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Examining the Narratives of Rural Healthcare Workers in the Implementation of Community-based Drug Rehabilitation Program

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Abstract. This study explored the narratives of rural healthcare workers involved in implementing the Community-Based Drug Rehabilitation Program (CBDRP) in the Philippines, addressing a critical gap in understanding grassroots implementation in rural contexts. The study aimed to examine the experiences, roles, and challenges healthcare workers face in delivering community-based rehabilitation services. Using purposive sampling, ten government-employed rural healthcare workers were selected through recommendations by the provincial drug abuse and treatment program coordinator. Semi-structured interviews were conducted, and data were analyzed using Clarke and Braun's (2014) thematic analysis, structured according to Murray's (2000**)** levels of narrative analysis: ideological, positional, and personal. At the ideological level, CBDRP was perceived as a mechanism for community reintegration, allowing Persons Who Use Drugs (PWUDs) to transform into contributing members of society. At the positional level, rural healthcare workers positioned themselves as pillars of rehabilitation and builders of sustainable partnerships, despite limited resources and institutional challenges. At the personal level, their narratives reflected transformational journeys marked by professional growth, resilience, and personal fulfillment. The study contributes to the limited literature on rural drug rehabilitation, emphasizing the pivotal role of healthcare workers in advancing public health-centered approaches in underserved areas. Implications include the need to enhance community engagement activities for PWUDs, implement targeted capacity-building for healthcare stakeholders, enact supportive local ordinances addressing the socio-economic barriers of PWUDs, and promote region-specific research to inform sustainable policy improvements. These findings highlight the value of integrating localized, culturally sensitive strategies within the national drug rehabilitation framework to ensure inclusive and sustainable recovery efforts across varying geographic contexts.

Keywords: Community-based drug rehabilitation program; Narratives; Person who used drugs; Rural health; Rural healthcare workers.

1.0 Introduction

Substance use disorder (SUD) remains a significant public health concern in the Philippines, particularly in rural areas where healthcare services and mental health resources are limited. This issue affects individuals, families, and communities, prompting government-led efforts to establish more inclusive rehabilitation models. One such model is the Community-Based Drug Rehabilitation Program (CBDRP), a strategic intervention designed to

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provide localized, accessible, and holistic support to individuals classified as low- to moderate-risk drug users (Department of the Interior and Local Government [DILG], 2018). Unlike traditional facility-based rehabilitation, CBDRP enables individuals to undergo treatment within their communities, maintaining social ties and receiving support from local healthcare providers (United Nations Office on Drugs and Crime [UNODC], 2020).

Globally, the shift from punitive drug policies to public health-centered approaches has been emphasized by institutions such as the UNODC (2023) and the World Health Organization (WHO, 2022), which advocate for community-based models tailored to local needs. While global and regional studies highlight the value of integrating community support systems into drug rehabilitation efforts, challenges such as stigma, limited infrastructure, and lack of trained professionals persist (Poudel et al., 2016; Friedman et al., 2019; Sarkar et al., 2018; Li et al., 2015). In the Philippines, these challenges are more pronounced in rural areas, where healthcare access is uneven and rehabilitation services are often underdeveloped (Palisoc & Dizon, 2021).

Rural healthcare workers are often the frontliners of CBDRP implementation, serving as program facilitators, health educators, and treatment providers. They play a crucial role in bridging systemic gaps and promoting recovery, despite facing logistical difficulties and social stigma in their communities (Gonzales & Santos, 2022). However, existing literature tends to focus on urban-centered evaluations of CBDRP, such as involvement of barangay officials involved in CBDR (Allado et al., 2019), exploring its impact on Filipino familial dynamics (Bunagan et al., 2019; Yusay & Canoy, 2019; Co & Canoy, 2020), the quality of life of drug users (Yamada et al., 2021), and program evaluation (Bautista & Teng-Calleja, 2022), with little emphasis on the first-hand experiences of rural healthcare workers.

This lack of rural-specific research creates a critical knowledge gap, especially given the unique structural and cultural conditions of remote communities. By foregrounding the narratives of rural healthcare workers, this study aims to provide a deeper understanding of their experiences, challenges, and insights in delivering community-based rehabilitation. The findings intend to inform policies and interventions responsive to the lived realities of healthcare workers and Persons Who Use Drugs (PWUDs) in rural settings.

Therefore, this study seeks to explore how rural healthcare workers in Biliran Province experience and navigate the implementation of CBDRP. Through a qualitative, narrative-based approach, the research highlights the perspectives of implementers often underrepresented in drug rehabilitation discourse. In doing so, the study hopes to support evidence-informed strategies that enhance the sustainability and effectiveness of CBDRP in marginalized areas.

2.0 Methodology

2.1 Research Design

The study utilized a qualitative research design to explore the narratives of rural healthcare workers in implementing the Community-Based Drug Rehabilitation Program (CBDRP). A qualitative approach was deemed appropriate to capture the depth and complexity of rural healthcare workers' lived experiences. Semi-structured interviews were utilized to collect rich, detailed accounts from rural healthcare workers. Thematic analysis, following Clarke and Braun's (2014) approach, was used to analyze the data. This process involved transcription, familiarization with the data, initial coding, and theme identification. Themes were structured based on Murray's (2000) narrative levels of analysis: ideological, positional, and personal. The interpersonal level was excluded due to the minimal influence of the interviewer on the respondents' narratives; this decision aligns with Riessman's (2008) notion that narrative meaning can be effectively derived even when interpersonal dynamics are not the central focus.

2.2 Research Locale

The study was conducted in the province of Biliran, Philippines, which is composed of eight municipalities. Each municipality has a Rural Health Unit (RHU) tasked with implementing local healthcare programs, including the CBDRP. The research focused on RHUs where healthcare workers were verified by the Provincial Drug Abuse Prevention and Treatment Program Coordinator to be actively engaged in the CBDRP. This ensured that only RHUs with active and operational programs were included in the study.

2.3 Research Participants

The study employed purposive sampling to select rural healthcare workers who met specific inclusion criteria. Eligible participants were government-employed rural healthcare workers, such as doctors, nurses, or midwives, holding a plantilla item and actively engaged in CBDRP implementation. They were required to have at least five years of experience in rural health services and a minimum of six months of active involvement in the program. Exclusion criteria included individuals who had not been actively involved in CBDRP within the past six months, lacked formal training or certification in CBDRP facilitation, were not government-employed healthcare workers, or declined participation. All ten healthcare workers who met the inclusion criteria participated in the study; no individuals were excluded.

2.4 Research Instrument

The primary data collection tool was a semi-structured interview guide, developed based on the study's objectives and Murray's levels of narrative analysis. The guide consisted of five open-ended questions to elicit rich, narrative responses. It also included probing questions to clarify and deepen the participants' accounts. The semi-structured interviews were specifically chosen for their flexibility, allowing the researcher to explore relevant issues while enabling participants to express their perspectives in their own words (Kallio et al., 2016). To ensure validity, the guide underwent expert review by two professionals affiliated with the University Research Co. (URC): a psychologist and a social behavior change specialist. These experts provided feedback on question clarity, cultural appropriateness, and alignment with the research framework. Revisions were made based on their input, including refining terminology, reordering questions for logical flow, and simplifying language to enhance participant understanding. The final version of the guide was available in both English and Filipino to accommodate language preferences.

2.5 Data Gathering Procedure

The researcher obtained formal approval from the Biliran Provincial Health Office and the Provincial Drug Abuse Prevention and Treatment Program Coordinator. A letter of intent was submitted, requesting a list of rural healthcare workers trained and actively involved in CBDRP implementation. Upon approval, participants were recruited through online and face-to-face invitations. Four of the ten participants were recruited online, and six through face-to-face engagements. All rural healthcare workers who expressed willingness received a digital informed consent form via Google Forms. Interviews were scheduled at the participants' convenience and conducted in person at their designated RHUs. Each session lasted between 15 and 40 minutes and was audio-recorded with the participants' consent. The recordings were transcribed verbatim. Member checking was conducted to ensure data credibility and minimize researcher bias. Participants were given the opportunity to review their transcribed responses to confirm accuracy and clarify. Additionally, the researcher maintained a reflexive journal throughout data collection and analysis to document biases, assumptions, and evolving insights, thereby promoting transparency and trustworthiness.

