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CLAimHealth: COLLABORATING, LEARNING, AND ADAPTING FOR IMPROVED HEALTH ACTIVITY

Good Practices and Promising Interventions, Technical Series No. 6: Engaging Local Chief Executives to Build Local Capacity and Strengthen Health Systems

March 31, 2021

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Photos depicting activities of IHLGP are courtesy of the Zuellig Family Foundation.

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ACRONYMS

BARMMHealth	Bangsamoro Autonomous Region in Muslim Mindanao Health Capacity Building
BLFP	Bridging Leadership Fellowship Program
CHLT	City Health Leadership Team
CHO	city health officer
CLAimHealth	Collaborating, Learning, and Adapting for Improved Health
CLGP	City Leadership and Governance Program
DOH	Department of Health
GPPI	good practices and promising interventions
HCPN	health care provider networks
HLGP	Health Leadership and Governance Program
IHLGP	Institutionalization of Health Leadership and Governance Program
IP	implementing partners
LCE	local chief executive
LGU	local government unit
OH	USAID Office of Health
PDOHO	Provincial DOH Office
PHO	provincial health officer
PLGP	Provincial Leadership and Governance Program
ReachHealth	Family Planning and Maternal and Neonatal Health Innovations and Capacity Building Platforms
RenewHealth	Expanding Access to Community-Based Drug Rehabilitation
SDN	service delivery network
TB Platforms	TB Platforms for Sustainable Detection, Care and Treatment
UHC	Universal Health Care
USAID	United States Agency for International Development
WHO	World Health Organization
ZFF	Zuellig Family Foundation

EXECUTIVE SUMMARY

This documentation and assessment activity aims to identify, describe, and validate good practices and promising interventions (GPPIs) implemented as part of United States Agency for International Development's (USAID's) Institutionalization of Health Leadership and Governance Program (IHLGP). GPPIs are interventions—tools, processes, and activities—that achieve IHLGP's objectives and are replicable in other settings.

The Collaborating, Learning, and Adapting for Improved Health (CLAimHealth) activity used an iterative qualitative approach to ascertain whether certain IHLGP interventions could be considered as GPPIs. This included document review, stakeholder consultations, interviews with local chief executives (LCEs) and health officials, and participation in meetings and key learning events. Using data from these sources, CLAimHealth assessed the prospective GPPIs based on standard GPPI criteria that CLAimHealth, the USAID/Philippines Office of Health, and other partners developed.

In this report, CLAimHealth describes these GPPIs and identifies facilitators and barriers to implementation to inform recommendations for further improvement. CLAimHealth used the insights gained from this GPPI documentation activity to answer the learning questions related to the IHLGP activity. These questions pertain to different dimensions of program institutionalization—the "I" in IHLGP. These dimensions are sustainability, change management, knowledge management, client satisfaction, and partnership building. Insights about these dimensions can inform future implementation, replication, and scale up of IHLGP's GPPIs.

Key Findings

IHLGP provides a strategy for direct LCE engagement to build local capacity to address priority health issues. The basic premise of IHLGP is that building local capacity for leadership and governance will lead to better health outcomes. The specific GPPIs implemented under IHLGP may not directly result in improved health outcomes, especially in the short-term. However, they build the foundation for community health improvement by developing positive attitudes, mindsets, and behaviors among LCEs and other local stakeholders—a key enabling condition for good health governance and decision making.

Ownership, co-ownership, and co-creation, the three segments of the Bridging Leadership Framework that underpin the IHLGP process, are vital in strengthening local leadership and the LCE engagement process. IHLGP's component GPPIs are designed in a structured, sequential, and synergistic way to mirror the process of transitioning from a traditional "top down" leadership framework to a model of collective leadership development, which is better suited to address complex and varied public health challenges of the communities in which IHLGP is working.

Based on this GPPI documentation and assessment activity, IHLGP has three good practices: deep dive, roadmap, and coaching. CLAimHealth found that these three practices delivered their intended immediate results, such as attitudinal change and concrete leadership actions.

Although the health improvements realized during the IHLGP period cannot be easily attributed to specific GPPIs, these early successes occurred in tandem with the implementation of these interventions.

- In the **deep dive** activity, a participant learns of system challenges by engaging directly with a health system client, such as an "index patient." The deep dive activity helps LCEs correct leadership blind spots (such as failure to recognize a particular public health problem), develop a more profound sense of ownership regarding the issue at hand, and enhance their personal vision for the health of their locale.

- The **roadmap** is a visual tool for identifying gaps in the health system and monitoring progress to address them. Designed after the health system building blocks framework, the roadmap provides a structure for diagnosing health system problems and planning interventions. It can also be used as coaching tool to engender motivation and accountability among stakeholders.

- **Coaching** pertains to engagement strategies for changing mindsets and perspectives, unlocking potential, improving performance, and enabling learning. Experiences in IHLGP indicate that coaching helps create a sense of ownership of and accountability for health decision making among LCEs. Both leadership and technical coaching, whether in a structured or informal, are vital in building the capacity of LCEs and other stakeholders for local health system governance.

Relationship building is essential for the successful implementation of IHLGP's good practices, and this is worth considering as a promising intervention for improving local health leadership and governance. While IHLGP did not have a discrete and explicit intervention for building relationships, it nonetheless did so formally and informally throughout the program, such as through formation of core teams and activity "pre-work," which is critical to obtain LCE buy-in to participate in other activities under IHLGP.

Relationship building is an important precondition for, an input to, and an outcome of implementing health leadership programs. The need for this derives from the fact that addressing complex social challenges such as public health problems is beyond the capacity of an individual leader or single sector, relying instead on enhanced collaboration and coordination that can only be realized through strong relationships among all stakeholders.

While individual GPPIs can be executed as stand-alone interventions, the IHLGP experience demonstrates that they are best implemented as a package to maximize their synergistic effect. Each GPPI plays an important function, and their simultaneous or sequential implementation will likely support more holistic leadership development. The deep dive allows for self-discovery and visioning; the roadmap provides structure for diagnosis, action planning, and monitoring; coaching engenders motivation and accountability; and relationship building measures serve as the "glue" that binds all interventions.

The experience of IHLGP also showed the flexibility of the GPPIs; they can be adapted to suit a variety of public health problems, different types of LCEs, and diverse local contexts. The deep dive activity was used to highlight a neglected yet pressing local health problem which varied

by location. The roadmap was customized for use in diagnosing gaps and monitoring progress in health system-wide actions, in addition to responding to specific public health issues such as tuberculosis and family planning.

IHLGP as a whole, as well as the specific GPPIs, have contributed to sustainability of leadership gains in several ways. IHLGP also contributed to the achievement of other institutionalization goals such as change management, knowledge management, client satisfaction, and partnership building. Early signs indicate that IHLGP and its GPPIs are preparing health systems and communities for long-term change. The challenge will be to ensure that these positive outcomes are retained, if not advanced, beyond the lifespan of IHLGP.

It is still too early to conduct an impact evaluation; however, there is some indication that IHLGP in general and the GPPIs in particular helped lay the foundation for introducing Universal Health Care (UHC) reform efforts and for timely, quick, and coordinated COVID-19 response. The LCEs generally agree that their experience with IHLGP and the specific GPPIs, (*i.e.*, deep dive and coaching) allowed them to easily convene stakeholders and coordinate resources around big transformation efforts, such as institutionalizing UHC and mounting an unprecedented response to the ongoing pandemic.

Recommendations

The identified GPPIs should be implemented as a package of interventions to maximize synergistic effect. As outlined in the key findings, the assessment found the best outcomes result when the identified GPPIs are implemented sequentially. This allows for compounding and additive effects on the program through relationship building, change management, and knowledge management. Though the GPPIs can be implemented individually, this would likely limit their potential impact.

Additional technical assistance and funding may be needed to sustain the implementation of GPPIs post-IHLGP. In handover sessions, LCEs and other stakeholders clearly expressed both interest and intention to continue implementing specific components of the IHLGP, particularly the deep dive, roadmap, and coaching. However, despite several years of support, various stakeholders also said they would like continued technical assistance, and possibly also funding, to ensure sustained implementation in the medium term.

Government agencies responsible for developing local capacity for health governance should leverage these GPPIs and harness the lessons learned from IHLGP. Agencies such as the Department of Health, Department of Interior and Local Government, Development Academy of the Philippines, and Commission on Population should adopt these GPPIs in their LCE engagement activities and incorporate them in the trainings that are offered to LCEs and other local stakeholders.

Other implementing partners (IPs) of the USAID Health Project can use these GPPIs in their own activities. Whether for family planning (Family Planning and Maternal and Neonatal Health Innovations and Capacity Building Platforms [ReachHealth]) or community-based drug use prevention (Expanding Access to Community-Based Drug Rehabilitation [RenewHealth]), the GPPIs can foster

ownership among LCEs and other public health stakeholders and catalyze multi-sectoral responses to the problems these projects are trying to address. IPs can also adapt the GPPIs to the unique nature of any given public health problem and to local contexts.

Certain other sectors, such as agriculture, fisheries, and other industries, should consider using the IHGLP approach, as they are integral to good health and the success of health outcomes. One of the key findings within the GPPI assessment was the need for intersectoral collaboration to address complex health issues, as seen with teenage pregnancy and nutrition. IHLGP tools and approaches, such as the deep dive and roadmap, can be applied in sectors such as sustainable farming and fishery operations, and others that are peripheral to the health sector but still are key to positive health outcomes.

Build in flexibility to adapt IHLGP to local contexts and different types of LCEs. The assessment found that all LCEs entered the program with different levels of experience, and specific geographic, political, and community contexts. The curriculum and approach ideally should be tailored to meet individual needs of LCEs and local government units (LGUs), as opposed to adopting a one-size-fits-all approach. ZFF and IHLGP staff, as well as LCEs, have suggested the possibility of developing a more intensive program and a "lite" version for LCEs who may not be available for intensive engagement.

Consider developing a structured relationship-building intervention, based on the existing successful relationship-building measures in IHLGP, that IPs can easily replicate and adopt. The IHLGP curriculum has numerous mechanisms for building teams, relationships, and partnerships woven into its design. These should be distilled into one document showing the different options for engaging and building relationships with LCEs, between and across sectors, for use by implementing partners and other stakeholders working in health.

When replicating GPPIs, embed research from the start. Parties planning to implement IHLGP's GPPIs should incorporate elements of learning and research to further understand whether and how health systems strengthening and health outcome gains can be directly attributed to specific GPPIs.

Leverage the interest of IHLGP alumni to coach, mentor, and provide training for new LCEs. Several LCEs expressed interest in participating in a community of IHLGP alumni to allow for cross-learning across regions, provinces, cities, and barangays, and in supporting new incoming LCEs. As previous program participants with extensive experience serving their communities, alumni are an untapped resource for sustaining the advances of IHLGP.

1. BACKGROUND

1.1. Good Practices and Promising Interventions

The Collaborating, Learning and Adapting for Improved Health (CLAimHealth) activity provides monitoring, evaluation, and learning support to the U.S. Agency for International Development (USAID)/Philippines' Health Project (2017–2023), which seeks to improve health outcomes for underserved Filipinos. CLAimHealth, one of twelve activities in USAID's Health Project, generates and uses high quality monitoring and evaluation data, documents good practices and promising interventions (GPPIs), and conducts implementation research.

With respect to GPPI, a **good practice** is defined as an intervention, technology, or methodology that, through a rigorous process of peer review and evaluation, clearly links positive effects to the practice, has been shown to be effective in a specific city and/or province, and can be replicated. A **promising intervention**, on the other hand, has strong quantitative and qualitative data showing positive outcome(s) but does not yet have enough evidence to support generalizable positive health outcomes and the potential for scale up. The context, process, and outcomes of these interventions should be assessed according to a standard set of criteria, namely: A good practice or high-impact intervention should meet most, if not all, of the following seven identified evaluation criteria: effectiveness, replicability, commitment, alignment, integration, inclusiveness, and resources.[1,2,3] Their effectiveness should be linked to the achievement of goals of the USAID Office of Health (OH) and the Health Project's high-level indicators.

For the duration of its contract (2018—2022), CLAimHealth will identify and document on an ongoing basis potential GPPIs of current and future USAID OH implementing partners (IPs). Collectively, these documents are designed to validate whether the recommended interventions are indeed GPPIs that should be replicated and scaled up at the national level. This report is the sixth of a technical series of selected GPPIs documented over the life of the Health Project.

This GPPI documentation process assessed specific interventions included in USAID's Institutionalization of Health Leadership and Governance Program (IHLGP), implemented by the Zuellig Family Foundation (ZFF) from 2017 to 2020. The graphic below shows the selection process for IHLGP's GPPIs.

