Bridging Inner & System Governance

Co-creating Responsive Health Systems for Better Health Outcomes of the Filipino Poor

A case study by Heidee Buenaventura for

INNER WORK *for*
SOCIAL CHANGE

Fetzer Institute

SYNERGOS
Building trust works

Contents

The Inner Work for Social Change Project

Synergos and the Fetzer Institute began the project on Inner Work for Social Change in 2018 to demonstrate how Inner Work and Bridging Leadership can make social action towards a better world more effective. Through six commissioned case studies and in dialogue with thought leaders, development practitioners, activists, and others, the project aims to spark a global conversation on how reflective practices can make social action more aware, more ethically attuned, and more sustainable.

Within the project, *inner work* is any form of reflective practice that increases awareness of self, others, and the systems in which complex social problems arise. Inner work is core to *bridging leadership,* which is the capacity and will to build trust and tap the fullest contributions of diverse stakeholders, helping them to come together across divides to work in concert for the common good.

About this case study

This case study from the Philippines focuses on the application of Bridging Leadership in addressing health system challenges to produce better health outcomes, especially for Filipinos living in poor communities.

The case study describes the development and achievements of the Health Leadership and Governance Program partnership between the Zuellig Family Foundations and the Department of Health. Stories from bridging leaders portray their personal, organizational, and community experiences in transforming their health systems to be more responsive to the health needs of their people. Leaders' stories illuminate the relationship between personal change and systemic change.

Baj Datinguinoo leaves one of their geographically isolated islands after her field visit

Zuellig Family Foundation photo

A Life for Another – Jackielyn's Story

As soon as Jackielyn told him the pain had started, Joseph knew it was time. After having six children, this was a familiar scene, almost routine. He helped Jackielyn move through the darkness to lie down on the bed, with only a lamp as their source of light and the sound of rain falling hard outside. When the pain became more regular, a sign that the baby would come out in a few hours, maybe minutes, they hurriedly sent for Aunt Denia, the village's traditional birth attendant, as they had done in the past. They would have wanted this time to give birth in the hospital because her seventh pregnancy classified her as high risk. But Jackielyn changed her mind for fear of being reprimanded because during her last prenatal check up, she heard a health worker scolding a patient for having so many children. So, they settled again at home, away from unwanted criticism and judgments. Joseph held Jackielyn's hand, as the pain had now increased, comforting her as they waited for help. But living in one of the farthest and most isolated villages in town, with no available transport on hand and amidst the heavy downpour, they knew Aunt Denia would take a while. But they patiently waited because they had no choice.

Jackielyn's pain was now at regular intervals. The baby was coming. Aunt Denia finally arrived but upon seeing her in pain, she advised Joseph that she had to give birth in the hospital. His relief turned to worry because they were miles away from the nearest hospital. With no forms of transportation nearby, they needed to travel on foot, through the heavy rains and muddy downward slopes. But 15 minutes after Aunt Denia's arrival, they heard the familiar sound of a baby crying. There was no need to go to the hospital anymore; their daughter had been born.

Later into the night, Jackielyn told Joseph her hips were hurting, and she was dizzy. Joseph learned she had barely slept after her delivery. She had also not stopped bleeding, her blanket already replaced three times. Aunt Denia and two of his kids sought help from the village's faith healer but returned clutching only a piece of ginger. Having no other options, they loaded an unconscious Jackielyn onto a hammock and struggled through the mud, floodwater, and rain to look for the nearest tricycle to get them to the municipal hospital. They had to slow down from time to time or else find themselves stuck in one of those deep, mud-filled patches. It was past three in the morning when they reached the hospital. Joseph rushed frantically to the door of the emergency room, but it was padlocked. He banged on the door, until after a long while, a security guard peeped through one of the opened jalousies and called to them, "There's no doctor here, go to another hospital. We can't do anything for you." Left again with no other choice, they travelled another 12 kilometers to reach the next hospital. Upon arrival, he ran straight to the emergency room, carrying his motionless, drenched wife. As he laid Jackielyn down on the bed, he felt a coldness that was not caused by the rain. He knew they were too late. His wife had already bled to death.[1]

Zuellig Family Foundation photo

Joseph and children visit Jackielyn's unmarked grave

The cost of being poor in the Philippines

Jackielyn's story is just one of millions of stories on the plight of the Filipino poor in accessing health care. Her story reflects the impact of health inequities brought about by a fragmented, poorly responsive health system. According to Romualdez (2013),[2] maternal mortality rates in low-income/rural areas (greater than 221 per 100,000 livebirths) were exponentially higher than in high-income/urban areas (less than 15 per 100,000 livebirths). The same applies to infant deaths, with more deaths (greater than 90 per 1000 livebirths) in low-income areas than in high-income ones (less than 10 per 1000 livebirths). A National Demographic and Health Survey in 2013[3] revealed significant disparity in terms of access to maternal health services between the poor and the rich. The rich enjoyed access to safe and quality delivery with higher facility-based delivery (91.2%) and assistance by skilled health professionals (96.2%). The poor, on the other hand, were able to deliver in a health facility at only the low rate of 32.8% and only assisted by health professionals 42.2% of the time. In addition, Table 1 shows reproductive health indicators in the richest group compared with those in the poorest wealth category.

Table 1. Reproductive Health Indicators by Wealth Quintile

Key Reproductive Health Indicator	National	By Wealth Quintile (Group)	
		Poorest	Richest
Actual fertility, births per woman	3.0	5.2	1.7
Wanted fertility, births per woman	2.2	3.3	1.4
Difference in actual vs wanted births	1.2	1.9	0.3
Birth Interval, months	35.1	31.2	50.6
Early childbearing, %	26.1	44.1	13.1
Contraceptive use (modern methods), %	37.6	33.0	43
Age at first marriage, yrs	22.3	19.8	23.4
Unmet need for FP(MWRA), %	22.3	28.2	20.5

A mother in Malapatan, Kihan, Sarangani traverses the difficult terrain riding a horse, the more practical option for its residents

A Filipino child born to the poorest family is three times more likely to not reach his fifth birthday compared to one born to the richest family. Three out of every 10 children are stunted. Around 1.5 million families become impoverished every year because of out-of-pocket payments for expensive health care. Many Filipinos just choose to not seek or to delay care due to high costs and unpredictable hospital bills. A typical Filipino has to wait long hours in public hospitals to receive care, only to be admitted to overcrowded rooms with incomplete services.[4] Being sick can be catastrophic for a poor Filipino family. And even if they desire to seek better care from private health facilities, they still end up in poorly staffed and serviced health centers and hospitals because they really cannot afford any better.

This was the challenging state of health of the poor in the Philippines, with a nearing deadline of meeting the Millennium Development Goal (MDG) targets. The MDGs were eight goals to address poverty, disease, hunger, illiteracy, environmental degradation and discrimination against women that UN member states agreed to try to achieve by 2015.[5] Progress in achieving the standards has been slow, with some targets barely attained and some not even met.[6] The current national health reality led to a public–private partnership as one of the strategic responses to the intensifying efforts for health reforms.

This is a case study on how the Zuellig Family Foundation (ZFF) came to form a six-year partnership with the Philippines' national health ministry, the Department of Health (DOH), through the Health Leadership and Governance Program (HLGP). The program was deemed a response to the increasing urgency of improving health outcomes, especially of poor populations. The case focuses on how leaders from different levels of government (national, regional, provincial, and municipal) involved in the program applied Bridging Leadership to drive health system changes for improved health outcomes of the people.

The case outlines the establishment of the Foundation's proof of concept from 2008 to 2013, highlighting lessons learned from implementation, and the strategies involved in the scale-up phase from 2013 to 2018.

About this case study

The Philippine case focuses on the application of Bridging Leadership in addressing health system challenges to produce better health outcomes, especially among the poor.

Broadly defined and as applied to this case, Bridging Leadership is a leadership approach for facilitating collaborative action towards social change through the processes of ownership, co-ownership, and co-creation.

Ownership is a leader's personal response to a system understanding of social divide, anchored on his/her values and principles. With ownership, the leader develops the understanding that one is part of the problem and is led to a personal response for a change agenda or solution. Recognizing one cannot do the work alone, the process of co-ownership enables the leader to bring together key stakeholders through trust-based relationship building to arrive at a shared vision and collaborative response. Co-creation is the collaborative response of partners and communities through innovative ways of addressing the issues and challenges.

The Bridging Leadership approach is also guided by the Theory U change framework. The ownership process is much like a small, individual U journey of awareness of one's self and environment, connecting to the source that drives one's thoughts, feelings, and actions, towards a personal vision of change. The co-ownership and co-creation processes are similar to a bigger U journey where, in transitioning from the self to the system, the leader journeys with other stakeholders, having a deep, shared understanding of what's happening, coming up with shared values and a shared vision and allowing a co-created change to emerge.

Desktop reviews of existing ZFF articles and case write-ups about the partnership, together with stakeholder interviews, provided content for the case study. The desktop review process included scoping and reading written cases, reports and policies documented by ZFF under its Community Health Partnership Program

and the Health Leadership and Governance Program partnership with the Department of Health (DOH).