2.6 Ethical Considerations

Ethical approval for the study was secured from the Polytechnic University of the Philippines Graduate School Research and Extension Office. The certificate of ethical clearance was released on February 7, 2024, under GSREC Protocol No. 2024-079. All participants provided informed consent prior to the interviews. Confidentiality and anonymity were maintained by assigning participant codes and securing all research materials in encrypted digital storage.

3.0 Results and Discussion

The study's findings provide an in-depth discussion. Three major themes were cited, which were further delineated into eight subthemes. The subthemes were then structured using Murray's levels of narrative analysis: ideological, positional, and personal, to capture the multidimensional narratives of rural healthcare workers in implementing the Community-Based Drug Rehabilitation Program.

3.1 Ideological: CBDRP as a Pathway to Community Reintegration

Community-Based Drug Rehabilitation Program (CBDRP) as a Pathway to Community Reintegration emerged as a central theme at the ideological level. This theme highlighted how the program facilitated rehabilitation and reintegrated PWUDs back to the community. It showed how CBDRP is a transformative potential tool to an

individual undergoing the program and its broader implications, reintegrating back to the community. The key theme revealed three subthemes: witnessing recovery, shifting societal perception, and rebuilding connections.

Witnessing Recovery as the Cornerstone of Reintegration

Rural healthcare workers' narratives, in which they witnessed a profound transformation, showcase recovery as a cornerstone of the reintegration of PWUDs into their communities. As they witnessed, recovery of PWUDs is not merely a cessation of substance use; it is a deeply rooted acknowledgment of personal growth, accountability, and a redefined sense of purpose that enables PWUDs to become functional and contributing members of society.

"The CBDRP program is helpful. Because when the PWUDs undergo the sessions, they understand the impact on themselves and their families. So, it helps in a way that they do not go back to their vices of using drugs." (R2)

"Within six months, they can develop techniques on what to do to avoid relapse. If ever they do relapse, that is okay, as long as they do not go back [to full substance use]. Some do not relapse at all. So far, you can see that their lives are doing well now. Back in 2019, during my first Community-Based Drug Rehabilitation Program (CBDRP), there were 13 participants. I even attended a seminar with them before a wedding. Two of my PWUDs (Persons Who Use Drugs) got married. Moreover, until now, based on our monitoring, they are still testing negative, negative [for substance use]. There really are some who stick to the strategies to avoid relapse. And in fairness, quite a number of them are following through. Then, when we see each other, they would greet me like, "Ma'am, how are you? just like that. And when you summon them, they still show up." (R7)

The rural healthcare workers recount how the CBDRP fostered a profound understanding among PWUDs about the effects of drug use on themselves, their families, and their communities. This newfound awareness became a cornerstone for change, as PWUDs began to internalize the consequences of their past behaviors. By confronting these realities, they cultivated a sense of responsibility to themselves, their loved ones, and the broader community. This realization, reinforced through consistent follow-up and support, contributed to a noticeable shift in their perspectives and actions. The rural healthcare workers emphasized that many of the PWUDs, previously entangled in cycles of substance use, now demonstrate a renewed commitment to living a drug-free life—a transformation evident in their interactions and decision-making.

Similarly, illuminated in the narrative is the importance of equipping PWUDs with tangible strategies for relapse prevention. Over the six-month program, PWUDs developed techniques to manage triggers and cope with challenges that could lead to relapse. While acknowledging that relapse might occur as part of the recovery process, the program instilled a mindset that viewed such setbacks as opportunities for growth rather than failures. Moreover, these strategies and learnings become the foundation of their recovery, leading them to rebuild and embrace their lives. Such a supporting narrative of a healthcare worker provided an inspiring example of two PWUDs who, having completed the CBDRP in 2019, enter married life and build stable lives. Continuous monitoring and follow-ups revealed their unwavering commitment to sobriety, demonstrating the lasting impact of their learned strategies.

These narratives reveal that the process involves a holistic transformation of the individual beyond the elimination of substance use. PWUDs learn to navigate life with newfound resilience, guided by the tools and support provided by the CBDRP. This transformation extends to the community as well, as individuals who were once marginalized due to their substance use are now reintegrated, contributing positively to the social fabric. The rural healthcare workers' narrative illustrates the profound role of community-based rehabilitation in PWUDs' journeys toward recovery. The program's emphasis on self-awareness, family dynamics, and societal impact fosters a sense of interconnectedness that motivates sustained behavioral change. In turn, this contributes to their successful reintegration as valued community members. As these narratives demonstrate, recovery is not a linear process; it is an evolving journey marked by PWUDs' resilience, self-discovery, and the unwavering support of a community that believes in second chances.

The findings resonate with San Patrignano (2019), which emphasizes that recovery from drug addiction and social reintegration are intertwined and complementary processes. This interplay between recovery and reintegration achieved sustained change in PWUDs necessitates not only addressing substance use but also promoting societal acceptance. In addition, it aligns with SDG 3's broader vision of promoting mental health and well-being, as

individuals recovering from substance use disorders require not only medical intervention but also social support systems that encourage their reintegration as valued and productive members of society (United Nations, 2015).

Shifting Societal Perceptions Through Inclusion

The narrative of shifting societal perception through inclusion depicts a shift from stigmatization to recognition and acceptance. This narrative demonstrates the power of community awareness in reducing stigma and fostering reintegration, a process made possible through the Community-Based Drug Rehabilitation Program (CBDRP). The narratives reflect how inclusion arises naturally from a change in societal perceptions and reshapes how communities view PWUDs and how these PWUDs redefine themselves as valuable members of society. The findings also align with SDG 10, particualry target 10.2, which aims to empower and promote the social, economic, and political inclusion of all, irrespective of age, sex, disability, race, ethnicity, origin, religion, or economic or other status (United Nations, 2015) where reintegration of PWUDs into society represents a crucial aspect of reducing inequalities, as these individuals often face systemic marginalization, stigma, and exclusion due to their history of substance use.

"For the community, people who already recognize them [PWUDs] as not as bad people or persons committing crimes against their sets of ideals for the community, rather, they perceive them [PWUDs] as people being reintegrated into their community. After being admitted to the CBDRP program parang hindi na sila matatakot because of stigma, social stigma. Being raised during, especially during the Oplan Tokhang. They have long accepted that they made a mistake, but are also willing to change." (R6)

"They thought it was just like that, but through CBDRP, the impact on the community, on the concerned people, created awareness. The PWUDs were boosted. Ahh, we are not just like this; we have value because we are integrated into the community and taught how to deal with upcoming problems."(R8)

The gradual change in community attitudes highlights how people began to see PWUDs not as criminals or societal outcasts but as individuals striving to reintegrate and make amends for their past. The rural healthcare workers describe how the stigma associated with substance use, especially heightened during the Oplan Tokhang era, initially created fear and alienation. However, with rural healthcare workers' efforts involving PWUDs to participate in the program actively, PWUDs openly acknowledged their past mistakes and demonstrated their willingness to change. This acknowledgment, coupled with their commitment to recovery, helped reduce the community's fear and fostered acceptance. The inclusion they experienced was not marked by grand gestures but by a shift in perception, allowing them to rejoin their community without the oppressive weight of judgment. Vigdal et al. (2022) highlight the importance of social communities, emphasizing that safe and non-stigmatizing environments foster positive self-change and improved relationship skills among individuals in recovery.

Illustrating how the CBDRP not only transformed the lives of the PWUDs but also reshaped the community's understanding of their potential. Before the program, many community members viewed PWUDs as individuals incapable of contributing positively to society. Through the program, however, people gained a new perspective, realizing that these individuals had inherent value and the capacity for change. This shift of societal perception of the community "boosted" the morale of the PWUDs, empowering them to shed the stigma and redefine their identities. Realizing they could be productive members of society gave PWUDs the confidence to rebuild their lives. Simultaneously, it inspired the community to recognize their reintegration as a collective success rather than an isolated outcome. It resonates with the notion of Perez et al. (2024), whose study highlighted that community acceptance and support are crucial enablers for PWUDs' help-seeking and sustained recovery. Less stigma and more participation in community activities are signs of a successful reintegration process.