[1] Ng E, de Colombani P. Framework for Selecting Best Practices in Public Health: A Systematic Literature Review. J Public Health Res 2015; 4:577. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4693338/

[2] Adamou B, et al. Guide for Monitoring Scale-Up of Health Practices and Interventions. MEASURE Evaluation PRH, January 2014. Available at: https://www.measureevaluation.org/resources/publications/ms13-64

[3] A Guide to Identifying and Documenting Best Practices in Family Planning Programmes. Geneva: World Health Organization; 2017. Available at: https://www.who.int/reproductivehealth/publications/family_planning/best-practices-fp-programs/en/

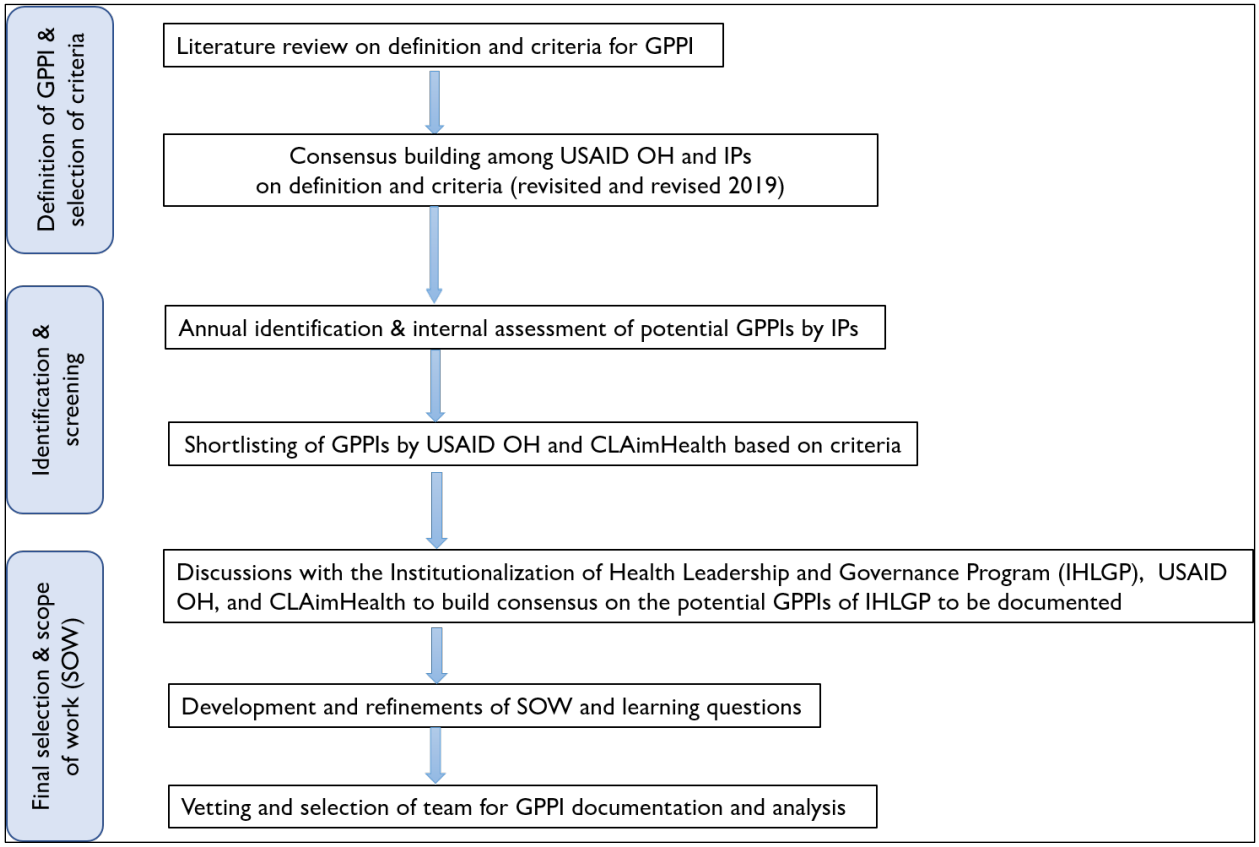


Figure 1. Selection process for good practices and promising interventions: institutionalization of the Health Leadership and Governance Program

1.2. Overview of the Institutionalization of Health Leadership and Governance Program

IHLGP is a three-year cooperative agreement between USAID and ZFF that aims to improve health leadership and governance as a means to strengthening local health systems, ultimately improving health outcomes and contributing to the achievement of the Sustainable Development Goals. IHLGP builds on the Health Leadership and Governance Program (HLGP) in the USAID-assisted sites, earlier implemented by ZFF, USAID, and the DOH from 2013 to 2016.

Within the three-year period, IHLGP was implemented across five regions (Western Visayas, Northern Mindanao, Zamboanga Peninsula, SOCCSKSARGEN, and ARMM); 10 provinces including their constituent municipalities (Antique, Guimaras, Zamboanga del Norte, Zamboanga del Sur, Misamis Oriental, Sarangani, South Cotabato, Sultan Kudarat, Tawi-Tawi, and Basilan); and six cities (Cagayan de Oro City, Iligan City, Zamboanga City, Koronadal City, Dipolog City, and General Santos City). ZFF originally planned to end the IHLGP Activity in July 2020 but extended it for three more months, officially ending on September 30, 2020.

IHLGP's main objectives (Figure 2) are to:

1. Improve leadership competencies of local health officials for better governance of health systems;
2. Strengthen support to HLGP and health leadership and governance initiatives by local government units (LGUs) with other civil society organizations and private sector partners at the regional level, and;
3. Institutionalize the HLGP by the DOH.

IHLGP's primary strategy to achieve these objectives is direct engagement with regional directors of the DOH and local chief executives (LCEs) such as provincial governors and city mayors, to build local capacity and strengthen the response to priority health issues at the provincial and city levels. Additionally, the project targets provincial health officers (PHOs), provincial chiefs of hospital, city health team leaders, city health officers (CHOs), city chiefs of hospitals, and others.

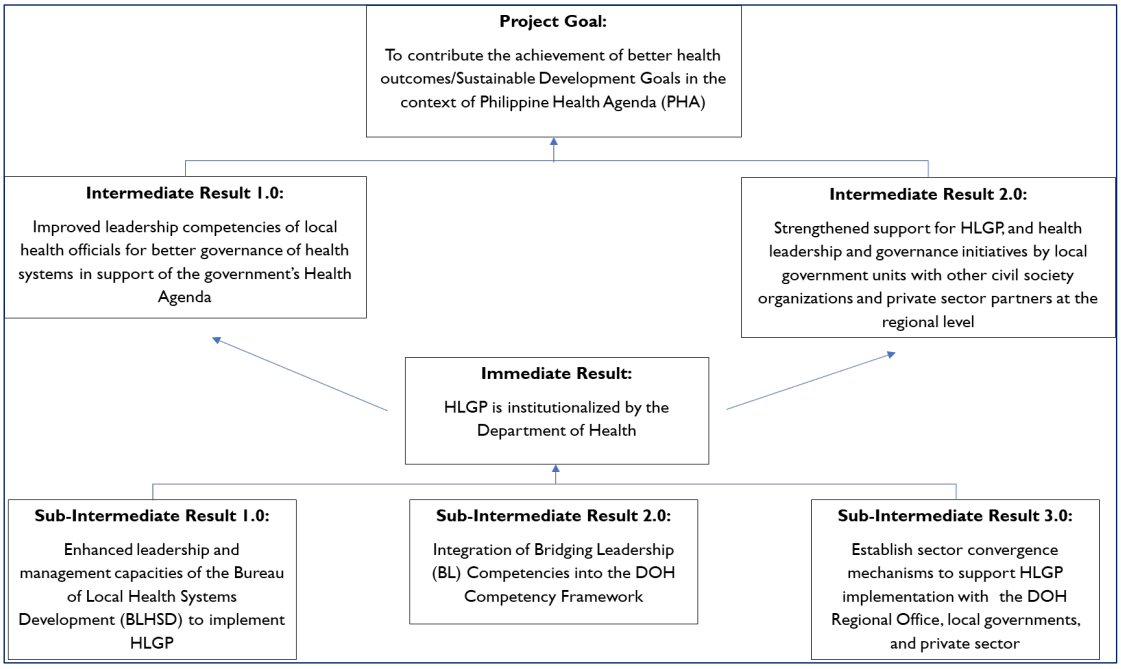


Figure 2. IHLGP results framework
(Source: Zuellig Family Foundation)

IHLGP engaged with LCEs by using tools, processes, and activities, that: 1) influence personal decision making; 2) develop leadership competencies; and 3) foster an enabling environment. These interventions are embedded in four programs (also known as "runways") that constitute the IHLGP: Bridging Leadership Fellowship Program (BLFP) for DOH regional directors; Provincial Leadership and Governance Program (PLGP) for governors and their teams; City Leadership and Governance Program (CLGP) for city mayors and their teams; and Barangay Health Leadership and Management Program for barangay chairpersons (see Figure 3). These four programs are complementary and were implemented to maximize effective and efficient leadership competency development and systems strengthening at the province, city, and barangay levels.

Figure 3. IHLGP's four programs, or "runways"

1.3 IHLGP's Theory of Change: Health Change Model and Bridging Leadership Framework

To understand the GPPIs implemented in IHLGP, it is essential to first understand the project's theory of change, which is informed by two frameworks. The first is the Health Change Model (Figure 4), developed by ZFF. The basic premise is that strong and responsive local leadership is key to changing systems that can achieve better health outcomes through mutually reinforcing improvements in supply (effective health services) and demand (increased community participation in the health care system). Given the devolution[4] of the Philippines' local health systems, IHLGP's primary leadership targets are the regional directors and LCEs, which are the provincial governor, the city or municipal mayor, and the barangay chairman, representing different governance levels. Through IHLGP, these LCEs along with health officers and other stakeholders strengthen their capacity through a combination of training, practicum, and coaching activities which help them appreciate their role in local health governance.

[4] In public administration literature, *devolution* is the "creation or strengthening of subnational levels of government (often termed local government or local authorities) that are substantially independent of the national level with respect to a defined set of functions." It is one of the four types of decentralization, the others being: *deconcentration* (shifting power from the central offices to peripheral offices of the same administrative structure); *delegation* (shifting responsibility and authority to semi-autonomous agencies); and *privatization* (transferring operational responsibilities and in some cases ownership to private providers). (Mills, A., Vaughan, J. P., Smith, D., & Tabibzadeh, I. (Eds.) (1990). Health system decentralization: concepts, issues and country experience. Geneva: World Health Organization. https://apps.who.int/iris/handle/10665/39053)

Figure 4. ZFF's Health Change Model[5]

To operationalize the Health Change Model, ZFF also adopted the Bridging Leadership Framework, originally developed by the Synergos Institute[6] and brought to the Philippines by the Asian Institute of Management.[7] "Bridging Leadership" is defined as the "capacity to build trust and tap the fullest contributions of diverse stakeholders, helping them come together across divides and work in transformative partnership."[8] Central to this leadership style is the recognition that complex social challenges, such as public health problems, are beyond the capacity of an individual leader or singular sector to resolve; thus, it is imperative to build trust in multi-stakeholder processes.[9] It also represents a paradigm shift in thinking about the role of a leader. For example, the framework shifts away from recognizing a leader as a commander and controller and recognizes a leader as a facilitator and convener (Figure 5).

Figure 5. Qualities of a "bridging leader"[10]

[5] Source: Zuellig Family Foundation.
[6] https://www.synergos.org/
[7] https://aim.edu/research-centers/team-energy-center-bridging-leadership
[8] https://www.synergos.org/bridging-leadership
[9] https://syngs.info/files/bridging-leadership-overview.pdf
[10] https://www.synergos.org/bridging-leadership

The Bridging Leadership process involves three main segments. First is ownership, defined as a leader who embraces responsibility over a complex social problem and recognizes that the only way to solve the problem is to convene relevant stakeholders. Second is co-ownership, defined as a process of dialogue and engagement, where stakeholders arrive at a common vision and collective response to the situation. Third is co-creation, defined as stakeholder adoption of a social innovation that leads to the desired societal outcome and then sustains it throughout new institutional arrangements. ZFF adopted this framework as a basis for the sequence of activities or interventions that comprise the IHLGP (Figure 6).

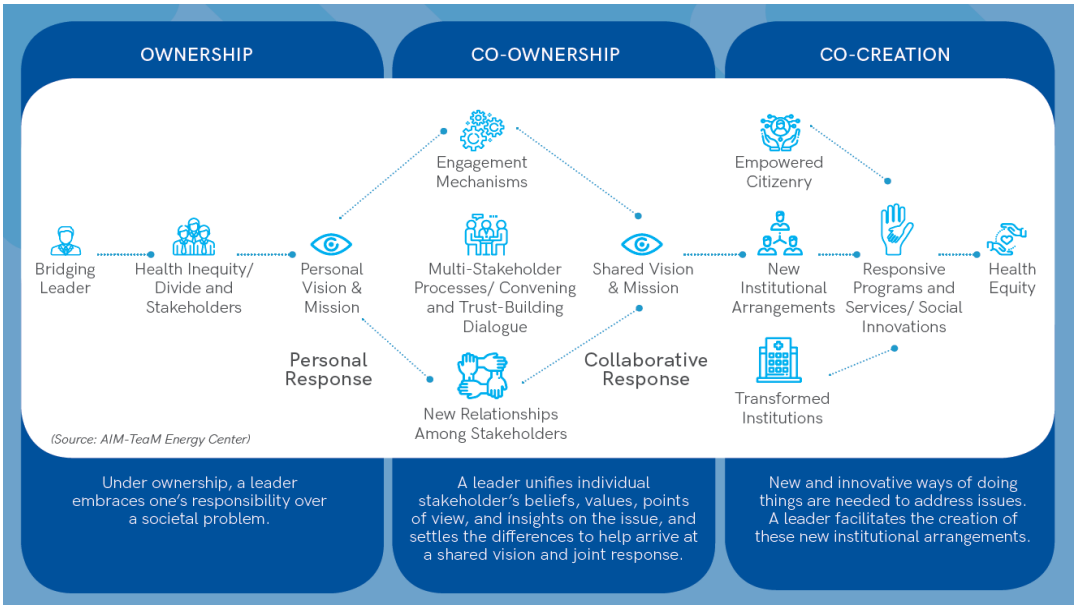


Figure 6. Bridging Leadership Framework adapted by ZFF[11]

Based on the Bridging Leadership Framework, ZFF also adopts the Bridging Leadership Competency System, which is guided by a set of standards, tools, and processes. One of the highlights is the enumeration of Bridging Leadership Competencies (Figure 7) which serves as the basis for the assessment of LCEs and other participating stakeholders in IHLGP. The assessment tool contains specific core behavioral elements that comprise the seven main competencies, and LCEs are rated on whether they are beginner, capable, competent, or exemplar. Such assessment helps the ZFF-IHLGP team determine the level of attention and support that they should extend to the LCE throughout the IHLGP process.

[11] Source: 2018 Annual Report of the Zuellig Family Foundation.

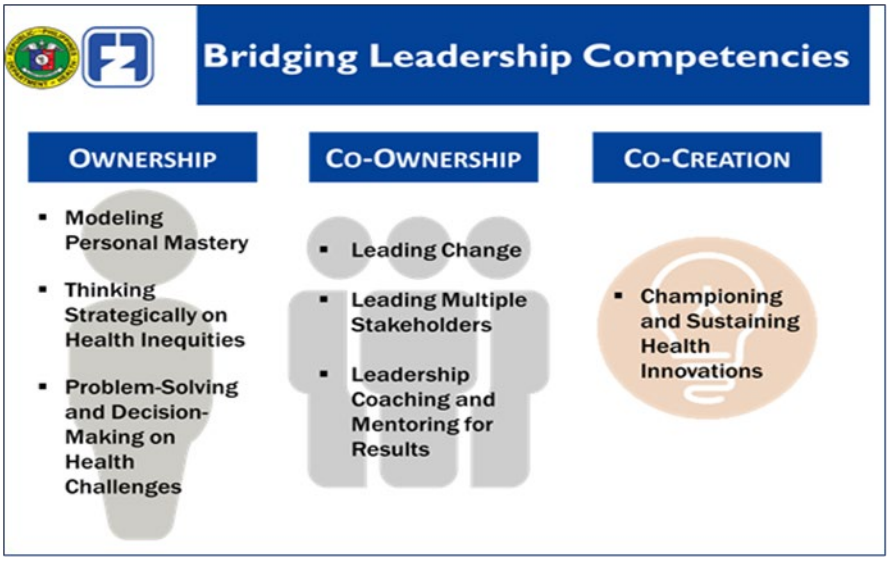


Figure 7. Bridging Leadership competencies[12]

1.4. Summary of IHLGP's Success

Over the course of IHLGP from 2017 until 2020, tangible changes can be seen across participating LCE's leadership and governance competencies Figure 8) as well as an overall increase in budget allocations for health (Figure 9). Multiple external factors make it impossible to attribute IHLGP efforts to improvements at the health outcome level with absolute certainty (Figure 10). However, metrics around targeted health areas, such as teenage pregnancy, maternal mortality rates, and TB case detection rates, have improved. While establishing causation or even association between GPPIs and health outcomes is impossible, this GPPI documentation process allowed for a deeper examination of how IHLGP interventions may be leading to more immediate program outputs, leadership acts, or good changes in behaviors and attitudes that may eventually contribute to the achievement of desired health system goals and health outcomes.

