Staying true to ZueLLig Family Foundation’s vision of becoming a catalyst in achieving better health outcomes for the poor, "Impetus" is used as the title of ZFF’s event proceedings to signify a compelling force to carry out public health system reforms based on the knowledge and experiences shared by health leaders, partners and experts.

- The State of Health
- Redefining Primary Healthcare
- Continuity of Care: Ensuring a Responsive CEmONC Hospital and Referral System for Maternal Health
- Making Systems Technology-Ready
- The Action Framework: Supply, Demand and Leadership as Applied in Local Health Systems
- Bridging Leadership as a Process to Address Health Inequities
- Sustained Gains of Improved Health System as Legacy: Outgoing Mayors' Preferred Post-Election Reality
TABLE OF CONTENTS

I. Executive Summary 3

II. Plenary Session: The Action Framework of ZFF: Supply, Demand and Leadership as Applied in Local Health Systems
   Group 1 Narrative:
   The Role of Barangay Health Board in Delivering Primary Care 11
   Bridging the Gap Between Traditional-Cultural Practices and Modern Medical Practices Through Local Leadership Development
   Group 2 Narrative:
   Seal of Health Governance: An Innovative Approach in Fostering Co-ownership and Accountability in the Grassroots Level 17
   Advancing Health Outcomes Through Local-Government-Church Partnership
   Healthcare in Muslim Mindanao 24
   Group 3 Narrative:
   Health Gains and Re-election: An Analysis of the Influence of Local Health Improvements on the 2013 Local Election Results in the Zuellig Family Foundation’s Select Partner Municipalities 30
   Health Facility Assessment of ZFF’s Donated Barangay Health Stations and Birthing Units
   Social Capital and the Implementation of Magna Carta for Public Health Workers: The Case of San Sebastian 40
   Rapid Assessment of Factors Influencing Access to Maternal Healthcare Services in the Zuellig Family Foundation Recovery Assistance Program Areas

III. Plenary Session: Bridging Leadership as a Process to Address Health Inequities 56

IV. Redefining Primary Healthcare 58

V. Continuity of Care: Ensuring a Responsive CEmONC Hospital and Referral System for Maternal Health 66

VI. Plenary Session: The Role of Social Media in Public Health 69
   Group 1 Discussion
   Making Health Systems Technology-Ready 72
   Adapting to Changing Times: Climate Change and Resilient Health Systems
   Group 2 Discussions
   Role of Information Technologies in Transforming Local Health Systems 79
   Relationship-Building Leadership: The Key in Restoring Health Systems Post-Yolanda

VII. Plenary Session: Sustained Gains of Improved Health System as Legacy: Outgoing Mayor’s Preferred Post-Election Reality 86

VIII. The State of Health 89

IX. Declaration of Support for the Sustained Commitment to Health Reform 92

X. #helecon2015: Health Social Media transcript
The Zuellig Family Foundation (ZFF), in its pursuit for better health outcomes for the Filipinos, most especially the poor mothers and children, initiated a series of capability-building interventions targeting local leaders to enable them to understand the country’s complex health systems and to come up with programs that are responsive to the needs of their constituents.

To recognize and highlight the transformative leadership and governance journey of its program partners, it held the National Health Leaders Conference (HELECON) on November 24 and 25, 2015 at the SMX Aura Premier Convention Center, Taguig City. Leaders from its various partner local government units (LGUs), government agencies, academe and other non-governmental organizations (NGOs) participated in the two-day event.

With a theme of “Co-Creating the Future of Philippine Public Health,” invited speakers, including governor, mayors, municipal health officers (MHOs) and community leaders from ZFF’s partner LGUs, shared how the health leadership training and coaching programs transformed them and strengthened their sense of purpose in addressing health inequities. Experts from the fields of public health, health information technology, social media, and climate change sectors shared fresh perspectives and innovations relevant to the emerging challenges in Philippine public health.

During the plenary sessions they shared the process of collaboration and consensus building among the different stakeholders and partners in formulating and implementing innovative and sustainable health programs for their respective municipalities. Improvements in health systems were discussed with the following indicators: municipal and barangay health governance, local Philippine Health Insurance Corp. administration, barangay health infrastructure, and maternal and child care service delivery. Better health indicators were also observed in terms of increase in rates of facility-based deliveries, skilled birth attendants and reduction in number of maternal deaths.

Vision for Philippine Public Health

Despite achievements in the improvement of public health, there are still challenges that needed to be addressed, especially with the upcoming change in national and local leaderships. Particularly, these are sustaining improved health outcomes and closing remaining gaps in implementing primary healthcare, addressing hospital deaths, ensuring community participation, developing resilient health systems, and applying technology and research evidence in health systems improvement. The speakers created a sense of urgency as they described these challenges and their effects in the local health systems. Opportunities for action were also presented as the roles of LGUs were highlighted. Based on the sessions, the emerging vision for Philippine public health is a system promoting better health outcomes driven by strong leadership and governance. This would be achieved through sustainable strategies such as:

- Applying principles of social determinants of health and community participation to achieve Universal Healthcare, especially at the municipal level.
Continuity of care among pregnant women by ensuring a responsive Comprehensive Emergency Obstetrics and Newborn Care hospital and referral system. This would be achieved through an effective provincial leadership program.

- Use of innovative information and communication technologies to support decision making, and market health programs to beneficiaries.
- Building disaster-resilient communities through leadership and coordination with other government sectors and NGOs, and development of Municipal Health Emergency Preparedness Response and Recovery Plan.
- Institutionalization of health strategies at the municipal level through ordinances and ensuring community demand for services.

During the last day, LGUs with exemplary local health system performance, health indicators, and with health leaders demonstrating excellent bridging leadership competencies, were recognized through the Zuellig Excellence Awards in Leadership for Public Health (ZEAL.PH). Recognition was also given to LGUs with consistent zero maternal or infant deaths.

**Impetus**

Staying true to Zuellig Family Foundation’s vision of becoming a catalyst in achieving better health outcomes for the poor, Impetus is used as the title of ZFF’s event proceedings to signify a compelling force to carry out public health system reforms based on the knowledge and experiences shared by health leaders, partners and experts.

For its first publication, Impetus will feature HELECON 2015. Included are the transcribed speeches of Health Secretary Janette Garin and ZFF President Ernesto D. Garilao, as well as summarized narratives of mayors and MHOs. Furthermore, tables, figures and other illustrations are provided in support of the narratives. Also inside are select tweets and Twitter analysis of the event.
Synopsis

The gap in maternal mortality rates between urban rich and rural poor women is an alarming sign of inequity in the provision of healthcare services. It is essential that quality healthcare is not exclusive to those who can afford it. If the access to healthcare by the rural poor is to be addressed, the regional health unit and municipal health system need to be improved. There is a need, therefore, to address the policy and resource support of the mayor, who can influence the community to make health decisions, and the power to mobilize resources toward improved health outcomes.

The Action Framework of the Zuellig Family Foundation (ZFF) requires the interfacing of three essential components: leadership, supply and demand. The first component refers to the health leaders themselves, and any action or intervention that will enable them to manifest their leadership abilities, particularly the Bridging Leadership (BL) competencies highlighted in the various leadership development programs of ZFF. The last two components refer to the technical aspect of the implementation, whether it is on the perspective of the healthcare provider or the clientele, i.e., the community members.

According to the framework, it is not enough to address only the patterns of supply and demand. We recognize that a discontinuity between the two contributes to delays in meeting the needs of the pregnant women. We should also make sure that there is a strong leadership on top of it to close down the gap between supply and demand.

ZFF Background

In 2008, the Zuellig family launched the ZFF and recasted its strategies for the foundation. I, being the newly appointed president, outlined what the ZFF has to do. This is in response to the mission of the ZFF, which was to improve the health outcomes of the poor, especially in rural communities.

Our focus on the poor and health inequities was greatly influenced by the advocacy of the late former Health Secretary Alberto Romualdez Jr. In his address to the University of the Philippines Centennial, he said that after the devolution in 1991, the health system got so fragmented it widened health inequities.

The rich urban communities had health indicators like those of developed countries; while those in rural areas like the Autonomous Region in Muslim Mindanao (ARMM) and Caraga, had indicators like that of sub-Saharan Africa. Quoting him: “Over 100 poor women die during childbirth for every 1,000 term pregnancies, while among the rich, the figure is less than 10.”

The gap between maternal mortality ratios (MMRs) in two different socioeconomic groups is an alarming sign of inequity in the provision of healthcare services. This shows that quality healthcare is exclusive to those who can afford it. There is a need, therefore, to improve the rural health systems for the poor.

For that to happen, it needs policy and resource support from the mayor, who has influence over his constituents and the power to allocate resources for health.

I will highlight this point through the ZFF Health Change Model (HCM).
ZFF Health Change Model
The role of leadership is critical in the development of the ZFF HCM. It states that to have better health outcomes, the constituents—especially the poor—must have better access to quality health services and programs. But these quality health services and programs will only be available at all times if you have public leaders who are responsive and accountable to their people.

Piloting the Approach
The ZFF HCM was first piloted under the Foundation’s Community Health Partnership Program (CHPP). It sought to see the interaction in leadership, supply and demand for health. It started in 2009 with a diverse group of mayors and municipal health officers (MHOs) coming from fourth- and fifth-class municipalities from different regions, including the ARMM. The health leaders were selected on the basis of their commitment to improve health systems and whose municipalities have high health burdens.

The CHPP is a two-year leadership and governance program which equipped mayors and MHOs the knowledge and skills to improve health systems and outcomes. ZFF coached these health leaders in between training modules, and monitored their municipal technical roadmaps. The intervention used the BL approach, which focused on the process of Ownership, Co-ownership and Co-Creation. CHPP would eventually have seven cohorts composed of 72 municipalities.

What are the results of this partnership?
For one, the municipal health systems are now more responsive to the needs of the poor. In looking at the consolidated municipal technical roadmaps, more than half (63.5 percent) have turned green, which means they have achieved the ideal target scores. Some of these indicators include an expanded local health board (LCB) in the municipalities, better Philippine Health Insurance Corp. (PhilHealth) coverage and better maternal and child health service delivery. Likewise, fewer mothers are dying in the CHPP local government units (LGUs). We are looking at maternal mortality since it is reflective of the status of primary healthcare systems, and it is sensitive to poverty issues.

From 43 percent (31), the proportion of CHPP LGUs reporting zero maternal deaths has gone up to 76 percent (55) by the first half of 2015.
We can also see that the MMR had continuously gone down.
The combined MMRs of these 72 LGUs went down to double digits in 2014. This is very evident after two years of partnership,
and was even sustained in 2014. The actual number of maternal deaths also decreased. The same trend was evident in ARMM, poor, and geographically isolated and disadvantaged area (GIDA) municipalities, though the latter still had a high MMR last year.

How did our partner municipalities achieve these improvements?

I say it was through public leadership. The decline in maternal mortality can be linked to how mayors and MHOs pushed for improved facility-based delivery (FBD) and skilled birth attendant (SBA) delivery.

According to the Philippine National Demographic and Health Survey 2013, the National FBD rate for rural areas was 51.3 percent, and ARMM was at 12.3 percent. Comparing these data with that of CHPP, poor LGUs reported better FBD results during the same year of the report (73.8 percent in 2013). This FBD rate has further increased to almost 82 percent in 2014.

In the same report, ARMM had only 12.3-percent FBD, but the CHPP ARMM LGUs were already reporting 39.2-percent FBD. While these figures are still below the national target of 90 percent, the trend among CHPP LGUs is increasing and even doing better than the national average. The same holds true for the SBA rates of the CHPP LGUs. The national SBA rate for rural areas was only 63.6 percent and 20.4 percent for ARMM.

The increasing FBD and SBA trends reflect how the barriers in maternal and obstetric care were addressed. An increasing trend in SBA suggests that more mothers are getting medical care by a health professional and an increasing trend in FBD suggests more mothers are being cared for in facilities.

I will speak more of these barriers and how the health leaders addressed them through the three delays model.

The Three Delays Model

The Three Delays Model was used as a framework during death reviews to drill down the “wicked” challenge of maternal mortality.

The model was adopted by the World Health Organization (WHO) to depict the role of community and health system in the use of emergency obstetric care. This model states that maternal mortality is influenced by barriers in making the decision to seek care, reaching the health facilities and receiving appropriate treatment. By breaking down these barriers, deaths will be prevented through timely and effective medical care.

---

5 Philippine National Demographic and Health Survey 2013

For poor mothers, ordinances were created to incentivize facility deliveries and health workers who bring mothers to rural health unit (RHU). Maternal and obstetric services were ensured to be free. PhilHealth coverage among the poor and indigenous people was widened to increase demand for these services.

Some LGUs also installed pregnancy-tracking system to ensure all mothers receive the continuum of prenatal to post-partum care. In barangays, captains, midwives and their community health teams were mobilized to bring health services to far-flung barangays. Free transportation systems were made available for high-risk pregnancies. Halfway houses were put up in strategic locations where mothers and their relatives stayed before and after delivery.

To ensure appropriate supply of health services for these mothers, the municipalities improved their RHUs. The improvement in the RHUs included adequate medical supplies, 24/7 operations, Basic Emergency Obstetric and Newborn Care (BEmONC) certification and skilled health professionals. For emergencies beyond the RHU’s capabilities, referral systems were institutionalized to bring patients to the hospitals.

Role of Leadership and Governance
Because of the devolved health system, the mayors have the primary role of ensuring quality local health services for these mothers.

The theory prototyped in CHPP posits that leadership acts of the mayors will improve municipal health systems and then lead to better health service delivery.

During the two-day conference, you will hear the narratives of the different mayors in describing their “acts of leadership” in improving health systems to achieve better health outcomes.

Looking back at the Three Delays Model, we see that the barriers in the third delay exist. Much has been done to prevent home deliveries, and much has been made to improve the RHUs.

However, most deaths are not occurring at the homes or RHUs anymore. Deaths occur at referral hospitals where the mayors have no more mandate.

This is the experience of our 72 CHPP LGUs, wherein 64 percent of deaths occurred in referral facilities or in transit toward a referral hospital. Also, 58 percent of hospital deaths had their deliveries in the hospitals. To give us a bigger picture, I will show you the results of maternal death reviews from CHPP and other ZFF programs.

Hospital and In-Transit Deaths
This is the information we have on 1,241 maternal deaths among the whole ZFF partner areas from 2014 to the first half of 2015. We can see here that 29 percent of the maternal deaths occurred at home.

But more alarmingly is the high percentage of maternal deaths occurring at a health facility which is 61 percent. Of these, 80.6 percent delivered at a referral hospital. This means that even when mothers delivered at the hospitals, there is still a large delay in receiving appropriate and adequate care (third delay) in the facilities.

The problem in hospital deaths reflects an inadequacy in supply of services for emergency obstetric care. As a response, ZFF implemented in 2014 the Provincial Leadership and Governance Program (PLGP) which was now supported by the Department of Health (DOH). A total of 33 provinces are currently involved with the objective of ensuring that each province will have a Comprehensive Emergency Obstetrics and Newborn Care (CEmONC) ready hospital where critical obstetric care for emergency pregnancies can be implemented.

The provincial leadership program involves the governors, chiefs of hospitals and the provincial health officers (PHOs). They initially made an assessment of the hospitals in reference to the seven critical components of a CEmONC hospital. The initial findings showed that most hospitals lack regular blood supply (thus the difficulty of managing fatal hemorrhages), absence of a regular obstetrician (resulting to poor management of high-risk cases), and the absence of a hospital management committee (resulting to stagnation of improvements in health services). The provincial leaders are now called into action through a two-module course with practicum in between to address these essential components of their hospitals.

Too young, Too old, and Too many
We are also able to look at the characteristics of mothers who died from 305 death reports in CHPP and other ZFF program areas. This is to give us a picture on what is still lacking in the supply and demand for health services.

---

7Based on reports from 384 LGUs from CHPP and partnership programs with United Nations Population Fund (UNFPA), United Nations Children’s Fund (UNICEF) and United States Agency for International Development (USAID); partial unofficial data
Maternal death review showed that almost half of the mothers who died are either too young or too old for child birth. As much as 39 percent are multi-gravidas having five children already or even more.

Physiologically, these conditions put mothers at a higher risk of maternal mortality or complications from pregnancies. Based from the experience of our municipalities, there is lack of demand for these family-planning services. Because of their cultures, misconceptions or beliefs, these women are not demanding for family-planning services as a means to avoid unplanned pregnancies.

These women only have two options for them to survive pregnancy—either to prevent pregnancy through access to family-planning methods or get high-risk obstetric care once they get pregnant.

The most difficult to address here is the incidence of teenage pregnancies. Anecdotal stories will tell us that these are hidden pregnancies associated with takot or hiya. To address these issues, CHPP has already worked with 45 of its municipalities (poor and GIDA) on a technical working group for family planning and teenage pregnancy. The rationale here is to expose to the health leaders the stories of teenage mothers that they cannot tell because of takot or hiya. The leaders are also taught how to advocate and provide for family-planning services as an option for these teenagers who do not want to have unplanned pregnancies.

Sustainability—Leadership, Supply and Demand

Finally, after seven years of rolling out this strategy and spending hundreds of millions for training hundreds of health leaders, and building 105 health stations and maternal shelters, has it been worth it?

Well, the strategy appears to have made a difference in maternal health and I’ve shown that earlier through the reductions in maternal deaths and increases in FBDs and SBA deliveries.

Our strategy also convinced other organizations and donors to partner with us. I kept mentioning earlier about our “other programs,” as I showed you about maternal deaths. Well, those other programs are the results of our partnerships with the United Nations Population Fund, MSD for Mothers, United Nations Children’s Fund, Unite States Agency for International Development and the DOH. These partners saw the value in what we did as a result of improvements in our CHPP municipalities. Our strategy complemented theirs, and so now we are working together to improve health systems and outcomes. Case in point is the DOH. I’d like to acknowledge the Aquino government’s focus on good governance, because this paved the way for our partnership with the DOH.

Also, its Universal Healthcare Agenda had the attainment of Millennium Development Goals (MDGs) as a strategic thrust. Since we started our strategy, the health targets of MDGs have been our yardstick in measuring our program’s success or failure. Now, the government is implementing its Hi-5 program to create the highest impact on health outcomes at the shortest possible time. This, along with the sin taxes, the reproductive-health law, and the health leadership and governance are expected to improve health outcomes.

So has it been worth it? You can say it has been well worth it. We’ve helped make improvements and we’ve convinced others to join us. However, the more relevant question is, can these be sustained? Let us look back into the ZFF action framework of leadership, supply and demand. The Action Framework of ZFF requires the interfacing of three essential components: leadership, supply and demand. The first component refers to the health leaders themselves and actions that will enable them to manifest BL competencies. The last two components refer to the technical aspect of implementation, whether it is on the perspective of the healthcare providers or the clientele who are the community-at-large.

Leadership

BL brings back these leaders to their loob (what they value) and gives them a sense of purpose. This reinforces the leaders’ innate passion to serve and the desire for good health leadership and governance. Mayors ensure good health services for their constituents because it is the right thing to do.

But there are external factors which encourage mayors to continue the leadership work. I mention two: First, the national government should provide performance-based incentives for good health outcomes. Second, good health governance is good politics and must be a factor for re-election. Mayor Joselito Escutin of Dao, Capiz can attest to this. He has been re-elected twice with the help of health governance. What we learned from the experience of our prototype CHPP LGUs is that there is still more that can be done on both of the supply and demand for maternal and obstetric health services.
**Improving the Supply**

During the mayors’ term, they improved the municipal health systems. The system-wide improvement is institutionalized by ordinances and policies such that whoever replaces them, the supply for good health services will continue. Resource mobilization, team-building, and networking have been done to ensure RHUs are BEmONC and PhilHealth accredited. These RHUs now have adequate medical supplies and there are adequate staff members who are skilled and well-compensated. The services are of high quality and focused on poor mothers in far-flung areas. Though, occurrence of deaths has shifted from the RHUs to the referral hospitals.

For the CHPP, fixing these referral hospitals is beyond the mandate of the mayors and their MHOs. Thus, in moving forward, a shift in focus is needed from the municipalities to the whole province. We will now be looking at improving the whole service delivery network for pregnant mothers through a collaborative leadership between the province and their municipalities.

**Improving the Demand**

Health is a right and the people must demand for good health. To be honest, the ZFF HCM has been weak on the demand side. We must now strengthen community participation. How engaged are community members in health services being offered? Health leaders are challenged to make their constituents demand quality healthcare by putting in place participatory mechanisms. Health summits are events where members of the community can learn about health and voice out their concerns. Citizens’ charter must be strengthened to give the public a strong voice in policymaking. These things can now ensure good health services are continuously provided regardless of changes in political leadership.

In conclusion, the interaction of leadership, supply and demand has the capacity to make health systems effective and equitable for all. A discontinuity between supply and demand contributes to delays in meeting the needs of pregnant women. A strong leadership, therefore, must be on top to close the gap between these two. We also learned that given the devolved health system, the leadership of the mayor is the key in sustaining developments in Philippine public health. We began with nine rural municipalities in 2009 and have since grown to 72 CHPP municipalities. The effectiveness of our strategy enabled us to attract other organizations including the DOH. These partnerships have brought our strategy to 576 more local government units. And as our reach expands to more areas, we also look forward to having a nationwide influence on health leadership in improving the Philippine health system.

Finally, let me thank two people responsible for making sure CHPP achieves its intended goals—Dr. Anthony Far-aon, the first director of CHPP, and Dr. Bien Nillos, the current director. They, the municipal health leaders and the staff, deserve the applause that I request you to give.

Thank you.

**Highlights**

1. The Three Delays Model has been used as a frame to drill down the wicked challenge of maternal mortality. This model states that maternal mortality is influenced by barriers in making the decision to seek care, reaching the health facilities and seeking appropriate care. By breaking down these barriers, deaths can be prevented.

2. Looking in the Three Delays Model, barriers in the third delay still exists, most deaths are occurring in referral hospitals where mayors have no mandate.

3. What is still lacking in supply and demand—Maternal Death Reviews show that mothers who die are either too young or too old, most multi-gravidas with five or more children already, lack of demand, in some cases, lack of supply for family planning services because of misconceptions or cultural beliefs.

4. Acknowledgement of Aquino administration’s focus on good governance which paved the way for engaging with the DOH. UHC and the attainment of the MDG, the health targets of the MDGs have been our yardstick in measuring success.

5. From nine municipalities in 2009 to 72 municipalities in 2015, expansions to 16 LGUs in 2012 and 189 in 2015, and replication to 97 in 2013 and 387 in 2015—through partnership with DOH and other NGOs.

6. The interaction of leadership, supply and demand has the capacity to make health systems effective and equitable for all. A discontinuity between supply and demand contributes to delays in meeting the needs of pregnant women. A strong leadership, therefore, must be on top to close the gap between these two.

7. Given the devolved health system, the leadership of the mayor is key in sustaining developments in Philippine public health (influence over constituents and the power to allocate resources for health).
The devolution of health to local government units (LGUs) in 1991 led to the fragmentation of health services and worsening of health outcomes in many poor LGUs. Not only were most mayors unprepared to oversee health, they had to work with limited budget to address other socioeconomic concerns.

Worse off are LGUs that are also geographically isolated and disadvantaged areas (GIDAs). These areas are not only mired in poverty, their geography makes them difficult to reach. Most have security issues, while others still have populations displaced by conflicts.

One such GIDA is Gamay in Northern Samar. Here, as a consequence of its health leaders—mayor and municipal health officer (MHO)—attending the health leadership and governance training program, a counterpart program for barangay leaders was also rolled out. Winning the commitment of barangay leaders for the improvement of health service delivery proved highly effective in the LGU’s quest to achieve better health outcomes.

Numerous struggles pushed Gamaynons to resiliency, overcoming the Moro raiders, the forces of nature, the demands of the times, and most of all, the desire to become a separate municipality from Palapag. Eventually, Gamay gained its local independence from Palapag and became a municipality on March 3, 1947.

Native to the place, Mayor Capoquian experienced how hard it was to live in this remote area located in the Pacific side of the province. Roads were unpaved and people were dependent on abaca and copra production for income. Going to the more urban part of the province (the municipality of Catarman) proved to be tasking and risky. One has to ride a banca navigating across an open sea at the mouth of the Pacific Ocean. Wave sizes always influence navigational activities. Alternately, to reach areas of trade drop-off, as well as better health facilities and services, a six-hour trek through the mountains had to be taken. Adding to the geographic burdens are the insurgency problem and the typhoons that regularly hit the province.

Mayor Capoquian started serving Gamay as a rural health physician. During his five years of service in the municipality, he was disappointed with the lack of local government support to the health sector. There was no improvement in health services—facilities were dilapidated and medicine supply was limited. He found it difficult to achieve ideal maternal and child health indicators since home deliveries, improvised home remedies, and traditional treatments were the accepted norms.

Although the Gamay District Hospital was established within the vicinity of Gamay serving the people in the Pacific towns of Lapinig, Gamay and Mapanas, the facilities and personnel could not suffice the increasing demands of patients for medical and surgical treatment. Because of this, patients needing major surgical cases and medical treatments were referred to the provincial hospital in Catarman, which would take three hours in land and sea travel. Given the situation, some high-risk mothers gave birth in transport vehicles along the way.

With people unsatisfied with the local administration, Mayor Capoquian fought against his relative during the 2007 elections. Despite political harassment and being an underdog, he unexpectedly won with a high margin of votes.

Mayor Capoquian desired to live on the principles of transparency, reform and good governance. He used his medical profession to capitalize and maximize initiatives and available resources in improving the health facilities and services at the rural health unit (RHU). He strongly believes that “health is wealth” and healthy people will make a healthy and progressive community.

The Zuellig Family Foundation (ZFF) partnered with Gamay in 2013 through its Community Health Partnership Program (CHPP). Mayor Capoquian, together with his MHO, were trained in developing local health systems through the ZFF action framework.

Mayor Capoquian strongly believed in the vision and strategies of ZFF in addressing health inequities and preventing maternal and child deaths. They learned to use their leadership capital in mobilizing resources to improve the Gamay District Hospital. Continuous dialogue with the governor won his support in developing the hospital through the
Gamay-Mapanas-Lapinig (GAMALA) Inter-Local Health Zone. Initially, engaging the governor was very difficult for them. Mayor Capoquian admitted not being an ally of the governor during the first six years of his term. However, the governor has recognized the mayor’s persistence and dedication after presenting a comprehensive and compelling work and financial plan to develop the hospital. This effort was also complemented by the Department of Health’s (DOH) Health Facility Enhancement Program (HFEP). Improvements were focused on structures and equipment to cater to more patients in providing primary healthcare services.

After understanding the gaps associated with GIDA, the health leaders of Gamay saw these issues as emerging, but resolvable. They focused on multistakeholder approach targeting barangay health leaders. After consultations in the far-flung barangays, it was evident to Mayor Capoquian that barangay level support for municipal-led health programs was nowhere to be found.

Healthcare was futile at the community level. Expectant mothers were consumed with learned helplessness, as going to the facility in the Poblacion required at least P400 and entail physical burden. A mother who wishes to deliver in a health facility will have to face the challenge of walking at least 1.5 kilometers to reach the nearest station where there is access to a motorcycle or motorboat to transport her to the nearest birthing facility.

Learning from the success of shared strategies and resources in the interlocal health zone, Mayor Capoquian thought of applying this in the barangay level. The Barangay Siyete Inter-Barangay Health Zone was innovated with the concept of co-creation between seven adjacent upland remote barangays. This is an inter-barangay cooperation that encourages sharing of resources in order to sustain and improve the health programs in the cluster of barangays. A revolving fund of P10,000 each year per barangay is being shared to support maternal and child health initiatives. The municipality also provides an additional P70,000 through the internal revenue allotment to fund the transport of patients for referral to the Gamay District Hospital.

To address other financial burdens of mothers during pregnancy, the Maternal Care Incentive Program was also implemented in 2015 providing P1,500 to mothers who completed prenatal checkups and delivered in the facility. Volunteer health workers, on the other hand, receive P500 as counterpart in this endeavor.

Mayor Capoquian described in detail how the inter-barangay health zone was created with the help of ZFF’s Barangay Health Leadership and Management Workshop:

- **Preliminary Preparations of IBHZ**
  In one local health board, it was discussed how to go about the possibility of clustering the different barangays in order to address the numerous health issues in the municipality. Support was elicited from all stakeholders who attended the meeting.

  Preliminary preparations and focus group discussions began in February 2014. Punong barangays and other barangay officials had a joint barangay health board (BHB) meeting together with the RHU personnel headed by the MHO. Discussions were made regarding the common health problems among the identified barangays.

  The barangay captains realized that an organized, concerted effort among them is needed in order to create a bigger impact in the area. Hence, the idea of an intra-LGU cooperation through the Inter-Barangay Health Zone (IBHZ) was easily accepted. A memorandum of understanding (Kasaaran) was signed in order to solicit the commitment of these respective barangay officials who would compose the IBHZ Board. Succeeding meetings were scheduled.

- **Barangay Health Leadership and Management Workshop**
  In order to strengthen the leadership skills of these barangay officials, the Barangay Health Leadership and Management Workshop was conducted in July 2014 spearheaded by the RHU in cooperation with ZFF which provided the training materials and technical assistance during the workshop. All participating barangays were assessed based on the Barangay Technical Roadmap. This provided an overview of the individual barangay health status.

  The focus of the said workshop was on the concept of Bridging Leadership and on the technical know-how in activating and functionalizing the BHBs. This governing body was essential in initializing targeted and pro-poor health programs in the community. The said training was expected to help in the health empowerment of the barangay officials being the local health leaders in the community. Also present in the training were the rural health midwives and the DOH...
nurses assigned in the identified barangays. They were important stakeholders who would provide the services and other technical assistance in the community.

- **Establishment of the IBHZ**

  A memorandum of agreement (MOA) was crafted to institutionalize the intra-LGU cooperation. This was supported by the Sangguniang Bayan which approved Resolution 35, Series of 2014, a resolution authorizing the local chief executive to enter into MOA with seven punong barangays for the IBHZ. The signing of the said memorandum took place during the Municipal Health Summit held in November 2014.