The narratives also highlight how inclusion is deeply intertwined with recovery. As PWUDs progress through rehabilitation, they not only address their struggles but also challenge societal misconceptions. Their transformation catalyzes broader community growth, fostering a culture of understanding and compassion. Programs like the CBDRP play a crucial role in facilitating this dynamic, ensuring that the reduction of stigma and promotion of awareness extend beyond individual success stories to create a more inclusive community fabric.

Rebuilding Social Connections and Community Bonds

The narratives on rebuilding social connections and community bonds among PWUDs showcase the journey of their rehabilitation from hesitation to active participation in the community, symbolizing reconnection into the social fabric of their communities. Through rural healthcare workers' flexible implementation of structured group-based activities in the program, such as tree planting, outreach programs, and community extension initiatives, PWUDs not only rebuild their sense of belonging but also reconnect their roles as contributors to community welfare.

"*Maybe just with the PWUDs and their involvement in the community. At first, we had a tree planting activity. In the beginning, they were too shy to go to a place. They felt uneasy and embarrassed. They were with police officers. They felt shy. However, in our next activity, it seemed like it was okay. They did not feel uneasy anymore; it was just normal.*" (R4)

"*Our KKDK program has 15 modules, but we add outreach programs like tree planting for community involvement to reintegrate them into the community. So maybe when we conducted the first week, someone tested positive, but there were none as we continued the sessions over time.*" (R10)

"*I observed that our PWUDs in the community are the ones submitting. They are the ones reporting that someone offered them something during the program. So someone offered me this, Ma'am. So, you have to be careful with them. Because that is part of integration, once you are integrated into the community.*" (R8)

"*In the community, they [PWUDs] say it is safer now because they admit that before there were issues, but now they say it is different, they have changed, and there is no source here anymore. There is a big improvement because the place is quieter on drugs.*" (R9)

The narrative reflects on the initial apprehension felt by PWUDs during their first community involvement activity—a tree-planting initiative. The rural healthcare workers recount how the presence of police officers and the unfamiliarity of the situation made PWUDs feel self-conscious and hesitant. However, the tension subsided as they continued to engage in subsequent group-based activities. The PWUDs began to feel more at ease, indicating that repeated exposure to community activities helped reduce their anxiety and fostered a sense of normalcy. This progression from hesitation to comfort highlights the importance of consistent community engagement in building confidence and breaking down barriers of stigma. The narratives emphasize the pivotal role of structured group-based community activities, such as tree planting and outreach programs, in fostering this reconnection. Structured community activities mirror Rao et al. (2021), advocating for integrating community services to manage substance use disorders, which is effective and emphasizes the importance of community-based care in addressing the high burden of substance use. The results extend this notion, demonstrating that activities like tree planting provide therapeutic engagement and reposition PWUDs as valued contributors. The structured-based community activities align with Hechanova et al. (2020), emphasizing the centrality of collective healing in Filipino culture, where recovery is intertwined with communal participation. As supported by Engelbrecht and Jonson (2016), activities that a group does reduce psychological shame, isolation, and helplessness.

Rural healthcare workers note that in addition to the standard 15-module program, supplementary structured activities like outreach programs and tree planting were introduced to enhance community involvement of PWUDs. These activities served as opportunities for PWUDs to engage and reconnect with their community in meaningful ways. Over time, their sustained participation led to noticeable changes in behavior and perception. What initially began with some PWUDs testing positive during early sessions transformed into a group that exhibited commitment and progress, as evidenced by improved attitudes and behaviors over time.

During their reintegration, PWUDs began actively contributing to community safety by reporting incidents or offers of illegal substances. This behavior not only demonstrates their commitment to change but also illustrates their growing sense of accountability. By taking on the responsibility of safeguarding their communities, PWUDs become active agents in fostering a safer environment. This reciprocal relationship between PWUDs and their communities reinforces trust and reflects the transformative potential of rehabilitation and community involvement.

The rural healthcare workers shared that PWUDs reported that there is a significant decline in drug activities in their area due to the absence of a local drug supply, reported by the PWUDs, leading to a quieter and more peaceful environment. This signifies PWUDs' contribution to the community due to their active involvement in CBDRP, which resulted in a collective behavioral change. These changes signify personal progress and a positive shift in the community dynamic. Further emphasizing rebuilding social connections and community bonds in sustaining reintegration is crucial for rehabilitation. The present study shows rebuilding community bonds for PWUDs as they become proactive agents of change, actively promoting community safety by reporting illegal activities and noting a significant decline in local drug-related incidents following their participation in the program. Increased participation in community events facilitates the breaking of addiction and promotes reintegration into society, leading to positive community impacts (Bragge et al., 2023). Moreover, the findings align with SDG 16: Peace, Justice, and Strong Institutions (United Nations, 2015), which aims to promote peace, security, and inclusive societies. The noticeable decline in drug-related activities has not only contributed to a safer environment but has also fostered a greater sense of peace and stability within the community. This progression reflects the reintegration of PWUDs into their communities as valued and responsible members.

In these narratives, rebuilding social connections and community bonds of PWUDs emerges as a critical element of CBDRP community reintegration. Rural healthcare workers are able to rebuild and reestablish PWUDs' place in the community through CBDRP implementation, transitioning them from being marginalized to becoming active contributors to their communities. This transformation is a testament to their resilience and a reflection of the community's capacity for acceptance and support. By fostering environments where PWUDs can actively participate and demonstrate their value, community involvement becomes a cornerstone for sustainable reintegration.

3.2 Positional: Rural Healthcare Workers as Central Agents of Implementation

Rural healthcare workers as central agents of Implementation emerged as the key theme at the positional level. This reflects their indispensable role in implementing the Community-Based Drug Rehabilitation Program, which revealed two subthemes: Being Pillars of Rehabilitation and Partnership Builders for a Sustainable Program.

Being Pillars of Rehabilitation

Being a pillar reflects the heavy burden of responsibility rural healthcare workers shoulder, emphasizing their pivotal role in ensuring the program's implementation. The rural healthcare worker describes themselves as the initiator in the process, from organizing and conducting screening activities to facilitating CBDRP sessions. Their hands-on approach extends to planning, documentation, and managing program logistics, making their involvement all-encompassing. The rural healthcare worker's assertion, *"If not me, who else will?"* captures their sense of indispensability. This sentiment highlights not only their dedication but also the challenges inherent in carrying such a significant weight of responsibility on their own. Their narrative portrays a deep personal commitment that transcends the formal requirements of their role, reflecting their determination to see the program succeed against all odds. This mirrors findings from UNODC (2015), which underscore the necessity of local healthcare workers' leadership in implementing community-based rehabilitation programs, particularly in resource-limited settings. In addition, healthcare workers are integral in delivering healthcare services in rural areas; hence, they are the first point of contact for individuals seeking healthcare, including drug rehabilitation services (Kalne, 2022a).

"*Mostly, I am the one who leads the program. Heavy. The program's success depends on screening, organizing the screening activity, and conducting CBDRP sessions. I am hands-on in planning and everything. In this response, I feel like if I had not worked hard for this program, this CBDRP in Kawayan would not have been implemented. If not me, then who else will?"* (R1)

"So now, I am the one handling this. Two of us were trained... but he/she cannot manage it anymore if I involve him/her. So I just decided to handle it alone. It is up to me now, but I can still manage." (R7)

"There is a lot of documentation and paperwork. A lot. You have to chart each individual, recording their responses and behaviors. Everything needs to be documented. It is like I am doing the work meant for an entire team. Sometimes, it gets overwhelming."(R10)

Similarly, their narratives also echo this sense of sole responsibility, noting that they have managed the program independently. Despite being part of an organization, the rural healthcare workers handled the program alone, as their counterparts could no longer manage the workload. Their narrative conveys resilience and adaptability, as they describe their willingness to bear the program's weight despite the challenges. *"It is just up to me now, but I can still manage,"* reflects their resolve to persevere despite overwhelming demands. This narrative stresses the reality that, in rural settings, healthcare workers often go beyond their official roles to ensure the continuity of essential programs. Consistent with the findings, rural healthcare workers often lack support services, which are more readily available in urban areas (Stopka et al., 2024), and rural healthcare workers can manage a heavy workload alone, which is exacerbated by the limited distribution of duties among trained staff (Souza et al., 2024). This shows their essential role in the CBDRP implementation, which the program wouldn't initiate if it weren't their initiative, despite a limited workforce. Moreover, their role as pillars highlights a sense of indispensability, illustrated by their proactive involvement in every program stage.