[12] See Annex 4 for the detailed elements of the Bridging Leadership Competencies.

BL Competencies	Guimaras		Zamboanga del Norte		Misamis Oriental		Sarangani		Basilan	
	Base	End	Base	End	Base	End	Base	End	Base	End
Modeling Personal Mastery										
Thinking Strategically on Health Inequities										
Problem Solving and Decision Making on Health Challenges										
Leading Change										
Leading Multi-Stakeholder Processes										
Leading Coaching and Mentoring for Results										
Championing and Sustaining Social Innovations										

Key: Green = exemplar; orange = competent; yellow = capable; red = beginner

Figure 8. Changes in Bridging Leadership competencies (2017-2019)[13]

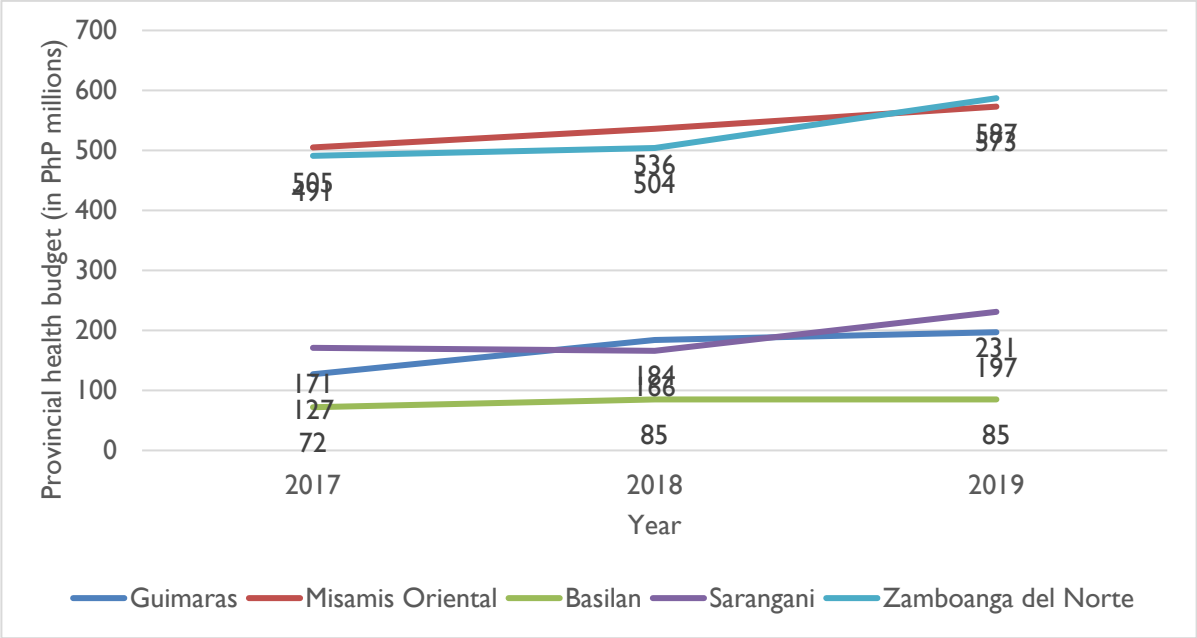


Figure 9. Provincial Health Budget Allocation, 2017–2019 (in PhP millions)[14]

[13] Source: ZFF-PLGP Program Completion Report.
[14] Source: ZFF-PLGP Program Completion Report.

Health Outcomes	Antique		Guimaras		Zamboanga del Norte		Misamis Oriental		Sarangani		Sultan Kudarat		Basilan	
	2017	2019	2017	2019	2017	2019	2017	2019	2017	2019	2017	2019	2017	2019
Maternal Death (Total)	8	6	0	0	11	10	1	1	6	5	4	5	4	4
Maternal Mortality Rate (per 100,000 live births)	90	68	0	0	96	80	9	8	54	50	30	40	111	89
Teenage Pregnancy (Women aged 15-24)	1,427	1,373	392	335										
Teenage Pregnancy Rate (% of women aged 15-24)	2.6	2.6	2.4	1.9										
TB Case Detection Rate (per 100,000 population)			55	61	55	60	44	51					56	36
Wasting Prevalence (% of children < 5 y.o.)	4	3							6	3				
Stunting Prevalence (% of children < 5 y.o.)	13	12							16	9				

Key: Boxes signify improvement from baseline to end line; yellow means no change; red means decline

Figure 10. Changes in health outcomes for the seven PLGP provinces (2017-2019)[15]

[15] Source: ZFF – PLGP Program Completion Report, derived from FHSIS and ITIS reports submitted by the provinces.

2. OBJECTIVE AND LEARNING QUESTIONS

This GPPI documentation aims to describe and validate the contribution of IHLGP's technical assistance in engaging LCEs through specific interventions such as tools, process, and activities, implemented to enhance engagement with LCEs and LGUs, and with the eventual goal of strengthened local health leadership and governance and improved health outcomes. These interventions were assessed using the GPPI criteria developed by CLAimHealth, OH, and other IPs.

This GPPI documentation also aims to answer main learning questions (Table 1) with respect to program institutionalization—the "I" in IHLGP. These questions are grouped into the following five dimensions: sustainability, change management, knowledge management, client satisfaction, and partnership building. Answers to these questions, developed by CLAimHealth, OH, and IHLGP, can provide more insights about IHLGP and its GPPIs for consideration in later implementation, replication, and scale up.

Table 1. Key learning questions across functions of institutionalization

Key Learning Themes	Learning Questions
Sustainability	• Are there "success stories" from LGUs demonstrating sustained improvements in selected health outcomes over time (comparing pre-IHLGP data to data obtained during the IHLGP period)?
Change Management	• How can we engage LCEs in strengthening LGU health systems? • What main strategies and tools have proven to be most effective? • Are there specific social behavior change lessons that can be shared for changing leaders' mindsets and behaviors?
Knowledge Management	• How do we package data and information in such a way that decision makers can process it and advocate for improved health services? • Which main strategies and tools have been demonstrated to be most effective?
Client Satisfaction	• How satisfied were clients (*e.g.*, LCEs) with the identified best practice strategies and tools? • What worked well and what did not? • Do they have any suggestions for improvements?

Partnership Building	• How do we build local capacity through engaging civil society (*e.g.,* nongovernmental organizations, academia) and the private sector? • What are the main strategies and tools that have been demonstrated to be most effective? • What has been the effort to strengthen community engagement and empower community members to demand health system change? • What are the opportunities that could have been tapped?

3. GPPI AS AN EVALUATION FRAMEWORK

As its evaluation framework, this documentation activity employs the definition of a GPPI proposed by CLAimHealth (see Section 1.1). CLAimHealth, OH, and other IP organizations developed a list of criteria along with guide questions, based on the literature documenting best practices (Table 2) to evaluate whether interventions are GPPIs or not.[16,17,18] Given that IHLGP is an intervention to enhance leadership, CLAimHealth determined the need to add another criterion for this documentation activity – accountability.

Table I2. GPPI criteria developed by CLAimHealth[19]

Type	Criterion	Main Question
Core	**Effective**	Is the practice or intervention measurably **effective**, per the defined aim or objective?
	Replicable	Is the practice or intervention **replicable**, requiring expertise and resources that may be generalized or adapted?
	Commitment	Is there a strong **commitment** for the practice or intervention at the local, sub-regional, and/or national levels, demonstrating the potential for sustainability and scale up?

[16] Ng E, de Colombani P. Framework for Selecting Best Practices in Public Health: A Systematic Literature Review. J Public Health Res 2015; 4:577. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4693338/
[17] Adamou B, et al. Guide for Monitoring Scale-Up of Health Practices and Interventions. MEASURE Evaluation PRH, January 2014. Available at: https://www.measureevaluation.org/resources/publications/ms13-64
[18] A Guide to Identifying and Documenting Best Practices in Family Planning Programmes. Geneva: World Health Organization; 2017. Available at: https://www.who.int/reproductivehealth/publications/family_planning/best-practices-fp-programs/en/
[19] See the detailed table with sub-questions in Annex 1.

Table I2. GPPI criteria developed by CLAimHealth[19]		
Type	**Criterion**	**Main Question**
Secondary	**Aligned**	Is the practice or intervention **aligned** across stakeholders?
	Integrated	Is the practice or intervention **integrated** (horizontally and vertically), to the extent possible, with existing health system structures?
	Inclusive	Is the practice or intervention **inclusive** (involving, collaborating with, and empowering key stakeholders in all phases of intervention)?
	Resourced	Are there **sufficient resources** to support the practice or intervention, including financial, physical, human, and technical resources?
	Accountable	Are **accountability** measures built in within the intervention?

Based on the GPPI definition and for evaluation purposes, the first three criteria can be considered core criteria (*i.e.,* they must be present for an intervention to be considered either a good practice or promising intervention). The main difference is the strength of evidence available to demonstrate effectiveness, replicability, and commitment. The other five criteria can be considered secondary criteria (*i.e.*, they do not define a GPPI but their presence enhances the GPPI's core qualities). Table 3 summarizes the distinction between core and secondary criteria in relation to the GPPI definition.

Table 3. Criteria rubric for evaluating GPPIs		
GPPI	**Core Criteria**	**Secondary Criteria**
Good Practice	Strong evidence	Strong or some evidence
Promising Intervention	Some evidence	
Not a GPPI	Weak or no evidence	Weak or no evidence

4. METHODOLOGY

4.1. Mixed Methods Approach

This GPPI documentation activity adopted an iterative qualitative approach (Figure 11), comprising a document review, stakeholder consultations, key informant interviews with LCEs and health officials, and participation in several meetings and events, including key IHLGP learning events.

Keeping in mind the aforementioned GPPI criteria, CLAimHealth identified and described an initial set of prospective GPPIs through consultations with the ZFF – IHLGP[20] teams, and review of key documents such as IHLGP's quarterly and annual reports, program designs and workshop manuals, and PowerPoint slides used to train participants.

These prospective GPPIs then served as the basis for the semi-structured interviews conducted with LCEs (three provincial governors and one city vice mayor) and health officials (two PHOs and two regional directors) who were suggested by the ZFF–IHLGP team.[21] The semi-structured interviews[22] focused on the interviewees' overall experience of the IHLGP as well as their detailed experiences with the GPPIs under investigation. During the interview, CLAimHealth utilized elements of the Most Significant Change approach[23] and asked interviewees to share success stories that demonstrate linkages between the GPPI and identifiable intermediate (*e.g.,* behavioral change) or long-term outcomes (*e.g.,* disease reduction). CLAimHealth then triangulated these testimonies with written accounts from available documents, such as reports from previous IHLGP colloquia. Other interviews questions probed problems faced during participation in IHLGP and recommendations for further improvement.

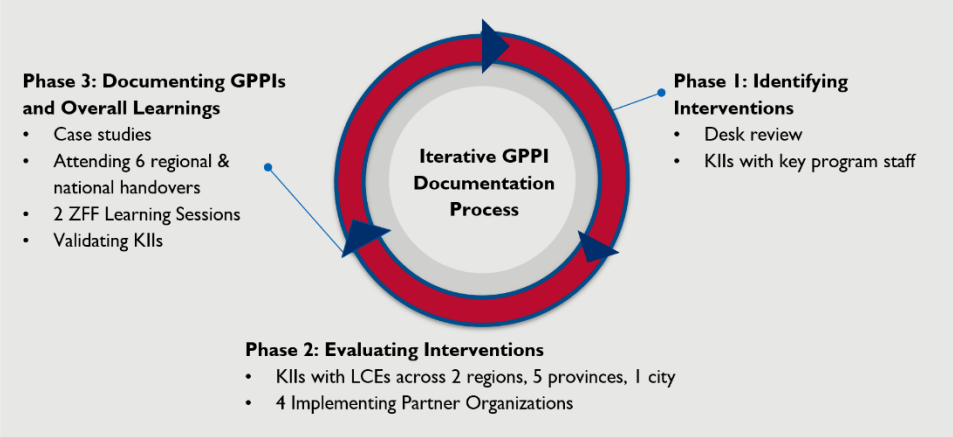


Figure 11. Mixed methods iterative approach

[20] Full list of informants from the ZFF-IHLGP team can be found in Acknowledgments.
[21] Full list of key informants can be found in Acknowledgments. For the key informant interviews, the ZFF-IHLGP team originally suggested five provincial governors, five provincial health officers, two city mayors, one city vice mayor, three city health officers, and two regional directors. For those not interviewed, reasons include non-availability due to COVID-19 and limited wireless connectivity, among others.
[22] Semi-structured interview guide can be found in Annex 2.
[23] As a full Most Significant Change process requires time to allow for repeated cycles of sharing and analysis of stories with contributors and stakeholders, this assessment only applied selected principles of the approach. For more information: https://www.betterevaluation.org/en/plan/approach/most_significant_change

CLAimHealth also consulted with other USAID IPs who either adopted (ReachHealth) or are considering adopting (TB Platforms, RenewHealth, and BARMMHealth) some or all of IHLGP's interventions.[24] These consultations generated additional inputs regarding the ways in which IPs have adapted or are planning to adapt IHLGP's interventions for their specific purpose and any challenges encountered in the process.