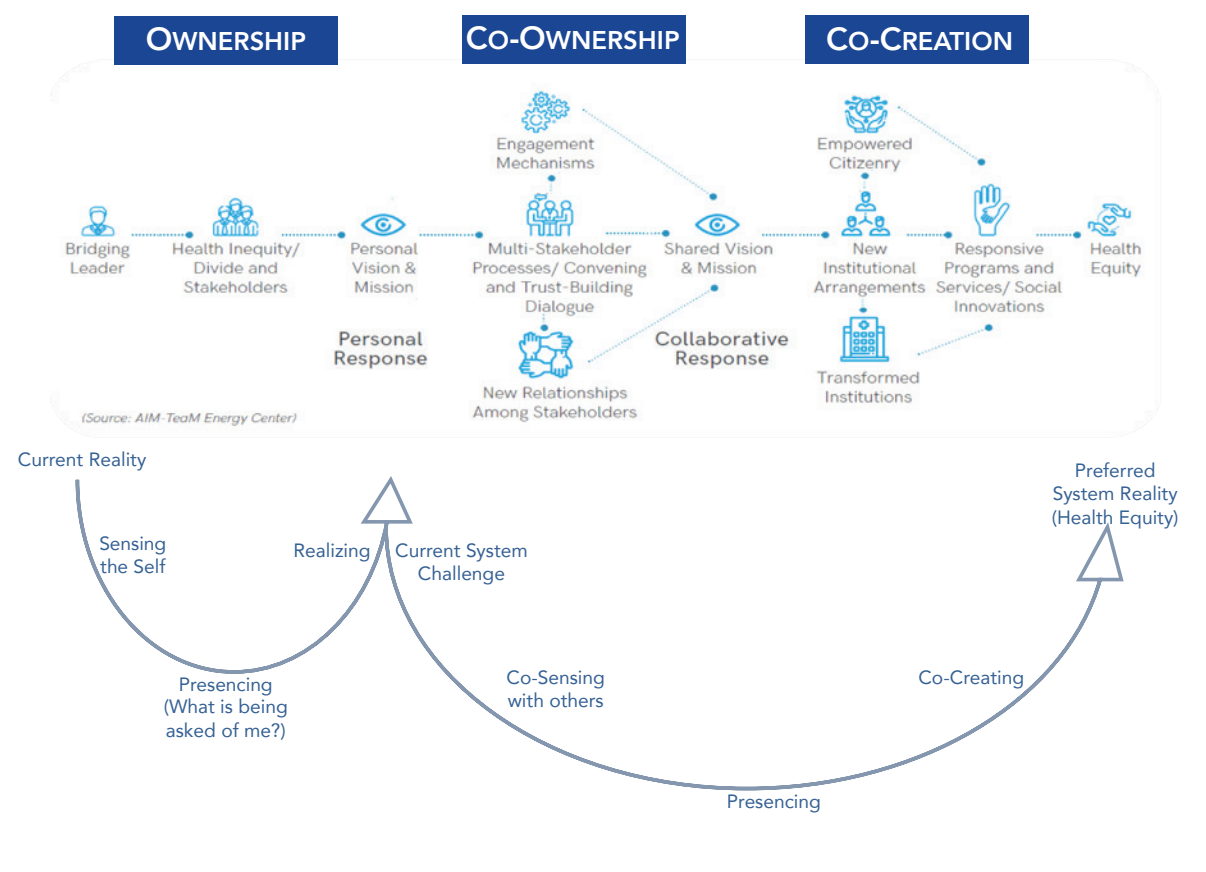
Target stakeholder interviewees came from the implementers and partners listed below, with actual interviews conducted only with those who responded to the interview request and gave their consent.

- National DOH office bureau representatives
- Regional directors and lead program coordinators
- ZFF program leads and operations officers
- Local government program recipients: provincial governors, municipal mayors, and their health officers

The case writer's participation in training and close-out activities under the program added depth and perspective to the case content.

Much of the case study builds on stories from Bridging Leaders that depict their personal, organizational, and community experiences in transforming their health systems to be more responsive to the health needs of their people.

Figure 1: Bridging Leadership Framework from AIM-TeaM Energy Center, integrating Scharmer's Theory U



Building a proof of concept: The Health Change Model

Since its inception, the Zuellig Family Foundation's (ZFF) vision has been clear and simple: to be a catalyst in improving the health conditions of Filipinos, especially the poor in the rural areas of the Philippines. It is built on the ideology that health is a right and that every Filipino, regardless of their position in society, should be provided with the best quality of healthcare they need.

Anchored on this philosophy, the Foundation, led by its president, Ernesto Garilao, explored different directions and suggestions on how to put its vision into action. First is to have a complete understanding of the realities that brought about the inequitable health conditions and the lengths the poor had to go through to avail themselves of basic healthcare and services. Analyzing the system came next, with its interconnected structures, processes, and stakeholders, all contributing to the gaps and poor health outcomes. With this system lens on the health challenge, the Foundation also took into account one important reality of the Philippine health system: its devolved setup that delegated health to the functions of the local governments.

Municipal leaders of Cohort 2 complete their first module of the Health Leaders for the Poor program

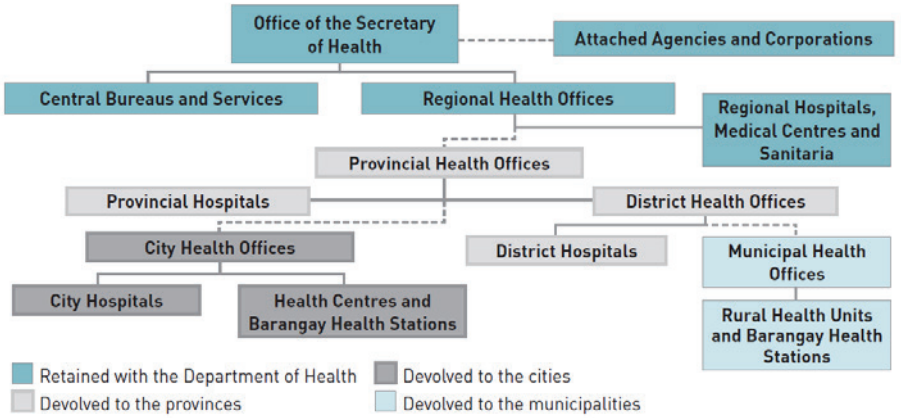
Prior to this devolved structure, the management of public health systems were centralized at the DOH, with the ministry having authority over health facilities, personnel, and budget. But the enactment of the Local Government Code of the Philippines in 1991 mandated the transfer of administrative and financial control over health facilities, personnel, and governance for health from the DOH to the elected leaders of the provinces, cities, and municipalities (Figure 2). The law gave full authority to the local government units to direct their efforts to attaining national goals.[7] However, this transfer of power and control was placed in the hands of political leaders who were not equipped to lead and govern the complexities of a health system. This gap in leadership and governance created further disparity in the access to health services, resulting in poor health outcomes, especially for the marginalized populations.

A 25-year assessment of the Philippine Health Sector Performance post-devolution clearly revealed the disparity.[8] The study claimed that the decentralization of the public health system brought unintended consequences, specifically, it

- weakened the implementation of the national programs due to the high transaction costs of engaging individual and autonomous local government units (LGUs)
- reduced the effectiveness of the public health delivery system as a regulatory instrument
- widened the variation in access to and the quality of public and private health care.

These consequences affected the capacity of the health system to influence health outcomes, thereby increasing health inequity.

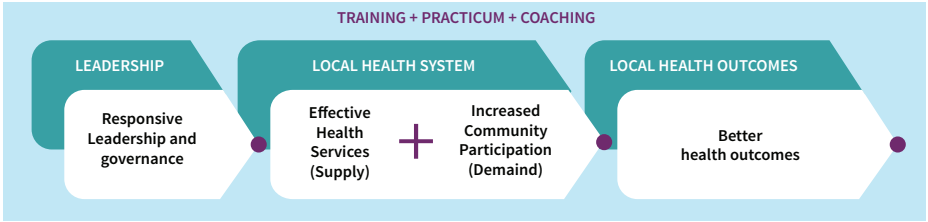
Figure 2. Devolved Organizational Structure of the Philippine Public Health System[9]



Given this context, the Foundation studied possible interventions, different approaches and models of leadership based on governance practices and experiences in this type of health system. The findings were then translated to ZFF's Health Change Model. This change model emphasizes the value of local leadership in creating and governing health programs and services responsive to the needs of the people, especially the poor. It asserts that, for better health outcomes to be achieved, people must have equitable access to health services and that a responsive health system can be influenced and facilitated by strong and committed local leadership.

Unique to the model is its recognition of the importance of political leadership in a decentralized system. The approach of working with local political leaders to address the health challenges in the system for better health outcomes was deemed unorthodox and counter-intuitive because health officers and workers are responsible for implementing health programs and providing health services. How could political leaders, with no expertise and credibility regarding health system strengthening, take the lead in the reforms? Taking this path came with risks but management and staff agreed that it was still a strategic and innovative direction to explore. The Foundation decided to build its proof of concept and proceed with prototyping the Health Change Model to an initial group of 10 municipalities in 2008. This grew to a total of 72 municipalities across the rural poor areas of the country by 2013.

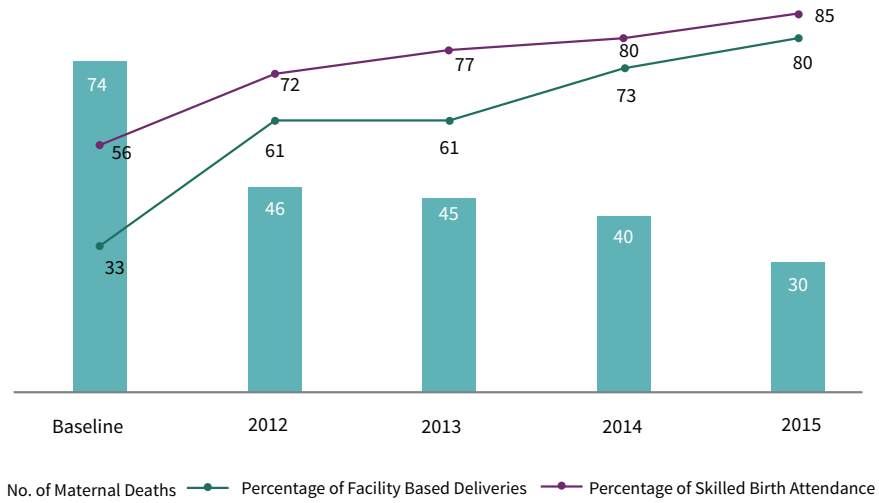
Figure 3. Zuellig Family Foundation's Bridging Leadership-driven Health Change Model



The Health Change Model was operationalized through the Health Leaders for the Poor (HLP) program under ZFF's Community Health Partnership Program. The program was a two-year Bridging Leadership development journey, designed with training, coaching, and practicum components intended to improve maternal and child health outcomes.

