Creating Spaces for a Community-Engaged Leadership for Health and Development

Meredith del Pilar-Labarda, M.D., DSD

Given the importance of health leadership and community participation in improving and sustaining health outcomes, it is important that the leadership processes that work to improve health systems through genuine community participation and empowerment be surfaced, described, and analyzed. In this context, this study investigated the relationship between health leadership and people's participation within the municipal health systems of selected municipalities in the Eastern Visayas Region, Philippines. It analyzed the underlying processes of this relationship and its impact on health outcomes.

The study used a mixed methods approach with primary data collected from workshop participants and local organizations in the enrolled communities in a 12-month period between 2017-2018. Key informant interviews (KIIs) and Focus Group Discussions (FGDs) were conducted with mayors, municipal health officers, barangay leaders, and barangay health workers (BHWs).

Results showed that local leadership and governance is significantly positively correlated with the other five building blocks of the health system namely human resources for health, health financing, access to medicines and technology, health information systems, and health service delivery. The practice of dialogue, multi-stakeholder engagement, systems and complexity thinking, and prototyping all yield positive health governance outcomes. The Bridging Leadership framework provided a scaffolding for an ethical leadership to bridge the gap between the powerful and powerless in society.

Key words: health and development, local health system, leadership and governance

Introduction

Advancing the rights and welfare of the marginalized in a rapidly changing society is a complex endeavor. While human wellbeing has been

linked to economic growth, there is increasing evidence that economic expansion has not led to equitable development and the global disparity between the socioeconomic classes has widened (Herrmann, 2014; Walby, 2018). It is asserted that the resurgent populist politics is a manifestation of popular discontent and protest against the impact of globalizing forces that leaves many communities and peoples behind in the midst of rapid economic growth (Luiz, 2014). The need to reconceptualize development that puts people and planet at the forefront have shifted efforts to human health and wellbeing as key in achieving real development (Cabeza-García et al., 2018; Eckermann, 2018; Kickbusch, 2014; Schuchter & Jutte, 2014). Sen (1999) argues that development is a process of expanding the real freedoms that people enjoy and that this process of expansion is both the primary end and the principal means of development. People's health and wellbeing grounds this process (Ruger, 2004) and highlights the importance of bringing forth an equitable and responsive health system to ensure health for everyone.

Building blocks of an equitable health system

But what makes up an equitable health system that is responsive to the needs of the people? The World Health Organization (WHO) defined health systems as all organizations, people, and actions whose primary intent is to promote, restore, and maintain health (WHO, 2007). This system, composed of interconnected parts, is characterized by complex relationships, power structures, and social determinants affecting health outcomes of populations. Transforming health systems can be an intractable endeavor, since they are comparable to a "living organism" in which the relationship between the parts generates behaviors and outcomes that are messy, unpredictable, and always evolving (Auspos & Cabaj, 2014). In the Philippines, the decentralization of the country's health system was meant to strengthen it. Instead, it resulted in system failure after devolution (Atienza, 2012; Cuevas et al., 2017). This highlighted leadership and governance within the health system as crucial in making sure that people's health is promoted, restored, and maintained. The Health Systems Framework of the World Health Organization (WHO, 2007) identifies six building blocks of an equitable health system, namely: leadership and governance; health financing; access to essential medical products, vaccines, and technologies; health information; health workforce; and service delivery. Among these six building blocks of health, it is leadership and governance that drives all the other parts of the system. Thus, when there is good leadership and governance, it can propel all the other building blocks so that the system becomes responsive to the needs of the people and the community, and

health outcomes are improved (J. Mfutso-Bengo, Kalanga, & Mfutso-Bengo, 2018).

Decentralization and impact on governance of local health systems

In the Philippines, local leadership and governance became an essential component of the local health system in providing health resources and service delivery to the communities after the devolution, as mandated by Republic Act No. 7160, otherwise known as the Local Government Code of 1991. Health service delivery was managed by a Local Health Board (LHB) at the municipal level. According to Section 102 of the said Republic Act:

> Every municipality shall establish a Local Health Board headed by the municipal mayor as chairman, the municipal health officer as vice-chairman, and the chairman of the committee on health of the Sangguniang Bayan, a representative from the private sector or non-governmental organizations involved in health services, and a representative of the Department of Health in the municipality, as members.
>
> (RA 7160, 1991)

This new arrangement made the Local Chief Executive responsible for the devolved health system in the municipality. This paved the way for health providers and for the health system to come under the management of non-health managers. In other words, in a devolved health setting, leadership and governance in health does not only mean the Municipal Health Officers (MHOs) at its helm but would also include the Local Chief Executives and the local administrative system. This has major implications when it comes to prioritization, planning, allocation of resources, and implementation of action plans.

