



Institute of Social Studies

Graduate School of Development Studies

**GENDER AND PRODUCTION OF SUBJECT POSITIONS:
How Community Health Workers in the Philippines
Locate Themselves in their Social Worlds**

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DEDICATION

PAST

In memory of a great woman,

Victoria, my grandmother.

PRESENT

To my mother, *Tarcela* and her sisters- *Carmela*, *Virginia*, *Felina*

To *Jem*

One special woman and a friend

To my sister, *Perla*

FUTURE

To my niece, *Denise Vera*

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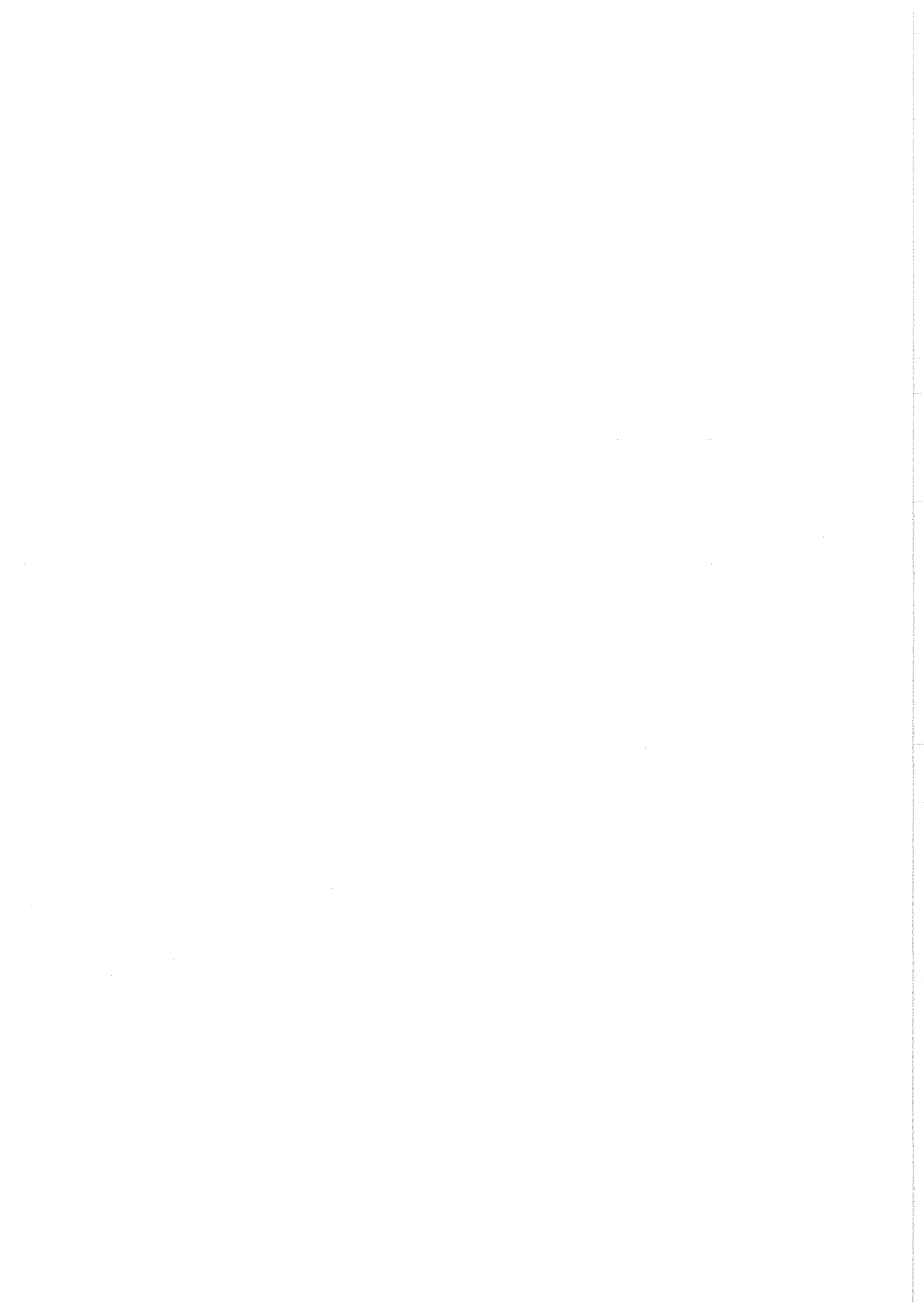
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LIST OF ACRONYMS

BHW	Barangay Health Worker
BHS	Barangay Health Station
CHW	Community Health Worker
CHO	City Health Office
DOH	Department of Health
LGU	Local Government Unit
LIKAS	Lingap para sa Kalusugan ng Sambayanan, Inc.
NGO	Non-Government Organization
PHC	Primary Health Care
SBHWFI	Sorsogon Barangay Health Workers Federation, Inc.
WHO	World Health Organization
WHSMP	Women's Health and Safe Motherhood Project



*There is a point where in the mystery of existence contradictions meet
where movement is not movement at all;
and stillness is not stillness;
where the idea and form, the within and the without are united;
where infinite becomes finite, yet not
(Rabindranath Tagore)*

INTRODUCTION

My interest in doing a research on community health workers (CHW)¹ began some years ago when I once served as a documenter in their annual convention. It was a bright sunny day in mid-March and more than 2,000 participants, mostly women between late 30s and 60s, were cramped inside a college social hall. Community health workers, coming from different parts of the province, gathered to rekindle their voluntary commitment in community service. They listened to speeches of invited guests and political leaders, and were informed by state agencies how to claim their benefits and rights. They also sang and danced, ate their packed lunch together, and drew raffle tickets for take-home prizes.

Meeting them as a group on that day left a lasting impression on me. When I first saw them I thought, ‘Wow, these people can elect our next governor!’ They were enthusiastic and proud doing their work, even though they are considered volunteers. The ‘volunteer’ aspect of their work was the tiny flame of inspiration - and challenge - that brought to life my interest about this topic and served as my starting point in doing this research.

SOME PRELIMINARY THOUGHTS

At the early stages of the research process, I began exploring this specific interest with questions such as, “If doing community health work is voluntary - meaning, they do not get a wage or salary but maybe, some incentives - why are these women (and some men) doing it? Don’t they need money for their families?” I found it perplexing that poor people would willingly render community services without monetary remuneration when they could use their time to earn money for their families’ material needs. Therefore, for months, I asked myself: “Is community volunteer health work an issue of empowerment or exploitation?” On one hand, I thought that they must be exploited because they engage in volunteer work² and most of them are women³. On the other hand, women CHW might also be empowered because they are able to participate in

¹ Community health workers are known as *barangay health workers* (BHW) in the Philippines. They comprise 72% of the total health workforce (DOH,n.d.). Throughout my discussion, I will use CHW, except when BHW is specifically used in official documents, organization titles and in quotes of my informants.

² Volunteer work is one of the sectors where women’s unpaid work is underestimated and invisible in the labour force and national income statistics (Beneria, 2003:134). It refers to work “whose beneficiaries must not be members of the immediate family...there cannot be any direct payment- it is unpaid work by definition, and the work must be part of an organized program” (ibid: 138).

³ Health work is informed by patriarchal ideas which socially construct women as naturally endowed with caring capacities (Misra, 2003:2) Because of this, women’s participation in the health sector, either paid or unpaid, is extremely high but ironically, ‘acutely undervalued’ (Folbre in Misra, 2003).

community activities, outside the confines of their homes. Unsure and tired of the endless debates going through my head, I decided to use the Research Paper to re-think this question.

To avoid simple 'empowerment/ exploitation' dichotomies, with which I started thinking about CHWs, I use the concept of subjectivity, focusing my research on struggle for subject positions and transformative politics in lives and engagements of CHWs from a southern province in Luzon, Philippines. I studied how they locate themselves in the intersections of unequal social, political, cultural and economic practices and power relations, and what their locations within these power relations mean for their engagements in transformative politics. My starting research questions are:

1. How are 'subject positions' of community health workers produced? In the context of which social, political, cultural and economic practices and relationships of power do CHWs become subjects?
2. What are the spaces within which CHWs locate themselves as health volunteers, and what strategies are used to enable these locations? Are there emancipatory and transformative potentials of these locations?

For an operationalization, these questions are further specified into inquiries how CHWs position themselves – individually and as organized in associations - within the following domains:

- The family and household relationships and responsibilities
- The communities in which they volunteer;
- The field of health care to which they belong; and
- The state (from national to local levels) that gives larger organizational and political, as well as more immediate local framework of their work

RESEARCH OBJECTIVES, RELEVANCE AND JUSTIFICATION

Theoretically, this research aims to contribute to the field of feminist theorizing on subjectivity. The concepts of 'subject' and 'subjectivity' are contested in feminist philosophy, social and cultural theory (Weedon, 2003:111). I define the struggle for subject position by the marginalized and excluded groups as a struggle to produce knowledge about oneself and one's perspectives of the world, and one's own realities; to acquire political recognition and representation; and to retrieve one's own history. Starting from the lives of the marginalized provides a possibility for valuation of reality, which holds the potential of challenging dominant norms, ideologies and

practices, which impinge on the everyday lives of women and men. Investigating the process through which subject positions are produced necessarily raises the question of how to subvert hegemonic power, resist, redefine and transform dominant power relations. Thus, this research aims to provide a discursive opportunity to identify spaces for empowerment and transformation, as much as it aims to make a contribution to the rich literature on feminist theorizing about women's and men's subjectivity and its implications on the social project of emancipatory and transformative politics. I also hope to contribute to the actual political struggles of women and men engaged in the community health work, for social recognition and transformation of their current undervalued status.

RESEARCH METHODOLOGY, METHODS AND DATA

In order to find answers to my research questions, I conducted semi-structured interviews⁴ with CHWs in one community in Bacon District, Sorsogon City, Sorsogon, Philippines from July to August 2007. To capture a wide range of diverse experiences, I used criteria such as sex, age and length of service in choosing the group and the community where I did my fieldwork.

I talked to 17 CHWs⁵, fifteen of whom are women. Nine of my informants are below age 65. Most of them reached secondary education, have served for less than 5 years as CHWs. Eight of my informants are above 65. Most of them finished elementary education and worked for more than 20 years as CHWs. Unlike the younger CHWs who are primarily motivated to earn a living for their family, the older CHWs rely on their husbands' pension benefit or grown-up children for economic support. The two male CHWs are in their mid-50s and are the primary breadwinners. One of them finished elementary school and has served for 24 years while the other is a graduate of a two-year secretarial course, has worked for 17 years and is currently the president of the CHW association at the district level.

Most of the interviews were individual, but I conducted also a group interview in the community health station. With their permission, I recorded almost all of my individual interviews. The length of my formal individual interviews with each of them varied, ranging from 30 minutes to more than an hour but the time spent with each person was much longer. I became a frequent visitor of the health station, and talked with them and observed them while they worked. I visited some of their homes after work or during weekends to talk with their families, or continue my interviews, and ask questions, which they seemed uncomfortable to answer while

⁴ See Hancock, B. (1998) on doing qualitative research

⁵ See Annex1 for detailed Profile of Community Health Workers

we were in the health station. One rainy morning, I also joined Remy, one of CHWs, in doing her neighbourhood round to monitor the blood pressure of some patients. During my fieldwork, I also kept a journal with my field observations and insights.

Talking with individuals and group help me understand the different meanings of community health work and how CHWs are positioned in the various social fields. Besides, I interviewed the rural health midwife (RHM) who serves as the immediate supervisor of the CHWs, official representative of the city health department in the community; the doctors and nurses who, although indirectly interact with CHWs, set the policies and guidelines which frame how CHW will perform their work; the City Mayor who executes and approves the policies legislated by the local council on health matters including issues of CHWs e.g. incentives; community leaders and members who serve as beneficiaries of the CHWs' services; the NGO representative which assists in building the capacities of CHW associations; and CHWs' family members.

To observe how CHW, as an organization⁶, position themselves within their group, in relation to the state, the health care system and the NGO, I attended various meetings of officers and members of CHW associations and conducted focus group discussions at the district, city and provincial federations' level.

I reviewed secondary sources such as Republic Act 7883, also known as Barangay Health Workers' Benefits and Incentives Act of 1995; Constitution and By-Laws of various CHW associations; the Manual of Operations of the Sorsogon Provincial CHW Federation, Inc. and the project evaluation and documentation reports of the NGO.