A high municipal health burden and commitment of the mayor to address their health challenges were among the selection criteria for inclusion in the program. The ZFF trained the mayors and their health leadership teams on concepts related to health system strengthening and the practice of Bridging Leadership. Supported by a health action plan and visual roadmap of their target system changes, they were then guided through a practicum period with activities designed to help them reach health system milestones linked to improvement in health outcome indicators. Each mayor and their partner health officer also received coaching and technical assistance to reinforce performance and accountability in the course of their practicum. The support developed the leaders' Bridging Leadership competencies to enable leadership acts to institutionalize health system reforms and contribute to improving their health outcomes. Bridging Leadership was central to the program because addressing health inequities and maternal and child health challenges requires convening diverse stakeholders and establishing trust-based relationships to enable collaborative action for system and social change.

Figure 4. Improvements in Selected Maternal Health Indicators in the 72 ZFF Prototype Municipalities (Source: ZFF CHPP Program Report)



The two-year journey resulted in drastic decreases in maternal deaths across partner municipalities (Figure 4). Critical health system interventions led and initiated by the mayors with their health teams contributed to improvements in maternal health indicators. The decrease in maternal deaths remained consistent from the initial cohort of 9 municipalities that graduated in 2010 to the collective 72 in 2015.

The prototyping of the Health Change Model yielded two important lessons about Bridging Leadership in health system development: 1) mayors, with their health leadership teams, can become health champions through a designed transformative learning experience; 2) the practice of Bridging Leadership introduced an alternative politics that can deliver results and outcomes.

A transformative approach to learning Bridging Leadership

The Foundation had to answer important questions to be able to design a leadership program responsive to the target leaders. How do mayors learn? How do we challenge the pervading political mindset that health is the accountability of the health sector alone; that health is not just about providing budgets for medicines, building health facilities, and conducting medical missions? How do we engage leaders, who are already experts in their respective fields, to learn Bridging Leadership and apply it to changing their health system to deliver results?

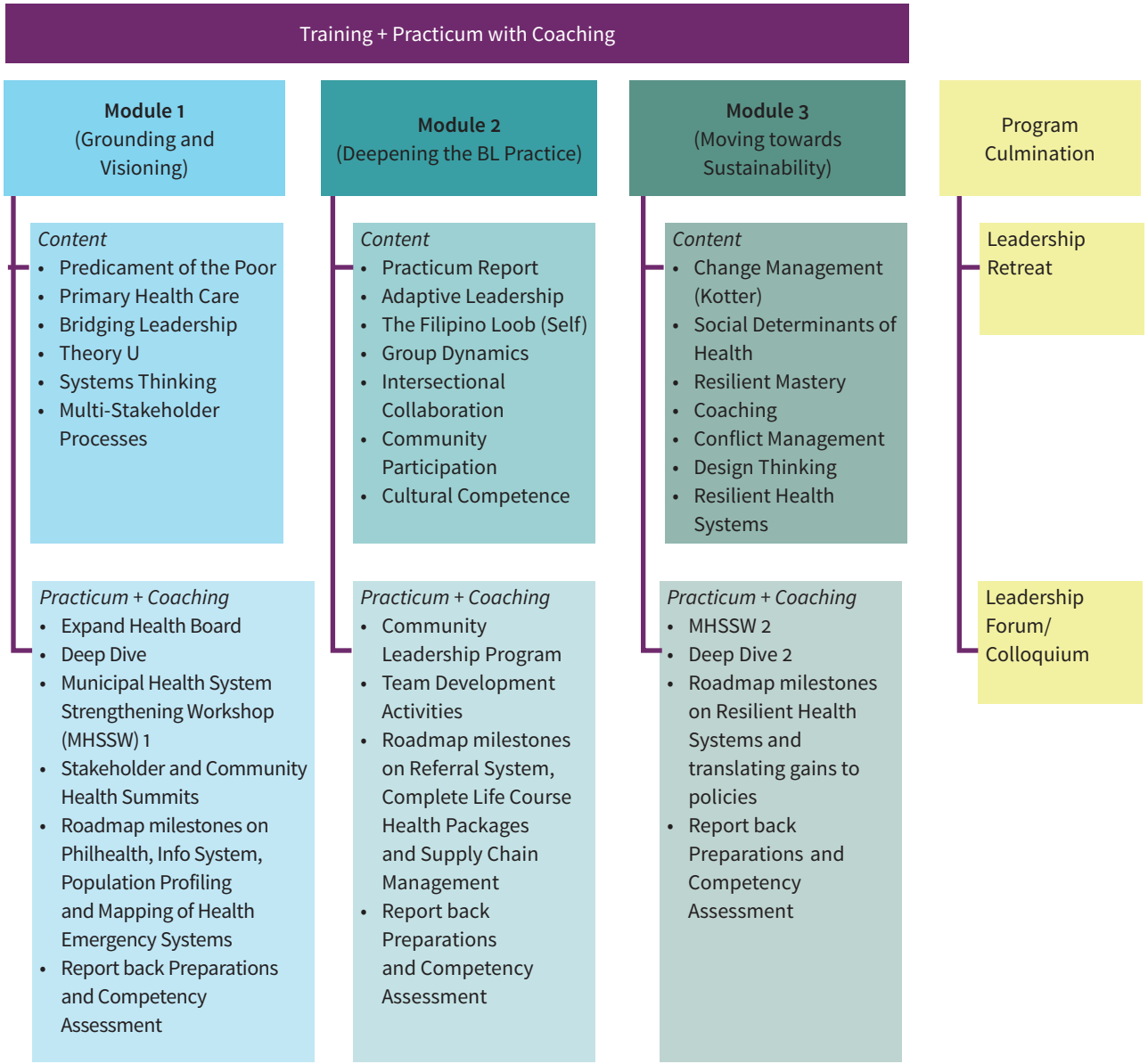
These questions led to a learning curriculum and design that were anchored on a transformative and practitioner approach, engaging the leaders in a co-learning and experiential process to maximize the depth and breadth of their experiences and practices. To change mindsets and influence behavior for results-oriented actions, it was crucial, too, for the learning experience to touch the core of the person if it was to dislodge ingrained assumptions, beliefs, and other internal impediments to change.

Mayor Alfredo Coro (fifth from left) of Del Carmen, Surigao Del Norte, part of Cohort 4, discussing one of their innovations with his barangay (village) chiefs

The program curriculum (Figure 5) was guided by Mezirow's transformative learning theory[10] which explains that influencing perspectives on change requires challenging the belief systems, values and assumptions underpinning different perspectives. Transformation begins when a powerful experience or catalyst causes an individual to question his/her current beliefs. With a view to enabling transformative learning, the curriculum followed a training-coaching-practicum design that applied the 70-20-10 model[11] for learning and development, which assumes that optimal learning comes from 70% job-related experiences, 20% social learning through interactions with mentors, coaches and experienced co-workers, and 10% formal training.

The training component of the program facilitated a mix of interactive, reflective, and hosting methodologies that allowed participants to reflect on their personal leadership and understand health inequity and the predicament of the poor in terms of accessing healthcare. Mayors were suddenly exposed to a reality that they were accountable for the health outcomes of their constituents, challenging the original perspective that the health workers are the ones expected to lead. They were introduced to a dysfunctional health system that produces maternal deaths and for which they were primarily responsible. Each was faced with a reality where all funding support, and budget for medicines and medical missions, were not responsive to the needs of their constituents. Exposure to these disconcerting realities facilitated critical reflections that allowed for the reassessment of their assumptions. Their health

Figure 5. Health Leaders for the Poor Program Curriculum Map (version 2)



Mayor Ruel Velarde of Tinambac, Camarines Sur, also part of Cohort 4, engages his barangay residents on some of their health programs

system performance was visually presented in a health system roadmap with a color-coding scheme that clearly displayed their system strengths and gaps. They were able to see the interconnectedness of the problems and how they were part of the complex system that had created the problem. As Maggay[12] aptly put it, with a deeper awareness of the realities of health inequity and its impact on the poor, they could not remain unmoved as they connected to the stories of deaths when they had the power to make a difference.By the end of the first training, participants had shifted their mindset from "health is not my accountability" to a strong ownership of leading the change.

Equipped with the skills and tools (roadmap, manuals, and learning journals) they needed to execute their action plan, the leaders went into their practicum for the on-the-job application and social learning to complete the transformational experience. Sensing journeys (deep dive), stakeholder interactions, coaching, mentoring, and peer learning opportunities further enabled rational discourse and actions to achieve health system milestones.

