Important but Neglected: A Qualitative Study on the Lived Experiences of Barangay Health Workers in the Philippines

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ABSTRACT

Background and Objective. Within a decentralized health system, barangay health workers (BHWs) are often the first point of contact for Filipinos seeking care. Despite their importance, BHWs are neglected in the health value chain. The study seeks to examine the lived experiences of BHWs, particularly their journey in navigating their roles within the community and the health system that encompasses their day-to-day realities, challenges, motivations, and the meanings they derive from their work.

Methods. The study draws on seven focus group discussions (FGDs) with BHWs (n=50), residents (n=7), and local government officials and health workers (n=7) of San Miguel, Bulacan. The qualitative data collected were analyzed using thematic analysis.

Results. Findings show that BHWs perform many roles, which are not limited to health and are dependent on orders from their superiors. Guidelines are vague in appointing BHWs, with personal connections valued more than technical qualifications. Their accreditation is hardly conferred any significance. There is also a lack of formal and structured training. The informality of these processes leads to an absence of quality assurance on rendered health services. The non-provision of incentives and benefits stipulated in RA 7883 also places their health and lives at risk. Furthermore, BHW's commitment to serve is used to excuse the inadequacy of their compensation and excessive workload.

Conclusion. BHWs take on diverse roles, from community organizers to healthcare providers, and are confronted with significant challenges encompassing politicization, inadequate training, and insufficient compensation. The study concludes with policy recommendations to improve the conditions of the neglected BHWs, with particular attention to coordinating, capacitating, compensating, career pathing, and connecting them to the health system.

Keywords: barangay health workers, community health workers, universal health care, health systems, Philippines

INTRODUCTION

Health in the Philippines is inequitable. For many, basic health care services remain out of reach.[1-3] This is especially lived by Filipinos in rural and far-flung areas, who are most impacted by the maldistribution of health facilities.[4-6] Nearly half of the Filipino population are unable to access primary care facilities within 30 minutes.[7] This persistent health inequity is a solemnly recognized yet unsolved issue in the country. The most recent and most comprehensive intervention to address this is the enactment of the Universal Health Care (UHC) Act in 2019. The UHC Act aims for every Filipino to have "equitable access to quality and affordable health care goods and services."[8] To reach this goal, strengthening primary health care is paramount.[9-12] Considered as the cornerstone of UHC, the importance of primary health care in UHC is jointly vouched by the Department of Health and

eISSN 2094-9278 (Online)
Published: July 15, 2025
https://doi.org/10.47895/amp.vi0.9589

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World Health Organization, with primary health dubbed as "the fairest and most affordable path to universal health coverage."[13] At the front lines of implementing primary health care are community health workers (CHWs).

CHWs refer to trained health workers with minimal to no formal medical training, tasked to provide patient-centered care and promote health. They act as essential cadres in the delivery of health services, especially in low- and middle-income countries.[14-21] The 1978 Alma Ata Declaration of Primary Health Care recommended their increased participation in primary health care, deploying them at the household level to connect community members to health facilities and services.[22-24] The Philippines was one of the first countries who adhered to this recommendation.[25]

In the 1990s, the Philippines moved toward a decentralized system through the enactment of Republic Act No. 7160 or the Local Government Code. The code ushered in the devolution of health services: the DOH overseeing the overall performance of the health system and the local government units in charge of direct delivery of health services. It also underscored the importance of first-level health facilities, such as rural health units and barangay health stations.[26-31] CHWs often act as the first point of contact with health systems in these decentralized health systems.[32] In the Philippines, the CHW initiative features barangay health workers (BHWs).[29,32]

The Republic Act 7883 defines barangay health workers as those who have "undergone training programs under any accredited government and non-government organization and who voluntarily renders primary health care services in the community after having been accredited to function as such by the local health board in accordance with the guidelines promulgated by the Department of Health (DOH)."[33] BHWs act as bridges between the community and the health system and are the first part of contact for patients in local health centers.[34,35] They also serve as the key source of information in rural and far-flung areas and in fact are crucial in delivering health services in these disadvantaged communities.[19,21,36] Furthermore, BHWs are tapped to fulfill the role of health navigators under the UHC system. The Department of Health seeks to train BHWs to be primary care providers in primary, promotive, curative, rehabilitative, and palliative care as part of the initiative to strengthen province-wide and city-wide health systems.[37]

Yet despite their integral role to the health system and the pursuit of universal health coverage, BHWs are considerably neglected in the health value chain. They are treated as volunteers rather than regular workers, thereby only earning compensation in the form of honoraria or allowances. The amount received by BHWs are unstandardized, inadequate, and often delayed.[35] This neglect has been most pronounced during the COVID-19 pandemic. Mobilized as frontliners in the COVID-19 response and tasked with monitoring the health status of community members and conducting contact tracing, BHWs constantly risked their health by interacting with potential—or even confirmed— carriers of the virus. Yet despite risking their lives, many report not receiving reciprocal care from the state, unable to receive the promised hazard pay in exchange for their service. According to BHW Partylist Representative Angelica Co, BHWs are only provided hazard pay when there are excess funds from the cash assistance.[36] This starkly demonstrates how BHWs are relegated to the least priority despite their essential contribution.

