Journal of Asia Pacific Studies (2013) Volume 3 No 1, 86-109

Information Delivery in the Provision of Barangay Health Services in Barangay Dawis, Digos City, Philippines

Dennis John F. Sumaylo, AB, MDC, Assistant Professor 1, Department of Humanities, College of Humanities and Social Sciences, University of the Philippines Mindanao, Davao City, Philippines

Abstract: *The main focus of this paper is to narrate, describe, and evaluate the information delivery in the provision of Barangay Health Services by observing the practices of the Barangay Health Workers (BHWs) at the Barangay Health Center in Barangay Dawis, Digos City, Philippines as a case in point.*

Two phases of data gathering were employed in this study. Phase 1 gathered information through interview from 14 BHWs regarding the various external communication tools they used in delivering information on various health care programs. In Phase 2, BHWs were evaluated on how they deliver information as perceived by their clients/patients. Variables considered in this phase are taken from the Interpersonal Communication and Counseling Manual of the Department of Health and HealthPRO. A total of 280 clients/patients were asked to evaluate the BHWs.

The study revealed the following findings.

Face-to-face interaction is the main method of delivering information in Barangay Dawis. The 14 BHWs were evaluated using three core criteria from two fields of communication: speech communication and health communication as reflected in the manual used by the Department of Health. Overall, the BHWs were rated good to excellent in all criteria. BHWs also use other forms of communicating and persuading clients/patients not necessarily part of the Interpersonal Communication and Counseling Manual. The use of fear to persuade was even employed by the BHWs. Also, when speed is a priority, BHWs utilize technology, in particular text messaging (SMS), in delivering information.

***Dennis John F. Sumaylo, AB, MDC**, University of the Philippines Mindanao, Davao City, Philippines*

Furthermore, the top-down flow of information affects the delivery of health intervention programs. Aside from possible communication breakdown due to communication noise, this can also be attributed to the lack of and/or inappropriateness of external communication tools. These tools include the BHWs as a medium of communication aside from flyers, leaflets, brochures, and fact sheets distributed to the various Barangay Health Centers in the City.

Another breakdown lies in the Interpersonal Communication and Counseling Manual of the Department of Health due to its faulty assumptions and the lack of focus on Health Communication as transactional in nature. The manual also failed to consider possible issues on disclosure in the whole communication process.

Training on the proper use of metaphors, analogies, and its relation to folk beliefs were not present in the same manual. It is evident that in the Philippines, specially in the Barrios, health care providers tend to use metaphors and analogies in disseminating information on health care intervention programs. Communication breakdown occurs in this level as well.

Lastly, this paper also explored the need to go beyond traditional communication channels and go for technology-mediated communication. The rules and resources within the context of Adaptive Structuration Theory of Marshall Scott Poole looked at the process of documenting how the BHWs negotiate communication to successfully disseminate information on health care intervention programs of the Department of Health properly.

This case study therefore provides an actual observation data of how the BHWs in Dawis, Digos City, Philippines use the traditional communication tools and supplement it with their own way of explaining health care messages according to their way of understanding it.

1. Introduction

The creation and implementation of the Health Intervention Programs of the Department of Health (DOH) in the Philippines goes through a lengthy process. As explained by Mary Divene C. Hilario, RN, MPH, the officer in charge of the Health Advocacy and Promotion Unit of the Department of Health Region XI, the Central Office of DOH, specifically

the National Center for Health Promotion, calls for a collaborative national workshop involving representatives from the Center for Health Development Regional Offices and consultants. The Central Office usually presents a prototype of a health intervention program including communication materials and training modules.

The consultative and collaborative national workshop aims to further enhance the prototype that might work for each region. Usually, the prototype is in Filipino or in English and later on adapted into various local languages. The prototype in this level is already pre-tested and is considered effective. Sometimes, the National Center for Health Promotion reproduces promotion collaterals (calendars, posters, etc.) by bulk and these are sent out to various regions as is.

Once translated and reproduced, these materials are now distributed to various provincial health offices. For Region XI, it covers 4 provinces (Davao del Sur, Davao del Norte, Davao Oriental, and Compostela Valley Province) and 1 city (Davao City). The provincial health offices then distribute these materials to their respective municipalities and component cities. The distribution of materials and training of health care providers are now passed on to the barangay level – the barangay health centers, through the city health offices and municipal health offices.