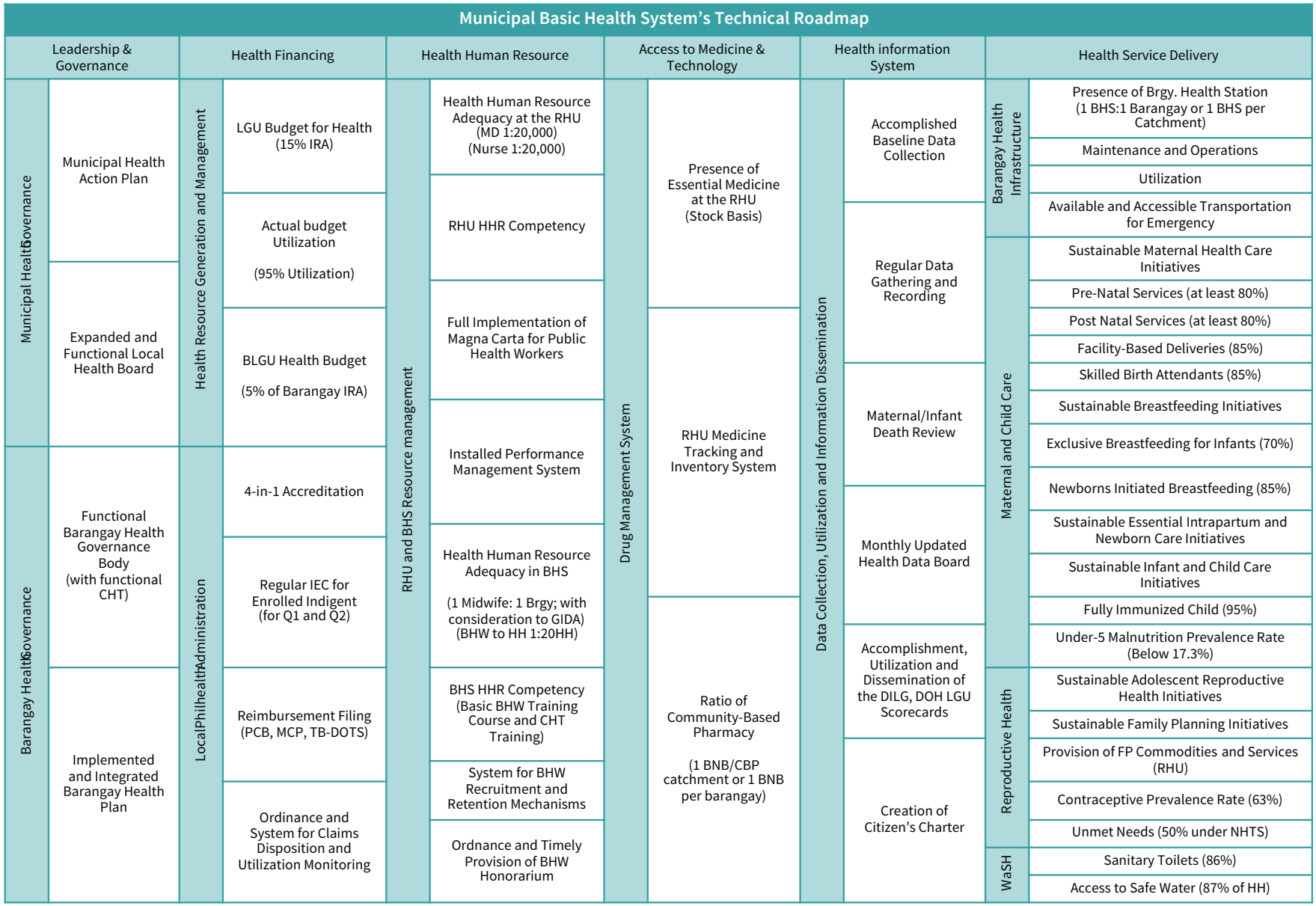
Coaching reinforced the transformational process. Defined by the International Coach Federation as a thought-provoking and creative process that inspires the coachee (leader) to maximize their personal and professional potential, the coaching sessions fostered the creation of awareness in the leaders on appropriate actions one must to do to change behavior and influence collective action.[13] A leadership retreat was also facilitated by the ZFF before the end of the program to help the leaders revisit their journey and reflect on their whole leadership experience.

The Foundation also designed assessment tools to provide rigor in evaluating leadership and system development. A Bridging Leadership competency assessment tool was designed to assess leadership development and the health system roadmap (Figure 6) which measures health system performance.

Overall, the program achieved its objectives because the learning approach was more personal than technical, more inspirational than instructional and applicable both in the leader's life and work. Not all leaders who underwent the program had the same experiences and achieved the same results. But for those who embraced the learning process and applied it wholeheartedly, they found a deeper meaning and purpose for their leadership that made the change transformational.

> ***I have attended several training sessions on leadership, and this is not the first time that I am hearing about these theories and concepts. But to be honest, I think this is the only time that it has been connected, in a more practical way, to who we are as a person and to what we are actually doing. I used to think that these theories were complicated, and I've been wondering about its practical use to me. It's like we went on a spiritual retreat. After our activity today on connecting to our loob (inner self), I realized it's simple. It's about what I can do to improve the system and how I can engage others to join me. More than the professional level as a doctor or a health leader, it becomes more personal. It starts from what is inside me – my desires, my dreams, my loob (inner self).***
>
> Dr. Amelia, municipal health officer and graduate of the Bridging Leadership Program[14]

Figure 6. Municipal Health System Roadmap as Measure of Health System Performance (version 1)



Bridging Leadership as alternative politics to deliver results and outcomes

The decentralization of health to local governments introduced vertical power dynamics in which little to no power was afforded to the people. Those in authority such as governors and mayors have full control over decision-making, policy-making and control of resources, and the status of the health system depends on how that power is exercised. For the longest time, this exercise of power was limited to policies and technical solutions and was rarely used specifically to create the responsive systems needed to impact social change. This context is why the Health Change Model was effective and strategic because core to the issue of inequity is how political directions influence health system performance and consequently health outcomes.

The concept of sharing power was previously unheard of, especilly from a political or expert standpoint. For both mayors and health officers, sharing the power was risky for several reasons. Others might not have the adequate knowledge, skills, or experience to take the right decision or action. Giving too much power to the people might result in increased demand or potentially overpower these leaders eventually.[15] This kind of situation required courage and an openness to try a different approach.

When the leaders realized the scale and complexity of the change that needed to happen, they recognized that a different and deeper engagement was needed for collective action. They needed to deploy an alternative approach to politics that was more participatory and empowering for partners and communities, enabling them to co-own the problem. They realized the need to connect their ***loob*** (inner self) to the ***loob*** of others for more meaningful actions to take place. They had to employ listening, empathy, and relationship-building processes with stakeholders, communities, and families. They had to share their decision-making power by facilitating dialogues and conversations, especially in policy-making and program planning.

Applying Bridging Leadership made democratic processes a more facilitative and empowering approach because of the shift in belief that solutions to complex problems can possibly come from the people and communities themselves. The leader acknowledged that s/he is part of the problem and that the solution will not come from him/her alone; that one must tap the wisdom and capacity of others and the communities and believe that they cannot understand the challenges themselves and solve them on their own.

Bridging Leadership practice also introduced an engagement process anchored on trust-building, an approach that strongly resonates with the Filipino culture. The culture of *kapwa* or shared identity reinforced the co-ownership process because it is about collaboration, supporting one another, pooling strength, and working together to achieve goals.[16]

> ***As a mayor, the question for me was how much power I am willing to share. For leaders like us, this can be a bit threatening. But in my experience, when I shared the decision-making process with farmers in one of the organized groups in my municipality, I saw that they can do it. That they have solutions that we were not even able to think of. Now, they are the ones who think and implement innovative solutions, we just provide the support that they need. In the past, I used to feel tired most of the time because I felt everything depended on me. Now, I can let them be, because I know we want the same thing for our community. The burden is not heavy anymore. I feel that I am not alone. Now I can focus on other issues in my municipality. I realized that the more I share the power, the more that I am empowered, too.***
>
> Mayor David, municipal mayor and graduate of the program[17]

The program results and key lessons from implementation established a strong proof of concept for the Health Change Model and how Bridging Leadership was an approach that delivers results. The potential for replication was high and, at a timely event, a big opportunity for scaling-up presented itself.

A scale-up partnership for greater impact: The Health Leadership and Governance Program

In late 2013, the country had only a few years to meet its targets by the 2015 MDG deadline. The Department of Health Secretary at the time, Dr. Enrique Ona, challenged the ZFF to replicate the Health Change Model and their health leadership program in the DOH, applying it to 609 priority poor municipalities[18] in the country. This was a partnership opportunity rarely given to a private family foundation. The Foundation accepted the challenge and the Health Leadership and Governance Program (HLGP) partnership was forged. The program aimed to create an immediate impact on achieving the health-related MDGs by improving local health systems in the 609 priority municipalities through improved leadership and governance at two levels: first at the national and regional DOH offices, then in the local government units (province, municipalities, and barangays or villages).

Given the scale of the partnership and the program – moving from 72 to 609 municipalities – and the Foundation's limited people and resources, strategic elements helped to ensure program success.

Strategic element 1: Enhancing leadership and governance capability at the DOH regional level

Leadership and management programs anchored also on Bridging Leadership were designed and customized for target participants, from regional directors, assigned program coordinators or managers, to DOH representatives assigned to the target provinces and municipalities. These programs aimed to equip them to be effective Bridging Leaders and coaches to their partner provinces and municipalities. Customized provincial, municipal, city, and barangay (smallest unit of government, at the village level) Bridging Leadership programs were also co-created with DOH. Like the prototype experience, these programs targeted the political leaders (governor, municipal mayor, city mayor, village captain) and their counterpart health officers and included a training-coaching-practicum design to be implemented across a 12 to 18-month period.