As such, this study intends to examine the lived experiences of BHWs. Lived experiences refer to one's embodied experiences of themselves and the world.[38] The study specifically seeks to explore the journey of barangay health workers in navigating their roles within the community and the health system, encompassing their day-to-day realities, challenges, motivations, and the meanings they derive from their work. These are complemented by insights from individuals in their lifeworld, including community members and local government officials. The present study seeks to contribute to a deeper understanding of how BHWs perceive and make sense of their role, and bring to light the overlooked conditions and contributions of BHWs in the Philippines.

METHODS

Research Approach and Paradigm

The study employs a qualitative research design to gain a comprehensive understanding of the subject of inquiry.[39] It specifically adopts the phenomenological approach. Defined as the reflective study of pre-reflective experience,[40] phenomenology seeks to "fully describe a lived experience."[41] The study is underpinned by the constructivist paradigm, which allows for in-depth exploration of phenomena.[42] Constructivism primarily aims to understand why and how phenomena occur and how people make meaning out of them.[43] The approach and paradigm are chosen since the present study centers on lived experiences.

Research Locale

The study was conducted in San Miguel, Bulacan. San Miguel is located in the third district of Bulacan, with a land area of 23,140 square kilometers. Its recorded population in 2020 is 172,073.[44] The landlocked municipality is politically subdivided into 49 barangays. All barangays had BHWs, reporting either to the barangay or the Municipal Health Office located in Poblacion. The focus group discussions (FGDs) with BHWs covered all barangays, broken down into five separate sessions (Table 1).

Data Collection

The study involved three groups of participants: BHWs, residents, and local government officials and health workers of San Miguel, Bulacan. Seven FGDs were conducted from October 6 to October 26, 2022 in a university located at Poblacion, involving a total of 64 participants (Table 2).

Table 1. Distribution of FGD Sessions according to Barangays

Barangays	No. of participants	No. of FGDs
Cluster A	10	1
Bulualto		
Pulong Duhat		
Bantog		
Sacdalan		
Bariton		
King Kabayo		
Pinambaran		
Cambio		
Sapang		
Buga		
Cluster B	10	1
Bagong Pag-asa		
Salacot		
Ilog-Bulo		
Bagong Silang		
Mandile		
Batasan Matanda		
Batasan Bata		
San Agustin		
Salangan		
Sta. Rita Matanda		
Cluster C	11	1
San Vicente		
San Jose		
Poblacion*		
Tigpalas		
Sta. Rita Bata		
Paliwasan		
Biclat		
San Juan		
Tibagan		
Labne		
Cluster D	10	1
Balite		
Camias		
Buliran		
Santa Ines		
Tartaro		
Masalipit		
Balaong		
Pulong Bayabas		
Pacalag		
Magmarale		
Cluster E	9	1
Bardias		
Santa Lucia		
Partida		
Lambakin		
Calumpang		
Maligaya		
Malibay		
Sibul		
Biak-na-Bato		
Total	**50**	**5**

**There were two participants from Poblacion, which was the site of the FGD.*

Note: There was at least one participant from each barangay of San Miguel, Bulacan.

Table 2. Distribution of FGDs according to Participant Group

Group	Description	No. of Participants	No. of FGDs
BHWs	Registered BHWs with at least one year of service	50	5
Residents	Residents with at least one dealing with BHWs	7	1
Local government officials and health workers	Barangay captains, barangay kagawad on health, rural health midwives, rural health unit members	7	1
Total		**64**	**7**

This is deemed sufficient to reach data saturation as it is within the recommended four-to-eight focus group range, found to be most applicable for studies with relatively homogenous populations and defined objectives.[45] The study also adhered to the recommended size of focus groups of between six to twelve participants, expected to be small enough to be conducive for sharing while large enough to allow for diversity.[46]

The study employed purposive sampling, intentionally selecting participants according to their ability to elucidate a specific phenomenon.[47] Participants of the present study were chosen according to their experience and knowledge related to BHWs. The recruitment of participants was done through prior arrangements with the Municipal Health Officer of San Miguel.

FGD guides were developed for each group of participants. The FGD questions followed a two-part structure, with the first part focusing on the lived experiences of BHWs. Researchers asked the participants to walk them through the day-to-day experiences of BHWs. The questions also covered how they learned about the job, the appointment process, training, and accreditation. The guide also covered questions on compensation, work-related challenges, and personal difficulties faced by BHWs. Meanwhile, the second part tackles the insights of participants on policy recommendations intended to improve the conditions of BHWs. These include exploring their roles as health navigators, probing the voluntary nature of their work, and dissecting their workload.

The FGDs adhered to an iterative process, which entailed reviewing data after each FGD session and making adjustments to the discussion guide. This process involved modifying certain topics based on newly gathered insights and broadening the scope to investigate emerging points of interest. Follow-up questions that drew out detailed responses were also integrated to enhance the depth and direction of the discussions in the subsequent sessions. Throughout the study, the researchers declare no characteristics or conditions that influenced the conduct or outcomes of the findings. The research team maintains rigor and objectivity and raises no conflicts of interest.

Table 3. Sex and Age among Barangay Health Workers

Characteristics	n (%)
Sex	
Female	50 (100)
Male	0 (0)
Intersex/Others	0 (0)
Prefer not to say	0 (0)
Age group (years)	
15 - 19	0 (0)
20 - 29	0 (0)
30 - 39	4 (8)
40 - 49	18 (36)
50 - 59	19 (38)
60 and above	9 (18)
Prefer not to say	0 (0)

Data Processing

The sessions were also audio-recorded with the written and verbal consent of the participants. The audio-recordings were transcribed thereafter, with the transcripts cross-checked against the recordings to ensure accuracy. The recordings were promptly destroyed after transcription. Additionally, the transcripts did not mention any names or identifying details, using identification codes in its place. All data were only accessible by members of the research team who had sworn to confidentiality. Excerpts used in the final report were similarly de-identified to ensure that they cannot be traced to the participants.

