Leadership Journey: Learning Journal and Workbook

Learning Journal For Leadership Development
Health Leadership and Management for the Poor
Module One: Grounding and Visioning
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Introduction to the Zuellig Family Foundation (ZFF)

The Zuellig Family: A Legacy of Giving Back

1901: From Switzerland, Frederick Zuellig (1883-1943) goes to Manila to work in a trading firm; then built a global Filipino business enterprise.

1916: Frederick becomes a partner in another trading firm that he buys six years later to form the F.E. Zuellig Inc.

1945: His sons, Stephen & Gilbert, start rebuilding the firm left in ruins after the World War II.

1950s-1990’s: Zuelligs build the company into a regional player through strategic acquisitions & partnerships.

1997: Pharmaceutical Health and Family Foundation is established for the health needs of communities around Canlubang, Laguna.

2001: Foundation is renamed Zuellig Foundation that focused on advocacy for public health policy reforms and training of health leaders & professionals.

2008: Following a review of the Foundation’s objectives, the focus shifts to “improving health outcomes for the poor”.

Foundation is renamed Zuellig Family Foundation (ZFF) to underscore its autonomy from the Zuellig group of companies and its change in strategies. ZFF stands as a defined manifestation of the Zuellig family’s desire to sustain a legacy of making healthcare an operative factor in nation building and improving the quality of life for all Filipinos.
VISION

We envision ZFF to be a catalyst for the achievement of better health outcomes for the poor through sustainable programs and services, with a primary focus on health inequities in rural areas of the Philippines.

MISSION

To enhance the quality of life of the Filipino by focusing on the achievement of targets in the country’s Millennium Development Goals for health, in partnership with the government and other stakeholders in the health sector.

GOALS

- Empower and build the capability of communities and individuals
- Train local health leaders to establish equitable and effective local health systems, and to be responsive and accountable for better health outcomes for the poor
- Disseminate information to health leaders and professionals as well as to healthcare institutions
- Advocate equitable policies in public health
- Form partnerships with other agencies
- Establish better access to affordable, high-quality essential medicines for poor communities
OPERATIONAL FRAMEWORK: Health Change Model

KEYMA RESULT AREAS

- Improved Leadership
- Improved Health Governance
- Increased Community Participation
- Effective Health Service Delivery
- Better Local Health Outcomes

SUSTAINABILITY INDICATORS

- Effective Leaders
  - Local Chief Executive
  - Community Leaders
  - Public Health Leaders
- Committed Leadership
- Functional Local Health Board
- Sound Health Policies
- Adequate Health Financing
- Adequate Human Resource
- Effective Barangay System
- Responsive Citizens on Health Programs
- Better Health Seeking Behavior
- Appropriate Innovative Health Programs
- Adequate Basic Health Services
- Appropriate Health Information Systems
- Competent Human Resource
- Improved Access to Medicines & Technologies
- Lower Maternal & Infant Mortality Rates
- Lower Malnutrition Prevalence Rate
- Lower Incidences of Infectious and Non-Communicable Diseases

ATTAINMENT OF THE COUNTRY'S MILLENNIUM DEVELOPMENT GOALS ON HEALTH
• Based on the WHO’s 6 Building Blocks of the Health System and the Foundation’s Health Change Model, the Foundation crafted the Roadmap for Provinces and Municipalities and for the HLMP Fellows

• The combined roadmap of provinces and municipalities is the roadmap of the HLMP Fellows.

• The aim of the roadmap is to guide the Fellow, province and municipalities on developing and integrating the components of the health system
Health Leadership and Management for the Poor Program

The main problem of the Philippine health care system is and has been the inequities among its population. The system is biased against the poor in terms of physical and financial access to appropriate health care, even to basic health care. Therefore, the poor becomes vulnerable to sickness and death.

Targeting health improvement for the poor and the community, therefore, will improve significantly health outcomes not only of the local community but the whole country as well. Health services for all especially for the poor will likely improve if the key health stakeholders are motivated and trained to do so.

In this light, Zuellig Family Foundation (ZFF) envisions itself to be a catalyst for the achievement of better health outcomes for the poor through sustainable healthcare programs and services [universal coverage, people-centered health service delivery, public policy, and leadership and governance], with a primary focus on health inequities in the rural areas in the Philippines. With this end in mind, ZFF implements The Health Leaders for the Poor (HLP), a Learning Program through its Institute for Health Empowerment Leadership and Policy Studies. The program aims to improve the leading and managing practices of key local health leaders to address the inequities in the health system through a leadership development program for local chief executives (decision-makers), the municipal health officers (providers) and the leaders of civil society and the private sector (community mobilizer). A streamlined version of this is the Municipal Leadership and Governance Program (MLGP) which is being implemented in partnership with the DOH and its regional offices, priority provinces, and other partners.

At the provincial level, the Foundation developed the Provincial Leadership and Governance Program (PLGP) to develop the health leadership of governors and PHOs for them to lead the development and reforms in the province-wide health system.

In order to effectively and efficiently support the health leadership teams – mayors, MHOs and community mobilizers and governors and PHOs – health leaders from key regional and provincial institutions, mandated to support the province-wide health system, must likewise be engaged and their health leadership capabilities enhanced, through a similar health leadership enhancement program.

The Health Leadership and Management for the Poor Program (HLMP) is a two (2) module, 12-month plus program that incorporates classroom sessions and fieldwork for key regional and provincial stakeholders working as convergence teams. It is anchored on health systems development and the bridging leadership process and utilizes the ZFF Health Change Model as operational framework for achieving MDGs for health.
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<td>▪ Multi-Stakeholder Processes – Introduction to Dialogue as a Trust Building Exercise</td>
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<td>▪ Innovative Systems – Technical Value Creation</td>
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<td>▪ Transformed Institutional Systems – improved health and other social outcomes (education, livelihood, etc.)</td>
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<td><strong>CO-CREATION</strong></td>
<td>New institutional arrangements</td>
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<td>▪ Innovative Programs</td>
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<td></td>
<td>▪ Technical Systems Development/Coalition Building</td>
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<td>▪ Resource Mobilization</td>
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<td>▪ Inter-local Health Zones</td>
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<td>▪ Institutionalization/Sustainability Mechanisms</td>
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How to Use the Leadership Journey Learning Journal and Workbook

The Learning Journal and Workbook contains session notes, worksheets and reflection questions for each session. The session notes are summaries of the topics discussed and worksheets are for individual exercises used in some of the sessions. The reflection questions are designed to capture what you have learned and to stimulate your thoughts and feelings.

There are no rules for using this Learning Journal and Workbook, except for the Worksheets which will have instructions for use. You can freely write or draw on the pages as you wish. If you don’t like a question, ask your own questions.

As you work, take the time to be still and listen inside. You have an inner voice which is your best teacher. You will hear the lessons as they resonate in your being. As you begin to heed the inner voice, you will see possibilities you could never have imagined.
Objectives of the HLMP Program

At the end of the one-year, two-module capacity building program, HLMP Fellows are expected to be able to:

1. Demonstrate the knowledge, skills and attributes of a Bridging Leader (months 1-12) as indicated in the HLP Integrated Training and Practicum Roadmap.

2. Support partner municipalities by accomplishing the final committed deliverables as indicated in their action work plans.

3. Started preparatory work towards institutionalization of the Health Change Model in their organization or areas of operation reflected in their organization’s policy, budget and work plan for the next year.

Bridging Leadership Competencies:

At the end of the course, the following Bridging Leadership Competencies would have been developed:

OWNERSHIP

1. **Self-Awareness:** Is conscious about strengths and limitations; is able to articulate where his/her leadership, values and beliefs are coming from.