The Barangay Health Centers play a crucial role in the delivery of health services in the Philippines. Health intervention programs designed by experts in the Department of Health are implemented in the grassroots level by Barangay Health Workers (BHWs). These BHWs are volunteers trained as frontline health service providers (HSP) of the government. Each BHW trained in basic interpersonal communication and counseling, is assigned to a particular area in the barangay in order to gather data by asking questions and listening effectively for them to correctly assess/diagnose the health concerns of patients/clients. Each BHW is also trained to discuss medically correct health information in the dialect or in a simple language that is easy to understand. (Handout to IPC/C Manual for HSP)

In the interview with Hilario, each participant from the regional offices in the national workshop is trained how to implement the health intervention program. The central office then expects the regional offices to conduct the same training in their respective regions, in particular, the provincial health offices. The provincial health offices then train the city health offices and the municipal health offices through the midwives assigned in each barangay.

Furthermore, Hilario mentioned that each region, province, municipality, city and even barangay level can create their own tools and ways to implement the various health intervention programs as long as it still follows the prescribe content. She even mentioned that it does not need any approval coming from the city health office nor the regional office.

Given these two structures that tends to compliment each other, it is appropriate to document how far a BHW follows and deviates from the prescribe format of implementing various health prevention programs of the Department of Health.

2. Methodology

This research documents and assesses the effectiveness of face-to-face interaction as external communication tool used by BHWs in implementing health intervention programs of the Department of Health using survey and interview as data-gathering tools.

There are two sets of respondents in this study. The first set of respondents are all Barangay Health Workers of Barangay Dawis, Digos City because they are the frontliners in implementing health intervention programs directed towards the immediate community. The data derived from the Barangay Health Workers include their opinions, impressions, and personal judgments on the traditional communication tools. The data likewise include the respondents' other methods of delivering these health intervention programs since the traditional communication

tools intended for the BHWs patients/clients are posters, leaflets, and face-to-face interactions. This study documented the methods of delivering health intervention programs adapting the survey questionnaire from WK Kellogg Foundation designed to document and assess the public relations communication tools of an organization (http://ola.wkkf.org/toolkit/assess/, accessed June 2008).

Each respondent is asked to identify and rate the communication tools directed towards their patient/client on a 5-point scaling system with 1 as the lowest and 5 as the highest. The ratings of each respondent are based primarily on their perception of how useful the communication tool/s is/are in delivering health care services. The qualitative data derived herein are from interviews of the respondents.

A total of 14 BHWs were surveyed and interviewed taking into consideration the whole population of BHWs in the area of study.

On the other hand, the second set of respondents comprises the clients/patients. The method of evaluation is adapted from Paulette Dale and James Wolf's *Speech Communication Made Simple: A Multicultural Perspective Second Edition (2000)* published by Addison Wesley Longman, Inc. The BHWs were evaluated on their Interpersonal Communication and Counseling Skills as perceived by the clients/patients. The criteria used is based on the Department of Health's Interpersonal Communication and Counseling Manual for Health Service Providers since the Center for Health Development Regional Office uses this manual to train BHWs in communicating with their patients/clients. Random sampling was employed and a total of 280 households were surveyed out of 899 households roughly comprising 31% of the total number of population.

All quantitative data from both sets of respondents were organized according to ordinal scaling and further subjected to computation for mean, frequency, and percentage.

Furthermore, this study is further delimited to the following:

- Significant others are not included in the elements observed because this study focuses on the health care provider and client transaction/interaction. The significant others of the patient/client, may it be parents, husband/wife, children, may greatly affect the transaction/interaction between the health care provider and the patient/client.
- Other non-verbal communication cues such as haptics, chronemics and proxemics are not considered.
- In terms of context/setting, only the house of the client and the Barangay are considered.
- The ratings/evaluations/assessments indicated in this study are non-parametric since all judgments presented herein are in the form of qualitative responses and are mostly based on the respondents' perceptions and self-judgments.
- Therefore, this study is limited in documenting the communication flow in delivering health care services and how the tools used in delivering these services are effective as perceived by the BHWs as frontliners of the DOH.