Data Analysis

Thematic analysis was used to analyze the qualitative data gathered, which identifies patterns of meaning or themes across a data set, allowing researchers to make sense of shared experiences.[48] The researchers extracted the recurring themes from the transcripts, conducting a preliminary coding through open reading. The transcripts then went through several rounds of coding to refine the identified themes. The themes were finalized through consensus among the team members to minimize subjectivities. To verify the trustworthiness of the data, triangulation was employed by situating the findings in the existing literature. The researchers also maintained an audit trail through the use of memos in their individual fieldnotes, which were collated after every FGD session.

Ethical Considerations

Ethical approval for the study was obtained from the University Research Ethics Committee (UREC) of Ateneo de Manila University. The researchers also obtained written informed consent from BHWs prior to conducting the FGDs. The participants were assured confidentiality and anonymity. Furthermore, it was clarified that their participation in the study is purely voluntary, and they are free to withdraw their participation at any time.

Table 4. Educational Attainment and Years of Service among Barangay Health Workers of San Miguel, Bulacan (n=50)

Educational attainment	n ()
No formal education	0 (0)
Elementary level	1 (2)
Elementary graduate	3 (6)
High school level	14 (28)
High school graduate	18 (36)
College level	11 (22)
College graduate	3 (6)
Prefer not to say	0 (0)
Years of service (years)	
1 - 5	6 (12)
6 - 10	15 (30)
11 - 15	13 (26)
16 - 20	5 (10)
21 - 25	5 (10)
26 - 30	1 (2)
31 - 35	1 (2)
36 and above	4 (8)
Prefer not to say	0 (0)

RESULTS

Demographic Characteristics

All BHWs in the study identified as female at birth (n = 50, 100%). This is aligned with the number of BHWs nationwide. As of November 2, 2022, the recorded number of BHWs is 232,243. The overwhelming majority of them are female, comprising 229,219. In stark contrast, only 3,024 are male.[49] When this gender imbalance was pointed out, the participants recounted knowing around three male BHWs, but acknowledged that most were female.

In terms of age, the majority of BHW participants (n = 19, 38%) are between 50 to 59 years old. In the national BHW registry, it was reported that the majority of BHWs were 60 years old and above, closely followed by the ages of 50 to 59 (Table 3).[49]

Thirty-six percent (36%) (n = 18) of the participants answered high school graduation as their highest educational attainment, echoing the national data. Finally, most participants have been in service for 6 to 10 years (n = 15, 30%). Notably, four participants (8%) have more than 35 years of experience (Table 4).

The Journey of a Barangay Health Worker

This study maps the journey of a BHW in San Miguel, Bulacan. It delves into the role they play in their community and in the health system as a whole. The present research also looks at the processes that BHW undergo, from appointment to receiving remuneration, and the challenges they experience. Table 5 compiles illustrative quotes for all five themes.

Table 5. Summary of Themes and Supplementary Quotes

Theme	Quotes
Performance of multiple roles	*We go to the patients to deliver medicine. We are called even at nighttime to inform us when someone tests positive for COVID-19 so we can get their data and provide them to the contact tracer. (BHW)*
Political nature of appointment	*If the barangay captain does not want you, even if you're qualified, you will inevitably be removed. (BHW)*
Limited impact of accreditation	*It was needed at first. However, due to the pandemic, there were no training and seminars held. We were renewed as long as we have volunteer experience. (BHW)*
Minimal conduct of training	*We are not trained to reach [BHW] competencies yet because there are no policies in place. (BHW)*
Inadequacy of compensation	*The little amount they receive is not commensurate with their contribution to the community. (LGU)*

Roles

The Implementing Rules and Regulations of RA 7883 outlines the general duties and responsibilities as a community organizer, educator, and health care services provider, but also acknowledges that the work of BHWs varies from community to community, depending on the agreement between the BHW and the community leaders.

Notably, there were BHWs who were initially unaware of the roles and responsibilities before joining:

> *Before I became a BHW, I had no idea what a BHW is and what they do. I had no experience. Those who are sick will come to you. I asked myself if I were performing the roles of a doctor, nurse, or midwife. Sometimes, people would call me, ask for my help and assistance.* (BHW)

Upon taking on the role, BHWs find themselves performing many tasks. They handle pregnancy, providing information on family planning and conducting prenatal and postnatal checkups. BHWs are also involved in vaccination drives. Their roles are mainly supportive, involving record-keeping and assisting the midwives who administer the vaccines. They also make announcements and follow up on those who do not show up.

For BHWs, persistence is a virtue. Many recount how they have to relentlessly remind residents, not only to vaccinate but to partake in health activities – family planning, prenatal care for pregnant women, and general maintenance of medicine for the residents. However, some BHWs face difficulties in convincing those who are hesitant to take the vaccine, stating *"We feel like we are not in the position to explain because we are not knowledgeable enough."*

BHWs are also involved in disaster and calamity responses. However, their roles are limited to relief operations and record-keeping. BHWs monitor disaster-prone areas, especially flood-prone areas that carry the risk of leptospirosis. They also document the aftermath of disasters, reporting damages incurred on buildings.