  The pooling of resources through the Common Health Trust Fund (CHTF) and the Work and Financial Plan was also discussed. The CHTF was directed toward funding for the improvement of the barangay health station in Barangay Bangon which would serve as the primary health facility for the seven barangays. The improvement of the BHS to become a birthing facility is ongoing. This will greatly improve access to health services by the people in the community even if they reside in far-flung barangays.

  During regular monthly meetings, the rural health midwives, together with the DOH-public health nurse, hold BHB meetings with the punong barangays and other members of the Board. All pilot barangays comprising the IBHZ are monitored based on the monthly accomplishment in terms of the different health indicators, particularly on maternal and child health.

  Prior to the conduct of the IBHZ program in the pilot barangays, most of them had low accomplishment in terms of maternal indicators such as antenatal care, postpartum visits and facility-based deliveries (FBDs). Since its conception, the punong barangays have been taking an active role in ensuring the realization of their goal of better health services nearest to their constituents. To complement this, Mayor Capoquian, through national funding, has prioritized the construction of access roads, especially in the GIDA barangays.

  These improvements in service delivery translated to achieving zero maternal deaths in 2015 and improvements in FBD and skilled birth attendant (SBA) delivery rate in Gamay. (See Table 1)

  The efforts in the municipality were recognized. The DOH awarded GAMALA as one of the best interlocal health zones in 2014 with Gamay District Hospital as its referral facility. Philippine Health Insurance Corp. (PhilHealth) also ranked Gamay as third best LGU partner in 2014 for its achievements in improving health using PhilHealth incentives. Mayor Capoquian was also recognized for his excellent bridging leadership competencies during ZFF’s first national health leaders conference.

<table>
<thead>
<tr>
<th></th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal Deaths</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Infant Deaths</td>
<td>2</td>
<td>15</td>
<td>19</td>
<td>8</td>
</tr>
<tr>
<td>FBD</td>
<td>49.3%</td>
<td>64%</td>
<td>86%</td>
<td>92%</td>
</tr>
<tr>
<td>SBA</td>
<td>49.3%</td>
<td>64%</td>
<td>86%</td>
<td>92%</td>
</tr>
</tbody>
</table>

Table 1: Health indicators for Gamay, 2012-2015
Having a doctor to serve the town was not enough to achieve the desired health outcomes. This was the lesson learned by the mayor of Lapuyan, a third-class town in Zamboanga del Sur. Composed of 26 villages spread across a mountainous area, Lapuyan is also predominantly Subanen, a group indigenous to the Zamboanga Peninsula.

The Subanen tribe adheres to its beliefs of seeking healthcare from the shamans, traditional healers and traditional birth attendants in the area. Thus, the challenge for Mayor Daylinda Sulong was how to encourage her Subanen constituents to avail of health services in the municipality’s rural health unit (RHU).

Together with her municipal health officer (MHO), she convened the stakeholders of her municipality and collectively initiated strategies and programs to resolve the gap between culture and health services. Through constant dialogue and collaboration with indigenous people leaders, the health issues and concerns of the municipality were addressed gradually. The experience of Lapuyan showed that a strategy promoting active participation of different stakeholders was key to health reforms in the municipality.

The municipal health office, also referred to as RHU, is the leading health agency in Lapuyan. It serves the 26 villages of Lapuyan in Barangay Poblacion and six satellite health stations in the villages (Barangays Tiguha, Maruing, Bulawan, Tininghalang, San Jose and Mandeg). However, some of the barangay health stations (BHS) are no longer operational due to structural problems that require immediate rehabilitation.

The RHU is a certified Sentrong Sigla Phase II Level I facility since October 2009, which means that the quality of service rendered at the health facility operates in accordance with the national standard. It is also Philippine Health Insurance Corp. (PhilHealth)-accredited for Out-Patient Benefit Package, Maternal Care Package, TB DOTS and Newborn Screening.

The main problem in health when Mayor Sulong assumed office was the immediate need of a doctor. After almost two years, she was finally able to get one and thought for herself that everything would be alright regarding health programs. She admitted that she relied heavily on her MHO in addressing all the health conditions of her constituents.

The other prevailing challenge was the lukewarm attitude of the Subanens in availing health services. They adhered to traditional healers when they needed help for their health condition. Pregnant women went to hilots to assist them in giving birth. This practice resulted to Lapuyan having six maternal deaths in 2009, which were mostly Subanens. Also, cases of home deliveries were increasing with the assistance of hilots. Aside from cultural belief as reason for not seeking facility-based delivery, these women neither had financial nor transportation resources. Some far-flung areas had difficult access to health services, as a result, women delivered at home using the services of hilots. They needed to traverse mountainous land areas, characterized mostly by rugged and steep terrains, by foot or horse riding, or cross hasty streams and frail bridges before they could reach nearby barangay health stations.

In 2009, Mayor Sulong found it to be a blessing for her municipality to be included in Zuellig Family Foundation’s (ZFF) leadership training for health. However, in the middle of the practicum, her husband fell ill. He had health complications due to diabetes. As a wife, Mayor Sulong immediately sought medical treatment for her husband. But, instead of going to a private hospital, she brought him to the RHU. She wanted her husband to utilize the health services in Lapuyan RHU since she thought that these were available anyway. She also wanted to set an example to her constituents that they need not go far to seek medical help. However, this was not the case. There were not enough resources in the RHU even for delivery of basic health services. With her husband’s health condition and the need to address the health concerns of her constituents, she realized the need to prioritize health agenda as a mayor. She also realized that she had to “come in” and get involved with ZFF’s program to achieve this. According to her, “kailangan at dapat na pangunahan ko ‘to” or else, Lapuyan would not prosper and have the kind of health services and system she has envisioned. She identified herself as the one who had the most influence
and ability to mobilize resources for health. However, she believed that she also needed to be passionate about it.

She and her MHO immediately put into practice the theories they learned in the ZFF training. The training helped her maintain a good partnership with her newly hired MHO. Through the dialogue process, the two of them were able to openly discuss and plan what to do next in improving the community. They religiously and successfully conducted the Bridging Leadership (BL) orientation with the stakeholders—barangay officials, health personnel, barangay health workers (BHWs), barangay nutrition scholars and civil service organizations.

During the conduct of the BL training among the different stakeholders, the participants realized that they also had the responsibility to “co-own” the problem presented and contribute to the realization of health improvement. It was made clear to them that they had their own tasks to perform and a collaborative approach was needed to address the different issues and concerns of the health situation in their locality.

These stakeholder processes led to the creation of ordinances and programs as specific response to the health challenges in Lapuyan:

1. Mayor Sulong consulted Subanen leaders to come up with ordinances to facilitate safe deliveries. These consultations were also attended by members of the Sangguniang Bayan. The result was the creation of an ordinance entitled, “An Ordinance Regulating the Practice of Trained Birth Attendants and on Safe Motherhood/ Maternal and Child Health in the Municipality of Lapuyan.”

The ordinance strictly prohibits the practice of home deliveries. This ordinance strictly implements that all deliveries should be done only in a health facility where proper management and intervention by a trained health staff is given to reduce or eliminate maternal mortality and infant mortality.

During the implementation of this ordinance, the health leaders of Lapuyan recognized and observed cultural sensitivity, especially in delivery of maternal care. Also, health information and education campaigns were tailor-fitted to the culture of Subanens.

As long as cultural practices do not compromise safety, they let the people practice them. The hilots, locally known as pandityan, are allowed to get inside the delivery room and perform rituals before the actual process of delivery. However, participation of trained or untrained hilots is not allowed during the actual process of delivery, only a trained health staff will be allowed to manage the expectant mother once delivery is taking place. In this way, disagreements between practice of cultural beliefs and modern medicine are avoided.

The culture-sensitive municipal ordinance on Safe Motherhood and Child Health can easily be replicated by those municipalities with Subanen populace or by any municipalities with indigenous people just like the municipality of Lapuyan. Identification of the possible stakeholders is the first step toward a successful partnership in health, for Mayor Sulong believes that, “Health work is teamwork.” She conducted a regular dialogue with all health stakeholders especially the barangay captains and the thimuay, the Subanen community leader, and discussed with them the importance of health and getting services at the RHU.

This is in her recognition that with issues hampering a certain program, convening and making stakeholders understand them is a crucial step in achieving one common objective. She cannot fully implement an ordinance without taking into consideration the stakeholders’ individual differences, especially on ordinances where culture is a major issue. According to her, in order for an ordinance to be effective, everybody should have a good understanding and knowledge of the rationale of the said ordinance.

2. To complement the ordinance created to bring deliveries at the facilities, the Sangguniang Bayan also pushed for the creation of maternal shelters, or “Bahay Ni Nanay.” The construction of a maternal shelter adjacent to a birthing unit or a health facility is a best practice that can be adapted by LGUs with some barangays that have poor access to basic health services, especially those concerning safe motherhood and child health. Birthing units should also be strategically located where other barangays have good access to it.

3. Improving the health service delivery within the RHU was also a priority to stimulate community access to services. The LGU responded to lack of RHU resources by appropriating P500,000 for the purchase of medicines and supplies. Due to lack of technical support from the Department of Health, the municipality gets funding assistance through engagement with other government sectors in social development and non-governmental organizations.

They also initiated a scheme for indigent clients wherein medicines were given for free, while for those who could afford, they sold them at a low cost with only
a 30-percent additional payment from the original price. They required barangay government to sustain the operation of Botika ng Barangay to provide easy access to essential medicines.

The local government of Lapuyan is in good partnership with ZFF. Aside from providing health leadership trainings for local health leaders (mayor, MHO, SB on Health) for two years, ZFF also provided two birthing units to the municipality with complete facilities for expectant mothers. The LGU only provided the lot for the construction as a counterpart. The LGU continuously upgrades the health facilities to be able to provide emergency obstetric and newborn care, as well as for the deployment of more skilled health workers. The RHU of Lapuyan and its three satellite birthing units in Balobo Tiguha, Maruing, and Bulawan are Basic Emergency Obstetric and Newborn Care- and PhilHealth-accredited with trained and skilled personnel. These facilities were also made operational 24/7.

Mayor Sulong also expanded the local health board and initiated the establishment of the barangay health board in Lapuyan so that health issues and concerns could be discussed in a governing body. She also strengthened the BHWs who were the front liners of their healthcare program by providing honorarium released quarterly. According to her, the sudden drop in infant and maternal deaths contributed to the high morale of the health workers and RHU personnel. With high morale and dedication, they were able to offer a 24/7 health services to their people.

Because of all these efforts, 80 percent of Lapuyan’s population were registered in the RHU utilizing its services. At present, an average of four to five mothers give birth weekly in the birthing facilities. Mayor Sulong can now say that the community is more responsive and cooperative to their health programs. For her, the successful BL trainings and stakeholders’ engagement also benefited her. She felt less burden on her shoulders in addressing health issues in their municipality. She felt that they could do more now that they were working together and realizing a shared vision for the sake of their Subanen brothers and sisters.

As a result, maternal and child health indicators have improved in Lapuyan. Maternal deaths decreased from six in 2009 to zero in 2011 to 2014. Lapuyan had one maternal death in 2015. Infant deaths have been reduced from 3 in 2010 to zero in 2011 to present. The rates of FBDs, skilled birth attendants, and contraceptive use increased throughout the years. Malnutrition rate has also decreased from 11.8 in 2009 to 5.0 in 2014. Lapuyan was also awarded as the “Best RHU in Zamboanga del Sur” for its excellent health service delivery. On the other hand, Mayor Sulong was recognized for her excellent BL competencies during ZFF’s first National Health Leadership Conference.
Synopsis
The Zuellig Family Foundation (ZFF) observed that while health services at the municipal level were making significant improvements, the same could not be said at the barangay (village) level. Villages, especially the far flung and hard to reach, lacked access to health facilities. Knowing his municipality was characterized by such villages, the mayor of Del Carmen rationalized his interventions for the benefit of his underserved and unserved barangays.

A fifth-class municipality on an island with interior and upland villages, the mayor was presented with diverse challenges in their barangay local health systems that necessitated adaptive leadership. Through adaptive leadership, the municipal leaders personalized the adaptive (non-technical) challenges to enable them to co-create out-of-the-box strategies that engage and capacitate key stakeholders in addressing complex system challenges like delivery of quality health services in hard-to-reach villages.

The local chief executive (LCE) of Del Carmen, together with his municipal health officer (MHO) and barangay health worker (BHW) president, embarked on a process of developing strategies that improved the health systems of the barangays specific to their geopolitical, socioeconomic and cultural settings. Realizing that the key to sustain health programs is the involvement of those at the grassroots level, the municipal leadership team led by its mayor successfully strengthened the health system at the barangay level by establishing a performance standards system and sharing accountability with the front line stakeholders at the barangay level.

Since some barangays have been active in health governance, they came up with the innovative awarding strategy called Seal of Health Governance (SOHG) to encourage them to continue their good health programs and further innovate to address other remaining health challenges at the barangay. The award became an incentive for all barangays to improve health in their communities. The innovation did not only produce the desired maternal and child health outcomes, it also strengthened the appreciation of health governance at the grassroots level, as manifested by the implementation of several barangay-based initiatives and a newfound community identity and solidarity. To encourage and sustain barangay initiatives, the mayor actively mobilized external partners—provincial and regional governments, private corporations and non-governmental organizations (NGOs)—to address the various social determinants of health present in the community.

Introduction: Narration of LCE’s Reflection
“Why should you care about health?” was asked to the municipal mayor two-and-a-half years ago during the final selection workshop of the ZFF Cohort 4 Health Leaders for the Poor (HLP) program.

In his attempt to answer the question, several events from the past entered his awareness. He remembered: a) himself being a sickly kid who used to frequent the hospital in Surigao due to severe allergic reactions; b) his two closest cousins who died at a young age due to pneumonia; c) his father who suffered a stroke that almost cost his life; and d) his sons who would make him panic whenever they’re sick. He then told the panel, “I care about health because it is personal to me.”

And being the municipal mayor, he gets to know more about the people he serves to the extent that everyone becomes his “instant” relatives. This, he added, makes health more personal to him.

About Del Carmen
The municipality of Del Carmen is located in Siargao Islands with a poverty incidence of 58 percent. Siargao Islands is on the eastern side of the Philippines with the Pacific Ocean on one side and a 33-nautical-mile distance from Surigao City—its main trading partner. The geographical characteristics of Del Carmen qualified the community to belong to the geographically isolated and disadvantaged areas (GIDAs) of the Philippines, but it is also a popular tourist destination hosting the International Surfing Competitions and the International Game Fishing Tournament. Del Carmen has a population of around 20,000, based on unofficial 2015 National Statistics Office survey, who are mostly farmers, fisherfolks, senior
citizens, government employees and students. Del Carmen also boasts of having the largest contiguous mangrove forest in the country—home to a rich biodiversity of flora and fauna and the most number of wild saltwater crocodiles.

Municipal Health Challenges
The mayor cited poor health indicators, poor data management and limited number of health professionals to cater to 20 barangays as his town’s challenges. These have been made more difficult due to other pressing factors like poverty and geographical isolation of some communities.

Ownership
Before joining the ZFF Cohort 4 HLP in 2012, Mayor Coro said, “My idea of health management is probably similar to 90 percent of the LCEs who would respond when asked—the MHO and RHU [rural health unit] will take care of the health issues and concerns.”

In accepting that health is personal, the young LCE assumed ownership of the health issues. He was determined to provide the best services to his people because they rightfully deserve so—they are family, friends and neighbors.

Mayor Coro acknowledges that he is not a doctor or an expert in any field of medicine. Being a first-time mayor in 2010 with no previous experience in government service, any information on the best way to run a local government unit (LGU) is very much welcome to him. His last job was managing global information-technologies systems for multinational companies.

Recognizing the added value of the ZFF program to address his leadership challenge in public health, Mayor Coro shared that he exhausted all means to get noticed to make his way into the HLP training program. Together with him in his journey is the MHO of Del Carmen, Dr. Marjory Vizconde, a native of Mindoro.

Co-ownership
It was during the Module 2 training with ZFF when the LCE realized the complex realities of his municipal health situation. Del Carmen has four island barangays, nine coastal barangays, an upland barangay, and six inland barangays under its area of responsibility. During his reflection, the mayor told himself, “Health is personal to me, why not make it personal for everyone as well?” With this in mind, he had to ensure that all grassroots stakeholders from the 10 barangays are capable of collectively owning and diagnosing their respective community health challenges and co-creating innovative solutions.

Thus, he came up with an innovative systems approach called the SOHG—the overarching program developed by Del Carmen Health System stakeholders that aims to foster co-ownership and accountability at the grassroots level.

The Seal of Health Governance: The “How To” of Monitoring and Evaluating the Progress
The mayor, together with the MHO and RHU staff, developed a health governance program to list all the Department of Health (DOH) programs and local initiatives needed to address the priority health targets. The local initiatives were copied from other practices that worked in other local governments. However, they realized that having a health program “bible” was not enough as they needed to validate the impact and results of the health programs on the communities regularly.

The SOHG was then developed to serve as a monitoring and evaluation tool for the health governance program of Del Carmen. The mayor’s vision—was a transformative process of leadership for the barangay leaders, whether the targets would be accomplished on time or not (realistic accomplishment based on the barangay’s own pace and ownership)—harmonized with the MHO’s perspective on the program standards and target accomplishment based on the DOH and Millennium Development Goal (MDG) timelines. These two different perspectives harmonized in the SOHG and paved the way to make health personal to barangay stakeholders.

As with their practice of consultative and participatory governance, the SOHG was then endorsed to the RHU for technical and realistic evaluation of its indicators and metrics. The process of finalizing the acceptable metrics to the indicators with the midwives, nurses and BHWs took eight months of negotiation. The mayor said that they literally had to experience walkouts, sweat, blood and tears—not due to the program concept, but to the realistic targets of indicators. The final SOHG was then presented to the Expanded Local Health Board to seek support of various health stakeholders and to the barangay health boards with the midwives, nurses and sanitation teams leading the way.

When asked how to manage difficulty in engaging the barangay officials and health workers, Mayor Coro responded, “Ikaw [mayor] talaga ang talaga ang lalapit. Show that you are with them. Minsan nahihiya lang. You need to initiate.” He added that once the LCEs are actively involved in all phases of health program implementation,
everyone will also follow.

During monitoring periods, the health and SOHG evaluation team made regular presentations to the Liga ng mga Barangay meetings and Barangay Health Assemblies to share results of the evaluation and challenge them to innovate in addressing health concerns.

The SOHG Incentives
The main idea of the SOHG is to have a set of indicators that when met, would mean a healthy community per their definition. Since the SOHG is evaluated quarterly, the barangay is made accountable regularly on the necessary actions to ensure that they meet the indicators. The SOHG has Gold, Silver and Bronze categories, each category has a corresponding cash reward and recognition: gold is P20,000; silver, P15,000; and bronze, P10,000. It is a competition not among every other barangay, but the ability of the barangay to meet the criteria. A look at the scorecard shows that aside from having the mayor’s picture to remind them that health is personal to him, it is very flexible to add new indicators depending on the need of the community. Some of the municipalities that replicated this program included education and other social determinants of health as indicators for a healthy community.

They launched the program in July 2012 during the Del Carmen Health Summit with the intent of holding the first awarding in July 2013. The mayor felt that a number of barangay captains thought the program was one of those political gimmicks, resulting to poor barangay participation. They never forced a barangay to participate. But as part of the risk, they still did to find the effectiveness of the relationship between health personnel and the barangay. During the first awarding in 2013, Del Carmen only had two bronze awardees and 50-percent participation rate. To some stakeholders, this may be a signal to raise the white flag, but the LCE and the proponents of the initiative did not give up and introduced the SOHG advocacy to a new set of barangay officials after the 2013 barangay elections.

In the Siargao Health Summit attended by ZFF in July 2014, the municipal health leaders were surprised with “positive problem” associated with the results. In 2013, the local government unit (LGU) spent only P80,000 for performance incentives. With that as benchmark, they assumed that the 2014 incentive expenses would be somewhat close to that amount. But upon evaluation, from two barangay bronze awardees in 2013, it became 14 awardees (12 bronzes and two silvers). The LGU was not financially ready for the 700-percent increase in awardees. It required them to raise P400,000 for prizes. But Mayor Coro happily shared that he would rather have this problem than face the problem of maternal deaths because for him, a life lost is never worth any amount of money.

In the third awarding of SOHG held in July 2015, Del Carmen has attained 100-percent participation of barangays with 10 silver awardees and 10 bronze awardees. During the Annual Health Forum, the barangay captains started to question the way metrics were obtained because they wanted to get the gold award. This was a milestone for the mayor and his team. They also presented the new metrics for 2016 namely Disaster Risk Reduction and Family Planning indicators.

Co-creation
In trying to meet the SOHG metrics, both the Municipal Health Team and Barangay Health Teams co-created several initiatives to address specific health issues needing extra attention. The SOHG provided the framework for the municipality and the barangays to operate and function in one direction—to lead the community to healthier, better lives.

Through the health governance operational framework, the municipal and barangay leaders, together with the community,

| BARANGAY MAHAYAHAY: SEAL OF HEALTH GOVERNANCE 2013 |
|-----------------|-----------------|----|
| CRITERIA        | ACCOMPLISHMENT  | SCORE |
| Maternal Death  | 0               | 10   |
| Infant Death    | 0               | 10   |
| Facility Based Child Delivery | 100% (10/10)  | 10   |
| Fully Immunized Child | 108% (13/12) | 10   |
| Malnutrition Rate | 11% (7/65)   | 8    |
| Sanitary Toilets | 85% (76/89)  | 9    |
| Barangay Budget for Health | 0      |      |
| Legislative Resolutions for Health | 6      |      |
| Gulayang Bayan in Barangay | 8      |      |
| Barangay Waste Management | 0      |      |
| Purok As a Health Partner | 10     |      |
| Botika ng Barangay | 6      |      |
| Barangay Health Board | 2      |      |
| Animal Management | 10     |      |
| Raw Score       | 99/140x100     |      |
| Percentage      | BRONZE         | 70.71 |
established different programs, partnerships and community-based innovations.

1. Resource Mobilization for Health
   a. Forging strong partnerships with the DOH, PHAP Cares, ZFF, Philippine Health Insurance Corp. (PhilHealth), Unilab, GlaxoSmithKline and other partners. The partnerships provided various technical support and resources like training, facilities improvement and operational needs.
   b. Launching the Radyo Kabakhawan Community Radio of the National Nutrition Council to improve nutrition education among the community and sustain gains from better health management.
   c. Computerization of the Health Information System with the Wireless Access for Health to improve patient care service and data management.

2. Annual Health Summit and Health Forum
   a. The health summit includes health fair, medical mission and forum. As part of Del Carmen’s tradition, overseas Filipino workers and other locals return for the town fiesta more than any other occasion. The LGU conducted its health summit days prior to the town fiesta to show the balikbayan that their loved ones are taken care of.
   b. The health fair is designed to make health look approachable and improve health-seeking behavior; medical mission is done to check on how much lechon (cholesterol) the fiesta-goers can risk eating, and the forum serves as a venue to share health issues and co-create innovative solutions among barangays.
   c. In 2014, the usual municipal-wide health summit was expanded to island level to tackle health issues of Siargao Islands. It was participated in by the nine municipalities of Siargao, the Provincial Health Office and the Region 13 DOH Regional Office. The conduct of the first island-wide Siargao Health Summit resulted to a number of good health outcomes including: 1) procurement of sea ambulances from the province to transport patients from islets; 2) regular arrival of surgical missions to address necessary surgeries from Vicente Sotto Medical Center; and 3) improvement of health facilities in some barangays. The 2015 health forum focused on barangay health services delivery with the BHWs and barangay captains giving insights into the issues on front line health services.

3. Community-Based Health Innovations
   a. Barangay Antipolo (2015 SOHG winner) makes their own toilets to address household sanitation issue allowing them to achieve 100-percent households with sanitary toilets and inspiring six other barangays to achieve the same. Barangay Antipolo is a regional finalist for the National Sanitation Award.
   b. Barangay San Jose (2014 SOHG winner) launched a clean and green campaign allowing them ownership of issues at the purok level and faster response.
   c. Barangay Mahayahay (2013 SOHG winner) collaborated with LGU Del Carmen and the Department of Agriculture to improve upland road access from the barangay to the health services and built farm-to-market road (health services access as the primary driver).
   d. Barangay Del Carmen started a healthy lifestyle program with a weekly Zumba session. Two other barangays followed suit.

Outcomes
Mayor Coro mentioned that the almost three-year partnership of his LGU with ZFF has given them the capacity to reform and improve their public health system producing tangible outcomes. The mayor humbly reported that:
1. In meeting the MDGs, they have maintained zero maternal deaths from 2011 to present (maternal deaths in 2013 and 2015 were attributed to third delay, or death in the referral hospital) and decreasing infant death. Improvements were seen in the detection and cure rates
of major communicable diseases present in the locality like tuberculosis and schistosomiasis.
2. Their facility-based deliveries (FBDs) and births attended by skilled birth attendants are at 95 percent due to available and accessible 24/7 birthing facility with PhilHealth accreditation and 100-percent PhilHealth coverage to all families.
3. They have more health facilities in the barangays, especially in the island communities and improved services including electronic medical records, ultrasound, dental and pharmacy management.
4. Better financial support and community leadership support for health programs.

Mayor Coro, together with his barangay leaders, visited various LGUs and NGOs to benchmark not only their initiatives, but also their leadership capacities. From their 10-day journey, the mayor was able to affirm his barangay stakeholders’ improved leadership capacities and could say that they are a fifth-class municipality with a first-class public service and citizenry.

**Next Steps and Remaining Challenges**

Priorities of Del Carmen for the year 2016 will still be the implementation of DOH programs and SOHG enhancement. Focus will be given to the following concerns for the next three years:

1. Nutrition focusing on the first 1,000 days for both mother and child
2. Family planning, especially for fisherfolks and their families
3. Teenage pregnancy which is at 19 percent
4. Tuberculosis

**Lessons Learned**

Mayor Coro said that his three-year journey with ZFF transformed him from “being an elected municipal mayor to a leader of Del Carmen.” Through the Bridging Leadership (BL) process, he was able to address many health leadership and systems issues. However, he emphasized that the BL framework was highly applicable to other sectors. They were able to apply the program to education, tourism, food security and livelihood.

To get things done, the mayor emphasized two major points: 1) improving local governance and 2) improving local leadership of municipal and barangay leaders. Development of roadmaps was a great tool to improve the mayor’s governance. With roadmap as a guide (education, health, food security), both local and external partners would know when and how to come in—“walang sapawan”.

Investment on the leadership improvement of both municipal and barangay leaders is a powerful complementary strategy of the mayor in improving health governance. He said that mayors have a lot of things to do and cannot do them alone. However, if local leaders are capacitated, they can meaningfully participate in the diagnosis of local health and development issues and in the co-creation of innovative solutions.

Mayor Coro called it “stupidity” to assume that only LCEs know the solutions to all the challenges in their town. His experience taught him that the grassroot leaders know the most effective and innovative solutions to their community’s problem. It would only take some encouragement from the mayor to empower them. He further added that mayors should be able to break the barriers of “hiya” due to lack of education. If done successfully, effective and innovative solutions will come from grassroots leaders.

Since joining the ZFF program, he had the privilege of visiting at least six regions to share his experience, presenting in various national events to encourage NGOs and private sector groups to collaborate with local governments for local health innovations, and being recognized for their efforts in health governance. Some of these were the Kaya Natin Health Governance Award (one of the Top 5) and Galing Pook Awards (semifinalist).

While Mayor Coro may be deemed young to effectively promote the HLGP, this can be replicated by working closely with the DOH and the Department of the Interior and Local Government so as not to be accused of political gimmickry. According to Coro, this program is very useful because there is no true leadership program to help mayors, with the most critical time being the first 100 days in office to plan the next 1,000 days.

Mayor Coro recognized that health would always be a dynamic sector. Unexpected issues may arise—occurrence of an outbreak or election-related issues. However, he reiterated that as long as the barangay leaders were engaged and empowered to give their communities the best health services and have the support of their municipal leaders, they could address whatever challenge that would come their way. Commitment to sustain good health outcomes is the best way to ensure that people have more opportunities to have better lives.

Sustainability of health outcomes and programs can be made possible by creating a demand for services. Mayor Coro emphasized that in creating demand among people, it is very crucial that the supply
(services) is sufficient and of high quality. Mayor Coro hopes that in the near future, they will be able to deliver demand-driven services. In order to do this, there should be a shift to greater community participation. The community should be able to demand for metrics/parameters they want to see and the LGU should be able to respond to those demands.

Aside from Del Carmen’s accomplishments in terms of health outcomes, its poverty incidence also improved (from 67.24 percent in 2011 to 58 percent in 2015) since it started implementing innovative public services allowing a healthier community to have better opportunities not only for themselves but for the community.

### Table 2: Del Carmen Health Outcomes, 2010 and 2015

<table>
<thead>
<tr>
<th>Governance</th>
<th>2010</th>
<th>2015 (to date)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of Municipal Health Budget</td>
<td>NO DATA</td>
<td>10%</td>
</tr>
<tr>
<td>Health Service Delivery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of BHS &amp; Birthing Units</td>
<td>5 BHS /1 RHU (not maintained )</td>
<td>13 BHS / 6 Birthing/ RHU (well maintained)</td>
</tr>
<tr>
<td>24/7 Operation of RHU-Main</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>Health Financing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PhilHealth Accreditation</td>
<td>NONE</td>
<td>RHU (PCB 1 &amp; 2, NBS) MCP AND TB DOTS on process)</td>
</tr>
<tr>
<td>PhilHealth Enrollees (Families)</td>
<td>2618 (95%)</td>
<td>4,655</td>
</tr>
<tr>
<td>Health Outcomes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility-Based Deliveries</td>
<td>75%</td>
<td>95%</td>
</tr>
<tr>
<td>Deliveries by Skilled Birth Attendants</td>
<td>75%</td>
<td>96%</td>
</tr>
<tr>
<td>Maternal Deaths</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Infant Deaths (including neonatal deaths)</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Fully Immunized Child</td>
<td>78%</td>
<td>81%</td>
</tr>
<tr>
<td>Malnutrition Prevalence Rate</td>
<td>22%</td>
<td>16%</td>
</tr>
</tbody>
</table>
Synopsis

There is the usual presumption that the State and the Church do not meet eye-to-eye on family-planning (FP) matters. On one end, the State is promoting a wide array of choices on FP methods, while the Church has been pushing for natural means. This has partly influenced the gap in health and social service delivery not only on FP provision, but also in the promotion of reproductive-health (RH) rights in general.