3. Results of the Study

Area of Study

Barangay Dawis is called Lawis by the IP (Indigenous People) group Calagan which means a body of water that has no outlet. It has a total land area of 175 hectares divided into residential and commercial lots. The Barangay is divided into nine puroks with 899 households each. As of 2007, the total population of the Barangay is 3,884.

The first inhabitants of the Barangay are the Calagans but Dawis, as it progressed into a commercial area with beach resorts and apartelles as major businesses, became a melting pot of several other local cultures which resulted to its having several dialects (B'laan, Tagakaulo, Bagobo, Muslim, Cebuano, Bol-anon, etc) spoken in the area.

In terms of budget, the barangay has an IRA of Php 1,109,784.00. It also receives Php 1,000,000.00 as aid from the City Mayor. A total of Php 100,000.00 also comes from the Real Property Tax and other Miscellaneous Income (Community Tax Certificate, Barangay Clearance etc.).

Currently, the barangay has 899 households divided into nine puroks. Each purok has several households as follows:

INSERT Table 1: Number of Household per Purok in Barangay Dawis, Digos City

A total of fourteen (14) barangay health workers service the total number of households. These Fourteen BHWs were assigned to the following areas/purok as follows:
INSERT Table 2: Number of BHWs per Area Ratio

Also, the following schedule is implemented by the Barangay Health Center.

INSERT Table 3: Weekly Schedule of the Barangay Health Center in Dawis, Digos City

Other programs include, a once-a-month weighing activity held for children 0 – 23 months old and a bi-annual weighing activity for 0 – 71 months old children. Other services include giving of Vitamin A twice a year, free anti-rabies injection once a year, giving of medicine for philariasis once a year, ligation twice a year and several medical missions either headed by the City Health Office or the Provincial Health Office.

Each BHW informs her/his clients/patients about the schedule during their house-to-house visit. Each client/patient is informed and educated about the importance of these consultations at these schedules since information dissemination and health education is done during these days at the Barangay Health Center. If the client/patient is not able to go to the barangay health center, the BHWs bring with them the medicines and distribute these house-to-house.

Also, clients/patients are informed about the various programs and schedules once they visit the Barangay Health Center.

Aside from being frontliners for Health Intervention Programs of the DOH, BHWs are also expected to do environmental scanning of their assigned area using the Community Based Information Sheet provided by the City Health Office. Each of them is also trained to perform this task.

Given this scenario, face-to-face interaction is the main method of BHWs in delivering information to their respective patient/client.

This study also assesses the external communication tools used by the Barangay Health Center in fulfilling its mandate that is to act as frontliners in providing health care services to and monitoring of the client/patient of the Barangay Health Centre or simply the residents of the Barangay. External communication tools are communication tools directed towards the clients/patients. These are posters, streamers, leaflets, one-on-interaction, direct mail, website, and more, produced by either the DOH Central Office or the City Health Office.

The Barangay Health Centre, working directly under the supervision of the City Health Office that is also under the Department of Health, offers services like monitoring, vaccination, pre-natal check-up, medicine disbursement, and referral to doctors.

INSERT Table 4: External Communication Tools used in Dawis, Digos City

For the BHWs to implement these programs, external communication tools are utilized. These include flyers, leaflets, posters, brochures, fact sheets, PSAs, and Face-to-Face Interactions. Posters are least used because the Barangay Health Workers do not bring these posters as they visit households in their area. One major reason is lack of copies. Even if the BHWs are trained in using printed IEC materials in spreading medically correct information, the

lack of materials is the main problem. With this, face-to-face interaction is the most commonly used method in dealing with the external public.

Among the external communication tools enumerated, only two external communication tools are identified as the most effective tools in relaying information to the external public – PSAs and Face-to-Face interactions.

Hilario also mentioned that each unit, may it be province, municipality, city, or barangay, is allowed to come up with communication tools to implement various health intervention programs without the approval of the regional office nor the city health office as long as each barangay health center follows the prescribe content and format of the central office. In Dawis, they do not produce/design their own communication tools so they intend to rely on the tools in which they have full control of – face-to-face interaction.

Since face-to-face interaction is considered most effective, it means that all useful information intended for the client/patient is handed down through small group discussions and one-on-one interactions making the Barangay Health Workers the responsible authorities in producing their own external communication tool. Another tool widely used by the BHWs is text messaging.