Throughout my research, I used feminist standpoint methodologies (Harding, 2005), taking my key informants' knowledge about their own situation and thus should be the starting point of the research. I tried to build an open, interactive and non-hierarchical relationship with them as suggested by Oakley (2004)⁷. As a result, this research became a form of sharing of personal stories and the way I related with them formed part of the context of this research. In addition, this brought up some ethical and political dilemmas.

One of the questions I asked myself during the research was: "Can I be a researcher and a policy advocate at the same time?" During my fieldwork, I attended a special meeting of city health officials drafting a policy proposal, to 'professionalize the standards of CHWs.' I was not

⁶ See Annex IV for the CHW organizational structure

⁷ See Hammersley, M.(2004) on his question about the non-desirability of the principle of non-hierarchical relationships between the researchers and researched

invited but relying on the fact that I knew most of them personally and they knew that I was doing a research on CHWs, I attended the meeting. I was there as a researcher but at the same time, I also carried with me my identity as an NGO worker with whom they previously worked with and would continue to engage with, in the future. They were not hesitant to ask me to write the minutes of the meeting, which I did. They also asked me to give some inputs. I could have explained the implications of the policy, after having talked with the CHWs, but I simply sat there and listened to what they were saying and held on to my role as a researcher. Afterwards, I asked myself, have I missed one great opportunity to advocate in behalf of the CHWs? If I had spoken up, city health officials could have listened and included my points of contention in the new policy⁸.

Authors such as Back & Solomos (2004) addressed this issue when they compared their approach to Ben-Tovim's work on politics of race. While Ben-Tovim intimately links research with pressure group politics in such a way that 'researchers should be activists and activists should be researchers and a research should be placed in the forefront of a political action' (Back & Solomos, 2004:475), they contend that the 'ultimate position which places [researchers] as advocates is deeply problematic' (Back & Solomos, 2004 :476) I share their position that research should be a politically engaged scholarship. Research is a political process and it should be politically useful and relevant⁹. Research can be purely an academic exercise or an intellectual pursuit but it is an essential element of every political action. Not all researchers are activists but all activists are called researchers (wherever they are) to inform their emancipatory strategies. I was confronted with both roles during my fieldwork and I chose one over the other. In that particular circumstance, I was there as a researcher with a specific purpose: to understand what city health officials think about CHWs in an open, comfortable, non-confrontational venue. My 'activist' role made me an 'insider' and I believed that I used it well enough to fulfil my role as a researcher. Despite feelings of disappointment, I learned that the purpose, context, and timing are important considerations when one assumes the dual roles of an activist and a researcher.

As to the limitation of this study, I did not aim to provide a generalization of the overall situation of CHW in the Philippines. The purpose of my study is to provide a glimpse into a slice of the reality lived by selected CHWs, to tell their stories with as much faithfulness to their words and meanings as possible, and to analyze them from my own standpoint and theoretical, methodological and political perspectives.

⁸ The new policy is now approved and subject to implementation.

⁹ See Weiss, C. (1979, 1986) article on the different uses of research

This paper is written and organized not only to present the answers to my research questions but also my own experiences in doing this particular research. As Harding (2004:461) argues, a researcher in feminist analyses does not appear as an 'invisible, anonymous voice of authority, but as real, historical individual with concrete, specific desires and interest.'

Chapter II presents CHWs in the context of the family. Chapter III deals with the different communities CHWs engage in. Chapter IV examines the engagement of CHWs in the local political systems. Chapter IV ties up the key findings and serves as a concluding chapter. But, first, Chapter I, with the theoretical context within which I position my research.

their communities, and families as produced through, and further producing, specific masculinity and femininities.

RETHINKING AGENCY AND SUBJECTIVITY

Before I went to the field, my understanding of the concept of 'subject' was that of an 'agent' as a 'subject of free will, the subject that determines his place in life that forges his destiny that decides to be free' (Hekman, 1995:202). A subject, who is governed by reason, exercises free will and is capable of action. With this, I expected to meet CHWs who are 'activists': organized, aware of their rights, empowered as they collectively fight against a system such as the state or the health care organization, which they perceive as oppressing them.

This initial conceptualization is a modernist definition of a subject, rooted in the humanist-liberal tradition (Weedon, 2003:113). A subject that has an essential 'I', produces knowledge and transcends historical, social and discursive influences. This view of a subject assumes that subjectivity is unified and rational and identity is unitary and hierarchical. 'It deals with identity in terms of "difference": the identity of masculine/feminine is different from its opposite' (Hekman, 1995:201). It also presupposes clear-cut distinctions between the margin and the centre where some are included and others are excluded. Paradoxically, this understanding of the 'agent' is linked to the understanding of a 'victim' - exploited victim who either suffers or are turned into active agents and fighters against their exploitation¹⁰. This is how I perceived CHWs when I went into the field: exploited, vulnerable and unable to free themselves from the clutches of the powerful. From the modernist perspective, they would not deserve the label of a 'subject'. (Hekman, 1995:202)

Nonetheless, during my fieldwork, I was continuously confronted by a rather different 'subject': one whom I cannot easily classify as either an activist or a victim. Following Hekman, and my struggles in the field, I call now such subject a 'discursive subject' (1995:197) This is a subject that is both constituted and constituting, 'a product of the fluctuating, changing and often conflictual historical and social influences that impinge on it' (1995:201). This is a conceptualization of subject, which displaces the 'activist/victim' dichotomy, and assumes that subjectivities are multiple, complex and fluid:

The discursive subject posits subjectivity based on differences, not difference, a heterogeneous, plural, non-hierarchical identity that is not essentialist or constructionist, but a displacement of that opposition. This discursive subject does not result in the elimination of the identity of

¹⁰ Another view of a subject is that of a 'social dupe': a constituted subject, a product of the forces that structure societal institutions.

women, but in replacing 'woman' with women whose differences are not erased (Hekman, 1995:201).

A discursive subject redefines agency. Agency which 'does not entail a reference to a prediscursive "I", but requires that subjects find agency within the discursive spaces open to them in their particular historical period' (Hekman, 1995: 202). In this understanding, '[a]gency is created by the discourse of that subject, that is, that it enables those who employ it to speak as agents' (ibid). Exercise of agency entails the use of tactics provided to us by the discursive mix that constitutes our social existence (Hekman, 1995:203).

The redefined understanding of creativity suggested by the discursive subject entails that subjects piece together distinctive combinations, that is, individual subjectivities, from the discursive mix available to them. Subjectivities are products of the discourses present to subjects, not removed from or preceding them..... Agents are subjects that create, that construct unique combinations of elements in expressive ways (Hekman, 1995:203).

In short, such conceptualization of agency and subjectivity means that they are in continuous and conflictual process of constitution, that being an agent/a subject is a continuous work in progress. This resonated very much, with what I saw in the field, and was relevant for my analysis. Such conceptualization, furthermore, leads to specific understanding of power.. Power, according to Foucault is exercised, dispersed, bottom-up, and productive as opposed to being (only) centralized, top-down, hierarchical and repressive (Sawicki, 1991:20-1). It is not only located in class, state or law but also in the body, sexuality and knowledge. This allows us to 'give an account of how subjects are *constituted* by power relations' (Sawicki, 1991:21; emphasis P.F), and not only oppressed. Through practices of disciplinary power, which are exercised on the body and soul of individuals, the power of individuals – as a capacity to define one's world and act in it – is increased at the same time as it renders them more docile (Sawicki, 1991:22).

Individuals are subject to disciplinary power, which is exercised over them and subtly and insidiously constrains their choices, desires and actions and at the same time, they are made into subjects by disciplinary power, which creates various positions and incites individuals to take them up (Allen, 2000:123).

Starting from the lives and experiences of CHWs, this study analyzes the production of subject positions of CHWs in the nexus of labour, production and reproduction as discursive and social practices. The voluntary nature of community health work is situated at the intersections of private and public spheres, paid and unpaid labour, production and social reproduction, blurring the clear-cut definitions of each sphere, and their oppositional dualities, as well as depending on them. Relations and discourses of gender are probably most indicative in this context. Scott (1999: 42-4) defines gender as a 'constitutive element of social relationships based on perceived differences between the sexes. It involves four interrelated elements: culturally available symbols

that evoke multiple, contradictory representations; normative concepts that set forth the interpretations of the symbols; social institutions and organizations and; subjective identity'. Gender is also a 'primary way of signifying relationships of power' (ibid: 44). This means that subject positions of the CHWs are gendered, immersed in the institutional and symbolic relations and discursive practices of the work they perform, and social contexts within which this work is given meaning: the family and the community, the professional structures of health care and the political structures.

Chapter II: Being a Community Health Worker in the Family

THE FILIPINO FAMILY

Family¹¹ is one of the discursive sites where gendered power relations are exercised. Governed by dominant notions and practices of masculinities and femininities, it prescribes what is acceptable, or not, in familial relationships. It dictates who is, or what makes an 'ideal' mother/father, wife/husband, daughter/son. Conformity with these social practices will produce approval, social recognition and acknowledgement from within the family members and the community in general.

There is a Filipino legend, which tells that both men and women emerged simultaneously from a bamboo branch. Unlike the Judeo-Christian explanation of Eve being created from Adam's rib, this story is interpreted as illustrating the equality of Filipino men and women. Thus, compared to other Asian families, authority in Filipino families is deemed 'not patriarchal, but more egalitarian where husband and wife share almost equally in financial and family decisions' (Agbayani-Siewert & Revilla, 1995:160)¹². This however does not mean that a man and a woman are equal in all aspects of family life, or that they are expected to perform the same roles.

As husband and father, a man is the '*haligi ng tahanan*' (pillar of the house). As such, he must be strong because he holds the house upright. He is the main breadwinner and must be able to support his family. In the Philippine Roman Catholic marriage rites, this breadwinning role of the man is symbolized by the groom giving *arrahae* or wedding coins to his bride¹³. As a wife and a mother, a woman is the '*ilaw ng tahanan*' (light of the house'). Sometimes, she is also referred to as the heart of the home because she provides love, care, and affection to her husband and the children. She is primarily responsible for the care of children and managing the household. However, due to increasing economic pressures on the family, Filipino women also help their husbands by supplementing the family income. Grown up and young children, especially girls, are trained to help their mothers in housework like cooking, cleaning and taking care of younger siblings while boys do the physical work outside the house such as fetching water and feeding the animals

¹¹ I recognize that family is not a homogenous entity and is not only a site of cooperation but also of conflict.

¹² <http://www.livinginthephilippines.com/philculture/family.html>

¹³ <http://www.weddingsatwork.com/unitycoins.shtml>.

Although in this division of duties and responsibilities the father is perceived as the main authority figure in the family, the mother wields considerable influence. She generally controls the finances, works full time even when there are growing children and perhaps, earns more than half of income for the family. Both parents have the duty to provide for the material needs of the children. In turn, Filipino children have the duty to respect, obey their parents and take care of them when they grow old.

The Filipino family is not limited to the nuclear family but is extended to a bilateral kinship system. It is further enlarged by the *compradrazgo* system, a Spanish colonial legacy.¹⁴ In addition to relatives by blood and marriage, Filipino families gain relatives through godparent rituals. Godparents are typically wealthier and well-known acquaintances, close friends, or neighbours of the parents who may include politicians or *balikbayan* (overseas Filipino worker on vacation). They act as sponsors of children during religious ceremonies such as baptisms and weddings and may assume the role of benefactors who may be expected to participate in providing spiritual and moral guidance to their godchildren, assist the family in time of financial need, contribute to the child's education, or assist in securing his or her employment. In addition to the *godparents*, employers and landlords may further be viewed as surrogate parents to adult family members. 'The *compradrazgo* system extends and binds family ties, loyalties, obligations, reciprocity, and interdependence among people in the community¹⁵'.

In the Philippines, like in many other places, family is central to the life of the individual as a 'source of one's personal identity and of emotional and material support; it also is the focus of one's primary duty and commitment'.¹⁶ 'Reliance on the family for love, support, and refuge has historically been as much an economic necessity as it is a cultural tradition. However, the relationship to family is not just a practical trade-off of autonomy for social security. It transcends socioeconomic, educational, and regional differences and is part of a collectivistic cultural orientation or way of perceiving the place of the individual in the social context' (Santos, 1983; Gochenour, 1990)¹⁷.