Amid the perceived differences, a leadership act proved that the government and the Church could work together in promoting health and social services to the people. Adaptive leadership—defined as leadership by working with people or groups to achieve decisions or a changed behavior—demonstrated by Mayor Velarde and his teammates, brought the people of Tinambac, Camarines Sur, to a reality they had never experienced before—decreased teenage pregnancy, increased facility-based delivery, increased tuberculosis detection and cure rates, and decreasing malnutrition among children.

The municipality of Tinambac is located in the northeastern part of the province of Camarines Sur. It is a first-class municipality consisting of 44 barangays, 11 of which are considered geographically isolated and disadvantaged areas. The current population of Tinambac is 70,745 and has a total land area of 344,081,126 square meters. The major sources of income for the people are coco-farming and fishing.

Bridging Leadership Story

Mayor Velarde shared that when he entered public service as local chief executive (LCE) nine years ago, major healthcare issues hurdled development in his community. Increased maternal and child mortality rates were alarming in the healthcare community, malnutrition was prevalent and poor sanitation was pervasive. Along with these problems were the limited availability of essential medicines, inaccessibility of healthcare facilities, inadequate financial and human resources, and a disengaged community which created health inequities.

Additionally, the issue of RH and the increased incidence of teenage pregnancy were present in his community. Dealing with these issues was not easy among healthcare providers, given the fact that they were seldom exposed to issues that tackled sexuality. Barriers in addressing these problems included beliefs, traditions and the conservative upbringing influenced by a conservative culture. It has been a long time that their communities turned a blind eye and refused to talk about the problem, but today, figures have spoken and statistics have been screaming for attention to fight this longtime issue. In 2013, 231 teenage pregnancies were recorded in Tinambac. Possibly, this would be the same number of teenagers who would quit school, lose opportunities to find better jobs, and would be at risk during pregnancy and delivery.

Although Mayor Velarde has years of experience as an LCE, Bridging Leadership really built his knowledge and capacity as a leader. He adopted different roles and responded to different needs. Upon his return to the municipality after a Zuellig Family Foundation leadership module training, Mayor Velarde called for a number of meetings to discuss rising concerns, coach rural health personnel, plan for the adoption of innovation he learned from the module training and fellow LCEs, and share accountability with barangay health workers and kagawads.

Mayor Velarde forged partnerships with different sectors of the community, government agencies, and non-governmental organizations to address their municipal health challenges. Leadership and governance block is the most complex and critical building block of any health system. It is where political will and priorities lie to address certain issues faced by the community. The previous situation of Tinambac’s health system paved the way for a stronger health system that it is today through the commitment of leaders and other stakeholders, most of all, its partnership with the Church.

To jump-start improvements in health leadership and governance, the local health board (LHB) was expanded. Mayor Velarde invited several Church leaders during the LHB meeting to enlighten him and other medical personnel regarding the stand of the Church on the issue of responsible parenthood and reproductive health (RPRH). Implementing RPRH was challenging because of the religious beliefs of the community, but Mayor Velarde courageously sought ways to have a dialogue with the
priests to discuss RPRH. The meeting became the avenue for Mayor Velarde and his team to realize that the Church was not an opponent in achieving better health outcomes in the area of RH. Faith-based organizations are influential sectors that can help in reviving morality among community members through values formation and spirituality. From then on, engaging the Church in the LHB started. Through their updated and validated database, the local government unit (LGU) had an objective data to show priests about the alarming health issues. The coalition of both sectors emphasized the commitment to build awareness and a stronger and supportive community.

In 2014, a two-day seminar on Responsible Parenthood and Family Planning was conducted. It was facilitated by the LGU and participated in by different sectors in the community, including pregnant mothers, newly engaged couples, parents, barangay officials, barangay health workers, barangay nutrition scholars, LGU employees, Kalipunan ng Liping Pilipina members, healthcare team, Philippine National Police (PNP) staff, and many others. Family Planning and Responsible Parenthood was discussed along with the introduction of the health calendar, a tool to disseminate information on the Standard Days Method as an effective and acceptable contraceptive method. The seminar was supported and endorsed by Rev. Fr. Rolando Octavus J. Tirona, Rev. Fr. Joey Gonzaga from the Archdiocese of Caceres-Family Ministry, and Sr. Nilda S. Corre from Daughters of Mary.

The seminar gathered religious affiliates and created awareness that the Church and the local government share the same advocacy when it comes to RH issues, contrary to what others think. In Tinambac, faith-based organizations are engaged during consultation and planning session, commissioning frameworks, policy development, service delivery and promoting RH advocacies. In Tinambac, Church leaders are involved in encouraging social responsibility and supporting social actions for health. The established partnership is seen as a key to identify potential opportunities and to address many of the health challenges associated with their current socio-political context.

The initiative to further strengthen their program to reduce teenage pregnancies has reached all school institutions in the municipality. Series of symposia on Adolescent and Sexual Reproductive Health (ASRH) among in-school youth was conducted. The organizing team was composed of Church leaders (priests) who gave good inputs on morality, values among youth and spirituality. The session instilled the value of responsibility, accountability and self-respect. Much emphasis was also given in identifying social roles of the youth in the community and the consequences that may result from their actions. Health personnel addressed issues related to ASRH. Topics included proper hygiene and sexually transmitted infections. With them were representatives from the Department of Education, PNP—Women and Children Protection Program, Department of Social Welfare and Development and youth organizations.

The stake of the Church as a key partner for health doesn’t end there. The faith-based sector is also active when it comes to information and education campaigns in the community. Right after the Holy Mass, they encourage pregnant mothers to seek prenatal checkup at the health center and deliver at the healthcare facility. They even promote Sagip Buntis Program—a local maternal health program in Tinambac. During wedding ceremonies, they also encourage responsible parenthood and FP among couples. Additionally, they encourage mothers to submit their children for immunization and newborn screening. In their fight against tuberculosis, Church leaders encourage members to seek medical assistance at the rural health unit when TB-related symptoms are observed. They also promote proper hygiene among the community people.

To further strengthen the partnership, the LGU has forged a dynamic relationship between the Church and community-based organizations such as the KALIPI to support the Church in achieving their shared goals for health. These include educating women in the community and empowering them to become more proactive members of the society and development.

The decision of the LGU and the Church to take social action to address healthcare concerns has contributed to a stronger and a more responsive healthcare delivery system in their municipality as evidenced by improvements in their health outcomes. As seen in Figures 1 and 2, there has been an increase in facility-based deliveries (FBDs) and deliveries attended by skilled birth attendants (SBA), as well as the detection and cure rate for TB. Whereas Figures 3 to 5 indicate a decrease in the incidence of maternal and infant deaths, malnutrition rate, and incidence of teenage pregnancies in Tinambac. The past years have been a great transformation for Mayor Velarde, from the superficial perspective on health to a broader concept which he is focusing on now. He is happy and proud that they have gone this far and has no plans
of going back. The knowledge that they earned from the ZFF partnership will be applied continuously as they move toward achieving their goals. He never thought of giving up the fight because he believed that if they—together with the Church, health personnel and the community—strive to become better than they were before, everything around them becomes better too.
Figure 4

![Graph showing the malnutrition rate from 2011 to 2014. The rate decreases from approximately 30% in 2011 to around 15% in 2014.]

Figure 5

Teenage Pregnancies

- 2013: 231
- 2014: 155
In the Autonomous Region in Muslim Mindanao (ARMM), health is generally not devolved to local government units (LGUs) unlike in the rest of the country. Control of resources is centralized within the Department of Health (DOH)-ARMM, while LGUs have limited power to address health issues within their municipalities. DOH-ARMM determines the health programs to be implemented in the ARMM. This means that bottom-up approach to budgeting and planning of health programs does not occur and there are no mechanisms to discuss with LGUs how best to allocate resources. Peace and security issues compound problems in ARMM municipalities. Despite these challenges, there are municipalities that thrive and able to deliver quality healthcare services to their people. Among these are the municipalities of Taraka in Lanao del Sur and Akbar in Basilan. Akbar also presents a unique situation in ARMM. Akbar has a devolved setup, but being a newly created municipality, it has no internal revenue allotment (IRA) and largely depends on financial assistance extended by the provincial government and the DOH-ARMM.

Given the non-devolved healthcare in ARMM, the mayors face several health challenges. The mayors have limited power in addressing health issues in their municipalities. They are unable to make independent and prompt decisions on mobilizing resources and designing specific interventions for unique health needs. Likewise, some municipalities do not have IRA like in Akbar, Basilan. The problems associated with the non-devolved setup is further aggravated by armed conflict that interferes with a community’s access to health services and hinders health personnel to provide health services in conflict areas. Health personnel also see working under such conditions to be risky, stressful, unpleasant and impossible. In fact, it was very difficult to convince Doctors to the Barrio to work in Akbar and Taraka due to security issues. Compounding these problems are the cultural practices of the people and misconceptions on Islam. Many believe that Allah permits deliveries only by a family member so they go to relatives who are traditional birth attendants. This is the reason most mothers prefer home deliveries. They also believe that women do not have rights to birth control, resulting in low contraceptive prevalence rate. Aside from this, unsafe traditional birthing practices are widely prevalent in Akbar, which consists predominantly of indigenous people.

In response to the challenges, Mayor Sali relied on networking to fund delivery of health services and construction of health facilities. Through continuous negotiations with non-governmental organizations and the Department of Social Welfare and Development, they have successfully constructed barangay health stations (BHS) and halfway homes.

Mayor Sumagayan, on the other hand, used a culture-sensitive approach in improving maternal health. She engaged Islamic religious leaders in advocating health promotion among pregnant women. She also invited these leaders during Buntis Congresses. To improve demand for facility-based deliveries, she put in place ordinances in giving incentives for mothers and midwives or barangay health workers (BHWs) who bring mothers to the facilities. This was complemented by ensuring supply of trained health human resources in the facilities by having an OB-GYNE specialist and nurses through a memorandum of agreement with DOH-ARMM. The strategies in her maternal health program were replicated in her tuberculosis-control program. The culture-sensitive information dissemination campaign “TB Patrol” not only informed the community about the disease, but also the misconceptions and stigma attached to it. The BHWs were also given P500 in incentives for every successful referral of TB patients. This was complemented by good supply management of anti-TB medicines provided by the DOH.

The personal response of the mayors of Akbar and Taraka has resulted to improvements in health indicators in both municipalities. In Akbar, Basilan maternal mortality ratio was reduced from 763.4 in 2013 to zero in 2014 and was sustained until 2015. Taraka, Lanao del Sur was able to maintain zero maternal deaths from 2011 until 2015. The tuberculosis cure rate has also increased from 63 percent in 2012 to 91 percent in 2014. This was accompanied by an increase in TB-detection rate of 43 percent in 2012 to 71 percent in 2014. Other improvements in health indicators can be seen in the figures presented.

Looking forward, the mayors know they need the support of the regional and provincial governments
to sustain the gains they have made in health. With the coming end of contract of DOH deployed nurses and midwives by end of 2015, they face the challenge of convincing health human resources to stay in their municipalities. This, however, entails not only financial considerations, but also addressing the peace and order in ARMM.

Figure 1: Rate of facility-based deliveries: Akbar, 2013-2015

Figure 2: Rate of skilled birth attendants: Akbar, 2013-2015

Figure 3: Rate of facility-based deliveries: Taraka, 2013-2015

Figure 4: Rate of skilled birth attendants: Taraka, 2013-2015
Health Gains and Re-election: An Analysis of the Influence of Local Health Improvements on the 2013 Local Election Results in the Zuellig Family Foundation’s Select Partner Municipalities

Jan Robert R. Go
Assistant Professor
Department of Political Science
University of the Philippines, Diliman

Synopsis
The 1991 Local Government Code devolved the health service delivery system to the lower tiers of the government. Part of the devolution was the mandatory creation of local health boards (LHBs) at the provincial, city and municipal levels. In 2008, the Zuellig Family Foundation (ZFF) focused its efforts on “health for the rural poor.” It ventured into a five-year plan calling for active participation in the national government’s health sector reform agenda. To this end, ZFF launched health leadership and governance training program called Health Leaders for the Poor implemented through the Foundation’s prototyping arm called Community Health Partnership Program.

The training intervention of the Foundation was aimed at strengthening the health and leadership capacities of mayors, municipal health officers (MHOs) and community leaders. This was to make systemic reforms for the benefit of poor constituents whose closest access to health services was given by their local governments in barangay and municipal clinics.

However, do these health reform acts of mayors lead to increased chances of winning elections?

The study examined if investments in health and the improvements in health outcomes affected the bid for re-election of local chief executives (LCEs) in ZFF partner municipalities in the 2013 local elections.

Methodology
The study was qualitative and employed case studies. Three qualitative techniques: document review, key informant interviews and focus group discussions were used in this research.

Eight municipalities (four won and four lost) mostly (7/8) of fifth-income class were selected. The cases were determined using the following criteria: (a) geographic location, (b) income class, and (c) results of the 2013 local elections. The eight municipalities to be studied came from North and South Luzon, Bicol region, the Visayas and Mindanao.

In each geographic area, two municipalities were studied: one where the LCE won the 2013 elections, and the other where the incumbent LCE lost. Most of the ZFF partner municipalities compatible with the geography and results requirements were fourth-income class municipalities. In cases where there were more than one municipality matching the criteria, the case municipality was randomly selected. Since the study was concerned with re-election of LCEs, the municipalities where the mayors maximized their allowable terms were excluded. Table 1 presents the cases for this study.

Key Findings

- Health is part of the LCE agenda, but it is neither the sole nor the top priority.
  - Health is not recognized as part of the LCE’s platform. An LCE’s background, such as his or her educational background, affects health agenda and service delivery in a municipality.
  - Public awareness on health projects and programs in most municipalities, specifically in the upland or far-flung barangays, is weak or limited.
- LHBs have been expanded.
  - Other sectors have been involved with some boards with a large number of members. One mayor verbalized that there was no LHB, but only between him and the MHO. Not all municipalities have barangay health boards. Security concerns, sense of urgency, LCE’s personality affect the activities.
- Public appreciation of the mayor’s performance in health is mixed.
  - While health performance is considered, the public also takes into consideration personalities, personality and presence of mayors. Vote-buying is also a factor, while a political party is not.
Recommendations

- Program level
  ⇒ For ZFF, community engagement needs to improve in health service delivery, management and administration.
  ⇒ There is a need to ensure that municipalities institutionalize health programs through ordinances to guarantee continuity when mayors are replaced.
- Individual level
  ⇒ Mayors have to be more active in health-related programs especially since presence is important; but they must avoid dole-outs in health cases.
  ⇒ They need to create a network of persons for health-related programs.
  ⇒ They need to institutionalize health programs and reforms.
- National level
  ⇒ Improve national-LGU linkages despite devolution.
  ⇒ Increase technical/resource support especially to LGUs with very limited resources.

Table 1: Eight municipalities/cases for the study

<table>
<thead>
<tr>
<th></th>
<th>Geographic Location</th>
<th>Income Class</th>
<th>2013 Election Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>LUZ1</td>
<td>LUZ</td>
<td>Fifth</td>
<td>Win</td>
</tr>
<tr>
<td>LUZ2</td>
<td>LUZ</td>
<td>Fifth</td>
<td>Lose</td>
</tr>
<tr>
<td>BIC1</td>
<td>BIC</td>
<td>Fifth</td>
<td>Win</td>
</tr>
<tr>
<td>BIC2</td>
<td>BIC</td>
<td>Fifth</td>
<td>Lose</td>
</tr>
<tr>
<td>VIS1</td>
<td>VIS</td>
<td>Fifth</td>
<td>Win</td>
</tr>
<tr>
<td>VIS2</td>
<td>VIS</td>
<td>Fifth</td>
<td>Lose</td>
</tr>
<tr>
<td>MIN1</td>
<td>MIN</td>
<td>Fifth</td>
<td>Win</td>
</tr>
<tr>
<td>MIN2</td>
<td>MIN</td>
<td>Second*</td>
<td>Lose</td>
</tr>
</tbody>
</table>

Legends: LUZ – Luzon; VIS – Visayas; MIN – Mindanao; BIC – Bicol

*Bicol was separated from the rest of Luzon because there was a significant number of municipalities in the area which was almost the same number as the number of Luzon, the Visayas and Mindanao.
Health Facility Assessment of ZFF’s Donated Barangay Health Stations and Birthing Units

Dr. Ma. Angeles G. Lapeña
Chief Technical Adviser
Global Resources for Assessment, Curriculum and Evaluation (GRACE)

Synopsis

As part of Zuellig Family Foundation’s (ZFF) pilot program in rural municipalities, it gave grants for the construction of health facilities to its partner municipalities. A study on the impact of 52 such health facilities to the community and assessment of health service quality was then conducted.

Interviews were conducted with five types of key informants: a) local government unit (LGU) key leaders such as the mayor, the Sangguniang Bayan (SB) member for Health and the municipal health officer (MHO); b) the barangay captain or kagawad in charge of health concerns in the community; c) a leader of a non-governmental organization (NGO) in the community; d) health service providers such as midwives, nurses and barangay health workers (BHWs), and e) women of reproductive health from 50 households per barangay.

ZFF’s contributions were felt by the communities, their LGU leaders, as well as their respective health workers. The construction of birthing clinics resulted in an increase in facility-based deliveries (FBDs). The clinics also became the regular venue for disseminating health programs to all BHWs who, in turn, rolled out the information to respective communities. It was also noted that the mere presence of birthing clinics was an effective reminder to households that health, particularly maternal health, is as important as their livelihood and their children’s education which must be prioritized. Other oft-cited ZFF contributions were the technical training for health workers and leadership training for mayors and local leaders, which helped shape their attitudes and behavior toward health, and enabled them to formulate and implement their health programs better.

Background and Project Rationale

Healthcare in the Philippines has been complicated by its unique geography and persistent poverty. Nevertheless, the country has committed to achieve Millennium Development Goals (MDGs) by 2016. In the progress report released by the National Statistical Coordination Board in May 2014, the Philippines was projected to have a high possibility of attaining the MDG of improved neonatal health (Goal 4). However, the probability of attaining improved maternal health (MDG 5) was medium to low. Limited access to health facilities due to geographic distance and transportation costs remains among the factors that contribute to maternal mortality (Department of Health [DOH], 2012; World Health Organization, 2011).

Among the strategies proposed by the DOH to improve these health outcomes is to ensure that quality healthcare services sensitive to the needs of geographically isolated and disadvantaged area (GIDA) communities are accessible and available (DOH, 2012). With the devolution of healthcare to individual LGUs (Local Government Code, 1991), the most effective means to bring health services closer to their constituents is to construct barangay health stations (BHS) and rural health units (RHUs). However, from 1999 to 2006, less than 2,000 BHS were constructed, and only 50 RHUs were instituted by 2002 (Herrera, Roman, & Alarilla, 2010). Furthermore, a report released by the Asian Development Bank in 2007 showed that these public health facilities were perceived to provide inadequate and low-quality services characterized by incorrect diagnoses, inferior medicines, unavailability of supplies, rundown facilities, long waiting time, inconvenient schedules and absent staff members (Herrera, Roman, & Alarilla, 2010). To address gaps in healthcare services due to limited health financing, one of the DOH’s strategies was to maximize public-private partnerships (PPPs) to increase efficiency and effectiveness of health service delivery systems (DOH, 2011). PPPs were recommended to enhance fairness in resource distribution (Herrera, Roman, & Alarilla, 2010; Manasan & Villanueva, 2006).

In 2008, ZFF began partnering with municipalities in GIDAs in an effort to improve leadership and governance. Through the Community Health Partnership Program (CHPP), two infrastructure grants per partner municipality were given by ZFF, providing a birthing clinic building and medical equipment. The goal was to reduce maternal and infant mortalities. The ZFF expected that training local leaders and construction of health facilities would improve the population’s access to health services and, therefore, improve health outcomes.

Specifically, the project done by Social Development Research Center (SDRC) was a two-pronged health
facility performance audit. It has two main objectives: first, to determine the impact of the foundation’s initiative of donating 52 health facilities to selected municipalities, and second, to assess the quality of services rendered by the donated facilities using DOH standards for primary healthcare facilities.

Under each of these two main objectives were specific research concerns, as follows:

1. To determine the impact of ZFF’s initiative of donating 52 health facilities to selected municipalities specifically in terms of the following:
   a. An increase in the population’s access to health services
   b. An increase in health-seeking behavior in the community
   c. An improvement of health outcomes in the community, and
   d. The reduction of maternal and infant mortalities

2. To assess the quality of services rendered by the donated health facilities using DOH standards for primary healthcare facilities.

Of specific research interest were:

a. The perceptions and views of the stakeholders on the donated health facility and its contributions, as well as outcomes in the community
b. The difficulties encountered in the operation of the health facilities
c. The critical success factors in the health facilities’ operations, and
d. Possible recommendations to assist the LGUs in further enhancing the operations of the donated health facility.

**Methodology**

The study aimed to audit the health-facility performance of 52 ZFF health stations and birthing clinics.

Performance audit instruments were first developed and approved by ZFF. Five instruments were approved for use in the interviews with these five types of key informants:

a. Mayor/SB on Health/MHO
b. Barangay captain/kagawad
c. NGO in the community
d. Health service providers (midwives, nurses, BHWs)
e. Women of reproductive health from 50 households per barangay

The instruments were standardized key informant interview schedules and checklists with items adapted from primary health facility performance-assessment tools previously constructed by the SDRC for its health-related projects.

ZFF-donated facilities in 52 barangays in 30 municipalities that were in operation for at least a year as of February 2014, were visited by SDRC field researchers from February 21 to April 16, 2014, on the specific dates shown in Table 1. Data gathering was targeted from February 21 to April 30, 2014, but data submission was extended until May 31, 2014 upon the request of local researchers who still had to conduct interviews with key informants living far from the ZFF-donated health facilities, typically in hard-to-reach upland barangays in catchment areas.

**Sampling Design**

The key informants were purposively selected given the inclusion criteria set by the researchers: a) LGU officials to include mayor/SB on Health/MHO, the barangay captain or kagawad for health issues and concerns where a ZFF-donated facility is located, b) members of the community including an officer of an NGO in the community and health service providers (midwives, nurses, BHWs).

Purposive and quota sampling procedures were used to select women of reproductive health from 50 households per barangay as key informants of the study. Exit interviews were conducted by SDRC’s local research teams which were also instructed to interview women who lived farther from the health facility. Of the 1,436 women who consented to be interviewed, 64 percent lived within walking distance from the health center, and 36 percent had to take a car ride, jeepney, tricycle or habal-habal (tandem-ride on a motorcycle) to reach their respective ZFF-donated health facilities. Only the data from key informants who allowed their responses to be consolidated with other key informant responses were included in the study’s database of responses. Informed consent was indicated in writing by the key informants on the study’s informed consent form.

The non-probability sampling design used (primarily purposive and quota sampling) does not allow the research team to generalize its findings from the key informant interviews to the members of the communities to which the key informants belonged. At best, the responses should be treated as indicative only of these particular key informants’ perceptions and opinions.
Summary of Findings

Physical and Social Environment

1. The locations of the facilities visited are mostly in catchment areas serving multiple barangays. (See Table 2)
2. Given the remoteness of the areas where the facilities are located, early referral is a key function of the health staff, transporting patients during emergency situation is a big challenge for the barangays and LGUs due to limited vehicles and bad road conditions.
3. Informants from birthing clinics with structural problems complain about the substandard quality of materials used by the contractors. Commonly, these informants report that parts of the building (ceiling, doors, windows, piping) start to deteriorate within the first year after its turnover to the LGU.
4. Beds, tables, storage cabinets, fences, water and electricity supply are just some of the gaps that the LGUs and barangays need to fill in order for the health stations to be optimally functional. Midwives report that they have difficulty in attending to childbirths especially at night without water and electricity.

Health Service Utilization/ Perceptions and Responses

1. ZFF-donated health facility staff lead activities such as the Buntis Congress to make would-be mothers and fathers more actively involved in the entire pregnancy period, and the Barangay Health Summit that teaches community residents on the leading causes of sickness and the different ways to avoid them. Thus, the ZFF-donated health facilities are instrumental in information dissemination and encouraging residents to practice health-seeking behavior.
2. Birthing clinics located in interior barangays are seen by residents not only as a health station serving pregnant women, but also as a health center where people can receive first-aid and primary health care.
3. These clinics commonly have a shortage of health staff, only a few stay for a 24-hour duty for security reasons, especially in clinics that do not have fences and electricity supply. Midwives are usually alone during childbirth; most of them request for at least two midwives on duty to reduce the chances of complications and accidents during childbirth.
4. Residents (especially in communities where residents are mostly of low education status, and among indigenous peoples and Muslim communities) still prefer to deliver at home assisted by traditional birth attendants, or hilots. These women, especially in the Muslim areas, are shy and do not want others to see their private parts. It is important, therefore, for information-dissemination programs to be designed according to the level of education of the residents (led by a local tribal leader is typically most effective) and schemes (legislation banning home deliveries and incentives) for hilots to refer pregnant women to the health center.

Program Implementation

1. Good working dynamics among the ZFF health leaders (mayor, MHO, community leader) are essential for sustained implementation of ZFF health programs.
2. The mayor is seen as the most influential person having the best leverage to implement health programs in the community. In municipalities where the mayor is actively engaged in health programs, more health-related initiatives and better health outcomes are observed.

<table>
<thead>
<tr>
<th>Key Informants</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mayor</td>
<td>17</td>
</tr>
<tr>
<td>Vice Mayor</td>
<td>2</td>
</tr>
<tr>
<td>Sangguniang Bayan Member for Health</td>
<td>6</td>
</tr>
<tr>
<td>Provincial Health Officer</td>
<td>1</td>
</tr>
<tr>
<td>Municipal Health Officer</td>
<td>17</td>
</tr>
<tr>
<td>Barangay Captain</td>
<td>11</td>
</tr>
<tr>
<td>Kagawad for Health</td>
<td>3</td>
</tr>
<tr>
<td>Total of LGU officials</td>
<td>(57)</td>
</tr>
<tr>
<td>Midwives</td>
<td>15</td>
</tr>
<tr>
<td>Nurses</td>
<td>8</td>
</tr>
<tr>
<td>Barangay Health Workers</td>
<td>5</td>
</tr>
<tr>
<td>Total of health service providers</td>
<td>(28)</td>
</tr>
<tr>
<td>Targeted clients (women of reproductive age)</td>
<td>(1,320)</td>
</tr>
</tbody>
</table>
3. There is a need for better road networks and presence of a regular transportation service (e.g., van-type ambulance, tricycle ambulance) to make referral systems function optimally.

4. There is a different structure in health governance in Autonomous Region in Muslim Mindanao (ARMM). Indigenous people and Muslim communities also have unique health-related beliefs and traditional practices. Therefore, an approach adapted to the uniqueness of ARMM is needed for health programs to be implemented and sustained effectively.

5. For example, in ARMM where the health system is not devolved, complaints on inadequate health budget and LGU participation are common. It is noted that mayors who have been trained by ZFF and receive constant coaching and monitoring on health programs are more engaged.

Critical Success Factors

1. MHOs, nurses, midwives and BHWs who are regular employees are observed to be more engaged and motivated toward improving the birthing clinic and implementing health programs initiated by both ZFF and their respective municipalities.

2. Municipal legislation banning home deliveries and legislation on sanitation and nutrition are key elements to sustain LGU and community participation. The political will of local leaders is seen to affect health-seeking behavior positively (this is especially noted in ARMM where mayors and local officials wield considerable influence as datus and royalty in the community).

3. Regularization and incentives are seen to have a positive effect on the quality of service given by the health staff. Furthermore, more nurses and midwives are needed in these disadvantaged areas. The workload for these staff is seen to be very high. Hiring staff who reside in the area or nearby municipalities is also seen as effective in encouraging these staff to have a sustained presence in the communities they are servicing.

Contributions of ZFF

1. The building of birthing clinics bridged the gap in accessing healthcare services for residents in GIDA municipalities. Previously, health workers conducted vaccinations and prenatal checkups in puroks or ku-bos. With the turnover of birthing clinics, health workers were provided with a regular base of operation where they could conduct health-related activities and implement health programs. These clinics also serve as quarters for midwives on night duty.

2. With the capacity-building training that ZFF provided for tri-leaders, key informants agreed that there was a change in the mindset of their officials. Although this was not observed in all areas that were visited, mayors and local officials were generally aware of the importance of health governance and more engaged in implementing health programs.

3. ZFF’s contributions to the communities included basic skills training in first aid, leadership and interpersonal relations for the health staff, as well as

<table>
<thead>
<tr>
<th>Mode of Transportation to the ZFF-donated health center</th>
<th>30 mins or less</th>
<th>More than 30 mins but less than 1 hours</th>
<th>1 to 1.5 hours</th>
<th>2 or more hours</th>
<th>Grand total</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Walk</td>
<td>1,114</td>
<td>14</td>
<td>19</td>
<td>3</td>
<td>1,150</td>
<td>87.1</td>
</tr>
<tr>
<td>Tricycle</td>
<td>160</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>162</td>
<td>12.3</td>
</tr>
<tr>
<td>Jeepney</td>
<td>71</td>
<td>0</td>
<td>2</td>
<td>4</td>
<td>77</td>
<td>5.8</td>
</tr>
<tr>
<td>Bus</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>0.3</td>
</tr>
<tr>
<td>Car</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0.2</td>
</tr>
<tr>
<td>Habal-habal (Single motorcycle)</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0.2</td>
</tr>
<tr>
<td>Skylab</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0.1</td>
</tr>
<tr>
<td>Ambulance</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Bicycle</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Others</td>
<td>89</td>
<td>0</td>
<td>2</td>
<td>91</td>
<td></td>
<td>6.9</td>
</tr>
</tbody>
</table>

multiple responses allowed
tracking and monitoring systems training on nutrition and pregnancy programs.

4. A health facility nearer interior barangays serves as an avenue for referral for patients having high-risk pregnancies and other medical conditions.