Furthermore, BHWs are critical actors in the COVID-19 response. A BHW shared, *"We go to the patients to deliver medicine. We are called even at nighttime to inform us when someone tests positive for COVID-19 so we can get their data and provide them to the contact tracer."* The work of BHWs mandates them to interact with potential – and even confirmed – carriers of the virus. Some BHWs shared how they contracted the virus and infected their family members, one of which died as a result. Aside from monitoring and providing medicine to COVID-positive patients, BHWs were also tasked to manage social assistance given to residents. Furthermore, the pandemic underscored how BHWs are expected to be available 24/7.

BHWs also assist community members in gaining and using PhilHealth coverage. Some even pay out of their own pockets to acquire the member's data records of residents. However, many BHWs have no coverage of their own. Those who do are covered not because they are BHWs, but because they are senior citizens or beneficiaries of the Pantawid Pamilyang Pilipino Program (4Ps). Some BHWs shared how their PhilHealth is covered by local government officials, but state how these coverages are coterminous. One BHW recounted how they got PhilHealth coverage initially, but had to pay for it themselves after a year. This elicited a sense of helplessness for many of the BHWs. As a participant expressed, *"I think to myself, if I get sick, who will assist me?"*

Furthermore, BHWs are sought by residents who need guidance in accessing healthcare facilities and services. BHWs not only provide directions but also handle the transportation of patients to the facilities and even accompany them throughout the entire process. Nevertheless, BHWs acknowledge that they sometimes fall short in answering the patients' questions, referring them instead to the hospital. They however expressed willingness to act as navigators of the health system when capacitated.

It is also noteworthy how community members rely on BHWs even in terms of finances. BHWs remarked how a typical issue faced by residents is their inability to shoulder the costs of healthcare services. In these instances, they turn to BHWs for assistance:

> *Community members also rely on us for finances. They approach us when they cannot pay for check-ups. We seek the help of councilors and other municipality officers or handle their requirements in getting a certificate of indigency.* (BHW 1)
>
> *For example, they'll say, "We have no money to pay for my child's hospitalization." Since I like my job, I help them by bringing them to the hospital and looking for people who can provide help. For those who are about to give birth but lack finances, we provide them money to purchase necessities for raising a child.* (BHW 2)

Residents are aware of the financial situation of BHWs. From the responses, it is clear that they do not expect BHWs to shell out money themselves, but rather reach out to

authorities who may help them or assist them in acquiring requirements to waive or reduce the costs. To make this happen, BHWs are expected to tap into their networks in the community, particularly their connections with local authorities.

BHWs are also pivotal in census taking, keeping records of the various illnesses in households. They also keep a record of those who are pregnant, high-risk, senior citizens, and residents who have recently passed away. These data are critical to the work of midwives:

> *BHWs have the information we need, such as the schedule of vaccination and who needs to be vaccinated. We have good communication. They were especially critical during the pandemic. We couldn't have created our report if not for the data they gather, since they are the ones most familiar with their barangay.* (Midwife)

Evidently, the roles expected of BHWs are not limited to health. Residents recount how BHWs even sometimes handle marital disputes. BHWs do virtually anything and everything. As one barangay captain stated, *"BHWs are all-around. They do everything we ask them to do."* BHWs are well aware of this set-up:

> *As volunteers, we accept whatever work is given to us. Because we are just volunteers.* (BHW)

The multiple roles of BHWs may be attributed to its ambiguity, being highly dependent on orders from the top. BHWs accept whatever work is handed to them, viewing themselves as *"the lowest member of the health team,"* equating their role to that of a health aide or even a servant.

Appointment

According to RA 7883, BHW applicants must apply at the Municipal or City Health Board or the BHW Registration and Accreditation Committee, who will evaluate their application and interview them when necessary. In reality however, this process is not met. In San Miguel, most barangay health workers do not even apply. Rather, the majority of BHWs are appointed by the barangay captain. Once elected, barangay captains appoint their own BHWs:

> *When the barangay captain won, he appointed me. I was then the solo parent president of our barangay. The barangay captain made me a BHW chairman once he was elected. But I had no idea then what BHWs do.* (BHW)

Barangay captains do not follow specific guidelines in selecting their appointees. This demonstrates the informal nature of the process, underscored further by BHWs who are appointed due to their familial ties with the barangay captain:

> *My grandfather ran for barangay captain. I have no background in being a BHW or a mother leader. I simply asked him to include me in [BHWs]. The councilor is also my uncle. When they won, they appointed me as BHW, but I don't have any background on what BHWs or mother leaders do. I just asked them to include me.* (BHW)

The role of personal relationships in appointing BHWs is an open secret in the community. Notably, BHW participants who gained their position through ties with local officials shared how they had no knowledge about the work of BHWs prior to being appointed.