Finally, this documentation activity coincided with the tail end of IHLGP, which allowed CLAimHealth to attend several close-out events including: the presentation of the endline assessment conducted by an external evaluator; six regional and one national handover ceremonies (where IHLGP synthesized lessons learned and handed over knowledge products to DOH); and an internal learning session organized by ZFF and attended by USAID IPs.[25] These events provided additional information about the GPPIs, including lessons learned, areas for improvement, and insights regarding the post-IHLGP sustainability plans for different stakeholders (*i.e.,* LGUs, and DOH regional offices).

Because this documentation activity was conducted in 2020 during the peak of the COVID-19 pandemic in the Philippines, CLAimHealth conducted all interviews, meetings, and events remotely via Zoom. All qualitative data collected were recorded, transcribed, and stored securely.

4.2. Limitations

The scope of CLAimHealth's GPPI documentation exercise was to "describe and validate the contribution of IHLGP's technical assistance in engaging LCEs and to recommend a cohesive package of effective interventions for IPs and other stakeholders to implement moving forward." Establishing causation between IHLGP's GPPIs and specific health outcomes, however, would require quasi-experimental methods (such as comparing IHLGP and control sites) and was beyond the scope of this exercise.

Nonetheless, the methods used in the project, which included document reviews, key informant interviews, and participant observation in learning sessions, allowed for deeper understanding of how specific GPPIs were effective in achieving their immediate outputs of engaging LCEs and their connection to institutionalization elements (*i.e.*, learning questions) of sustainability, change management, knowledge management, client satisfaction, and partnership building. Moreover, program data that were reviewed as part of the documentation process demonstrated positive changes in various health outcomes where GPPIs were successfully implemented.

[24] Full list of informants can be found in Acknowledgments.
[25] Full list of events, including dates, can be found in Annex 3.

5. IHLGP's GOOD PRACTICES AND PROMISING INTERVENTIONS

5.1 Introduction to IHLGP's Four GPPIs

Complex public health interventions such as IHLGP have multiple interacting components. To fully understand how complex interventions and their elements can achieve their intended outcome, unpacking these is essential. This GPPI documentation process is akin to unpacking the "black box" of IHLGP (Figure 12) and identifies specific constituent interventions that help strengthen health system governance, as conceptualized by ZFF's Health Change Model—ultimately aimed to improve health outcomes.

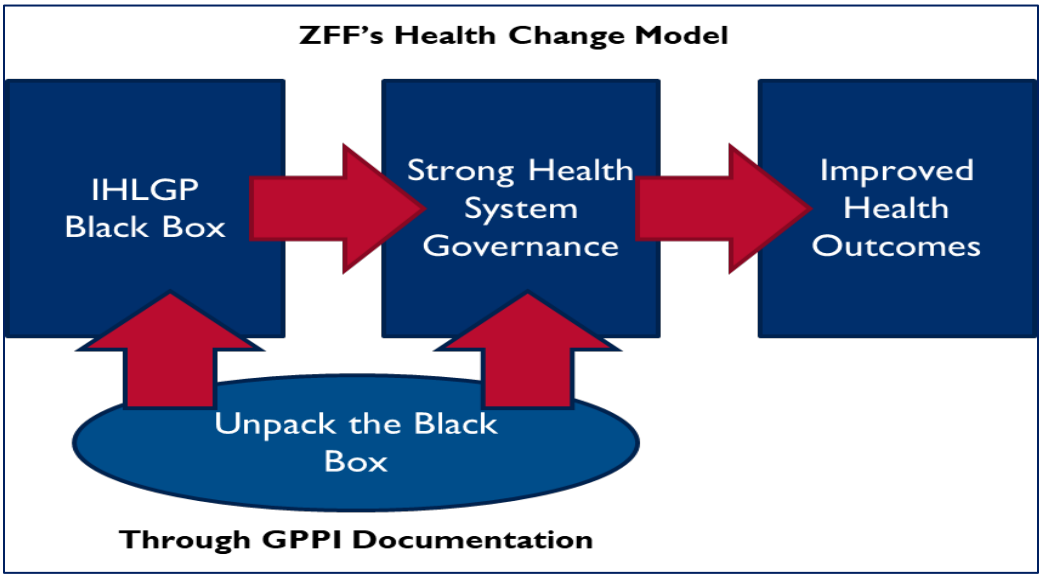


Figure 12. Unpacking the black box of IHLGP through the GPPI documentation process

This process of deconstruction revealed three interventions among the many that comprise IHLGP that stood out as good practices: deep dive, roadmap, and coaching. The deep dive is an activity where a participant sees the challenges firsthand of a system from the perspective of other stakeholders. The roadmap is a visual tool for identifying gaps in the health system and monitoring progress in addressing them. Coaching pertains to engagement strategies for changing mindsets and perspectives, unlocking potential, improving performance, and enabling learning. These three interventions will be discussed extensively in the succeeding sections.

Why are these three considered good practices? As mentioned in the Methodology section, good practices are characterized by three core criteria: effectiveness, replicability, and commitment. An intervention is deemed effective if it can deliver its intended result; if it is replicable (if, by design, it has a high likelihood of being implemented again in another setting); and if it engenders commitment, demonstrated by the willingness and demonstrated capability of stakeholders to continue implementing it beyond the project's lifespan. The later sections will elaborate how the deep dive, roadmap, and

coaching exhibit these qualities, in addition to other secondary criteria such as alignment, integration, inclusivity, resources, and accountability.

In addition to these three good practices, this exercise revealed that a fourth group of activities, those that enable relationship building, is worth highlighting. This cluster of activities create the precondition for the effective execution of the abovementioned good practices. Because of limited evidence (*i.e.,* stakeholder accounts or written documentation) of effectiveness, replicability, and commitment for this set of activities, this will be classified as a promising intervention for now.

The promising intervention and the three good practices described above can be implemented as stand-alone interventions for narrower scopes of work. For instance, the roadmap can be used as a monitoring tool for specific public health programs, while the deep dive can serve as an immersion activity for newly hired health officials. However, the experience of IHLGP, as supported by numerous stakeholder accounts, highlights the synergistic relationship among these interventions, and that they need to be implemented together to achieve maximum impact. Therefore, CLAimHealth highly encourages that those who wish to adopt these interventions in the future, especially for strengthening local health system governance, implement them as a package.

Moreover, the experience of IHLGP shows the importance of executing the good practices in a synergistic and partially sequential manner (Figure 13). The deep dive is the most logical first activity before the LCE and the team proceeds with using the roadmap. Meanwhile, relationship building activities such as the preparatory work with health officials and the creation of core teams are a crucial first step before subjecting an LCE to the deep dive activity, and these measures will continue once the team begins using the roadmap. Starting with relationship building, continuous coaching must then be executed throughout the process—from deep dive to roadmap—to ensure accountability and learning.

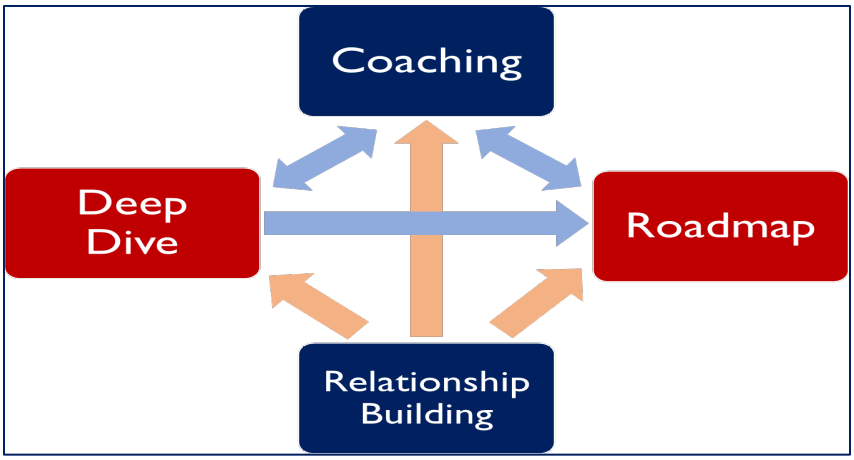


Figure 13. The synergistic and partially sequential nature of IHLGP's GPPIs

5.2 Deep Dive

While several activities happen at the start of an IHLGP runway (*i.e.*, PLGP or CLGP), the most visible and memorable is the deep dive. ZFF describes it as "a leadership learning journey where the participant directly experiences the challenges of a system from the perspective of other stakeholders." During the deep dive, the LCE (*e.g.*, a governor or mayor) immerses in the community, usually a barangay with the poorest health indicators, and interacts with an "index patient" who embodies the community's most pressing health needs (Figure 14).

Figure14. Deep Dive activity of Governor Steve Solon of Sarangani (L) with DOH Region XII Regional Director Dr. Aristides Tan (R)

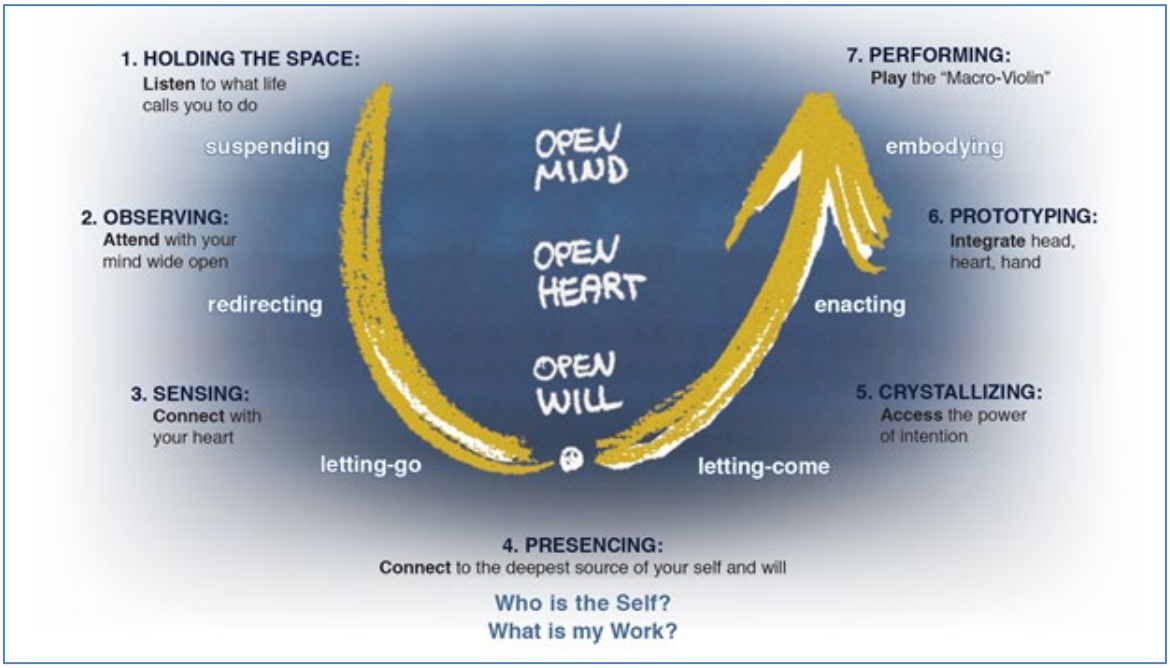
This GPPI assessment found that the deep dive met the good practice criteria. Documents and stakeholder accounts deemed it effective in terms of accomplishing its intended immediate result, which is to help the LCE identify unresolved health inequities in a province or city. Following the identification is initial concrete action. Typically, the LCE declares the identified health issue as a priority and convenes a multi-stakeholder team that conducts a deeper analysis of the situation.[26] In terms of replicability, LCEs, health officials, and ZFF-IHLGP staff have described situations where the deep dive activity was repeated by another team or for a different health issue. This good practice is also inclusive, involving different stakeholders in the deep drive itself, in addition to its preparation, design, and processing.

The concept of deep dive is inspired by "Theory U," developed by Otto Scharmer (Figure 15). This framework posits that to effect change, leadership "blind spots" must first be discovered through "presencing," a combination of presence and sensing where an individual connects to the inner source of inspiration and will. To achieve presencing, leaders must embark on a deep dive sensing journey, which pulled them out of their daily routine to allow them to experience the organization, challenge, or system through the lens of different stakeholders. Deep dive sensing journeys bring participants to unfamiliar

[26] Applying the Bridging Leadership Framework, this is when ownership transitions into co-ownership.

places, people, and experiences that are most relevant for the respective question they are working on.[27]

Figure 15. Theory U—the basis of Deep Dive[28]



Because LCEs may be preoccupied by myriad aspects of local government and may lack adequate health background, they may have limited understanding of health inequities in the province or city. IHLGP's deep dive activity provides an opportunity for governors and mayors to address this blind spot. Furthermore, through deep dive, the LCE develops a more profound sense of ownership, the first segment of the Bridging Leadership Framework, toward the public health issue encountered. As the LCE engages in conversations with the index patient, active listening and dialogue skills are also improved. Overall, the entire exercise aids in enhancing the LCE's personal vision for the health of the province or city (Figure 16).

[27] https://www.presencing.org/resource/tools/sensing-journeys-desc
[28] Scharmer CO. Theory U: Learning from the Future as it emerges. 2009. Berrett-Koehler: San Francisco. Chapter 21.

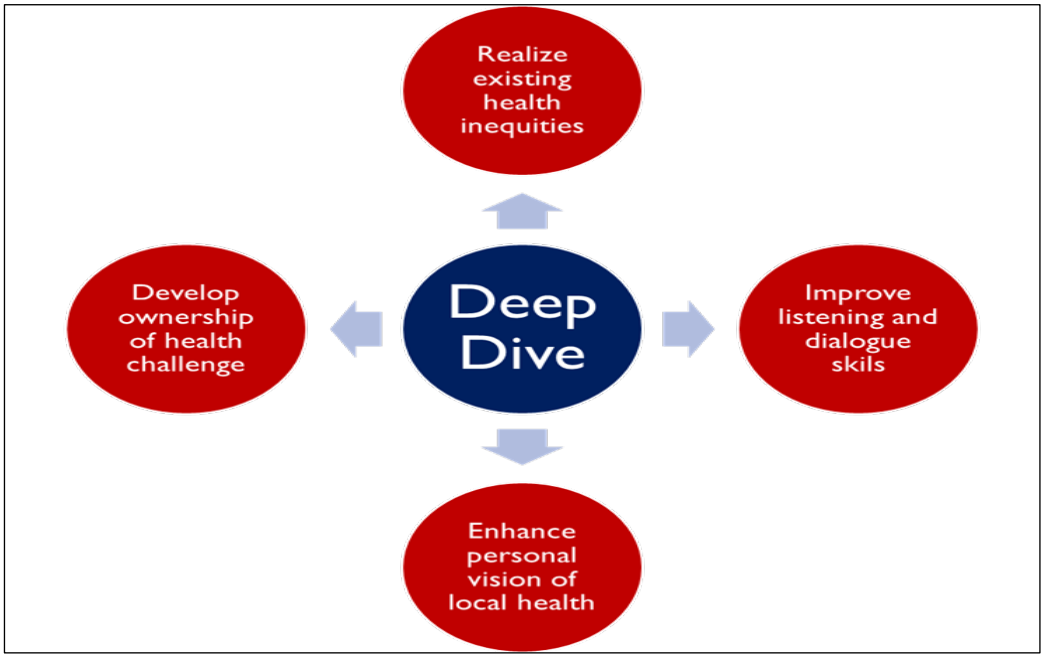


Figure16. Functions of Deep Dive

In IHLGP, the deep dive activity is not a one-time event; rather, it is a two- to three-month process at the beginning of the runway. It comprises multiple steps: initial situational analysis; selection of the deep dive site; dry run of the activity; pre-dive orientation with the LCE; deep dive proper; and post-dive debriefing. The execution of this entire process involves a variety of stakeholders, including the regional director (and staff), the PHO or CHO, and the ZFF–IHLGP team.[29] Several materials are prepared for the deep dive including the roadmap, health equity matrix, and the province/city infographic (see Figure 17 for an example of a city infographic), which is a visualization of the different components, issues, and metrics of the local health system.