The narratives offer insight into their work's meticulous and demanding nature, particularly in terms of documentation and reporting. They recount the exhaustive requirements of charting each individual's response and behavior, emphasizing the volume of paperwork involved in monitoring program PWUDs. The phrase "*parang lahat nasa akin*" captures the overwhelming nature of their role, as they navigate tasks that a team would typically manage. Their narrative reveals the dual burden of being the program's operational backbone and the primary documentarian. This combination can lead to burnout and reflects their commitment to maintaining the program's integrity. This finding echoes the study of Hechanova et al. (2018), which highlights how healthcare workers in rural settings often go beyond their formal roles due to resource constraints, taking on multiple responsibilities to address gaps in program implementation. The narratives highlight rural healthcare workers' role as pillars and their status in their own healthcare workers' face, including the absence of sufficient manpower and the demanding nature of the program. It captures the overwhelming burden of managing the program's logistics and maintaining its integrity.

These narratives collectively portray rural healthcare workers as the backbone of the CBDRP, acting as both the initiators and sustainers of the program's operations. Their positioning as pillars is shaped by necessity and personal dedication, as they often fill gaps in resources and manpower. Their stories reveal the challenges of operating in rural settings, where limited support and infrastructure place additional strain on individual healthcare workers. Despite these challenges, their commitment ensures that the program remains functional and practical, highlighting their indispensable role in the rehabilitation and reintegration.

Being a Partnership Builder for Sustainable CBDRP

In addition to serving as pillars, rural healthcare workers position themselves as Partnership Builders for Sustainable Program as the second subtheme, leveraging collaborations with various stakeholders to enhance the program's impact. Their narratives emphasize the importance of partnerships with Local Government Units (LGUs), law enforcement agencies, and other organizations in ensuring resource mobilization, participant engagement, and program sustainability.

"There is no problem with implementation here because when it comes to LGU support, it's all good. They even bought me a printer, and we also have a new projector. The expenses are just charged to the funds allocated for drug-related programs. There's also funding from the government, but when it comes to support, I don't have any problems, really. Our LGU allocates 300,000 thousand pesos annually specifically for drug-related programs. I'm mandated to use that amount. This year, I've been spending it gradually, really." (R7)

"And then, together with Sir Brian, since the municipality allocated a budget for the entire course and program. After the program, once they graduate, they are given incentives 5,000 thousand pesos each, yes, in cash. Then, they also receive one sack of rice from the LGU, which was given to them" (R8)

Rural healthcare workers illustrate the strong support and partnership from LGUs, detailing how annual budgets are allocated specifically for drug rehabilitation, ensuring the availability of essential resources such as printers, projectors, and program funds. This financial backing not only alleviates logistical concerns but also emphasizes the LGU's commitment to the program. Similarly, how the municipal government extends its support by providing incentives, such as cash and rice, to graduates of the program. These tangible rewards serve as a motivating factor for PWUDs and reinforce the community's recognition of their efforts toward rehabilitation. As highlighted by Mutschler (2024), inter-agency collaborations are essential in community-based residential treatment settings for effectively addressing substance abuse issues. Rural healthcare workers serve as key facilitators of partnerships between agencies involved, emphasizing their critical role of inter-agency collaboration in creating a supportive atmosphere and fosters the sustained implementation of programs addressing substance use. The partnership of rural healthcare workers with Local Government Unit plays a pivotal role in the program. According to the narratives, the Local Government Unit provide financial and logistical support is pivotal, ensuring the program's sustainability. Annual budget allocations for drug rehabilitation and incentives for PWUDs who graduates from the program illustrate the commitment of local governments. Their commitment to providing support has enabled rural healthcare workers to sustain the implementation of the CBDRP, particularly through the provision of incentives for enrolled PWUDs, encouraging their continued participation in the program. The study findings support to Hechanova et al. (2018) as stated that strong partnerships with local government agencies are critical for sustaining community-based health initiatives. In addition, adequate financing and access to essential resources are among the key enablers of implementing community-based drug and care in Philippine local governments (Hechanova et al., 2023).

"For example, the police. We mostly just coordinate or tap the PNP, like saying, 'Sir, please have the PWUDs come over.' So for instance, if the PWUDs need to be summoned, it's the PNP who does the summoning. Then we take care of monitoring their attendance for the session." (R4)

"Our task is really to deliver the modules. The KKDK and the GINHAWA. And then the lessons and modules. But the task of the PNP, they are the ones who inform. The duty of the PNP together with the DILG, their task is to inform." (R8)

"And then, when we invited participants, we asked the police to help us go to their houses to inform them. The police are also supposed to be present during the sessions. They're usually just stationed nearby". Although there are times they can't be there – of course, they have other duties – but most of the time, they're really there on the sidelines. So, since we have the police with us, the PWUDs behave properly." (R9)

In addition to resource mobilization of PNP, rural healthcare workers coordinate closely with law enforcement agencies like the Philippine National Police (PNP). The rural healthcare workers describe how the PNP assists by summoning PWUDs to sessions, emphasizes the police's presence during activities, which fosters order and ensures PWUDs compliance. Such partnerships establish a structured environment where PWUDs feel guided and monitored throughout their community rehabilitation journey. Moreover, the partnership with law enforcement, such as the Philippine National Police (PNP) during the implementation of CBDRP, ensures PWUDs compliance and program order during sessions conducted by the rural healthcare workers, reinforcing a structured rehabilitation environment. The process done by the rural healthcare workers is the same how a pilot program in Vietnam showcased the advantages of integrating law enforcement with health and social services to support drug users (Oppenheimer et al., 2022).

"In CBDRP programs we need to coordinate to other agencies like the DSWD, the DILG, because we need to include them in the participation ahh.. implementation of CBRP sessions. Then other agencies" like PDEA." (R6)

"This CBDRP lasts for six months – it's really long. Our module-based program is actually good for only three months. So we just made adjustments to involve the DSWD, the PNP, and our religious group." (R7)

"We are not working alone. The DSWD, PNP, and the religious sector are also involved." (R10)

"So now, our focus is on aftercare since the PWUDs are already done with the main program. It seems like they're no longer acting out. The aftercare program is now under the care of the MSWD (Municipal Social Welfare and Development). It runs

for 18 months under the MSWD. But we also want to continue doing random drug testing to monitor them, while the PNP handles surveillance." (R9)

Moreover, collaboration extends to other agencies such as the Department of Social Welfare and Development (DSWD), the Department of the Interior and Local Government (DILG), and even religious groups. The inclusion of these organizations in program activities, ensuring a holistic approach to rehabilitation. For example, the MSWD supports aftercare programs for PWUDs, taking over their monitoring after completing the initial six-month rehabilitation phase. This partnership initiation from rural healthcare workers reflects an effort to sustain the progress of PWUDs and reinforce their reintegration into the community, echoes to a successful community-based rehabilitation programs rely on multi-sectoral collaboration, involving healthcare providers, law enforcement, local governments, and civil society organizations (UNODC, 2018).