**Behavioral Changes**

1. With a birthing clinic near the community, residents were encouraged to seek prenatal checkups more often. There was also an increase in FBDs. The long distance and cost of travel to the poblacion hindered mothers to get a checkup and deliver their babies in the health center. (See Table 3)

2. Local leaders were more aware of their roles as health leaders and advocates. Key informants agreed that implementing health programs in their respective communities was an effective political strategy.

3. With the advent of the Pantawid Pamilyang Pilipino Program (4Ps), residents in the barangays were more encouraged to participate in health activities and avail of health services like prenatal checkups and immunization. Not doing so would mean that they would be ineligible for their 4Ps’ benefits.

**Additional Insights**

1. Partnerships with NGOs (e.g., Habitat for Humanity for Bahay ni Nanay and Oxfam for sanitary toilets) are seen to be helpful in addressing the gaps that still exist in the overall health and development aspect in these GIDA communities.

2. New staff and newly elected officials need to train under ZFF to be in harmony with previous local administrations’ health programs and advocacies.

<table>
<thead>
<tr>
<th>Reasons for Visit to ZFF-donated health center</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accessible location</td>
<td>610</td>
<td>46.2</td>
</tr>
<tr>
<td>Helpful employees</td>
<td>482</td>
<td>36.5</td>
</tr>
<tr>
<td>Different types of services</td>
<td>475</td>
<td>36.0</td>
</tr>
<tr>
<td>Better facilities</td>
<td>387</td>
<td>29.3</td>
</tr>
<tr>
<td>Betterservices</td>
<td>350</td>
<td>26.5</td>
</tr>
<tr>
<td>Less time of waiting</td>
<td>324</td>
<td>24.5</td>
</tr>
<tr>
<td>Access to medicines</td>
<td>178</td>
<td>13.5</td>
</tr>
<tr>
<td>All those mentioned</td>
<td>83</td>
<td>6.3</td>
</tr>
<tr>
<td>Others</td>
<td>20</td>
<td>1.5</td>
</tr>
</tbody>
</table>

3. Informants agree that ZFF’s constant monitoring is helpful to them and hope that ZFF will continue to supervise and monitor them even after the contract has ended. Constant monitoring encourages them to sustain their level of performance and avoid low health outcomes. As one key informant said, “Nahihiya po kami kung hindi namin pagbubutihin kasi sobra-sobra na ang naibigay sa amin ng Zuellig. We know that we should also do our part.”

**Conclusions**

ZFF’s contributions have been significantly felt by the communities, their LGU leaders, as well as their respective health workers. The construction of birthing clinics resulted in an increase in FBDs. (See Figure 1)

The clinics also became the regular venue to disseminate health programs to all BHWs who, in turn, rolled out the information to their respective communities. It was also noted that the mere structure—the presence of birthing clinics—was an effective reminder to households that health, particularly maternal health, is as important as their livelihood and children’s education that must also be prioritized. Another well-cited ZFF contribution included the technical training for health workers and leadership training for the mayor and local leaders. The key informants (i.e., mayors, MHO and other health workers) highlighted the training’s effectiveness in changing their attitude and behavior toward health in general and for the creation and implementation of health programs. (See Figures 2 and 3)

Given the data gathered and summarized from the audit visits conducted in the 52 ZFF-donated health facilities, the following conclusions are put forth by the SDRC research team:

1. The health facilities donated by ZFF to selected communities have made a strong impact on people’s consciousness about maternal health. Because of the facilities and the other programs provided by Zuellig, target health facility clients—including members of their respective families—became more conscious of their health needs. The effect of ZFF programs in the areas enabled the lying-in clinics to not only cater to mothers, but also to serve as regular clinics for other members of the community. (See Table 4)

2. The location of the donated health facilities has significantly improved the community residents’ access to health services. The accessibility of the donated health facilities was a key explanatory factor behind community members’ increased health-
Figure 1: Rate of facility-based deliveries of 30 sampled municipalities

Figure 2: Proportion of fully immunized children among the 30 sampled municipalities

Figure 3: Proportion of exclusively breastfed infants among 30 sampled municipalities
### Table 4: Perceived health status over the past three years of women of reproductive age

<table>
<thead>
<tr>
<th>Perceived health</th>
<th>Own health</th>
<th>Children's health</th>
<th>Other family members' health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Status</td>
<td>Frequency</td>
<td>Percentage</td>
<td>Frequency</td>
</tr>
<tr>
<td>Fully Recovered</td>
<td>769</td>
<td>58.3</td>
<td>774</td>
</tr>
<tr>
<td>Better than before</td>
<td>353</td>
<td>26.7</td>
<td>379</td>
</tr>
<tr>
<td>Almost the same</td>
<td>105</td>
<td>8.0</td>
<td>72</td>
</tr>
<tr>
<td>Worse than before</td>
<td>53</td>
<td>4.0</td>
<td>45</td>
</tr>
<tr>
<td>Frequent Illness</td>
<td>27</td>
<td>2.0</td>
<td>41</td>
</tr>
<tr>
<td>No data given</td>
<td>13</td>
<td>1.0</td>
<td>9</td>
</tr>
<tr>
<td>Total</td>
<td>1,320</td>
<td>100.0</td>
<td>1,320</td>
</tr>
</tbody>
</table>

### Table 5: Client satisfaction with ZFF-donated health centers’ operations

<table>
<thead>
<tr>
<th>Sources of client satisfaction</th>
<th>Mean</th>
<th>Standard deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Center Operations:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cleanliness and orderliness of the HC</td>
<td>3.42</td>
<td>0.72</td>
</tr>
<tr>
<td>Attention to the actual purpose of visit</td>
<td>3.34</td>
<td>0.7</td>
</tr>
<tr>
<td>Shorter queue line</td>
<td>3.3</td>
<td>0.73</td>
</tr>
<tr>
<td>Less expensive</td>
<td>3.27</td>
<td>0.87</td>
</tr>
<tr>
<td>Good ability of the HC employees</td>
<td>3.26</td>
<td>0.73</td>
</tr>
<tr>
<td>Less time of waiting</td>
<td>3.25</td>
<td>0.77</td>
</tr>
<tr>
<td>Adequate space for individual checkup</td>
<td>3.2</td>
<td>0.77</td>
</tr>
<tr>
<td>Different types of services are being provided</td>
<td>3.17</td>
<td>0.83</td>
</tr>
<tr>
<td>Tools/instruments are well-functioning</td>
<td>3.16</td>
<td>0.82</td>
</tr>
<tr>
<td>Regular supply of medicines/utilities</td>
<td>2.65</td>
<td>0.99</td>
</tr>
<tr>
<td>Enough supply of medicines</td>
<td>2.6</td>
<td>0.97</td>
</tr>
</tbody>
</table>

1 (Not Satisfactory), 2 (Less Satisfactory), 3 (Satisfactory), and 4 (Very Satisfactory)

### Table 6: Client satisfaction with ZFF-donated health centers’ personnel of surveyed

<table>
<thead>
<tr>
<th>Sources of client satisfaction</th>
<th>Mean</th>
<th>Standard deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Center Personnel:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Understands the language used by patients</td>
<td>3.49</td>
<td>0.64</td>
</tr>
<tr>
<td>Gives recommendations/prescriptions</td>
<td>3.41</td>
<td>0.67</td>
</tr>
<tr>
<td>Corresponding Attention given to patients</td>
<td>3.37</td>
<td>0.67</td>
</tr>
<tr>
<td>Diagnose the patients very well</td>
<td>3.36</td>
<td>0.72</td>
</tr>
<tr>
<td>Polite and sincere</td>
<td>3.36</td>
<td>0.67</td>
</tr>
<tr>
<td>Addresses concerns/questions of the patients</td>
<td>3.35</td>
<td>0.72</td>
</tr>
<tr>
<td>Confidentiality</td>
<td>3.33</td>
<td>1.36</td>
</tr>
<tr>
<td>Has orderly system of work</td>
<td>3.32</td>
<td>0.76</td>
</tr>
<tr>
<td>Adequate Privacy</td>
<td>3.29</td>
<td>0.74</td>
</tr>
<tr>
<td>Follows clinic hours</td>
<td>3.19</td>
<td>0.84</td>
</tr>
<tr>
<td>Availability of doctor</td>
<td>3.28</td>
<td>0.80</td>
</tr>
<tr>
<td>Overall Satisfaction</td>
<td>3.18</td>
<td>0.67</td>
</tr>
</tbody>
</table>

1 (Not Satisfactory), 2 (Less Satisfactory), 3 (Satisfactory), and 4 (Very Satisfactory)
seeking behavior.
3. Client satisfaction with the physical aspect of the ZFF-donated health facilities, including orderliness and cleanliness, and the improved quality of service by health providers, may have increased the health-seeking behavior of the community residents. (See Tables 5 and 6)
4. Sustainability of the donated health facilities and their essential components (electricity, medicine, water, complete and working medical equipment, and consistent availability of medical staff) will ensure that the health facilities provide quality health services at all times, especially during emergency situations.
5. The ZFF partnership with LGUs is an essential program at the grassroots level because by providing health facilities and capacity-building programs for LGU leaders, ZFF has enabled local government health units to be more efficient in health service delivery, thus improving the health status of the constituents of ZFF partner communities.
6. The key players in the ZFF partnership with LGUs are the mayors. It is critical for ZFF to nurture relationships with LGU health service leaders and frontliners like MHOs and health service providers, as well as to engage newly elected mayors to sustain partnership relations with ZFF and their predecessors.
7. Closer DOH coordination with LGUs is needed for smoother implementation of DOH programs requested by LGUs. The needs of the LGU, health leaders, health staff and the community residents must be considered prior to implementation of DOH programs by LGUs.

Recommendations for LGUs to further enhance operations of ZFF-donated health facilities

Given the positive impact of the ZFF program on selected municipalities, there is a need to sustain ZFF’s efforts. The creation and passing of policies and resolutions relevant to the program by the LGUs may help sustain these.
1. The monitoring system of ZFF is very important to the program’s sustainability and should continue to be implemented and improved further. Training in the use of electronic tools in implementing client feedback and monitoring systems should be explored. It is important for ZFF to monitor the operation of donated facilities even after construction to ensure sustainability and accountability. Monitoring is crucial to allow ZFF to validate if partner LGUs have indeed shelled out counterpart funds for the operation of the facilities.
2. ZFF should expand its partnership with other similar LGUs in GIDAs. It will be helpful for ZFF to partner with LGUs not only to provide infrastructure interventions (i.e., construction of birthing clinics), but also to design and implement activities, strategies and programs to address the holistic healthcare needs of partner communities.
3. To address the lack of health staff and budget problems, ZFF and LGUs may consider deployment of skilled and competent medical interns and doctors and encourage them to train and practice in areas where doctors and health staff are greatly needed.
4. ZFF may also consider expanding its partnership with other companies and organizations to address the need for larger laboratory equipment (X-ray machines, ultrasound, blood test equipment) to be housed in the health facilities. Clients need to maximize the time that they are in the ZFF-donated health facility, especially because some residents in GIDAs are compelled to take time off from work for several days and spend limited family funds to travel across islands to have medical procedures done.

References:
In 2013, Zuellig Family Foundation (ZFF) included the municipality of San Sebastian, Samar as one of its partner municipalities in the Health Leaders for the Poor (HLP) program. As a geographically isolated and disadvantaged area (GIDA), three municipal officers (MHOs) were invited to attend four leadership modules spread within two years.

Given the crucial role played by the local leader, ZFF designed and adopted the Bridging Leadership (BL) framework with the premise that by empowering local leaders who are knowledgeable on the intricacies of health problems and issues, these leaders will be in the best position to suggest and sustain solutions to health problems within their respective municipalities.

By highlighting the roles of local leaders, rearrangement of previous ways of delivering health services and inclusion of new actors in the decision-making processes, the framework suggests institutional transformation in local health delivery systems. These changes are best understood by looking into the existing arrangements within political and health institutions. Municipal leaders have some freedom in the interpretation and enforcement of existing institutional rules and regulations. Additionally, current socioeconomic and political conditions can also provide the needed maneuvering space for municipal administrators and other community members to create their own interpretation of existing health-related rules and policies constructively. While these may be considered small changes for now, they can be the starting point for more significant and long-lasting transformation of local health delivery systems.

Applying this framework to San Sebastian, the local government unit (LGU) is viewed as a distributional instrument (Mahoney and Thelen 2010) that is perpetually challenged to come up with decisions pertaining to health resource allocation and distribution. Sociopolitical leaders (i.e., mayor, MHO and other municipal leaders) are viewed to be motivated in creating arrangements deemed beneficial to their own interests. Through training and coaching sessions provided by ZFF, an efficient and effective health delivery system became an integral part of these leaders’ interests.

The sociopolitical context of San Sebastian was characterized by financial and administrative disarray created by the previous administration, generally perceived by community members as a failing bureaucracy. This provided the needed space for the current administration to exercise some veto powers in its interpretation and implementation of existing health policies.

The role of selected social actors was also highlighted. Case in point was the accommodating attitude of the mayor who also encouraged the public health workers (PHWs) to initiate the request for an improved implementation of Magna Carta for Public Health Workers (MCPHW). Armed with knowledge of existing health policies covering PHWs, the municipal health workers of San Sebastian lobbied for additional compensation as stipulated in Department of Budget and Management (DBM) and Department of Health (DOH) Joint Circular 1, Series of 2012 and the MCPHW (Annex M). The PHWs of San Sebastian have been receiving the following: 1) hazard pay equivalent to 25 percent of their base pay; 2) laundry allowance of P150 per month, and 3) subsistence allowance of P1,500 per month. While they still have to receive their longevity pay and remote assignment allowance, the PHWs of San Sebastian are quite happy with what they are receiving. And because the municipality has adopted the salary scale of first-class municipality, the salaries of PHWs in San Sebastian are significantly higher (by about 43 percent to 54 percent) compared with the salaries of other municipal employees.

The genial personality of the local chief executive (LCE) also facilitated the creation of networks of trust relationships within and outside the municipality. To date, additional partnerships have been established. These partners have provided additional material and non-material resources to improve the health delivery systems of San Sebastian. These additional networks further bolstered the level of trust and confidence on the current administration.

With sufficient amount of support, the mayor and his select group of trusted advisors were able to push for the allocation of needed financial resources to upgrade the implementation of MCPHW. As a sixth-
class municipality, San Sebastian has barely enough to meet its past and present financial obligations. Given the potential improvements in the delivery of basic health services, the needed amount for the subsistence and living allowance, plus the hazard pay of all the PHWs, represented a measly 0.8 percent to 0.10 percent of the municipal budget between 2013 and 2015. This case illustrates that once health is made a priority of the municipality and given enough support from the community, policies supportive of improving health services can be achieved.

The incorporation of the required budget into the municipality’s annual budget makes the stipulation more or less institutionalized. As emphasized further by a senior municipal official, “Once an additional compensation like this has been awarded and included in the annual budget, it would be difficult to do away with.”

In the end, the unfavorable sociopolitical context in the municipality empowered the leaders of San Sebastian to have the discretion in the interpretation and enforcement of existing health policies. At the same time, the improved level of trust and social networks within and outside San Sebastian provided the needed political and financial resolve to push the municipality to work in making its local health delivery system more effective and efficient. The following factors facilitated the improved implementation of MCPHW in San Sebastian:

1. The policy environment (Republic Act [or RA] 7305 and DBM and DOH Joint Circular 1, Series of 2012) that enabled the implementation of such health initiatives.
2. The local sociopolitical context that provided the local leaders some leeway in the interpretation and implementation of these health initiatives.
3. The heightened level of trust and confidence on the LCE. This provided the mayor with sufficient amount of social capital that encouraged a select group of local officials to rally behind him. Additional linkages and networks were established within and outside San Sebastian providing mechanisms to access additional resources for the municipality.
4. The additional resources made available to the members of the community further boosted the current administration’s level of social and political capital to allocate, without stiff opposition, the needed resources to increase compensation and allowances of local health workers.
5. The institutionalization of improvements in the implementation of MCPHW; the additional compensation for health workers is covered by a Sangguniang Bayan (Municipal Council) resolution. Once part of the annual municipal budget, future municipal administration has no choice but to continuously implement these improvements.

While some observers deem the implementation of MCPHW in San Sebastian as inadequate, the improved implementation is already an achievement given the huge resource constraints faced by the municipality, a bureaucracy with insufficient funds to regularly pay its employees and honor its commitments with previous debtors. It would have been much easier for the current municipal administrators to hide behind the exclusions stipulated in the MCPHW, but they did not. San Sebastian still has a long way to go to be considered a model of health development but it is slowly changing as indicated by the small achievements in the delivery of health services and implementation of the MCPHW. Hopefully, sustaining these changes would permanently transform the local government unit (LGU) to be more efficient and rational in its delivery of basic health services.

Viewed this way, institutional stability and change are propelled from sources that may be both external and/or internal to the institutions. This resulted to a much improved situation for the local health workers in San Sebastian. While this is a good step, the study argues that the observed positive changes are only the beginning of a longer-term improvement to fully improve the health delivery systems in San Sebastian. As with any institutional transformation, a longer time frame is needed, but as argued by Mahoney and Thelen (2010) gradual changes already taking place in San Sebastian are equally important.

Taking off from the case of San Sebastian, the municipality went through a series of processes that emboldened the institutions and the actors within to implement the much-needed changes in the health delivery systems including the improved implementation of the MCPHW. By taking into consideration the unique challenges faced by individual municipality, other localities may learn from the following important steps taken by San Sebastian.

**Identified Success Factors**

**A. Leadership Style of the Mayor**

Many research participants interviewed mentioned the leadership style of the current mayor as one of the factors that helped San Sebastian to move
forward. To date, some of his successful projects included the improved health service delivery, such as vaccination for senior citizens and pneumonia vaccines. The Development Management Officer IV of the regional health unit (RHU) was quite impressed that despite the absence of regular potable water supply in the municipality, there was no typhoid outbreak. There was no measles outbreak too similar to what she experienced as a former municipal nurse. For this research participant, these were already accomplishments for the municipal health office (MHO). She acknowledged however, that the municipality still needs to achieve its Maternal, Neonatal and Child Health and Nutrition targets.

There are also two operational barangay health stations (BHS) and a Tuberculosis Directly Observed Treatment, Short-Course (TB DOTS) center. The BHS were funded by the Australian Red Cross, while the TB DOTS was an initiative of the DOH. Although these projects were initiated by the previous administration, these facilities were finished and eventually turned over to the municipality after the current administration allocated the needed money representing the municipal counterpart. Without this counterpart, the turnover of these facilities wouldn’t be possible.

On a broader scale, the monthly remittances to the General Service Insurance System (GSIS) were resumed to allow municipal employees to avail of GSIS benefits. The regular payment of salaries of the LGU staff is also attributed to the current mayor. Initially, the mayor faced some resistance on the resolution appropriating a certain percentage of the municipality’s annual budget for debt repayments. However, with sufficient explanation and persuasion to opposing members of SB, the council realized the importance of honoring the financial accountabilities incurred by the previous administration.

The same SB agreed to the incorporation of the budget for additional payment of PHWs. This was relevant according to the municipal treasurer because once these additional payments were incorporated in the annual municipal budget, it would be difficult to take them back. In a way, the additional payments of the PHWs in San Sebastian as allowed by the MCPHW were already institutionalized.

Also, after decades of going through rough roads to reach San Sebastian, the construction of the road connecting the municipality to the national highway (Maharlika Highway) is halfway finished. The road construction started in the early part of 2015 and is expected to be finished by 2016. The provincial governor agreed to shoulder half of the budget. The remaining half would be shouldered by the LGU. Again, this is another indication how trust (social capital) begets more trust. According to interviews with the Municipal Local Government Operations Officer (MLGOO), the provincial government was impressed with the changes made by the LCE of San Sebastian and encouraged the governor to provide the needed counterpart money to start the construction of the municipal highway from Calbiga to San Sebastian.

Almost all of the LGU officials interviewed cited the current LCE for being accessible and always present in the municipality. One key informant even said, “Sa lahat ng mayor na naabutan ko dito sa San Sebastian, siya lang ang palaging nandito. [Of all the mayors we had in San Sebastian, he is the only one who is always around.]”

Even to those who are not directly working under the mayor, he is generally described as a “champion of health” and “supportive” of various health initiatives in the municipality. One interviewee attributed the improvements in the municipality to the mayor’s “capacity to listen.” In spite of his age (79 years old), he is always present and accessible in the municipality. As a rule, he listens to the concerns of his staff and constituents but does not readily commit the resources of the municipality without consulting with concerned staff. For major decisions, he regularly seeks advice of the MLGOO and the municipal treasurer on the intricacies of local government operations and the limited financial resources of San Sebastian.

His judicious use of government resources, to a certain extent, can also be considered as a plus factor. For many residents of San Sebastian, the LGU, and by extension, the incumbent LCE is perceived as the biggest patron. However, the mayor tries to put a stop to this perception and refrains to dole out cash as expected by many residents when he visits the barangays. Although this is a step in curbing patronage politics in San Sebastian, many residents, who are used to asking money from local politicians, are not too happy with the change from previous administrations, even giving the LCE the moniker, kuripot (stingy).

The mayor, however, is unperturbed. His experiences as a native and retired chief of police of San Sebastian provided him a full understanding of the people and the challenges faced by his municipality. He is also a seasoned politician with three terms as vice mayor before running as mayor in 2013. His simplicity is reflected in his vision for the municipality which is “tuldukan ang kahirapan [to end poverty].” His very simple, almost
self-effacing demeanor, makes it easy for a common Sebastiyanon to connect with this mayor.

Although these are not all health-related initiatives, these changes impact on the local health delivery system to rationalize the existing local bureaucracy. In the long run, a more efficient and less corrupt LGU would be able to provide better health services to San Sebastian residents.

**B. Partnership with Zuellig Family Foundation**

While it may be premature to impute all the health gains in San Sebastian to the presence of ZFF, many of the research participants, especially the municipal leaders and health workers, were emphatic of the crucial role of ZFF. Based on the interviews and the focus group discussions (FGDs), the partnership with ZFF brought the following changes:

1. **A Cohort of Health Champions with Strong Leadership Potentials**

   A sense of leadership that is more connected with the community is very much appreciated by those who were able to attend the Bridging Leadership (BL) courses offered by ZFF. For the local leaders and health workers, they now have a better understanding of their “leadership roles” to find solutions to health and other health-related issues. One training participant was struck by how much the first module targeted the “heart” of the participants. She appreciated how they were made aware that “leaders should have a heart for the poor given the hard reality of health services provision on the ground.”

   Another research participant shared how the ZFF training modules opened her eyes to the possibility of doing more to help improve the health situation of the municipality. For this health worker, she had a stronger sense of ownership of health-related initiatives in the municipality and realized that they, the municipal officers and workers, could actually initiate health projects in the municipality.

   The ZFF training made them conscious of the importance of selling these projects and initiatives to other stakeholders on the ground. Once these stakeholders “buy into” their health projects and initiatives, the municipal officers and workers could then rely on these additional partners on the ground. Indirectly, this would result to less tension and resistance in the course of project implementation. Trust is, indeed, crucial to build more social capital (Field 2003) that could result into having more partners and supporters for health programs and initiatives.

2. **Improved Network with Potential Development Partners**

   The partnership with ZFF provided San Sebastian with the needed social capital by expanding its social network, including the trust (Field 2003) of other possible partners for the municipality’s health and development projects and initiatives. The positive results of ZFF’s initial engagements in San Sebastian bolstered the level of trust of other funding agencies in providing additional help to the municipality. Through social connections (social network) of previous MHO, the municipality was able to request for a new ambulance from the RHU after 10 years. A key informant attributed the quick release of the ambulance to the positive assessments made by the regional head office due to the improvements in the municipality’s implementation of the MCPHW. Today, there is a more efficient referral system from the RHU to the provincial and, whenever needed, to the regional health facilities.

   Based on the interviews conducted in San Sebastian, the training provided by ZFF expanded the network of participants and empowered them to explore other potential partners for local development initiatives. Examples here included the request submitted for another ambulance from the Philippine Charity Sweepstakes Office (PCSO). Through the ZFF training and mentoring, municipal leaders also became aware of an alternative source of cheaper medicines, the PITC Pharma (PPI), a government-owned and controlled corporation that sells medicines at drastically reduced prices. The decision to buy medicines from PPI resulted in huge savings for the municipality.

   The ability to network with other possible partner agencies was also evident in the interviews done with various officials of the municipality. For example, the MHO has taken advantage of every opportunity, whether it is a conference or a training course, to be always on the lookout for possible development partners. The health workers have been “proactive” in connecting with organizations that could possibly partner with the municipality in providing the needed services (i.e., Gawad Kalinga for housing) for the residents of San Sebastian.

   Since May 2014, PBSP Impact Program has been the partner of San Sebastian for the control and management of tuberculosis. Two international humanitarian agencies, OXFAM and Save the Children also provided additional assistance. Save the Children provided additional equipment (i.e., beds and examination tables) and supplies (e.g., Hyposol) for birthing facility and rural
health units. Meanwhile, OXFAM recently released a total of 28 fishing boats to help fishermen whose equipment were damaged by Typhoon Ruby in December 2014.

While the health targets of the community are still to be reached, the deep sense of service to the community manifested by the municipal health workers is, by itself, an accomplishment. True to the appreciation of Field (2003), these empowered agents (individuals) use all their existing networks as social capital to find the necessary resources for the municipality. In the end, the social networks established initially through ZFF provided new and alternative sources of partnerships for San Sebastian.

3. A More Holistic Development Paradigm

Another interesting note about the officials of the municipalities that were interviewed was their holistic and systemic view of improving the health situation in the municipality. For one, there is an acknowledgment that health is invariably connected with the livelihood opportunities available to the residents of San Sebastian. Unless the economic issue of the municipality is sufficiently addressed, the overall health condition of the municipality will, likewise, not improve perceptibly. According to one health worker, “Any health initiative in the municipality will not be sustainable unless the livelihood issue of the families in San Sebastian is sufficiently addressed.”

Another health worker emphasized the need for forward thinking. For example, he would like to address the housing problem of the municipality, especially the most vulnerable households residing in the easily flooded barangays of San Sebastian. By relocating the households, the resources of the municipality will not be dissipated in evacuating and housing these families every time there is a storm (surge). Thus, the LGU, including the RHU, can focus its much-needed resources on regular health projects.

While these municipal leaders and health workers were aware of the connections between socioeconomic conditions and health, it was emphasized and reinforced many times in the ZFF training they attended. To be able to achieve a long-term improvement in the health conditions of San Sebastian residents, all health workers also emphasized the urgency to address the other basic services in the municipality. They mentioned the need for a regular supply of potable water in the whole of San Sebastian to prevent water-borne diseases and to remove the additional economic burden of having to “buy” potable water regularly. The group also emphasized the need for families to have alternative livelihood opportunities. One FGD participant pointed out that achievements in health gains would be temporary until families would have enough money to buy food for sustenance.

While it may be too early to tell, this emerging holistic development paradigm of the leaders and health workers of San Sebastian is valuable knowledge. It is a resource, a form of social capital that can be tapped in encouraging health workers, local leaders and other stakeholders to work together for a longer-term sustainable development agenda for San Sebastian. Moreover, the same social capital will be handy in future social networking attempts of these actors for potential development partners of the municipality.

C. Existing Government Programs and Guidelines to Improve the Delivery of Basic Services

The improvement of remuneration for the health workers of San Sebastian was not difficult to implement because of the existing laws and provisions protecting the welfare of health workers. As indicated in our interviews with these health workers, they actually cited the provisions of RA 7305, or The Magna Carta of Public Health Workers, and also, the Joint Circular 1, Series of 2015 on the Rules and Regulations on the Grant of Compensation-Related Magna Carta Benefits for Public Health Workers, in making the request with the municipality of San Sebastian to increase the amount of hazard payment provided to them.

The contract of the previous Doctor to the Barrio (DTTB) ended in 2013 and at that time, the municipality had no MHO pending its request for another DTTB. As a result, the bulk of health-related work fell on the shoulders of the lone nurse and two midwives in the municipality. Armed with the knowledge of the provisions of RA 7305, these health workers utilized this knowledge, plus their crucial role, in the health delivery system of the municipality as social capital to connect and lobby with concerned municipal officials so that the additional provisions as stipulated in RA 7305 could be implemented in San Sebastian.

As a matter of fact, the full implementation of the MCPHW as defined by the health workers in San Sebastian, did not go through the usual process of local health board resolution that needed approval of the SB. As one municipal official claimed, “...there is no need to come up with a resolution since the provisions that these workers are requesting for, are already stipulated in the
magna carta law.”

True to the premise of Giddens’ structuration theory (1976 and 1984), San Sebastian’s health workers acting as empowered individuals or agency used available resources (social capital) to negotiate for a more beneficial implementation of the existing rules covering the health workers (RA 7305, or The Magna Carta of Public Health Workers, and also, the Joint Circular 1, Series of 2015 on the Rules and Regulations on the Grant of Compensation-Related Magna Carta Benefits for Public Health Workers). As a result, these health workers were able to renegotiate a better position within the municipality.

While there were factors that facilitated the implementation of improvements in the health delivery systems, there were factors that also hindered some of these initiatives. The challenges were both structural and personal and discussed in the next section.

Remaining Challenges

1. The socioeconomic condition of San Sebastian

The municipality has a minimal population growth rate of 1.15 percent in 2007 (San Sebastian Municipal Profile c. 2014). One research participant claimed that the municipality was actually an “out-migration” area because there were very limited economic opportunities in the municipality. Meanwhile, another interviewee expected no drastic economic improvement in San Sebastian within the next decade. Still another municipal worker mentioned that around “75 percent of the population is classified poor, and only about 300 families are considered non-poor.”

Aside from the seasonal nature of their livelihood, the situation even got worse for the fisherfolks of San Sebastian. There was a noticeable dwindling volume of fish caught in Maqueda Bay. Some research participants attributed the situation to “overfishing” and the lack of policy from the Department of Agriculture (DA) to protect or rehabilitate selected portions of the bay. Some farmers have been experiencing huge losses every time seawater comes in and inundates their rice farms. The saline water kills the rice resulting to minimal or zero harvest for these farmers.