The relationships between and individual and the family, the positioning of this relationship within the wider social context, and gender dimensions of all these relationships are relevant for how community health workers perceive themselves and their work. Throughout the interviews, CHWs reflected on their work from within their familial relationships and

¹⁴ <http://www.livinginthephilippines.com/philculture/family.html>

¹⁵ <http://www.livinginthephilippines.com/philculture/family.html>

¹⁶ <http://www.livinginthephilippines.com/philculture/values.html>

¹⁷ <http://www.livinginthephilippines.com/philculture/values.html>

responsibilities. These family relationships and responsibilities were related to the community health work in many different ways, depending on the person's gender and age.

BEING A COMMUNITY HEALTH WORKER IN THE FAMILY

Community health workers hold different views and feelings about themselves and the work, they do which conform, challenge, or extend the dominant notions of being a man or a woman in their family and community. These views and feelings are linked to dominant notions and practices of being a 'man' and a 'woman' in the family, and the expectations to fulfil the prescribed role of a husband and a wife, a father and a mother, which are crucial for the views and feelings of community health workers about their work and experiences.

'I am happy because my life is not only confined at home', Joy, one of the CHW told me. As a wife and a mother, Joy is aware that it entails staying in the house to take care of her children. From her statement, doing community work is a respite from the drudgery of domestic work. It can also be seen, however, as extending the woman's mothering role. Community health work then, offers women the opportunity to exercise their own power and influence and gain the esteem of others, by extending the dominant notions of being a care-provider within the confines of the home to the larger community.

Effects of power relations, emanating from acts of negotiations of one's place within the family and community can be manifested in different ways such as combining familial roles and community work, exchanging the breadwinner-homemaker roles assigned to husband and wife, or family bonding and solidarity. For example, women CHWs often bring small children to seminars or meetings. This reflects the expectations that while women's community work is important, their primary role is to take care of the children. However, one of the younger, female CHW told me: *'When I have a duty in the centre, my husband takes care of the children'* (Joy). This reflects flexibility of the husband-breadwinner-outside home /wife-housewife-stay-at-home-mother roles. A statement: *'My granddaughter helps me in preparing my reports'* (Mercy) shows yet another set of intersection between work and familial trans-generational relationships of help and care. She has blurred eye vision and receives help from her granddaughter.

Thus, the 'family work' - the effort to comply with dominant expectations or to expend the space for different ways of being a (grand)mother or a wife, a father and a husband - and the community work are continuously compared, contrasted and negotiated. As the following excerpts show, for women, this struggle mostly centres around their duties of motherhood and home keeping; for a man, the struggle is mostly about the role of breadwinner and authority:

My children said it is ok [for me to work as BHW] because there are no more young children (Eda)

My husband said it is ok but sometimes I cannot attend to the household chores. As for example in October, we will conduct a survey, we will be out of the house almost everyday. (Miranda)

These statements seem to show that women CHWs need a 'permission' of the family to invest their time in community health work. This tells how hugely important family is as a site within which women get social recognition. To be a good mother and wife, one has to perform these roles in the recognized ways. Therefore, the statement about the household chores may mean that the husband sometimes complains about it; however, it may also mean that the woman herself feels that she is not doing 'proper work' at home as well as is expected of her as a wife and mother. If the role is performed differently than prescribed, there has to be a justification, explanation, and obviously, permission from the family members, as well as from oneself. Women CHWs seem to have often gotten these (self-)permissions (more or less) because they, and their family seem to be getting something else—a sort of benefit— in place of 'regular' mother/wife performances: *'It is alright with my husband because it helps us in the family'* (Joy).

Dominant power relations that assign specific family roles to men mean that men too must negotiate being a CHW within their families, as the following quotations show:

Sometimes she [wife] also gets angry when (because) there are things that need to be done at home and I have work to do. I just explain to her that I do not stay the whole week in the centre, anyway. My children, though, seem to be proud that even though their father does not earn any salary, he is BHW; and he does it for public service. (Filomeno)

This statement shows how manhood is associated with breadwinning and particular type of work in the house. To be a breadwinner and be able to care for the economic needs of the family is a source of man's pride. If a man does not perform his role as a breadwinner, it is a cause for shame¹⁸. In this statement, not being a breadwinner is compensated for by being recognized by the children as doing something good for the community. For this particular CHW, the work offered a sense of personal worth in the eyes of one's own offspring that linked family and the community:

What if in the future, my grandchild asks me "Grandfather, what have you done for our community during your time?" Then I can tell him that I checked and monitored the blood pressure of people in our community, informed pregnant women of our monthly immunizations. I can also show him my certificates from the trainings I attended." (Filomeno)

Family members of CHWs express many views about community health work and its value for the CHWs, and the family. Spouses of the CHWs often view its value from the

¹⁸ see Silberschmidt, M (2001)

perspective of the family and the material and other benefits they can derive: *'It is good because it can help us in our livelihood, even though it is not too much.* (Miranda's husband, also similarly articulated by Joy's husband). This is an ambiguous message from husbands who acknowledge the financial/material benefits of their wives' work as CHW but at the same time, note that it is not helping much. Such ambiguities are also present in the words of Veronica's husband, who says:

It is good because she gets [physical] exercise and will not have high blood pressure. Although I told her to stop working [as CHW] because of the issues about their honorarium [monetary benefit]

Here, the health benefit of a woman stands in contrast to the lack of material benefit to the family. In other cases, there is a trade-off of individual and family benefits. Filomeno's wife notes: *'We can ask for free medicines'*. Therefore, even if her husband is not doing his household chores, and is not bringing salary, his work provides another form of family support. Felomino's wife further says:

Sometimes even when there are things to be done here at home, he prioritizes his work in the centre. He was already hired in the past to work but what can we do? He wants to be a BHW

She seems resigned to the fact that she cannot do anything to convince her husband to get a 'proper job'. Therefore, in many ways, it seems that community health workers – men or women – are the ones to make a decision about engaging, and staying on, in the community health work. Miranda's husband's words confirm this: *'Whatever she decides, it is fine. If they will no longer have their honorarium, she can decide to stay. Or if she can find another job, she can also leave'*.

These statements reflecting the views of the spouses of CHWs are continuously negotiated to conform or alter how these family members view community health work, which in turn, influences how CHWs position themselves in relation to their spouses and families, and their performance of work within the family and the community. Interestingly, unlike the spouses, children seem to view the value of community health work from the perspective of CHWs, and not (only) the family.

[Her work] is fine with me because she enjoys it. The problem, she works more than a government employee. As early as six o'clock in the morning, she leaves our house to do her rounds in monitoring blood pressure of people who asked her to visit them. Sometimes, even in the middle of the night, someone knocks at our door or calls out her name because there is a pregnant woman who is about to give birth and need assistance. In such cases, she stays outside until the wee hours of the morning. (Mercy's daughter)

It is Papa's (father) joy to serve others. (Filomeno's daughter)

I am happy because Mama (mother) attends training and seminars (Miranda's daughter)

Another interesting family aspect of the community health work is the apparent succession of the CHWs by their family members: 'My daughter-in-law will replace me after I stop serving as BHW,' Amanda told me. I asked how this 'replacement scheme' began and was told by the provincial federation president told me that he first tried it in his community and shared the idea with the presidents of other CHWs' association. The NGO and the Provincial CHW Coordinator also liked the idea and it became adopted as an informal, unofficial policy of the CHW associations. This practice is a mixture of keeping the benefit and transmitting the skills and knowledge within the family. This is in many ways what family as an institution should do within the dominant practice, especially in the context of mother-daughter/ mother-daughter-in-law transmission of knowledge. However, the 'knowledge' here is not just the dominant one (i.e. learning the role of a mother/ wife, or a father/ husband) but also medical skill, social networks, and engagements which reflect how the community health workers (successfully) negotiated within their families their role of CHW, and how it influences and shapes their relationships in the family and in the community.

We only serve once a week We are also able to exercise (when we do our rounds in our area of assignments). We lasted this long because we are already widowed. It relieves our loneliness when we miss our children. (Teresa)

From this statement, one can see that there is a continuous and dynamic process of negotiation - not only with the others, but also with oneself- as the CHWs continue to reposition themselves in relation to their families. Within different family members even when they are absent, the community health work is seen in a different way, and individual CHWs position themselves differently, depending on how much they have agreed upon, and negotiating successfully the meaning of that work for and within the family. The work obviously has a meaning for the CHW her/himself individually, but it is the meaning of that work for the family (acceptance, value of material or non-material benefit) and within the familial relationships (as a negotiation of the dominant relations and meanings of wife/husband/ mother/father), that has to be established in order for the community health worker to be 'free' to do it.

The analysis above shows that the boundaries between an individual, his/her family, and that communities are not fixed, sharp and distinct – rather, there is a continuous blurring of these boundaries, and the dominant roles and responsibilities of women and men as individuals, within families and communities, are re-negotiated continuously. An individual, a family and a community give meanings to and acquire meanings from each other. Community health work provides individuals a space to acquire new knowledge and skills. As they provide health care to their family, neighbourhood and community, the way they view themselves and the world around

them is constantly changing. One of the most important aspects of these dynamics is the meaning of the `community' itself – for the CHWs, as well as for the others who set the formal coordinates of their work.

Chapter III: Communities of Health Work and Workers

Community health work is defined by international declarations such as *Alta Ama*, national laws such as Republic Act 7883, local state and organizational policies. Within these definitions of health work, there are also specific underpinning assumptions about what is 'community' within which the CHW are supposed to work, and into which they are supposed to engage. At the same time, interviews with the CHW show that 'community' means many different things, and that – depending on where and how the CHW position themselves – they refer to many different 'communities': their own neighbourhood and village and villages where they work; community of their immediate co-workers in their health station; or a larger community of CHW, be it in the formal association or as a group with specific social and professional standing and interests.

A few issues appear to be relevant for defining community work by both the state and the community health workers themselves: their skills and knowledge about health issues; their ability to exercise these in a caring and supportive way when communicating with people in their care; their motivation and the voluntary nature of their work, and the monetary remuneration for this work.

In the following sections, I will first explore the meanings of 'community' in the documents that define 'community health work' and 'community health workers', and then analyze what 'community' means for the health workers themselves.

DEFINING 'COMMUNITY' OF THE COMMUNITY HEALTH WORK AND WORKERS: THE STATE, HEALTH CARE SYSTEM, CIVIL SOCIETY AND CHWS ASSOCIATIONS

Legal regulations and state perspectives

The concept of mobilizing members of the community to deliver basic health services has at least a 50-year history (Lehmann and Sanders, 2007:5). The earliest known CHW programs are the Chinese barefoot doctors and village health workers in Thailand. They serve not only as health auxiliaries but also as advocates and agents of change in the community. This view was reflected in the 1978 *Alma Ata Declaration*, signed by 150 nation members of the World Health Organization (WHO). It formally adopted the primary health care (PHC) as an approach to expand the accessibility of health services in communities particularly in developing countries, where professional medical interventions are not available or are inadequate. As a 'Health for All' strategy, PHC approach rests on the principles of *participation* which promotes self-reliance and determination of communities in maintaining the health and well being of their population; *inter-sectoral collaboration* among different stakeholders on health care and management; *equity*,

which takes into consideration the structural causes of ill-health such poverty, unequal power structures and gender gap (WHSMP, n.d:13). The primary health care (PHC) approach marked a paradigm shift in the concept of health and health care service delivery by redefining it as not exclusively the domain of the health care professionals, but also of others sectors in the society such as the state, the civil society and the community.

According to Kabeer & Raikes(1992:1), the “notion of ‘community’ [primary health care] sought to incorporate was never clearly spelt out” Thus, what are the meanings and assumptions about ‘community’ underpinning the PHC approach? PHC approach seems to assume a notion of community criticized by many authors. That is, communities which are seen as ‘homogenous, static, harmonious units within which people share common interests and needs’ (in Cooke and Kothari, in Guijt and Shah, 2001:6). Guijt and Shah argue that this, “simplistic articulation of community conceals power relations within ‘communities’ and further masks biases in needs and interests based on terms of age, class, caste, ethnicity, religion and gender” (in Cooke and Kothari, 2001:6). Kabeer and Raikes (1992:1) also maintains that ‘communities are not abstract and homogenous groups of individuals, but rather women, men and children who have different health needs and play different roles in assuring that these needs are met’.