[29] A sample program design of the deep dive activity can be found in Annex 5.

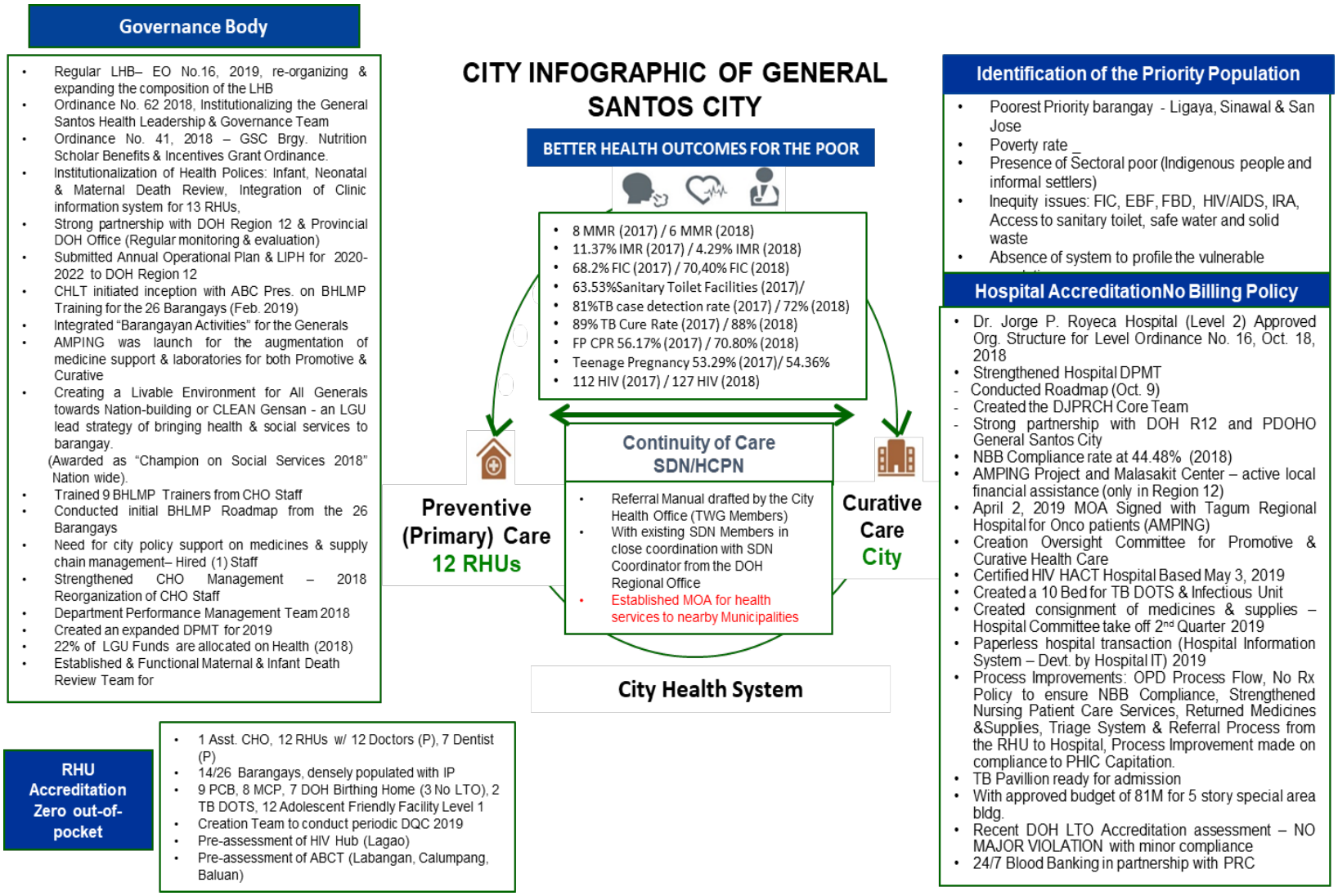


Figure 17. Example of a city infographic from General Santos City[30]

[30] Source: Zuellig Family Foundation

Facilitators to successful execution of deep dive

- **Undergoing the deep dive as the first main activity of IHLGP is logical in terms of the Bridging Leadership Framework and has a powerful emotional, humanizing, and humbling effect which creates a lasting impression on LCEs and other participating stakeholders that remains throughout the IHLGP journey.** Even if the encounter happened a few years ago, all LCEs and other officials vividly remember the deep dive experience, including the characteristics of the index patient, and refer to that experience as a moment of epiphany.

- **The deep dive can be adapted for different public health problems because the preparatory team can select any index patient.** The deep dive is the LCE's gateway to discovering persistent health inequities that are potential leadership blind spots, even among leaders with many years of tenure in office. As a result, preparatory teams, including the PHO and Regional Director, have a unique opportunity to select a neglected health concern that they want to bring to LCEs attention. This does not mean that other health issues will be overlooked. Rather, the index patient serves as a gateway to other health and social issues, as the sick and poor typically suffer from the interplay of multiple problems in the community (aligned with the social determinants of health approach).

- **LCEs must be open to being in a vulnerable position for the deep dive to succeed.** Leaders may believe they are already aware of all problems in their jurisdiction, as many LCEs admitted after conducting the deep dive. To overcome feelings of resistance and a sense of ego among LCEs, the deep dive team must first invest in building relationships to later persuade LCEs to partake in immersive experiences.

- **"Pre-work" among multiple stakeholders is vital for deep dive's success.** In a way, the deep dive activity can be viewed as "setting up" the LCE in an unfamiliar place to be able to achieve presencing. Thus, the deep dive team must carefully execute the preparatory phase of deep dive, which includes selection of site and index patient, initial situational analysis, and dry run of the deep dive proper.

Barriers to successful execution of deep dive

- **Timing of the deep dive proper can be challenging due to the LCEs' busy schedules.** As a result, advanced scheduling and close coordination with LCEs' personal staff are key.

- **Inadequate processing of the deep dive experience may lead to dilution or loss of learnings and inability of LCEs to translate them into leadership acts.** The deep dive team must both understand the local health situation and have requisite coaching, listening, and dialogue skills to facilitate a productive and inspiring conversation during the post-deep dive debriefing session.

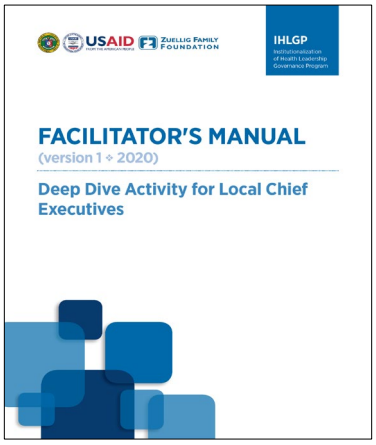
Recommendations

- In addition to introducing the deep dive activity to other participating LCEs who did not take part in IHLGP, the deep dive activity can also be embedded in leadership training programs for first-time LCEs, such as those offered by the Local Government Academy of the Department of Interior and Local Development.

- While the deep dive is used in IHLGP particularly for health issues, it can also be adopted for raising awareness among LCEs regarding other social concerns such as extreme poverty, gender inequality, or drug addiction. For example, RenewHealth adopted the deep dive for a USAID health project focused on community-based drug rehabilitation.

Resources

ZFF-IHLGP produced a facilitator's manual (right) for conducting the deep dive activity for LCEs. To obtain a copy, contact: communications@zuelligfoundation.org.



Case Study 1. Deep dive brings to light the problem of malnutrition in Sarangani

As a behavior change intervention, the deep dive activity targets the LCE, who is the key decision maker and convener in local health governance. But preparing and executing the activity requires the involvement of multiple actors, including the DOH Regional Director and the PHO. To prepare for the deep dive activity of Sarangani Governor Steve Solon, a multi-stakeholder team, which included DOH Region XII Director Dr. Aristides Tan and PHO Dr. Arvin Alejandro, identified the index patient and conducted a dry run to ensure smooth and meaningful execution.

The index patient was a 40-year-old woman who lost two children to pneumonia and severe malnutrition. Despite living just a nine-minute walk from the local rural health unit, the children were unable to access primary care. The mother did not finish high school, while the father worked in a distant locale, sending to his wife the little money he earned. The family did not have a sanitary toilet, and they had to walk 15 meters to access clean water.

During the deep dive activity, Governor Solon was deeply moved when he saw the surviving malnourished child. He ensured the family that they would be given all the necessary assistance. The child's status initially improved, but the boy later succumbed to severe malnutrition. When Governor

Solon learned about the outcome, he realized that treatment alone is not enough; he must also prioritize the prevention of childhood malnutrition. He made it his mission to ensure that no child in Sarangani will ever experience that same level of malnutrition again.

Dr. Alejandro spoke about the power of a single story to not only open the eyes of the governor to a neglected public health issue, but also to mobilize other stakeholders. "In our meetings with municipalities and barangays, we begin our presentation with a PowerPoint slide telling the story of the index patient," Dr. Alejandro said, "and you can see tears in people's eyes."

Since the deep dive activity of Governor Solon, important nutrition programs have been launched, including training of all health workers to diagnose and treat malnourished children and establishment of public-private partnerships bringing together health, nutrition, and agriculture sectors. As a result of the province's efforts in combating malnutrition, from 2017 to 2019 Sarangani reduced the prevalence of stunting from 16 percent to 9 percent and wasting from 6 percent to 3 percent.

Case Study 2. Maternal health core team activated by deep dive in Zamboanga del Norte[31]

When Governor Roberto Uy (Figure 17) of Zamboanga del Norte embarked on his deep dive activity, it was his first time ever to visit the Zamboanga del Norte Medical Center (ZDNMC). The index patient was a woman who was seven months pregnant with her first child. Governor Uy learned that she had traveled for two hours to ZDNMC in Dipolog City from the coastal town of Sindangan. At first, she hitched a ride on a dump truck to reach a local health center, only to be referred to a private hospital for admission due to gestational hypertension. However, the private hospital lacked the needed diagnostic services, and she was later referred back to ZDNMC. During the same visit, Governor Uy also learned of another pregnant mother who bled to death in another private hospital, this time due to lack of available blood supply for transfusion.

Upon hearing these stories, Governor Uy instructed Dr. Esmeralda Nadela, acting ZDNMC hospital administrator and officer-in-charge of the Provincial Health Office, to engage both public and private hospitals to address gaps in the province's blood supply chain. He also hand-picked the members of the core team to be convened by Dr. Nadela that will analyze the province's health situation and identify solutions to help achieve health targets. After months of investigation, the core team identified cultural, financial, and supply-side barriers that lead to maternal deaths in the province.

The deep dive also catalyzed other positive steps to address chronic challenges surrounding maternal health in Zamboanga del Norte. These included the establishment of a 24/7 high-risk maternal clinic at ZDNMC; full implementation of facility-based delivery and skilled birth attendance; conduct of Quarterly Integrated Neonatal and Infant death review along with Maternal Death Review; and allocation of additional budget for hiring new obstetricians and nurses and for installing a blood supply system in the province.

[31] Adapted from the report of IHLGP Colloquium Series Part 2: "Universal Health Care in Times of Disruptions," held July 22, 2020.

Figure18. Governor Uy with the index patient during his deep dive[32]

5.3 Roadmap

The technical roadmap is a tool used throughout the different runways of the IHLGP. It can be adapted for specific target health areas such as tuberculosis (TB) and family planning, and was recently adapted for the establishment of resilient service delivery networks (SDN) (now called health care provider networks, or HCPNs, under the 2019 Universal Health Care [UHC] Law).

The primary purpose of the roadmap is to provide a technical guide for health leaders and stakeholders to determine gaps in the health systems and plan interventions to address them. In addition, the roadmap provides a monitoring tool to track progress of health system strengthening interventions, complements the ZFF health leadership development program, and can be used as a coaching tool for stakeholders across the health system.

The IHLGP curriculum contains a comprehensive process for developing technical roadmaps. As outlined below in Figure 19, the process starts with a review of existing evidence and data and a "situationer," or situational analysis. The situationer includes a variety of stakeholders, who may be different in each location, and incorporates updated health data, a method of prioritization that is based on urgency and magnitude (vis à-vis organizational capability and effects of inaction), and a description of how stakeholders were engaged. This foundation then works toward the baseline roadmap process, as this workshop requires certain background information prior to the development process.

The roadmap targets are set by the LCEs, stakeholders, and coaches. Several LGUs have developed new roadmaps to address targeted health areas and have successfully developed and executed the set targets.

[32] Photo from the report of IHLGP Colloquium Series Part 2: "Universal Health Care in Times of Disruptions," held July 22, 2020.