Mothers, barangay health works and health workers attributed the high incidence of malnutrition in San Sebastian to lack of livelihood opportunities in the area. The children do not have enough to eat (walang makain) and this is the primary reason many children in San Sebastian are underweight. Based on the 2012 Municipal Profile of San Sebastian, the average yield per hectare is between 10 and 20 sacks with an average tenant farmer earning about P1,600 to P3,200 cropping cycle per year. There are two cropping cycles per year, one is from June to July while the other one is from November to December. According to FGD participants, the volume is sometimes not even enough to pay the loan used to buy the farm inputs. This situation further exacerbates the marginalized living conditions of the farmers in San Sebastian.

In the long term, the inadequate income of the 80-percent fishing and farming dependent households in San Sebastian severely limits their capacity to provide the needed sustenance for the members of the family. Much of the assistance provided temporary improvement on the health conditions of selected household members. In this sense, development initiatives that do not address the root cause of the problem appear to be only “cosmetic” or palliative, at best.

2. The limited income of the LGU

Since there are limited businesses in the municipality, its tax base is quite small. According to the municipal treasurer, the municipality is 98-percent internal revenue allotment dependent. This has both direct and indirect implications on the delivery of basic services including health services. The capacity of the LGU to finance development projects is minimal. Unless assisted by the national government or other external organizations, it will be difficult to construct basic infrastructure, such as potable water system and irrigation system. The absence of these two basic infrastructure severely limits the development potential of the municipality. For the health workers, they see the urgency of addressing the water problem of the municipality as having a direct implication on the health conditions of the residents. One health worker is thankful that they have not encountered any health outbreaks like diarrhea given that potable water is widely unavailable in the municipality. During the FGD with the BHWs, however, they have confirmed that diarrhea is increasingly becoming a concern in some barangays.

Mothers and some BHWs also mentioned how the lack of irrigation system negatively impacts on the nutrition of the children because farmers are dependent on the season to do their cropping. This means planting cycles in San Sebastian is limited to two cycles a year and a lower yield per hectare. The huge amount of money needed to address this problem is definitely beyond the capacity of the LGU. The municipality has a standing application with the national government and
was promised to have its irrigation system constructed soon. Given the current financial liability of the LGU with GSIS and Land Bank of the Philippines, the capacity of the LGU to implement even small infra project is severely limited.

3. The existing health infrastructure and health force structure

The leaders, health workers and residents of San Sebastian are thankful because they now have a MHO through the DTTB program of the DOH. However, research participants also express the desire to have a permanent doctor for the municipality who does not have to leave the community after two years. While all the key informants express satisfaction with the quality of work and dedication of the past and current MHO, both of whom are DTTB, they regret that the DTTB program of the DOH lacks continuity. Physicians, even those who have the heart for development, have different strategies, projects and initiatives making it difficult to sustain the health gains made by each doctor. Furthermore, each new doctor needs time to get adjusted to local culture. This requires additional effort on the part of every new MHO instead of focusing solely on providing quality health services to the people of San Sebastian.

Since the municipality has a birthing facility that needs to be manned 24/7 and two barangay health stations (BHS) in Campiyak and Hita-asan, the three rotating health workers are also inadequate. These workers go on 24-hour duties in the birthing station and during the day, they also do routine health procedures in the RHU and BHS. In effect, all three health workers are working more than 40 hours a week without overtime pay. In lieu of overtime pay, municipal health workers are allowed to have days off. Between their 24-hour duty at the birthing station and routine duties at the RHU/BHS, they barely have time to visit other BHS at Barangay Hita-asan. With the increasing number of TB patients, the municipality also needs the regular presence of a medical technologist to do the sputum test and follow-ups, including the monitoring of other household members exposed to the disease.

4. The perceived weak personality of the mayor

The inability of the mayor to come up with quick decisions and be less “consultative” was perceived by some to be a sign of weakness. For these research participants, the mayor was at times considered weak and indecisive resulting in problems not being properly addressed. Though the participants did not directly verbalize it, there seemed to be an implicit expectation for local leaders to be more dominant and assertive (e.g., Hollnsteiner 1963).

A number of research participants mentioned the predisposition of the mayor to consult his staff before he makes a final decision. In some instances, members of the mayor’s staff were perceived to be “too powerful,” much to the dismay of some residents and municipal workers. As pointed out by Field (2003: 86), the consultative process can actually be dominated by a small group of community leaders. These community leaders may use their own social capital or networks to make sure that others are excluded and their views deemed as illegitimate. This is exactly what Field (2003) referred to as “negative” social capital, when individuals sharing a particular network use their connections to use available resources to better themselves and to further exclude those who are not part of the network.

This attitude of the current mayor can be understood better in the light of administrative problems encountered by the previous administration. The mayor explained that he wanted to make sure that he was not violating any rules and procedures. Also, given the challenging financial situation of the municipality, he wanted to make sure that there were enough funds before committing the municipality to any new project and initiative.

5. Pervasive local culture

Many research participants were hesitant to admit that there were political schisms within the municipality. If ever there were, “naayos naman at napapag-usapan [resolved and discussed].” However, additional probing indicated that the mayor and a good half of the SB did not see things eye to eye. Some health workers were also hesitant to support the programs and initiatives of the current administration even when the merits of such programs were evident. For them, support for the programs is equated with support of the incumbent. Apparently, there was no distinction between programs and personalities, and for some residents, actions and decisions were still primarily determined by personal, rather than communal interests.

A pervasive “traditional world view” of some residents was also indicated by the residents’ inability to plan their future such as controlling their respective family sizes, saving even a small amount for future needs and the practice of expecting dole-outs from the government. As one municipal officer lamented, “Ang mga tao dito hindi nagpapalano, madami mag-anak, ubos-biyaya. [People here do not plan, they have too many children and use all available resources.]” Another local official cited the “over-dependence” on LGU and other
organizations providing assistance to the community. This pattern of mendicancy, wait-and-see attitude and passivity to external events may be construed by some observers to be indications of Lewis (1961) highly controversial culture of poverty thesis.

Specific to health-related concerns, there is still a need to address the health-seeking behavior of the residents. Even with the availability of medicines and services at the RHU, many mothers still do not avail of these services. One health worker cited that this behavior was partly due to the “poor road conditions in the municipality” and it could be partly addressed with good information and education campaign.

She cited that given the many incentives being offered to mothers to avail of RHU services, there is no reason San Sebastian is not reaching its health targets. Compared to what she encountered several years ago, the conditions now are much better. San Sebastian has a birthing facility and the continued support of the DOH in terms of additional medicines and equipment. There is also the capitation fund from Philippine Health Insurance Corp. that can be used to augment the operating budget of RHUs. However, San Sebastian’s achievement of its health targets remains low. She attributed this to the “passive attitude” of the local health workers to do more aggressive information and education campaigns in the barangay and to encourage mothers to go either to the RHU or the BHS.

Without justifying these practices, the disadvantaged social locations of many in San Sebastian meant that they have very limited access to resources and are bound by stifling social rules. For individuals with precarious existence, the strategies for survival is quite limited. Theirs is a lifelong economic and social deprivation that encourages the practice of latching on to someone who can provide the much-needed resources. And in areas with limited opportunities like San Sebastian, one of the time-tested survival strategies is to find a patron (a government or private organization or individual) who can provide even a portion of the much-needed resources for survival. Meanwhile, the passivity of some workers may have stemmed from generations of not seeing any palpable structural change on the ground. There is no point in slaving to death knowing that no drastic change is likely to happen anytime soon.

Conclusions
For some observers, the implementation of MCPHW in San Sebastian may seem inadequate. However, the improvements made in its implementation are already an achievement given the huge resource constraints faced by the municipality—a bureaucracy with insufficient funds to pay its employees regularly and to honor its commitments with previous debtors.

It would have been much easier for the current municipal of administrators to hide behind the exclusions stipulated in the MCPHW. As stated in DBM and DOH Joint Circular 1, Series of 2012, the implementation of RA 7035 is subject to availability of funds. Thus, LGUs actually have some leeway on how much and what specific provisions of the MCPHW will be given to their health workers. As LGUs vary in financial capacity, this resulted to uneven implementation of the law, not only across, but also within municipalities. In the case of San Sebastian, however, the confluence of structural and individual factors made the improvements in the municipal health delivery systems possible.

The research participants attributed this limited success to five major factors, namely:

1. The policy environment (RA 7305 and DBM and DOH Joint Circular 1, Series of 2012) that enabled the implementation of such health initiatives;
2. The local sociopolitical context that provided the local leaders some leeway in the interpretation and implementation of these health initiatives;
3. The heightened level of trust and confidence on the LCE. This provided the mayor with sufficient amounts of social capital that encouraged a select group of local officials to rally behind him. Additional linkages and networks were established within and outside San Sebastian providing the mechanisms to access additional resources for the municipality;
4. The additional resources made available to the members of the community further boosted the current administration’s level of social and political capital to allocate, without stiff opposition, the needed resources to increase the compensation and allowances of the local health workers; and
5. The institutionalization of the improvements in the implementation of MCPHW, the additional compensation for the health workers is covered by a SB resolution. Once part of the annual municipal budget, future municipal administration has no choice but to continuously implement these improvements.

Recommendations
San Sebastian still has a long way to go before it can be considered a model of health development. The municipality needs to address both structural and cultural
issues so that the small gains that have been achieved can be institutionalized and be made sustainable. According to Mahoney and Thelen (2010), institutional change does not necessarily have to involve massive and drastic upheavals. Similar to the small gains thus achieved in San Sebastian, institutions can transform in a more gradual manner. Rules, for example, can be strictly adhered to and/or negotiated by social agents to effect a more gradual institutional change. Given the duality of structures (Giddens 1976 and 1984), this slow and gradual institutional change would ultimately alter the available resources and pervasive rules within the institution. As indicated in the preceding discussion, the LGU of San Sebastian is slowly changing as indicated by the small achievements in the delivery of health services and in the implementation of the MCPHW. Hopefully, sustaining these changes would transform the LGU to be more efficient and rational. One good indication of such transformation is the capability of the LGU to continuously improve the delivery, not only of health, but all other basic services. A revitalized LGU would also expand the quality of networks available to the residents within and outside San Sebastian. These networks serving as social capital would enable the establishment of better partnerships with other development organizations keen on providing assistance to San Sebastian. This would eventually result in an overall better life for the residents of the municipality.

1. Strengthen Further Local Institutions for the Delivery of Basic Services

The delivery structures, not only of health services but also other services in San Sebastian, have already been invigorated. Leaders have been capacitated to think outside the box and to think of strategies in partnership with other stakeholders and the rest of the community. However, a mechanism must be developed to make sure that the consultation process followed by the local government is inclusive, genuine and reaching down to the level of the barangay. To avoid negative social capital that foster exclusive networks, social networking in San Sebastian should extend to all members of the municipality and go beyond individuals that are closest to the mayor. In this manner, development programs and initiatives would have a wider support base.

2. Creative Blending of Traditional and Modern Cultural Practices

As with many modernizing societies, two cultural patterns of behavior exist side by side in San Sebastian. One set reflects the efficient and rational modern bureaucracy while the other reflects the more traditional and personalistic pattern of social relations. As suggested by De Charentenay’s (2014) hybrid politics, the solution to any social problem should not be through the destruction of the traditional way of life but rather through the creative merging of traditional structures and modern bureaucracy.

Applying this notion to the challenges facing San Sebastian, stakeholders must be encouraged to go beyond personal relations with the municipal officers in the hope of gaining favors for the family and community. Emphasis, rather, should be on working to make existing local government institutions efficient in delivering quality basic services. The propensity to focus on immediate personal networks even among municipal officers should be discouraged. Instead, efforts to make these networks more inclusive should involve all residents of the municipality.

Also, in the spirit of strengthening and rationalizing the local bureaucracy, all workers especially health workers, should always aim for greater efficiency and have a proactive attitude toward service delivery to achieve targets. This does not, in any way, recommend the complete negation of important traditional values. Rather, what is being recommended is a creative combination of modern and traditional cultural patterns that would encourage a more efficient bureaucracy.

The everyday strategies of the people of San Sebastian to recognize the existence of both modern and traditional social structures provide the necessary resources to strengthen the LGU and other local institutions in the municipality. These institutions would be rational, efficient and, at the same time, inclusive enough to accommodate cultural diversity.

3. Pursue of a Long-Term Holistic Development Goal for the Municipality

The leaders, workers and ordinary residents of San Sebastian are quite knowledgeable about the complexity of problems confronting them. The connection between health issues and other development problems such as livelihood and absence of basic infrastructure is very clear to them. Thus, in the long term, an improved health profile of the municipality can be pursued in conjunction with the delivery of other basic services, such as a reliable water system and irrigation system for the municipality. Given the resource constraints perennially faced by the LGU, better networking skills and opportunities especially for the leaders of the municipality should be fostered.
Synopsis

This study examined maternal healthcare utilization among the beneficiaries of the Zuellig Family Foundation Recovery Assistance Program (RAP) implemented in select Philippine municipalities devastated by Supertyphoon Yolanda (International name: Haiyan) in 2013. The program aimed to increase the demand for maternal healthcare (MHC) services among poor women by providing temporary support in the form of cash incentives received after availing of prenatal care, facility-based delivery (FBD) and postnatal care services. The objectives of the study were to compare the socio-demographic profile, health-seeking behavior and perceptions regarding MHC services of RAP beneficiary women who did not give birth in a health facility and those who availed of FBD services; determine the demand-side and supply-side factors involved in their utilization of MHC services; as well as identify the leverage points and bottlenecks in program implementation.

Employing both interview and household survey, the findings showed that mother’s education, age at first pregnancy, and availment of complete and timely prenatal care visits were significant determinants in the utilization of FBD among the beneficiaries of the RAP.

Methodology

The study employed a mixed-methods approach using interviews and a household survey with a nested qualitative component. The data was derived from a sample of beneficiary mothers from the municipalities where the program was implemented. The probability of FBD and the probability of mothers having complete and timely prenatal care visits were determined using probit analysis. Marginal effects for selected socio-demographic, demand-side and supply-side variables were estimated to identify the determinants of MHC utilization.

The key findings suggest that mother’s education, age at first pregnancy, and availment of complete and timely prenatal care visits are significant determinants in the utilization of FBDs among the beneficiaries of the RAP. Moreover, the findings reveal that the probability of mothers having complete and timely prenatal care visits are directly and significantly associated with the provision of urinalysis services during a previous visit, transportation costs incurred, child’s birth order, and the mother’s age at first pregnancy.

The results suggest that, aside from socio-demographic factors, the demand for MHC is also an important driver for FBD. This finding is supported by

Sampling and estimation procedure

- Mixed-methods approach, with data derived from a sample of beneficiary mothers from the 11 municipalities where the program was implemented.
- The probability of FBD and the probability of mothers having complete and timely ANC visits were determined using probit analysis (marginal effects).

\[ y_i = \alpha + \beta T_i + \sum_{p} \gamma X_{pi} + \eta_i \]

Where

- \( y \) denotes the outcome for individual \( i \)
- \( \alpha, \beta, \gamma \) are fixed parameters
- \( T \) is the covariate of interest representing individual, household, demand-side factors and supply-side factors
- \( \eta \) is the random error term
- \( X \) is a set of \( p \) individual-specific variables
qualitative responses on healthcare-seeking behavior and perceptions regarding MHC services. The importance of supply-side factors, especially in a post-disaster setting such as the availability and accessibility of healthcare services, is pronounced in prenatal care utilization. These findings provide evidence of the importance of supply- and demand-side factors in influencing MHC service utilization at different stages.

**Highlights**
Determinants of MHC utilization (What factors influence RAP beneficiaries’ access to essential MHC services?)

**FBD—Household characteristics**
- Completed at least high school—women with higher educational attainment have a higher likelihood of delivering at a health facility. Level of education matters as only those who completed high school or higher were found to have a significant effect on FBD.
- Has had miscarriage—women who have had a miscarriage were more likely to deliver at a health facility. These women are usually classified as high-risk and would therefore receive extra attention from health workers.
- Age at first pregnancy—those who had their first pregnancy at a younger age were more likely to deliver at a health facility. Women who became pregnant earlier had more children, on average. This could indicate more exposure to information regarding safe pregnancy.
- Household size
  - **FBD—Demand for health services**
    - Complete and timely number of prenatal visits
    - Had FBD for other pregnancies
  - **Prenatal—Mother’s characteristics**
    - Makes maternal health-related decisions
    - Age at first pregnancy
  - **Prenatal—Household characteristics**
    - Household is a Pantawid beneficiary
  - **Prenatal—Supply of health services**
    - Mother was given urinalysis
    - Travel time to prenatal facility

**Perceptions of the mothers**
- Reason for home-based delivery for recent pregnancy – *naabutan*, no safe transportation going to the facility
- Reason for FBD for recent pregnancy—FBD is perceived to be safer
- If there was no incentive—perceived good quality of staff and services

- Experience of RAP beneficiary women in utilizing MHC services

**Implementers’ perceptions and experiences with MHC provision**

- **Dimension of Factors (FGD and KII highlights)**
  - [Geographical accessibility] For women in geographically isolated and disadvantaged areas (GIDAs), timing the prenatal on the same day as the incentive disbursement was essential.
  - [Availability] A number of health centers were still undergoing reconstruction after Yolanda.
  - [Affordability] If lab services are available at the health facility, no cost is borne by the mother. Otherwise, the mother has to cover lab fees.
  - [Acceptability] For some mothers whose delivery suddenly occurred, it was likely that there was no intention to deliver at a health facility.
    - ⇒ Some prefer to deliver with TBAs who provide “after-care” services
    - ⇒ Incentives encouraged earlier prenatal care visits, leading to timely and complete utilization of PHC

**Conclusions**
- Pregnant women from post-disaster and GIDAs face several demand and supply barriers and enablers
- The accessibility and quality of services are motivations for women to avail themselves of MHC services
  - The importance of supply-side factors is more pronounced for PNC utilization
- Aside from socio-demographic factors, women’s perceptions and knowledge of MHC are also an important driver for FBD.
- Conditional-cash incentives should be complemented by addressing demand and supply-side issues:
  - Providing information campaigns to encourage MHC service utilization
  - Making health facilities more available and accessible
    - ⇒ Investing in diagnostic service
    - ⇒ Investing in “halfway homes” for pregnant women
- Focus efforts on pregnant women with individual characteristics that predispose them to underutilize FBD or other MHC services.
### Table 1: Determinants of MHC utilization: FBD (Mother’s characteristics)

<table>
<thead>
<tr>
<th>Survey variable</th>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
<th>Model 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>First pregnancy</td>
<td>0.1225</td>
<td>0.0948</td>
<td></td>
<td>0.0883</td>
</tr>
<tr>
<td></td>
<td>[0.1029]</td>
<td>[0.1154]</td>
<td></td>
<td>[0.1176]</td>
</tr>
<tr>
<td>Completed at least elementary education</td>
<td>0.0368</td>
<td>0.0584</td>
<td>-0.0305</td>
<td>0.0594</td>
</tr>
<tr>
<td></td>
<td>[0.1267]</td>
<td>[0.1108]</td>
<td>[0.1297]</td>
<td>[0.1117]</td>
</tr>
<tr>
<td>Completed at least high school</td>
<td>0.2484***</td>
<td>0.2956***</td>
<td>0.1944*</td>
<td>0.2937*** [0.0807]</td>
</tr>
<tr>
<td></td>
<td>[0.0866]</td>
<td>[0.0814]</td>
<td>[0.0991]</td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>-0.0153</td>
<td></td>
<td>-0.0118</td>
<td></td>
</tr>
<tr>
<td></td>
<td>[0.0852]</td>
<td></td>
<td>[0.0845]</td>
<td></td>
</tr>
<tr>
<td>Has had miscarriage</td>
<td>0.1846***</td>
<td></td>
<td>0.1859** [0.0717]</td>
<td></td>
</tr>
<tr>
<td></td>
<td>[0.0714]</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Makes maternal health-related decisions</td>
<td></td>
<td>0.0153</td>
<td></td>
<td>[0.0808]</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of children</td>
<td>-0.0402</td>
<td>0.0410</td>
<td>-0.0029</td>
<td>0.0397</td>
</tr>
<tr>
<td></td>
<td>[0.653]</td>
<td>[0.0443]</td>
<td>[0.0251]</td>
<td>[0.0449]</td>
</tr>
<tr>
<td>Age</td>
<td>-0.0100</td>
<td></td>
<td>-0.01254</td>
<td></td>
</tr>
<tr>
<td></td>
<td>[0.0443]</td>
<td></td>
<td>[0.0465]</td>
<td></td>
</tr>
<tr>
<td>Age at first pregnancy</td>
<td>-0.3110**</td>
<td></td>
<td>-0.3027* [0.1570]</td>
<td></td>
</tr>
<tr>
<td></td>
<td>[.1576]</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*p&lt;0.1; ** p&lt;0.05; *** p&lt;0.01</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: Standard Error in Brackets

### Table 2: Determinants of MHC utilization: FBD (Household characteristics)

<table>
<thead>
<tr>
<th>Survey variable</th>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
<th>Model 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Household is a Pantawid beneficiary</td>
<td>-0.0206</td>
<td>0.0162</td>
<td>-0.0094</td>
<td>0.0222</td>
</tr>
<tr>
<td></td>
<td>[.0947]</td>
<td>[.0790]</td>
<td>[.1106]</td>
<td>[.0798]</td>
</tr>
<tr>
<td>Household size</td>
<td>-0.0309*</td>
<td></td>
<td></td>
<td>-0.0324*</td>
</tr>
<tr>
<td></td>
<td>[.0181]</td>
<td></td>
<td></td>
<td>[.0181]</td>
</tr>
</tbody>
</table>

### Table 2: Determinants of MHC utilization: FBD (Demand for health services)

<table>
<thead>
<tr>
<th>Survey variable</th>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
<th>Model 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete no. of prenatal visits</td>
<td>0.1060</td>
<td>.2620+</td>
<td>0.0916</td>
<td>0.2762+</td>
</tr>
<tr>
<td></td>
<td>[0.0773]</td>
<td>[0.1809]</td>
<td>[0.1748]</td>
<td>[0.1830]</td>
</tr>
<tr>
<td>Complete and timely no. of prenatal visits</td>
<td>0.1671</td>
<td>0.0909</td>
<td>0.1551*</td>
<td>0.0955</td>
</tr>
<tr>
<td></td>
<td>[0.1862]</td>
<td>[0.0826]</td>
<td>[0.0927]</td>
<td>[0.0825]</td>
</tr>
<tr>
<td>Had FBD for other pregnancies</td>
<td>0.2386*</td>
<td></td>
<td>0.2762+</td>
<td></td>
</tr>
<tr>
<td></td>
<td>[0.0929]</td>
<td></td>
<td>[0.1830]</td>
<td></td>
</tr>
</tbody>
</table>
### Table 4: Determinants of MHC utilization: FBD (Supply of health services)

<table>
<thead>
<tr>
<th>Survey variable</th>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
<th>Model 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother was given urinalysis</td>
<td>0.1528</td>
<td>0.1205</td>
<td>0.2050</td>
<td>0.1286</td>
</tr>
<tr>
<td>[0.1375]</td>
<td>[0.1343]</td>
<td>[0.1754]</td>
<td>[0.1312]</td>
<td></td>
</tr>
<tr>
<td>Mother was given CBC test</td>
<td>0.0088</td>
<td>0.0892</td>
<td>-0.0205</td>
<td>0.0753</td>
</tr>
<tr>
<td>[0.1234]</td>
<td>[0.1209 ]</td>
<td>[0.1416]</td>
<td>[0.1162]</td>
<td></td>
</tr>
<tr>
<td>Transportation cost</td>
<td>-0.009</td>
<td>[0.0015 ]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Travel time to prenatal facility</td>
<td>.0100</td>
<td>[0.0012]</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Table 5: Determinants of MHC utilization: Prenatal (Mother’s characteristics)

<table>
<thead>
<tr>
<th>Survey variable</th>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
<th>Model 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>First pregnancy</td>
<td>0.1969</td>
<td></td>
<td>0.1962</td>
<td></td>
</tr>
<tr>
<td>[0.1548]</td>
<td>[0.1462]</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Completed at least elementary education</td>
<td>0.1092</td>
<td>0.0468</td>
<td>0.0421</td>
<td></td>
</tr>
<tr>
<td>[0.1567]</td>
<td>[0.1848]</td>
<td>[0.1584]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Completed at least high school</td>
<td>-0.0718</td>
<td>-0.0873</td>
<td>-0.0455</td>
<td></td>
</tr>
<tr>
<td>[0.0980]</td>
<td>[0.1094]</td>
<td>[0.0964]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>0.0917</td>
<td>0.1245</td>
<td></td>
<td></td>
</tr>
<tr>
<td>[0.0971]</td>
<td>[0.0930]</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has had miscarriage</td>
<td>0.0675</td>
<td>0.1018</td>
<td></td>
<td></td>
</tr>
<tr>
<td>[0.1224]</td>
<td>[0.1124]</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Makes maternal health-related decisions</td>
<td>-0.1756 *</td>
<td></td>
<td>[0.1028 ]</td>
<td></td>
</tr>
<tr>
<td>Number of children</td>
<td>-.0439</td>
<td>-.0082</td>
<td>-.0302</td>
<td></td>
</tr>
<tr>
<td>[0.0546]</td>
<td>[0.0333]</td>
<td>[0.0545]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>-.0406</td>
<td>.0657</td>
<td>.0957+</td>
<td></td>
</tr>
<tr>
<td>[0.0197]</td>
<td>[0.0653]</td>
<td>[0.0957]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age at first pregnancy</td>
<td>-.1326* [.0697]</td>
<td></td>
<td>-.1382** [.0662]</td>
<td></td>
</tr>
<tr>
<td>+ p&lt;0.15; * p</td>
<td></td>
<td>&lt;0.1; ** p&lt;0.05; *** p&lt;0.01</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: Standard Error in Brackets

### Table 6: Determinants of MHC utilization: Prenatal (Household characteristics)

<table>
<thead>
<tr>
<th>Survey variable</th>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
<th>Model 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Household is a Pantawid beneficiary</td>
<td>-0.0961</td>
<td>-0.1663+</td>
<td>-0.1771</td>
<td>-0.1947* [0.1065]</td>
</tr>
<tr>
<td>[0.0923]</td>
<td>[0.1098]</td>
<td>[0.1305]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Household size</td>
<td>.0410+</td>
<td></td>
<td>.0323</td>
<td></td>
</tr>
<tr>
<td>[0.0259]</td>
<td>[0.0242]</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Table 7: Determinants of MHC utilization: Prenatal (Supply of health services)

<table>
<thead>
<tr>
<th>Survey variable</th>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
<th>Model 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother was given urinalysis</td>
<td>0.3854***</td>
<td>0.2977**</td>
<td>0.2747+</td>
<td>0.2366+</td>
</tr>
<tr>
<td></td>
<td>[0.1236]</td>
<td>[0.1444]</td>
<td>[0.1883]</td>
<td>[0.1546]</td>
</tr>
<tr>
<td>Mother was given CBC test</td>
<td>0.0977</td>
<td>0.2977**</td>
<td>0.2747+</td>
<td>0.2366+</td>
</tr>
<tr>
<td></td>
<td>[0.1530]</td>
<td>[0.1444]</td>
<td>[0.1883]</td>
<td>[0.1546]</td>
</tr>
<tr>
<td>Transportation cost</td>
<td>0.0489</td>
<td>-0.0402</td>
<td>-0.0440</td>
<td>0.0633</td>
</tr>
<tr>
<td></td>
<td>[0.1428]</td>
<td>[0.1320]</td>
<td>[0.1773]</td>
<td>[0.1458]</td>
</tr>
<tr>
<td>Travel time to prenatal facility</td>
<td>-0.0119*</td>
<td>-0.0402</td>
<td>-0.0440</td>
<td>-0.0066***</td>
</tr>
<tr>
<td></td>
<td>[0.0061]</td>
<td>[0.1320]</td>
<td>[0.1773]</td>
<td>[.0022]</td>
</tr>
</tbody>
</table>

### Figure 1: Reasons for home-based deliveries despite RAP incentives

- **n=30**

- **Main reasons**
  - Delivery suddenly occurred at home: 16
  - Preference to deliver at home: 4
  - Long distance to the health center: 2
  - Unavailability of safe transportation: 3
  - Delivery occurred earlier than midwife's...: 3
  - Cost of delivery an issue: 1
  - Fear of hospital procedures: 1
  - Respondent is related to TBA: 1

- **Supporting reasons**
Figure 2: Reasons for home-based deliveries for recent pregnancy

n=79

- FBD perceived to be safer: 26 main reasons, 1 supporting reason
- Perceived good quality of facility, staff and services: 9 main reasons, 14 supporting reasons
- Knowledge that HBD is forbidden: 16 main reasons, 1 supporting reason
- Classified as high-risk pregnancy: 14 main reasons, 2 supporting reasons
- Short distance to the health facility: 6 main reasons
- Knowledge that delivery is free or low cost: 3 main reasons, 2 supporting reasons
- Identified as caesarian delivery: no main or supporting reasons
- To receive pregnancy diagnosis: no main or supporting reasons
- Due to RAP cash incentive: no main or supporting reasons

Figure 3: Experience of RAP-beneficiary women in utilizing MHC services

Travel to the health center

- FBD: 89% very bad, 13% bad, 24% indifferent, 59% good, 0% very good
- Non-FBD: 17% very bad, 7% bad, 27% indifferent, 47% good, 0% very good

Services offered at the health center

- FBD: 4% hospital beds, 23% medical supplies, 74% trained attendants
- Non-FBD: 10% hospital beds, 10% medical supplies, 80% trained attendants
For women in GIDA areas, timing the prenatal on the same day as incentive disbursement.

Availability
A number of health centers were still undergoing reconstruction after Typhoon Haiyan.

Affordability
If laboratory services are available at the health facility, no cost is borne by the mother. Otherwise, the mother has to cover laboratory.

Acceptability
For some mothers whose delivery suddenly occurred, it is likely that there was no intention to deliver at a health facility.

Some prefer to deliver with Traditional Birth Attendants (TBAs) who provide "after-care" services, such as giving mothers baths, washing dishes and laundry, or cleaning around the house while the mother is recovering from her delivery.

Incentives encouraged earlier PNC visits, leading to the timely and complete availment of PNC.