Personal relationships with former BHWs also hold weight in appointments. Several participants shared how they eventually "replaced" their relatives who were formerly BHWs:

> *My mother-in-law used to be a BHW. Since she's quite old, she had me accompany her during house-to-house visits and other tasks. After one year of accompanying her, the midwife told me that my mother-in-law should retire and I should take her place.* (BHW)

BHWs describe the appointment process as "*napopolitika*"– politicized. They acknowledge that the length of their stay depends on their relationship with the barangay captain. Participants shared how barangay captains tend to remove BHWs and replace them with their supporters. As one BHW spelled out, *"If the barangay captain does not want you, even if you're qualified, you will inevitably be removed."*

This is validated by the response of a barangay captain participant, who explained, *"If the BHW outrightly goes against me during elections, I will not appoint them because I cannot work properly with someone who does not believe in me. If they believe in me, they will not speak against me during the campaign period. I prefer appointing someone who I know can help me and believes in me. That ensures we have a good relationship. How can I work with someone who does not believe in me?"*

During some cases where there is threat of replacement, the midwife gets involved. One BHW recounted how the midwife disapproved of her appointment, preferring the BHW she replaced, *"When we met the midwife, she did not like us. She preferred the BHWs before us. She did not know us and did not want to accept us."* She shared how the municipal health officer, together with the barangay captain, had to intervene and vouch for them.

Meanwhile, some dismissals were prevented by midwives themselves:

> *When the new barangay captain assumed the role, he insisted on removing three of us remaining BHWs. But we were protected at the municipal and provincial level. We retained our roles despite the new barangay captain. We were stationed at the RHU instead.* (BHW)

Nevertheless, the influence of the midwife is limited. They can only retain the BHW in the municipality and the region, but not in the barangay. As a result, some BHWs do not receive honoraria at the barangay level.

To lessen the likelihood of replacement, BHWs were advised to remain apolitical. One BHW recounted, *"The midwife advised us to remain silent over the candidate we will vote for. Just vote on the ballot on the day of the election. Don't join political campaigns because it will be taken against you. That's why I lasted for 30 years, I followed her advice."* This lends further credence to the politicized notion of BHW appointments.

As there are no formal guidelines in appointing BHWs, appointments tend to be arbitrary. After one year of volunteering, appointees automatically become BHWs. They are not required to take a qualifying exam or undergo an interview. The only requirement, as surfaced in the FGDs, is to volunteer for a year. According to the participants, there is the assumption that BHWs already know everything they need to know after one year of volunteering.

Furthermore, there are no technical qualifications to become a BHW. Some BHWs cite willingness to volunteer as the only qualification. Most participants emphasized the importance of attitude, to which skills are only secondary. One barangay captain narrated what they look for in a BHW, stressing the significance of trust, *"In selecting a BHW, the first qualification is trustworthiness. Someone who will obey me – not in wrongdoings, of course, but I look for someone who is willing to volunteer and serve."* They further noted how skills can be learned over time, justifying the perceived preeminence of attitude over skills.

Accreditation

RA 7883 states that registered BHWs who have actively rendered voluntary primary health care services in their locality for at least three years are qualified for accreditation. The application for accreditation is reviewed by either the Municipal or City Health Board or its duly constituted Barangay Health Worker Registration and Accreditation Committee (BHW-RAC). In practice, BHWs are almost always automatically accredited. One BHW participant recounted the accreditation process in their barangay:

> *We collect the names of each BHW. Then we seek the signatures of the midwife, BHN, MHO, and mayor. We then forward the documents to the provincial office in Malolos, which is automatically forwarded to the region. Afterwards, we are accredited.* (BHW)

Broadly however, most BHW participants were unfamiliar with the accreditation process. Many admit that they do not know who conducts accreditation. They are only familiar with the yearly renewal of their accreditation status, which requires BHWs to have undertaken at least one training approved by the MHO. However, this requirement was waived due to the COVID-19 pandemic. A BHW shared, *"It was needed at first. However, due to the pandemic, there were no training and seminars held. We were renewed as long as we have volunteer experience. The strictest requirement was having at least one year of volunteer experience."* The midwife is the main authority in deciding their renewal, deciding based on their performance, which are primarily gleaned from the submitted reports by the BHWs.

Notably, there are instances where BHWs are accredited but not appointed. BHWs cite politicization as the culprit. Despite being accredited, the barangay captain can choose not to appoint the BHW at the barangay level. In these cases, the MHO usually intervenes.

Training

RA 7883 requires BHWs to undertake training programs under any accredited government and non-government organization. However, similar to the application and accreditation process, this is not fulfilled. Participants revealed that they did not have training prior to assuming the role. This is acknowledged by local government officials. A barangay captain shared how there are newly appointed BHWs who do not know how to perform their roles at first:

> *During the beginning, they did not know how to do tasks as simple as taking blood pressure. They are not perfect upon appointment and admittedly fall short in several tasks.* (BHW)

Even once they assume the role, BHWs rarely receive formal training. Instead, they primarily receive on-the-job training. Many of them gain experience by shadowing and assisting the midwife. Some senior BHWs also volunteer to guide newer BHWs. The reliance on on-the-job training over formal training is also acknowledged by local government officials, with one recounting, *"BHWs learn how to do their work in the process, through the conduct of meetings, lectures, and seminars. Over time, they are trained under the guidance of local officials, midwives, and workers in the rural health unit."*

Newer BHWs especially receive minimal formal training: *"They reason that it's expensive and outside the budget. We get our training instead when we are stationed at the health center. We gain actual training in assisting in the national immunization program, administering first aid during accidents, and taking blood pressure of those who are pregnant."*

The amount of supplementary training also varies among BHWs. Some BHWs recounted receiving additional training for diseases like tuberculosis and dengue, but admit that these were not regularly given. They also shared how BHWs hold an annual conference where they receive refresher courses, with the most recent one garnering nearly 360 attendees. For the most part however, BHWs rely on whatever training is given to them. When they do seek specific training, these requests are often unaccommodated, citing lack of budget. This leads to a sense of resignation. When asked what training they would like to receive, the participants merely reiterated that they depend on whatever is given to them. Alarmingly, some BHWs reported how they were not trained to respond to the pandemic despite serving as frontliners.