Over the years since the implementation of devolution, it has long been debated if it was indeed the right thing to do. Almost 30 years later, it is still being critiqued by many, especially those who are frontline actors in the public health arena. Mitchell and Bossert (2010) present two seemingly opposing perspectives and differing viewpoints on the use of decentralization—that of the governance perspective and the health-systems performance perspective. Their study showed how decentralization affects the achievement of the country's health systems goals, as taken from the experiences of six countries namely Bolivia, Chile, India, Pakistan, the

Philippines, and Uganda. Two thought-provoking questions were asked in their paper—Are you doing the right thing? Are you doing the thing right? The governance perspective on decentralization would generally argue that decentralizing the health sector is the right thing to do as long as conditions of good governance exist. The health performance perspective, on the other hand, is not at all clear if it is indeed the "right thing" to do when applied to many functions of service delivery regardless of whether or not it is "done right" (Mitchell & Bossert, 2010). In the context of the Philippines, evidence presented in their study showed that, after decentralization, health governance scored medium to high on the exercise of local discretion across key health functions. However, decentralization did not translate to better health outcomes. Key indicators such as the increasing maternal and infant mortality rate, and the increasing incidence of malnutrition and infectious diseases such as tuberculosis and HIV prevailed in many communities (Mitchell & Bossert, 2010). All of these happening amidst the diaspora of health workers overseas, triggered by job dissatisfaction due to overwork, under compensation, and "political helplessness" in a devolved health setting (Labarda, 2011).

The Challenge of Leadership and Health Governance

Central to the issue of health governance is capacitating local stakeholders to take over the responsibility of taking care of the health of their population. How are Local Chief Executives being capacitated and coached such that they understand the intricacies of the health system and the complex health challenges that their communities face, in the light of the devolution? How do they empower the communities to participate in the planning, decision making, and implementation of relevant health programs that would improve their health status and wellbeing? It was in this context that the Department of Health (DOH) in collaboration with a non-profit organization (Zuellig Family Foundation or ZFF), partnered with 12 academic institutions all over the country to build the leadership capacity of local health stakeholders. In 2013, the Municipal Health Leadership and Governance Program (MLGP) started to train mayors, municipal health officers, and local health boards in identified communities with poor health system indices. Hoping to build a more equitable health system, especially for the poor, it sought to improve maternal and infant health outcomes at the municipal level by training and coaching stakeholders using the "bridging leadership" framework. Conceptualized as a development framework in the context of glaring social inequities, the bridging leadership framework provides opportunities and spaces for individuals to undergo a transformative process of self-

realization, owning and embracing issues, engaging other stakeholders and directing them towards collective response to bridge the social divide and create a more equitable community (Institute of Medicine, 2015). When applied to the challenges of a devolved health sector, it sought to promote collective action in addressing complex health issues together with other stakeholders. Initially guided by a technical roadmap that is consistent with the World Health Organization's six building blocks of an equitable and functioning health system, the multi-stakeholder approach and their collective action co-creates new realities that transform and build a more equitable health system. This health system approach aims to effectively harness and mobilize health leadership towards creating policies, service delivery mechanisms, competent health human resources, and a financing environment that are all responsive to the health needs of the communities.

The first iteration of the leadership program focused on maternal and child health and engaged 640 cities and municipalities, and 33 partner provinces all over the country (ZFF, 2015). The second iteration of the program was anchored on Primary Health Care as the health development approach, with emphasis on health equity, universal access to care, community participation, and inter-sectoral approaches to health (ZFF, 2017).

Research Problem

It is important to understand how health leadership and community participation impact health system performance, especially in low resource settings. This paper sought to describe and analyze the personal journey of transformation among stakeholders of the bridging leadership program in selected municipalities, and the emergent leadership processes that work to improve health systems through genuine community participation and empowerment.

Research Objectives

Specifically, this study aims to:

1. Describe the state of the local health systems in participating municipalities in the Eastern Visayas region in terms of key health indicators vis-à-vis the Primary Health Care Roadmap/scorecard;
2. Identify ways how local leadership creates spaces for people participation in the health system;
3. Investigate how institutional arrangements and collaborative mechanisms like dialogue provide opportunities for increasing

community participation in the local health system.

1.5 Methodology

The study used a mixed methods approach with primary data collected from workshop participants and local organizations in the enrolled communities within a 12-month period between 2017-2018. Key Informant Interviews (KIIs) and Focus Group Discussions (FGDs) were conducted with mayors, municipal health officers, and barangay leaders. FGDs were also conducted with members of selected people's organizations. Most of the FGD data were collected during the actual conduct of the Municipal Leadership and Governance Program (MLGP) workshops participated in by municipal mayors and Municipal Health Officers (MHOs) from 19 MLGP municipalities in the Eastern Visayas region. The FGDs among municipal mayors and MHOs were in the form of conversations between and among the participants during the training, facilitated by the researcher and other MLGP faculty. Further, to include the voices of other stakeholders in the community, FGDs were also conducted among Barangay Health Workers (BHWs) and selected organized people's groups in the three selected municipalities. Leadership and people participation constructs and processes were gleaned primarily from the stories and narratives of both the health leaders and community members taken from FGDs and KIIs.

