering 20 barangays in two municipalities and one island municipality in Quezon Province were set-up with the potential of providing health care to 626 households grouped into family clusters.

The training team also introduced a recording system to document and monitor the implementation of their CHPs. This included records on 1) Treatment of Patient, 2) Health Education, 3) Meetings of CHWs, 4) Herbal plants per family, 5) Herbal plants and their medicinal value.

The training of members of KUMARE was particularly significant because the organization already had existing programs to address the socio-economic situation of the members. However, when a member of the family got sick, whatever savings they had were quickly depleted on hospitalization/emergency expenses. With training on basic health skills, they could their manage these diseases at home and savings was spent on food, on the education of the children and other needs of the family.

As a result of PIM Level 2, many participants demonstrated heightened sense of service to the community as noted from their reflections and their commitment to pursue their program and their responsibilities as Community Health Workers. They realized the value of sharing oneself with others and how this enriched oneself as well. They also realized not to be afraid of committing mistakes as the experiences become the means to improve themselves.

Reflection of a Participant:

Makalipas ng 5 araw, nung una sa level 1 ay naboboring na, parang mahirap, bahagi ng kahirapan, habang tumatagal ay pasarap ng pasarap ang nangyayari at nararamdaman. Nagpapasalamat sa mga nag-ambag ng kaaalaman at nagbahagi ng karanasan. Natutuwa na yung pagbabahagi ng sarili mo ay doon ka rin matututo. At naramdaman ko rin sa 5 araw na yon na tayo pala ay di dapat matakot na magkamali. Sa pagkakamaling iyon, doon natin nakikita at nag-uumpisang itama kung ano ba ang mga pagkakamaling iyon.

Nagpapasalamat na simula pa sa level 1, yung mga sakit, datos mula sa survey ay nalaman natin, at ako ay maligayang maligaya dahil tayo pala ay certified CHW na. At ito ay yayakapin ko dahil ito ay responsibilidad. Hindi lamang sa sarili ko, sa pamilya ko bagkus ay sa komunidad.

Kahit pala wala tayong pinag-aralan sa medisina, ngayon maipagmamalaki ko na ako ay isang nurse o doctor sa aming lugar, na ito ay aking babaunin sa aking pag-uwi at sana'y magampanan ko ang mga napag-aralan ko dito at makatulong sa komunidad.

By August or September of this year, INAM hopes to gather again the CHWs for PIM level 3.

3. KAUNLARAN NG MANGAGAWANG PILIPINO (KMPI), NCR

PIM Level 1, September 28-October 1, 2010
PIM Level 2, November 23-26, 2010

Kaunlaran ng Manggawang Pilipino, Inc. or KMPI is a foundation established by a leading workers' union in the country to help improve the socio-economic condition of the workers through various initiatives. Among its priorities are: 1) promotion of livelihood projects among the democratic labor centers and their affiliate unions; 2) promotion of all types of workers' cooperatives, including labor-owned and labor-managed enterprises; 3) undertake other socio-economic projects that will improve the social and economic well-being of the members; 4) undertake projects that will provide workers with affordable housing units; and 5) promotion of workers' education. Its programs include: 1) development of generic drugs retail outlets. 2) conduct of technical/vocational to re-train workers and the general public for other employable skills; and 3) provision of technical assistance to cooperatives and/or enterprises owned and initiated by workers.

In line with government's thrust of promoting equity in health, KMPI registered as a drug distributor with the BFAD to be able to put up and supply generic drugs retails outlets located in the workplace and communities. This ensured the availability and accessibility of affordable, safe and effective quality essential drugs to all. KMPI set up Botika ng Barangay (BNB) outlets, providing generic and essential medicine to the communities and as a source of income of members of the community. They tied up individually with local operators that provided a minimum amount of investment, while KMPI provided generic drugs, and having pharmacists, oversaw the dispensing of drugs in their outlets.

INAM met KMPI through Dr. Ruben Caragay, one of the evaluators commissioned by EED to evaluate INAM's training program. KMPI at that time was searching ways to enhance their programs in the communities particularly their Botika ng Barangay (BnB) project. KMPI hoped that the establishment of the CHPs in their areas would make their programs more sustainable, hence after several consultations that included a brief orientation of the PIM Curriculum, a partnership was forged between INAM and KMPI for the conduct of PIM Level 1 -3 Training for BnB operators in selected communities assisted by KMPI. PIM Level 1 and Level 2 trainings were conducted on September 28-October 1 and November 23-26, respectively.