2. **Understanding of Health Challenges (Content Mastery):** Able to identify priority issues and interrelationships of causes and effects of the issues.

3. **Vision:** Takes a long-term view and builds a shared vision with others; acts as a catalyst for organization

4. **Change Mastery:** Able to identify and respond to adaptive leadership challenges.

5. **Resilience:** Deals effectively with pressure; remains optimistic and persistent even under adversity; recovers quickly from setbacks.
CO-OWNERSHIP

6. **Multi-stakeholder Processes (Dialogue):** Able to create a space where people can come together to build mutual understanding and trust across their differences, and to create positive outcomes.

7. **Team Development/Team Work (Interpersonal):** Works well with people; builds trust within the team; manages and influences people to work well together in pursuit of common goals.

8. **Coaching & Mentoring:** Provides guidance and support to his/her team members and facilitates his or her personal development.

9. **Conflict Management:** Explores differences and understanding of another’s perspective; facilitates surfacing, discussion and resolution of differences within the team.

CO-CREATION

10. **Creativity & Innovation:** Develops new insights into situations; questions conventional approaches; Encourage new ideas and innovations, designs and implements new or cutting edge programs/processes.

11. **Networking, Partnership Development & Coalition Building:** Able to analyze stakeholders and interests and identify stakeholders that will pursue his/her goals and objectives in partnership, network or coalition.

12. **Resource Mobilization:** Able to generate resources to support programs and services.
Objectives of Module One: Grounding and Visioning

By the end of the module, the HLMP Fellows will be able to:

1. Develop personal awareness through
   - Reflection of leadership journey
   - Assessment of leadership capital
   - Identification of personal vision/purpose;
2. Analyze health inequities to gain understanding of the poor and their predicament;
3. Explain multi-stakeholder processes and practice dialogue skills;
4. Develop innovative strategies and new institutional arrangements that would address health inequities; and
5. Develop a 6-month plan to address identified health challenge
The Poor & Their Health Care Predicament

Health is a human right. All Filipinos must have fair, just, and equal access to health care.

The Right to Health

- Availability
- Accessibility
  - Non-discrimination
  - Physical
  - Information
- Acceptability
  - Cultural
  - Social
- Affordability
- Appropriateness
- Quality
- Equity

“The enjoyment of the highest sustainable standard of health is one of the fundamental rights of every human being, without distinction of race, religion, political belief, economic or social conditions” – Begins the preamble to the World Health Organization Constitution

“... shall protect and promote the right to health of the people and instil health consciousness among them.” - Article II, Section 15 of the 1987 Constitution

Disease and the Health Burden of the Poor

Health Equity

- Infant Mortality Rate and Maternal Mortality Ratio are higher in low income rural areas than in high income urban areas, while life expectancy at birth is higher in high income urban areas than in low income rural areas.

<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>High Income/Urban Areas</th>
<th>Low Income/Rural Areas</th>
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<tbody>
<tr>
<td>Life expectancy at birth</td>
<td>&gt;80</td>
<td>&lt;60</td>
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<tr>
<td>Infant Mortality Rate</td>
<td>&lt;10</td>
<td>&gt;24</td>
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<tr>
<td>Maternal Mortality Ratio</td>
<td>&lt;15</td>
<td>&gt;150</td>
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Infant Mortality Rate and Under 5 Mortality Rate are highest in the poorest regions of the country.

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<thead>
<tr>
<th>REGION</th>
<th>HEALTH INDICATORS</th>
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<tr>
<td></td>
<td>Infant Mortality Rate</td>
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<tr>
<td>Philippines</td>
<td>25</td>
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<td>Ilocos</td>
<td>24</td>
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<tr>
<td>Central Luzon</td>
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<td>National Capital Region</td>
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<td>CALABARZON</td>
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<tr>
<td>CAR</td>
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<td>MIMAROPA</td>
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<td>Bicol Region</td>
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<td>Eastern Visayas</td>
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Regional disparities in socioeconomic indicators

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<td>MIMAROPA</td>
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<td>Bicol</td>
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<td>Eastern Visayas</td>
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<td>Western Mindanao</td>
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<td>ARMM</td>
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Children with no vaccinations relate to mother’s low level of educational attainment.

Children with no vaccinations relate to mother’s low level of educational attainment.

The percentage of mothers with low level of educational attainment who receive very little antenatal care from a health professional and whose last live birth was protected against neonatal tetanus is low.
Health Seeking Behavior of the Poor

- Health financing mechanisms utilized by the poor to access medicines are those which are formal, but charitable, welfare or dole-out systems
- Community-based charitable and dole-out mechanisms dominate how the poor access medicines
- The poor spends more for health (out of pocket expenditures or OOP)
  - For every P100, the poor spends P55 from her/his own pocket while government spends only P45.
  - In the target of the Health Sector Reform Agenda or Formula One, by 2010 PhilHealth will pay P80 for every P100 worth of health care services and out-of-pocket (OOP) expenditures will only be P20.

Expectations and Realities of Health Systems

- Health Financing
  - Total expenditure for health in 2010 is only 3.6% [WHO Report, 2011] of GDP, far from WHO's recommended 5% of GDP spending for health
- Health Services Organization and Governance
  - Fragmentation of health system
    - Public/Private segregation
    - Over-specialization
    - Discontinuities between levels of care
    - Geographic disparities in quality and quantity of services
- Health Human Resources
  - Production of health professionals
    - de-linked from the actual needs of the country
    - mainly influenced by market forces
  - Unavailability of funds renders Magna Carta for Public Health Workers and Barangay Health Workers' Incentive Law ineffectual in most areas of the country
- Health Information System
  - At best rudimentary and ministerial
  - Data flow is hierarchical (local offices to central offices)
  - Difficult for some levels of stakeholders, especially individuals, families and communities, to use for decision-making
- Access to Essential Medicines
  - 40% of the population cannot afford to buy the medicines they need
  - Less than 30 percent of the population has regular access to essential drugs
  - Problem of rational drug use – thousands of pharmaceutical products sold under different brand names, doses and preparations
Strategies to Improve Health Outcomes

**Strategy 1:** Establish a well-defined package of health services that will be guaranteed by government (“the core package”), starting with the most essential and cost-effective health services.

- Must be cost effective and affordable and takes into account specific groups within the population and their needs.

**Strategy 2:** Implement fully the National Health Insurance Act of 1995

- To re-focus commitment to the social mandate of universal insurance coverage (100%) and guaranteed access for the poor, as established through the National Health Insurance Act that created PhilHealth in 1995.
- Ensure that when a sponsored PhilHealth patient utilizes a government managed hospital, there will be zero co-payments.

**Strategy 3:** LGUs responding to the challenges of Universal Health Care.

- LGU best health practices as awarded by Galing Pook Foundation
  - Ensuring universal Philhealth coverage in their localities;
  - Improving access to hospital services by enabling indigents to pay in kind or via services;
  - Implementing holistic socio-economic and environmental programs covering nutrition, food production and health services;
  - Permanent health services in far flung islands and mountain barangays.

**Strategy 4:** Introduce programs to improve health human resource development to meet the parallel (and often-competing) needs of the local health system and the international demand for Filipino health workers

- Special Labor/Migration Policy for the health care workforce different from the government labor export policy.
- Health workers must be offered incentives to stay through measures such as realistic salary scales, non wage benefits, and full implementation of the Magna Carta for Health Workers.
- Create a locum (temporary replacement) for LGU health professionals who need to pursue continuing health professional education.
Strategy 5: Ensure universal access to essential medicines

- The 20 most critical and lifesaving generic drugs must be made available in all health facilities and all barangays, especially Rural Health Units, Botika ng Bayan and Botika ng Barangay.
- Tap social health franchises in community pharmacies especially Botika Binhi and Health Plus (or the National Pharmaceutical Foundation).