Ownership was not easily established at the beginning of program implementation and was initially borne out of compliance. "It was an order from the national office, we had to comply," said Dr. Jaime Bernadas, regional director of the Center for Health Development Central Visayas. When the program was presented to him, he accepted the invitation because it was required. But in the course of the partnership and his experience in the Bridging Leadership Fellowship Program for regional directors, he realized that Bridging Leadership put a name and framework to what he had been trying to do since he had entered the ministry. As an accomplished physician and former political leader himself, he had been exposed to different approaches to social change that ended up in programmatic interventions. For Dr. Jaime, the Bridging Leadership process was a fit to what he was looking for to make their health reforms more effective and responsive:

Health Leadership and Governance Program Memorandum of Understanding signing, May 16, 2013.

Health is political. Addressing politically relevant issues like health will not work without political directions, leadership response, and management skills. The Bridging Leadership approach provided a systematic framework on how to do interventions and addressing the problems from a whole-of-systems perspective. The program resonated to my belief that governance is the backbone of reforms and Bridging Leadership provided the process to do good governance.

As he underwent his own leadership journey in the program, he applied Bridging Leadership and led his own change agenda in fixing his regional health system to improve health outcomes. Aside from complying with the management team, budget, and policy requirements, he anchored the region's capacity building initiatives on Bridging Leadership and trained all relevant personnel, most especially his DOH representatives, who would be the coaches of their municipal partners. He also strengthened his presence and support to the provinces and municipalities, serving as partner, coach, and mentor to provincial governors and municipal mayors.

From a program management perspective, Ms. Baj Datinguinoo had her own Bridging Leadership experience. Baj was the designated HLGP Coordinator of the Center for Health Development MiMaRoPa. In her 18 years of service in the DOH, she saw how the ministry had been implementing the usual top-down, technical programs on the health frontlines. "We've been trying a lot of things to bring change, almost everything – consultations, local and international training – and we have yet to achieve improving the lives of others." Burdened with how their regional health outcomes had stagnated, especially with the added challenge of delivering quality health care to their island provinces, Baj had longed for something new to happen and for their interventions to be more responsive to the needs of the people in the geographically challenged areas they serve. When she underwent the program, she saw the novelty and relevance of the leadership approach and strategically aligned it with their program operations. She heeded the call to lead program implementation and deployed relationship-building processes to mobilize her staff, co-regional leaders, and local government partners. In every leadership transition with a new regional director, she took the initiative to connect and engage in order to facilitate director support and buy-in. With leadership support and an inspired team, they were able

Director Jaime Bernadas with his provincial partners, Governor Hilario Davide III and Dr. Rene Catan of the Province of Cebu

to engage strategic municipal and provincial partners to enroll in the program and contribute to improving regional health systems through collaborative and innovative work. Even without budgetary support from the national DOH office, they were able to mobilize the funds and resources needed by their local partners to implement their respective action plans and innovative programs.

To Baj, the Bridging Leadership experiences of their mayors, municipal health officers, Doctors to the Barrios (community-deployed doctors from the DOH), council members, and other partners made the difference in the improvement of their regional health system: "In our partnership with the local government units, we were able to trailblaze a creative management and development of the health care delivery systems and presented better ways of co-creating more responsive and appropriate health services to the people."

Under this strategy, the Foundation ensured that all policies, systems, and procedures were co-created with the DOH and not one-sidedly asserted. The program was given

space to evolve and improve as the national health agenda requires. The first cycle of the program supported Universal Health Care to achieve the MDG targets. When a new administration was put in office in 2016, the program design was enhanced to support a new health agenda, the Philippine Health Agenda, to contribute to the achievement of the Sustainable Development Goals (SDGs). The SDGs are the current global goals, related to the MDGs, adopted by the UN Members States in 2015. These integrated goals call for action to end poverty, protect the planet and ensure peace and prosperity for all people by 2030. With these global targets, the program changed from the initial focus on maternal and child health to a primary health care approach, which is a more comprehensive, equity-grounded health development approach putting emphasis on the contribution of community participation and inter-sectoral collaboration.

Strategic element 2: Establishing regional academic partners for training support

The next critical element in the partnership was developing regional training providers. Because of the reach of implementation, more trainers would be needed to meet the demand of running the training on a national scale. Eleven academic institutions were tapped to become the academic partners for various regional offices of the DOH. Faculty teams per institution underwent their own Bridging Leadership programs, supported by coaching, mentoring and technical assistance, to enable them to train the municipal leadership teams in their regions. A trainer certification program was developed and implemented to ensure quality of training across all regions.

The University of the Philippines (UP) Manila School of Health Sciences (SHS) was the first academic partner to be engaged in the program. “The program had an intersectionality with our community work in SHS. What was interesting about it was seeing the mayor, not just the health officer, talking about health,” said Dr. Meredith Labarda, one of the program coordinators and faculty. “After being exposed to the training, we were interested and motivated to go into the partnership because Bridging Leadership put a science or system to what we do in our communities. I also thought it was an opportunity for faculty development and personal growth.”

The academic team was given an initial cohort of municipalities from Eastern Visayas. With capacity building support from the Foundation, their faculty team was trained and mentored until they were able to independently run their training activities and manage the program. Their partnership with the region lasted through six years (two cycles) of the program. From the perspective of a trainer, Dr. Meredith was able to witness a paradigm shift in the exercise of political leadership by their enrolled municipal partners. Through the Municipal Leadership and Governance Program (MLGP) experience, political leaders who originally viewed health issues and health challenges as the responsibility of the health sector alone became drivers of the solutions to improve their health conditions. She was able to experience how

Dr. Meredith Labarda facilitates a Bridging Leadership training session

Dr. Ryan Guinaran facilitates one of their BL training activities for their local government leaders

increased ownership and accountability on the part of the leaders enabled changes in system processes that led to improvement in the system and health indicators.

For Dr. Ryan Guinaran of the Benguet State University Open University (BSU-OU), there was an obvious value for the faculty team to be part of the program. It could serve as extension services for their accreditation purposes, along with the enrolment fees and alumni pool they could obtain. On a personal level, he saw the program as a wider platform to contribute to systemic change as well as opportunities for lessons learned and connecting to the grassroots. He saw the relevance of the program in "filling in a leadership vacuum in terms of health leaders so that they become more effective and outcome-based and at the same time, undergoing a personal journey of transformation or affirmation." He appreciated the uniqueness of the program in a way that Bridging Leadership begins with "ako (me)," compared with other leadership approaches he was exposed to that start in reference to others. "There's a novelty in it where leadership concepts are dissected, made cool and sexy, aligned to the BL framework and made practical. It brought freshness to the usual old or business-as-usual approach to leadership."

The BSU-OU partnered with two DOH regional offices (Cordillera Autonomous Region and Region 1) in the six-year partnership with the DOH and the ZFF. Successes and failures occurred across program experiences, but Dr. Ryan repeatedly saw that when the practice of Bridging Leadership took root, these leaders changed their mindsets and practiced a different culture of collaboration. Communities became partners and innovations became the norm. The gains in relationships and co-creations ultimately contributed to improvement in systems and health indicators.

Strategic element 3: Facilitating resources to support local health system responsiveness

The third important element was mobilizing resources to support regional and local government initiatives. The national office allocated a budget to fund training for all target regional and local government leaders. Regional offices provided different forms of support needed by enrolled municipalities to help them in their planned practicum activities and action plan-related initiatives. Their assistance came in the form of additional health workers, medicines and supplies, health facilities and funding to strengthen health service delivery needs.

Director Jaime Bernadas also invested in Bridging Leadership capacity-building programs that went beyond the target leaders of the HLGP. He funded deepening leadership training to improve the performance of their office and services to the local governments, as well as additional training and practicum activities on request of the local governments. He mobilized additional funds to the academic partners to enroll other municipalities not included in the original target of the program. Enrolled municipalities were prioritized for health facility enhancement and health human resource augmentation.

Together with the regional director assigned to their office, Baj poured resources into their partner municipalities in support of their health system improvement plans. Aside from a monetary grant given to the mayors after their first training to support their action plans, the regional office provided other forms of resources in the form

of deployed additional doctors, nurses and midwives, land and sea ambulances for geographically challenged villages, health facility enhancement support, medicines and medical supplies augmentation and other resources as needed by the partners. In addition, the regional office funded training activities to support the practicum of the mayors and their teams. The strong partnership forged by Baj, her team and their office with the provinces and municipalities resulted in different innovations and co-creations to help improve regional health system performance.

A partnership of this scale was not without challenges, including the constant changes in leadership: in secretaries, bureau and regional directors, and the local government leaders after every election. As Dr. Malou Gajitos, one of the main program coordinators at the DOH national office, said, "A change in leadership always results in system changes – changes in priorities, structures, even human resources." If a new director did not consider the program a priority, expect that program to take a backseat and ongoing implementation to stall. Similar challenges were encountered at the regional level, where regional directors were subject to regular reshuffling of regional assignments.

Dr. Malou Gajitos opens discussion about the program with regional leaders and program partners

Addressing the challenge required constant re-engaging and re-orientation. If there were opportunities to include the newly assigned heads in ongoing leadership training, Dr. Malou would encourage their participation so they could be on the same page. "I had to apply what I learned from our training – suspending judgment, reframing, listening, and dialogue." These practices fostered buy-in and support for the program from new leaders. The regions encountered this same challenge every election season, when there are transitions of new governors and mayors. Every new leadership entailed new engagements and new relationship-building. "We addressed this by strengthening the core group of the LGU, and also leveraging budget, grants, and incentives as a springboard for buy-in and engagement," said Director Jaime.