The quantitative research approach was used to analyze the local health system performance using the six building blocks of health in the municipality's Primary Health Care roadmap/scorecard. Data on key health indicators of the 19 MLGP municipalities came from the Field Health Information System (FHSIS) of the Department of Health (DOH) Region 8 Office.

Results and Discussions

Profile of Respondents

Region VIII MLGP Cycle 2 Participants

In the Eastern Visayas region (Region 8), 21 municipalities from the different provinces initially enrolled in the program, but only 19 continued up to the third and last module. Seven of these municipalities were from Eastern Samar, five from West Samar, five from Leyte, one from Northern Samar, and one from Biliran. A total of 38 mayors and Municipal Health Officers (MHOs) from these 19 municipalities participated and completed the module workshops.

More than half (63%) of the participants were female. It can be noted that among the mayor participants, majority were males (71%), while among the MHO participants, the majority were females (63%). The average age for the participants was 47 years old, and around the same mean age for mayors (48 years old) and MHOs (46 years old). Majority of the mayors (84%) and MHOs (90%) were married. More than half of the mayors (58%) were college graduates, 37% had post-graduate education and one (5%) was an elementary graduate. All (100%) of the MHOs on the other hand, as required by professional regulations, were Doctor of Medicine graduates and licensed Physicians (Tables 1 and 2).

In terms of length of service, most of the MHOs had already served an average of 12 years, while most of the mayors (74%) were on their first term as local chief executives. It can also be noted that majority of the mayors (79%) had family members who were also part of local politics or had served in the past as elected officials. Most of their family members were either former mayors, vice-mayors, Sangguniang Bayan members, or barangay captains. Further, among the nine female mayors, six were wives and two were daughters of the immediate past mayors of their respective municipalities (see Tables 1 and 2).

Organized Groups in Selected MLGP Municipalities

Some organized groups from three chosen MLGP municipalities were also invited to participate in the Focus Group Discussions. Among these were two groups of organized Barangay Health Workers (BHWs) from two municipalities, farmers and their spouses in one farmers' organization, public tricycle drivers from one tricycle drivers' association, and a group of fishermen from an organized fishermen's group.

Table 1
Profile of MLGP Mayors in Eastern Visayas

	Mean	***Frequency***	***Percentage***
Age (in years)	48.0		
Length of service (years)	3.0		
Female		9	47%
Married		16	90%
At least high school education		18	95%
With relatives in politics		15	79%

Table 2

Profile of MLGP Municipal Health Officers (MHOs) in Eastern Visayas Region

	Mean	*Frequency*	*Percentage*
Age (in years)	46.0		
Length of service (years)	12.00		
Female		15	79%
Married		17	90%
At least high school education		19	100%
With relatives in politics		15	79%

The State of Local Health Systems of the MLGP Municipalities

Municipal Primary Health Care Roadmap/Scorecard

All the municipal PHC roadmaps or scorecards of these 19 municipalities from the region were monitored by the DOH through its Development Management(?) Officers (DMOs) that were deployed in the different municipalities. These municipal scorecards were collected over a span of 12 months at three time points: (1) before the start of Module 1 (Time 1); (2) before the start of Module 2 (Time 2); and (3) before the start of Module 3 (Time 3).

Trends in the Six Building Blocks during the Program Period

After undergoing two modules, the state of the six building blocks of the local health system used in the municipal roadmap showed significant improvements from their baseline levels. Figure 1 below shows the upward trend of the scores for the various blocks from Time 1 (Pre-Module 1) to Time 2 (Pre-Module 2) and Time 3 (Pre-Module 3).