After completing PIM Level 1 and 2, a CHP was set-up in each of the seven (7) urban poor communities in Taguig, Las Pinas, Montalban, Quezon City, Caloocan City and Valenzuela City in the National Capital Region; and provided health services to their respective family groups. Thirty-seven (37) trainees from the said communities participated in the training; 21 of whom completed PIM Level 1 while 16 were without PIM Level 1, despite repeated reminders with KMPI that only those with PIM Level 1 can move to PIM Level 2. Participants from two communities in Quezon City did not conduct any survey, a situation that was

addressed by having them formulate an action plan that included the conduct of a survey and data analysis.

INAM was challenged by the training because of the background and sense of individualism displayed by the participants during the initial encounter with them in PIM level 1. Coming from urban poor communities whose daily survival is a struggle and at times whose situation was used by others to advance personal interest or political agenda, they have developed a culture of mistrust with others and individualism. However, significant changes were noted as the training progressed and from PIM Level 1 to PIM Level 2.

CHW presenting their barangay's survey results

Most participants came from urban poor communities who used to work in factories and were former members of workers' union. Most of them were BnB operators or were planning to set up botika ng barangay in their own communities.

The BnB operators were at first reluctant to pursue the course because they initially felt that this is in conflict with their objective of generating income from the BnB. If they taught people how to manage common diseases without having to buy medicines, their income would be affected. However, they also strongly felt the need to serve their communities. The challenge for them was how to keep a balance between their need to profit from their community-based pharmacies and their desire to serve their communities.

In PIM Level 1, the participants learned how to craft a survey form which they used to gather information. This in turn informed them of the real situation and the major problems besetting their communities and consequently informed them how to respond to these problems.

In PIM Level 1, perceived common diseases studied included pulmonary tuberculosis, measles, cough and colds, asthma, gastro-enteritis, malnutrition, diabetes, sore eyes, arthritis and urinary tract infection (UTI). The training team introduced an integrative approach to the management of these diseases such as simple massage for fever among children, or the use of herbal medicine such as *oregano* for fever. The generic medicine being sold at their community pharmacies also provided options for the urban poor.

As a result of PIM Level 1, the following changes were noted:

- The participants saw the need for cooperation with other members of the communities to address problems and issues that affected them. Previously, they took individual actions, for example, the Botika ng Barangay rather than community action.
- With the shift from individual towards collective approach, the participants slowly developed trust with other members of the community. Normally, they would not share issues and stories about their families especially regarding diseases that would create stigma for them and their families, but in the course of the training, the participants shared experiences and stories about their personal lives.
- The PIM training created a venue for mutual respect where one listened to another's point of view. At the start of the training, the participants would "compete" by talking loudly with a tendency to judge other participants. In the end, they would listen intently to one another and would be extra careful in their choice of words to avoid hurting their co-trainee.
- The place of PIM in the BNB set-up started to take shape. At first, they were very apprehensive on the direct effect of PIM, that is reducing the income of BnB. After a few days, community service as a motive became more predominant.
- Their attitudes regarding herbal and integrative medicine also changed, from dismissing it as "self medication" and unreliable, to becoming more appreciative of its health benefits. With the discussion on BHST, they gained enough knowledge and confidence to share their own experiences and added their own knowledge on the use of herbals. This is in contrast to their attitude at the beginning of the training wherein they would laugh at or ridicule some members using medicinal plants.

These changes were further enhanced when they were gathered again for PIM Level 2. In PIM Level 2, the training team walked them through the analysis of the results of the survey and identified the three (3) major problems in each of the communities. To help address the problem of lack of knowledge on health care, a commonly identified problem in all of the communities, the training team facilitated the basic health skills training on the top common diseases identified from the survey.