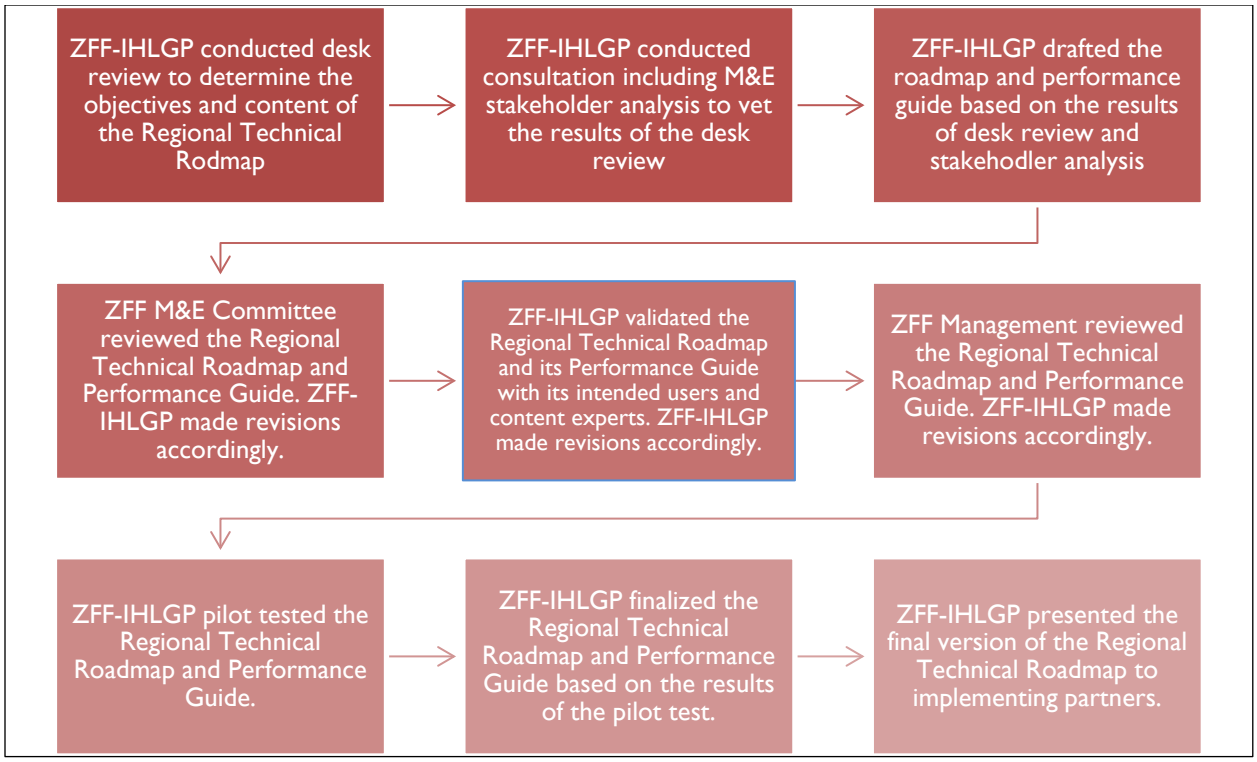
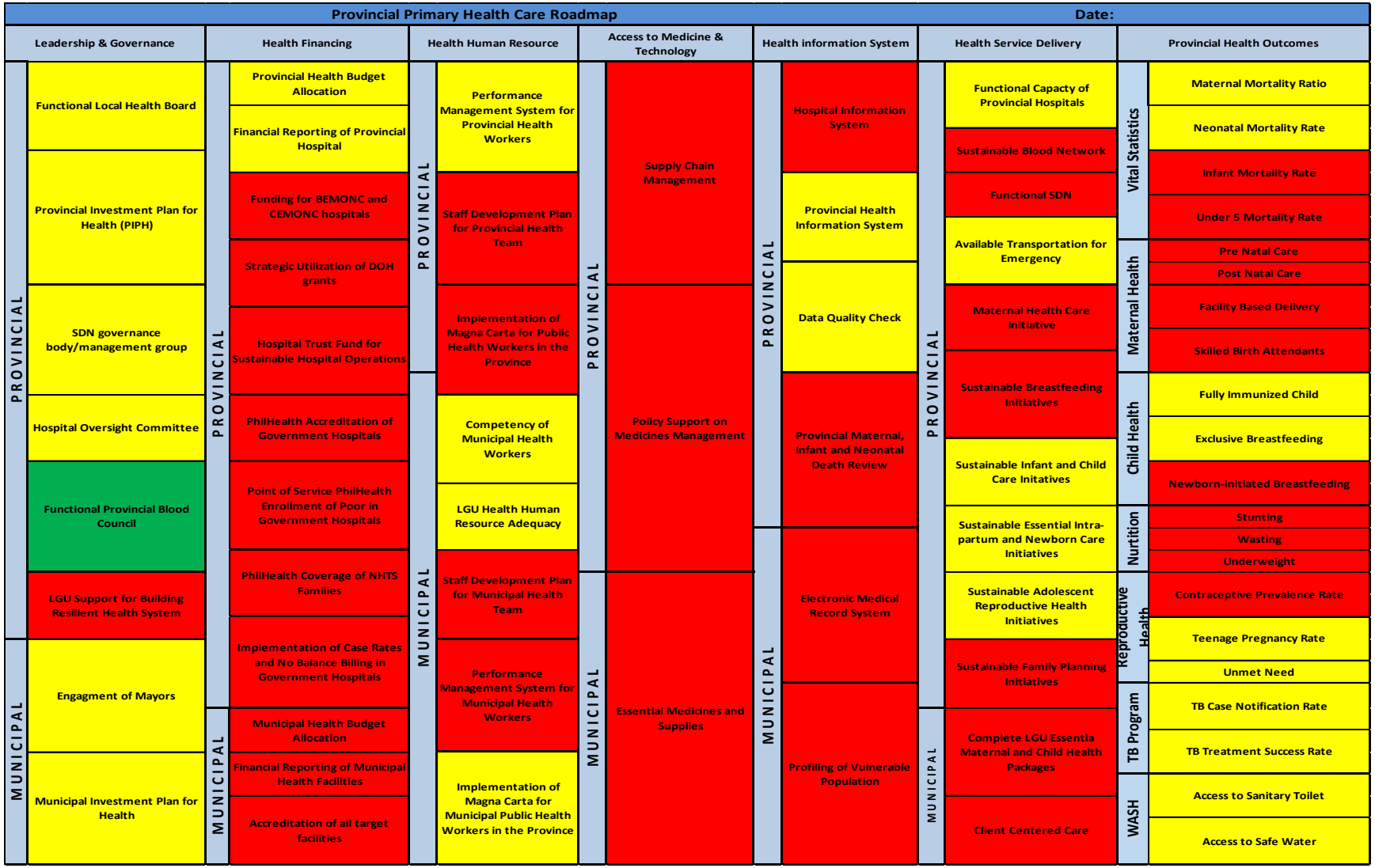


Figure 19. Process flow of the regional technical roadmap development[33]

The roadmap (Figures 20 and 21) is a visual tool comprising columns that represent the six building blocks of the health system: governance, financing, health workforce, information system, service delivery, and medicines and technologies (defined by the World Health Organization[34]) which the DOH has adopted as the framework for its national policies and plans. The introduction and use of roadmaps support the systems approach to improve service delivery and health outcomes and reinforce leadership capability interventions, specifically the program module on systems thinking and coaching. The roadmap includes project outputs, such as building a guiding coalition and staff development plan for program managers. The roadmap also includes a section related to the Philippine Health Agenda indicators, connected to larger health outcomes, which are in line with the Philippine Health Agenda for 2016–2022 for strengthening health systems and the formation of resilient service delivery networks. The roadmap follows a color-coding scheme corresponding to progress of the different indicators.

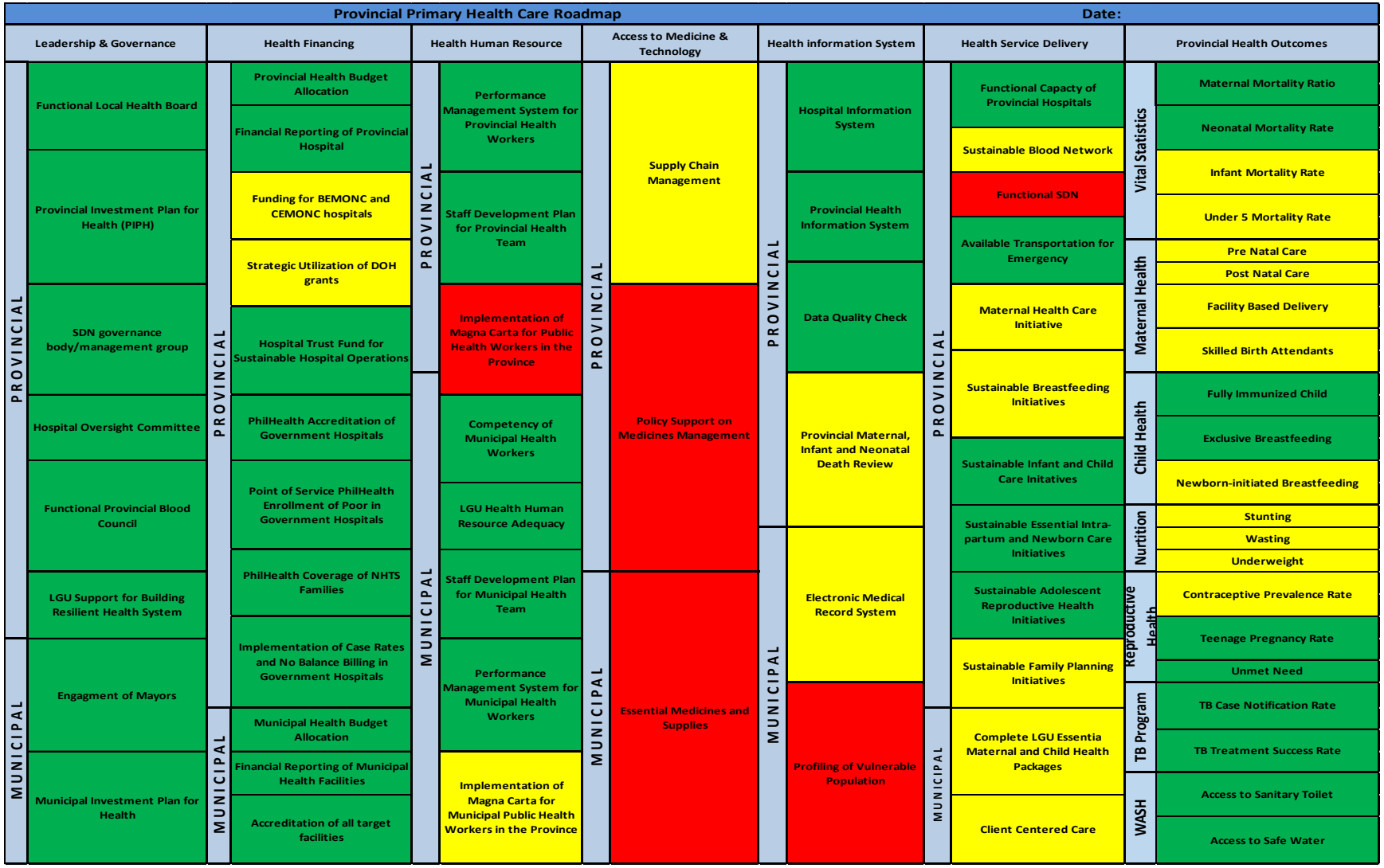
[33] Source: Bridging Leadership Fellowship Program (BLFP) Regional Technical Roadmap User's Guide.
[34] WHO (2007). Everybody's business—strengthening health systems to improve health outcomes: WHO's framework for action. Geneva, Switzerland: WHO. Retrieved from https://apps.who.int/iris/handle/10665/43918.



Red=Non-functional and gaps need to be prioritized; Yellow=Functional but needs to be strengthened; Green= Strong and functional, and needs to be sustained.

Figure 20. Example of a baseline technical roadmap[35]

[35] Source: Zuellig Family Foundation. More sample roadmaps of hypothetical local health system scenarios can be found in Annex 6.



Red=Non-functional and gaps need to be prioritized; Yellow=Functional but needs to be strengthened; Green= Strong and functional, and needs to be sustained.

Figure 21. Example of an endline technical roadmap[36]

[36] Source: Zuellig Family Foundation

The roadmap is a widely used tool in business and development sectors and is meant to allow participation. It was found to be a key tool for LCEs and other health system stakeholders to identify gaps in the health system, prioritize problems, and plan for solutions. Roadmaps are filled out and studied as a team, which is composed of LCEs, their health teams, and other stakeholders. Figure 22 outlines depicts the main ways that health system stakeholders used the roadmaps.

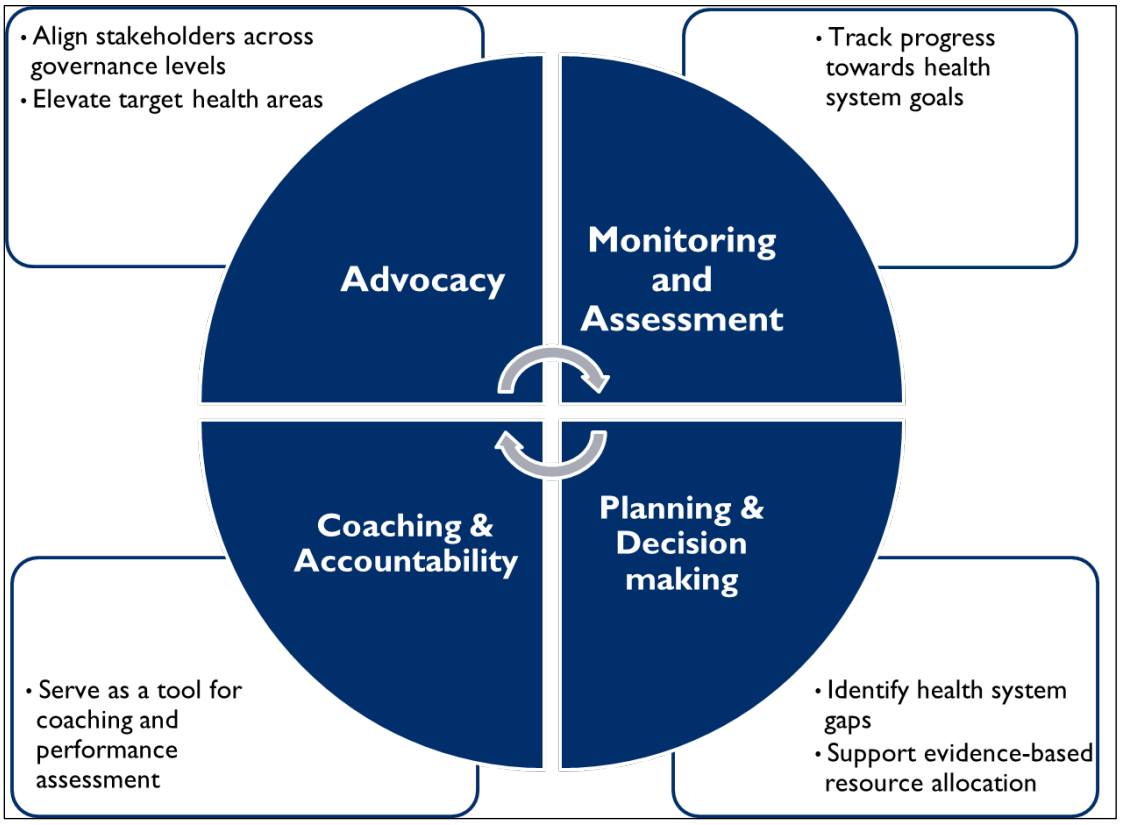


Figure 22. Uses of technical roadmaps

The GPPI assessment found that the roadmap intervention met the criteria outlined in the Methodology section and is therefore considered a good practice. The assessment identified utilization of the roadmap across all participating geographies, a desire to continue using the roadmap post-IHLGP, and demonstrated replication of the roadmap for different focus health areas (*i.e.,* ODF, hospital scorecards, UHC), and at the barangay level. The roadmaps were developed in alignment with WHO's health system building blocks framework and have also incorporated a section on social determinants of health and health outcomes. The process for developing the roadmap includes rigorous review of the data and the inclusion of stakeholders across the locality, including DOH, LGUs, and external stakeholders. Additionally, its use is integrated with local investment and development plans for health.