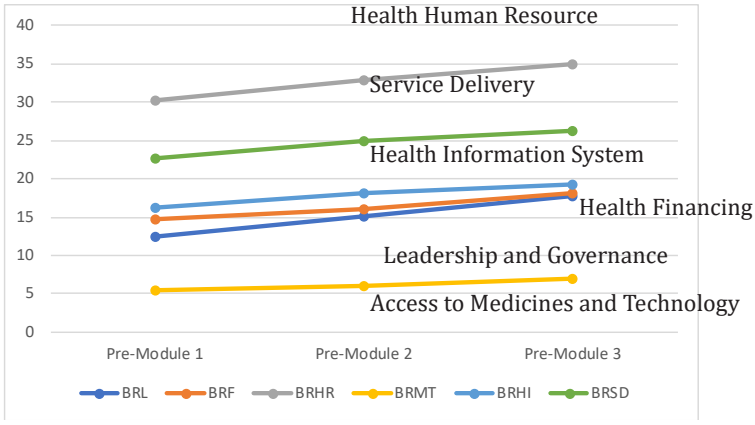


Figure 1. Trends in the Six Building Blocks for Health Scores of MLGP Cycle

Comparison of Primary Health Care Scorecards Before and After the Modules

To assess if the mean scores of each building block at Time 3 were significantly different from the baseline data at Time 1, a statistical test using analysis of variance (ANOVA) was done. Results were in the expected direction as shown in Table 3. Leadership and Governance scores at Time 3 were found to be significantly different from Time 1 at $p < .001$. All the other five building blocks (Health Financing, Human Resources, Access to Medicines and Technology, Health Information System, and Health Service Delivery) at Time 3 were also significantly different from those in Time 1 at $p < .001$.

These provided evidence that, among the participating municipalities, the mean scores of each health system block showed a significant difference before and after the leadership program, as measured by the health scorecards. But can we attribute these changes to the MLGP training itself? It would have been ideal to set up a group (with characteristics similar to those of the MLGP cohort) that did not undergo the training to serve as a control group (Morgan & Winship, 2015). Given the limitation of the study design, we cannot infer causality in the relationship between the training that the mayors and municipal health physicians underwent and the outcomes in terms of the health system indicators in the primary health care scorecards. However, the improvements among the various health system indicators before and after the MLGP training are sufficiently robust.

Table 3
Summary for Analysis of Variance of Health Building Blocks

Building Blocks for Health	Df	F	η	p***
Leadership	1	419.20	.52	.000
Finance	1	31.65	.48	.000
Human Resource	1	17.86	.34	.000
Medicines and Technology	1	16.37	.33	.000
Health Information	1	27.79	.45	.000
Service Delivery	1	20.15	.37	.000

***Significant at $p < .001$. Df = degrees of freedom. F = F statistic. η = eta.

Further, a closer look at the MLGP scorecards for all the municipalities showed the Health Leadership and Governance block to have the highest slope or rate of change at 2.6 compared to the other five building blocks, when scores were computed from Pre-Module 1 to Pre-Module 3 (see Table 4).

Table 4

Rate of Change (Slope) of the 6 Building Blocks for Health Scores

	Leadership and Governance	*Health Financing*	*Health Human Resource*	*Medicines and Technology*	*Health Information System*	*Service Delivery*
Time 1	12	14.7	30.2	5.5	16.3	22.6
Time 2	15.1	16	32.8	6	18.1	25
Time 3	17.8	18.1	35.1	7	19.3	26.2
Slope	**2.6**	1.7	2.4	0.8	1.5	1.8

When the strength of one-to-one correlation of the six building blocks was tested before Time 1 (T1), data showed that only the Leadership and Governance building block was moderately correlated with the Service Delivery block at T1 at $p < 0.5$. No other correlations from the other building blocks were noted at T1 (see Table 5).

Furthermore, when the strength of correlation of the six building blocks was tested after the two modules (T3), data from Table 5 show that the Leadership and Governance building block was strongly correlated with the Human Resources building block at $p < 0.01$. It was also noted to be moderately correlated with the Access to Medicines and Technology building block at $p < 0.01$ and the Health Information System building block at $p < 0.5$. Data also showed that the Human Resources building block at T3 was moderately correlated with the Access to Medicines and Technology building block at $p < 0.5$. Lastly, the Access to Medicines and Technology building block was noted to be weakly correlated with the Service Delivery building block at T3 (see Table 5).

Table 5

Correlation Matrix of Various Building Blocks for Health System

Variables	Mean	SD	1	2	3	4	5	6	7	8	9	10	11
1. Leadership_T1	12.5	2.04	-										
2. Finance_T1	14.56	2.12	.38	-									
3. Human Resource_T1	30.06	3.64	.46	.46	-								
4. Medicines Technology_T1	5.39	1.14	.29	.20	.45	-							
5. Health Information_T1	16.39	2.00	.22	.25	.29	.24	-						
6. Service Delivery_T1	22.39	2.38	.55*	.37	.47	.33	.08	-					
7. Leadership_T3	17.22	3.04	-.11	-.07	-.28	-.22	.14	.27	-				
8. Finance_T3	18.11	1.64	-.11	-.04	-.35	-.18	-.17	.24	.41	-			
9. Human Resource_T3	35.00	3.38	-.02	-.23	-.03	0	-.18	.34	.70**	.44	-		
10. Medicines Technology_T3	6.94	1.16	-.34	-.13	-.39	.11	-.14	.28	.66**	.50*	.57*	-	
11. Health Information_T3	19.28	1.18	-.04	.19	-.15	-.22	.30	.09	.50*	.20	.13	.36	-
12. Service Delivery_T3	26.17	2.66	-.20	-.16	-.04	-.20	-.33	.39	.43	.09	.31	.48*	.21

Note: Subscripts T1 and T3 refer to Time 1 and Time 3 respectively. * $p < 0.5$). ** $p < 0.01$. *** $p < .001$.