The knowledge and skills on health and the major problems identified provided the basis for the participants to determine how they saw themselves contributing to the resolution of the problems. They began by identifying their responsibilities as CHWs and from these responsibilities they formulated their one-year plan which became their CHPs. As CHWs, the participants saw themselves giving health education, providing services, treating sick persons in their communities, monitoring the health of families they surveyed, coordinating with their barangay council and leading the community in environmental sanitation. A CHP was formulated for each of the seven areas mentioned earlier and a system of "monitoring" was set-up where the CHWs will gather after six months to update each other on the progress of the implementation of their plan.

By learning the integrative approach to managing common diseases and teaching this to their neighbours through conduct of health education, members of their communities will gain access to healthcare services through their CHPs. Options to take care of their health will be available to them.

The place of BnBs became clear to the participants. Having knowledge on the common diseases from the survey helped them determine what medicines should be readily available in their BnBs, so as to provide options for the poor to consider. Hence, for diseases such as hypertension that would need a medical referral, the BnBs would be in a position to make these medicines available at cheaper prices as a service to the community,

4. SINACABAN PIM Level 3, Municipality of Sinacaban, Misamis Occidental
October 3-10, 2010

The PIM Level 3 in Sinacaban, Misamis Occidental was INAM's second PIM Level 3 since we started conducting PIM trainings in February 2008. The first PIM Level 3 was conducted with Quidan Kaisahan of Negros Occidental. Thus, this experience was a learning opportunity for the training team because it helped refine the prerequisites of PIM Level 3 and what needs to be put in place in PIM level 1 and 2 so that the materials needed to facilitate PIM Level 3 would be available i.e. PIM Level 1 and 2 experiences, records, one-year implement-ation of CHPs; that is conducting PIM I and 2 from the perspective of PIM Level 3. The experience highlighted the value of having sufficient information and proper documentation to arrive at appropriate decisions for the training.

Sr Dulce facilitating PIM Level 3 training for Sinacaban CHWs

The training in Sinacaban is also INAM's first PIM partnership with an LGU to successfully progress from PIM Level 1 to PIM Level 3. The Municipal Health Officer has been very supportive since PIM Level 1 and the completion of PIM Level 1-3 training already ensured access to health services delivered through the CHPs and referred to the RHU.

24 participants came to attend the training, with ten not having completed PIM Level 1 and two not having either training in PIM Level 1 nor PIM Level 2. The material needed to facilitate PIM Level 3 were the experiences of the CHWs from PIM Level 1 and PIM Level 2, including the one-year implementation of the CHPs. Thus, it was important that participants attended both PIM Level trainings and had experiences in implementing their CHPs.

Because of the gap in the experience of the participants, the team decided to conduct separate sessions. The 12 CHWs who completed PIM Level 1 and PIM Level 2 proceeded to PIM Level 3. A separate session was conducted for those who completed PIM Level 2, so that they could catch up and learn the PIM Level 1 knowledge and skills they needed. The training team facilitated simultaneous trainings and during the last day of PIM Level 3, the CHWs who have finished their PIM Level 1 and 2 trainings were integrated into the PIM Level 3 training. However, only those who have completed the PIM Level 3 sessions were considered as CHP Managers.

The training team faced with many challenges in the course of facilitating PIM Level 3. While Barangay CHPs were formulated in PIM Level 2, the RHU decided to implement them on a catchment basis (a group of barangays/communities, make-up one catchment) with the Rural Midwives of the RHU supervising the implementation instead of the CHWs themselves calling the shot in the implementation. The CHPs became channels for implementing the programs of RHUs. Secondly, there were barangays with only one CHW present in the training.

Sinacaban CHW sharing his views during PIM training

Considering all these, the training team walked the participants through the management cycle and helped impressed upon the CHWs the knowledge and skills they acquired from PIM Level 1 and 2 and in the implementation of their CHPs. One-year records on treatment of patients, health education and meetings of CHWs were presented to illustrate monitoring and its importance. The records also provided information to evaluate the CHPs. From the evaluation, recommendations to further enhance the CHPs were identified by the CHWs. This helped bring into the consciousness of the CHWs the importance of organizing the 880 households surveyed into family clusters to ensure effective and efficient implementation of their CHPs. For instance, instead of gathering the 880 households together to conduct health education, the CHWs can conduct the health education in their family clusters. This ensures that every household is able to access the health services being provided by the CHPs. The same holds true for treatment of sick members of the clusters. Every member of the family cluster is taken cared of.