Highlighting where rural healthcare workers actively build partnership also with religious sector incorporate religious and spiritual practices, such as reconciliation and penance, providing PWUDs with a sense of spiritual renewal and moral support. This approach showed the importance of incorporating religious practices in the rehabilitation process. Consistent with studies of Ghazalli and Ramly (2023) stated that spiritual and informational assistance have an importance in the rehabilitation process and Walag et al. (2024) found that integrating religious support into community-based programs boosts client satisfaction and completion rates by addressing both internal and external motivations. This also aligns with the Transformation Rehabilitation Plan emphasizes a community-based strategy for drug prevention consist of healing and moral recovery to embrace a new way of life (Mazo, 2020).

The narratives of rural healthcare workers being partnership builders collectively describe their pivotal role by fostering collaborative relationships, that bridge the gaps in resources, manpower, and program implementation. Their ability to coordinate with diverse stakeholders ensures the seamless operation of the CBDRP and enhances its impact on PWUDs and the community at large, echoing to the findings from study of Martin et al. (2022), emphasizing that effective community-based rehabilitation requires active involvement from governments, and collaboration with community stakeholders, such as the police and cultural organizations as they are the key enablers in the success of community-based drug treatment programs. By bringing together local government units, national agencies, police enforcement, and religious sector, rural healthcare worker fosters collaborative environment that ensures resources, expertise, and support system are effectively utilized. Strengthening inter-agency coordination among healthcare providers, law enforcement, and community organizations is also crucial, as collaboration between the health, social welfare, and criminal justice sectors ensures a more holistic, patient-centered approach to rehabilitation in the community (UNODC, 2018). By leveraging these partneship, rural healthcare workers not only foster a holistic approach but also address SDG 11: Sustainable Cities and Communities with its broader vision of creating a sustainable and participatory communities (United Nations, 2015) through multi-sectoral invovlement to foster sustainable rehabilitation for PWUDs (DDB, 2018).

As rural healtcare workers shows their role goes beyond clinical care, bridging the gaps to give comprehensive care to these vulnerable populations e exemplifies how they not only act as pillars of the program but also as connectors, uniting various entities toward the shared goal of rehabilitation and reintegration of PWUDs into the community also this shows best practices in community-based interventions and serves as a model for other rehabilitation initiatives.

3.3 Personal: Transformational Journeys of Rural Healthcare Workers

The implementation of Community-Based Drug Rehabilitation Program has led a profound experience for rural healthcare workers, within these experiences, Transformational Journeys of Rural Healthcare Workers emerged as a central theme at the personal level, highlighting subthemes of narratives of overcoming challenges of participation and implementation, defining success, and personal and professional growth.

Overcoming Challenges in Participation and Implementation

Rural healthcare workers expressed overcoming challenges in participation and implementation that tested the program's feasibility and capacity to engage PWUDs throughout the program. Their narratives reveal overcoming challenges such as barriers rooted stigma-related, denial, reluctance and the socioeconomic constraints among

PWUDs that limits their ability to participate that affects rural healthcare workers implementation, illustrating the complexities of facilitating rehabilitation in rural areas.

"*In the beginning, the [CBDRP] program was really difficult especially with our clients, the surrenderers. It was hard for the police to get them because they had to go house to house and fetch them since they were hesitant to undergo the sessions. It's like they weren't ready or willing yet. I don't really know what it is with them maybe it's hesitation? There's definitely hesitation, and some were afraid to be seen by others when they come to the center to participate in the [CBDRP]. They were afraid that people would find out they were attending… During the first session, they were still hesitant. But by the second or third session, they started opening up. They began sharing, they were no longer hesitant. They were willing to share, and then willing to change. They really didn't go back to using drugs.*" (R2)

"*Before, they were really hesitant to enroll, like they were in denial. They said they didn't really use drugs. So, when we invited participants, we asked the police to go to their houses to inform them. Then during the sessions, we had the police present. So, because the police were there, they behaved properly.*" (R9)

"*Challenges? One was what I mentioned earlier, the initial denial and hesitance to enroll in the program. They only enrolled as if it was a requirement. However, we constantly monitored them. We always checked attendance – no absences allowed. And over time, we noticed that the denial and hesitation gradually disappeared because they no longer missed sessions*" (R10)

The initial phase of CBDRP implementation was marked by pervasive stigma and denial resulted as barriers to participation among PWUDs. Exhibited profound reluctance to engage with the program, driven by fear of being stigmatized by their community. The idea of being seen at the center created anxiety among PWUDs, as they feared judgment and exposure in the community. This apprehension stemmed from internalized stigma, wherein PWUDs associated rehabilitation centers with societal judgment rather than healing.

Denial of substance use further compounded resistance, noted from a narrative where denial of substance use was another significant barrier, with some individuals refusing to acknowledge their dependency to drugs. For many, enrolling in the program felt more like fulfilling a requirement than a genuine commitment to rehabilitation. These barriers pose a significant challenge for rural healthcare workers in initiating the program wherein societal stigma hinder rehabilitation efforts. As the program operates on a voluntary engagement model, it cannot compel PWUDs to enroll. This lack of enforcement further complicates the efforts and frustration to rural healthcare workers in ensuring active participation and program implementation.

The study's findings validate the current literature on the role of stigma as barrier to CBDRP. Initial barrier experienced by the rural healthcare workers were PWUDs resistance due to societal stigma of being seen attending sessions further complicate engagement efforts, with some PWUDs hesitant to fully commit to the program due to denial or superficial compliance. This shows that PWUDs has internal stigma where they associate rehabilitation centers with societal judgment, which aligns with findings stigma to pose significant obstacles to rehabilitation and community reintegration, as social exclusion discourages individuals from seeking treatment leads to decreased use of health services (Bakos-Block et al., 2024). Consistent with other studies, in rural areas, the close-knit nature of communities can lead to confidentiality concerns, further deterring PWUDs from seeking treatment (Stopka et al., 2024; Winiker et al., 2023). Moreover, stigma remains a pervasive barrier affecting both the willingness of PWUDs to engage in treatment and the attitudes of healthcare providers (Ashworth et al., 2024). This reflects how stigma and confidentiality concerns deter participation in rural settings despite efforts of rural healthcare workers. Aligns with the findings that fear of stigma is a prominent barrier for help-seeking among PWUDs in rural areas due to social networks are tighter (Perez et al., 2024).

However, continued effort led to gradual improvement. The reported hesitancy diminished by the second or third session PWUDs gradually overcoming stigma. This shift underscores the role of trust-building in mitigating stigma-driven resistance. Law enforcement involvement, though initially seen as coercive, helped with initial engagement and monitoring. Allowing enough time and involving law enforcement helped reduce denial and dropout rates, leading to sustained engagement.

"*The number one challenge was time – the time availability of the target participants, since most of them are breadwinners. So, when they spend time attending our sessions, that's one day lost for their livelihood. The LGU used to provide groceries. Now that those are no longer available, we adjusted the sessions so they wouldn't have to be away from work for too long – holding them in the afternoons for a shorter period, just so they could still attend.*" (R1)

"*Livelihood is affected, yes, because the implementation runs for three days. That means three days without income. Many of them [PWUDs] also have jobs, and they don't want to neglect their work. They need to feed their families… To avoid problems with the surrenderers, we had a budget for groceries and rice, so it wasn't really a major issue.*" (R2)

"*At the very beginning, during the initial activities, there were more participants. But as days passed, some would already be absent… That's how it is. But it's understandable some of them had work. So we made adjustments. We gave them rice. We also gave something else after every session.*" (R5)

"*One of the challenges is their ability to participate. They have family commitments. It's a conflicting demand, between their families and work responsibilities, especially as breadwinners. That's one of the challenges. However, the LGU addressed this by offering incentives in the form of goods, like rice, canned goods, noodles, and so on..*" (R6)

"*Of course, many of them have jobs. So when the sessions run long, it affects their livelihood. The LGU helped by providing rice. On those days, their basic needs were supplied..*" (R8)

Another critical barrier was the conflict between program participation and livelihood of PWUDs. It was highlighted how time constraints affected breadwinners, who often viewed attending sessions as a loss of income for their families. The program's implementation required PWUDs to spend several days in sessions, which directly impacted their ability to work and provide for their households. This sentiment was echoed by another rural healthcare worker, who noted that for many PWUDs, the opportunity cost of missing work outweighed the perceived benefits of rehabilitation. Rural healthcare workers further emphasized how these conflicting demands between family, work, and program participation posed a significant hurdle in ensuring consistent attendance and engagement.