The Barangay Health Workers were also asked to identify the external communication tools they consider as important and if they need more skills in producing these tools.

These include public service announcements, community meetings, one-on-one interaction, and designing/writing semi-annual/annual reports. The rest of the popular communication tools like campaigns in print and new media were considered less important.

It should also be noted that although the semi-annual/annual report is classified for both internal and external publics in the field of public relations, the respondents perceive this as an internal communication tool only.

This study also aims to know if the currently used external communication tool is effective in relaying information. This way, the authority concerned will develop a method of improving the identified tool for patient/client. There is emphasis in external communication tools because the nature of the organization is service-centered.

The evaluated external communication tool is face-to-face interaction since it was identified as the most commonly used tool. This means that the Barangay Health Workers were evaluated as a medium of communication. They were evaluated using three core criteria in the context of speech and health communication. Under health communication, four health care variables are examined. These are empathy, trust, self-disclosure, and confirmation. On the other hand speech communication evaluates the delivery, content, and handling of message.

INSERT Table 5: Over-all Evaluation of BHWs as Medium of Communication

Table 5 shows that the over-all evaluation of the Barangay Health Workers as a medium of communication is Good. It means that face-to-face interaction is a good tool in delivering information to the clients/patients. The Barangay Health Workers are able to persuade the clients/patients to go to the Barangay Health Centre to avail of the programs and services that they offer. It also means that the Barangay Health Workers have enough knowledge on the subject matter. Furthermore, the external public communicates openly with the Barangay Health Workers because they are trustworthy. In terms of delivery, the Barangay Health Workers are good speakers based on the high average results in the different variables under delivery.

For individual analysis, each Barangay Health Worker was given an assigned number according to their questionnaire.

1 - Esterlita Candia
2 - Shirly Aballe
3 - Corazon Alcala
4 - Emma Navaja
5 - Linda Capuso

6	-	Cerila Empic
7	-	Nelda Francisco
8	-	Ma. Concepcion Hyde Luang
9	-	Norma Bolon
10	-	Leonila Gelves
11	-	Julita Labor
12	-	Luzvisminda Llagas
13	-	Feliciana Navaja
14	-	Nerry Bocoya

INSERT Table 6: Individual Analysis of Respondents in Delivery, Health Care Variables, and Content

4. Discussion

The flow of communication in the grass root implementation of health intervention programs is discussed under three subheadings: The Flow of Information, Supplementary Communication Tools, and Transactional Communication Model and Issues on Disclosure.

The Flow of Information

As described, the Barangay Health Center works under the supervision of the City Health Office. All communication materials for clients/patients are from this agency making the flow of information top-down flow.

On the other hand, the top-down flow of information affects the delivery of health intervention programs. Aside from possible communication breakdown due to noise, this can also be attributed to the lack of external communication tools like flyers, leaflets, brochures, and fact sheets distributed to the various Barangay Health Centers in the City and the lack of capacity for each center to produce its own materials. That is the reason why Barangay Health Workers rely on face-to-face interaction only, supported with printed communication materials of which they are also trained in using. These printed materials come from the Department of Health Central Office and are given to the City Health Office through several channels. Since most ofthe materials follow a generic content, these may not help in the

process of implementing various health intervention programs. The communication tools used by the Barangay Health Workers should be tailor fitted to the needs of each Barangay.

Hilario also said that there are instances that the regional office translates a material from the central office to Bisaya but this action also depends on the capacity of the region, the municipality, and the city to reproduce this material that can be perused by all barangays. She even mentioned that sometimes the Center for Health Development Regional Office produces just one copy of a translated material that is used, not in the barangay lectures, but in schools.

Furthermore, since the top-down flow of information affects the delivery of health intervention programs, it can also affect the delivery of such program at the barangay level because all kinds of information coming from the City Health Office are handed down to the midwife assigned in the Barangay. The midwife then passes the information to the Barangay Health Workers. Since the BHWs rely on face-to-face interaction, they only pass on what is handed down to them by the midwife. This flow of information is affected if the information coming from the City Health Office is not properly passed on to the midwife. This indicates that the top-down flow of information affects the effectiveness of the external communication tools identified in this study.