Women who are culturally and socially assigned to be health care givers within their own families become health care providers in their own neighbourhood and locality¹⁹. As Raikes (1992:19) observes, ‘Almost all of the tasks which [a PHC] identifies as ‘essential’ [primary health care services] have traditionally been in the domestic sphere (e.g. health education, improving nutrition, access to clean water, immunization of children, basic care of pregnant women and young children, family planning and provision of basic curative care). A PHC, while stressing the importance of mobilizing local communities to manage health care delivery, assumes that ‘women will provide the resources, the times and the skills for these activities’

Community health workers, as²⁰implementers of primary health care, are expected to perform triple roles as (a) community organizers who will ‘mobilize the community towards self-reliance; (b) [health] educators who will ‘provide knowledge and skills to community members in the prevention and management of simple illnesses’ and (c) health care service providers who will ‘render primary health care services to the members of the community’ (RA 7883

¹⁹ In particular, women come from relatively poor families who cannot afford increasing costs of health care services and sees community health work as source of benefits. (See section on caring for rewards). In addition, women who have lower educational levels as compared to professional workers.

²⁰ Bhattacharyya , et al and Gilroy & Winch identified 34 different titles used to call CHWs in various countries (Lehmann& Sanders, 2007:3)

Implementing Rules and Regulation, 1995: Rule II, Section 8a-c). In my fieldwork, I observed that CHW are performing more of their roles as health care service providers and educators than community organizers. As such, they become more of an additional wo/manpower resource of the public health care delivery system in extending its curative services, instead of assuming a role of promoting the preventive and rehabilitative aspects of medical care and mobilizing the community to become self-reliant (Bautista, 1992:39). This also implies that, instead of making the process of health planning and development community-based and participatory, health care delivery system remains centralized in the health station, focused on curative services and dependent on the technical expertise of the professional health worker. Consequently, CHWs are accountable to these structures, rather than to the assumed 'community'.

Bautista (1992:39) pointed out that "performing the community organizing role is one of the BHW's weaknesses because their training and preparation focuses on promotive, preventive and curative aspects of health". While I observed the same in my fieldwork, I argue that CHWs do not assume this role due to the conflicting assumptions about community.

In Republic Act 7883, community refers to a '*barangay, purok* or zone in a rural or urban are, where a BHW render primary health care services (IRR of RA 7883, Rule II, Section 5h). This definition of community as a specific *geographical* area is what Cleaver (2001:44) implied when she wrote that, 'community' in participatory approaches on development is often seen as a 'natural' social entity characterized by solidaristic relations". If differences based on terms of age, class, caste, ethnicity, religion and gender are acknowledged, there is recognition of the commonality of interests and needs (Li 1996, in Cleaver, 2001:45).

The PHC approach emphasizes "community participation over dependence on doctors and promises not only improved health care for the public but also popular empowerment" (Pesigan, et al., 1992: Foreword). As such, it relies on the notion of community, which is built around solidarity and self-reliance. Communities however are multiple, overlapping and shifting social-spatial sites of differences and conflict. (Cleaver:1999:603). Community organizing should thus involve recognizing the diversity of needs and interests, which govern relationships and dictate how people will relate to each other. If community organizing involves challenging dominant cultural and institutional practices of which CHW are members, their communities are also the places where they derive recognition and approval for their work, and thus they are put in a 'double-bind' position of 'wanting to serve them all' but at the same time, challenging dominant norms and practices on which some of this recognition and approval are premised. Dominant notions of femininity and masculinity in the context of family relations and responsibilities, as seen in the previous chapter, are an apt example.

In conclusion, Cornwall (1998) encourages development practitioners to question assumptions about gender differences in various societies and specific given contexts. Cleaver also states that, “more realistically, ‘community’ may be seen as site of both solidarity and conflict, shifting alliances, power and social structures” (2001:44)

‘Community’ in the health care system

Community health workers perform their duties and responsibilities under the auspices of the Department of Health (DOH), the lead agency of the government, mandated to ensure universal access and provision of quality health care and regulation of providers of health goods and services.

Prior to 1987, Philippines has a centralized public health system, controlled by DOH at the national level. In 1987, decentralization began. From the central level, primary and secondary health service provision was transferred to local district health level. In 1991, through the Local Government Code, health services were further devolved from the Department of Health to the provincial, city and municipal local government units. Preventive care, through the Rural Health Units (RHU) and Barangay Health Stations (BHS) – i.e. community health stations - was delegated to the city/municipal levels while the provincial government took over the management of hospitals at the provincial, district, municipal and community levels. The Department of Health retained specialized hospitals in Metro Manila and tertiary hospitals in the regions. It also retained its regulatory and supervisory functions over local government units and private health providers (DOH, 2004).²¹

Community health workers work in the *barangay* health station (BHS) which is the smallest unit in the health care system structure. A rural health midwife (RHM), assisted by a cohort of trained CHWs, usually heads the BHS. The BHS is administratively under the jurisdiction of the community but it is technically under the supervision of the City Health Office (CHO). The CHO oversees the overall implementation of health programs and services in the area is headed by a city health officer, (a medical doctor) who is appointed by the City Mayor.

The position of the CHWs within the health system affects how they, and their different communities are defined by the health officials. At the same time, health officials, whose concern is to ensure the well-being of the population, seem to hold specific meanings of community and those definitions position CHWs in various ways. Thus, CHWs engage in a process of continuous re-defining and re-positioning their work and its meanings, within the health care system. The

²¹ A detailed discussion about the political and health care systems can be found in Chapter 5

questions of relevance here are not only who is defining CHWs, but also what their interests are, and how they see themselves in relation to those who can meet these interests.

Professional or not, community health workers are seen, by health officials, as members of the health care system. As such, they are also seen as a community, in themselves, in the sense that they constitute a group of health workers. However, Cain and Yuval-Davis ask:

“Is ‘the community’ everybody who lives in a certain area, is ‘the community’ a particular grouping conscious of itself as a grouping or is the community, paradoxically all those who have been excluded from feeling part of the community?” (Cain and Yuval-Davis in Shaw, 2006:6)

Community is also defined to “suggest any or all of the following: common needs and goals, a sense of common good, shared lives, culture and views of the world and collective action” (Silk in Panelli and Welch, 2005:1590). If health care system is seen as a unitary, solid, entity comprised of individuals (professionals and non-professionals) bounded by a common purpose and responsibility, ensuring good health of the population, then CHWs are not only a community in themselves, but also a community with the professional health workers. Nevertheless, this is not really so. *‘They are our partners in the delivery of health care...’* Erlinda, a rural health midwife said about the CHWs. In this instance, CHWs are regarded as ‘partners’ – which assume certain level of equality - in work, but clearly not ‘one of us’. The relationship between the CHW and the health professionals and officials is not always a ‘partnership’. Community health workers are trained by the health officials to enhance their knowledge and skills in carrying out their tasks, and while this set of knowledge and skill is what links health professionals with the community health workers, but it is also something that CHWs have to prove to possess, in order to be accepted: *‘They [CHW] should know what is happening to the households assigned to them.’ (Irene, Public Health Nurse)*

City health officials acknowledge the important roles of community health workers, but more as an extension of the professional health worker. As Irene, public health nurse told me, *‘The work of BHW is important because they are in charge of the neighbourhood’* In this instance, community is seen in spatial terms, the specific place of assignment where CHWs work is based, following administrative-spatial boundaries of a village or a neighbourhood. Defining community, this way is significant for both the health officials and the CHWs themselves. Community is a site where CHWs engage in, as representatives of the health care system - their partners - where they leave the mark of their medical expertise. The credibility of the medical profession depends on these ‘extension workers’ who are under tutelage of health professionals.

For the CHWs, the community is also the place where they display their medical and social knowledge and skills which can bring them recognition and approval from beneficiaries of

their services, as well as from the city health officials. This social-spatial community is the space where CHWs build continued solidarity with, and the belonging to, the health care professionals, as well as the beneficiaries.

Consequently, while being considered part of 'community of health workers', because of commonality of goals, CHWs remain a separate community both within and outside the health care organization. As pointed out by Cohen (1985 in Shaw, 2006:6), one of the classic ironies of the term community is that the assumed unity it implies also draw attention to boundaries and the discrimination they signify: between those 'in' or 'out'. Moreover, as Cleaver (1999:7) puts it, "The very definition of community ... involves defining those who are included in rights, activities, benefits and those who are excluded because they do not belong to the defined entity". CHWs are both included and excluded, depending on the place where they find, or position, themselves, in the complex set of relationships between the health care providers and health care consumers. Firstly, they are distinct from the professional health workers, positioned below in the hierarchal organization because of their lack of, or limited educational qualification, and shorter professional training. Secondly, the level of expertise is related to the fact that CHWs are volunteers. They perform their duties and responsibilities under the auspices of the health care system but they are not part of it, in the sense that they are not considered its employees. In addition, this voluntary – i.e. presumed non-remunerated - position of the CHW has an impact on how they are seen by the health care professionals:

Motivation of some BHW in working has now become more focused on receiving incentives rather than on a sense of initiative and the spirit of volunteerism' (Dr Jake)

Furthermore, health professionals seem to see honorariums and benefits of CHW as a personal favour to them, and not as their right. As the rural midwife puts it, "*If you are a volunteer, whatever is given to you should be enough. If RHM does not receive a hazard pay, why should BHW?*"

Obviously, in performing their work, CHWs have to manoeuvre, moving in and out of different and competing assumptions underlying definitions of their work and their belonging to the communities of professional and voluntary health workers, as well as their beneficiaries.

NGO perspectives on community, community health work, and CHWs

Non-government organizations like the *Lingap para sa Kalusugan ng Sambayanan, Inc.* (LIKAS, Inc; Care for the Health of the People)²²), whose current projects on health involve enhancing the leadership and management capacities of CHWs associations to foster self-reliance and a sense of autonomy, seem to hold a different view about CHW upon which assumptions about ‘community’ can be drawn.

LIKAS highlights the vision for ‘*autonomous and self-reliant organizations championing health delivery to the grassroots*’ (LIKAS, 2006: Rationale) built on notion of a ‘solidarity model’ of community within the CHWs organization, to establish its identity as an independent, distinct entity from the health care organization. It perceives CHWs as a group of individuals who is a partner of the formal health care system, but whose autonomy must be sought and maintained. The WHO definition of CHWs as ‘being supported by the health system but not necessarily part of the [health care] organization’ (Lehmann and Sanders, 2007:3) seems applicable to how LIKAS view and work with CHW. LIKAS recognizes the significant role CHWs. ‘*They are frontline providers of health services; without CHW, health services will be paralyzed*’. It seeks to firm up the capacities of CHWs, not only as health extension workers but also as teachers and leaders in the community. As such, it actively works for the registration of CHW associations to become legitimate people’s organizations, which bear legal personality and thus, can be represented in decision-making bodies such as the Local Health Board. It also spearheads trainings on health, governance and gender to build up the ‘community’ of volunteer health workers. LIKAS acknowledges that ‘While most CHW are women, the provincial federation president is still a man’ (NGO Program, staff). It also recognizes the different fields where CHWs engage and which affect the functioning of the organization. Family and neighbourhood are especially seen as fields where CHWs assume different responsibilities, which may be in conflict with the responsibilities of CHWs.

Oftentimes community health workers, who are mostly women, are overburdened with work in the household and community. They perform multi-tasking roles. Aside from being a community health worker, some of them also work as pastoral council members, catechists or traditional birth attendants or nutrition scholars. When they have trainings, BHW with young children need to bring them. Even when BHWs serve as volunteers in the community, when they get home, they

²² LIKAS, based in Irosin, Sorsogon, was founded in 1978 by a group of medical students and young professionals who started with community based health programs. Using participatory integrated area development framework, it expanded later on, to work with farmers through community organizing and socio-economic enterprises (WAND-UNIFEM, 2006:37). Currently, it actively works in partnership with local government units, non-government organizations, and people’s organizations in implementing its programs on gender, health, governance, environment and enterprise development.

still need to perform the household chores they left behind when they left the house to go the centre to report for duty. (NGO program officer)

In LIKAS, there seems to be recognition of common interests between the NGO and the CHWs' organizations and this 'commonality' is rarely questioned. NGO is seen as an ally whose agenda is aligned with the CHWs associations. However, it can also be that the CHWs' association may simply reflect the interests of the NGO and not of its collective membership.

Community health workers associations

Republic Act 7883 "recognizes the rights of [community] health workers to organize themselves, to strengthen and systematize their services for their community and to make a venue for sharing their experiences and for recommending policies and guidelines for the promotion, maintenance and advancement of their activities and services" (1995: Sec 2). This provision is often cited as the basis for unity of CHWs, reflected in the different Constitution and By laws of CHW associations at various levels: community, city/municipality, provincial and regional levels. It sees CHWs as a distinct social group sharing common work-related interests, in internal solidarity and consensus. This sense of a 'solid' community serves an important function in pursuing the interests of the CHWs.