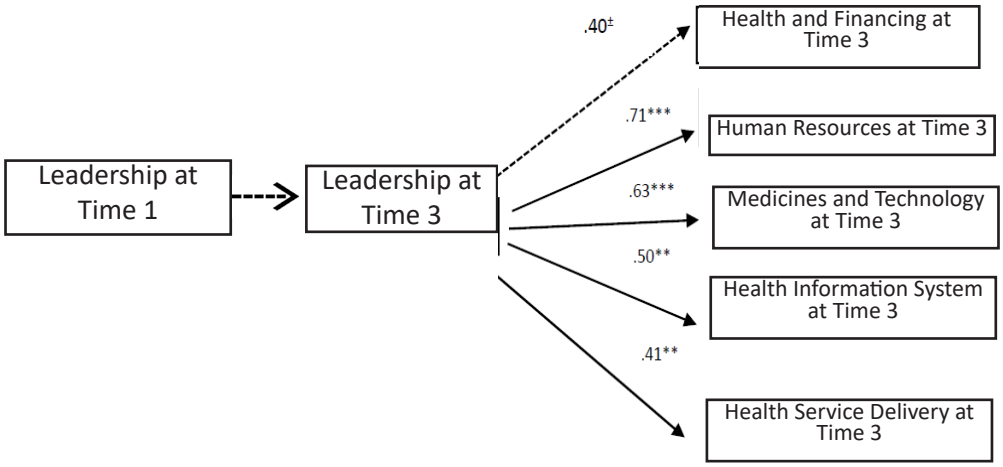
Testing Association Between Leadership and Other Building Blocks

Among the six building blocks for health, it was the Leadership and Governance block that showed much improvement in the scorecard when the baseline was compared to the data after the MLGP training was done (see Table 4). To test if there was an association between the Leadership and Governance block after the training and all the other five building blocks, a path analysis using linear regression modeling was done (see Figure 2). Results showed that

the Leadership and Governance building block at T3, controlling for the Leadership and Governance block at T1, is significantly associated with all of the different building blocks—Health Financing at p <.10, Human Resource at $p < .001$, Access to Medicines and Technology at p < .001, Health Information System at $p < .01$, and Health Service Delivery at $p <$ 0.5 at T3. This means that better Leadership and Governance scores at T3 were associated with better scores/outcomes for all the other five building blocks, controlling for baseline leadership scores at T1.

It is also noteworthy that among the six building blocks, Leadership and Governance appeared to have the largest rate of change during the period of reckoning. Although this might be due to differences in the baseline scores and the scale of these scores, a cursory examination of the rate of change (see Table 4) from the different time points showed that this is hardly the case. Leadership, Health Financing, Health Information System, and Health Service Delivery appeared to be similar in terms of baseline score and scale. Only Health Human Resource and Access to Medicines and Technology appeared to be at the extreme ends of the scores.

Modeling the relationship between these six building blocks is an important issue to address. They were originally conceptualized as contributing to the overall goals of improving levels of health equity, responsiveness, social and financial risk protection, and improved efficiency of the health system. The means by which they would achieve these goals was through increasing access, coverage, quality, and safety of health care. There is increasing recognition, however, that these blocks are not static, and some components drive the other blocks. And there is mounting evidence that the Leadership block is a key driver of an equitable health system (Mikkelsen-Lopez et al., 2011). This is consistent with extant literature on the role of leadership and governance in building equitable health systems (WHO, 2007; ZFF, 2015; Mikkelsen-Lopez et al., 2011; Kohler & Martinez, 2015; Anwari et al., 2015). Leadership, then, is not simply one ingredient among many, and it appears to be a key driver in the process.



Note: ± p < 0.10 is considered significant based on social science standards

Figure 2. Path Analysis using Linear Regression Modeling .

Key Health Indicators

To assess the health status of the community vis-a-vis the changes in local health leadership and health system performance, this study monitored two key health indicators of all the participating municipalities that are important markers of the overall health of a society, namely Infant Mortality Rate (IMR) and Maternal Mortality Ratio (MMR). Data for both key health indicators were taken at two points during the program—first as baseline data before the start of the Module 1 training and second after the Module 2 training and practicum. The use of the IMR and MMR acknowledges the fact women and children are often the most vulnerable groups in a community. They appear to be sensitive indicators to the levels of health system performance vis-à-vis the weakest members of the community. Previous studies have shown that inequality is a powerful predictor of infant mortality and maternal mortality. The more unequal a society is, the higher the infant and maternal mortality rates are (Ruiz et al., 2015).