Another critical challenge was funding. "We had no adequate fund," Dr. Malou said. Their Bureau of Local Health Systems Development (BLHSD) is the main program owner of the partnership, lead coordinating bureau, and the primary resource provider of the program. "We basically had to beg for funds from other offices. And when we could not give the funding support, the regional offices had to step in." Creative means to acquire additional funding included tapping available budgets of other offices and engaging the regions to find ways of mobilizing their resources. These alternative arrangements succeeded because of the relationships and engagement built between the partners in the course of program implementation.

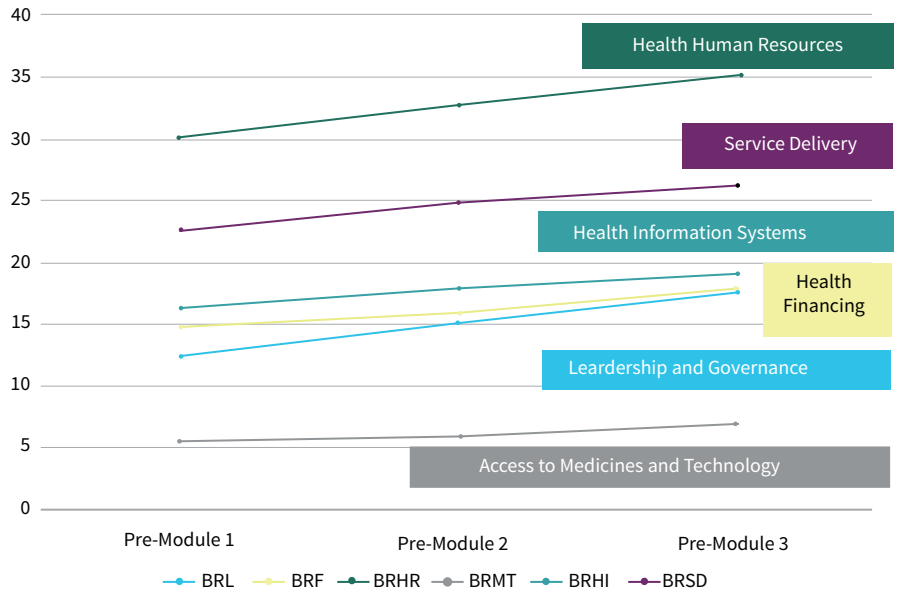
Other challenges that emerged included technical system requirements such as establishing monitoring and evaluation systems, academic rigor in implementing training, and poor quality of training and coaching. Both the ZFF and the DOH endeavored to address every challenge through constant dialogues and ensuring interventions were co-created with the DOH and other relevant partners. For every challenge, especially in behavior and relationships, Bridging Leadership had to be practiced by the ZFF, academic partners, and the DOH, not just the local government leaders. This response strengthened and sustained the partnership for six years.

Reaping the gains of improved leadership and health system performance

In the two cycles of implementation, results from the program experience involved personal stories of transformation, health system reforms, improved health indicators and outcomes and even the application of Bridging Leadership to other sectors outside health (social welfare, agriculture, peace and security, among others). In the study[19] conducted by Dr. Meredith, involving the program experiences and performance of their select cohort municipalities, all of the six building blocks for a functioning health system indicated in the health system roadmaps of the participating 19 municipalities showed significant improvements and an upward trend in the scores. She assessed the results at three different time points from 2015 to 2018 (Figure 7). Among the six building blocks, leadership and governance appeared to have the largest rate of change during the period of assessment to which the program could have contributed.

In terms of outcomes, the study assessed the maternal mortality ratio (MMR) and infant mortality rate (IMR), two sensitive indicators of health system performance that also reflect inequality in the system.[20] Table 2 shows 16 municipalities that were able to maintain zero maternal deaths or reduce the ratio to zero. The same result was seen in terms of IMR (Table 3), with 13 towns lowering or maintaining zero mortality from 2015 to 2018.

Figure 7. Trends in the Six Building Blocks of Health of MLGP Cycle 2 Easter Visayas Municipalities



Lapuyan, Zamboanga del Sur mayor Daylinda Sulong (left) holds a dialogue with their indigenous group on the implementation of health programs

Table 2. Maternal Mortality Ratio per 100,000 Livebirths of MLGP Municipalities

PROVINCE	MUNCIPALITY	MMR	
		2015	2018
EAST SAMAR	San Pedro	-	0
	San Nicolas	246.6	0
	Santa Catalina	0	0
	San Raphael	414.9	0
	San Vicente	0	0
	Santa Philomena	0	0
SAMAR	San Lorenzo	0	0
	Santa Monica	0	0
	Santa Clara	0	0
	Santo Tomas	337.8	0
	Santa Rosa	0	0
NORTH SAMAR	San Sebastian	0	0
LEYTE	Santa Estrella	173.6	934
	Santa Laura	255	0
	Santa Barbara	0	877
	San Pablo	0	0
	San Francisco	0	0
BILIRAN	San Juan	0	0

Table 3. Infant Mortality Rate per 1,000 Livebirths of MLGP Municipalities

PROVINCE	MUNCIPALITY	IMR	
		2015	2018
EAST SAMAR	San Pedro	20.	0
	San Nicolas	1.23	0
	Santa Catalina	0	0
	San Raphael	17	17.5
	San Vicente	6.8	0
	Santa Philomena	3.7	0
SAMAR	San Lorenzo	0	47.6
	Santa Monica	22	0
	Santa Clara	6.7	0
	Santo Tomas	0	0
	Santa Rosa	0	0
NORTH SAMAR	San Sebastian	0	166.7
LEYTE	Santa Estrella	5.2	0
	Santa Laura	7.7	0
	Santa Barbara	7.7	8
	San Pablo	13.8	0
	San Francisco	7.6	14
BILIRAN	San Juan	5.4	0

During the lifespan of the partnership, the ZFF, together with the DOH, contributed to improving health outcomes for the poor through transformed health systems across the country. During its six-year cycle, the program produced 1,485 trained municipal leaders and teams, 197 provincial leaders and teams supported by 1,259 trained DOH national and regional leaders, and academic faculty from all over the country.[21] But beyond the numbers are the narratives of changed perspectives and strengthened relationships. The program experience has presented an alternative approach to how a more meaningful and effective path to systems change can be achieved.

A story of personal and system transformation: Bridging Leadership in practice

Mayor Sam Parojinog's leadership journey began by signing a sheet of paper. He remembered his first day in office as a newly elected mayor, with his health officer enthusiastically telling him about the MLGP sponsored by the DOH regional office. As a veteran government official, starting from the grassroots as the village captain for 13 years, to council representative, vice mayor, and then rising to the highest position in town, one might think he was already an expert leader. But upon hearing the word governance, he knew he still had a lot to learn. He had become a leader by not being intimidated that he had finished only his elementary education. He signed and became the only mayor in their province at that time to take on the challenge of changing his health system.

It was a different perspective for Dr. Wynona Vega (known as Dr. Nona), the municipal health officer. In terms of her technical expertise and experience, she actually did not seem to need the training program. She is a doctor, a former assistant chief of hospital, trained in pediatrics, radiology and sonology; she even received a WHO scholarship to study health systems development abroad. So, when the program was first presented to her, she was not open to it: "I'm already full of training, what else can I learn? The program looked like too much work." But it was a package deal. When the mayor commits, the health officer needs to participate as well.

With different learning backgrounds and expertise, both leaders proceeded with the program, opening up to what Bridging Leadership was and how they would learn and apply it. Together, they agreed to attend the required training days, participate

in coaching sessions with their DOH representative partner, perform activities in a practicum period, and implement an action plan to improve their health system roadmap and indicators.

Creating ownership to drive the change

During their first training day, both leaders remembered the impact of learning what health inequity really meant. Through intentionally designed experiential and visual activities, they were made to feel what it was like to be poor and how a family can be pushed into further poverty when one member gets sick. They were exposed to the reality that in their current health system, those already well-off have more access to support from the mayor's office while the poor remain in the villages, not receiving the healthcare they badly need and desire. "The way the content was presented touches down to the core of the heart. I leave each training day tired and drained emotionally and mentally, because of the burden of our reality," said Nona.

Provided with a system lens, both leaders could understand how interconnected the causes of the problems were and how different stakeholders contributed to the overall severity of the challenges. Even with the technical content of the sessions, Mayor Sam could understand the concepts as they were related to their actual practices and presented through simple learning exercises and structured play.

Bridging Leadership was introduced as a leadership approach to address complex challenges such as health inequity. Unique to the approach was the importance of the leader's ownership of the challenge that begins with connecting to their inner self. A bridging leader was defined as a leader compelled by values and principles to make a personal response to the inequities s/he is faced with. Knowing that this inequity is a big undertaking, the bridging leader is required to engage stakeholders to arrive at a shared vision and collaborative response through trust-building dialogue and mechanisms.

Through reflective exercises (leadership lifelines, values, and leadership capital inventories) and interactive discussions, Mayor Sam and Dr. Nona were shaped by connecting to who they are as persons and leaders and by revisiting their purpose and values. Mayor Sam realized that reflecting on his leadership journey affirmed his values and choice to lead based on who he is as a person. "I came from a poor family. I learned to be true to myself, to be honest and not corrupt, to be transparent and to have courage as I serve as mayor. I choose to do this because my children must see me practicing my values and how staying true to my values gave me my success. I want to model it to them. Who I am as Sam when I go home is the same as the Sam they see in office."

Dr. Nona was able to relate how her ups and downs and her faith contributed to who she is and where she is now. "I was able to relate my service to the people as my way of serving God. As I take care of the people, He also takes care of me." This connection to religion or spirituality was a common insight from other participants. As a predominantly Catholic country, purpose is often related to one's calling from God and the reflective exercise of connecting to purpose and values allowed participants to connect purpose and service to others as their ministry and service to God.