Health Care Variables (empathy, trust, self-disclosure, confirmation, and control) are also affected by face-to-face interaction. All Barangay Health Workers are residents of Barangay Dawis and each of them is assigned in a specific area. It is not a pre-requisite that if they serve the *purok*they live in. Instead, each *purok* is assessed in terms of its health care needs.

Since Barangay Dawis is a small barangay with 899 households, it is not impossible to know everyone in the area. If a Barangay Health Worker is assigned in an area where she is known, empathy, trust, and self-disclosure can easily be achieved. Confirmation and control are established after the three health care variables are present.

Furthermore, familiarity of the residents with the Barangay Health Worker is important in building the HSP-client/patient relationship.

It is good to note that the BHWs, due to lack of printed communication materials, also rely on text messaging as alternative communication tool to disseminate information on various health intervention programs. Given the fact that there are a few printed materials available for dessimination and since most of them are not trained to produce their own communication materials, barangay health workers devised a way for them to communicate with each other to keep them posted of the activities of the barangay and of the clients/patients in their assigned area of responsibility.

There are several reasons why members of an organization find various ways to communicate with their publics. According to Marshall Scott Poole's Adaptive Structuration Theory, "members in groups are creating the group as they act within it." This shows that if there were gaps within the process of fulfilling the mandate of the Barangay Health Centre, BHWs would look for solutions, not necessarily mandated by their superior, to fill the gaps in the communication process. They continuously monitor their areas by all means necessary.

This would further lead to the use of *rules* and *resources* within the context of Adaptive Structuration Theory. Rules are defined as "propositions that indicate how something ought to be done or what is good or bad." (Griffin, 2006) The basic trainings BHWs get from the City Health Office on how to handle clients/patients are considered rules in this context. These are sets of theories and how-to-instructions in order for them to reach their goal – to provide medical intervention. Resources, on the other hand, are "materials, possessions or attributes that can be used to influence or control the actions of the group or its members." (Griffin, 2006.) Relationships and expertise on the subject matter, two of the variables the BHWs are evaluated upon, are considered resources. Since they could not bring printed materials during their home visits due to lack of copies and costly production of their own communication tools, they

need to improvise. This improvisation – the use ofan alternative communication tool, is based on their relationship with the people in their assigned area. Since they received trainings from the City Health Office, they are considered the person-in-authority when it comes to health concerns making them sort of "experts" in medical intervention. This also proves Poole's claim as cited in Griffin (2006) that "group structures can constrain members from acting freely" making improvisation inevitable. The lack of training in business communication and the inductive method of processing group interactions resulted to improvisation in the part of the BHW.

There are several reasons why they need to go beyond traditional communication channels and go for technology-mediated communication. To address the needs of their external publics, BHWs identified the following needs:

Training in culturally-rooted face-to-face interaction;

Training in public speaking;

Training in Environmental Scanning;

Training in processing group interactions;

Training in Message Development; and

Training in Event Planning.

With these needs identified, it is clear that there are a lot of things to be done for the BHWs to be well equipped with knowledge and skills in the field. But to provide all these trainings to all BHWs would be expensive. There is also a need to factor-in the fact that being a BHW is voluntary and in Dawis, the BHWs are sometimes co-terminus with a government official. They can only keep their post for at most 3 years. Given this fast turnover of volunteers, it would be very expensive to repeat the same training every 3 years.

Since not everyone has the skill to design communication tools intended for their clients/patients, they resort to the

simplest and fastest way to communicate with each other – text messaging.

Supplementary Communication Tools

All BHWs rely on text messaging to inform their clients/patients in their respective areas of responsibility about the various health intervention programs of the Barangay Health Center.

According to Nelda Francisco, one of the BHW respondents, text messaging makes their work easier and it makes transmitting information faster. Linda Capuso also points out that the only problem they encounter with this tool is lack of prepaid credit. But with the unlimited text and call promo of telecom companies, this tool will be less expensive compared to printing posters and the use of other traditional media. Other than that, face-to-face interaction is still the medium used in delivering information and instruction to the clients/patients of their assigned area.

It is also good to note that the BHWs get the cell phone number of a representative from each household. This way, it will be easy for the BHWs to inform the residents of their assigned area of any activity of the barangay health centre reducing the physical cost of the BHW.