The CHWs' associations at all levels - *barangay*, district, city, provincial and regional - seek to promote and ensure the collective welfare of the CHWs by providing support to enable them to effectively perform their duties and responsibilities. It also aims to access resources and opportunities, on behalf of the community health workers, to enhance their personal and professional development. As previously mentioned, CHWs associations are not part of the organizational structure of the Department of Health although they work with a designated CHW coordinators. These associations are assumed to be independent, organized groups which serve as partners of the public health care system in the delivery of its primary care services. By assuming the notion of a community which is 'united by an effective system of cooperation' (SBHWFI, Article II, Section 1), CHWs' associations are able to access resources needed by the association through partnerships with the government, non-government organizations, institutions and groups. In the province of Sorsogon, the provincial federation and most of the municipal associations are officially registered as a people's organizations, and their representatives sit as members of the Local Health Board in their respective localities. Some officers or members also serve as elected public officials or assume other positions in the community.

However, notions of a unified and solid ‘community’, defined by commonality and cooperation, may conceal unequal roles and hierarchical power relations in the association. Or as Cleaver wrote,

Project approaches to community, where they recognize power, tend to adopt over-simplified approaches to it, little recognizing processes of conflict avoidance, negotiation and accommodation between people’ (1999:603).

One issue I found relevant to this was the no-election decision made by the Board of Trustees (BOT) of the CHW Provincial Federation in 2006, which extended the 3-year term of all CHW Municipal Presidents and Provincial level officers. This was questioned during a workshop by a male participant because there was no provision on the ‘extension of term’ in the federation’s Manual of Operations; the reason was unclear why some associations held an election and others did not; and why the members were not consulted about the matter (LIKAS, 2006) Interestingly, these questions were not addressed by the CHW federation officers themselves but rather by the state health officials and the NGO staff. According to the Provincial CHW Coordinator, the presidents requested for the extension to be able to replicate the associations’ activities from the higher to the lower levels.

In my fieldwork, while CHWs are predominantly women, the presidents of the provincial and regional federations are men who have been occupying their posts for more than 10 years. The male president of the district where I conducted my field work gave me an insight why they, like other CHW federation officers- both male and females- may not have been replaced. *‘I will not simply give up my position because I was elected by the majority of the members. They have to beat me in a general election... Being an officer is a great benefit to me. As officers, we are prioritized in terms of trainings so we can travel to other places. We also receive the latest information from the doctors and nurses to the organization.’*

LIVING WITHIN THE COMMUNITIES: DEFINING ONESELF

With these various perspectives of the law and state, the health institutions and the non-government organizations, which prescribe who and what a CHW does in the context of a ‘community’, what then constitutes ‘community’ for the CHWs?

Caring for health and recognition: family, neighbourhood, and the ‘people’

Within their neighbourhoods and among those for whom they care, CHWs see themselves as individuals who have multiple roles to play:

Our work is to help the people. For example, if I have a neighbour who has a cough, I advise him or her to go the centre for consultation. If he/she cannot go to the centre, we ask for a cup from the centre, collect their phlegm, and bring it to the technician (Lina).

We go around our area of assignment to conduct anti-dengue campaign... we also have TB partners [which administer medication before breakfast for 6 months] (Nelly)

We also inform those who are scheduled for immunization to go to the centre. (Filomeno)

CHWs see themselves as someone who has the responsibility towards the community, and who, as a representative of the public health system must be knowledgeable about not only health, but also how to relate well with others. Thus, community health workers view their work as requiring different kinds of knowledge and skills:

BHW should always smile and should not frown even if they have lots of work. There are those who do not want to be immunized, so I ask them to sign the form which will relieve us of the responsibility in case something happen to them and to certify that they do not want to avail the services of the health station. (Mercy)

It is good when we are around [in the health station] because when clients arrive, we invite them to come in and talk with them. If we are not around, it is a pity because if they do not know anyone they have to wait for a long time... (Teresa)

I donated my time and service for the people so I can help them, I take care of them, inform them. They will ask me, 'where should I go?' Sometimes, they do not want to go to the centre because they do not know anyone. For example, someone came to me and asked where she should bring her x-ray result. So, I told her but she said to me that she does not know anyone there. Of course, I have to go with her because she is a member of my household cluster. So, I helped her. I was even able to ask medicine on her behalf... Because of this, she thanked me saying that 'if you haven't accompanied me, I would have just left when they told me that they cannot give me medicines'. They [neighbors] thank me because they know that someone takes care of them. (Lina)

Thus, for CHWs, community means many different things. It is the *place* from where they work, a site in which they exercise their skills and competencies; and a social context in which they establish *relationships* with people for whom they provide health services, and who reward them with a sense of pride and recognition. However, as the next section shows, community has other meanings too: it is a *source* of many different rewards and a *site of struggle* for these rewards; and, ultimately, *it is one of the crucial sites where the subject positions of CHWs are produced.*

Caring for rewards

Aside from a sense of recognition for the work they do, CHWs also receive other forms of rewards from various communities they engage with. One of these rewards is a sense of power,

associated with medical skills and knowledge. As *Nelly* puts it, ‘*I enjoy it a lot when they call me doctor*²³’.

Another, significant reward is in different forms of benefits. When I started with my research, I believed that because they do not get a proper salary CHWs are exploited, thus victims; but that they strategize nevertheless and learn how to ask for and receive, and how to utilize, different benefits for individual, familial as well as collective good²⁴.

CHWs receive monetary or non-monetary forms of incentives from various sources. Depending on what ‘community’ they are located in, these incentives and rewards are given different meanings, and through them, the self-definitions of the CHWs are produced. As *Eda*, one CHW says: *We are volunteers so we do not receive a salary. We are only given incentives.*

The local government gives CHWs monetary benefit on a regular basis. The Municipal Government of Bacon began giving them monetary incentive – a honorarium - in the mid-1990s starting with PhP 50(€0.83)²⁵ per month and later on, PhP500 (€8.33) cash gift every December. When the Municipalities of Bacon and Sorsogon merged to become Sorsogon City in 2001, the honorarium of CHWs began to increase from PhP700 (€11.66) to PhP1,500 (€25) per month in 2007. They receive it quarterly, provided they submit a quarterly accomplishment report. In the new policy²⁶ in Sorsogon City, CHWs who reach the age of 60 are entitled to receive a PhP10,000 (€166.66) cash gift as a ‘retirement’ benefit.

Aside from the honorarium, the health office also issues official identification cards to accredited CHW: ‘*Having an ID helps a lot because when you go to the hospital, you can show them your ID and they can give you discounts. You can also show your ID when doing transactions in the bank (Carolina) They are also given free uniforms and t-shirts. Carolina also said that ‘It is good to have a uniform because when you go to offices, they can easily recognize you so you will not have difficulty in asking for help’.*

The doctors, nurses or midwives in the health centre also gives CHWs free medicines when CHW family members are sick. Considering that most of the CHWs with whom I spoke cited this reason why they decided to engage in doing community health work at the first place,

²³ I will come back to the issue of power later

²⁴ See Schugurensky, D, et al (2005) for different categorization of volunteers

²⁵ €1 = PhP60

²⁶ Sec 9b, Executive Order 15-2007 (An Order Adopting New Guidelines for Acceptance of Volunteers, Registration and Accreditation of Barangay Health Workers and their Benefits) signed 08 October 2007, Sorsogon City, Sorsogon Philippines

means that this is a significant benefit. The health office also provides CHWs with seminars and training to enhance their knowledge and skills in service delivery.

The community, through the local council, gives CHWs honorarium starting with PhP20 (€0.33) per month in the 1990s which continued to increase to PhP300 (€5). Recently, it was raised to PhP400 (€6.66). *'It is a pity if we do not give them any honorarium because they are also a big help in our barangay'.* (Barangay captain).

The community council also occasionally subsidizes transportation and meal costs of CHW association representatives when they attend attending seminars. In December, the community council also invites CHWs for a Christmas party. If applicable, the local council also enrolls CHWs, together with other indigents in the community, for free health insurance. NGOs, together with the government, also provide CHWs with trainings, with free food and accommodation and materials such as bags, notebooks and folders. In the past, organizations such as World Vision also gives them free t-shirts during project activities. The CHW association also provides capital for income generating projects, transportation subsidy during meetings of association officers and raffle prizes during annual conventions. Members of the CHW association where I conducted my fieldwork was also able to borrow small amounts of loan from their group fund derived from the cash prizes they won during CHW gatherings as well as from penalties imposed for being late in going to office.

These many different kinds of rewards – while appreciated in themselves – are also powerful symbols of CHWs different positioning within, and understanding of, each of these 'communities', and of themselves as CHWs. The actions of the CHWs within and towards each of these communities are a result of their careful analysis of the past and future benefits and their value for each individual, for the association, and for the community health work. At the same time, these individual and collective benefits – be they respect and gratitude, or medicines and honorariums – are a source of motivation and strategizing for the future. As the following sections shows, power relationships are a significant element of CHWs positioning within the different communities in which they operate.

Caring for each other and the work, and for the proper order of things

Community health workers are assigned a day every week to report for duty in the barangay health station. They usually arrive before 8 o'clock in the morning to clean and put the health station in order before the rural health midwife and their clients arrive. On a regular day, they assist the midwife by checking and recording the blood pressure of clients who come to the centre or talk with clients while they wait for their turn during consultations. They may also perform

other tasks as may be required by the midwife such as arranging files and reports. During immunization day of infants, scheduled every month, they prepare the materials needed by the midwife and weigh children and their mothers. Every year, they conduct house-to-house visits to weigh 0-72 month old children and administer vitamin A supplements. At the end of every quarter, they submit an accomplishment report which is submitted to the CHW Coordinator before they can receive their honorarium. Occasionally, they also attend health-related trainings conducted by the City Health Office or other activities they may be required.

CHWs see themselves as a group who should strive and maintain to work in harmony and cooperation. They put high value on their relationship with each other.

I am happy when we are together, we dance and join contests (Gigi)

We are like family here, especially the old ones. We seldom had any quarrels in the past. (Teresa)

Nevertheless, this ideal of happy, harmonious family is deceptive. Power relations within the 'community of health workers' is different than between a community health worker and his/her clients, be it in the immediate neighbourhood, or the village to which they are assigned. For example, medical knowledge and skill puts a CHW clearly in the advantage – and thus in a position of power – towards a sick neighbour, or neighbour's child. Clients depend on the CHW for so many things: medicines, check-ups, company, understanding. CHW also has – for his/her own family - an access to income and medicines that the neighbour's family may not have, and this may be an important element of differentiation, and thus power. Within the station, however, different hierarchies operate. First, there are superiors –with more medical knowledge and skill and higher-up in medical and organizational hierarchies. In the health centre, CHWs are under the supervision of a rural health midwife. She may be younger in age but as far as CHWs are concerned, she must be accorded with respect because she possesses expertise that is more professional. They expect her to relate with them in a considerate manner, to know how to treat them well and kindly and to advise what to do in their work. These relationships within the organizational structures, demand that the CHWs position themselves, and are positioned by others, differently.

We know how to follow what the RHM asks us to do. BHW should have good attitude, no tantrums, and not so talkative. (Eda)

We lasted this long, more than 20 years, because our midwife leads us well... Even though they change from time to time, when a new midwife arrives, we listen what she wants us to do. (Filomeno)

Secondly, among themselves, all CHWs are supposed to have similar knowledge and skill, and thus be in relatively similar positions of power towards each other. But this is clearly

not so, because other relations of power (besides organizational hierarchies and structures) such as age, gender, the amount of medical knowledge and skill, years of experience, etc., become relevant in these relationships, producing conflict, frustration, and dissatisfaction.