The study highlighted program participation affected breadwinners, who often viewed attending sessions as a loss of income for their families that often led to decreased participation or dropouts. The program required significant time commitment, which many PWUDs viewed as a loss of income, reflecting findings by Stopka et al. (2024) that personal and financial priorities can act as barriers to treatment. It was the most common barrier cited in the study of Perez et al., (2024) where there is a conflict between work schedules and treatment sessions. Most of the service users belong to marginalized sector which express needs related to livelihood support (Pelegrino, 2022). Additionally, in the Philippines, poverty is a salient factor found as a socioeconomic challenges that impact the implementation of community-based drug rehabilitation program. However, these barriers of participation were confronted by the rural healthcare workers evident in their narratives, they relied on LGUs support of necessities, provide program flexibility, and involvement of law enforcement, as they expressed some difficulty confronting these barriers, especially the mentioned barriers often fall outside of rural healthcare worker's control such as stigma and socioeconomic constraints yet provide only temporary resolutions.

To overcome these barriers, rural healthcare workers relied on Local Government Units (LGUs) for providing necessities to PWUDs and implemented program flexibility. Recognizing the necessity of economic incentives, LGUs provided groceries, rice, and canned goods to offset PWUDs lost wages. These interventions reframed participation as a mutually beneficial exchange, aligning rehabilitation with immediate basic needs. Moreover, temporal adjustments further enhanced accessibility. Sessions were condensed or rescheduled to minimize disruption to livelihoods. These modification by rural healthcare workers show the CBDRP's adaptability to PWUDs socioeconomic conditions.

These narratives paint a nuanced picture of the realities faced by both the rural healthcare workers and PWUDs during the CBDRP's implementation. The rural healthcare workers confront barriers that addresses PWUDs reluctance and mitigating socioeconomic issues and fostering trust within a stigmatized community. It is important to note that these barriers emerged during the initial implementation of CBDRP but did not prevent its

ongoing implementation. However, rural healthcare workers overcome these barriers with resolutions to ensure the sustained participation of PWUDs.

Defining Success in the Implementation

Overcoming these barriers faced in the implementation of CBDRP, rural healthcare workers accomplished success illustrating through their narratives, reflect not only the program's impact on PWUDs but also their milestone and breakthroughs of the rural healthcare workers' efforts implementing the program. The narrative highlighted the program's progress through the significant number of completers, emphasizing how feedback from PWUDs who completed the program revealed life-changing experiences. The transformation observed in PWUDs, such as improved lifestyles and reduced substance dependence, translated into a sense of accomplishment for the healthcare workers, as well as for the Rural Health Unit (RHU) and Local Government Unit (LGU).

"*So far, there has been progress because they completed the program. Most of them, we were able to produce program completers. I've heard feedback from PWUDs who completed the program saying it changed their way of life. So, it created a positive impact on their lives, and hearing that, it felt like the success of the program also translated to the success of the RHU (Rural Health Unit) and the LGU.*" (R1)

"*We were awardees last year from ADAC – Regional Awardees..*" (R3)

"*In Caibiran, more than around 90% of PWUDs attended regularly. Attendance was mostly at 90%. Out of 32 participants, we were able to graduate 28..*" (R4)

"*Back in 2019, during the initial implementation of the CBDRP, there were 22 who started the program, but only 14 successfully graduated. Then in the second batch, we had 25 enrollees and had zero dropouts. Even those who dropped out during the first batch re-enrolled and successfully completed the program.*" (R6)

A high attendance rate with 90% of PWUDs consistently participating in sessions. Out of 32 enrolled PWUDs, 28 successfully graduated from the program, highlighting the rural healthcare workers' ability to engage and retain PWUDs throughout the process. A rural healthcare worker also recounted the progression of the program from its initiation in 2019, where 22 PWUDs started, and 14 successfully graduated. In subsequent batches, improvements were noted, with 25 enrollees completing the program without any dropouts. Remarkably, even PWUDs who had dropped out during the first batch were re-enrolled and successfully finished the program, reflecting the rural healthcare workers' persistence and commitment to ensuring no one was left behind. Furthermore, a rural healthcare worker shared a moment of pride, noting that their efforts earned recognition at the regional level, where they were awarded by the Anti-Drug Abuse Council (ADAC). This highlights the success of their initiatives and the impact of their work in addressing substance use at the community level.

These narratives demonstrate the success of the CBDRP, driven by the unwavering efforts, strategic collaboration, and transformative influence of rural healthcare workers. Despite being implemented it in a rural setting with limited resources, and health workforce, and a demanding six-month duration for both PWUDs and rural healthcare workers, the program has yielded positive outcomes. The rural healthcare workers have successfully guided PWUDs participations through rehabilitation process, ensuring their continued participation and persistence until graduation, despite numerous challenges. Their stories reflect not only the success of transforming the lives of PWUDs but also the well-earned recognition for its effectives in community-based rehabilitation. The findings that rural healthcare workers define success are consistent with the study of Shaver et al. (2023) that healthcare workers experience a sense of success as they facilitate the positive impact of their interventions and witness meaningful change among PWUDs lives, such as significant reductions in substance abuse levels and improvements in mental health.

Personal and Professional Growth in the Field of Rehabilitation

Beyond overcoming challenges and defining their success, the CBDRP fostered significant Personal and Professional Growth in the Field of Rehabilitation among rural healthcare workers, emerging as the third subtheme. Initially, rural healthcare workers held misconceptions and biases toward PWUDs, viewing them

through a lens of judgment and stigma. However, through training, direct interactions, and facilitating sessions, they gained a deeper understanding of the complex personal struggles faced by PWUDs.

"*At the start, before I was trained and educated about PWUDs, I used to think they were ignorant about the world that they were worthless, that they weren't good people. But once you talk to them, you realize they have their own reasons for ending up in that situation. It's like they lacked support from their families, which led them to make the decisions that got them involved in those kinds of activities.*" (R5)

"*During the first implementation of these programs, I was somewhat against their personalities, especially regarding drug use. But as time went on, I got to know them, I became friends with them. That's when I realized that they really need help in dealing with their addiction.*" (R6)

"*Now I know how to relate with them. Before, when we found out someone was a user or a pusher, we'd have certain ideas about them, we'd be hesitant or even afraid. But now, I understand their reasons. Before, when we heard someone was a user or a pusher, we immediately thought they were just addicts, we were afraid of them. But after facilitating the program, that fear disappeared. Now, I know how to engage and interact with them.*" (R9)

Rural healthcare worker shared an initial bias toward PWUDs, perceiving them as individuals with no purpose or value. However, through engagement and communication in the implementation of CBDRP, they realized that many PWUDs acted out of a lack of familial support and unresolved personal struggles. This shift in perspective allowed the respondent to move beyond judgment, fostering empathy and understanding of the broader contexts that contributed to substance use. Similarly, a rural healthcare worker admitted to harboring negative perceptions about PWUDs and their behaviors at the start of the program. Over time, however, consistent interactions and relationships with the PWUDs led to a transformation. By building friendships and gaining a deeper understanding of addiction, the respondent recognized the importance of offering support rather than judgment, solidifying their commitment to helping PWUDs overcome their struggles.

The narratives highlighted how facilitating the program dispelled their initial fears and prejudices. They admitted feeling apprehensive about interacting with PWUDs due to societal stereotypes. However, as they facilitated sessions and uncovered the reasons behind the PWUDs substance use, their fear and hesitation faded. The experience taught them how to navigate relationships with PWUDs with confidence and compassion, enabling more meaningful interactions. The findings is consistent with Samandari et al. (2022) study which showed that healthcare professionals who undergo substance use disorder training exhibit significantly improved attitudes toward individuals with substance use disorders. Moreover, their narratives revealed how direct contact with PWUDs served as a strong predictor of positive attitudes, aligning with findings by (Ferreira et al., 2022), demonstrated that familiarity through professional or personal experience reduces stigma and fosters more supportive approaches to care. Rural healthcare workers described how building relationships with PWUDs not only dispelled stereotypes but also strengthened their commitment to providing meaningful support.