Strategy 6: Implement Extraordinary Actions to Drastically Reduce IMR/CMR/MMR

- Start the practice of one resident midwife for every barangay
- Ensure emergency transportation services for mothers-in-labor needing higher level of treatment
- Establish halfway houses beside RHUs and Hospitals for pregnant mothers living in far-flung areas to stay in when they are already near their delivery date
- Establish a working referral system for Comprehensive Emergency Obstetrical Emergencies
- Accredit all midwives with PhilHealth and all BHS and RHUs as birthing facilities.
- Utilize cell phones to report all maternal and child deaths in real time

Strategy 7: Ensure that the Poorest have Access to Quality Health Care

- Have an electronic Master List of Families who are the
  - Poorest
  - Uneducated
  - Remotest
- Provide them the essential health care packages for MDG 4, 5 and 6 and enroll them in PhilHealth.
- Ensure every girl child is in school from Grade 1 to Grade 6 - if ever until high school.
CHDs, PHOs, DSWD and PhilHealth: Their Role in Achieving MDGs and Universal Health Care

**Action Points for HLMP Fellows**

- **CHDs as program owners** of the Municipal Leadership and Governance Program (MLGP)
- **CHDs fast tracking** the provision of financial and technical support to provinces and municipalities
- **Pro-active engagement** of governors and mayors by CHD – DOH Reps and CHD managers as coaches for the province
- Governor and PHOs as steward of municipalities and co-owners of the MLGP
- PHOs to **fast track** the provision of financial and technical support to municipalities and barangays
- Make the **hospitals and RHUs** as showcase of Universal Health Care
- Integration of service delivery system from the BHS to the RHU to the hospitals
- PhilHealth to ensure education of ALL poor households on their benefits and ensure that their members are able to utilize services when needed
- Ensure fast tracking of accreditation of facilities and reimbursement of claims
- Help PHOs operationalize NBB
- DSWD to ensure access to and utilization of services of 4Ps and other technical/financial assistance.
- Academic partner as training providers for health leadership programs and provision of technical assistance.
Reflection Questions

What are my personal feelings and thoughts about our health situation?

What do I think are the factors that contribute to the health situation?

What can I do to address the situation?
The Bridging Leadership Framework

Understanding Health Inequities

Inequities refer to differences in the availability of health opportunities to different individuals. In an inequitable society, individuals have varying access to health opportunities necessary for better health outcomes.

What explains health inequities?

[Diagram showing the Bridging Leadership Framework with influence, institutional arrangements, opportunities & programs, human condition, and various factors like MMR, IMR, Malnutrition, HIV, TB, Malaria, and categories of influence including Community Voice & Participation, Leadership, Economic, Social/Health, Political, Government, Civil Society Organizations, Private Sector, and Traditional.]
Why Inequities are complex challenges

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<th>Intervention Approach</th>
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<td>Social</td>
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<td>Multi-Stakeholder Engagement</td>
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<td>Generative</td>
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<td>Creative</td>
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**The Need for a Leadership Approach to Address Social Inequities**

The U Process says that sustainable change means understanding the underlying causes of the current reality. Once a leader connects to his/her passion (regenerating), s/he works to break these underlying causes (the old structures, processes, and thinking) and develops new thinking, processes, and structures (or transform leadership, build new institutional arrangements, develop pro-poor policies and develop innovative programs – health change model) to support the new reality.
The bridging leader, whose values and principles compel him to make a personal response to address inequities and societal divides, recognizes that the complexity of the problem can only be solved by convening the stakeholders to the divide.

Leader: Refers to a person who has influence over a group, either through formal or informal arrangements.

Bridge: Root word “leith”
- To go forward
- To cross the threshold
- Towards the light

Bridging Leadership is a leadership approach for addressing Health Inequities

- Beyond the capacity of one sector alone to resolve
- Needs collaborative action of all three sectors – government, private sector, and civil society
- Resolutions to social issues must be shared by the multi-stakeholders
- Need for bridging leaders to bring diverse stakeholders to own the issue and its resolution.

WHY?
Bridging Leadership consists of Ownership, Co-Ownership and Co-Creation.

**PERSONAL OWNERSHIP**

- Self Awareness
- Conducting Issue Analysis
- Performing Stakeholder Analysis
- Personal Vision

**CO-OWNERSHIP ALLIANCE**

- Convening Multiple stakeholders
- Fostering Trust Building Dialogue
- Facilitating Participatory Planning
- Developing a shared vision thru VMOKRAPI

**CO-CREATION ALLIANCE**

- Developing New Institutional Arrangements
- Conducting Responsive & Innovative Programs
- Generating and Exacting Accountability
- Monitoring and Evaluating Progress
- Achieving outcomes

---

The Bridging Leadership Process

**OWNERSHIP**

- Health Inequity/Divide and Stakeholders
- Personal Vision & Mission
- Engagement Mechanisms

**CO-OWNERSHIP**

- Multi-Stakeholder Processes/ Convening and Trust-Building Dialogue
- Shared Vision & Mission
- Collaborative Response

**CO-CREATION**

- Empowered Citizens
- Responsive Programs and Services/ Social Innovations
- Health Equity

*Source: AIM-TeaM Energy Center*
The Bridging Leadership Process: Ownership

The Bridging Leader owns the issue, understands its systemic analysis and recognizes the interests of its many stakeholders. The Bridging Leader makes a personal response to the issue.

Ownership is a function of three things: personal values and experiences, current involvement and societal issue.

Ownership starts with the Bridging Leader developing self-awareness.

- Reflects on his/her life journey, gifts and inner divides (Life Purpose)
- The Leader owns the issue.
- Understands the systemic context of inequities (Divide)
- Makes a personal response to transform his/her reality

The leader is on his/her path when he/she is able to understand himself/herself and the issue that he/she is asked to face and this is consistent in his current involvement.

An individual becomes a bridging leader, when he/she takes his/her life’s purpose in addressing the issue that confronts his/her society.
The Bridging Leadership Process: Co-Ownership

The Bridging Leader **convenes** the stakeholders of the issue. Through a process of **dialogue** and **engagement** the stakeholders arrive at a shared response.

Co-Ownership starts with the Bridging Leader

- Identifying and engaging with other stakeholders through multi-stakeholder processes *(Stakeholder Analysis)*
- Listens and integrates the perspectives of others *(Generative Dialogue)*
- Facilitates space for collective reflection and ownership of the divide to come up with a collaborative response to the issue.
The Bridging Leadership Process: Co-Creation

New institutional arrangements are new and innovative rules for and ways of doing things. Over time, the new arrangements that are inclusive, accountable and transparent lead to more empowered citizens and more responsive institutions.

Empowered citizens and responsive institutions, supported by new arrangements, collaborate on responsive programs and services that bring about health equity.

Co-creation is developing new institutional arrangements that are
- inclusive,
- accountable
- transparent and
- lead to more empowered citizens and more responsive institutions.
Reflection Questions

What are my 3 most important insights on Bridging Leadership?

In what ways can I bring the Bridging Leadership Framework to address inequities in access to health services?

Who will I share these learnings with and how?
Ownership: My Leadership Journey

Authentic Leadership

- Authentic leaders are genuine people who are true to themselves and to what they believe in.
- They engender trust and develop genuine connections with others.
- Because people trust them, they are able to motivate others to high levels of performance.
- They are prepared to be their own person and be true to themselves.