We (older BHW) know how to respect the younger people but the younger ones should also know how to respect the old... But if they defy me, I will smack them in the face. If you can't be humble, especially when you are new, leave. We have been here a long time, since 1984, our hair is grey, follow us because we came ahead of you... (Lina)

When conflicts arise, they must be discussed by the group or resolved by the higher authority: If there are conflicts or misunderstanding, we talk about it. If the issue remains unsettled, we submit to whatever the higher authority tells us. (Filomeno)

In most cases, especially in dealing with superiors and in times of conflict within the 'community', CHWs must, 'Be humble because you are 'under' [the authority of a health professional]. (Eda)

'Magpakumbaba' is the Filipino translation of 'be humble'. *Magpakumbaba* means to bend down in submission or deference to authority. This term is entirely opposite of what I expected of CHWs. When I began my research, I was expecting them to be activists, an organized group of men and women who felt that they are oppressed and marginalized, and thus fighting for their rights. There are formal laws such as the Republic Act 7883, which give them a 'weapon' and a right to claim what is their due. But, as this section and the following chapter show, *magpakumbaba* is the CHWs' own style of engaging with institutional power, be it within the health station or in local and regional politics. It is the sense of disposition built and acquired through continuous engagement of power. (Mahmood, 2001) It is worth noting that *magpakumbaba* connotes a positive posture, not out of coercion or weakness, but rather, a creative expression of how the CHWs see themselves in relation to other people and their world.

Chapter IV: Engagement in the Political Systems

In this chapter, I will discuss how community health workers engage in the formal, public political system and analyze how they exercise power to achieve their ends.

I will argue that political power is exercised not only through formal channels but also through informal networks of community health workers. This means that boundaries between the public (law, state, community) and private (family, marriage, home and kinship) spheres are blurred, and engagements with politics continuously flow from one sphere to another. In such way, both spheres influence and give meanings to each other.

Following Hekman (1995), CHWs, as subjects, use their agency and creativity in relating and interacting with political structures based on 'discursive mix' available to them, using their own creative ways of achieving their ends.

IN THE HANDS OF THE LOCAL POLITICIANS

Philippines is a republican and democratic state, which patterned its political system to the United States. The government is divided into three branches: the executive headed by the president; the legislative body, which is comprised of two chambers: the House of District Representatives and the House of Senate, and the judiciary branch. It has a unitary system in which power emanates from the central authority²⁷.

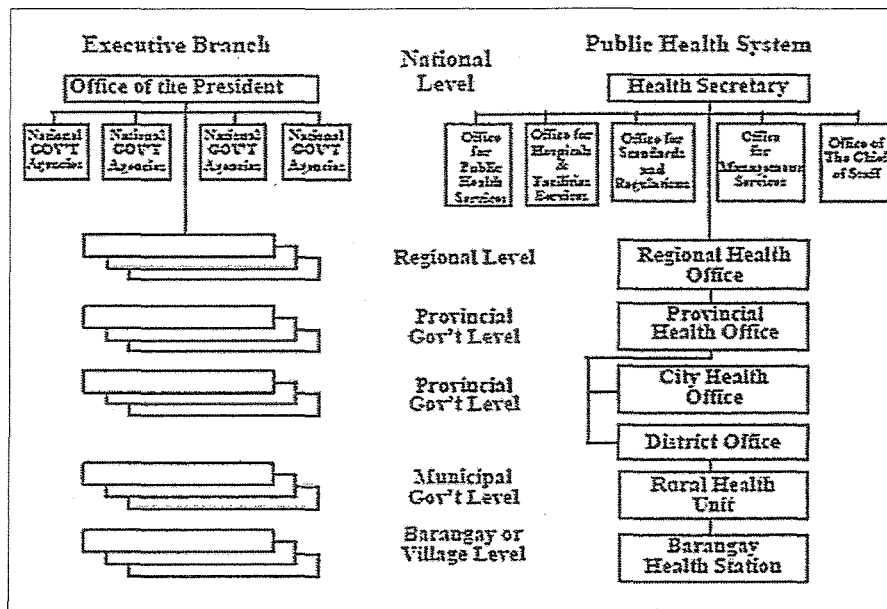
The lowest political unit is the *barangay* (village) which consists of at least 2,000 inhabitants. Sub-divided into several clusters of households, it is administered by a council headed by a *punong barangay* (*barangay* captain). Each *barangay* is required to convene a local development council composed of representatives from different sectors in the community to assist in defining, analyzing problems and identifying strategies to resolve them. The *punong barangay* as the chief executive is mandated to implement laws and policies, both local and national, and ensure the provision and maintenance of basic infrastructure and facilities in the community such as the *barangay* health station. In the *barangay* where I did my fieldwork, the local community council allocates an annual budget of PhP10,000 (€166) for medicines, in addition to the supply given by the City Health Office.

Several *barangays* comprise a city or a municipality. A Mayor serves as a head of the city/municipality tasked to execute local laws enacted by the local legislative council in accordance with national policies. Regarding health concerns, the Mayor is responsible for

²⁷ <http://www.gov.ph/aboutphil/a15.asp>

making available and accessible primary health services, maternal and child care, and communicable and non-communicable disease control services; access to secondary and tertiary health services; purchase of medicines and equipments' (Local Government Code, 1991: Sec 17). He/she also heads the Local Health Board in proposing annual health budget and advising the legislative committee on health. The highest political structure at the local level is the province composed of municipalities or cities. Every province may be divided into congressional districts, each having its own elected representatives. Regions are sub-national administrative units composed of provinces linked by common attributes e.g. ethnicity or language. This structure of authority is reflected in the health care system (see figure 1).

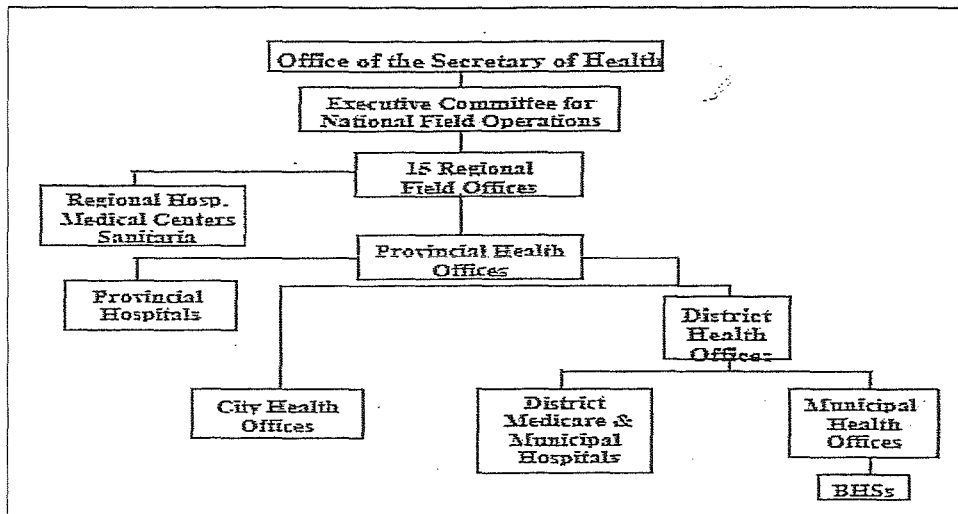
Figure 1: Comparing Governance to Health Structure



Source: Javier (n.d.) http://www.who.int/hrh/en/HRDJ_2_1_02.pdf

In 1991, the Local Government Code (LGC) was implemented in the Philippines, which decentralized/devolved basic services, such as health, agriculture and social welfare, from the national government to the local government units. It involved the transfer of assets, liabilities, records, and personnel in such a way that national government agencies like the Department of Health (DOH) play a minimal managerial and supervisory role. This move gave local authorities at the different political levels - barangay, municipal/city and province - the power and responsibility to decide and implement their own projects (Furtado, 2001:109).

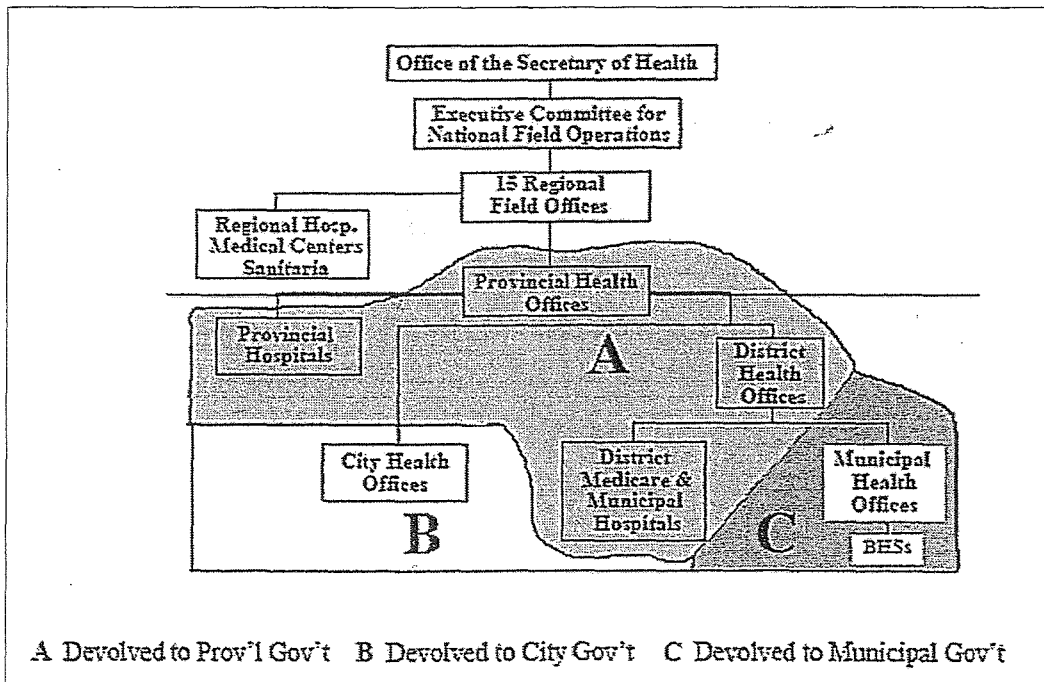
Figure 2: DOH Structure (Pre-Devolution)



Source: Javier (n.d.) http://www.who.int/hrh/en/HRDJ_2_1_02.pdf

With the implementation of the Local Government Code, the implementation of primary health care has also been devolved and is now in the hands of the local chief executives (LCEs) who are elected public officials serving either the *barangay*, the city/municipality or the province.

Figure 3: Health Structure (1993, Post-Devolution)



Source: Javier (n.d.) http://www.who.int/hrh/en/HRDJ_2_1_02.pdf

Table 1. Levels of Administrative Authority and Persons Responsible within Local Governments for the Health Sector by Type of Local Government Unit

<i>Local Government Unit Type</i>	<i>Authority over health care provision</i>	<i>Persons Responsible within the Local Government</i>
Provinces Highly Urbanized/Chartered Cities	Hospital based health care (district and provincial hospitals) and technical assistance to public health care programs for all lower level local governments	Governor for Provinces (elected) Mayor for Cities (elected) Provincial/City Health Officer and Provincial/City Health Officer Staff (devolved)
Municipalities Component Cities	Public health care programs	Mayor (elected) Municipal Health Officer, Public Health Nurse, Midwives (devolved)
Barangays (villages)	Primary health care programs	Barangay Chairperson (elected) Barangay Health Worker (volunteers)

Source: Nierras (2002) <http://www.swan.ac.uk/cds/pdf/NIERRAS.pdf>

The devolution of health services from the national to the local government units (LGUs) has affected health care system delivery (Franco, 2006; Furtado, 2001). Due to disparities in Internal Revenue Allotments (IRA) of LGUs and the political will of local executives, health spending was severely affected. Fragmentation of health services occurred. Salaries of health workers – both professionals and volunteers - are dismally low as their benefits and incentives are dependent on the priorities of the local government executives.

To appease the demoralization of health workers, new laws were enacted to boost their morale. In 1992, the Magna Carta for Public Health Workers was passed by Congress to provide incentives to doctors, nurses, medical personnel. In 1995, Republic Act 7883 also became a law, which provided what incentives and benefits are due to CHWs and how they can avail of them.

To facilitate and approve the registration and accreditation of community health workers, a Registration and Accreditation Committee (RAC) may be created in the local government unit through the Local Health Board. The committee will be composed of the municipal or city health officer or its equivalent as chairperson; a representative of non-government/people's organization implementing a health-related program in the locality; the CHW federation president and the DOH representative to the Local Health Board (Rule III, Sec 1). The RAC ensures that CHW who receive incentives have fulfilled the necessary requirements.

In terms of funding, Republic Act 7883 does not explicitly name the source of funding for the provision of incentives and benefits of CHW, but states in Section 17 that every incentive

or benefit for community health workers requiring the expenditure of local funds shall be reviewed and approved by the Local Health Board to ensure that only deserving community health workers receive them. Implementing Rules and Regulations (IRR) of RA 7883 spell out the roles and responsibilities, and the procedures and requirements of the CHW, to be able to access the incentives and benefits.