The health care providers also acknowledge the fact that posters are not enough to communicate health messages. When speed is priority, BHWs resort to technology.

Transactional Communication Process and Issues on Disclosure

In accordance to the goal of the Department of Health to adopt Behavior Change Communication (BCC) as one of its main approaches in addressing a particular health issue, the IPC/C Manual highlights the need for a transactional form of communication – a give-and-take scenario. Although it is evident in the result of the study that this has always been the objective, it is only recently that *"the government tried to adopt a more systematic and more deliberate approach to equip health service providers facilitate and support behavior*

change in their patients/clients." (Handout to IPC/C Manual for HSP)

INSERT Image 1: Transactional Model of Communication

It is deemed important that the health care providers be trained in alternative ways of delivering health intervention programs to their clients/patients. However, there is a problem in terms of level of disclosure of client/patient to BHW.

The reason why people do not disclose is the same reason why BHWs are/should be residents of the barangay they serve. If clients/patients have difficulty disclosing to their doctors, how much more to a BHW who is no stranger to them?

As Parrott said, disclosing, and even simply talking about health, "defines our *self*." It builds an identity and somehow "connects to our self-concept." These "identities form not just around our health status but also around those who work in health care and places where care is given." (Parrott, 2009)

For instance, the family planning program, which involves selling of contraceptives like pills and the dissemination of information about various family planning methods through lectures in the barangay health centers and house visits, may have helped educate couples. But there are some who ends up getting pregnant despite educating them about family planning methods. These women, who diligently attend the lectures, would not easily disclose to the BHW of their pregnancy for fear of judgment which will end up to an untimely announcement of their pregnancy through grapevine dissemination.

This scenario happened to Nelda Francisco. As BHW, her task also includes monitoring of those couples identified to have used a method of family planning. If this couple would not inform the BHW, one problem of non-disclosure would be exclusion to some health care services of the barangay health center intended for pregnant women just because nobody knew.

There are two possible focal points where communication breakdown are seen: 1) the IPC/C Training Manual; and 2) promoting (mis)understanding in communicating about health concerns.

The IPC/C Training Manual

According to Hilario, the IPC/C Training for HSPs is generic in nature. She also said that each health care program training include how to effectively communicate with clients/patients. The primary concern is to deliver a correct health care education program. The manual also works on the assumption that since a BHW is a resident of the barangay, clients/patients would easily disclose to them.

Emma Navaja also mentioned that they were trained both in verbal and non-verbal communication which includes eye contact, facial expressions and gestures, and even highlighting physical appearance.

In fact, after carefully studying the manual, it provides a complete guide on how to conduct oneself as a BHW. The only setback in the manual is downplaying health communication as transactional communication. It focused only on the sender of the message adhering to a linear type of communication. This in turn results to BHWs devising ways to get accurate responses from their clients/patients. There should be a part in the manual that trains the BHWs in understanding their clients/patients.

Tomas Andres (1988) said that to be a community trainer/facilitator/leader, one should go beyond information giving and data gathering. It should also include problem-identification and analysis, as well as interaction with the community.

With the current IPC/C Manual, it only educates BHWs around information giving and data gathering. Therefore, problem-identification and analysis, and identifying solutions only revolve around information giving and data gathering.

In fact, text messaging as a solution to information giving and sometimes data gathering is not part of the manual even if DOH-Central Office is aware of this. It is the initiative of BHWs to use this method for them to fulfill their duties and responsibilities.

As an additional tool to the traditional print and face-to-face interaction, there is now a need to develop a training on crafting brief messages like text messaging.

In the context of compliance, BHWs use reward and punishment system to elicit action from their clients/patients. As Nelda Franscisco puts it, *"usahay hadlukon namo sila para lang muadto sa center."* (Trans. Sometimes we scare them just so they visit the (Barangay Health) Center.)

Scaring them means not including them in the future programs of the Barangay Health Center. This strategy is definitely not in the IPC/C Manual and even Business Communication Manuals. In business communication, the "YOU" attitude should be observed in crafting messages. (Bovee, 2010)

It is then evident that BHWs suffer from emotional labor since their roles often change in the community. At on point they are concerned and caring HSPs, on the other, they are strict headmistresses imposing rules and giving punishments to those who disobey. Although most often they follow the IPC/C standards in dealing with client/patient, sometimes they deviate from the SOP and instead use reward and punishment system.