The Journey to Authentic Leadership: Your Life Story

- Authentic Leaders consistently say they find their motivation through understanding their own stories.
- The stories of Authentic Leaders cover the full spectrum of life’s experiences.
- Many leaders find their motivation comes from a difficult experience – a difficult challenge.
- The difference with authentic leaders lie in the way they frame their stories.

Importance of Verbalizing One’s Leadership Journey

- Allows the discovery of what motivates one to lead; allows the discovery of the source of the passion for leadership.
- Allows one to uncover the patterns which point to one’s life purpose.

“Core Purpose frames all our life and career experiences into a meaningful whole. When we understand purpose, all the challenging experiences of our lives serve to forge identity, character and meaning.”

-Kevin Cashman

Purpose

- The dominant message that your life proclaims.
- Related to the particular challenges or groups/sectors that move you so strongly to the extent that it is irresistible for you to make a response.
Worksheet 1: My Leadership Lifeline

My Life Story

Since our childhood, we have encountered the complexity of human life, emotions, relationships and physical limitations. Some of these experiences leave a lasting impression on our being and shape us as leaders. Some become inspirational and others remain as deep wounds. Either way, they inspire and enable our leadership journeys. This exercise is designed to help you discover some of these life-gifts. Please reflect and journal your thoughts in response to the questions below. You are not required to share these reflections (in themselves) with others. However, you may like to bring some insights or stories during collective reflection process at the workshop to facilitate enrichment of your learning.

What were key personal and leadership experiences, both positive and negative, that shaped my present self as leader? Why are these experiences important to me? What did I learn from these?

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Eg. No woman should die giving birth but maternal deaths are increasing in my municipality. Mothers continue to die in their household even if the facility is already upgraded to BEMONC.</td>
<td>Eg. Do I just let the MHO do the work since mayor seems to be not listening or taking action or do I continue being involved in taking action I chose to continue working. I can still find other strategies that might work</td>
<td>Eg. Increased facility-based deliveries Be more committed to render services</td>
</tr>
</tbody>
</table>

1.

2.
From among my mentors or role models [family, work and social or professional networks], who were the most influential in my development as a person and as a leader? What did I learn from them?

<table>
<thead>
<tr>
<th>MENTOR/ROLE MODEL</th>
<th>WHAT I LEARNED FROM THIS PERSON</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Eg. Father Gallos</td>
<td>- Do what you love to do and be excellent in doing it</td>
</tr>
<tr>
<td>2.</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td></td>
</tr>
</tbody>
</table>
LEADERSHIP LIFELINE

[Plot your life experiences on the life-line/graph below. “Highs” may represent the moments of happiness, joy, achievements etc., while “Lows” may represent the more reflective, challenging phases of your life. Connect the life events and observe any emerging patterns in your lifeline.]

KEY PERSONAL AND LEADERSHIP EXPERIENCES:

HIGHS

- Elected high school student government president
- Father died

LOWS
Sample Leadership Lifeline

Highs

- Married childhood sweetheart
- Elected Mayor, prioritized education and livelihood
- Strengthened partnership with NGOs and Civil Society on Health
- Elected Provincial Chairman of the League of Municipalities

Lows

- Father lost in Mayoralty Elections
- Mother died due to Tuberculosis
- Experienced Dengue Outbreak in the municipality
Reflection Questions

What are the significant milestones – high and low points – of my leadership journey thus far? Are there patterns in my life story which point to my purpose in life?

Who influenced my leadership journey and why?

Why is it important to verbalize my leadership journey?

How is my purpose in life related to the work I am doing now? Where and why will I apply these lessons in my work?
# Worksheet 2: My Leadership Capital

**Instruction:**
Answer the following guide questions to assess your leadership capital.

## My Leadership Capital Inventory

1. **What is my existing Leadership Capital?**

   - **EXPERIENCES:** Eg. 5 years as PHO
   - **EXPERTISE:** Hospital Administration
   - **EDUCATION:** MPH

   ![Diagram](image)

   - **VALUES:** Eg. Compassion, Discipline

   - **SOCIAL/RELATIONSHIP CAPITAL**
     - **LOCAL**
     - **NATIONAL**

     - **POLITICAL:** Eg. Mayor Romeo Jose
     - **SOCIAL**
     - **ECONOMIC**
     - **HEALTH:** Eg. Former Health Secretary Jaime Galvez Tan
     - **RELIGIOUS/CULTURAL:** Eg. Bro. Vincent Lomaad

2. **To what extent am I using my existing Leadership Capital to address health inequities?**
Leadership capital is the ability to get things done.

Values or Ethical Capital

Values are the cornerstone principles and convictions on which you base your decisions. Values are what you consider valuable or non-negotiable. These are principles and convictions you will never sacrifice. Ethical capital is the capacity to recognize ethical breaches before or after the fact and have the courage to deal with them appropriately. A shared ethical framework for decision-making leads to an enduring sense of organizational pride. A leader must be able to do what is morally right.

Relationship or Social Capital

People (non-family) you know who can give you access to resources/connections. Trust relationships are important in relationship capital. Relationship capital can grow, disappear or stagnate (like financial capital). Relational capital is the capacity to create, nurture and manage good-quality relationships. It is the capacity to achieve beneficial outcomes by building relationships with an awareness of contemporary societal and cultural issues.

Experience or Resilience Capital

It is the experience and skills that you gain in a particular type of job. It is knowledge that you gain from life and from being in a lot of different situations. Having gained such level of experience, leaders are expected to develop resilience which is the capacity to respond productively and responsibly to adversity, change and challenge on the physical, mental and emotional level.

Expertise or Creative Capital

Expertise is a special skill or knowledge that you get from experience, training or study. More than just having the expertise, leaders are expected to be creative and innovative. Creative Capital is the capacity to respond adaptively to a diversity of contexts, to anticipate and lead change, and to help oneself and others think differently to foster innovative solutions to increasingly complex challenges—challenges that have no precedent.
NAME: ________________________________________   REGI
REGION/PROVINCE: _______________  

Reflection Questions

What did I learn about my leadership capital? How did I feel when doing an inventory of my leadership assets? Why?

How can I maximize these to impact on the health conditions in my region or province?

What assets do I need to further develop? How will I do it? What resources do I need to develop these assets?
Ownership: My Current Health Reality

The Realities That We Face

There are different levels of reality that an individual faces – community/municipality, provincial/regional, national and even global. At each level, there are also different factors that contribute to the reality.

It is important to step back and analyze the system or the situation. A bridging leader must understand that the present issues and concerns are the product of the different levels of reality.

Problem Tree Analysis

One way of analyzing the current situations is by looking at an issue and identifying its causes and effects.