It is on the provision of these rewards in forms of incentives that the link between the public sphere of local politics, the professional sphere of CHWs and CHWs' associations supported by the NGOs, and the private sphere – CHWs as individuals, their families and kins - is established. The political and legal context sets the rules of engagement for CHWs' entry into politics. It provides the scope and the limits of their work and what they can and cannot do.

I conducted my fieldwork in July and August, and a synchronized national and local elections were held in May. In the region where I conducted research, a change of political leadership occurred particularly in the city government. As mentioned in the previous chapter, the Local Government, both the city and the *barangay*, gives monetary benefit – honorarium- to CHWs. For instance, in the *barangay* where I did my fieldwork, the *barangay* captain appoints the community health workers upon the recommendation of the rural health midwife and the concurrence of the *barangay* council. While it is not legally clear if *barangay* captains should appoint them or not, the accepted administrative norm is to provide an appointment paper to the CHWs so they can claim their incentives. The amount is determined based on the discretion of the *barangay* captain and the council. The same is true of the city government. While a Local Health Board exists, there is no functional Registration and Accreditation Committee. A local legislation which serves as a basis for determining the amount of honorarium given to CHW was also absent, thus, it was also dependent upon the whims of the politicians whether they want to give the honorarium or not, how much when and to whom.

Community health workers I talked with said that increases in honorarium usually happened during election time. CHWs associations are also favoured by large amounts of financial support during election period, whether they solicit it or is voluntarily donated to them by politicians. As mentioned by CHWs themselves, during their annual convention last May 2007, they were flocked by political candidates, even though they did their best to make alternative arrangements. These practices led to the perceived 'politicization' of CHW as the following statement attest:

²⁸ Other benefits include hazard allowance, enrichment programs, free legal assistance and preferential access to loans. (Sec 9)

BHW are volunteers. Their concern is to assist the doctors, nurses in implementing the health program. The problem is that during election times, the motives of their leaders become like that of politicians. (the newly elected city mayor)

It was because of this perceived ‘politicization’ of CHWs that a proposal was made to ‘professionalize the work of CHW’ in the local government²⁹. The new policy entailed emphasis on the voluntary nature of community health work, and improvement of the quality of service delivery of CHWs. In addition to the existing requirements of RA 7883 (from 1995), age limit was set in 2007 at 65³⁰ as a ‘retirement’ age, the same as for government officials. Interested volunteers must also be literate, or must be at least with high school graduate³¹. This clearly discriminated some of the oldest CHWs who had much less schooling, but had many years of experience.

Like the state officials and the local politicians, the NGO also advises the CHW and their organizations to be non-partisan during elections. One of the main concerns of the NGOs is the political participation of CHW associations in local governance. CHW association presidents sit as representatives in the Local Health Board. However, presence in LHB of the CHW president does not automatically mean that concerns CHWs are talked about in the board. For example, I attended a meeting of key city health officials to talk about the proposed policy for community health workers. When I looked for the CHW president during the meeting, I was informed that the Mayor has specifically identified who will attend the meeting and she was not invited because she belongs to the ‘other’ – previous - not the current mayor’s ‘camp’.

EXERCISE OF POLITICAL POWER COMMUNITY HEALTH WORKERS-STYLE

So how are all these old rules and regulations, the new, changed local governments, and the plethora of different institutions, affecting the ideas of ‘politicization’ of CHWs, and how are CHWs perceiving their own involvement, and involving in local politics?

BHW are like Red Cross, non-sectarian, non-partisan; but we are victims of two opposing political forces. Last elections, I was asked to be one of the leaders [of a political candidate] here in our community but I said no. I told myself, ‘what if, for example, my candidate wins or either way, loses? People who know where I am politically affiliated might ignore me when I inform them about schedules of our immunizations or other activities in the centre’. They might not listen to me or follow me when they know that I did something unpleasant or which they did not like (Filomeno)

²⁹ The proposal was approved and signed by the City Mayor last 08 October 2007.

³⁰ Then again reduced to 60 years

³¹ A registered CHW must have a minimum of 1-year voluntary service; to be an accredited CHW, 3-year

Obviously, CHWs see their relationship with their local elected officials through their relationship with the community whose health care they provide for. Nevertheless, they also see it as a relationship in which politicians exert power over them and thus cannot be easily challenged because they wield influence. As one CHW officer puts it, “*What can one BHW do against a barangay captain [who appoints and can dismiss her]? Should we crash ourselves to a wall?*” Local politicians decide how much and when CHWs can receive their incentives. Being aware of this dependence of the local politicians, CHWs can also feel a sense of gratitude towards them:(

We thank our (former city mayor) because we were able to receive honorarium.. It is good to have a woman leader because most of us (BHW) are women. She (former city mayor) was interested in our activities. We do not know now that we have a new male mayor whether he will also be active. (Lina)

Consequently, as the following quotations show, this dependence makes many CHWs take a position that they are obliged to follow and obey whatever local politicians say:

Whatever they ask you to do, for example, they requested you to go to the barangay, you must go. But sometimes, even the tasks of council members are passed on to us... It seemed that we can not say no because they give us honorarium. (Carolina)

Whatever they tell us, it is alright. We just wait whatever will be given to us (Eda)

If the barangay captain decides to give you an honorarium, remain silent. If you quarrel with others, nothing will happen. (Jaime)

We must follow based on what is prescribed and implemented by the government. (Filomeno)

Now that we have a new Mayor, [we must do] whatever he says...We cannot make a request because he makes the decisions whether he will give us salary or not. There is nothing we can do [if the Mayor decides not to give us our honorarium]. It won't be good if we barge into his office and demand. What can we do if he does not want to give us until the end of his [three year] term? But we haven't lost hope because he was recently inaugurated. If he tells us in a meeting that we will not be given [honorarium], then that would be it... (Lina)

A CHW association officer at the district level also commented:

Our Constitution and By-Laws are useless because we cannot follow it. Whatever the politicians say, that's what we do.

However, this apparently submissive position of a dependant does not mean that CHWs are totally powerless, or do nothing to protect their interests. As Eda and Jaime note, they try to exert influence:

We were not paid before... We went to our barangay captain and asked for our honorarium from him. He granted our request and now we are receiving 400 pesos every month.

We requested Councillor Baldon to pass the Ordinance ensuring the security of tenure of barangay health workers: that in case there will be changes in who sits as elected public officials, BHW should be retained in the pay roll of the city government and can receive honorarium, irrespective of their political affiliations.

The CHW associations also adopted standard way of dealing with issues such as dismissal of CHW, which prevent a CHW from receiving an honorarium.

When a BHW is dismissed, for example, because she is known to have supported the opponent of the winning candidate, sometimes, officers of the organization or the midwife talk with the barangay captain to convince him not to dismiss the BHW. (CHW federation officer, female)

Furthermore, CHW also often seek other, less direct ways of engagements. They use informal channels - not the formal institutions but the people who can serve as go-between them and the Mayor. These are, for example, relatives who work in the city government or acquaintances who they think can speak to the Mayor on their behalf. They often choose not to work through their formal associations but through their personal and family contacts. Some went on their own to talk with the Mayor because he is one of their wedding principal sponsors, and as such seen as a part of extended family networks (like in the *compradazgo* system of Godfathers).

It was 2 ½ years before I received my honorarium so I decided to talk to [(former city health officer)] because my brother-in-law works as his sister's driver. I compiled all my certificates from the training, showed it to him and told him that there is a BHW from another barangay who recently died and whose slot I can take in receiving the honorarium (Carolina).

Few months later, Carolina began receiving her honorarium from the city. Hekman's (1995) notions of agency and creativity come here into play. Carolina actively sought for information and did not simply wait for the authorities to give her an honorarium, which is useful to her family. She made use of the resources at her disposal - her social network that was built not only through family relationships or kinship but also through her being a CHW, and thus knowing what is happening in another *barangay*. One of the reasons cited by CHWs in working as volunteers is that they can meet many people. Being a CHW allows them to meet 'big' people such as local politicians especially during BHW conventions and seminars. They also get to know and meet the doctors and nurses, whom previously they knew only by name. By knowing these people in person, they feel that they can easily approach them when they need some help. They strategize, both individually and as a group, what possibilities are available to them in dealing with people in power. And, as the following statements show, they are very well aware of the stakes in hand:

CHWs should keep a low profile during the elections so politicians would not know where they are affiliated. If they want to support a candidate, they should do it as subtle as possible. (Nelly)

We had a meeting yesterday and we discussed if we can see the Vice-Mayor to help us in talking with the Mayor [not to transfer our midwife to a new assignment] but one of our members, whose son works in the city government, told us that it is not a good time to talk with the Mayor right now. So, we will just wait. (Amanda)

Community health workers also comply with some practices, even though these may not be according to the official rules. For example, when a *barangay* captain chose to give honorarium even before a BHW fulfils the requirements for registration or accreditation, CHW oftentimes react by attributing it to luck or good fortune of their fellow CHW. Despite feelings of resentment by some CHWs, it seldom happens that a formal complaint will be filed to proper authorities so as that their co-workers will not be able to receive an incentive. A sense of solidarity and a self-interest prevails.

My field interviews also show that state officials, too, use both formal and informal channels in relating with the CHWs. But when CHW relates with them, politicians often want the communication done through formal channels. A city mayor told me:

The officers of CHWs association should come to seek an audience with me and not let the 'small ones' come talking to me... The problem is they have too much pride.

This statement indicate quite an opposite interpretation of CHWs strategies of communication from what CHWs indicated in the above cited reflections on the relationship with the politicians. Their ways of communication – which I characterize using the local term, '*mapagpakumbaba*' - being humble - shows their understanding of the official power structures and their own – dependent – place within them. Thus, CHWs preference not to engage in a confrontational manner in dealing with structures of power is both a recognition of these power relations, and engagement with them with the means affordable to them. This allows them to draw moral, professional and financial benefits in a situation of unequal power relations, and have a sense of personal and collective worth and autonomy.

Conclusion

This research aimed to understand how subject positions of community health are produced. The production of these subject positions, defined as multiple, contradictory and conflicting, is situated in the context of social relations that transcends the boundaries of the family, community, health care system and official politics. This paper explored various meanings attributed to the community health work, and community health workers, in these overlapping contexts, to be able to understand how community health workers position themselves and are positioned within them.

Findings of this paper show that subject positions and subjectivity of CHWs are continuously negotiated and challenged as power is exercised in many different domains of interaction – in marriage and parental relations, among CHWs and in the hierarchies of the health-care system, and in the corridors of local governments. Depending on the specific social field, community health workers assume different subject positions. A social field can be seen as a ‘dynamic, multi-dimensional set of relationships containing possibilities for liberation as well as domination’ (Sawicki: 1991:9)

In the family, dominant notions of femininities and masculinities, and their meanings and practices offers CHWs different possibilities for subject positions, with rewards and costs in forms of monetary and material benefits, recognition, and approval. But while community health work provides women a space to extend her influence as a care-taker from the home to a larger community, and thus exercise some power, it also requires that them continue to perform their socially prescribed roles as mothers, home makers and wives, or re-negotiate these roles and escape them, by providing the family another kind of benefit. On the part of male CHWs, while community health work is not regarded as a source of income, it is seen as a source of man’s pride and recognition. Because CHWs’ work is seen as bringing benefits to the family, what is culturally defined as a man or a woman in the family is negotiated, extended and redefined.

Community, this research shows, means many different thing to many different people. For CHWs, community means the health care system, the neighbourhood or the CHW association. In the health care system, CHW are individuals, partners in health-care delivery, by not necessarily subjects of the health-care organization, participation and mobilization. As an implementer of primary health care, a CHW is both an outsider and an insider; can be seen as an extension of the medical professionals but not a part of the structure, because of differences in education and professional qualifications. Thus, the CHWs perspectives on the heath system, and the world of health is largely excluded from the upper corners of the health-care system’s

hierarchies. Within the community health care centre they may find some space to influence and exert change, but there too, different hierarchies operate, based on age, length of experience, and the belonging to the official health system (with only the midwife being a part of the system). In the neighbourhood where CHWs deliver health services, they define themselves as accorded respect, gratitude and approval for the services they render. They see themselves as representatives of the medical profession, and at the same time linked to the people they serve and thus, must possess different kinds of knowledge and skills, must exercise power in different ways. Between the family, community and of people who are served, and the health station, a micro-cosmos of struggles and strategies is employed to preserve material and non-material benefits of work as well as forge new arrangements. Here normalization takes place; disciplinary power is exercised subjecting individuals, as well as making them subjects who challenge dominant practices.