The closest the manual can provide to understanding client/patient is defining what motivation is and identifying the barriers to behavioral improvements. Aside from role-playing during the training as an application of the various phrases to "motivate" client/patient, BHWs have no other trainings in motivating adults.

Andres (1988) discussed a method of understanding the Filipino community. The BHWs should be trained in

understanding the Filipino, his sources of values and his role and understanding of development. Afterwhich, a more specific method of motivating should be designed by the DOH Central Office patterned after the Adult Learning Cycle as discussed by Ortigas (2008) in *Group Process and the Inductive Method.*

Promoting (Mis)Understanding in Communicating about Health Concerns (Parrott, 2009)

This aspect of communicating health concerns is coined by Parrott (2009) to explain another area of possible communication breakdown.

According to Parrott (2009), "our ability to understand sumptoms, give informed consent, and make informed decisions about health come from communicating about health." There is communication breakdown if the HSP and the client/patient do not understand each other specially if the HSP uses medical jargons.

Doctors usually rely on metaphors and analogies in explaining health issues to clients/patients. Juan Flavier (2002) even documented the various metaphors and analogies he used in educating rural folks on family planning.

The communication breakdown happens when the metaphor and/or analogy does not work. Oftentimes, an analogy and/or metaphor only works if there is enough common field of experience between sender and receiver of the message as illustrated in the transactional model of communication.

Sometimes, folk beliefs interfere with new medicine. With Barangay Dawis, this should also be taken into consideration since the barangay has become a melting pot of various cultures and traditions and beliefs. This is true with other barangays in the country. Health communication is not just transactional it becomes intercultural as well.

Geist-Martin, Ray, and Shart as cited in Angelelli and Geist-Martin (2005) clearly emphasized that "the differences in health care beliefs and practices of persons seeking and providing health care can lead to problems in communication with one another."

5. Implications

The changing health communication landscape tells us that with the improvement of technology, newer and better tools are used to relay information to elicit action. As cited in *Speaking of Health: Assessing Health Communication for Diverse Population* published by the Institute of Medicine of the National Academies (2002), various "innovative uses of current technologies"now includes Tailored Print Communication, Telephone Delivery Interventions, and Interactive Health Communication.

These forms of communication also change with the constant improvement of the medium itself i.e. smartphones. However, despite improvements in the way we communicate, face-to-face interactions between HSPs and clients/patients us still necessary.

Also, various efforts to use other communication tools in delivering health care services have been documented as well – the Leprosy Intervention Project in Nepal, HIV/STDs Intervention in Vanuatu, and Health Information Drive in Nigeria – all uses Theater in delivering health care information. The debate now situates on the issue on which communication tool best transmit information and elicit action from the clients. (Dagron, 2001)

Moreover, several studies conducted already proved that the traditional communication tools – posters, flyers, etc., are not always enough in transmitting information and eliciting action. Combining these media alternatives with the traditional communication medium will help in information dissemination and health education activities of the barangay health centers in the country.

Also, knowledge of folk healing practices is important in designing a targeted communication tool for health education. (Geist, 2000) This way, the provider will be able to communicate to their clientele with empathy, sensitivity, and open-mindedness.

If these elements in face-to-face communication are perfected, patients will be more open to the various health intervention programs provided by the barangay health workers.

Overall, text messaging is best used to inform and instruct compared to other traditional tools used to communicate within the describe communication scenario. But despite the use of a fast and convenient way to inform and instruct, problems are still encountered. Clients/Patients and even Barangay Health Workers still consider the information less formal which makes it easy for them not to act on it. A good example would be coming in late for a meeting of BHWs just because they were informed via text message.

However, the informality of text messaging perceived by the clients/patientsmay not always apply because the BHWs also use face-to-face interaction to reinforce text messaging as text messaging reinforce face-to-face interaction. Yet heads of families, wives, and children have their own personal reasons not to attend regular check-ups and vaccinations done in the health centre. They may have received a text message from their assigned BHW yet it is up to them to act on the information.