Creating awareness of purpose and the values that drive their actions, both leaders related these powerful reflections to the current reality of their health system and how they have contributed to its current situation. Mayor Sam was presented with problematic health data and a predominantly red (below target) health system roadmap, vividly seeing his failing health system through the numbers and colors. He and Dr. Nona analyzed the causes, asking as many "Whys?" as needed to get to the root causes of the problems. He was able to understand the different components of the health system – health financing, health human resources, access to medicines and technology, health information system, and health service delivery, all of which he realized were driven by leadership and governance.

The inner journey of connecting to their purpose, passions, and values and relating them to their current reality brought both leaders to a realization that they are part of the complex system that created the problem. Dr. Nona says: "It made us think about our actions, made us reflect deeply on why the system is like this – how we are reactive to the problems, why the programs are still not working, why the people are not empowered, how we are both the problem and the solution." For the mayor, this realization brought an important shift in perspective to anchor how he would respond to the challenges. "I realized that health is not just a simple problem. And when a person gets sick, it is not only the doctor's responsibility. I, as mayor, am more accountable and I must lead the change." Both leaders connected to a deeper source

Dr. Nona (left) and Mayor Sam (center) arrive together for their end-of-program colloquium

of understanding about what was being asked of him/her and arrived at a personal response and commitment to change.

Building co-ownership towards co-created change

Going into their practicum period, with a clear picture of the change they wanted to happen and a plan of action, Mayor Sam and Dr. Nona acknowledged that the vision was too big for them to do alone. From the training, they were able to identify the critical stakeholders they needed to engage. More importantly, the learning experiences equipped them with the basic skills on how to build relationships through different multi-stakeholder processes, including dialogue.

For both leaders, their deep dive sensing journey created a shared experience with their stakeholders that jumpstarted their desire for collective action. It is one of the required activities in their practicum to enable a deeper understanding of the health situation through the eyes of their stakeholders and constituents. Mayor Sam and Dr. Nona decided to approach it differently by organizing a community conversation represented by different households, instead of visiting just one family. What was initially intended as a simple consultation was transformed to a community dialogue.

Sam narrated, "We went there ready to listen to their issues and needs. We approached it by facilitating a conversation to come up with a shared understanding of the issues and challenges, instead of just coming up with a wishlist of interventions."

Nona added:

> ***We asked them what were the causes of the problems, why is it a problem? What were the reasons these challenges happened? When we arrived at a shared understanding, we thought of a shared change we could aspire to together and explored how to achieve it. Then we asked, if this is now our understanding of the issue, what can be the solutions and how can each of us contribute to the solutions? We recognized that even how small you think a person is, they can contribute to the change.***

Another milestone they were able to accomplish was engaging municipal and village leaders and stakeholders in similar Bridging Leadership training to influence buy-in towards a shared vision and collaborative plan of action. Together with the mayor, Nona presented the current health situation in the municipality. As a group, they analyzed the cause-and-effect relationships within their system and reflected on how each contributes to the problems. With a shared understanding and vision, individuals committed to execute their shared plan of action. Through the workshop, Nona experienced a collective shift in each participant's perspective on health – that health is not just about the absence of disease but the overall well-being of the person and that each stakeholder was part of the problem that produced the broken system. More importantly, they were also part of the solution. They realized that health is complex in nature, requiring a systems approach and improving it involves different stakeholders, not only the health team. It was affirming to feel the shift from blaming to a mindset of "What can I contribute?"

Aside from the deep dive and leadership workshops, they also expanded their governing bodies to include all relevant stakeholders and organized stakeholder interactions in the form of village assemblies, health summits and health congresses, among others. These dialogic encounters provided the opportunity for them to listen, connect, and develop relationships, contributing to their own personal and leadership development. Mayor Sam recalled, "As mayor, I felt a shift in dynamics with the community through these milestones. When I truly listened to them, I learned about all their problems. We were also able to level that off with the challenges, Dr. Nona and I cannot solve them all; they also have the responsibility to contribute."

Dr. Nona also expressed how applying Bridging Leadership facilitated a better approach in engaging staff, municipal partners, and communities.

> ***Before, my understanding of leadership was as a leader, you tell your members to do it. I had a linear perspective: If you're not on board with me, you're against me. But having understood deeply the root of inequities, the social determinants of health and how I am expected to be a bridge, to apply ways and means to engage, that each is part of a collaborative experience, I had to change my perspectives. I have to engage others; I have to find ways to connect. Before, I was a perfectionist and one can't make mistakes but now, knowing the importance of listening and building relationships, I've opened myself better to others, to my staff. Before in meetings, it was me always talking. But now, it's: You talk, I'll listen. Give me your suggestions and we'll try it. Give me inputs. I was reminded to humble myself and ask for help. I also became generous with affirmations. I've even applied this not only in work but to my role as a wife and mother to my daughters.***

Monthly coaching sessions also helped in their leadership development and action plan implementation. The coaching partnership fostered a safe space for both leaders to talk about personal or work-related agenda and enabled actions that helped them become better leaders. Their academic trainers and DOH coaches encouraged them to also practice self-care by ensuring personal support networks, developing self-care habits, and undergoing renewal experiences. "I became happier," said Dr. Nona, "my work as a public health worker became meaningful again. I had a formula again on how to live towards my best self. The heart became the source of our actions."

Through all of these interactions and relationship-building initiatives, Mayor Sam observed a different engagement with the villages and his partners. He and Dr. Nona now experienced how simple collaborative actions made their work easier. In the case of their nutrition program, he was able to establish a partnership with the community in improving their access to food.

"Task delegation helped foster a collaborative mindset. I provide the seeds, they plant and grow their food. For farming support, I provided the heavy equipment and gasoline, I paved the road, but they worked for their harvest." Dr. Nona explained how they have an information-sharing mechanism with their villages, especially in dealing with emerging issues such as rising numbers of teenage pregnancy, open defecation, and infectious diseases. She recalled the time when there was a sudden rise in dengue cases in the municipality and preventive measures had to be implemented to control the spread of disease. When the health team led by Dr. Nona talked to the affected communities, they analyzed the causes together, talked about what was expected from each of them and how they could work together, and then proceeded to identify clear accountabilities, with the health office in charge of mapping and case investigation and the village chief gathering household representatives for community assemblies for feedback and information. Upon presentation of the findings with possible recommendations, the village council committed to leading the clean-up and elimination of breeding sites. They advised the health team to return in four days and check their progress. Going through with their commitment, all breeding sites were gone after four days such that there was no need to do community fogging anymore.

Dr. Nona related that,

> ***The mindset now is, if this is the situation, what can I do? Instead of the old response before of just waiting for the mayor and the health team to help them. Through BL, we can share the burden of the health challenges with others, it's just a matter of how to effectively engage them so***

they will also own the challenge. Gone are the days of pointing fingers, planning for them. We now are thinking of the solutions together, planning with them. The interventions became more sustainable because the community are doing the solutions on their own.

Case writer's perspective during Mayor Sam's interview

As he sits across me, sharing the stories of his journey over the past 18 months, the mayor displays a profound sense of joy, accomplishment, and pride. There is a gleam in his eyes as he shares the accomplishments in his town, how a simple visit and dialogue with community members, just listening to their perspectives and needs, initiated a movement of self-initiated community response that contributed to the positive changes in their health system.

But what engages me is the humility and silent pride he radiates as he still cannot believe he will be culminating his leadership journey the next day. "Who would've thought an elementary graduate can earn a leadership certificate from the University of the Philippines." We end the conversation with an expression of his excitement of going back home and proudly showing his certificates to his staff and constituents.

Bridging Leadership: The power of personal transformation to drive system change

Across the prototype and scale-up experiences, one constant theme resonated among leaders who were able to internalize and live the Bridging Leadership approach: personal transformation and ownership drive system change. The experience confirmed that being the leader is more than the knowing and doing. The person within the leader – the being, identity, character, and values – is integral to their ability to lead.

Dr. Ryan described the most important contribution of Bridging Leadership this way: "If an egg is broken by an outside force, life ends. If an egg is broken by an inside force, life begins." The gains and reforms from the program were external work steered by Inner Work. For him, if percentages are given to the Bridging Leadership framework, it's 100 for ownership and 50-50 for co-ownership and co-creation. If you put the 100% on the ownership, it will facilitate the other processes and drive the change. "You cannot dictate ownership; it has to grow from within. But warmth is also needed from the external to nurture the leader as provided by ZFF, DOH, and the academic partners."

The ownership process of Bridging Leadership challenged paradigms and facilitated a shift in mind where the leaders saw themselves as part of and not separate from the system.[22] This powerful realization was an integration of different levels of awareness that began from the awareness of the self that is anchored in purpose and values. From that level, one then connects to an awareness of the system, seeing oneself as part of the system that created the current reality and culminating in an awareness of commitment and action for the change to happen. This transformative journey experienced by those involved in the program affirmed that structural changes will not be meaningful and sustainable if not founded on strong core work.

Reflecting on her Bridging Leadership journey, Dr. Meredith said,

The BL experience is an experience of transformative leadership. And the transformation of the leaders who embraced the process became authentic because it connected to their source. For me, being an Evangelical Christian, transformation is not possible if not connected to our source. My personal advocacy is to change the system and for the system to be transformed, I need to connect it to my spiritual core. Though the concepts and experiences were not directly spiritual, the reflective experience allowed me to connect deeply to my personal level. That was why even if implementing the program was difficult, with the challenges of the bureaucracy, delays in the system and changes in leadership, we applied what we learned and pushed through. To me, the experience is something beyond the DOH-ZFF-academic partnership program, it was my personal belief and advocacy.