Nevertheless, many BHWs express wanting to receive training of various nature. One BHW shared how they want

to receive first aid training, reasoning *"Many of us take patients to the hospital and accompany them in the ambulance."* Another BHW underscored the importance of training for those who are involved in health delivery. Furthermore, training makes BHWs feel qualified in their roles. When asked how they know they are qualified to fill the BHW position, the participants cite the training programs and seminars they attended.

The Technical Education and Skills Development Authority (TESDA) offers a training program for BHWs called Barangay Health Services NC II. Those who have completed the course and the corresponding assessments are deemed competent to become a barangay health worker. However, while most participants are aware of the existence of these competencies, with some expressing that they want to attain them, they admit that they have not reached these. According to a participant, *"We are not trained to reach these competencies yet because there are no policies in place."* They also shared how no one prepares programs for them to attain these competencies.

Compensation

Since BHWs are volunteers, they only receive compensation in the form of honoraria. Moreover, they are only eligible to receive incentives after one year of volunteering. Presently, their compensation depends on the internal revenue allotment (IRA) of the barangay, and not all barangays are created equal. As a result, the amount BHWs receive is inconsistent across barangays. This variability emerged as a point of concern for the participants. One BHW complained about receiving different amounts despite doing the same work.

The compensation received by BHWs come from three different levels. BHWs in San Miguel receive monthly remuneration from their barangay, with the amount ranging from 800 to 1,000 pesos. They also receive 1,000 pesos quarterly from their municipality and 3,500 pesos from the provincial office. However, BHWs have to physically go to the offices to pick up their payments, spending for their own transportation. For some, the expenses can cost up to a fifth of the payment they receive, stating "*We receive 1000 pesos quarterly from the municipal office, spending 200 pesos for transportation.*" During the peak of the pandemic, this arrangement was temporarily suspended in adherence to safety protocols, with the barangay treasurer collecting the payments from the municipal office and bringing them to the barangay center where the BHWs can more easily acquire them. However, after the restrictions were eased, the old arrangement was brought back. Barangay captains are aware of the inconvenience of this set-up, but claim that it is out of their control, as the decision on how to distribute compensation lies with the officials at the municipal and provincial level.

Furthermore, BHWs grapple with the inadequacy of their remuneration. All BHW participants agree that they receive very little compensation despite their heavy workload. Even midwives and barangay captains recognize how the BHW's meager pay is not proportionate with the services they render:

> *We really need them. […] We hope that they get an increase in their payment.* (Midwife)
>
> *The little amount they receive is not commensurate with their contribution to the community.* (Barangay captain)

Despite their meager remuneration, BHWs spend out-of-pocket for various expenses related to their work, such as photocopying materials, load, and transportation. BHWs are thus unable to generate savings, and are often pushed to borrow money from family members, friends, and microfinancing schemes to meet their household expenses. By itself, being a BHW is not seen as a viable source of income. BHWs typically have other working family members, such as their spouses or children. Furthermore, BHWs are not full-time workers. Most of them take on part-time jobs, primarily in the food and service industry. From the responses, the most common sideline of BHWs is direct selling. Some participants reported how their role as BHWs actually helped them in direct selling by creating and sustaining a network of clientele. Midwives and local government officials are also generally supportive of the BHWs' part-time work.

BHWs also find it hard to rely on their compensation because of delays in payment. In fact, some participants recounted that they have to regularly remind the units for their compensation. BHW participants also expressed feelings of resignation when their remuneration gets delayed, chalking it up to their voluntary status:

> *They told us that we were just volunteers. We should not wait for compensation.* (BHW)
>
> *They said that we were only helpers, volunteers, so we must be patient.* (BHW)

BHW participants also raised the issue of mandatory retirement for BHWs at the age of 65. They expressed feeling unappreciated by the lack of retirement pay for BHWs:

> *We implore the government to pay attention to us BHWs. Currently, once we turn 65, we are automatically removed from being BHW without receiving anything. There isn't any form of compensation to show appreciation for our lengthy years of service. We are just nonchalantly removed. That's painful to us.* (BHW)

Finally, BHWs intimated their desire to be regular government employees instead of volunteers, with fixed salaries and employee benefits. They are also willing to have salary deductions in exchange for PhilHealth and Government Service Insurance System (GSIS) coverage. However, this must come with an increase in compensation. The regularization of BHWs and increase in their compensation are similarly supported by local government officials and midwives.

DISCUSSION

BHWs perform various roles as community organizers, educators, and healthcare providers, although their responsibilities may vary across communities based on agreements with local officials. Some BHWs enter the role despite having no prior knowledge of their duties and soon find themselves assisting in a wide range of activities, from family planning to disaster relief and pandemic response. Despite their vital contributions to the community and the health system, BHWs often face challenges such as the threat of removal due to politicization, inadequate training, and insufficient compensation. They have expressed desire for improved conditions, including better remuneration, provision of formal training, and regular employment.