This will bring into focus the issues of stability and change of the alternative media used. There is now the question of how stable and reliable text messaging and face-to-face interaction are as communication tools. There is also a need to accept the inevitable change that someday, text messaging, and perhaps face-to-face interaction, will be replaced with another tool that will make information dissemination easier, faster, and more convenient for both parties involved in the communication process.

The BHWs can be trained in IPC/C but it is still up to the BHW to come up with a mix of strategic communication interventions to make the health intervention programs of the government more accessible. May it be the use of technology like smartphones or using reward and punishment as strategy to mobilize the community, the BHWs ultimate goal is to deliver these health intervention programs to the people they serve.

Afterall, in health communication, the ultimate goal is behavioral impact. For someone to act on something, that person needs the following: correct information, education, persuasion, community involvement, advocacies, mobilized society, and a committed government, all applied to health behaviors. (Handout to IPC/C Manual for HSP)

Bibliography:

Books

Andres, Tomas Quintin D. (1988). *Community Development: A Manual.* New Day Publishers, Quezon City, Philippines.

Angelelli, Claudia V. and Patricia Geist-Martin. (2005). "Enhancing Culturally Competent Health Communication: Constructing Understanding Between Providers and Culturally Diverse Patients." Pp271-283. In: Ray, Eileen Berlin. Health Communication in Practice: A Case Study Approach. Lawrence Erlbaum Associates, Inc., New Jersey.

Apker, Julie. (2005). *"Role Negotiation, Stress and Burnout: A Day in the Life of Supernurse."* Pp245-260. In: Ray, Eileen Berlin. Health Communication in Practice: A Case Study Approach. Lawrence Erlbaum Associates, Inc., New Jersey.

Barangay Primer. Republic of the Philippines.

Baskin, Otis, Aronoff, Craig, and Dan Lattimore. (1997). *Public Relations: The Profession and the Practice.* Brown & Benchmark Publishers, Dubuque, IA.

City Primer. Republic of the Philippines.

Dale, Paulette and James Wolf (2000). *Speech Communication Made Simple: A Multicultural Perspective* (2nd ed.) Addison Wesley Longman, Inc.

Dagron, Alfonso Gumucio. (2001) *Making Waves: Stories of Participatory Communication for Social Change*. The Rockefeller Foundation, New York.

Flavier, Juan M. (1974). *My Friends in the Barrios.* New Day Publishers, Quezon City, Philippines.

Geist, Patricia. (2000). *"Communicating Health and Understanding in the Borderlines of Co-Cultures."* Pp341-354. In: A. Samovar and R.E. Porter. Intercultural Communication: A Reader. Wadsworth Publishing Company, Belmont, CA.

Griffin, Em. (2006). *A First Look at Communication Theory* (6th ed.). McGraw Hill, Boston, MA.

Lesley, Philip. (1998). Lesley's Handbook of Public Relations and Communications. NTC Business Books.

Littlejohn, Stephen W., & Karen A. Foss. (2005). *Theories of human communication* (8th ed.). Thomson Wadsworth.

Local Government Code of 1991. Republic of the Philippines.

National Academy of Sciences. (2002). *"New Communication Applications and Technologies and Diverse Populations."* Pp179-223. In: Institute of Medicine of the National Academies. Speaking of Health: Assessing Health Communication Strategies for Diverse Populations. The National Academies Press, Washington, DC.

________________________. (2002). *"Health Communication Campaigns Exemplar."* Pp76-126. In: Institute of Medicine of the National Academies. Speaking of Health: Assessing Health Communication Strategies for Diverse Populations. The National Academies Press, Washington, DC.

Ortigas, Carmela D. (2008). *Group Process and the Inductive Method: Theory and Practice in the Philippines.* Third Edition. Ateneo de Manila University Press, Quezon City, Philippines.

Parrott, Roxanne. (2009). *Talking About Health: Why Communication Matters.* Wiley – Blackwell, UK.

Manuals

Department of Health and HealthPRO. (2012) Interpersonal Communication and Counselling Manual for Health Service Providers.

Online Sources

McNamara, Carter. (2007) *Thinking About Organizations as Systems*. Retrieved June 22, 2008.

_______________. (2007) Basic Definition of Organization. Retrieved June 22, 2008.

_______________. Communications Toolkit. Retrieved June 13, 2008. [On-line] Available from: http://ola.wkkf.org/toolkit/assess/.