Facilitators to using the roadmap for health systems strengthening

- **Visual nature of the roadmap helped to communicate gaps in the health system and motivate LCEs to make progress.**

    - The color coding of the roadmap (red, yellow, green) helped to highlight gaps, what was going well, and where data might be missing. LCEs were motivated to transform areas of red to green and could see progress during review sessions.
    - LCEs mentioned that it was helpful to have all the information in one place, allowing stakeholders to use systems thinking and see all components of the health system at once. This approach also allowed for LCEs to have a clear overview of the stakeholders' engagement needs, and the management and finance components.

- **The roadmap is used synergistically with other planning and development tools and can be used across stakeholder groups.** Stakeholders provided numerous examples of how the roadmap was used in conjunction with other tools, such as the municipal development matrices, local investment plans for health, Philippine Development Plan matrices, and hospital scorecards. The roadmap was used to clearly outline the expected outputs and outcomes.

- **The structure of the roadmap allows for flexibility and addition of components that are important to specific contexts and geographies.** There are several examples of LCEs adding new indicators relevant to the targeted health area, including adding the hospital scorecard with staff satisfaction, timely payments of staff, and robustness of data entry. Other LCEs created a new roadmap for every program they wanted to improve. This created a clear picture of the current situation and a way forward.

- **The roadmap provides structure and clearly depicts system limitations, which encourage focus on targeted health areas.** The GPPI review clearly showed the usefulness of the roadmap as a critical tool for planning and executing health system improvements, which was informed by data from the situational analysis. The focused approach to public health is supported by the use of concrete evidence and data to select target health areas.

Barriers to using the roadmap for health systems strengthening

- **Up-to-date and robust health system data are not always available.** However, the use of roadmaps may incentivize local health systems to invest in implementing a basic health information system that collects data used in the roadmap for monitoring.

- **The process flow of developing the technical roadmap was heavily reliant on external technical assistance (account managers and other ZFF staff).** The process to develop and score roadmaps may be challenging for LGUs to replicate without substantial external support.

Recommendations

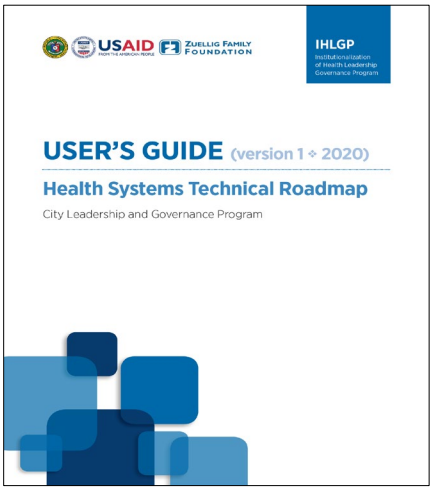
- Specific capacity building efforts and documentation may be needed to support the development and execution of UHC roadmaps.

- The roadmap should continue to be used in conjunction with the situational analysis, deep dive, and coaching elements of IHLGP.

- The roadmap process may consider the inclusion of representatives from regional and national offices to ensure buy-in and shared understanding of issues and targets.

Resources

ZFF-IHLGP developed several User's Guides (right), which outline the steps for developing and using technical roadmaps at each governance level (province, city, hospital), for TB and family planning. To obtain a copy of these guides, contact: communications@zuelligfoundation.org.



Case Study 3. Roadmap innovations support the strengthening of Sarangani's health system

Dr. Arvin Alejandro, Sarangani's PHO, was an early participant in HLGP, starting in 2013. He took to heart the key principles of IHLGP and raised the bar related to utilizing health and development data in creating new and targeted roadmaps for Sarangani. Dr. Alejandro stressed that PHOs and MHOs must know the financial and management details of their health system so that they can use funds effectively and make progress towards health and development outcomes.

In 2015, the province set a goal to be open defecation free (ODF). Dr. Alejandro worked with Global Water Security & Sanitation Partnership, the World Bank, and other stakeholders across the province, municipalities, and barangays to develop a Provincial Sanitation Roadmap. The roadmap was utilized as the "bible" of the implementation plan and was the first of its kind presented at the national level. The roadmap provided a mechanism for implementing a province-wide initiative, in this case achieving ODF. Each barangay was required to be fully involved and to submit data to ensure verification that 100 percent of barangays in the province are ODF. The roadmap also was used as the indicator of progress which the stakeholders were able to track. Through the intervention, all the seven municipalities were declared ODF and the province was declared ODF at their Annual Health Summit.

Since the success of the Provincial Sanitation Roadmap, the health systems stakeholders have developed a Provincial Malaria Roadmap, Maternal, Newborn, Child Health & Nutrition Roadmap, and

Hospital Roadmap, which include innovative indicators tracking staff satisfaction, timely payments, and robustness of health system data. The province plans to continue to use this tool and finds it critical to sustaining the successes in strengthening the overall health system.

Case Study 4. In Region IX, synergy between the roadmap and the local investment plan, a development planning tool

Throughout her career, DOH Region IX Director Dr. Emilia Monicimpo served numerous regions before transferring to Zamboanga around 2018. She first experienced the HLGP interventions in 2012 when she was assigned to DOH Region VI in Guimaras and had seen the impact of the tools and approaches to health system strengthening.

Through her extensive experience, she has found ways to clearly link the roadmap tool to the local investment plan (LIP), which includes the priorities of the region. Within the first quarter of the year, the LIP is submitted and reviewed by LGUs, which provide comments to ensure alignment across the LGU plans. The LIP reflects the plan activities, sources of resources, and overall requirements of implementation, and the roadmap has come to complement the LIP by providing metrics and specific indicators that can be tracked across regional priorities.

Different regional stakeholders appreciate the roadmap for allowing all intervention outputs to be included in one document and outlining strong and weak points in the system. Dr. Monicimpo and her team plan to continue using the roadmap tool and ensuring alignment across existing workplace structures and processes.

5.4 Coaching

Another good practice is coaching, which is the trademark of IHLGP, and is defined by the International Coach Federation[37] as "partnering with clients in a thought-provoking and creative process that inspires them to maximize their personal and professional potential."[38] The goal of coaching is to unleash potential. In the context of IHLGP, it is assumed that the LCEs and other health officials have the potential to further strengthen their leadership and governance skills, regardless of their technical knowledge around a public health problem. Coaches may provide advice or suggestions, but they do not dictate the answers. Instead, they ask questions that motivate the LCE to reflect deeply about the problem or examine it through a different angle.

[37] https://coachfederation.org

[38] Coaching is different from *training*, which is similar to teaching and pertains to acquisition of new skills or upgrading of existing skills. In short, coaching enhances performance, while training transfers knowledge and skills. Coaching is also often confused with *mentoring*, a term which is also used widely in the IHLGP. Mentoring is more development driven, looking not just at the professional's current job function but beyond. It usually entails a more experienced or knowledgeable person (mentor) guiding someone less experienced (mentee or protégé), with the goal of aiding in the mentee's holistic career development. Meanwhile, coaching is more performance driven, designed to improve the professional's on-the-job performance. Hence, a mentoring relationship tends to be more long-term, while in coaching the relationship is likely to be short-term—such as the duration of the IHLGP. (https://www.kent.edu/yourtrainingpartner/know-difference-between-coaching-and-mentoring)

Based on this GPPI evaluation, coaching met the good practice criteria. Documents and stakeholder accounts deemed that it accomplished its intended immediate result, which is to inculcate a sense of ownership and accountability for health decision making among LCEs.[39] Its replicability is supported by accounts of implementation even among stakeholders not originally intended to be coached in IHLGP (*i.e.*, other elected officials at provincial and city government levels). LCEs also expressed commitment to sustain skills they developed through coaching, keep the culture of coaching in the workplace, and even volunteer to be coaches to other LCEs after retirement (hence a proposal by ZFF to establish an alumni program).

In IHLGP, coaching is both an activity for LCE engagement and a competency that is measured under the Bridging Leadership Framework.[40] Coaching is embedded in all the runways of the IHLGP (BLFP, PLGP, CLGP), but it first targets the DOH Regional Directors, who are expected to acquire and apply coaching skills in their interaction with the provincial governors and city mayors during the practicum phase (Figure 23). Prior to IHLGP, the relationship between regional directors and governors was largely transactional, where DOH regional offices would request local health data and progress reports from provincial governments at regular intervals.

Figure 23. Dr. Aristides Tan, DOH Region XII Director, participates in a coaching workshop

To introduce coaching in HLGP, ZFF invested in training for its staff on how to become coaches. ZFF IHLGP's account managers (responsible for different regions) are considered default coaches. Apart

[39] While the long-term effectiveness of coaching can be gleaned from the temporal relationship between coaching acts and improvements in health system and outcome indicators, direct short-term effectiveness is more difficult to measure because coaching exercises are not documented in writing based on global coaching practice standards (to ensure confidentiality and privacy). In IHLGP, ZFF account managers only record the occurrence of coaching in monthly accomplishment forms and coaching logs without any detail pertaining to the issues being discussed.

[40] In the Bridging Leadership Framework under Co-ownership, one of the competencies being assessed is "leadership coaching and mentoring for results." See Annex 4 for the specific core behavioral elements under coaching in the Bridging Leadership Competency Assessment Tool.

from the regional directors, other stakeholders who receive coaching training from ZFF staff include the development management officers (DMOs) at the DOH regional offices, PHO staff, and City Health Leadership Team (CHLT) members. Senior coaches, such as senior ZFF officials and former secretaries of health, are also occasionally invited to coach governors during executive sessions and other convenings. IHLGP has established two categories of coaching: "leadership coaching," for LCEs, focuses on governance and decision-making issues; and "technical coaching," for health officers and hospital directors, focuses more on technical issues in public health programming or hospital management.

Facilitators to effective coaching of LCEs

- **The positive and collegial nature of coaching encourages friendships with LCEs and health officials.** Coaching emphasizes leaders already having innate wisdom and potential that needs to be unlocked. These leaders live and hold professional experience in their locales. They also know the culture and background of their constituents. Thus, they are best positioned to develop their own local solutions. In recognition of this, the interaction between the coach and the leader adopts a non-confrontational and non-prescriptive attitude, which creates a safe space for open and honest conversations to avoid tension and resistance.

- **The act of coaching can be flexibly executed in formal or informal settings.** IHLGP distinguished formal from informal coaching, even though coaching is traditionally thought of as being the former. Formal coaching is scheduled in sessions between regional directors and LCEs every quarter, as well as in executive sessions and other scheduled convenings and meetings that are a part of IHLGP. Meanwhile, informal coaching occurs on an ad hoc basis when an opportunity arises, such as being seated at the presidential table during ceremonies or while queuing at the buffet. Coaches take advantage of these moments to engage LCEs with powerful "coach-like" questions that usually begin with "what if," "why," or "how."

- **In IHLGP, the implementation of coaching alongside other GPPIs such as deep dive and roadmap generates a meaningful conversation.** The insights from the deep dive activity and the use of roadmaps together produce raw material for discussion during coaching sessions. Coaching then serves as the platform for processing these insights. For instance, coaching sessions can connect deep dive realizations to information depicted in the roadmap. When used during the coaching session, the roadmap provides a visual aid, a tracking tool, and an accountability reminder.

- **Repetition of coaching exercises can turn into habit.** In addition to being a leadership development tool, coaching can also be viewed as a positive and enabling approach for day-to-day interaction in the workplace. Governors and mayors who have undergone coaching can then apply the skills, for instance asking "coach-like" questions, in their everyday dealings with staff, constituents, and other stakeholders. There are some accounts where coaching was deemed "contagious" and that a "coaching culture" can spread across teams.

Barriers to effective coaching of LCEs

- **Limited buy-in from LCEs to participate in coaching activities may have a dampening effect on other health officers and stakeholders, and as a result limits everyone's participation.** The coach must do adequate "pre-work" (as referred to in the next section on relationship building) to ensure that the first coaching encounter is persuasive, inspiring, and satisfying.

- **Unclear understanding of coaching may lead to unmet expectations.** It is important that the leadership develops programs that adopt coaching as an intervention and articulates clear definitions and expectations. This will ensure that coaching is not confused with other activities such as mentoring, training, or counseling.

- **Overcomplicated coaching techniques may discourage LCEs and other participants to continue in the program.** Coaches must deploy simple, thought-provoking, inspiring questions that will facilitate sincere answers from LCEs and ensure LCEs can emulate the technique when it is their turn to coach their employees.

- **Incorrect matching of coaches and LCEs may result in an unsatisfying coaching experience**. Coaches and LCEs must be aligned in terms of level of maturity, experience, and expertise. Sometimes, gender may also need to be considered.

Recommendations

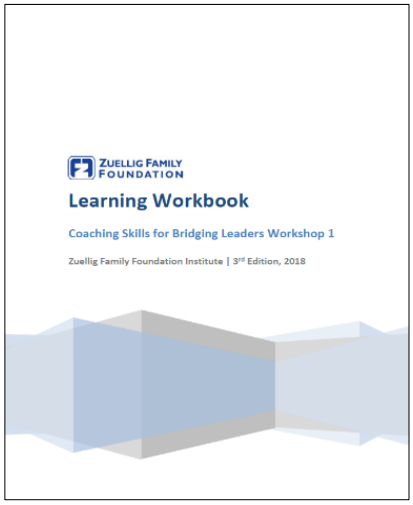
- Building on the more generic and widely used coaching guides, ZFF/IHLGP produced a workbook, "Coaching Skills for Bridging Leaders Workshop." This can be adopted as an easy-to-read guide on how to coach LCEs and other health officials with emphasis on health governance issues. The workbook also includes samples of powerful "coach-like" questions and strategies to build a "coaching system" or a "coaching culture" within an organization such as a local government.