Diverse Interpretation of RA 7883 Exposes BHWs and the Community to Vulnerabilities

RA 7883 or the BHWs' Benefits and Incentives Act is the most recent reform involving BHWs. The Act is part of participatory strategies employed under the Primary Health Care Approach, aimed at making health services more accessible.[50] However, the interpretation of the Act varies across geographical areas, owing to the decentralization of the health system. While the DOH sets the agenda for the national program, LGUs are responsible for its implementation.[51]

The Local Government Code designates BHW appointment to be at the barangay level, providing the barangay captain with the appointing power, whereas accreditation is done under the municipality and the province. This set-up results in conflicting interpretation and implementation of RA 7883, as evidenced by the case of San Miguel, Bulacan. Majority of BHWs are appointed without adhering to basic qualifications set out in the Act, with little to no consideration to their credentials. As a result, BHWs may be perceived as accountable to the political leader who appointed them rather than the community they serve. With proper implementation, accreditation may serve as a helpful tool in legitimizing the role of BHWs. Moreover, it can provide them with job security, acting as a buffer against the influence of local politics.[52]

The lack of standardized training also emerged as a point of concern. While RA 7883 mandates BHWs to undergo training programs under accredited organizations, BHWs of San Miguel are not trained before filling the position. As of writing, there is currently no standardized training program that BHW aspirants and appointees go through. Moreover, the implementation of training programs depends on local governments and their prioritization. While TESDA released the Barangay Health Services NC II, it remains unimplemented in the municipality. The noncompliance with the appointment, accreditation, and training requirements stipulated in RA 7883 results in the absence of quality assurance on health services rendered by BHWs to the community.

Furthermore, participants report not receiving the incentives and benefits stated in RA 7883. According to the Act, "Volunteer barangay health workers in rural and urban areas, exposed to situations, conditions, or factors in the work environment or place where foreseeable but unavoidable danger or risks exist which adversely endanger his health or life and/or increase the risk of producing adverse effect on his person in the exercise of his duties, to be validated by the proper authorities, shall be entitled to hazard allowance in an amount to be determined by the local health board and the local peace and order council of the LGU concerned."[33] However, despite promises from the national and local government, BHWs do not receive these hazard allowances. The absence of hazard pay makes BHWs vulnerable to health risks. This peril becomes heightened during the COVID-19 pandemic as BHWs interact with potential carriers of the virus. BHWs are composed mostly of older adults, mainly female senior citizens[53], making them even more vulnerable. Moreover, in the absence of financial assistance, participants shared how they had to pay for their own expenses when they and their families contracted the virus. This demonstrates that the failure to adhere to RA 7883 puts the health and lives of BHWs at risk.

Politicization of BHWs Disrupts the Delivery of Health Care

Despite being part of the local health workforce, BHWs are atypically and heavily politicized. They are aware of the importance of political positioning in their recruitment and continuous participation in the BHW program. BHWs feel the need to align themselves politically with elected officials to maintain their position.[52] Among BHWs of San Miguel, there is a similar acknowledgement that one must not openly go against the barangay captain to keep their jobs. This is aligned with previous literature, where involvement with the "wrong" politician – that is, the politician who does not win – becomes a disadvantage for the BHW.[35] In the present study, the main recourse of BHWs was to remain uninvolved with any candidate during the election period. There is an understanding that being apolitical is necessary to remain BHWs.

The politicization of BHWs is illustrated by the preference for personal connections over technical qualifications in BHW appointments. It is worth noting that merit-based appointments do occur. Some BHWs are appointed based on their previous volunteer experience in community activities or in assisting BHWs.[35] BHW participants in the present study similarly shared how they were recruited to become volunteers themselves after assisting BHWs in their work. However, there remains a personal aspect, as these participants are often personally related to the BHWs they assisted, replacing them when they become unable to do their jobs often due to sickness or old age. Furthermore, appointments based on merit are scarce, with the majority being political in nature.

Previous literature warns against the politicization of BHWs and its adverse effect on the broader participation of the community. The perception of BHWs as political appointees is found to discourage community members from volunteering themselves. Politicization also allegedly causes an erosion of trust between BHWs and community members as a result of frequent replacement of volunteers.[35] However, this runs contrary to the findings of the present study, wherein BHWs continue to enjoy a high level of trust and appreciation among residents. Residents view the BHW role as extremely helpful to the community and have even considered becoming BHWs themselves. Residents also recognize the difficulty of fulfilling the BHW role, demonstrating considerable respect for BHWs. Despite being aware of the politicized appointment of BHWs, this is not thought to interfere with their perceived altruistic motivations and the rigor of their work.

A critical consequence of the politicization of BHWs however is their periodic replacement. In the aftermath of local elections, BHWs who do not support the new administration are often dismissed and replaced with the allies of the elected official.[35,52] This frequent turnover causes a massive strain on government resources. The training and resources invested in the replaced BHWs are wasted when their services end with the new administration. Despite the already limited budget and human resources, more training needs to be conducted for new BHWs. Furthermore, the frequent replacement of BHWs negatively impacts their integration in the health system, resulting in disrupted rapport between BHWs and the community – an essential component of BHW work.[35] The politicization of BHWs affects the effectiveness and sustainability of the BHW program, which may result in fragmented delivery of care.