In the CHW association, CHW are projected as a unified, harmonious entity to be able to access material support outside the organization. Within the association, however, conflicts and misunderstandings occur which are seldom taken into public because of the threat it could pose to the association. NGOs, furthermore, while supporting the CHWs associations, act as their representatives, and thus at the same time chisel off some of their autonomy. In the political system, CHW assume a different position all together, using, what Mahmood (2001) calls acquired disposition: they use space of subordination as site of power, humble themselves to persons in authority to be able to fulfil their ends. They soften, bend and make porous the boundaries of formal and informal, private and public, and use discursive mix on their disposal in various ways of engaging with structures of power (Hekman, 1995) In engaging with marginalized groups, it is important to recognize these discourses in their social fields of interaction, and to analyze dynamics between their implications on the lived experiences of people who use them, or re-create them

This study revealed that there are no clear cut boundaries between different social fields in which CHWs live: they flow from each other and give meanings to each other. Boundaries between an individual, his/her family and community are not fixed, sharp and distinct. The distinction between the private and the public is blurred. But this does not mean that there are no dominant political, economic and social structures of power that impact the world and work of the CHWs. Beyond the reach of their own struggles and engagements, CHWs are subjected to these structures, and remain marginalized within the health system, and dependent within the local government systems.

Still, in the introduction of this paper, I wrote, 'Wow! These people can elect our next governor!' I believe they can. But how and what will make it possible will depend on many things, not only on them. I started this research thinking about empowerment and exploitation dichotomy, but I learned from the field that there is more to it than merely fitting CHW in neat categories of exploited victims and empowered agents. And while I struggled to overcome my own starting assumptions, and to find my own position vis-à-vis different subjects of my research, I recognize the complexity and richness of their lived experiences, and I understand that plurality and multiplicity of sources of resistance and cooperation are necessary for a substantial social transformation of the lives of CHWs in the Philippines. Sawicki (1999) puts forward radical pluralism that I also find helpful, in an inspiring way:

Coalition building rooted in an appreciation of certain commonalities in our struggles combined with a form of consciousness raising that aimed to highlight the limits of our individual experiences, rather than to point to shared experiences, appeared to me a viable strategy for building a more inclusive, pluralistic feminist politics. (Sawicki: 1991:12)

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Annexes

ANNEX 1: Profile of the Community Health Workers

Name	Profile
Mercy	69, female, widow, elementary graduate, earns 1,500 monthly from small variety store & occasional laundry washing, with 9 grown up children, 3 of whom lives with her; served as BHW for 24 years, recruited by an acquaintance
Juliet	54, female, widow, elementary graduate, receives 3,000 monthly pension; with one grown up son working overseas; lives alone; served as BHW for 6 years; recruited by the rural health midwife (RHM)
Leah	33, female, married, graduate of two-year computer course; earns 7,500 monthly from income of tricycle & small variety store; with 2 months old ; lives in the house of her mother-in-law who is also a BHW; served as BHW for two years; recruited by RHM to replace mother-in-law
Lina	64, female, married, high school drop out, earns 3,000 monthly from support of children and income of husband; with 9 grown up children; served as BHW for 24 years, recruited by fellow BHW
Nelly	40, female, married, finished 3 rd year HS, earns 5,000 monthly from income of tricycle and store; with growing-up children, began serving as BHW in 2006 to replace mother-in-law
Teresa	73, female, widow, finished second year HS, receives 5,000 monthly pension; with 7 grown up children; with youngest single son still living with her; served for 24 years, recruited by RHM
Veronica	71, female, married, graduated in elementary level, earns 10,000 monthly from sewing; with 10 grown up children, served for 24 years; recruited by RHM
Felomino	53, male, married, graduated in elementary level, earns (75/day) monthly from farming and fishing, with 5 growing up children, served for 24 years as BHW; recruited by RHM
Jaime	54, male, married, graduated two-year secretarial course; earns 4,000 monthly from working as laborer and doing farm work; with 4 growing up children; served the past 24 years, recruited by RHM
Amanda	71, female, second year high school, earns 5,000 monthly family income, 7 children (1960, 1962, 1963, 1964, 1965, 1969, 1970, 1971) served the past 23 years as BHW, CWL member

Name	Profile
Joy	34, female, married, high school graduate, earns 2,000 monthly from income as dealer of retail fashion items and work of husband as farmer; with 5 growing up children; replaced old BHW in 2004
Carolina	38, female, married, finished 2 nd year college, earns 4,000 monthly from wage of husband, income of store, with 4 growing up children, began in 2003 as BHW & replaced mother who was a former BHW
Miranda	36, female, married, finished high school, earns 5,000 monthly from income of husband as farmer & watchman employed by city gov't; with 5 growing up kids, began in 2003 as BHW
Glenda	69, female, widow, finished elementary; earns 1,900 monthly from honorarium; with 5 children (45, 42, 41, 38, deceased) served as BHW for 25 years; CWL, Senior Citizen
Vicky	With 3 grown up children; 23,000 from pension of deceased husband and son (Air Force) Served for 25 years; recruited by a doctor's mother to be a BHW; living with daughter & 4 grandchildren
Gigi	68, female, widow, finished 2 nd year secretarial, receives 6,800 as monthly support from children & grandchildren, with 8 grown up children; served for 22 years as BHW; recruited by BHW
Eda	76, female, widow, finished 1 st year HS, receives 10,000 support from children living abroad, with 8 grown up children, served for 23 years as BHW, recruited by BHW

Source: *Field work Interviews (July-August 2007)*

Annex. II Semi-Structured Questionnaires

A. Community Health Workers

Personal Information

Name:

Nickname:

Date of Birth

Age:

Address:

Name of Spouse:

Occupation of Spouse:

Number of Children:

Sources of Family Income:

Monthly Family Income:

Interview Guide Questions:

1. Can you tell me how and when you started working as a CHW?
2. What are the activities that you do as a CHW?
3. What are your reasons for working as a CHW?
4. What benefits do you receive as a CHW from the city government, health office, community and NGO?
5. What difficulties do you encounter in your work? How do you deal with them?
6. Community health workers are volunteers. Please give your comment.
7. What does your family (husband/wife/children) say about you and your work as a CHW?
8. How would you describe your relationship with the rural health midwife (supervisor), your co-workers, members of the neighbourhood cluster you are assigned; local community officials?

B. CHWs Association Officers

1. Who are community health workers?
2. Community health workers are volunteers. Please give your comment.
3. How does one become a CHW?
4. What are the benefits entitled to a CHW?
5. What issues and problems confront the CHW? How are these being addressed? By whom?
6. What are the programs and activities of the CHWs associations? How are these managed? By whom?
7. In what ways do CHWs associations work with the local government unit, the health office, and the non-government organizations?

C. Health Officials

1. Who are community health workers? What are the tasks expected of them?
2. Community health workers are volunteers. Please give your comment.
3. How does one become a CHW? What are the requirements?

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4. What are the benefits entitled to a CHW?
 5. What difficulties do CHW experience in their work? In what ways do you help them?

C. Non-Government Organization

1. Can you tell me about your program on CHW? In what ways do they help CHWs?
2. Who are community health workers?
3. Community health workers are volunteers. Please give your comment.
4. What are the current issues and concerns confronting CHW? How are these being addressed?

D. Local community leaders and members

1. Who are community health workers? What are their activities in the community?
2. What benefits do you give them? What are the conditions?
3. In what ways do you work with them?

E. Family Members

1. What can you say about your spouse/parent working as a CHW?

ANNEX III. List of Interview

A. Barangay Health Workers

1. Mrs. Lourdes Dominguiano
2. Mrs. Catalina Dioquino
3. Mr. Gil Jamolin
4. Mr. Noli Detoito
5. Mrs. Josefina Vargas Deniega
6. Ms. Jocelyn Detera
7. Ms. Eleanor Dooc
8. Mrs. Myrna Dooc
9. Mrs. Patria Habla
10. Mrs. Molly Divina Gonzales
11. Mrs. Analie Diaz
12. Mrs. Marilyn Deocareza
13. Mrs. Ma. Minerva Deri Collantes

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14. Mrs. Juana Diaz
 15. Mrs. Estela Escaro Dineros
 16. Mrs. Sotica Despabiladeras
 17. Mrs. Remedios Zuniga Despabiladeras

B. Department of Health

1. Ms Ruby Dizon, Regional BHW Coordinator, CHD, DOH RO V
2. Ms. Nena Estevez, PHN, Provincial BHW Coordinator, Sorsogon Provincial Health Office, Sorsogon

C. Sorsogon City Health Office

1. Dr. Ruel Rebutillo, Assistant City Health Officer
2. Dr. Abril Capistrano, District Health Officer, Bacon District, Sorsogon City
3. Ms. Marlene Monje, Public Health Nurse III, City BHW Coordinator,
4. Ms. Rina Rodriguez, PHN, Bacon District
5. Ms. Heldigunda Diesta, Rural Health Midwife, Poblacion, Bacon District

D. Sorsogon City Local Government

1. Hon. Leovic Dioneda, Mayor, Sorsogon City
2. Hon. Onofre Dioneda, Barangay Captain, Poblacion, Bacon District

E. Non-Government Organization

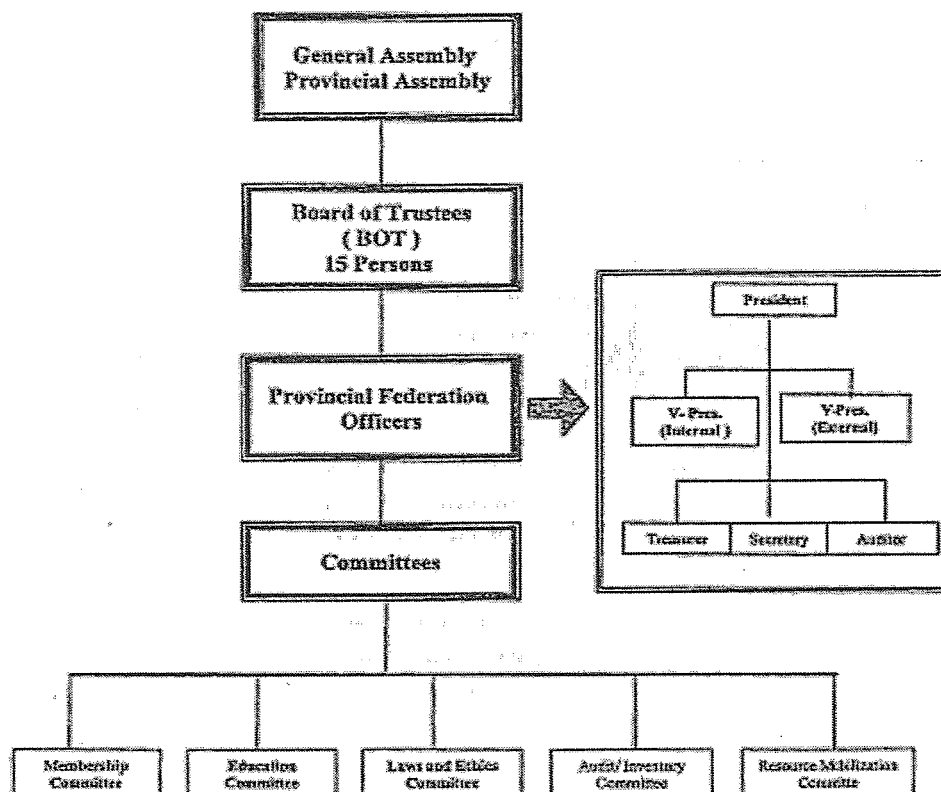
Ms. Ester Hular-Lastrilla, Program Officer, *Lingap para sa Kalusugan ng Sambayanan, Inc.* (LIKAS), Irosin, Sorsogon

F. BHW Officers

1. Jonathan Lorbes, Bicol Regional BHW Federation President
2. Bicol BHW Regional Federation, Inc Officers
3. Sorsogon BHW Federation, Inc. Officers
4. Sorsogon City BHW Federation, Inc. Officers
5. Bacon District BHW Officers and Members

ANNEX IV CHW Organizational Structure

Organizational Structure
SORSOGON PROVINCIAL BHW FEDERATION, Inc



Source: Manual of Operations Sorsogon Provincial BHW Federation, Inc (2006)