Infant Mortality Rate (IMR)

Based on the data from 2015 to 2018, five municipalities were able to maintain zero IMR while 11 municipalities were able to lower their IMR or reduce it to zero. However, five other municipalities were recorded to have infant deaths from 2015 to 2018. There was anecdotal evidence that these infant death records were brought to light due to the stricter

monitoring of birth outcomes by the DOH and ZFF as part of the training program accountability. The spike in IMR among some municipalities was attributed to more accurate record keeping from increased surveillance.

Maternal Mortality Ratio (MMR)

The same scenario was seen in terms of the maternal mortality ratio (MMR) among the MLGP cohort municipalities. Sixteen towns either maintained zero maternal deaths or reduced the number to zero, while two municipalities had an increased MMR during the period of assessment. These two municipalities were both found in Leyte province. Again, anecdotal evidence pointed to stricter record keeping and accuracy in reporting as a driver in the spike of maternal death figures in the participating municipalities.

Given the above data, IMR and MMR as outcome indicators lag behind the other changes in the health system. They are sensitive measures of inequality in general, and of social determinants of health in particular, but they could not be expected to change quickly without addressing other drivers of health outside of the health sector (e.g., poverty, education, gender relations).

Revisiting the Building Blocks of a Functioning Health System

The WHO health system building blocks appeared to be useful in tracking the changes of the local health system at the level of the participating municipalities. Initially conceptualized to measure health performance at the country or macro-level, the six building blocks as operationalized in the MLGP program to measure the status of health system functioning of local government units generated robust evidence of their relationships to each other. However, in line with the discussion above, there is a need to reconfigure the six building blocks with the Leadership and Governance component as the driver of a functioning health system. The other five blocks are directly associated with changes in Leadership and Governance. No other building block has the same level of influence on the other components of the WHO health system building blocks.

There is support in the literature on the essential role of health leadership and governance in health system transformation (Bradley, Taylor, & Cuellar, 2015; Manyazewal, 2017; J. Mfutso-Bengo et al., 2018; J. M. Mfutso-Bengo, 2016; WHO, 2010). The research results add evidence

to the importance of looking at leadership as critical in driving health system changes. A reconceptualized WHO health systems framework with leadership as the key driver of health system changes will be congruent with the experiences at the local health system level.

The Practice of Bridging Leadership: Changes in perspectives on health

Political leaders and health professionals in the MLGP training program initially viewed health issues and health challenges as the domain of the health sector alone. The health sector operated in some sort of a silo, separate from the rest of the functioning of the local institutions except for the occasional meetings to seek for financial and other resources. Results of the study showed that these assumptions prevail despite the implementation of the Local Government Code in 1991.

In addition, health issues were traditionally perceived in an instrumental way, as a means to an end, and not valued by themselves (e.g., as means to higher incomes, educational opportunity). Why does this perspective create problems on the ground? Since health is viewed as just a means to an end, it is traditionally not given much importance, unless the individual or the person is already experiencing pain or suffering as a consequence of ill health. This probably explains why individual health is not given much attention in the day-to-day lives of the community people, hence health preventative and promotion measures fail. In the same way, local leaders also do not give as much priority to health issues as they would to building infrastructure in the community. This is in contrast to Sen's (1999) health capability approach where health is perceived to be valuable in itself. An individual's health expands the ability to exercise freedom and increases the capacity for desired functionings to pursue wellbeing and approach the world with courage and freedom (Sen, 1999). Thus, health should not just be a means to an end, but also an end in itself.

Further, it was a jarring experience for many of the participants to realize that the health problems of the community have a lot of putative causative mechanisms (i.e., health inequity is a complex systemic problem), necessitating multi-stakeholder approaches to tackle such complex problems effectively. After undergoing experiential and structured learning exercises and health data analysis of their respective municipalities, some participants expressed that they were part of the complex system that created the problem. From not feeling accountable for health issues because "I am not a doctor," participants were able to probe deeper into the system, tracing how their roles affect the bigger whole, and how other

sectors and stakeholders affect the health system. Perhaps this is what Senge described in learning organizations as systems thinking—the "shift of mind" from seeing ourselves as separate from the world, from seeing problems as caused by someone or something "out there" to seeing how our own actions create the problems we experience" (Senge, 2006). This systems perspective also leads to the realization that an individual is only one part of the system, and that there are other parts of the system that need to be engaged. However, engaging other stakeholders can be a socially complex problem, which means that the people involved see things very differently leading to a more polarized problem and getting stuck (Kahane, 2004). This reflects that health, like other complex systems, is characterized by self-organization, constant changes, feedback loops, non-linearity, time gaps between inputs and outputs; it is historically grounded and even well-intentioned interventions produce unintended consequences (Savigny & Adam, 2009).