The key health issues or challenges in our municipality, which correspond to the trunk of the tree. The causes of these issues or challenges are similar to the roots of a tree, while the effects of these issues or challenges can be likened to the fruits of a tree.
<table>
<thead>
<tr>
<th>Community</th>
<th>Health Team</th>
<th>Financing</th>
<th>Access to Medicines</th>
<th>Human Resources</th>
<th>Service Delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Team</td>
<td>Activated LHB 1 session/month</td>
<td>100% enrolment</td>
<td>Botika ng Barangay 1:2</td>
<td>MD 1:20,000</td>
<td>Zero Maternal Mortality Ratio</td>
</tr>
<tr>
<td></td>
<td>Expended LHB</td>
<td>4-in-1 accredited</td>
<td></td>
<td>PHN 1:20,000</td>
<td>at least 80% Facility Based Delivery</td>
</tr>
<tr>
<td></td>
<td>LHB resolutions 1 resolution/month</td>
<td>100% utilization of Capitation/Reimbursement</td>
<td>Drug Management Policy</td>
<td>RHM 1:5000</td>
<td>at least 80% Skilled Birth Attendants</td>
</tr>
<tr>
<td></td>
<td>100% Activated Barangay Health Boards</td>
<td>15% LGU Budget for Health</td>
<td></td>
<td>BHW 1:20 HH</td>
<td>100% Complete Prenatal Check ups</td>
</tr>
<tr>
<td></td>
<td>Barangay Resolutions in support for health</td>
<td></td>
<td></td>
<td>RSI 20,000</td>
<td>100% mothers given TT</td>
</tr>
<tr>
<td></td>
<td>Facility Based Delivery</td>
<td></td>
<td></td>
<td>Personnel Trained in</td>
<td>Zero Infant Mortality Ratio</td>
</tr>
<tr>
<td></td>
<td>2. Expanded Program of Immunization</td>
<td></td>
<td></td>
<td>EPI</td>
<td>100% Child Protected at Birth</td>
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<tr>
<td></td>
<td>3. Infant and Young Child Feeding Program</td>
<td></td>
<td></td>
<td>IMCI</td>
<td>100% Newborn Screened</td>
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<tr>
<td></td>
<td>4. TB DOTS</td>
<td></td>
<td></td>
<td>BEMONC</td>
<td>Zero Under-Five Mortality Ratio</td>
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<tr>
<td></td>
<td>5. Healthy Lifestyle Program</td>
<td></td>
<td></td>
<td>NBS</td>
<td>Decreased Malnutrition Rate</td>
</tr>
<tr>
<td></td>
<td>Organized Community Health Teams 1:1 ratio</td>
<td></td>
<td></td>
<td>TB DOTS</td>
<td>100% target-age children dewormed</td>
</tr>
<tr>
<td></td>
<td>SB Ordinance on Facility-Based Delivery</td>
<td></td>
<td></td>
<td>IYCF/Nutrition</td>
<td>100% target-age children given Vit. A</td>
</tr>
<tr>
<td></td>
<td>SB Ordinance on TB DOTS</td>
<td></td>
<td></td>
<td>Health Advocacy</td>
<td>Zero Deaths due to TB</td>
</tr>
<tr>
<td></td>
<td>SB Ordinance on EPI</td>
<td></td>
<td></td>
<td>Family Planning</td>
<td>at least 80% CDR</td>
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<tr>
<td></td>
<td>SB Ordinance on Nutrition</td>
<td></td>
<td></td>
<td></td>
<td>at least 85% Cure Rate</td>
</tr>
<tr>
<td></td>
<td>SB Ordinance related to PHILHEALTH</td>
<td></td>
<td></td>
<td></td>
<td>Fully Immunized Children 95%</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Zero incidence of Measles</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>100% children with pneumonia treated</td>
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<td></td>
<td></td>
<td></td>
<td>100% children with diarrhea treated</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>100% HH with access to potable water</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>100% HH with proper garbage disposal</td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td>100% patients with DM managed and referred</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>100% patients with HPN managed and referred</td>
</tr>
</tbody>
</table>
Problem Tree

Focusing on one Health Challenge highlighted in the Millennium Development Goals specific for Health, trace the Root Causes of this Challenge in your partner municipality and the Effects of this poor health outcome.

EFFECTS
Reflection Questions

What do I feel about the problem/challenge identified in this session? Is it surmountable or hopeless?

What is my part in the problem or challenge?

What can I do to help overcome the challenge/problem?
Ownership: My Preferred Health Reality

In Theory U, after you have uncovered your current reality, you will now have to define your preferred reality. The preferred reality needs to be supported by new thinking, processes, and structures.
Worksheet 4: Solution Tree

Instructions: Review your Problem Tree. Reverse Your Problems by replacing them with Solutions or Strategies to create the desired Health Outcome.
You may also use a rich picture to graphically illustrate the preferred future.
Reflection Questions

What do I feel about the desired future we envisioned for our partner provinces or municipalities? Is it realistic and attainable?

What is my role in the attainment of that desired future?

What do I need (knowledge, skills, attitudes and resources) in order for me to play my role in the attainment of that desired future?
Eight Points for Personal Mastery
Leading with Awareness and Authenticity
(From Leadership from the Inside Out by Kevin Cashman)

Keep in mind the following principles as you begin to master your ability to lead with more awareness and authenticity.

1. **Take total responsibility.** Commit yourself to the path of personal mastery. Only you can commit to it, and only you can walk your own path to it. No one else can motivate you. No one else can do it for you.

2. **Bring beliefs to Conscious Awareness.** Commit to the process of clarifying your conscious beliefs. Practice by pausing to reflect on how some of these beliefs open you up and how others close you down. Practice reinforcing the ones that open up possibilities and energize you, as well as others.

3. **Developing Awareness of Character.** Developing an awareness of when you are leading with the qualities of Character and when you are being led by the qualities of Coping. Doing so requires that you courageously examine beliefs and limitations generating the qualities of Coping.

4. **Practice Personal Mastery with Others.** Personal mastery requires risk and vulnerability. It means placing ourselves in situations where we may not be accepted or validated by others for who we are or what we think or believe. If we do not take this risk we will be led by the expectations of others. As a result, we might unknowingly compromise our integrity.

5. **Listen to Feedback.** Even though Personal mastery is self-validating, sometimes other people hold keys to our self-knowledge. Rather than spending our energy defending a rigid state of self-awareness, we can think of Personal Mastery as a continuous, lifelong learning process.

6. **Consider Finding a Coach.** There is nothing “wrong” with getting support. Having a coach as your partner might be the most “right” thing to do. Coaching can free self-awareness and facilitate some helpful directions for growth.

7. **Avoid Confusing Self-Delusion with Self-Awareness.** Self-assessment can be the least accurate leadership assessment. To remedy this, use grounded validated assessments with a solid research history to ensure that your growing self-awareness is real.

8. **Be Agile.** Sometimes the strengths that helped you lead in your present state of development may hamper your future chances of success. Understand and appreciate your strengths, but be flexible and adaptable.
Ownership: Introduction to Systems Thinking

“A health system, like any other system, is a set of inter-connected parts that must function together to be effective. Changes in one area have repercussions elsewhere. Improvements in one area cannot be achieved without contributions from the others. Interaction between building blocks is essential for achieving better health outcomes.” (Everybody’s Business, Strengthening Health Systems To Improve Health Outcomes, World Health Organization)

A Local Health System refers to all the activities whose primary purpose is to promote, restore or maintain health. It involves the formal health services...as well as traditional healers...health promotion and health enhancing intervention...encompasses several political and civil organizations.” (World Health Organization, 2000)
“The village of Tanyong lies beside the river of Malabon in Metro Manila. The village has a land area of 5 hectares and a population of 12,400 or 1,850 families. To reach the houses of Tanyong, one has to cross unsteady makeshift wooden bridges, and it is not uncommon to hear of children falling into the murky black waters of the river. The river serves as the sewer and main garbage disposal system of the village. A survey done in the village revealed that only 10% of the households had toilets, while 90% used the river to dispose of human wastes. Only 10% availed of water piped into their houses; 90% had to buy water from entrepreneurs who fetched water from 2 deep wells in the village. 5 gallons of water cost between P15-30, depending on the distance of the house from the well. None of the families living in the village owned the house nor the land they live on.

A small room rented out for P500-P1000 per month; while a bigger room rented out for P1500-2000 a month. Jaime and his family lived in the village of Tanyong. Jaime was 24 years old, while his wife Lucy was 27. They had four children: Jocelyn, 5 years old; Marites, 4 years old; Antonio, 2 ½ years old; and Rosario, 1 year and 4 months old.