FGD and KII highlights

Dimensions of factors

Over-all experience with health workers

Helpfulness of health workers
Bridging Leadership as a Process to Address Health Inequities

Dr. Hermeraldo Catubig
San Pablo, Zamboanga del Sur

Mayor Benjamin Maggay
Cervantes, Ilocos Sur (UMAK Batch 1)

Mayor Divina Velasco
San Gabriel, La Union (HLGP Region 1)

Health inequities are differences in health conditions that are unjust and undesirable. These differences are results of socioeconomic status and discriminating practices or policies. In the country, being poor and living in rural communities may put women and children at greater risk of poor health outcomes. These disparities dictate the quality of health and availability of health opportunities among the disadvantaged individuals. The problem of health inequity can be seen in the higher number of maternal deaths among low-income regions of the country compared to high-income ones. There are also marked differences in access to birthing facilities and skilled birth attendants between the two income classes. Although health inequity requires immediate action, its nature as a social problem makes it difficult to address. Dealing with health inequity requires the Bridging Leadership (BL) approach which recognizes the complexity of the problem and the need for multisectoral collaboration to address it.

The three municipalities represented in the plenary session came from three Zuellig Family Foundation (ZFF) programs. San Pablo, Zamboanga del Sur underwent health leadership for the poor under the Community Health Partnership Program (CHPP). The CHPP is a two-year partnership with rural municipalities to address health inequities and achieve the Millennium Development Goals on Health. The primary objective of the CHPP is to empower and build the capability of communities and individuals. It also aims to 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.

In 2010, Cervantes, Ilocos Sur underwent Municipal Leadership and Governance Program through the partnership with University of Makati. This program was a one-year partnership program for mayors and municipal health officers (MHOs) wherein they were expected to improve their municipal health indicators as part of their course deliverables.

Recognizing the success of the ZFF’s Health Change Model (HCM), a partnership was formed in 2013 to address the need of the Department of Health (DOH) for a leadership and governance program. This partnership was a joint implementation of the department’s three-year Health Leadership and Governance Program, with ZFF providing the leadership capability-building programs and technical support to the DOH Regional Offices. San Gabriel, La Union was one of the municipalities under HLGP through partnership with the DOH Region 1.

To achieve their objective of addressing health inequities, all the three programs used the BL approach anchored in the ZFF HCM. In the plenary session, the three health leaders from the different programs discussed how the BL approach was used to address health inequities in their municipalities.

The three health leaders all came from fourth-class municipalities having average annual income of only P25 million to P35 million. Prior to ZFF engagement, all the three municipalities were characterized by low budget allocation for health programs, inaccessibility to quality health services and poor utilization by the community. For these municipalities, poor access to quality health services was due to bad road conditions, absence of health facilities and lack of trained health workers. Cervantes, Ilocos Sur was also considered a geographically isolated and disadvantaged area, thus, it was difficult for health services to reach far-flung barangays. The health leaders attributed poor utilization of health services to the cultural beliefs and traditional practices of the community people. The effect of culture to utilization of health services was more evident in Cervantes, comprised mostly of indigenous people. These health challenges in the municipalities translated into poor health indicators such as low facility-based deliveries (FBDs), low

1The BL process has been used by health leaders to address health inequities in their municipalities. Through the BL process of ownership, co-ownership and co-creation, bridging leaders own the issue; recognize their roles in the problems; engage other stakeholders for common understanding; establish new institutional arrangements; and co-create concrete steps, programs and services to bring about health equity.
rate of skilled birth attendants (SBAs) and incidences of maternal deaths. 

Through the BL approach, the health leaders were able to own these health challenges and took personal action. For Mayor Maggay, ownership of the problem meant having a deeper understanding of the health problems. He understood that these problems were complex and caused by a multitude of factors. According to him, it opened his eyes to see the health inequities in the municipality. For Dr. Catubig, ownership taught him to be a responsive leader. Initially, he felt disappointed when he saw the health problems in his municipalities and how the different factors aggravated them. However, he eventually saw it as a leadership challenge to make himself accountable for improving health sector in San Pablo. Mayor Velasco also shared this leadership challenge as she considered herself in the position to make significant changes for the community. The health leaders also mentioned personal values or experiences as sources of motivation whenever they find addressing the health problems to be very difficult.

After owning the problem, the health leaders shared their vision to other stakeholders through co-ownership. Dr. Catubig was able to maintain a good relationship with his local chief executive through dialogue. From being a subordinate, he felt as if they were partners in planning and implementing. Mayor Maggay used the concept of co-ownership to engage tribal leaders of the indigenous people in the barangays. He made sure that there was shared responsibility between the government and the community in improving health outcomes. Mayor Velasco also recognized that as a leader, she should establish a strong connection with stakeholders to secure their collaboration and to sustain their participation. An evident sign of how co-ownership was established in the three municipalities was the creation of active local health boards (LHBs). The LHB was seen to be very instrumental for health programs to progress. Sectoral representatives, especially the indigenous people, community leaders and even religious groups, were made to converge, plan and implement health programs themselves. The mayors and their MHOs also trained the members of the LHB on BL.

What are the results of these formed partnerships? The health leaders of San Pablo were able to co-create health programs adaptive to the needs of the community members. They focused on making health services available and accessible to the people. Through the Health Facility Enhancement Program of the DOH, a birthing facility was constructed in the main rural health unit (RHU). This has been operational 24/7 since 2010 through a solar power system. Roads and bridges for health were also constructed to connect barangays to the RHU. In addition to this, a halfway house was built along with procurement of emergency land and sea ambulances.

The health leaders of Cervantes focused on strategies to improve demand for health services by indigenous people. The first-ever indigenous people congress was held to advocate against practice of unsafe alternative medicine and gain mutual agreements in support of municipal health programs.

Women empowerment was the strategy used by the health leaders of San Gabriel to improve maternal and child health outcomes. They used networking to start a core group of RHU staff, midwives, and mothers who did data collection, validation and analysis of maternal health indicators. They also developed barangay health zones focusing on building capacities for women through health promotion, education and livelihood support.

The use of BL to address the health problems in the municipalities was found to be effective. All the local government units experienced an increase in FBDs and rate of SBAs through improved health-seeking behavior and participation of the community. San Pablo has been able to sustain zero maternal deaths for two years. Blood-letting activities have also been sustained until today. San Gabriel, on the other hand, has zero maternal deaths since 2009. There was also a decline in teenage pregnancies in the municipality. Cervantes had only one maternal death in 2015.

There are still health challenges that need to be addressed in each municipality. However, the upcoming elections could mean that the achieved health gains may cease to continue. Strategies used by health leaders to ensure sustainability include: a) enacting policies, executive orders and ordinances for next leaders to implement program; b) empowering the community to demand for services, and c) grooming other leaders to follow in their footsteps.
Redefining Primary Healthcare

Dr. Ernesto Domingo
Professor Emeritus, UPCM
Ramon Magsaysay Awardee, National Scientist

With special participation of:
Dr. Ma. Esmeralda Silva
Dr. Fely Marilyn Lorenzo
Dr. Ramon Pedro Paterno
Members, Universal Health Care Study Group

Synopsis

Primary healthcare (PHC) forms an integral part of a country’s health system, primarily focusing on the health of individuals, families and communities, as well as addressing the overall social and economic healthcare through active involvement and participation of communities\(^1\). It also plays a key role in achieving an acceptable level of health by making essential healthcare universally accessible in an acceptable, continuous basis, and affordable manner. It, therefore, follows that PHC should be an internal part of the overall development of a society. Aside from addressing the main health problems in the community, PHC encompasses primary care, health promotion and education, disease prevention, population health, and community development within a holistic framework, aiming to provide essential community-focused healthcare\(^2\). Countries identified to have developed primary healthcare system have better health outcomes among their population at a lower cost. In addition, PHC is highly significant in shaping the country’s investment choices\(^3\).

The first step a country can take to promote health equity for its people is the promotion of Universal Healthcare (UHC), providing access to full range of health services with financial protection. In line with this, PHC should be the foundation of UHC, which is the goal stated in the Philippine Constitution that every Filipino has the right to health and society has an obligation to look after the health of its people.

The session presented the identified gains and issues of the evolution of PHC approach, as espoused by different policy regimes from pre-primary healthcare era to the present “Kalusugang Pangkalahatan” (KP), or UHC, regime in the country. Social determinants of health including, but not limited to, socioeconomic status, education, geography were also discussed together with the pillars of UHC in determining the performance achievements and gaps. Finally, recommended PHC models that need to be instituted and implemented in the Philippines in order to attain the goals of UHC were also presented.

Defining Primary Healthcare

Dr. Domingo emphasized that there are various definitions of PHC. In the Philippines, one definition used is synonymous to UHC—All Filipinos are not only covered, but also can use needed healthcare based on health needs and not on ability to pay. This is in line with health being a fundamental human right as stated in the World Health Organization and the Philippine Constitution (Article II, Section 15). This means that Filipinos do not need substantial amount of out-of-pocket spending to use healthcare services. This does not translate to charity, since costs will be covered by taxes or Philippine Health Insurance Corp. (PhilHealth) premiums. This definition was also the basis of the Aquino Health agenda on KP—“a focused approach to health-reform implementation ensuring that all Filipinos, especially the poor, receive the benefits of health reform.”

Dr. Domingo also presented data from the survey “The Future of Health: Strengthening Health Promotion to Address Non-Communicable Diseases in the Philippines” showing that only 1.5 percent of the total population get hospitalized. This means that only 1.5 percent of the population access healthcare services and when they are already sick. The focus of PHC, therefore, should be providing healthcare services to the greater population even before hospitalization.

\(^3\)King, H. et.al. (2001). The Primary Health Care Strategy. Wellington, New Zealand: New Zealand Ministry of Health
He also presented the definition of PHC based on the declaration of Alma Ata and referred to the last sentence as the definition of “primary care”, which is the first level of contact of individuals, the family and community with the national health system, bringing healthcare as close as possible to where people live and work, and constitutes the first element of a continuing healthcare process. For him to establish PHC, the country should first focus on delivering primary care services.

**Historical trend in the Philippines’ primary healthcare (1970 to present)**

According to Dr. Silva, PHC implementation varied significantly in the Philippines across time since its adaptation from Alma Ata Declaration. It has been fragmented and outdated. Geographic factors; unavailability of health facilities, medical supplies and health human personnel; social barriers; and other indispensable costs in accessing healthcare limited PHC implementation in the country. Because of these, there is a need to revisit PHC, especially now that it is being adopted in the KP.

Dr. Silva presented the initial findings of their study, “Refiguring Primary Healthcare in the Context of Kalusugang Pangkalahatan.” In the presentation, information was given on the different health service delivery practices and patterns using PHC approaches in the country. Health system performance was also linked with PHC practices. Finally, PHC gaps and practices were identified, which were later on used to craft applicable models of PHC to ensure better implementation.

According to Dr. Silva, literature indicates that there has been no change in the PHC concept since its launch in 1978 despite the constant need for PHC to adapt to its evolving social setting. In recent years, however, emphasis has been given in the following concepts: a) achieving universal health coverage, b) focusing on entire population, particularly the disadvantaged, c) creating healthy environment, d) public and private health systems partnership, and d) efficient utilization of resources.

Dr. Silva presented the trends in health indicators from pre-PHC era to KP. It was shown that the Philippines has been lagging behind its Asian neighbors over the years. It can be seen below that the average number of years Filipinos expect to live is lower than the global median, even lower than Vietnam and Thailand.

The risk of dying among pregnant women, infants and children under 5 years also remain higher compared to the global median, Vietnam and Thailand. There is also no observable improvement in the trend of maternal mortality ratio from 1990 to 2013.

Prevalence of tuberculosis and mortalities associated to it have decreased throughout time.
However, the country still lags in controlling tuberculosis compared to the global median, Vietnam and Thailand.

For the identified health indicators, Dr. Silva also presented the rate of improvement per period of PHC adaptation. In general, the rates of change in health outcomes were not fast enough to show significant improvements. For indicators referring to mortality (life expectancy, infant and under-5 mortality), the highest rate of change was during the period of early PHC adoption and expansion (1978-1990).

Figure 2: Maternal mortality ratio (per 100,000 live births)*


Figure 3: Infant mortality rate (per 1,000 live births)
Further improvements have been minimal thereafter. This has also been highlighted by Ernesto D. Garilao during the discussion. Because of the devolution, the responsibility for health was handed down to municipal leaders who have little knowledge on health. The result was the stagnation of improvements in health outcomes.

Also, preliminary findings suggest that there is a low to moderate presence of PHC over the years.

**Social Determinants, Primary Healthcare and Primary Care: The Present**

Dr. Paterno introduced the concept of social determinants of health (SDH) as the root cause of disease and health inequities. The impact of SDH was demonstrated in the individual, national and intercountry level. In the individual level, disease is not limited to biologic causes requiring treatment or cure by medication. It is complicated by the individual’s economic, geographic status, or gender which place him or her at a disadvantage in the community. Within the country, health inequities exist between rural and urban regions because of these SDH. Health indicators are significantly better in urban regions (Metro Manila, Cebu, Davao) compared to rural regions (Bicol, Samar/Leyte, Autonomous Region in Muslim Mindanao).

The health inequities brought about by these social determinants also extend across countries.

**Table 1: Life expectancy at birth**

<table>
<thead>
<tr>
<th>Period</th>
<th>PH</th>
<th>Global Median</th>
<th>Thailand</th>
<th>Vietnam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-PHC (1970-1977)</td>
<td>0.1170</td>
<td>0.3840</td>
<td>0.7296</td>
<td>0.4622</td>
</tr>
<tr>
<td>PHC Early Adoption and Expansion (1978-1990)</td>
<td>0.3084</td>
<td>0.3861</td>
<td>0.3447</td>
<td>0.6584</td>
</tr>
<tr>
<td>Devolution (1991-1998)</td>
<td>0.1563</td>
<td>0.1931</td>
<td>0.3191</td>
<td>0.0205</td>
</tr>
<tr>
<td>HSRA (1999-2004)</td>
<td>0.1411</td>
<td>0.2973</td>
<td>0.2228</td>
<td>0.2403</td>
</tr>
<tr>
<td>Fourmula1 (2005-2010)</td>
<td>0.1480</td>
<td>0.2911</td>
<td>0.1360</td>
<td>0.2985</td>
</tr>
<tr>
<td>KP (2011-2013)</td>
<td>0.1615</td>
<td>0.2121</td>
<td>0.1493</td>
<td>0.1781</td>
</tr>
<tr>
<td>1970 - 2013</td>
<td>0.1952</td>
<td>0.3018</td>
<td>0.3782</td>
<td>0.3336</td>
</tr>
</tbody>
</table>
### Table 2: Maternal mortality ratio*

<table>
<thead>
<tr>
<th>Period</th>
<th>Philippines</th>
<th>Global Median</th>
<th>Thailand</th>
<th>Vietnam</th>
</tr>
</thead>
<tbody>
<tr>
<td>1970 - 2013</td>
<td>0.2963</td>
<td>-1.5889</td>
<td>-0.6444</td>
<td>-4.0277</td>
</tr>
</tbody>
</table>


### Table 3: Infant mortality rate

<table>
<thead>
<tr>
<th>Period</th>
<th>Philippines</th>
<th>Global Median</th>
<th>Thailand</th>
<th>Vietnam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-PHC (1970-1977)</td>
<td>-0.0440</td>
<td>-2.3189</td>
<td>-2.6690</td>
<td>-1.1488</td>
</tr>
<tr>
<td>PHC Early Adoption and Expansion (1978-1990)</td>
<td>-1.1313</td>
<td>-1.9755</td>
<td>-1.7011</td>
<td>-0.9923</td>
</tr>
<tr>
<td>Devolution (1991-1998)</td>
<td>-1.1155</td>
<td>-1.2821</td>
<td>-1.1226</td>
<td>-0.9655</td>
</tr>
<tr>
<td>HSRA (1999-2004)</td>
<td>-0.5371</td>
<td>-1.2314</td>
<td>-0.8000</td>
<td>-0.7000</td>
</tr>
<tr>
<td>Formula1 (2005-2010)</td>
<td>-0.5000</td>
<td>-0.7922</td>
<td>-0.5486</td>
<td>-0.6000</td>
</tr>
<tr>
<td>KP (2011-2013)</td>
<td>-0.5000</td>
<td>-0.9500</td>
<td>-0.3500</td>
<td>-0.5000</td>
</tr>
<tr>
<td>1970 - 2013</td>
<td>-0.9116</td>
<td>-1.4470</td>
<td>-1.3544</td>
<td>-0.9199</td>
</tr>
</tbody>
</table>

### Table 4: Under-5 mortality rate

<table>
<thead>
<tr>
<th>Period</th>
<th>Philippines</th>
<th>Global Median</th>
<th>Thailand</th>
<th>Vietnam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-PHC (1970-1977)</td>
<td>-0.0738</td>
<td>-4.1226</td>
<td>-4.1929</td>
<td>-2.0488</td>
</tr>
<tr>
<td>PHC Early Adoption and Expansion (1978-1990)</td>
<td>-2.0049</td>
<td>-3.1420</td>
<td>-2.4577</td>
<td>-1.7500</td>
</tr>
<tr>
<td>Devolution (1991-1998)</td>
<td>-1.9024</td>
<td>-1.5903</td>
<td>-1.4762</td>
<td>-1.5917</td>
</tr>
<tr>
<td>HSRA (1999-2004)</td>
<td>-0.8371</td>
<td>-1.7060</td>
<td>-1.0000</td>
<td>-1.0486</td>
</tr>
<tr>
<td>Formula1 (2005-2010)</td>
<td>-0.7400</td>
<td>-0.8332</td>
<td>-0.6629</td>
<td>-0.8229</td>
</tr>
<tr>
<td>KP (2011-2013)</td>
<td>-0.75</td>
<td>-1.1355</td>
<td>-0.4500</td>
<td>-0.7</td>
</tr>
<tr>
<td>1970 - 2013</td>
<td>-1.5627</td>
<td>-2.1595</td>
<td>-1.8970</td>
<td>-1.5358</td>
</tr>
</tbody>
</table>
Countries with high gross national income (GNI) per capita have significantly longer life span compared to countries with low GNI per capita.

The socioeconomic indicators of a country have been used to determine the impact of social determinants in its health outcomes such as poverty incidence, unemployment rate, and gross domestic product (GDP). Dr. Paterno presented the status of these indicators as reported by the National Economic and Development Authority and United Nations Development Programme of the Philippines on “The Philippines Fifth Progress Report on Millennium Development Goals.” It was shown that the country had slow progress in reducing poverty, unemployment rate and poverty among employed. Also, there was decreasing industry sector share in the national GDP.

Given these gaps in the status of social determinants of the country, the need for PHC approach has been more evident. The PHC principles indicate that the existing gross inequality in health status between developed and developing countries and within countries are politically, socially and economically unacceptable. It was recommended that the government must take the lead to attain UHC through socioeconomic development. This could be done through intersectoral interventions, SDH approach and advocating for the community’s right and duty to participate.

With regard to KP as a means to address health inequities, three results areas based from its pillars of strategy (financial-risk protection, access to quality healthcare and achievement of Millennium Development Goals, or MDGs) have been presented by Dr. Paterno. For financial-risk protection, the 2010 goal of KP was to expand coverage, increase benefit payments, include outpatient benefits, use alternative forms of payment mechanisms, improve marketing to increase beneficiary knowledge and improve information system in PhilHealth. In 2013, despite increased PhilHealth reimbursements and Department of Health (DOH) budget, out-of-pocket expenditures remained high at 56.3 percent. This means that households incur unplanned high-volume expenditures which, in turn, push them into poverty. The need to pay out of pocket can also mean that households do not seek care when they need it or when their conditions are already severe. For access to quality healthcare, primary thrusts of KP focused on health-facility enhancement, health human resource deployment and complete treatment package. There is a need, however, to monitor how these interventions are being implemented, particularly in the quality of facilities enhanced and management of supplies for complete treatment packs. Finally for the achievement of MDGs, latest estimates indicate high probability of achieving the targets for: a) under-5 mortality rate, b) infant mortality rate, c) prevalence of malaria, d) malaria death rate, and e) TB case detection and cure rates. On the other hand, there is low probability of achieving the targets: for a) maternal mortality ratio, b) immunization rates for measles, c) contraceptive prevalence rate, d) TB death rates, and e) eradication of extreme poverty.

Dr. Paterno reiterated that the implementation of KP must be focused on primary care, the first level of contact in the national health system by bringing healthcare as close as possible to where people live and work. In the country, health leaders still focus on building hospitals in every municipality. However, only 1.5 percent of the population are being serviced by hospitals. Aside from this, maintaining hospitals is more expensive and difficult.

**Effective and Responsive Models of PHC Toward UHC**

Dr. Lorenzo presented the preliminary results of their study on developing a PHC model geared toward UHC. The model was based from literature, best practices, gaps and challenges experienced by the DOH and local government units in implementing PHC. She highlighted that the proposed model would not be a “one size fits all” model since the Philippine health system required multiple PHC models responsive to the varying needs of individuals and communities based on specific contexts. Thus, PHC models should be standards-driven, but acceptable to the communities, as well. The primary basis of the model is the United States Agency for International Development Health Systems Framework.

This model was redesigned to highlight SDH and the role of community and patients across all health-system functions. This model will also incorporate nine PHC indices: a) First Contact, b) Comprehensiveness, c) Continuity of Care, d) Coordination/Referral, e) Community Participation, f) Universal Coverage, g) Intersectoral Action, h) Cost Effectiveness, and i) Quality Appropriate Technology.

Consideration of this model and other standards-driven model would be the following:

1. Relevance of implementing PHC models. PHC is
relevant in achieving the Sustainable Development Goals and the wider goal of universal access to health through acceptable, accessible, appropriate and affordable healthcare. If implemented well, it will advance health equity and promote human and national development. PHC also strengthens the integration of community, primary, district healthcare and preventive services.

2. Intersectoral collaboration is vital as health depends on more than health-sector efforts alone. PHC stresses the importance of intersectoral collaboration, social justice and community participation with empowerment.

3. Broad range of preventive and curative services provided within PHC makes it cost-effective to address large population health challenges in low-income and middle-income countries like the Philippines. The municipalities have a big role in improving rural health unit services to bring quality primary care services even in the farthest barangays. This was emphasized by Garilao during the discussion. There is a bigger chance that PHC interventions will succeed in improving health outcomes if the municipal leaders are made accountable for health.

4. Concern with PHC approach is the scarcity of proposed strategies for implementation and monitoring for accountability and scale-up programs.

5. Integrate health system vertical approaches (programs for priority diseases) with horizontal approaches (strengthen services for all health programs). As a result, develop Integrated Primary Healthcare Services in a phased or step-ladder manner.

6. Recognition that highly trained and motivated human resource is key to PHC implementation.
Continuity of Care: Ensuring a Responsive CEmONC Hospital and Referral System for Maternal Health

Hon. Mohamad Khalid Dimaporo
Governor
Lanao del Norte

To drastically reduce maternal deaths in the provinces, continuity of care must be provided to pregnant women during their prenatal, labor and delivery, and post-partum stages. Pregnant women, whether high risk or not, should be identified by the rural health units (RHUs) and should be able to avail of health services at appropriate facilities at specific periods in their pregnancy. Those who are not high risk and who do not develop complications at any stage of their pregnancy should be managed by RHUs that are compliant with Basic Emergency Obstetric and Newborn Care (BEmONC) standards and are Philippine Health Insurance Corp. (PhilHealth)-accredited, both of which will ensure quality pre-natal, facility-based delivery (FBD) and post-partum care, as well as financial-risk protection for the mother. If RHUs are properly monitoring pregnant women, those categorized as high risk would have been identified during their pre-natal checks and referred to the Comprehensive Emergency Obstetric and Newborn Care (CEmONC) hospital for further diagnosis and management. Disruption of the continuity of care may lead to fatal consequences.

The presence of any or a combination of the three delays—delay in the decision of the mother to seek appropriate care (Delay 1); delay in reaching the appropriate facility (Delay 2); and delay in the provision of appropriate management in the health facility (Delay 3)—disrupts the continuity of care. Places of deaths may provide indications on the kind of delay that may have led to maternal deaths. Data from the 33 Provincial Leadership and Governance Program (PLGP) provinces of the Zuellig Family Foundation (ZFF) showed that in 2014 there were 578 maternal deaths, of which 57 percent died in the hospitals, 3 percent died at the RHUs, 12 percent died at home, 5 percent died in transit and 23 percent had unknown places of death. Those who died at home had Delay 1 factors, those in transit may have had Delay 2 and Delay 1 factors, and those that died in the hospital may have had all three delays.

Strategies for the delays were developed and vetted to the provincial PLGP teams including the governors. For Delay 3, it was addressing seven key issues in hospital CEmONC services—24/7 availability of obstetricians, supply of safe blood and medicines, strict implementation of the no-balance billing (NBB) and point-of-care (POC) enrollment for financial-risk protection, and making functional the maternal mortality and morbidity audit and the hospital management committee. This has been the priority intervention since most public hospitals are directly under the provincial governments’ administrative control. For Delay 2 it was to make sure that there were ambulances that will be able to transfer the mother from the municipalities to the provincial hospitals, and if needed, from the provincial hospital to the Department of Health (DOH) regional medical centers or any higher level facility; maternal waiting homes were, likewise, recommended. For Delay 1 it was having an integrated pregnancy tracking system, ordinance and incentives.

The story of Lanao del Norte will showcase how a governor’s leadership led to improvements in referral systems and in their hospitals.

A look into preliminary maternal deaths in the different Philippine regions showed that most deaths occurred in hospitals, followed by homes. (See Figure 1) The Figure 2 shows the role of municipalities and provinces in these deaths. To reduce cases of deaths, health system strengthening, particularly integrated Maternal, Neonatal, and Child Health and Nutrition (MNCHN) services must be made available. (See Figure 2) The ZFF has been engaging municipalities to improve their local health systems. But the ZFF has also begun a leadership and governance program for provincial leaders to make sure the integrated MNCHN services are realized. This resulted to the PLGP, a two-module training with practicum in-between modules.

One of the governors who have undergone PLGP is Mohamad Khalid Dimaporo of the province of Lanao del Norte in Northern Mindanao. Of the 22 municipalities in the province, 14 are either fifth or sixth class. Its maternal deaths rose steadily between 2011 and 2013. (See Figure 3) Its FBD, while increasing between 2011 and 2014, was still way below the ideal 90 percent.

Governor Dimaporo believes safe motherhood is a right and wants to see zero death in his province. He worked to improve health leadership and governance by expanding the local health board (LHB). He then strengthened his partnerships with health leaders by working with the different mayors and municipal health officers (MHOs), the DOH, the Mother Bles Foundation, ZFF and other agencies.

Hospitals were renovated and equipment were upgraded to meet the DOH standards. To ensure the regular supply of medicines, bulk procurement was implemented to prevent gaps in deliveries. Health human resource was strengthened and specialists were hired.
Table 1: Where and why do mothers die in 31/33 PLGP provinces (October, 2015)

<table>
<thead>
<tr>
<th>Total Deaths</th>
<th>Home</th>
<th>In-Transit</th>
<th>RHU/Clinic</th>
<th>Hospital</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>578</td>
<td>71 (12%)</td>
<td>30 (5%)</td>
<td>14 (3%)</td>
<td>330 (57%)</td>
<td>133 (23%)</td>
</tr>
<tr>
<td>282</td>
<td>16 (6%)</td>
<td>9 (3%)</td>
<td>2 (1%)</td>
<td>169 (60%)</td>
<td>86 (30%)</td>
</tr>
</tbody>
</table>

Figure 1: The role of provincial and municipal local government units in reducing maternal mortality ratio

Figure 2: Integrated MNCHN service package

Source: Villaverde-Strengthening the Philippine Health System to Attain MDG 4 and 5
Available Blood Supply

Working with the ZFF, Governor Dimaporo discovered that one of the main causes of maternal deaths in the provincial hospitals is the insufficient supply of blood products. As a response, he established partnership with Red Cross and provided the budget to ensure adequate supply is available.

The young governor believes that financing is the foundation and the key to sustainability of healthcare for local government units. In 2008, Governor Dimaporo adopted the economic enterprise model for the hospital. He has allocated P80-million budget to the hospital which they need to “revolve” and replenish from PhilHealth reimbursements. In this way, the income of the hospital doesn’t get lost in the general fund. The province has opened a separate special account for the hospital for the governor to personally see how much fund was secured by the hospital for its operations in the following year.

The provincial government also has started the NBB policy since 2008. The governor went to the barangays and used, “Walang bayad para sa gamot. Walang bayad sa duktor. Everything’s free!” as his campaign slogan. He strongly believes that this has helped him win the election.

Governor Dimaporo mentioned that ZFF helped him realize that to achieve zero maternal deaths, provincial government needs to harmonize the efforts of their health systems—hospital, interlocal health zones (ILHZs), municipal, barangay.

The provincial government started to improve the hospital referral system by coordinating closely with the RHUs and ILHZs and improving the data management system of the hospital. These efforts gave birth to an integrated high-risk pregnancy tracking system which allows the hospital to get an advance list of names of potential high-risk mothers and to be prepared. Hospitals were also encouraged by the provincial local chief executive to be evaluated using the CEmONC hospital scorecard of ZFF to determine areas of hospital system that need to be addressed.

Retention and annual capacity-building trainings of barangay health workers were done to ensure that the front line workers are competent and skilled to deliver basic health services and track the high-risk patients.

Inter-LGU cooperation, through the activation of ILHZs, has been an effective strategy of the governor to further improve the referral system. To date, there are five active ILHZs that were formed. Each ILHZ has its common trust funds that were established through a memorandum of understanding (MOA).

Acceleration of MCP accreditation was made possible through signing of MOA between municipal MCP facilities and medical specialists of the provincial hospitals and through partnership with Mother Bles Foundation.

Social-risk protection of the indigent becomes a provincial priority as well. Indigents in the municipalities were enrolled through POC. Improved health leadership and governance through the conduct of regular dialogue meetings with mayors and MHOs and regular expanded LHB meetings become a driver to achieve strengthened referral system and blood network.

In 2013, before ZFF came into the picture, Lanao del Norte has 12 maternal deaths, but recent data show that the province was able to bring the baseline data down to three maternal death cases.
Social media is meant to be a venue for engagement. Its popularity can be useful for public health as well. The discussion looks into the different levels of social engagement for the purpose of public health communication. The health messaging brought about by social media can potentially address the need for community engagement and participation in public health programs.