The training also helped the CHWs clarify the relationship of their CHPs with the RHU. The Rural Health Midwives assigned in each of the catchment will coordinate the programs of the RHU through the CHWs in each of the catchment.

After five days, five Community-Managed CHPs were set-up in each of the five catchments in Sinacaban. Each CMHP is being managed by 2-7 CHP Managers.

In the exit meeting with the Municipal Health Officer, the training team shared the results of the training, the difficulties encountered and recommendations. It was recommended that to facilitate clarity in the relationship of the CHWs with the RHU, a PIM Orientation can be conducted for the RHU staff. Also, since one of the recommendations was to improve the conduct of the health education using the process and format introduced by INAM, a training on facilitation of health education can be conducted for the Rural Midwives and other staff of RHU. In this way, the capability of the RHU is also enhanced and they will see the work of the CHWs as complementing their work at the RHU and not as competitors.

INAM, in addition, clarified from the MHO her vision of the CHPs and opened the possibility of the CHPs being integrated into the Municipal Development Plan so that the major problems identified from the household survey are addressed. In this way, the CHP becomes the vehicle for community development and community participation is ensured through the CHP.

The Sinacaban PIM Level 3 experience provided insights on how PIM Level 1 and Level 2 are being conducted and therefore served as basis for the department to revisit the PIM Facilitators' Guide and the staff's experiences in facilitating PIM 1 and PIM 2.

5. KFLC PIM Level 3, Jolo, Sulu

January 27-31, 2011

PIM Level 2 in Sulu Province was conducted two years ago and despite several postponements, PIM Level 3 was finally conducted on January 28-30, 2011 with 12 CHWs from 4 barangays of Patikul and Jolo municipalities participating. Twenty-one (21) CHWs originally came to attend the training but since only 12 had completed PIM Level 1 and PIM Level 2, only they were qualified and were permitted to take the training.

The training team felt that the requisites of PIM Level 3 were already made clear to the partner during the PIM orientation with KFLC in September 2010. In fact, part of the plan of KFLC was to convene a CHW Assembly to determine the status of CHP implementation and prepare for PIM Level 3. Allowing this incident to pass as if agreements were not made would not help KFLC be more responsible and accountable to the partnership.

It was gathered from the consultation with the staff of KFLC and the CHWs themselves that KFLC channels the implementation of its programs through clusters and areas that composed the clusters. For instance, a cluster was composed of several areas and these areas included different barangays. Hence, there were clusters where the CHW belonged to the same barangay but not necessarily in the same area.

However, clustering was based on the availability of the KFLC staff known as community mobilizer. If a community mobilizer resigned, the cluster also ceased to exist and the areas that composed the cluster were integrated into other active clusters. The initial activities with the CHWs revealed that the CHPs drafted during PIM Level 2 were not implemented as designed. However, CHWs conducted activities as individual CHWs belonging to a particular cluster and not as part of CHPs. Hence, there was lack of material in terms of the implementation of the CHP. The training was therefore redesigned and after recalling the knowledge and skills gained from PIM Level 1 and 2, as well as the responsibilities of a CHW, the training proceeded to the reorganization of cluster CHPs into Barangay CMHPs. The CMHPs served as springboard to discuss *Implementation*, *Monitoring* and *Evaluation* as important phases in the management cycle.

The training team also opened the possibility of Jolo CHW Assembly to provide a venue for the exchange of experiences and evaluation of the CHPS.

After 4 days of actual training, consultations with the partner before the training, in between and after the training, twelve (12) CHWs finally completed the course and became CHP Managers with each CHP Manager having clear responsibilities to their CMHPs and family groups or *tumpukan.* In the end, 3 CMHPs were formed, namely CMHPs of Gandasuli and Latih in Patikul and San Raymundo in Jolo.

A CHP manager discusses the new plan for their CHP

The experience with KFLC provided insight and learning in terms of partnership - that is preparation for trainings is dependent on the level of consciousness of the partners in terms of understanding the PIM Curriculum, its prerequisites and process. We cannot exact from the partner what it does not fully understand.

Another insight derived from the experience is when we are able to learn from our experience, we become consistent in our actions. The prerequisites INAM now requires for PIM trainings were derived from the experiences of conducting PIM trainings. Our experience taught us these prerequisites.