Jaime was among the 70% of the population who migrated to Metro Manila from the provinces looking for a better life. Jaime, like his father, was a poor peasant, but the land did not produce enough to support Jaime’s family and so they migrated to Manila. In Manila, Jaime worked as a laborer in a construction site. He earned P165 a day, and this was hardly enough to support his family. He and Lucy were chronically in debt. Lucy usually strove to fit 3 meals a day within a budget of P50, and often skipped meals in order to feed her children. In these times, Lucy found strength in her faith, and repeated in her mind what she had heard the Bishop say in a sermon: “Blessed are they who suffer, for they shall inherit the kingdom of God.”

Lucy grew up in a rural community and graduated from high school, unlike Jaime who completed only 3 years of elementary education. She did not learn the proper ways of caring for children. When her oldest child was still a baby, she was told by a physician that she should...
not breastfeed because she had a heart ailment. She was told instead to buy an infant formula from a nearby pharmacy that was owned by the same physician. Lucy, however, had no heart ailment according to another physician who had examined her a few years later.

But since she was forbidden to breastfeed, she raised all her children on condensed milk because this was more affordable than formula milk. She did not know the importance of sterilizing her children’s feeding bottles and rubber nipples, nor could she afford to do it regularly. She was also not aware of what food was nutritious for her children. As a result, all her children were malnourished. They were prone to respiratory tract infections, and frequently had fever and diarrhea. Their abdomens were large and protruding. They frequently passed out worms (parasites) in their feces, which Lucy believed to be good. She believed that intestinal parasites aided in the proper digestion of food.

The 2 youngest children, Antonio and Rosario, were not vaccinated because Lucy was frightened when Jocelyn and Marites developed fever after receiving their vaccinations. Jaime scolded her when this happened. Besides, the village health center did not have enough vaccines for all the children in the village. Rosario, the youngest, was the most sickly among Lucy and Jaime’s children. She was very thin, pale and invariably suffered from diarrhea.

One day, Rosario contracted measles. Lucy brought her to the nearest public health center, where medical consultation was free. The nurse in the center, however, informed Lucy that the center had run out of medicines, and that the budget for medicines for the year had been used up. The request for additional budget for medicines was turned down by the City Council because they suspected the City Health Officer and the Mayor of misappropriating funds intended for medicines. Lucy decided to buy the medicines prescribed for Rosario: Carbocisteine for the cough (P109), a preparation for the diarrhea (P243), and an antibiotic (P150). Though Rosario was still sick after a bottle of each of these meds were consumed, Lucy could not buy additional medicines because she did not have money left.

Rosario continued to have diarrhea and was soon dehydrated. Lucy then brought Rosario back to the village health center, but the nurse in the health center advised Lucy to bring Rosario to a larger facility, a private hospital nearby. In the hospital, Lucy was required to give a deposit of PhP1200 before Rosario could be admitted. It was a good thing that Jaime was able to borrow PhP1500 from the village leader at usurious rates. Because Rosario was so anemic, Jaime needed to donate blood that was transfused to Rosario. After only one night in the hospital, Lucy and Jaime’s bill piled up to PhP 4,125 and was increasing fast. Every item used in the treatment of Rosario like cotton balls, alcohol, gauze and tape, was charged and added to their bill. Jaime and Lucy finally decided that it was best to take Rosario home against the doctors’ advice. They had to sign a document absolving the hospital and the doctors of any legal liability, should Rosario’s condition deteriorate. Jaime and Lucy were told to bring Rosario back to the hospital when they had enough money to pay for the hospital services or to bring Rosario to a government (public) hospital.
After one week of continuous fever and diarrhea, Rosario further weakened and eventually died.

**QUESTION: WHY DID ROSARIO DIE?**

**Worksheet No. 5.** Make a Case Analysis similar to Figure No. 1 in answer to the Question, “Why Did Rosario Die?” What factors led to the death of Rosario?

Severe Dehydration

Malnutrition

DEATH OF ROSARIO
Understanding Dynamic Complexity

We normally look at problems as having a cause and an effect.

But there is actually a circular relationship between cause and effect.

An issue or problem has many factors.

Complex issues (like poverty or health) cannot be solved with linear problem solving.

Understanding systems thinking: relationships are circular; and that the problem is a result of a system.
Dynamic Complexity

The issue is not a result of a simple cause and effect relationship; there is a larger system that accounts for the inequity.

System

A system is group of interacting, interrelated, or interdependent elements forming a complex whole.

Systems Thinking

The key in comprehending systemic STRUCTURE is to move from the EVENT level to thinking at the PATTERN level.

Systems thinking is thinking that it is the STRUCTURE that causes the PATTERN which produces the EVENT.
Implications of Systems Thinking

- Emphasizes circular relationships;
- Emphasizes wholes rather than parts, and stresses the role of interconnections — including the role we each play in the systems at work in our lives;
- No one person/sector is the cause of the output;
- All parts of the system are involved in the creation of the output
  - What is my role in this system?
  - What is being asked of me personally?

- Systems thinking means nobody is to blame but everybody is part of the problem.
- Solving a system means addressing all parts of the system at the same time.
- Health inequities are multi-factorial and all the factors need to be addressed simultaneously.
Reflection Questions

How would I describe the system I face in my partner provinces or municipalities?

What is my role in the system? How am I contributing to the system?

What can I do to change this system?
Co-Ownership: Multi-stakeholder Processes

**Further Implications of Systems Thinking:** if we understand that there is a system, we understand that the system involves different stakeholders.

We understand that solving the system requires the collaborative work of the different stakeholders; stakeholders need to understand the system and agree to change it.

**Social Complexity**

Different stakeholders view the issue differently; there are different perspectives that, depending on where each is coming from, are all correct.

**Many Factors of Poverty: Who are involved?**

Different stakeholders have different backgrounds, so we have to understand where each is coming from.
Dealing With Complexities:

Social Complexity – actors have diverse perspectives and interests. Such situations cannot be addressed by experts and authorities, but only through direct involvement of the actors or stakeholders.

Dynamic Complexity – Cause and Effect are distant in space in time. Causes are not obvious and cannot be readily determined through first-hand experience. Such situation cannot be addressed piece by piece, but only by looking at the system as a whole.

Generative Complexity - The future is unfamiliar and undetermined. Such situations cannot be addressed by applying lessons or rules of thumb from the past but only by tuning into emerging futures.

Societal Learning and Multi Stakeholder Processes: these are processes by which the community, groups or societies learn how to innovate and adapt in response to changes in the social and environmental conditions (Woodhill, 2005). These are processes by which the community addresses complex issues is an alternative to classical strategies for governance:

- Government and experts make decisions for society to “solve our problems”.
- Social change should be left largely to market forces with minimal guidance from the government.

Stakeholder Analysis

Stakeholder - is an individual or group that makes a difference or that can affect or be affected by the achievement of the organization’s objectives.

Three Criteria for Determining the Relative Importance of a Stakeholder Group:

- Is in a position to damage or weaken the authority or political support for decision-makers or their organizations;
- Its presence and/or support provides a net benefit, strengthens implementing agencies, and enhances decision-makers’ authority (and capacity to secure compliance with decisions); and
- Is capable of influencing the direction or mix of implementing organizations’ activities.
### Stakeholder Analysis Matrix

<table>
<thead>
<tr>
<th>Stakeholder Group</th>
<th>Group’s Interest in Issue</th>
<th>Resources Available</th>
<th>Resource Mobilization Capacity</th>
<th>Position on Issue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Stakeholder Group</td>
<td>Estimate of the level of interest of the group in the issue (e.g., high to low). It is also useful to indicate exactly what those interests are.</td>
<td>Summary of resources held by the group or to which it has access. (These may include financial, information, status, legitimacy, coercion.) Include specifics.</td>
<td>Estimate of which and how easily a group can mobilize resources in pursuit of objectives (May be defined as high to low or may use quantitative indicators such as +5 to -5.)</td>
<td>Estimate of the group’s position on the issue. (E.g., pro or con, or positive to negative, or nominal quantitative measures such as +3 to -3.)</td>
</tr>
</tbody>
</table>

Source: Stakeholder Analysis by Derick W. Brinkerhoff and Benjamin L. Crosby
Worksheet No. 6: Stakeholder’s Analysis

List Down as many stakeholders as possible (within and outside of your province or region) and rate them according to their power of INFLUENCE and the Impact they receive from any intervention.