"The most important impact of BL to me is hope. Hope is important, especially working in a bureaucracy," said Baj. In her years in government service doing the collaborative work she does in the region with local government and sectoral agency partners, she was oftentimes brought to a point where she had to ask herself if the

work was still worth it, if she could still carry the burden. She has experienced too many times how ungrateful government service is, how she has been hurt by office politics and gossip, crab mentality, and professional jealousy. She has reached a point where she has said enough is enough, with her tired mind, body, and heart. But she still chooses to continue and bounce forward. For her, the connection to purpose and her values from the Bridging Leadership experience gave her the hope to accept frustrations and failures, but not give up. The whole journey – time provided for reflections, the circle practices, dialogues, and encounters, reflections on successes and failures from co-creating with others – has given her a deeper understanding of herself and clarified why she pursues and persists and for whom – each and every Filipino in the islands of MiMaRoPa.[23]

> ***It made me have a hopeful mindset, to focus on the good in every person. It served as fire to positively influence others. As I work to make a significant dent in public service, I will do so on the side of boldness. If I err, may it be for too much audacity and not for too little. In knowing what I ought to do, everything else is secondary, I simply know that the place I want to live in is that of service.***
>
> Baj Datinguinoo

The Bridging Leadership experience consistently emphasized the need to reconnect to the core of being. As reflected in the stories of mayors, doctors, and other leaders who embraced the experience and became successful in reforming their health systems, the level of personal mastery and ownership of the leader drove and sustained the change they wanted to happen. As underscored in the Theory U,[24] addressing complex challenges requires meeting the challenges in a more conscious, intentional, and strategic way. The framework points to connecting to the inner source from which one operates, allowing it to influence thoughts, emotions, and actions towards a co-created change. Related to this, the Bridging Leadership journey of the leaders communicates how personal commitment to addressing any complex challenge such as health inequity required an open mind, an open heart, and open will. The leader's response upon connecting to the deepest part of the U (inner source) determines whether one remains in their current reality or moves towards the envisioned change. If we are to relate it to the Filipino context, connecting to the U is connecting to the loob (inner self), the inner principle of affection, disposition, feelings, attitudes, thought, decision, responsibility.[25] This connection resonates spiritually as well. Having this perspective of a sacred obligation motivates the leader all the more to greater accountability and better performance. The leaders were brought to the foundations of who they are as people, crystallizing a deeper sense of being that enabled them to put more meaning, importance, and impact into their work.

The consistent narratives present an approach where leaders' commitment to personal change facilitated systems change – Inner Work transcended to external work. The leaders were able to show how an increased level of personal mastery enabled them to be inspired in their work, connect better to others, bear the costs of leadership, and persist even if the work becomes difficult. In this uncertain and generative reality we now live in, this approach to change and system transformation is something worth welcoming and exploring. As Dr. Ryan put it, "The debates have been whether the driver to effective social changes are more personal or systems-oriented. It was never an either/or. It was both and together."

Continuing the mission towards health for all Filipinos

When Hope Remains – Jackielyn's Story Continued

Seated on a wooden bench, Joseph found himself sharing the details of what happened to his wife Jackielyn with the highest authority in the province, Governor Joeben Miraflores. They were informed that the governor would come for a visit, something unheard of for their family. It had been two years since the death of his wife. Life was still the same, poor and simple. He tried to compose himself, still in disbelief at being surrounded by different government officials. Aside from the governor, on his left were the DOH regional director and other provincial DOH leaders. They were there to hear Joseph's story, on how their system had failed his wife. As they wrapped up the conversation, they told Joseph that they would now visit the hospitals where Jackielyn was brought. They wanted to experience what happened that night, to take the roads they had travelled and talk to the hospital staff involved during that emergency. Before leaving, Governor Joeben called him to a corner together with their village captain. He then told him that he would provide a scholarship for the education of his eldest daughter. Joseph stood there grateful for being listened to, for being given kindness and compassion for what his family had experienced.

Continuing on their deep dive journey, the governor was deeply affected by the story he had just heard. He thought he was doing good because he had invested so much to improve their hospitals. But now he learned a mother had died because one of the hospitals was without a doctor. What was broken in their system that allowed a mother to die just because of childbirth? In their journey down to the last hospital, he talked to village leaders and members about the health situation in the *barangay* (village), to the rural health unit beside the hospital, and to the hospital staff. To his disappointment, he learned the community did not know about the services available to them and how they can be accessed. He saw the poor conditions of health workers and patients in the hospitals. The conversations brought him to a realization that the behavior of the people and workers was probably because of previous bad experiences with government services, that their access to health services was affected by opportunities for education and employment. As one of his constituents shared. "I am not given attention at the hospital because I am poor."

When their deep dive ended, Governor Joeben's vision for change was clear: to make the provincial health system of Aklan responsive, especially to his poor constituents. Though everything cannot be covered by the government, at least he could make the services affordable for the poor. He was determined to do his best not to let another Jackielyn suffer and die. Together with his team and partners, he was set to build a better system that works for the poor and the people.

(Excerpts from the Deep Dive report and visit to Jackielyn's family by Governor Joeben Miraflores)

Governor Joeben Miraflores (leftmost), during his Deep Dive activity, together with Joseph, DOH and ZFF partners

As a new era in Philippine public health begins with the passage of the 2019 Universal Health Care law, the future for health leaders becomes more challenging and uncertain, but still hopeful. It is a future where Bridging Leadership becomes even more appropriate because political differences have to give way to greater cooperation and collaboration to build province-wide and city-wide health systems. Given what has transpired in the Zuellig Family Foundation prototype in local governments and the HLGP partnership, the Foundation is hopeful that there is a critical mass of bridging leaders who can actively influence the policies and the systems that can bring real reforms to Philippine healthcare; bridging leaders with stories that can serve as springboards of hope to continue working together for the elusive dream of health for all Filipinos.

Acronyms

BL	Bridging Leadership
DOH	Department of Health
CHD	Center for Health Development
CHPP	Community Health Partnership Program
HCM	Health Change Model
HLGP	Health Leadership and Governance Program
LCE	Local Chief Executive
LGU	Local Government Unit
MDG	Millennium Development Goals
MHO	Municipal Health Office/Officer
MLGP	Municipal Leadership and Governance Program
SDG	Sustainable Development Goals
UN	United Nations
ZFF	Zuellig Family Foundation

Zuellig Family Foundation photo

Notes

[1] Retelling of a maternal death case in 2016 based on the deep dive experience of the Aklan provincial health team led by the governor, with the story told by the deceased's husband, birth attendant and family members.

[2] Dr. Alberto Romualdez. *Health Care and the Poor: The Need for Universal Health Care*. September 2013

[3] Philippine Statistics Authority (PSA) [Philippines], and ICF International. 2014. *Philippines National Demographic and Health Survey 2013* (Manila, Philippines, and Rockville, Maryland, USA: PSA and ICF International).

[4] Department of Health. *Philippine Health Agenda 2016–2022*.

[5] World Health Organization. https://www.who.int/topics/millennium_development_goals/about/en/

[6] Philippine Statistics Authority MDG Watch, 2015. https://psa.gov.ph/mdgs-main/mdg-watch

[7] Republic Act No. 7160 – An Act Providing for a Local Government Code of 1991.

[8] C. I. A. Panelo, O. J. C. Solon, R. M. Ramos and A. N. Herrin, *The Challenge of Reaching the Poor with a Continuum of Care: A 25-Year Assessment of Philippine Health Sector Performance* (Quezon City, 2017).

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[12] M. P. Maggay, *Transforming Society* (Institute for Studies in Asian Church and Culture, 1996).

[13] M. B. A. O'Neill *Executive Coaching with Backbone and Heart: A Systems Approach to Engaging Leaders with Their Challenges* (Hoboken: John Wiley & Sons, 2007).

[14] KII and FGD Transcript, page 24, lines 1146-1153 of Meredith Del Pilar-Labarda, MD. *Transformative Leadership and Governance as a Development Process: Building Equitable Health Systems and Filipino Well-being. Dissertation for Doctor of Social Development.* May 2019. For data privacy considerations, the name of the person quoted from the study is not the interviewee's real name

[15] *Ibid*.

[16] G. K. De, *Kapwa: The self in the Other: Worldviews and Lifestyles of Filipino Culture-bearers* (Pasig City, Philippines: Anvil, 2005).

[17] KII and FGD Transcript, page 27, lines 1303-1310. Meredith Del Pilar-Labarda, MD. *Transformative Leadership and Governance*.

[18] Introduction to Bottom-Up Budgeting in National Government Agencies. https://www.scribd.com/doc/172766607/What-is-Bottom-Up-Budgeting

[19] Meredith Del Pilar-Labarda, MD. "Transformative Leadership and Governance as a Development Process: Building Equitable Health Systems and Filipino Well-being" (PhD Dissertation, May 2019).

[20] J. I. Ruiz, K. Nuhu, J. T. McDaniel, F. Popoff, A. Izcovich and J. M. Criniti, "Inequality as a Powerful Predictor of Infant and Maternal Mortality around the World." *PloS One* 10, no. 10 (2015): e0140796. https://doi.org/10.1371/journal.pone.0140796.

[21] *Zuellig Family Foundation Annual and Sustainability Report, 10 Years as a Catalyst for Better Health Outcomes in the Philippines* (2018).

[22] P. M. Senge, *The Fifth Discipline: The Art and Practice of the Learning Organization* (New York: Doubleday/Currency, 1990).

[23] This stands for the four main islands of the region – Mindoro, Marinduque, Romblon, Palawan.

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