Reliance on the Benevolence of BHWs Perpetuates their Exploitation

The desire to serve their community motivates BHWs to become and remain volunteers. The participants commonly cite their willingness to help as their driving force to remain BHWs. Notably, many of them described their work using the same phrase *"mahirap pero masarap"* – difficult but rewarding. They shared how they gain fulfillment from being of service to others. This is a sentiment that can be traced in previous studies, where BHWs are primarily motivated by care and their desire to contribute to their communities. This often compels them to cover the travel costs and purchase medicine and even rice for residents with insufficient resources.[35,52]

Their goodwill does not go unnoticed. BHWs have considerable social capital, enjoying a great deal of respect and appreciation from local government officials, health workers, and residents alike. The role of BHWs is described as a form of martyrdom taken up by those willing to make sacrifices for the sake of the community. However, extolling the benevolence of BHWs risks overlooking the realities of their exploitation. For instance, BHWs' commitment to serve is often used to excuse the inadequacy of their compensation. Despite the consensus among all participant groups that the remuneration BHWs receive is severely lacking, BHWs themselves are willing to overlook their meager compensation. They believe that their social relationships with their fellow BHWs and the broader community compensate for the absence of financial incentives.[35] In fact, "honorarium, incentives, and annual benefits" only ranked sixth among the motivations of BHWs, with "ability to help the community" ranking first.[54] However, in viewing compensation as secondary and even optional, there is a tendency to reduce the gravity of the financial struggles of BHWs. As such, calls to raise their compensation may be diluted.

The same pattern can be observed when it comes to the workload of BHWs. Another consensus among participants is that BHWs take on an excessive amount of work. Unlike with compensation however, there is lesser demand to address this issue. While some BHWs expressed wanting to reduce their workload, the dominant sentiment is its docile acceptance as an irrevocable part of their job. In fact, BHWs are considered indispensable because of their ability to handle whatever work is handed to them and regardless of how much. Furthermore, while local government officials and health workers recognize the shortage of midwives, nurses, and doctors, there is scant attention paid to the understaffing of BHWs. The DOH's recommendation of 1 BHW per 20 households is not followed in practice.[54,55] BHWs of San Miguel typically deal with 200 to 300 households. Even the lowest number of households a BHW handles is in the range of 50 to 70.

BHWs are perceived as heroes or even martyrs, praised for doing the work that many reasonably decline. As one local official participant articulated, *"No registered nurse or degree holder will volunteer as a BHW, knowing the compensation and the amount of work. Only those who are motivated by volunteerism will take on the role."* However, dependence on volunteerism creates instabilities. As volunteers, BHWs have weak accountability and can hypothetically opt out of doing their responsibilities at any point in time. Furthermore, invoking volunteerism only creates more overlooked and overworked BHWs. Relying on their benevolence without improving their conditions takes advantage of BHWs. Hence, the outcome is not only a fragile system but an exploitative one.

BHWs are indispensable members of the health workforce. They are the first point of contact for many Filipino households and form the backbone of primary health care delivery.[32,34,35] If BHWs decide to collectively boycott work, it is likely that the Philippine health system will collapse. Yet despite their importance, the struggles of BHWs remain overlooked and unaddressed. BHWs grapple with informal and politicized processes, meager compensation, exposure to multiple risks and hazards, and unreasonable workload.[35,52,53] Despite their essential contributions to the Philippine health system, BHWs have received limited scholarly attention. The

present study seeks to contribute in bridging this research gap by shedding light on their lived experiences, particularly in the context of policy inconsistencies and politicization.

Limitations

The present study carries certain limitations. Firstly, the research is geographically limited to one municipality, which may not fully capture the diversity of experiences faced by BHWs across different regions in the Philippines. The qualitative design of the study may limit the generalizability of the findings. This limitation is particularly important to note due to the decentralized nature of the health system in the Philippines. Nevertheless, the insights from the present study provide a valuable starting point for understanding the issues faced by BHWs.

CONCLUSION

The study sheds light on the lived experiences of BHWs. It reveals the multifaceted roles that BHWs play, from community organizers to educators and healthcare providers, and how these roles are shaped by local agreements and the political landscape. It also highlights the significant challenges BHWs face, including politicization, inadequate training, and insufficient compensation, which impact their ability to perform their duties effectively. By capturing the experiences of BHWs, residents, and local government officials, the study offers a deeper understanding of how BHWs perceive and navigate their roles, uncovering the often-overlooked conditions and contributions of BHWs in the Philippines. These findings contribute to a better understanding of the complex realities faced by BHWs.

In light of these findings, the study makes several recommendations. Firstly, there is a need for a coordinated, computerized system for census and patient record-keeping to reduce redundancy and manual work of BHWs. Secondly, BHWs must be capacitated and certified through targeted training, legal literacy programs, and a policy review of RA 7883. The third recommendation involves transitioning BHWs from volunteers to regular government employees with fixed salaries and benefits to ensure fair compensation and accountability. Additionally, BHWs must be connected and integrated in the health system especially in the context of UHC. Finally, the study advocates for developing clear career paths and increasing awareness of professional development opportunities, such as scholarships and ladderized programs.

Policy reforms are urgently needed. The authors hope that the findings of this research will serve as a roadmap for policymakers and concerned stakeholders to improve the conditions of BHWs and consequently contribute to addressing longstanding health inequities, guided by UHC.

Statement of Authorship

All authors certified fulfillment of ICMJE authorship criteria.

Author Disclosure

All authors declared no conflicts of interest.

Funding Source

This study was funded by AIA Philippines (formerly Philam Foundation).

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