<table>
<thead>
<tr>
<th>Stakeholder</th>
<th>Power of Influence (1 to 5 with 5 being of Highest Influence)</th>
<th>Impact From Intervention (1 to 5 with 5 being of greatest impact)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Eg. Governor</td>
<td>5</td>
<td>5</td>
</tr>
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<td>2.</td>
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<td>6.</td>
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<td>7.</td>
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<td>8.</td>
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<tr>
<td>9.</td>
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</tr>
</tbody>
</table>
Plot your Stakeholders:

“Influence” refers to the degree by which the stakeholder can affect the issue.
“Impacted upon” refers to the degree by which the stakeholders are affected by the issue.

MORE INFLUENCE

<table>
<thead>
<tr>
<th>Information Giving</th>
<th>Dialogue</th>
</tr>
</thead>
<tbody>
<tr>
<td>e.g. media, opinion formers</td>
<td>e.g. government departments, other NGOs</td>
</tr>
</tbody>
</table>

LESS IMPACTED UPON

<table>
<thead>
<tr>
<th>Information Gathering</th>
<th>Consultation</th>
</tr>
</thead>
<tbody>
<tr>
<td>e.g. general public</td>
<td>e.g. local communities</td>
</tr>
</tbody>
</table>

LESS INFLUENCE
Reflection Questions

Who are the important stakeholders in my partner provinces or municipalities?

How would I describe the relationships between these stakeholders?

How would I describe my relationship with these stakeholders?

Are there relationships that are detrimental to the resolution of the system I face? What do I do to address these relationships?
Dialogue is a leadership capital used in multi-stakeholder processes. The word dialogue derives from two Greek words: “Dia”- through and “Logos”- word or meaning.

It is a conversation or exchange of ideas and opinions between two or more people that is aimed at resolution of differences. It requires listening to each other’s views to develop mutual understanding not only of the ideas, but of each other’s value base, interests, goals and concerns. It is not about “winning” an argument, but about finding common ground.

**Dialogue vs. Debate**

<table>
<thead>
<tr>
<th>Debate</th>
<th>Dialogue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assumes that there is a right answer and you know it</td>
<td>Assumes that many people have pieces of the right answer</td>
</tr>
<tr>
<td>Combative</td>
<td>Collaborative</td>
</tr>
<tr>
<td>About winning an argument</td>
<td>About exploring common ground</td>
</tr>
</tbody>
</table>

**DEBATE** means to discuss or examine a question by presenting and considering arguments on both sides. Debates do not lead to an integration of views.
The Three Movements in the Dialogue Process

**Discussion**
- Bringing together many voices, stories, perspectives
- Shared inquiry, exploration, discovery
- Shared meaning-making & co-construction of knowledge

**Decision-making**
- Authority decides and informs
- Authority consults and then decides
- Negotiation
- Consensus
- Vote

**Deliberation**
- Reason argument
- Serious examination of possible solutions
- Careful weighing of tradeoffs
- Reasoned and informed judgment

Multi-Stakeholder Processes: The Three Essentials of Dialogue

1. Equality and the absence of coercive influences.
2. Listening with empathy.
3. Bringing assumptions into the open.

Basic Theory of Cross-Cultural Communication

Assumptions and values support and motivate our behaviors and actions. We can easily observe behavior and actions, but often we must do some “sleuthing” to discover assumptions and values.

Assumptions motivate behaviors and actions towards others so it is necessary to bring them out to achieve better understanding.

Early conceptualizations of the layers or depths of culture were developed by Edward T. Hall, Gary Weaver, and L. Robert Kohls.
Practices Essential to Dialogue

Listening

- We always prepare to speak but never to listen; listening is taken for granted
- Difficult to do as we impose meaning on, or interpret in, our mind what people say
- We end up having our own interpretation

Listening together

- Allowing a “voice/meaning” to emerge from all of us
- Things we have been thinking about similarly surface naturally
- The right next steps simply becomes obvious

Respecting

- Opposing can come from a belief that you know better than everyone else or can come from a stance of acknowledging the wisdom in others
- To respect is to see people as having the right to speak

Suspending

- How we see things: we can remain stuck and certain that our perspective is the correct one, OR
- We can put aside first our perspective and acknowledge the feelings and thoughts that arise without feeling compelled to act on them
To suspend is to by-stand with awareness in order to see what is happening more objectively.

**Reframing**

- Involves altering one’s beliefs about the nature of the problem, issue or challenge at hand
- Involves breaking out of our normal categories of analysis and reexamining our beliefs and assumptions
- Individuals identify their core assumptions and deliberately replace or reverse them in order to gain alternative perspectives.
- The goal is to acquire a “breakthrough experience,” a significant change in outlook. The essence of this type of thinking is **paradigm shifting**.

**Levels of Conversation**

![Four Fields of Conversation Diagram](source: Scharmer)
The four fields of conversation are talking nice, talking tough, reflective dialogue and generative dialogue.

**Downloading** refers to people talking nice and being polite with each other during conversation.

**Tough talk** or debate between two or more people refers to a clash of opinions. Both re-enact the past.

**Reflective dialogue** is inquiring and reflecting on the context where the opinion of the other person is coming.

**Presencing** or **generative dialogue** is achieved through inquiry and being aware of where the conversation is heading. Reflective and generative dialogues are re-enactments of emerging futures.”

Remaining in the fields of reflective dialogue and debate means the stakeholders are giving primacy to the parts, i.e., the conversation revolves around just the two persons talking. Moving the conversation to generative dialogue as well as talking nice, gives primacy to the whole where the two already want to know where to bring their “future.”

For complex issues, our goal is to bring the conversation from merely talking nice to presensing or generative dialogue. This is the only way for us to achieve co ownership which will be explained further in the next slide.

**The U-Process: Three Movements**
Co-ownership is divided into three steps: Sensing, Presencing and Realizing.

**The first step is sensing.** The leader should allow the stakeholder to share his/her story. He/She should be able to bring out what is important for this stakeholder just by listening and letting the issues emerge. Through this process he/she will learn what the other values and what he will do if he does not get what he wants. The key is not to be judgmental when other stakeholders are talking. Because governors or mayors and health leaders such as Municipal health officers are programmed to make decisions, they have to consciously remind themselves to listen first.

**The second step is clarification.** After hearing the stakeholders’ stories, it is important that the listener does not become defensive about the opinions raised. Instead he/she should suspend judgment, ask questions to further clarify the position of the other person or reframe the statement made. The point is to get more information in order to get a clearer picture of the issue. As you get more information, you get the intensity of the problem. This results in the second step of the process which is a shared understanding of the issue or **pre-sencing**.
The third step in the process is realizing. This is the point where the leader and stakeholders agree on the plan of action. It is important that leaders do not become slave to the budget or other constraints. The point of this stage is for innovations and new strategies/structures to arise. Dialogue is used for resolving complex issues. Moving to a preferred reality becomes much easier if both the leader and the stakeholders know this process.