It was in this context that engagement in multi-stakeholder processes and dialogues was appreciated, leading the MLGP participants to seek real-time information from the field, increasing their field of awareness, and challenging long-held class and gender-based biases against the poor and marginalized sectors. In the practicum phase of the health leadership program, mayors joined the MHOs and the RHU team in going to the barangays for health service delivery to understand the complexities of health problems and find solutions by witnessing and experiencing at least part of it for themselves. The challenge in solving problems with high social complexity does not yield to easy solutions generated by authorities alone, but rather, the people involved must participate in creating and implementing solutions (Kahane, 2004). This meant talking and listening to community people to deliberately involve them in understanding their health predicament and in creating and implementing solutions to their own problems.

Leading by Creating Spaces for People's Participation in the Health System

Making people participate in the conduct and implementation of health programs has always been a challenge for health leaders, even if services are geared towards improvement of health status. Yet, despite these setbacks, mayors and MHOs in the MLGP program continue to create spaces and opportunities for people participation, acknowledging the fact that health programs will be difficult to implement, and health improvements will be difficult to reach without the community's help and

participation. Local leadership is thus crucial in making sure that there are spaces for people participation in the local health system.

Involvement of Organized Groups in the Community

There are many ways that local leadership can provide such spaces. In Region 8, for instance, maternal and infant deaths have remained a challenge, especially in far-flung barangays where access to birthing facilities is difficult. Even if pregnant women and their family members would like them to give birth at the health facility, most of the time they cannot afford the transportation fare, or they cannot find available means of transport especially in emergency cases. In Municipality A, the Local Chief Executive together with her Municipal Health Officer (MHO) and health team spearheaded the organization of a group of volunteer public transport drivers to provide transportation to pregnant mothers from Geographically Isolated and Disadvantaged Areas (GIDA) needing to go to the health facilities when they are due to give birth. The group was later named as *Habal-habal* and *Motorcycle Emergency Drivers* (HAMED) and was mainly composed of tricycle and single motorcycle or *habal-habal* drivers in the municipality. When the partnership was started, the local officials and health team encountered challenges such as setting the tariff at a reasonable level and making the community understand that the program was not only owned by the LGU, but that all have a big role to play in making the lives of other barangay people better. This awareness drive and the attempt to make the HAMED service an important part of an innovative solution for health issues was initiated by the local health leadership.

Involvement of Community Leaders

One strategy that Municipality B employed to implement programs on sanitation, specifically on the construction of sanitary toilets, was through the involvement of its barangay leaders. The mayor made sure that, even if the program was supported by the municipal budget, the different barangays would also give a counterpart, as a sign of their support and participation. In this municipality, the project was allocated a budget of Php1.5 million and they wanted to ensure that the toilet bowls they purchased would not go to waste. Thus, they coordinated with the Department of Social Welfare and Development (DSWD) in identifying the poorest members of every barangay. And as part of their partnership with the barangay, for every ten households that were given sanitary toilets and construction materials by the municipality, the barangay would also identify and provide construction materials to five more poor households in their barangay.

The partnership agreement also stipulated that barangay officials would take responsibility for the proper and timely construction of these sanitary toilets. After a dialogue, it was agreed that every barangay was to appoint a Sanitary Inspector to monitor the construction of the toilets in their own barangay. To clarify roles and responsibilities, an orientation was held for all Sanitary Inspectors at the barangay level. At the household level, families started to make structures for their sanitary toilets, sometimes using their own money when necessary.

Involvement of Leaders at the Family and Household Level

In Municipality C, where the focus was on child malnutrition, it was observed that community people, particularly mothers, were more receptive to health programs, especially when it involved their children. The local mayor took the issue on as one of her personal advocacies, made sure that she knew the malnutrition records and status of her municipality, and did something to address it together with the community people. One window of opportunity that they saw to actively involve family members, especially mothers, in giving proper nutrition to their children was through health education during the Nutrition Month celebration every March.

Creating Spaces for Dialogue

For some program participants, the dissonance between their prejudice and biases and their experiences on the ground shifted their focus of attention and allowed them to identify with some of the struggles faced by the community people, increasing the space for empathetic listening. This process of "deep listening" when practiced in dialogue allows the leader to shift the origin from where his or her listening originates—from the boundaries of one's own mental cognitive organization to seeing how the world unfolds through someone else's eyes (Scharmer, 2007). Participants had the opportunity to practice this during their interactions with the community during their MLGP practicum. For many leaders who took the program seriously, they transitioned from the practice of mere information dissemination to creating spaces for real dialogue where people are encouraged to participate in discussions. Some even took it to the next level and institutionalized these arrangements in the form of a People's Assembly, and the expansion of the Local Health Board and the Barangay Health Board to include other non-health stakeholders in the discussions on health.