Social media is a collection of digital channels and tools designed to be engaging and used for mass communication. Social media must be interactive with communication synchronous and collaborative among numerous participants. Of the different social media available, Facebook is found to have the most engagement.

The Role of Social Media in Public Health

Dr. Gia Sison
Co-founder
HealthXPH

Given the many types of social media and their possible uses, Dr. Sison emphasized its applications to public health. Social media can be integrated with traditional public health communication channels such as forums and conferences. Aside from sharing municipal good practices through conferences and publications, Dr. Sison recommended the use of social media to target wider audience and for faster adoption. Other than good practices, municipalities can share public health messages within their communities through the Internet. In a Pew Research, 59 percent of adults used the Internet to find health information, while 35 percent sought information about emerging health conditions online.

Through social media, we can target and reach diverse audiences

- 59% of adults based on Pew Research have used the internet to look for online health information
- 35% had gone online specifically to understand an emerging health condition.
According to Dr. Sison, social media can serve as public-relations arm in public health to feel or hear the pulse of the community being served. This is very important as she described the recent years as the advent of the need for community participation and engagement in ensuring success of public health programs. Through social media, municipalities can gain insights on what health information may be important and interesting to their community members. The real-time aspect of social media is a key component to ensure that communication efforts are relevant, meaningful and useful to them.

Dr. Sison defined social media engagement for public health through several activities. It can mean “listening to social media conversations”. Public health organizations can use social listening to identify health information needs of the public and what they are saying on social media channels about priority health topics. By doing so, health program planners can learn more about their intended users as social media conversations unfold in real time. As an example, Adolescent and Sexual Reproductive Health advocates can scan publicly available social media content like Facebook posts of teenagers on the use of contraception. From these, they can find gaps in the message being communicated to the public and understand what they care about these topics. The information can then be used in planning for a more cohesive and comprehensive communication strategy on priority health topics.

Aside from simply listening, organizations can also engage influencers and their conversations. These influencers can be other organizations or single individuals that exhibit credibility, persistence in convincing others and ability to drive conversations. This can be done so that the public can take notice of or even support priority health topics.

Engagement in social media can also mean creating opportunities for users to interact with their organization or among themselves. This can lead to a ripple effect across social media sites resulting to increased interaction among users. An example is the healthxph.net where Dr. Sison and her team created an open environment for communication where no opinion is right or wrong. This became an avenue for discussion on the role of social media in child participation rights.

To improve user interaction, organizations should welcome and solicit user-generated content from social media. This includes encouraging users to share stories, participate in message creation, and collaborate on ideas or strategies that can be shared on their organization’s media channels. This has been used by HIV advocacy groups and cancer support groups to increase user interactions and reactions to their public health messages. Dr. Sison also reminded that in soliciting user comments or opinions, one has to be mindful of responding
to comments or questions received through social media channels. Failure to do so may lead to public’s loss of interest or participation.

In social media engagement, organizations are also encouraged to create opportunities to integrate online and offline engagement. American Red Cross did so by offering training to individuals on social media on how to report during disasters. These trained individuals are able to monitor and engage activities on disaster areas then report back through the social media team of Red Cross.

Organizations can also use social media as leverage for community engagement. For municipalities, this means integrating the use of social media in public health programs to increase community participation.

In doing social media engagement, organizations must be aware of the risk of losing message control. Negative or uncivil comments from individuals can misdirect the message their organization is trying to deliver. To avoid this, there is a need for proactive engagement with social media influencers to encourage thoughtful and constructive dialogues leading to a common understanding. This, however, requires more commitment of time and effort. The higher the level of engagement, the more effort is needed to adequately and effectively maintain a consistent and coordinated engagement approach.

In conclusion, Dr. Sison summarized social media engagement in eight simple ways.
In today’s electronically linked and networked world, it is inevitable and even unavoidable for local health systems in the Philippines to embrace the use of information and communications technologies (ICTs). With more data and information generated, health centers will find it more difficult to stick to the paper-based health information systems. National health initiatives from the Department of Health (DOH) and Philippine Health Insurance Corp. (PhilHealth) will be mandating the use of electronic health records, epidemiologic and reimbursement reports, so there is an urgent need for local health systems to adapt and to change management and administrative practices in order to be ready for ICTs.

This session will discuss with local chief executives and local health leaders on how to mainstream and integrate the use of ICTs to local health systems in order to improve health service delivery and health outcomes.

This includes a rundown of elements needed to make health systems technology-ready: hardware and software, ICT infrastructure, human resource development, policy overall change management. As a case study, there will be a discussion on Molave Development Foundation Inc.’s (MDFI) experience in the pilot implementation of the Ligtas Buntis mobile application in rural municipalities in Oriental Mindoro, the challenges encountered, lessons learned and the next steps. From this experience, recommend steps and strategies that local government units (LGUs) and local health leaders can take in order to successfully implement a public health change management initiative. As always, the key ingredients in truly making a local health system health-ready are political will and innovative approaches to changing health policy and governance, which will bring about sustainability.

According to Dr. Ramos, most LGUs already have some form of ICT. The type of technology, how ICTs were used and the degree of implementation, however, differ. Some use them for records keeping, others for generating reports, while some have already integrated ICTs to all levels of their health systems. Also, most hospitals have been using ICTs for generating and storing patients’ records. However, only a small number of rural health units (RHUs) have this kind of technology. He emphasized that paper-based data collection and storage is the most commonly used, but it is associated with risks of information loss and breach of privacy. Moreover, paper-based data accumulate so much space and retrieving information takes longer time.

Dr. Ramos described the case of a second-class municipality in Laguna wherein his team was able to convince the RHU to address the problems associated with paper-based data. The first thing they did was to identify the rationale with the municipal health officer (MHO) why a shift to ICTs was necessary. An assessment was done and showed that as much as 35 percent of maternal cases were not reported due to inaccuracy and data loss during collection. Midwives lost their notes after home visits and sometimes midwives did not actually do home visits and fabricated the information in their notes. These resulted to information being unusable and not fit for analysis during monitoring of maternal health status and program reviews. Given this reason, their team and the MHO were able to convince the mayor on the need for ICTs to improve collection and analysis of useful health data. Capacity-building was then done for the RHU staff to adopt the technology.

In the scenario described, the value of ICTs lies on the following characteristics:

a. Accuracy—information generated truly reflects the health situation
b. Validity—the methods used to get information are appropriate
c. Quality—information is useful
d. Timeliness—information is available and retrievable as soon as it is needed, especially during disasters or outbreaks
e. Safety and security—information is not easily lost or stolen
f. Privacy and confidentiality—following rules of ethics, information about every patient is not publicly available without the patient’s consent

To give the audience a grasp of what ICTs look like in recent years, Dr. Ramos also described the trends in hardwares, softwares, databases, analytics, policies, and human resources being used in ICTs. Hardwares are now mobile as tablets, smartphones and phablets have replaced desktops and laptops. Mobility of hardwares has also pushed for the invention of telehealth/telemedicine devices which combine health equipment with digital
technology, such as digital stethoscopes, glucometers, pulse oximeters and the RxBox. Softwares, which are the applications you install in the hardwares, are focused on health information systems and electronic medical records with public health applications. Examples of these are Ligtas Buntis, Community Health Information Tracking System, Smart’s SHINE (Secured Health Information Network and Exchange), and the Wireless Access for Health. Databases are recently being stored in the World Wide Web using cloud-based applications instead of physical hard drives. Ligtas Buntis has already been using cloud-based applications in storing health registries. Data analysis has also been more scientific and systematic that a lot of information is being generated. Big data analytics are used to create different types of high-volume data faster.

In terms of policies, other countries already have standards on how to guide or respond to the use of ICTs for health. The country, however, is still on its way in implementing policies to standardize ICTs for health and ensure their quality. Nomenclature of data should also be made the same all over the country whatever ICTs the municipalities are using. Data submission should follow a prescribed standard by the DOH to maximize the utility of ICTs. Reimbursements should also be institutionalized through policies to facilitate adoption of ICTs. This is very relevant since the DOH and PhilHealth now require some municipal data to be submitted to them electronically.

Capacity-building for ICTs among human resources for health is also very timely. Change management theories should be revisited to improve health information literacy. Currently, this is the biggest challenge the country is facing in terms of using ICTs for health. There is a limited number of health workers who are competent in the use of ICTs.

Dr. Ramos’ concrete example on the use of ICT integrating the trends and concepts previously discussed was the Ligtas Buntis (Safe Motherhood System). This initiative was implemented by MDFI in 2010. It is an application specific to e-Health Promotion and Tracking System for Maternal Health Community Care. It enhances general recording and reporting of maternal health data by barangay health workers and supports the process of maternal health behavior change. It also addresses the current maternal health challenges of the public health sector especially in recording and reporting prenatal and postnatal registry, providing health messages to pregnant women, and increasing utilization of maternal health services of the RHU.

The features of the Ligtas Buntis are:

- Maternal health reporting (prenatal and postnatal registry)
- Listing of registered women per barangay for sending broadcast messages
- Broadcasting of needed maternal health information in text form in areas such as baby development, maternal nutrition, pregnancy care, pregnancy complications, common problems in pregnancy, breastfeeding, postnatal care, baby care and family planning
- Responding to text questions from mothers and providing advice
- Promoting complete prenatal visit, facility-based childbirth and postnatal visits
- Recording of all sent messages by the system and archiving received messages from registered patients

The Ligtas Buntis has also been piloted in Pakistan and Indonesia. Achieved outcomes of this initiative in a span of one year included: increased accuracy and timeliness of reporting pregnancies in the community, increased participation of pregnant women and their families during the prenatal period, and increased facility-based deliveries. The technology was awarded by Information Society Innovation Fund – ASIA in 2012.

For Dr. Ramos, the continuous adoption of ICTs for health especially in the municipal level holds some challenges and opportunities. Municipalities whose mayors have strong political and prioritization for health can maximize the benefits of ICTs. Standards are still lacking but coordination among the different ICTs for health providers can help the DOH develop comprehensive policies. Lack of competent human resources and additional costs of ICT infrastructure hinder the adoption of technology in poor municipalities. However, they must see the long-term impact and benefits of these technologies. Prioritizing health means prioritizing quality information used for decisions affecting health.
Adapting to the Changing Times: Climate Change and Resilient Health Systems
Dr. Renzo Guinto
Campaigner
Healthy Energy Initiative, Health Care Without Harm-Asia

Synopsis
This year, the Lancet once more released a new report on climate and health, this time examining the needed actions in order to address climate change and protect human health. The 2015 Lancet Commission on Health and Climate concluded that tackling climate change could also be the “greatest global health opportunity of the 21st century.” The report emphasized the role of the health sector in adapting to the health impacts of climate change, through building resilient health systems, enhancing capacity for responding to disasters, and improving surveillance of climate-sensitive diseases. Furthermore, it highlighted the potential contribution of the health sector in mitigating climate change, both through reducing its own carbon footprint in hospitals and other health facilities and through advocating for mitigation options that have huge public health co-benefits, such as cutting our reliance on fossil fuels and shifting to healthy renewable energy.

Now more than ever, health systems at all levels—local, national and global—should embrace its role in addressing climate change, building resilience and protecting human health. The Philippines, in particular, can demonstrate leadership in confronting these novel challenges and adapting to the changing times.

Climate Change and its Health Impacts
Definition of Terms
Climate change has been defined as change of climate which is attributed directly or indirectly, to human activity that alters the composition of the global atmosphere and which is in addition to natural climate variability observed over comparable time periods (United Nation Framework Convention on Climate Change).

Body of literature indicates that climate change has various impacts which include health consequences, agriculture and forest impacts, and impacts on natural resources. In particular, health concerns such as weather-related mortality, communicable diseases, and respiratory illnesses may happen. (See Figure 1)

World Health Organization (WHO) defines health system as a total of all the organizations, institutions and resources whose primary purpose is to improve health. To make a health system functional and responsive, it needs staff, funds, information, supplies, transport, communications and overall guidance and direction. And it needs to provide services that are responsive and financially fair, while treating people decently as shown in Figure 2.

According to Intergovernmental Panel on Climate Change, Resiliency refers to capacity of a social-ecological system to cope with a hazardous event or disturbance, responding or reorganizing in ways that maintain its essential function, identity, and structure, while also maintaining the capacity for adaptation, learning and transformation.

The climate change is both the greatest global health threat and biggest global health opportunity of the 21st century according to Lancet. It is the greatest threat to global health as it has different pathways of producing health consequences. Climate change influences the behavior of the vectors, the composition of the air, temperature, and the food system and, as a result, cases of infectious diseases, respiratory diseases, malnutrition, and other dire health consequences become more prevalent. (See Figure 3)

Role of the Health Sector in Adapting and Mitigating the Health Impacts
Because of the various changes in our environment and the health danger that follows, our health systems should be able to adapt and respond as well.

Lancet highlights climate change could also be the biggest global health opportunity of the 21st century. Climate change will threaten 50 years of gains in global health and development. All other progress in maternal and child health, in eradicating infectious diseases, and in eliminating malnutrition globally will be threatened if not reversed. The problem is no longer technical or economic but political so it is important to bring the issue of climate change not only to the leaders of the national level but also to the local government leaders. The health sector has a vital part to play in accelerating progress to tackle climate change, as it did with tobacco and public sanitation (Lancet Commission, 2015). To guide the healthcare community in establishing a climate-resilient health system, four-point agenda for health and climate has been developed. (See Figure 4)

4 Point Agenda for Health and Climate
1. Build resilient health systems
   According to World Health Organization (WHO), climate-resilient health system is one that is capable to...
anticipate, respond to, cope with, recover from and adapt to climate-related shocks and stress, so as to bring sustained improvements in population health, despite an unstable climate.

In order for a country to build climate-resilient local health system, it is imperative to develop and implement enabling policies. For example, the Philippine health sector has several policies on climate change which include the following:

- Department Circular: Adaptation of Climate Change Framework for Health
- Philippine Strategy on Climate Change Adaptation for the Health Sector
- DOH Department Personnel Order 2010 – 2977: Creation of a Technical Committee for Climate Change and Health
- DOH Administrative Order 005, Series of 2012: National Policy on Climate Change Adaptation for Health Sector
- DOH Department Personnel Order 2011 – 2458: Creation of a Climate Change Unit

The United Nations lauds the Philippines for having the best climate policies in the world. However, the challenge is the translation of these policies into implementable programs.

The WHO has released a new framework for climate-resilient health system that will guide leaders and other actors in changing mindset from disaster response to climate resilience. (See Figure 5)

The shock or stress is a test to the health system’s capacity to deal with disturbance. Vulnerability is dictated both by the level of exposure, sensitivity and capacity to respond. We want to reduce the exposure while improving the adaptive capacity. Among the outcome options, the most ideal one is to be able to transform the health system.

The WHO added other blocks to the six building blocks of health system to make it climate-resilient and these include (with some measurable outputs):

- Leadership and governance includes the presence of climate & health (C&H) task force or focal person at the LGU level, well-developed C&H plan and monitoring mechanism, and a functional inter-agency committee.
- Health workforce refers to availability of training courses, presence of contingency plans for deployment, and risk communication capacity both at the national and local levels.
- Vulnerability, capacity and adaptation assessment can be done by baseline of health conditions and existing resources and identification of vulnerable groups and risks.
- Integrated risk monitoring must be in place through early detection and warning, indicators for surveillance and periodic reviews.
- Health and climate research (research agenda, access to data, multidisciplinary research partnerships, research funding and evidence to policy); Climate-resilient and sustainable technologies and infrastructure (health facilities, energy, water, and sanitation adapted to climate risks; steady pharmaceutical supply; eHealth; sustainable design; green procurement);
- Management of environmental determinants of health (integrated monitoring, strengthening regulations adapted to extreme climatic conditions, coordinated management);
- Climate-informed health programs (disease programs to consider climate-related stresses, risk maps, analysis of seasonal trends, contingency plans);
- Emergency preparedness and management (risk assessments, contingency plans, emergency response plans, community empowerment); and
- Improved climate-sensitive universal health coverage must be in place to significantly address the immediate needs and sustain health financial stability of the affected households.

2. Monitor the health impacts of climate change

Presented Global Green and Healthy Hospitals (GGHH)

⇒ Gave examples, best practices on how not to do harm to climate (proper disposal of hospital wastes, alternative green energy sources

3. Advocate for mitigation measures for health benefits

⇒ Intersectoral collaboration is important;
⇒ The Philippines can rely on renewable energy as stable power source

4. Reduce health sector ecological footprint

⇒ The Paris Platform for Healthy Energy (held in Paris on December 5, 2015)
⇒ Climate treaty is a health treaty, too!
⇒ Climate change and health are both in the Sustainable Development Goals and the challenge is how to come up with an integrated approach in building a climate-resilient health system.
⇒ Determinants of health must also be addressed to improved health
⇒ CHEAP Solution—Climate, Health, Equity in All Policies
Figure 1: Potential climate change impacts

Climate Changes

- Temperature
- Precipitation
- Sea Level Rise

Health Impacts
- Weather-related Mortality
- Infectious Diseases
- Air Quality-Respiratory Illnesses

Agriculture Impacts
- Crop yields
- Irrigation demands

Forest Impacts
- Change in forest composition
- Shift geographic range of forests
- Forest Health and Productivity

Water Resource Impacts
- Changes in water supply
- Water quality
- Increased Competition for water

Impacts on Coastal Areas
- Erosion of beaches
- Inundate coastal lands
- Costs to defend coastal communities

Species and Natural Areas
- Shift in ecological zones
- Loss of habitat and species

United States Environmental Protection Agency

Figure 2: The WHO health system framework

System Building Blocks

- SERVICE DELIVERY
- HEALTH WORKFORCE
- INFORMATION
- MEDICAL PRODUCTS, VACCINES & TECHNOLOGIES
- FINANCING
- LEADERSHIP / GOVERNANCE

ACCESS COVERAGE

QUALITY SAFETY

IMPROVED HEALTH (level and equity)

RESPONSIVENESS

SOCIAL & FINANCIAL RISK PROTECTION

IMPROVED EFFICIENCY
Figure 3: Pathways to health effects of climate change

Figure 4: The four-point agenda for health and climate

<table>
<thead>
<tr>
<th></th>
<th>Adaptation</th>
<th>Mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>WITHIN</td>
<td>Build resilient health systems</td>
<td>Reduce health sector’s</td>
</tr>
<tr>
<td>BEYOND</td>
<td>Monitor the health impacts of climate change</td>
<td>Advocate for mitigation measures for health co-benefits</td>
</tr>
</tbody>
</table>

Figure 5: The WHO conceptual framework for resilience

Resilience = Decreased vulnerability + Increased capacity, Improved choices & opportunities
Figure 6: The WHO building blocks of a climate-resilient health system
Synopsis

The process of change is difficult especially in transforming health information systems. Initial investments of time, human resources and capital are challenging to establish. However, numerous opportunities are available to facilitate public health services. An important opportunity is the increasing adoption of health information technology.

Information technology (IT) plays a crucial role in defining “sure win” strategies to tackle issues about health systems in a local (municipal) setting. It can be a vital tool and critical link to strengthen local health system. The gains collected and the successes achieved since the 2012 inception of Wireless Access for Health (WAH) in the municipality of Ipil have been continuously inspiring the community and its neighboring areas. Aside from being one of the top 5 performing localities in the country in terms of excellent health governance system, Ipil has become a benchmark in local health system transformation.

With the use of IT, health personnel, as well as the municipal officials, do not only record and encode, but also utilize the data for purposive program planning and interventions. Therefore, IT enables local health leaders to obtain, use and communicate high-quality data and translate these to quality healthcare services.

While local governments have a key role in pushing the agenda, it is equally important to strengthen collaboration with non-governmental organizations, the private sector and other key stakeholders. It is clear that enhancing the use of modern technology is an excellent investment to improve the local health system.

Municipal Profile

Ipil is the capital town of Zamboanga Sibugay. It is a first-class municipality with a total population of 72,232 distributed over 36,690 hectares of land. The place is inhabited by Christians, Muslims and Lumads who thrive on agriculture, fisheries, commerce and trade as main sources of income.

The municipality faced the following challenges:

1. Poor Health Data Management and Accuracy
   - This resulted in lack of evidence-based health program planning; hence, despite several health programs, it was not meeting its targets and problems were recurring.

2. Lack of Health Personnel and Low Performance and Productivity, as a result:
   - There was poor patient tracking and monitoring.
   - It took a long time searching through voluminous patients’ records.
   - Records were lost due to natural decay and/or following calamities that caused damage to records.
   - There was no monitoring system on workload of rural health unit (RHU) personnel.

3. Poor Community Demand and Support for Health Services and Programs
   - Passive community support to local government unit (LGU)-led programs
   - Negative perception on the services that the RHU can offer
   - Poor client compliance to follow-up consultations

4. Fair Health Leadership and Governance
   - Because of the poorly established health information system, the mayor could not monitor the status of the municipality’s health programs and indicators so appropriate actions were not readily implemented.
   - “Things that are not well-monitored are not well-managed.”

These challenges contributed to poor health indicators of the municipality.

BRIDGING LEADERSHIP STORY

Ownership

Mayor Alibutdan’s initial motivation to participate in the Zuellig Family Foundation (ZFF) trainings was to avail of the Department of Social Welfare and Development projects. He eventually admitted that his motivation changed after becoming a bridging leader.

Transformation is contingent on both the message and the messenger. Messenger like former Health Secretary Jaime Tan Galvez, M.D., plus the powerful message from the “Kwento ni Rosario” struck Mayor Alibutdan. He felt humiliated knowing that Region IX is next to Autonomous Region in Muslim Mindanao in having the
greatest health inequity, and that Zamboanga Sibugay is the third poorest province in the country in terms of health services.

After reflecting on these challenges, he realized his responsibility in delivering the best government services for his people. He desired to deliver high-impact health services to his people by knowing the magnitude and extent of the problem. He also realized from the ZFF training that the complexity of health inequities required the support of other stakeholders.

Knowing that he could not address the challenges alone, Mayor Alibutdan conducted a series of relationship-building dialogues with LGU officials, health workers, hospital owners and other stakeholders such as national government agencies, Church leaders, civil society organizations and private sector representatives. The dialogue focused on notifying them of the health realities in the municipality of Ipil.

He personally took the lead in advocating health programs to the grassroots level by engaging the barangay officials, nurses, midwives, barangay health workers (BHWs), barangay nutrition scholars and community health teams (CHTs). To ensure their commitment and share his vision, Mayor Alibutdan also taught them the bridging leadership. This resulted to a collective sense of urgency of addressing the health challenges and have a collaborative response.

With an empowered health team led by Mayor Alibutdan, they started to plan and implement new health programs targeted to improve their municipal health system scorecard. For them, the best way to start addressing their health challenges was to understand the magnitude and extent of the problem through improved data collection. They also believed that their decisions should be based on the health challenges data to prevent wastage of resources on unnecessary strategies.

They proposed a community-based health information system that integrates collecting, encoding, analyzing and even utilizing data to address health issues. ZFF was then able to partner with WAH and introduced its technology to the health leaders of Ipil.

The health leaders were able to formulate objectives for the WAH technology. These include having a paperless database system where information can be made readily available to clients in the shortest possible time. They also aim to use the generated data to inform health personnel and leaders about the municipality’s daily health census. This includes morbidity and mortality status so that clients can be reminded of schedules of consultations and checkups. The information can also be used in planning for medical supplies and health services in the RHU.

**Outcomes**

Through the ZFF Bridging Leadership Theory and the technology introduced by WAH they were able to achieve four key results areas:

1. Improved health data management and accuracy

   The availability of health data became their springboard to success. The up-to-date medical records gave them information on the municipal health status
from time to time, prompting them to execute resolutions and ordinances on program institutionalization.

As a result, the local leadership was able to propose, design and implement programs specific to health problems such as high incidence of diarrheal cases. Among the implemented strategies were routine scheduled vaccination, mobile immunization by rural health midwives, vitamin supplementation and deworming. Because of WAH, they registered 56,685 RHU patients, which was 78 percent of the total municipal population.

### Presence of quality health data and improved date management and accuracy

- **Registered Patients**
  - Catchment Population: 72,232
  - Total Overall Patient: 56,685
  - 78% Registration Rate

### Statistics aggregator
- Enables our RHU to submit report electronically in e-FHSIS format
- Faster health data reporting to the LCE and the province
- Provides Monthly Monitoring of health indicators at the Barangay and Municipal level, (Province Later)
- Upholds standard practices and processes for data quality check

### Synchronized patient alerts via SMS
- Utilize the use of cellular phones to send automated information and reminders to patients for RHU scheduled consultations and other related health promotions

The local government of Ipil through WAH, employed the synchronized patient alerts via SMS to provide constant reminders to pregnant mothers, clients with children for immunization and family planning clients of their next scheduled visit to the healthcare facility. At the same time, the system sends the same reminder to the barangay chairman and the rural health midwife assigned to a particular client to inform them of the agreed schedule of visits. This system enhances the capacity of the health workers to follow up clients, supplement the BHWs and CHTs in prompting clients regarding availment of health services.

In 2012, the coverage of immunization increased to 100 percent. Newborn screening was improved from 35 percent in 2013 to 80 percent in 2014 and for the same years, Garantisadong Pambata Program covered 100 percent of the total population under 5 years old.

In 2012 and 2014, mass immunization for measles, mumps and rubella resulted in 100-percent coverage. Cases of measles and other infectious diseases were kept at a controllable level with a “zero outbreak” record in the past five years. In 2009, the prevalence of malnutrition, being high at 13 percent, was gradually decreased to 9 percent in 2011 and then 8 percent in 2014.

In terms of data management, the usually tedious process of searching for patient’s records and the likelihood of losing them was lessened. They had also maximized the physician-patient contact time.

3. Better health leadership and governance

For Mayor Alibutdan, the most notable change that happened as a result of ZFF engagement was the change in mentality and outlook on health issues between him and the other health leaders. He was more hands-on in promoting health agendas. The WAH technology was very helpful for him to make informed decisions by accessing real-time municipal health data at WAH online portal.

4. Increased community demand and support for health programs

There was a marked improvement in the health-seeking behavior of their constituents. According to Mayor Alibutdan, patients are now eager to go to the RHU and to every barangay health station because they are assured of the facility’s quick, data-driven and excellent health services program. The inclination to go to the RHU for consultations rose and the level of compliance to follow-up checks increased.

To ensure sustainability of the WAH initiative in Ipil, they committed a separate line-item for the development and sustenance of local health information system in the annual budget.
Lessons Learned

In the process, Mayor Alibutdan learned that the ultimate solution to health problems did not reside on the mere provision of medicines but, more important, on capacitating and empowering people with bridging leadership and good governance. As leaders, they learned to be concerned about their people, particularly the poor. In confronting health issues, individuals should inspire ownership and co-ownership of the problems so that everybody becomes role players in the co-creation of long-term solutions.

“It is not enough that we build infrastructures such as canals, roads, bridges and buildings. But most of all, our programs should be directed toward saving, preserving and improving the lives of our people—that is, making life better by putting emphasis on effecting innovations that directly impact constituents.”
Relationship-Building Leadership: The Key in Restoring Health Systems Post-Yolanda

Hon. Melchor L. Mergal
Mayor
Dr. Socorro S. Campo
Municipal Health Officer
Isabel Abella
Municipal Planning and Development Officer
Mr. Danilo Duran Lacasa
Municipal Disaster Risk Reduction and Management Officer
Health Leaders of Salcedo, Eastern Samar

Synopsis
Salcedo, a fifth-class municipality in Eastern Samar, was among the areas devastated by Supertyphoon Yolanda (international name: Haiyan), regarded as the deadliest typhoon in the country’s modern history. According to the Eastern Samar Provincial Disaster Risk Reduction and Management Council, all 41 barangays of the municipality were affected with damages to agriculture estimated at P51 million and infrastructure at P548 million, respectively. In terms of health facilities, Salcedo’s rural health unit and five of its seven barangay health stations (BHS) were totally damaged.

The mayor described how Bridging Leadership (BL) competencies enabled him, along with his municipal health office and other municipal officers, to restore and improve their health system. With the assistance of the Department of Health (DOH) and non-governmental organization (NGO) partners, they reconstructed, as well as built, new health facilities to improve health service delivery in their municipality. Incentives were also given to ensure zero maternal death. They also sought to strengthen their health system through the development of their Health Emergency Preparedness Response and Recovery Plan (HEPRRP).

Restoring Health Systems Post-Yolanda
For Mayor Mergal, Yolanda was the biggest challenge he faced in the first term of his leadership. He was mayor for five months only when Yolanda struck Salcedo, Western Samar. Yolanda destroyed coastline communities in terms of infrastructure and livelihood. The municipal health system was also affected. Salcedo’s RHU and five of the seven barangay health stations were totally damaged. This resulted to dysfunctional health service delivery especially in responding to infectious disease outbreaks and injuries. Sanitation was a challenge since there was poor access to safe water and sanitary toilets. Access and availability of maternal health services were also compromised with the damages to health facilities and roads. There was also a decline in available human resources for health as nurses, midwives and doctors themselves were victimized by the typhoon. These gaps in health service delivery resulted to a drop in percentage of women given prenatal and postnatal services. Moreover, the number of teenage pregnancies has increased. Health information system was also rendered useless as health records were lost along with the facilities.

A month before Yolanda, Mayor Mergal and Dr. Campo, the municipal health office of Salcedo, were enrolled in the Municipal Leadership and Governance Program (MLGP). The MLGP was implemented by the Zuellig Family Foundation (ZFF) together with the DOH, the University of the Philippines Palo-School of Health and Sciences and United Nations Population Fund (UNFPA). For Mayor Mergal, the MLGP training was a blessing as he applied the BL framework in managing the aftermath of Yolanda. Mayor Mergal saw Yolanda more of an opportunity rather than a disaster. He was able to manifest the values of resiliency, resourcefulness and good interpersonal relationship to rebuild his municipal health system.

Mayor Mergal developed these values early in his childhood. His father was a fisherman and his mother was a farmer. Raising 13 children on a measly income made it difficult for his parents to provide basic needs, especially education. They also lived along the coast of Leyte Gulf Area where strong winds and big waves strike especially during typhoons. His parents taught him the values of resiliency, resourcefulness and establishing
good interpersonal relationship with people. With these values, he was able to develop his capacities and maximize available resources to achieve his goals in life such as being mayor of Salcedo. These were the same values he used in owning, co-owning, and co-creating strategies during his MLGP engagement.