Reflection Questions

How have I applied dialogue in my work?

Was I able to identify communication needs that I need to address to effectively engage in dialogue?
Co-Creation: Action Planning

At this point, you need to identify priority issues and potential areas for immediate action to sustain your leadership role and contributions. Your Leadership Development (Worksheet 5) and Colored Outcomes Worksheet (Worksheet 3) will help you systematize your re-entry plans for the next six months.

Review the Health Leadership Roadmap for this purpose. This could help you identify areas for action.
<table>
<thead>
<tr>
<th>Governance</th>
<th>Financing</th>
<th>Medicines/ Technology</th>
<th>Health Information</th>
<th>Human Resource</th>
<th>Health Facilities &amp; Services</th>
<th>Service Delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Municipal Health System</td>
<td>Health Budget</td>
<td>LGU - more or less 15%</td>
<td>Accuracy</td>
<td>Adequate</td>
<td>Proportionate # of health facilities</td>
<td>Regular manpower assigned</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>of Medicines</td>
<td>Manpower</td>
<td>Essential medical equipment &amp;</td>
<td>Essential medical equipment &amp;</td>
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<td>Ratio</td>
<td>supplies</td>
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<td>Available mode of transportation</td>
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<tr>
<td>Barangay Health System</td>
<td>Barangay Health Board</td>
<td>4-in-1 Accreditation</td>
<td>Adequate</td>
<td>Competent</td>
<td>Purok System/ Community</td>
<td>Purok System/ Community</td>
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<tr>
<td></td>
<td>Referral System</td>
<td></td>
<td>Number of Medicines</td>
<td>Health Workers</td>
<td>Community Health Team</td>
<td>Community Health</td>
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<tr>
<td></td>
<td>Cluster of Barangays</td>
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<td>Team Mapping</td>
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<td>PhilHealth</td>
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<td>Pregnancy</td>
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<td>Activation of LMB</td>
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<td>BHV Retention</td>
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<tr>
<td>Ordinance &amp; Policies</td>
<td>Births attended by skilled</td>
<td>Enrollment &amp;</td>
<td>Reliable</td>
<td>Competent</td>
<td>Maternal &amp; Child Health</td>
<td>Maternal &amp; Child</td>
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<tr>
<td></td>
<td>professional</td>
<td>Utilization of</td>
<td>data gathering</td>
<td>Health Workers</td>
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<td>Health</td>
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<td>Benefits for</td>
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<td>Workers Mapping</td>
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<td>indigents</td>
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<td>Multi-stakeholder and</td>
<td>Health Summit/Fair</td>
<td>Enrollment &amp;</td>
<td>Computerized</td>
<td>Performance</td>
<td>Nutrition</td>
<td>Nutrition</td>
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<tr>
<td>Community Involvement</td>
<td>Brgy Health Assemblies</td>
<td>Utilization of</td>
<td>data gathering</td>
<td>Management</td>
<td>Malnutrition Data Board</td>
<td>Malnutrition Data</td>
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<tr>
<td></td>
<td>Biggy Health</td>
<td>Benefits for</td>
<td></td>
<td>System</td>
<td>PABASA on Nutrition</td>
<td>Board PABASA on</td>
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<td>Scorecard</td>
<td>indigents</td>
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<td>Nutrition</td>
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<td></td>
<td>Family Health</td>
<td>Mothers: Buntis</td>
<td>Drug</td>
<td>Translate</td>
<td>Infectious Diseases</td>
<td>Infectious</td>
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<td></td>
<td>Card</td>
<td>Baby Bank</td>
<td>Management</td>
<td>data into</td>
<td>Tuberculosis</td>
<td>Tuberculosis</td>
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<tr>
<td></td>
<td>Entitlement &amp; Education</td>
<td></td>
<td>System</td>
<td>action</td>
<td>HIV/AIDS</td>
<td>HIV/AIDS</td>
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</table>
Worksheet 7: Leadership Development Plan

Think about everything that you have learned in this module and how you will apply and practice in the next six months what you have learned.

<table>
<thead>
<tr>
<th>Things that affect others negatively I should be more aware/conscious about</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Attitudes do I have about work, family, etc.</td>
<td></td>
</tr>
<tr>
<td>▪ How I behave towards my colleagues, staff, family, constituents, etc.: My mannerisms</td>
<td></td>
</tr>
<tr>
<td>▪ How I relate with them. How I communicate with them</td>
<td></td>
</tr>
</tbody>
</table>

New Commitments to make

New Practices to Begin

Potential Obstacles

“Things that I need to help me overcome the obstacles

When will I do them? How do I know that I have succeeded?

Adapted from the Leadership Growth Plan in Leadership From the Inside Out by Kevin Cashman
**PROBLEM PRIORITIZATION**

1. **As a HLMP Fellow, what technical leadership acts can you perform to improve your partner province’s or municipality’s least successful programs?** *Bilang HLMP Fellow, ano ang mga aksyon pang technical leadership na pwede ninyong gawin para tugunan ang mga nabigong programa?*

2. **As a HLMP Fellow, what changes in behavior or attitude can you make to improve your partner province’s or municipality’s least successful programs?** *Bilang HLMP Fellow, ano ang pagbabago sa sarili na pwede ninyong gawin para masiguro ang sustainability ng mga technical na programa*

<table>
<thead>
<tr>
<th>Needs Improvement/Least Successful Programs</th>
<th>Technical Strategies</th>
<th>Change in Behavior/Attitude (Adaptive Leadership)</th>
<th>Time Frame</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
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<td></td>
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<tr>
<td>2.</td>
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<td>3.</td>
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<td>4.</td>
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</tbody>
</table>
**ACTION PLAN TEMPLATE**

Review your partner province’s/municipality’s indicators and action plans. **What health indicators are not performing well?** Group these indicators according to the 6 building blocks of a strong local health system. **How will you address these health indicators to improve them?** Consider your role as CHD, PHO and LHIO. **How would you support each of them so that they reach their desired outcomes?**

<table>
<thead>
<tr>
<th>Region/Province</th>
<th>Members</th>
<th>Time Period:</th>
</tr>
</thead>
</table>

**ACTION PLAN**

<table>
<thead>
<tr>
<th>MDG Goal</th>
<th>Target Outcome</th>
<th>Current Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eg. Lower Maternal Mortality Ratio</td>
<td>162 MMR</td>
<td>52 MMR</td>
</tr>
</tbody>
</table>

**STRATEGIES**

<table>
<thead>
<tr>
<th>Service Delivery</th>
<th>Human Resource</th>
<th>Access to Medicines</th>
<th>Health Financing</th>
<th>Health Information System</th>
<th>Leadership</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPAs Time frame</td>
<td>Person/s Responsible</td>
<td>PPAs Time frame</td>
<td>Person/s Responsible</td>
<td>PPAs Time frame</td>
<td>Person/s Responsible</td>
</tr>
</tbody>
</table>

Eg. BEMONC training for municipalities X, Y, Z;
Synthesis

What do you remember about the following? Write down what you remember without going back to your notes.

What explains health inequities?

Source: Sen, as modified
Creativity – Different Levels of Change

Levels of Conversation

Four Fields of Conversation

Source: Schamfort
Shifting the Leadership Perspective: The U-Process: Three Movements

Bridging Leadership

Bridging Leadership is a leadership approach for addressing Health Inequities

- Beyond the capacity of one sector alone to resolve
- Needs collaborative action of all three sectors – government, private sector, and civil society
- Resolutions to social issues must be shared by the multi-stakeholders
- Need for bridging leaders to bring diverse stakeholders to own the issue and its resolution