"*I also learned lessons for myself from the content we imparted. Before I even delivered the lessons, I was already learning something. And throughout the series of sessions, we facilitators also gained insights – things we could apply personally. It was an added benefit, especially since our work involves dealing with different kinds of people.*" (R4)

"*Even we, who are not PWUDs realized many things as we used the modules.*" (R7)

"*Going through the CBDRP process, even for me, it felt like something changed or was added to my personal perspective and in how I do my work.*" (R8)

Several rural healthcare workers noted how their professional knowledge expanded through the program. They emphasized that while teaching and imparting lessons, they also gained valuable insights and learnings for themselves. They described the process as a continuous cycle of learning, where the lessons they facilitated enriched their own perspectives and enhanced their ability to work with diverse populations.

A rural healthcare worker echoed this sentiment, acknowledging how using the program modules provided realizations and personal growth, even as a non-PWUD. Similarly, it was reflected on how their involvement in the program contributed to personal and professional development. They described experiencing changes in their outlook and approach to their work, attributing this transformation to the program's unique challenges and lessons. This dual impact reflects findings by Allado et al. (2019), which highlight that facilitating CBDRP modules helps healthcare workers develop valuable life skills. The program's twofold benefit: rehabilitating PWUDs into the community while fostering the growth of rural healthcare workers. These narratives showed growth illustrate how rural healthcare workers implementation in the CBDRP led to profound shifts in their understanding of addiction, empathy toward PWUDs, and professional capabilities. Highlighting the dual impact of the program: not only does it transform the lives of its PWUDs, but it also fosters personal and professional growth of rural healthcare workers.

4.0 Conclusion

This study aimed to explore the narratives of rural healthcare workers in implementing the Community-Based Drug Rehabilitation Program (CBDRP) in Biliran Province, Philippines. The findings offered insights into how these healthcare workers experience, interpret, and navigate their roles in delivering community-based interventions for persons who use drugs (PWUDs). Using Murray's (2000) level of narrative analysis framework, their experiences were examined across ideological, positional, and personal levels. At the ideological level, CBDRP was seen as a pathway to community reintegration. Rural healthcare workers shared how they witnessed recovery, observed shifting societal perceptions, and facilitated the rebuilding of social connections for PWUDs—contributing to their reintegration as valued members of the community. At the positional level, rural healthcare workers emerged as essential actors in CBDRP implementation. Despite limited resources, they acted as pillars of rehabilitation and partnership builders, coordinating with government agencies, law enforcement, and community organizations to ensure continuity of care and program sustainability. Laslty, at the personal level, rural healthcare workers underwent their own transformational journeys. Initial apprehensions and biases evolved into deeper understanding and professional growth. Their involvement in CBDRP strengthened their commitment to community-based mental health and substance abuse recovery. While the study highlights valuable contributions, it is not without limitations. The research was conducted in a single province using purposive sampling, which may affect the generalizability of findings. Future research may address this by including other rural provinces or conducting comparative studies across different geographical and socio-cultural contexts.

5.0 Contributions of Authors

Equal contribution of authors.

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7.0 Conflict of Interests

The authors declares that there is no conflict of interest in conducting this research. All findings and conclusions were derived objectively, without any influence from personal, financial, or institutional interests.

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9.0 References

Allado, M. A. D., Gumba, N. G. M., Melo, K. J., & Hechanova, M. R. M. (2019). A narrative analysis of the experiences of barangay officials involved in community-based drug rehabilitation. Philippine Journal of Psychology, 52(1), 39-64. https://archium.ateneo.edu/psychology-faculty-pubs/107

Ashworth, M., Thunström, L., Clancy, G. L., Thompson, R. A., Johnson, D., & Fletcher, E. (2024). Facts and personal recovery stories to reduce substance use disorder stigma and increase support for recovery housing: A us randomized study. International Journal of Mental Health and Addiction, 22(6), 4034–4050. https://tinyurl.com/ytrc453x

Bakos-Block, C., Yatsco, A., Cohen, A. S., Vega, F., & Champagne-Langabeer, T. (2024). "My addiction doesn't define me"—Experiences of stigma among mothers with opioid use disorder. Pharmacoepidemiology, 3(1), 57–68. https://doi.org/10.3390/pharma3010004

Bautista, R. D., & Teng-Callega, V. F. (2021). Community-based drug rehabilitation programs in the Philippines: A systematic review of the literature. Substance Abuse Treatment, Prevention, and Policy, 16(1), 1-15.

Bragge, P., Delafosse, V., Cong-Lem, N., Tsering, D., & Nielson, S. (2023). Community impacts of residential alcohol and drug rehabilitation services. The Sax Institute. https://doi.org/10.57022/jgsk1115

Bunagan, K., Tabo, C. E., Bautista, V., Melgar, M. I., Co, T. A., & Hechanova, M. R. (2019). Engaging the family in recovery: Outcomes of a community-based family intervention. Philippine Journal of Psychology, 52(1), 155–183. https://doi.org/10.31710/pjp/0052.01.06

Clarke, V., & Braun, V. (2014). Thematic analysis. In T. Teo (Ed.), Encyclopedia of Critical Psychology (pp. 1947–1952). Springer New York. https://doi.org/10.1007/978-1-4614-5583-7_311