Resiliency was demonstrated by Mayor Mergal when he did not yield to the challenges brought by Yolanda. These were aggravated by being a newcomer to politics. Mayor Mergal admitted that Yolanda tested his commitment, but chose not to be discouraged. As mayor, he believed that he should stand strong for his constituents. For him, he could not let them down given the tragedy his people were facing.

Mayor Mergal practiced good interpersonal relationship starting with his municipal health office. Initially, he was very worried relating to her since she was the sister of the mayoralty candidate he defeated in the 2013 elections. This was addressed through the MLGP when they were asked to practice dialogue and analyze Salcedo’s health challenges together. According to Mayor Mergal, the MLGP engagement marked the start of their excellent working relationship to address health challenges. From the MLGP, they learned the BL competencies of ownership, co-ownership and co-creation. After owning the challenges, they prioritized improving health systems guided by a technical roadmap. To achieve this, they would always sit together to plan their strategies. Mayor Mergal also has high regard for the opinions of his municipal health officers, saying, “Pagdating sa health, Dr. Campo is my boss.” This good interpersonal relationship was the key in rebuilding Salcedo’s health system when Yolanda struck.

The health leaders of Salcedo were able to come up with relationship-building strategies to gain resources in rebuilding their municipality. Their rehabilitation and recovery framework helped them win the support of the government and the local and international NGOs. The rehabilitation and recovery framework contained Salcedo’s rehabilitation plan, relevant data needed, post-disaster assessments, identified gaps and assistance needs. This framework facilitated the partnership between Salcedo and supporting partners. For these partners, it was a reflection of the readiness to absorb technical and financial support the LGU needed.

To sustain the partnerships, they had inter-cluster coordination meetings twice a month with all their partners. Updates on ongoing rehabilitation and recovery activities were discussed to avoid duplication of assistance in terms of area coverage and beneficiaries. In this manner, the usage of resources from the national and international partners were maximized and did not go to waste.

In addition to these group processes, Mayor Mergal also had one-on-one discussions with their partners. Faster time to respond was seen essential during disasters and emergencies. In the experience of Mayor Mergal, personally talking to partners shortened the process of communication and hastened rehabilitation strategies. He also personally led the monitoring and evaluation of strategies and reported them to their partners. The formed partnerships and the resources generated allowed for the reconstruction of health facilities and service delivery to vulnerable populations. Their strategies included:

1. Recovery Assistance Program for pregnant and lactating women with ZFF and the US Philippines Society which provided six-month cash and material incentives for:
   a. Pregnant and lactating women availing of prenatal, facility delivery and postnatal checkup at the RHU.
   b. Setting up and maintaining the RHU’s pregnancy-tracking system to improve health information and update health records.

2. Reconstruction of the following facilities through funding by partners:
   a. Salcedo RHU by MSF (Medics San Frontiere)
   b. Five BHS by Health Futures Foundation Inc. (HFI) and Plan International
   c. Six Health Posts by Plan International, European Community Humanitarian Aid Office and Disasters Emergency Committee

3. Reconstructed facilities were also upgraded to provide better health services:
   a. Upgrading of six BHS as birthing facilities by HFI, DOH Health Facility Enhancement Program (HFEP) and International Organization for Migration
   b. Upgrading of two island Health Posts as birthing facilities by DOH HFEP
   c. Second-floor expansion plans for the RHU by DOH HFEP

4. Provision of new facilities:
   a. Maternity Waiting Home by ZFF and US-Philippines Society
   b. Eight mobile clinics from Plan International
During the duration of the post-Yolanda Recovery Assistance Project (December 2013 to July 2014) Salcedo was able to maintain zero maternal death, 100-percent prenatal and postnatal visits, 89 percent facility-based deliveries (FBDs), and 99 percent skilled birth attendants. One of their barangays, Barangay Caridad, was also awarded the Barangay with Best Sanitation Practices in Region 8. The other barangays of Salcedo were replicating the successful efforts of Barangay Caridad with 35 out of 41 barangays of Salcedo already practicing best sanitation practices. In 2015, their initiatives for health were also recognized and affirmed during the Provincial Health Summit. Salcedo garnered the awards as champions on LGU scorecard, national tuberculosis program, maternal and neonatal child health nutrition program, and on sanitation practices. DOH Region 8 also awarded Salcedo the Best Performing Cohort Yolanda MLGP Enrolled Municipality.

Moving forward, the health leaders of Salcedo plan to sustain the post-Yolanda Recovery Assistance Program by passing the Maternity Care Incentive Package Ordinance. This will provide incentives to pregnant mothers, midwives and barangay health workers upon compliance with four prenatal and four postnatal visits and FBDs. The fund will be taken from the Maternal Care Package Philippine Health Insurance Corp. reimbursements. They have also drafted Salcedo’s HEPRRP in collaboration with health and non-health LGU officials. This will help mitigate the impact on health and environment if another disaster occurs. Salcedo’s HEPRRP and the continued support of the government and NGO partners will ensure health system resilience in times of emergencies and disasters.

For Mayor Mergal, even if Salcedo was devastated by Yolanda, it helped them develop capacities to improve health. It spurred urgency to take action and establish good relationships working together for the improvement of health. This resulted in the fulfillment of a shared vision for Salcedo: “A resilient municipality where everyone can take care of themselves, where no one is left behind, where they can stand better after they fall, where they can take into account the future generation, and where they are responsible in every action they make.”
In the devolution era, every national strategy to implement health reforms would have to undergo the challenge of localization. While the Department of Health (DOH) has allocated substantial resources to address various gaps in the health system, the role and contribution of various stakeholders in local health system are crucial in the achievement of better health outcomes. As front liners, local leaders have to respond to enormous challenges to address the needs of their communities.

A threat to better health outcomes is the dynamics of local politics. The nature of political transition may have an impact to local health system as a new set of politicians will be elected with fresh agenda and platforms under their administration and political power. Three local chief executives (LCEs) under Zuellig Family Foundation (ZFF)-Community Health Partnership Program (CHPP) have owned the challenge induced by political transition and established means to create a responsive health system that would produce better health outcomes. The discourse would highlight how leadership was used to change the current structure, process and culture and make the community own the challenge in transforming its local health system into one that is responsive, equitable and adaptive—a system that generates better health outcomes especially for the poor.

The session highlighted the leadership journey of three outgoing mayors and how they applied the Bridging Leadership (BL) approach to improve health outcomes in their municipalities. With the coming 2016 elections in mind, these mayors were able to implement strategies to sustain the legacy of improved health systems.

Mayor Viola of Hinatuan, Surigao del Sur and Mayor Sayangda of Santol, La Union started with ZFF’s Health Leaders for the Poor (HLP) in 2012. Mayor Arboleda of Looc, Romblon, on the other hand, started as early as 2011. Mayor Sayangda and Mayor Arboleda underwent the HLP training under the partnership with University of Makati.

Prior to the ZFF partnership, the three mayors thought that their municipalities were doing well with their health systems. Mayor Viola thought health service delivery in his municipality was beyond adequate with the existence of Hinatuan District Hospital and a diligent municipal health officer. Mayor Sayangda, on the other hand, received various awards for the municipality of Santol in 2011, which included recognitions as the “Most Child-Friendly Municipality” and “Best Poverty Program Implementer” in Region 1. She later found out that infant deaths still occurred in the municipality despite childcare services being delivered in rural health units (RHUs).

During the ZFF training, the mayors assessed their municipalities using the World Health Organization (WHO) Health Systems Framework. Initially, Mayor Viola identified the lack of birthing facilities and effective transport mechanisms for mothers living in far-flung barangays as main reasons for the occurrence of maternal deaths. In the case of Santol, La Union, health facilities were present, but mothers still preferred to give birth at home. Mayor Sayangda also identified low immunization rate as a reason for poor infant health in her municipality. Some members of the community refused to have their children immunized due to misconceptions and lack of knowledge on the benefits of vaccination.
To make matters worse, barangay officials lacked the ability to lead and manage strategies to improve health. They left these matters to health personnel like the midwife and the barangay health worker. This was also the problem of Mayor Arboleda along with inadequate services in the RHU and the lack of community participation in health programs. Moreover, all three municipalities reported having “reds” in their municipal technical scorecards, particularly in ensuring functional local health boards (LHBs).

During the practicum phase, the mayors applied their learnings on dialogue, multistakeholder processes, and resource mobilization to improve health situation in their municipalities. They all started with engaging other local leaders to establish their LHBs and barangay health boards (BHBs). The mayors were able to do this by hosting dialogue sessions and introducing the BL framework to local leaders.

Mayor Viola provided a concrete example on how the LHB members consolidated and integrated municipal strategies into a unified municipal health action plan. A workshop was conducted on convergence planning which resulted to additional financial resources for health. This was done through the coordination of the Municipal Planning and Development Office (MPDO) and the municipal budget officer. The Community-Based Management Information System was also introduced to the MPDO to identify and enroll indigents to the Conditional Cash Transfer scheme for the Pantawid Pamilyang Pilipino Program of the Department of Social Welfare and Development (DSWD). The Municipal Social Welfare and Development Office also participated with the municipal health officer (MHO) in planning strategies for nutrition. These strategies were supported by school heads, especially in data recording and reporting of nutritional and immunization status of schoolchildren.

The three mayors also strengthened barangay health governance through dialogues with barangay officials and coaching them on budgeting and implementing their annual barangay health action plans. Mayor Viola, for example, ensured through a protocol that barangay annual budget plans would not be signed unless the budget for health was specified. Mayor Sayangda, on the other hand, extended multistakeholder processes at the barangay level. Convergence meetings were conducted in every barangay including kagawads, barangay nutrition scholars, barangay health workers (BHWs), school representatives, barangay captains, secretaries and treasurers. The WHO Health Systems Framework was introduced to them by Mayor Sayangda herself for each one to understand his role in these convergence meetings. This resulted to improved support at the barangay level for community-based interventions by grassroot workers. To complement these initiatives, additional health workers were hired in the RHUs and trained on emergency response.

Birth units were also constructed through the DOH’s Health Facilities Enhancement Program. These birthing units were located in strategic areas close to far-flung barangays. To facilitate transportation of emergency cases in these birthing units, transport groups were organized in cooperation with operators. The three mayors also had their RHUs Basic Emergency Obstetric and Newborn Care and Philippine Health Insurance Corp. (PhilHealth) accredited. These were made operational 24/7 to ensure responsiveness to obstetric emergencies.

The initiatives of the three mayors resulted to improvements in their health outcomes. In Hinatuan, Surigao del Sur there was an increase in facility-based deliveries (FBDs) from 72 percent in 2011 to 92.5 percent in 2015. There was a reduction in infant deaths and 114-percent increase in PhilHealth enrollment. They also did not have maternal deaths in 2015.

Moreover, there were noted improvements in the implementation of TB programs which resulted to 100-percent TB detection and cure rates. In Looc, Romblon zero maternal death has been sustained for nine years with at least 98-percent FBD and skilled birth attendant (SBA) rates in 2015. The municipality was also given the “Well-Managed Community Grant Fund Award” given by KALAHICIDSS Project. Santol, La Union had an increase in FBD from 54 percent in 2011 to 82 percent in 2015 and an increase in SBA from 82 percent in 2011 to 99 percent in 2015. They have sustained zero maternal death since 2012 and only one death in 2015. The indicators in
their municipal score cards have also turned mostly green.

Given the political transition, sustainability of health gains are ensured through institutionalization of reforms and ensuring community participation. They expect the local leaders to continue their support for the health programs and sustain new arrangements and collaborations since they have been engaged through BL. The expansion of LHBs and BHBs and health programs has also been institutionalized through ordinances and memorandum of agreements. Infrastructure development, such as the mentioned birthing units and RHU improvements is also seen as a means to ensure that FBDs are sustained. These infrastructures are expected to outlast several changes in leadership. To ensure quality of service in these facilities, accreditation has been done and institutionalized through ordinances.

Community demand for improved health services was also seen as a means for the new leadership to adopt the health reforms started by the outgoing mayors. This is the reason the three mayors ensured community participation in planning and implementing the mentioned health initiatives. For them, the best way to engage the community members is to gain their trust through consistency and persuasion. Consistency means being truthful to their vision of improved health for the community members. Persuasion could be in the form of information and education campaigns to improve the community members' health-seeking behavior.

Being part of the political system, the three mayors plan to sustain their municipal health gains through political influence.

Mayor Sayangda believes that department heads would be the successors and instruments to continue the reforms that have been started. Mayor Arboleda, being not on her last term, decided to run for mayor. Last, Mayor Vida decided to run as vice mayor.

Doing the strategies above was not easy for the three mayors. However, these barriers were seen as adaptive challenges which their BL skills could address. The mayors described political differences as a common hindrance to sustaining improvements in health. Initially, local leaders supported other political parties or have other sectors as priority. Continuous persuasion and introducing the BL framework during convergence meetings eventually gained their support. Some local leaders may not support the political views of these mayors, but they were able to go beyond politics and supported the health programs. Another challenge was the perceived complacency of the community members. Improving community participation addressed this and the mayors emphasized that health leaders must be physically present in the communities to achieve this. The bigger challenge for them was the difficulty in addressing public health issues. Mayor Sayangda expressed that initially she was frustrated with the complexity of the problem. Poor health system has been present in her municipality for a long time. For her, ZFF helped in building her resiliency through continuous coaching. She is applying this coaching strategies to her constituents. Resilient local leaders are expected to continue improving their health systems despite the mayors being out of office.
I am pleased to be with all of you today. Our participants: municipal mayors, municipal health officers (MHOs), and community leaders are the foundations of a strong and responsive health system. This National Health Leader’s Convention has been an opportunity for us to appraise where we are today as far as our ongoing journey toward Universal Healthcare (UHC) is concerned: what our achievements are, what we have done, and what we have yet to do. The most important question we need to answer, as we approach the post-Millennium Development Goal (MDG) era and the change in administration, is this: “What is the future we desire for the Philippine healthcare system?”

Let me thank the Zuellig Family Foundation (ZFF), headed by its Board of Trustees, for working with the Department of Health (DOH), local government units (LGUs), MHOs, and community leaders in improving health outcomes using the Health Change Model (HCM). This model recognizes the importance of local health ownership and leadership in bettering the health of our people, especially in far-flung communities. The significant gains in health in the local populations covered by your program attest to the effectiveness of the HCM. For these achievements, on behalf of the DOH, I congratulate all of you.

I believe that in a topic as important as the future of the Philippine healthcare system, your voices must be heard. The future is best conceived if most of our stakeholders are consulted and listened to. For any plan to succeed, broad support from all our stakeholders is indispensable. For the past two days, we have discussed how we can better improve local health service delivery for UHC.

This morning, I will be presenting the state of health in the Philippines. Hopefully, this presentation will be a good starting point in collectively deciding what the future of Philippine healthcare will be.

UHC, or Kalusugan Pangkalahatan (KP), is the Aquino Health Agenda. Its three thrusts are to provide financial-risk protection, secure access to quality health services and facilities, and achieve public health MDGs.

For many years, the DOH budget has only increased incrementally and gradually. This has been more evident after the implementation of the sin-tax law wherein the budget increased to P83.7 billion in 2014 from P53.23 billion in 2013.

For fiscal year 2016, we are proposing a budget of P122.7 billion.

The increase in health budget has been utilized to fuel the major gains in health in this administration. We will present the achievements of the health sector and then the work that we still have to complete for UHC.

For financial-risk protection, the Aquino administration started with a DOH allocation of P5 billion to subsidize the premiums of the poor, and ensure their enrollment and coverage in Philippine Health Insurance Corp. (PhilHealth). This was only able to enroll 22 million of the Sponsored Poor with only a 51-percent enrollment of the total population, utilizing about P530 million a week in PhilHealth benefits.

After a decade of arguing over the definition of the poor, the Aquino administration finally established the National Household Targeting System for Poverty Reduction (NHTS-PR) as the list of the poor in the country to converge on for assistance. Recognizing the need to financially protect the poor from highly impoverishing cost of sickness, the budget for the premium was increased annually to its current level of P37 billion. This is a 640-percent increase from its 2010 level. This enrolled 45 million poor, raising total coverage to 87 percent with a weekly benefit utilization of P1.5 billion. Most of the current PhilHealth reforms and benefit packages we now know started in this administration.

In 2010, only four in every 10 women have given birth in a health facility, while only 84 percent of infants were fully immunized for vaccine-preventable deadly diseases. Within this administration, we all won a 14-year battle to pass the reproductive-health (RH) law. The national immunization law was also passed, which upholds the right of each infant to be immunized.

We have now also been providing additional vaccines to protect our children and senior citizens. As of the first quarter of this year, we now have seven in every 10 women giving birth in our health facilities, and as of 2014, nine in every 10 infants are protected from deadly vaccine-preventable diseases.

Let us now look at our MDG targets for combating infectious diseases. In 2010, only seven out of 10
tuberculosis cases were diagnosed and only eight out of 10 were cured or completed full treatment.

Our resolve, strong partnerships with development partners, and heavy investments in our national TB program have allowed us to have significant improvements in TB.

As early as 2012, we have already attained our MDG target of treatment success rate with nine out of 10 TB cases cured or completed full treatment, which indicates significant improvement in this program. Substantial gains were achieved in malaria: from 19,955 diagnosed cases of malaria in 2010 and 23 malaria-free provinces, we have added five more malaria-free provinces, and have decreased the incidence of malaria to only 4,905 cases.

These results may be explained, among others, by a 32.53-percent increase in the 2015 malaria-control program budget compared in 2010 and the assistance of Global Fund and other non-governmental organizations.

In our third thrust of ensuring access to quality health services and facilities, we have focused on the enhancement of existing barangay health stations (BHS), rural health units (RHUs), and DOH and LGU hospitals.

From just P3 billion for enhancement of health facilities nationwide in 2010, we have increased funding by 333 percent, to P13 billion in 2015. To date, we have upgraded infrastructure and equipped 685 DOH and LGU hospitals, 2,626 RHUs, and 2,862 BHS.

In this administration, we have deployed 448 UHC implementers and doctors to the barrios, 77,198 nurses and 12,237 midwives. In 2015, we have started deploying nurses to our barangays to improve our community health services.

We have also repositioned our treatment pack of drugs to contain a complete dose of drugs for one month to diabetes and hypertension, clubs which we will be releasing in December. All hypertension and diabetes patients will be receiving free medicines.

Our response to the devastation of Supertyphoon Yolanda (international name: Haiyan) involved all sectors, partner agencies, and local and foreign governments, with the result that there were no major disease outbreaks.

Ladies and gentlemen, partners in health, we need to build on these achievements by closing the gaps in UHC. We need to ensure that all RHUs and BHS are TSeKaP accredited.

Studies also show that only four in every 10 confined poor patients experience no-balance billing (NBB), this is why we need to ensure an increase in NBB by 70 percent this year and 95 percent in 2016.

Sa pagtatapos ng Aquino Health Agenda, isa sa bawat limang BHS ay dapat maging maternity care package (MCP) accredited. Lahat ng mga RHUs natin sa bawat munisipyo ay dapat maging three-in-one accredited.

For areas with no BHS for reasons such as lack of land ownership, we will solve this bottleneck together with the Department of Education (DepEd). We will build BHS in schools, which will cater to the catchment area of the barangay, and at the same time, function as school clinic. We intend to build 3,200 BHS in schools in 2015 and 2016.

And, to invigorate our dental health program especially in far-flung and hard to reach areas, the DOH, DILG, LGUs and DepEd will be deploying mobile dental services to all provinces in 2016.

Maternal health is a worldwide standard of how we care for the vulnerable. We need to stop our mothers from dying. Our goal is to address pregnancy-related deaths by intensifying and scaling up facility-based deliveries and maternal health services.

For nutrition, where there are two malnourished children out of 10 children under 5 years of age, we need to reduce it by at least 8 percent by 2015.

In recent years, we have seen a rapid increase in HIV/AIDS cases. We are increasing HIV testing and treatment services to address this, giving priority to the most at risk population, or MARP.

Ladies and gentlemen, there is much to do before this administration ends. UHC-High Impact Five (Hi-5) strategy was launched this April 2015 for implementation in 2015 and 2016 to achieve the goals of UHC/KP.

The UHC-KP Hi-5 strategies will synchronize and intensify actions on 1) maternal health, 2) infant health, 3) child health, 4) HIV/AIDS, and 5) services delivery network. These strategies will prioritize the poor and vulnerable population which belong to the 1) NHTS-PR households, 2) 44 priority provinces, 3) bottoms-up budgeting areas, 4) accelerated and sustainable anti-poverty program areas, and 5) whole of nation initiative areas. It is premised on achieving breakthrough UHC goals through intensified actions at regions and DOH hospitals, with specific tangible outputs in 2015 and 2016.

Hi-5 activities in regions are:

- UHC caravan/ roadshows, to bring UHC and RH services to communities;
- RAIDERS, or reach and innovate desired rational...
scores, tracing of defaulters of immunization and other services for targeting service delivery;

- Garantisadong Pambata, child-focused services, delivery of mass deworming in August and February each year with the DepEd, micronutrient supplementation and other services;
- Increasing access to HIV testing, increasing access to testing for HIV/AIDS and treatment;
- Establishing functional service delivery networks to ensure continuity of services for families, across political and geographical boundaries; and
- Diabetes and hypertension clubs, providing free medications namely 1) losartan, 2) amlodipine, 3) metoprolol, and 4) metformin.

Intensified hospital Hi-5 strategies, on the other hand, employ the following strategies:

- Alagang pinoy brand of DOH, a Hi-5 theme dedicated to improving customer satisfaction and high standard patient-centered care in DOH hospitals;
- Strengthening service delivery network, matching families to a network of maternal and childcare providers;
- Kapit Bisig Para sa KP, a medical and surgical caravan in the priority poverty areas in the Philippines.
- Access to medicines to ensure that no patient is burdened with high drug and hospitalization costs.

This is our Hi-5 calendar to guide us all in actions that will be supportive of each other’s work in UHC. The future directions in our continued journey toward UHC are still anchored in the three main strategies of KP/UHC: financial-risk protection, improving our health facilities, and advancing public health.

For financial-risk protection, we need to convert universal coverage into increased PhilHealth utilization, especially for our Sponsored Program members. To this end, we must facilitate the awareness of PhilHealth members about their benefits and membership services. We must also push for full PhilHealth accreditation in all government facilities. This will enable our members to utilize their PhilHealth benefits and, at the same time, help government health facilities become self-sustaining with PhilHealth reimbursements.

We also need to ensure complementation of both DOH and LGU health facilities through mapping of health resource facility and health facilities. This mapping will then guide the DOH in the provision of needed infrastructure, equipment, or human resource support to LGUs. The establishment of PhilHealth-accredited women and child centers in geographically isolated and disadvantaged areas will also ensure that our gains on reducing maternal, infant, and under-5 mortality and morbidity are sustained. To enhance public health, we propose the following:

- Provision of complete immunization for infants, children, and senior citizens
- Ensuring access to medicines for vulnerable populations for chronic conditions (hypertension, diabetes), infectious diseases (TB, malaria, neglected tropical diseases, emerging and re-emerging infectious diseases), selected cancers (breast, leukemia, colorectal)
- Bulk procurement to further lower prices of medicines and other medical supplies

As I conclude, let me reiterate that the success of UHC depends largely on the effectiveness of local health systems in achieving national health objectives. The HCM has been proven to be a catalyst in harnessing the energies, talents, and commitment of LCEs, MHOs, and community leaders in improving the health outcomes of their constituents. Upscaling the HCM on the national level will surely enhance our ongoing KP Hi-5 initiatives.

In order to address the post-2015 challenges, different sectors in the society must work together to address social barriers to healthcare. LGUs must have stronger capacities as the front line planners, resource programmers and implementers of policies and programs at the grassroots level. Local leaders must have a stronger sense of accountability to achieve better health outcomes in their areas. Private and public partnerships as a mechanism in the provision of investment and service delivery should be strengthened. Community as a primary stakeholder must be empowered and self-reliant. Lastly, health gains must be sustained beyond 2016.

The future of Philippine healthcare is in our hands. While we discuss and brainstorm today, the greater imperative is for all of us to unite, transcend our differences, aspire together and work together for better health for our people.

_Tayo ay mangarap, magkaisa at magtulong-tulong upang makamit ang kalusugang tuloy-tuloy para sa pamilyang Pinoy._

_Magandang hapon sa inyong lahat._
Declaration of Support for the Sustained Commitment to Health Reform

This Declaration is a summation of the different aspirations and pledges of health leaders and workers from different sectors of the Philippine society, particularly those at the front lines and in local government units. These are expressed with deepest confidence and awareness of the collective accountability to bring healthcare services to society’s peripheries and achieve better health outcomes for the poor.

I

We declare that health is a basic right of every Filipino, and it promotes the intrinsic and inviolable dignity of every human. It is the foremost duty of health leaders, elected or otherwise, to ensure that everyone, rich or poor, has access to quality healthcare. We envision a society where all Filipinos are physically, mentally, and socially healthy, and able to realize their full potentials. We call upon Philippine leaders to ensure that this right is affirmed and protected, and that all structures be put in place to guarantee the fulfilment of this fundamental human right.

II

We declare that every Filipino has a responsibility in building a healthy nation, where no one is isolated or ostracized. We call upon the nation’s leaders to provide the means and opportunities to facilitate the active involvement and participation of every Filipino in the pursuit of a higher quality of life.

III

We declare that through our collaborative efforts, the achievement of better health outcomes for every Filipino will be attainable. We envision having every Filipino walk the path to better health outcomes molded by scientifically and ethically-sound principles. We call upon Philippine leaders to co-create this vision with various stakeholders through an inclusive process of dialogue to arrive at a collaborative response.

IV

We declare that local government units (LGUs), being front liners, play a critical role in reducing health inequities and achieving better health outcomes. We envision having LGUs headed by transformed local leaders, and having empowered constituency that demand adequate health and social services, and better health outcomes. We call upon national leaders to provide LGUs the means, support and opportunities to improve their local health systems.

V

We declare that to achieve better health outcomes, there must be enhanced partnerships and dynamic working relationships based on trust among leaders at the national and local levels, and civil society organizations. These collaborations will result in pro-health and pro-poor policies and actions grounded on the principles of equity and justice.

VI

We declare the importance of having Universal Health Care. All leaders must make sure every Filipino will have access to available, acceptable and affordable quality healthcare regardless of social status, educational background, religion, ethnicity, sexual orientation, gender identity and expression, and financial capacity. We call on the nation’s leaders to ensure the continuity and enhancement of the Universal Health Care program so that genuine universal healthcare is realized soon.

VII

We declare the importance of continuity of care, so every health leader must ensure each Filipino
receives the right care from the right people at the right place and time. We envision a less fragmented healthcare system, where all key actors are working together to ensure no person is neglected and no life is wasted due to a lack of healthcare at any point in the system. We call on leaders, from national down to the barangay, to ensure the following: properly functioning referral systems, motivated and well-compensated healthcare workers, sufficient and well-maintained health equipment, well-stocked supplies of medicines, and accurate and utilized health information.

VIII

We declare the primacy of health such that everyone must consider it a priority and integral part in every policy and action of the government and the private sectors. We call on every leader from both sectors to co-create the policies and programs that will ensure the creation of a better public health system.

IX

We declare our continued support and commitment for the improvement of the health of all Filipinos. We declare ownership of this challenge, and we will strive to share this vision and mission with others to help improve a complex health system through a collaborative response. We affirm our commitment and dedicate ourselves in the work for better health outcomes for every Filipino now and in the future.
#helecon2015: Healthcare Social Media transcript

Aiming to reach wider audience engagement and participation, social media platforms, including Twitter, were utilized during the conference. Using the #helecon2015, participants shared their insights and comments on the different sessions. Below is a transcript of tweets on November 24 and 25, 2015.

@cathycmd  Tue Nov 24 14:29:03 PST 2015
Public health service is more than work it is more personal #helecon2015

@juliadominik  Tue Nov 24 02:01:09 PST 2015
Participation of all sectors in the society is must in addressing global health issues #helecon2015

@juliadominik  Tue Nov 24 18:30:47 PST 2015
Burden of disease is heaviest on the poor. They should be a priority. #helecon2015

@jhoomharz  Tue Nov 24 12:45:20 PST 2015
To prevent maternal death, mothers should have a prenatal check-up to ensure the health status both the baby and the mother. #helecon2015

@jhoomharz  Tue Nov 24 13:29:51 PST 2015
Let the church be partners in providing healthcare to all people :) #helecon2015 https://t.co/31tcny7qB85

@alvinakdis  Tue Nov 24 17:01:48 PST 2015
HELECON2015 #UniversalHealthCare Primary Health Care is the first level of contact of individuals, the family,... https://t.co/6YUN6GGrk

@alvinakdis  Tue Nov 24 17:20:23 PST 2015
HELECON2015 #UniversalHealthCare As to measure quality, there is no data present for KP similar to the pre-PHC era in the 70s

@jhoomharz  Tue Nov 24 20:18:59 PST 2015
Guidance within the teenagers should be implemented about teenage pregnancy #helecon2015

@chic_marilatet  Tue Nov 24 21:56:51 PST 2015
“Primary health system seems to require multiple Primary Health Care models responsive to the needs of communities” – Dr. Lorenzo #helecon2015

@zzf_foundation  Tue Nov 24 23:50:45 PST 2015
Basic Model of Primary Health Care by Dr. Fely Marilyn Lorenzo #helecon2015 https://t.co/Ooe7wy9UEk

@chic_marilatet  Tue Nov 24 09:25:46 PST 2015
“Health reform is a good politics” – Gov. Khalid Dimapor #helecon2015

@elenmethyanne  Tue Nov 24 18:36:12 PST 2015
What is the use of beautiful hospital when there is no medical staff? #helecon2015 #HHR

@amkapuran  Tue Nov 24 18:42:56 PST 2015
Thank you Zuiig Foundation! Proud to be a part of #helecon2015. So much to do for our country’s health reforms. https://t.co/Lp0GT1L2R

@docjing22  Tue Nov 24 19:00:54 PST 2015
Gov. Dimaporo: “My biggest mistake before was not working out the connection with the RHUs coz I thought it’s the LGUs job” #helecon2015