While these arrangements have indeed changed how participation processes are practiced on the ground, it is also important to interrogate

the nature of the power relations that surround and imbue these potentially democratic spaces—the levels, spaces and forms of power (Gaventa, 2006). In his "Power Cube" framework, Gaventa argues that the different levels (i.e., global, national, local), spaces (i.e., closed, invited, claimed/created), and forms (i.e., visible, hidden, invisible) of power must align horizontally and vertically simultaneously to bring about successful change. The challenge, however, is how to determine which "alignment" of strategies is best for a particular issue, given that many combinations and "alignments" are possible, and their interaction with each other makes it even more complex. In essence, he pointed out that issues need not be addressed by a single strategy only, but rather, several strategies should be explored and understood in the light of the different dimensions of power for real transformative change to occur (Gaventa, 2006). On the ground, leaders should continue to explore and test these strategies to make these spaces for participation work in their own context, in order to produce sustainable innovations that will improve people's health and wellbeing. Similarly, in the Theory U framework, this process is known as prototyping—the process of exploring the future by doing, rather than by thinking and reflecting (Scharmer, 2007).

Acknowledging now that health issues are complex and evolving, the mayors together with their MHOs tried to explore new ways of doing things by going to the people, asking, listening, and trying to make sense of what was happening around them. Most of these were experienced during the actual Deep Dive activity of mayors and MHOs where they had experiential learning activities with some selected groups/households in their respective communities. For many of the participants, the activity sufficiently moved them to a decision to commit to changes in the health system and forge cross-sectoral collaboration to address the social determinants of health inequity.

Lessons and Insights

Towards a Community-Engaged Leadership for Health Equity

The Municipal Leadership and Governance Program (MLGP) sought to capacitate local leaders as "bridging leaders" to address health inequities in their communities in the context of prevailing social and economic divides. Their challenge as leaders amid this inequality is to "bridge" the gap created by these social divides. The process of conscientization in their journey to become bridging leaders who seek to address these social inequalities started with self-awareness of their principles and values. This allowed them to ground their personal response

to these divides and understand how they are part of this complex system that perpetuates these inequities. Understanding that health inequities are rooted in the lived social conditions of the people is integral to understanding the healthcare predicament of the poor. Several of the tools used to address health disparities included the primary health care approach to achieve "health for all,"; the bridging leadership process of ownership, co-ownership, and co-creation; building leadership and social capital; systems thinking and complexity approach; multi-stakeholder processes, dialogue, and rapid prototyping.

The practicum period also provided the participants with the opportunity to implement their action plans based on RAPID change using the principles of iterative learning and inter-sectoral collaboration. The mid-program checkpoint during Module 2 celebrated "quick wins" and provided space for reflection on the challenges the participants faced as bridging leaders. Their insights were deepened by the practice of adaptive leadership in the context of the cultural understanding of "loob." They also crafted their personal response as bridging leaders into a public narrative that shifted their personal story, into a story of "us" and called for collective action into forging a story of "now" to co-create new institutional arrangements.

The final lookback in the last module focused on addressing the social determinants of health, the broader social conditions that generate health inequalities beyond the health sector. Gearing for the long haul in the struggle for substantive changes beyond the health system, participants are called to resilient leadership, building resilient organizations and partnering for resilient communities. The challenge is to co-create community-centered actions through the exercise of community-engaged leadership where communities participate meaningfully in all levels of decision-making.

Limitations

To ascertain the sustainability of these community empowerment processes, a longitudinal study to follow up the participating communities and track changes through time should be done in the future. It would also be important to disaggregate data in the local government primary health care scorecards to reflect gender, class, and other social inequalities relevant to health outcomes in the community. Further studies looking at the critical factors that differentiate successful bridging leaders from those who were not could likewise shed light on the contextual elements that contribute to the process. Lastly, expanding the concept of leadership to include participants from various levels of organizations, institutions, and

communities would allow the exercise of transformative leadership to permeate deeper layers of social relations and other sub-structures that drive sociocultural changes.

Conclusion

The Bridging Leadership framework used in the MLGP program provided a scaffolding for ethical leadership to bridge the gap between the powerful and powerless in society. It started by acknowledging that leaders are part of the problem and that substantive solutions to societal problems need a shift in awareness to allow for emergent realities to breakthrough—from actions that emanate from the poor themselves. There is evidence to suggest that this model of leadership that seeks to fully engage the various stakeholders in the community has the potential to create new institutional arrangements and strengthen existing structures for community participation to tackle complex problems like the social determinants of health. Beyond the personal commitment of local leaders to initiate meaningful changes in governance, shifting the dynamics of power to these mechanisms of democratic participation like the barangay health boards, local health boards, and provincial health boards could bridge the gap between the vulnerable and the powerful. Making these institutions accountable and answerable to the poor, however, would entail a highly engaged and empowered citizenship. This goes back to the capability approach of health where expanding the freedoms of people to do and be is critical to the whole development project. This iterative process where social conditions generate increased human capability would, in turn, lead people to envision, plan, act, and build a better future together for their communities.

Note:

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