Co, T. A. C., & Canoy, N. A. (2020). The lived experiences of recovering Filipino persons who use drugs (PWUDs) without family support. Journal of Ethnicity in Substance Abuse, 21(4), 1389-1490. https://doi.org/10.1080/15332640.2020.1861493
Dangerous Drugs Board. (2018). Community-based drug rehabilitation program guidelines. Retrieved from https://dbb.gov.ph
Department of the Interior and Local Government. (2018). Guidelines for the implementation of community-based drug rehabilitation programs. Retrieved from https://tinyurl.com/5bn728ju
Engelbrecht, A., & Jobson, L. (2016). Exploring trauma appraisals in trauma survivors from collectivistic cultures. SpringerPlus, 5(1), 1565. https://doi.org/10.1186/s40064-016-3043-2
Ferreira, V. L., de Andrade Tostes, J. G., Knaak, S., da Silveira, P. S., Martins, L. F., & Ronzani, T. M. (2022). Attitudes of health professionals towards people with substance use disorders in Brazil, controlling for the effects of social desirability. Health & Social Care in the Community, 30(5). https://doi.org/10.1111/hsc.13749
Friedman, J., Mann, N. C., Hansen, H., Bourgois, P., Braslow, J., Bui, A. A. T., Beletsky, L., & Schriger, D. L. (2021). Racial/ethnic, social, and geographic trends in overdose-associated cardiac arrests observed by us emergency medical services during the COVID-19 pandemic. JAMA Psychiatry, 78(8), 886. https://doi.org/10.1001/jamapsychiatry.2021.0967
Ghazalli, F. S. M., & Ramly, A. F. (2023). Readiness of families to support a community based drug rehabilitation program: A case study in Terengganu. International Journal of Academic Research in Business and Social Sciences, 13(12), 1615–1620. https://doi.org/10.6007/ijarbss/v13-i12/20060
Gonzales, M. & Santos, R. (2022). Challenges in the implementation of community-based drug rehabilitation programs in rural philippines. Journal of Public Health Research, 15(3), 214-229.
Hechanova, M. R. M., Alianan, A. S., Calleja, M. T., Melgar, I. E., Acosta, A., Villasanta, A., Bunagan, K., Yusay, C., Ang, A., Flores, J., Canoy, N., Espina, E., Gomez, G. A., Hinckley, E. S., Tuliao, A. P., & Cue, M. P. (2018). The development of a community-based drug intervention for filipino drug users. Journal of Pacific Rim Psychology, 12, e12. https://doi.org/10.1017/prp.2017.23
Hechanova, M. R. M., Teng-Calleja, M., Canoy, N. A., & De Guzman, J. M. (2023). Community-based drug rehabilitation and care in Philippine local governments: Enablers, barriers, and outcomes. International Perspectives in Psychology, 12(1), 26–37. https://doi.org/10.1027/2157-3891/a000058
Hechanova, M. R. M., Waelde, L. C., & Torres, A. N. (2020). Cultural implications for the provision of disaster mental health and psychosocial support in Southeast Asia. In M. R. M. Hechanova & L. C. Waelde (Eds.), Community, Environment and Disaster Risk Management (pp. 3–13). Emerald Publishing Limited. https://doi.org/10.1108/S2040-726220200000021001
Kallio, H., Pietilä, A. M., Johnson, M., & Kangasniemi, M. (2016). Systematic methodological review: Developing a framework for a qualitative semi-structured interview guide. Journal of Advanced Nursing, 72(12), 2954–2965. https://doi.org/10.1111/jan.13031
Kalne, P. S., Kalne, P. S., & Mehendale, A. M. (2022). Acknowledging the role of community health workers in providing essential healthcare services in rural India: A review. Cureus, 14(9), e29372. https://doi.org/10.7759/cureus.29372
Li, L., Comulada, W. S., Lin, C., Lan, C. W., Cao, X., & Wu, Z. (2015). A community-based intervention for Chinese HIV-positive drug users. Journal of the Association of Nurses in AIDS Care, 26(5), 595-608. https://doi.org/10.1016/j.jana.2015.03.001
Mazo, G. N. (2020). Transformational rehabilitation: Community-based intervention to end the drug menace. International Journal of Research -GRANTHAALAYAH, 5(12), 183–190. https://doi.org/10.29121/granthaalayah.v5.i12.2017.494
Murray, M. (2000). Levels of narrative analysis in health psychology. Journal of Health Psychology, 5(3), 337–347. https://doi.org/10.1177/135910530000500305
Mutschler, C. (2022). Recovery within a community-based residential treatment for substance use problems: Program theory development and the impact of COVID-19 (Doctoral dissertation). Toronto Metropolitan University
Oppenheimer, E., Nong, T., Khuat, O., Nguyen, T., Do, X., & Pham, V. (2022). Police-mediated legal and social assistance to people who use drugs in two districts in Hanoi, Vietnam. Journal of Community Safety and Well-Being, 7(Suppl_1), S45–S51. https://doi.org/10.35502/jcswb.249
Palisoc, M., & Dizon, L. (2021). Healthcare workers' perspectives on drug rehabilitation in rural areas: Barriers and opportunities. Philippine Journal of Health Sciences, 14(2), 99–115.
Pelegrino, J. T. (2022). Drug rehabilitation program from the lens of surenderees. International Journal of Sciences: Basic and Applied Research, 62(1), 235–249. https://tinyurl.com/mws3hnmb
Perez, A. R., Yusay, C. T., & Hechanova, M. R. (2024). Barriers and enablers to help seeking, treatment adherence and recovery among community-based drug rehabilitation clients in the Philippines. Drugs: Education, Prevention and Policy, 1–9. https://doi.org/10.1080/09687637.2024.2373073
Poudel, A., Upadhyay, D., Shrestha, R., & Khadka, S. B. (2016). Effectiveness of community-based rehabilitation model for drug abusers in Nepal. Journal of Addiction Research & Therapy, 7(3), 1000276.
Rao, R., Dhawan, A., Parmar, A., Yadav, D., & Bhad, R. (2021). Improving treatment of substance use disorders through community drug treatment clinics: An experiential account. Indian Journal of Community Medicine, 46(3), 370. https://doi.org/10.4103/ijcm.ijcm_998_20
Riessman, C. K. (2008). Narrative methods for the human sciences. Sage Publications.
Samandari, H., Khave, L. J., Janani, M., Farazmand, S., Motafavi, S. S., Gholami, J., Rawson, R. A., & Noroozi, A. (2022). Evaluation of a training program in general practitioners' attitude toward the integration of substance use disorders services in primary health care. Iranian Journal of Psychiatry and Behavioral Sciences, 16(3). https://doi.org/10.5812/ijpbs-128965
San Patrignano. (2019). Handbook on social reintegration of recovered drug users. Retrieved from https://www.sanpatrignano.org/wp-content/uploads/2020/10/3-reintegration_bassa.pdf
Sarkar, S., Balhara, Y. P., Kumar, S., & Saini, V. (2017). Community-based interventions for substance use disorders: A systematic review. Journal of Psychoactive Drugs, 49(2), 148-159. https://doi.org/10.1080/02791072.2017.1305382
Shaver, S. R., Forsyth, O., & Meritus, D. (2023). Effectiveness of therapeutic community rehabilitation program for drug abuse in social institutions. Law And Economics, 17(3), 203–217. https://doi.org/10.35335/laweco.v17i3.45
Souza, C. D. S., Carneiro, J. A., Santos, D. L., Gomes, B. E. N. M., Souza, M. S., De Almeida, J. M. G., Soares, W. M. F., Da Costa, F. M., Alves, D. R., & Silveira, J. C. S. (2024). The work of nurses in rural primary health care in Montes Claros, Minas Gerais, Brazil. In Communication and culture: Multidisciplinary perspectives (1st ed.). Seven Editora. https://doi.org/10.56238/sevened2024.014-010
Stopka, T. J., Estadt, A. T., Leichtling, G., Schleicher, J. C., Mixson, L. S., Bresett, J., Romo, E., Dowd, P., Walters, S. M., Young, A. M., Zule, W., Friedmann, P. D., Go, V. F., Baker, R., & Fredericksen, R. J. (2024). Barriers to opioid use disorder treatment among people who use drugs in the rural United States: A qualitative, multi-site study. Social Science & Medicine, 346, 116660. https://doi.org/10.1016/j.socscimed.2024.116660
United Nations Office on Drugs and Crime. (2018). Community-based treatment and care for drug use and dependence: Information brief for Southeast Asia. Retrieved from https://www.unodc.org
United Nations Office on Drugs and Crime. (2020). Global study on community-based drug rehabilitation approaches. Retrieved from https://www.unodc.org
United Nations Office on Drugs and Crime. (2023). The evolving global drug rehabilitation strategies. Retrieved from https://www.unodc.org
United Nations. (2015). The Sustainable Development Goals report. Retrieved from https://sdgs.un.org/goals
Vigdal, M. I., Moltu, C., Bjornestad, J., & Selseng, L. B. (2022). Social recovery in substance use disorder: A metasynthesis of qualitative studies. Drug and Alcohol Review, 41(4), 974–987. https://doi.org/10.1111/dar.13434
Walag, A. M. P., Melliza-Descallar, R. B., Patana, J. T., & Hechanova, M. R. (2024). Community-based drug rehabilitation clients' motivation, satisfaction and the factors affecting their completion of the rehabilitation and aftercare program: A convergent mixed methods study. Canadian Journal of Family and Youth / Le Journal Canadien De Famille Et De La Jeunesse, 16(3), 151–171. https://doi.org/10.29173/cjfy30042
Winiker, A. K., Schneider, K. E., White, R. H., O'Rourke, A., Grieb, S. M., & Allen, S. T. (2023). A qualitative exploration of barriers and facilitators to drug treatment services among people who inject drugs in West Virginia. Harm Reduction Journal, 20(1). https://doi.org/10.1186/s12954-023-00795-w
World Health Organization. (2022). Community-based approaches to drug dependence. Retrieved from https://www.who.int
Yamada, C., Tsutsumi, A., Izutsu, T., Tuliao, M. T. R., Matsuo, H., & Tanaka, E. (2021). Quality of life among people who use drugs living in poor urban communities in the Philippines. International Journal of Drug Policy, 93, 103160. https://doi.org/10.1016/j.drugpo.2021.103160
Yusay, C. T. C., & Canoy, N. A. (2019). Healing the hurt amid the drug war: Narratives of young urban poor Filipinos in recovering families with parental drug use. International Journal of Drug Policy, 68, 124–131. https://doi.org/10.1016/j.drugpo.2018.10.009