- The LCEs, Regional Directors, and other health officers who underwent coaching, training, and practicum during IHLGP can be tapped as alumni coaches who could coach other LCEs in different jurisdictions.

- The linkages between coaching and other GPPIs, such as deep dive and roadmap, can be made more explicit in program designs/runways to maximize their potential synergistic effect for enhancing LCE engagement and strengthening health governance.

Resources

ZFF-IHLGP produced a learning workbook for "Coaching Skills for Bridging Leaders Workshop" (right). To obtain a copy, contact: communications@zuelligfoundation.org.



Case Study 5. Coaching ensures sustainability amid leadership transition in DOH Region IX

In any organization, leadership change often brings a certain level of uncertainty on whether positive reforms that have been initiated will be sustained. Fortunately, this was not much of a concern for Dr. Emilia Monicimpo (Figure 24), who is set to retire in 2021 as regional director for the DOH Regional Office in the Zamboanga Peninsula (Region IX).

When asked how the IHLGP helped ensure the sustainability of health system improvements in the region, Dr. Monicimpo attributed it to coaching. She explained that her training in coaching through the IHLGP instilled in her a systems thinking approach, which then enabled her to recognize the different actors of the health system and how they are tightly interconnected. "We cannot work together if the system is broken," she said. Furthermore, becoming a coach herself enabled her to coach her staff in the regional office as well, unleashing their hidden potential. "I am confident that when I retire, the ones left in the office will continue our successful efforts," she stated. Finally, according to her, the coaching experience allowed the creation of new partnerships that are built on trust—which is central in the Bridging Leadership Framework.

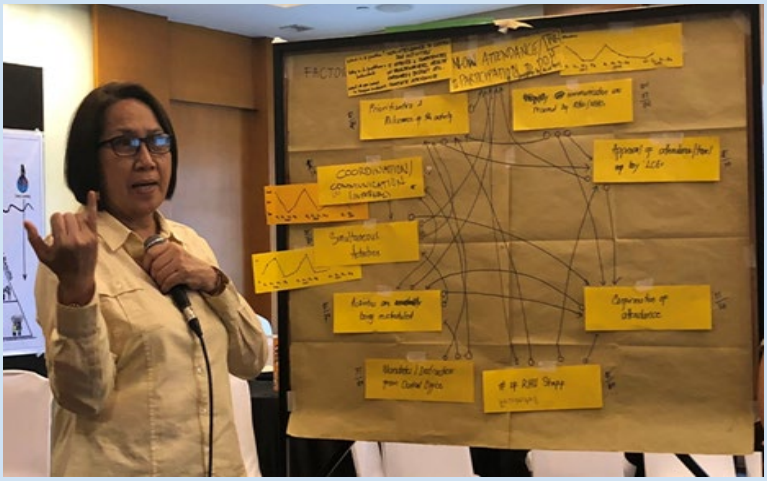


Figure 24. Dr. Emilia Monicimpo, DOH IX Regional Director, during one of the IHLGP workshops

Case Study 6. Consistent coaching aids in better situational analysis in Guimaras

A medical doctor by profession and a former PHO, Guimaras Governor Samuel Gumarin thought he had done enough to improve his province's health system. However, when he joined the IHLGP and embarked on the deep dive activity, he discovered that the health plan he formulated more than 10 years ago did not achieve its goal. Health care services remained fragmented, and despite the high budget allocated for health, health care was still beyond the reach of those residing in geographically isolated and disadvantaged areas.

Among the different activities of the IHLGP, Governor Gumarin expressed deep appreciation for coaching and attributes to it his improved situational analysis of his province's public health. "The deep dive made me own my responsibility… but the coaching exercise confirmed my gut feeling about the state of our health system," he remarked. He also said that the coaching sessions helped him better understand and make use of the roadmap, which is an important tool for situational analysis and progress monitoring.

He especially appreciated the coaching he received from Mr. Jeromeo Jose, IHLGP's Provincial Leadership and Governance Program (PLGP) program manager. "When there is a problem, we think of Sir Jerry," he said. Coaching also enhanced his interactions with mayors, who are his partners in fixing the province's fragmented health services. Today, the province of Guimaras has achieved progress in different health issues, especially in reducing teenage pregnancy, though more challenges remain.

5.5 Relationship Building

Strengthening health systems through leadership and governance initiatives is inherently political and complex, requiring strong relationships throughout the implementation and management process. Through the collection and analysis of qualitative data from LCE interviews and evidence review, the theme of relationship building and management throughout IHLGP implementation emerged as a key component to programmatic success. Strengthened relationships across governance levels and sectors allowed for greater collaboration and accountability to reach health system goals and created a more enabling environment overall.

> *"One of the best outcomes [of participating in HLGP] is the increased levels of camaraderie and communication between the levels. Communication and openness to new ideas. Working together has improved—issues and concerns are addressed through compromise."*
>
> *- Dr. Aristides Tan, DOH Region XII Director*

While IHLGP did not institute a specific "relationship-building and management" intervention, numerous program components created opportunities for public sector convergence, public-private convergence, team building, and open areas for collaboration. CLAimHealth found the majority of "success stories" involved a convergence across stakeholders, from regional offices to the barangay level. The importance of these convergence mechanisms was particularly prominent when LCEs were asked about preparations made for UHC implementation and mobilizing diverse actors in response to the COVID-19 pandemic.

> *"Changing systems, institutions, and behaviors starts by changing mindsets, and mindsets are changed through relationships, not through activities alone."*
>
> *- Jeromeo Jose, PLGP Manager*

Using the GPPI criteria, CLAimHealth found the relationship-building mechanisms to be a promising intervention that has the potential for replicability by other stakeholders. In addition, relationship building demonstrated effectiveness in strengthening collaboration across stakeholders toward specific health goals. The replicability of this potential intervention was found in success stories that emphasized the importance of relationships to achieve goals. Relationship building as an intervention also reflects other secondary GPPI characteristics such as inclusivity and accountability. Relationship building is enabled through an array of formal and informal mechanisms throughout IHLGP (Table 4).

Table 4. Examples of relationship building and convergence mechanisms throughout IHLGP		
IHLGP Runways	**Formal development or strengthening of teams**	**Informal activities**
BLFP – Regions	• Guiding Coalition (Figure 22)	"Pre-work" Informal coaching Becoming "text-mates" Informal events Colloquia Award ceremonies
PLGP – Provinces	• Core Group • Strengthening the Expanded Local Health Board • Provincial Investment Planning for Health • SDN Governance Body/Management Group • Hospital Oversight Committee • Functional Provincial Blood Council • Provincial Health Office	
CLGP – Municipal/City	• CHLT • Strengthening Functional Local Health Board (with secretariat) • Provincial Investment Planning for Health • SDN Governance Body/Management Group • Hospital Oversight Committee • Functional Provincial Blood Council • Councilors for Health • Community engagement activities with intersectoral participation • City Health Office	
Barangay Health Leadership and Management Program – Barangay	• Barangay Health Leadership Team (through the CLGP)	
Priority Health Areas	• Technical working groups for priority health areas • Multisectoral Coordinating Committee for TB Elimination Monitoring	

Figure 25. Members of Region X's guiding coalition discuss next steps

Facilitators to relationship building and sector convergence

- **IHLGP's buy-in from internal and external stakeholders early on was critical to engage LCEs.** The GPPI assessment found that the first stage in relationship building is the "pre-work" to get buy-in and commitment from LCEs to participate in IHLGP. Frequently, buy-in was obtained through the coordination and activation of stakeholders working closely with the LCEs that were easier to access, such as the PHOs, MHOs, and administrative staff. Building a relationship with stakeholders close to the LCE allowed for a more nuanced understanding of the needs and personality of LCEs and helps inform more effective approaches for motivation and support.

- **Platforms for coordination between internal and external stakeholders allowed for increased accountability and relationship building among participants.** IHLGP included interventions for team building, such as developing a guiding coalition, core group, provincial and CHLTs, and strengthening existing entities such as the local health board. All the groups provided platforms for convergence and relationship building across different levels of governance, sectors, and political parties. The platforms supported the co-development and co-ownership of health issues across localities while also creating accountability systems for LCEs.

- **Opportunities for informal connection allowed for deeper relationship building and openness among LCEs.** A key theme that arose from interviews with LCEs was the increased level of comfort and openness they felt with their fellow public servants. Many mentioned that interactions through technical working groups and IHLGP events such as the colloquium helped

cultivate personal connection with fellow politicians in their region. As a result of these connections, LCEs were more comfortable in communicating, sharing information and resources, and collaborating on health issues. Relationships were then solidified and maintained through more informal mechanisms such as becoming "text-mates" and going out for drinks.

- **Strategic sequencing of interventions allows for relationship building at each stage of IHLGP implementation.** The "pre-work" phase sets the stage for relationship building with the LCEs. For example, once governors have entered the program, the deep dive allows for engagement with communities and a deeper understanding of their localities' health systems. Following this, the core group's formation is informed by the deep dive experience and relationships are further strengthened through the coordination of a shared goal across the team. The process continues through the utilization of the roadmap in team meetings to track progress and coordinate future planning. Lastly, coaching was a key element of relationship building across governance levels (*i.e.,* regional directors coaching governors, mayors coaching barangay captains), but also internally through LCEs coaching their teams and receiving coaching from ZFF – IHLGP's account managers.

Barriers to relationship building and sector convergence

- **Key coordinating teams, such as the Provincial Core Group or CHLT, should include community representatives.** The team structures did not allow for stakeholders across the region to be involved and may have inadvertently created barriers to more fluid cross-governance collaboration.

- **Political divides (*i.e.,* difference in political party affiliation) may limit the extent of engagement between stakeholders, underscoring the importance of intentional relationship-building measures.** Though IHLGP was able to bridge political divides in most jurisdictions, engagement was occasionally limited in cases where LCEs or other stakeholders were not receptive to working with the opposite party. There is also a common concern that engaging with politicians from other political parties or governance levels may be interpreted as a request or favor and would require reciprocal action in the future.

Recommendations

- **Develop a structured intervention specific to relationship building and accountability setting throughout IHLGP.** The following is an example of what this might look like:
    i. Pre-work stage: Identify and engage critical internal stakeholders close to LCEs early on and involve them through the process.
    ii. Include indicators to track relationship development and maintenance at the input, output, and outcome level.
    iii. Provide training on building social capital across stakeholder groups.
    iv. Support and encourage informal relationship building through social events.
    v. Utilize the presence of national or regional policies to support collaboration across

stakeholders (*i.e.,* UHC).

vi. Develop health leadership team structures that span across governance levels and sectors (*i.e.*, DOH regional directors – governors – PHO – CHO – mayors – barangay chairpersons).

vii. Involve the provincial and city councils from the beginning to ensure alignment across legislative bodies.

viii. Ensure documentation of key steps and components of this new intervention for dissemination and learning.

Resources

The formal and informal relationship building measures are mentioned in various knowledge products developed by ZFF-IHLGP, including the program manuals for BLFP, PLGP, and CLGP. To obtain copies, contact: communications@zuelligfoundation.org.

Case Study 7. "No man is an island, especially during this time in COVID" – Experiences of the COVID-19 Response in Misamis Oriental

The COVID-19 pandemic, which started in early 2020, became the greatest test to local health systems in the Philippines. Among several examples of IHLGP supporting LGU's readiness and response to COVID-19 was the story from Governor Yevgeny Emano of Misamis Oriental, which highlighted the critical nature of strong relationships and partnerships to address the magnitude of the pandemic.

The first demonstration of the value of good relationships was when IHLGP, through the DOH Regional Director, tried to obtain buy-in from Governor Emano to participate in the Provincial Leadership and Governance Program (PLGP). It took four invitations and repeated convincing from his PHO and other key team members before he finally decided to participate in the PLGP. Without the support and buy-in from his team, Governor Emano would not have taken the time to learn more about PLGP and realize its value and use to strengthen the health systems within their area.

The second key area of relationship building for the governor was to engage mayors in his province, as a significant proportion were not aligned to his political party. He found that many of the existing programs and reporting structures were not aligned due to differences in political affiliation, and this was leading to duplicated efforts and ineffective resource utilization. Additionally, the structure was heavily top-down with information flowing from the provincial level to the inter-local health zones, but without a system for information to come back up from barangays or municipal levels. Participating in PLGP provided him with tools to set a direction across political lines and affiliations and to listen to LCEs at the municipal level and incorporate them into strategic health plans.

Governor Emano stated that PLGP was the preparation needed to address COVID-19, as all the tools and collaboration he experienced through the program, including the roadmap, systems thinking, and strengthening the Provincial Health Board for collaboration were critical to their prompt response. As

a result, one of the key levers Governor Emano mentioned was an existing relationship with all the mayors in his province, with whom he spoke and collaborated immediately as the pandemic hit. He mentioned that "the mayors used to be strangers to me," before participating in PLGP; now they can work as a team across the province to address any issue that arises. As Governor Emano approaches his last term, he feels confident that the lessons and skills have been passed through the health system and that even as another governor replaces him, the province will continue to work on strengthening the emerging Health Care Provider Network.

5.6 Leadership Frameworks in IHLGP

Apart from the GPPIs evaluated and discussed above, one of the hallmarks of the IHLGP is its use of multiple leadership frameworks as the basis for the design and selection of the activities as well as content for coaching and training. The entire IHLGP framework is inspired by the Health Change Model developed by ZFF and is operationalized using the Bridging Leadership Framework pioneered by Synergos Institute. The individual GPPIs and other interventions are also inspired by other leadership frameworks. In addition, other frameworks and approaches such as systems and design thinking are covered as content in the training modules for PLGP and CLGP's executive sessions.

IHLGP's experience demonstrates the possibility of applying existing leadership frameworks and approaches—commonly taught in business and policy schools—to program design for LCE engagement and strengthening local health system governance. Table 5 summarizes these frameworks. However, because the whole package of IHLGP interventions may be hard to replicate in its entirety, modified versions that select and prioritize a few frameworks will also likely have value. This will tighten the curriculum, provide focus, and avoid overwhelming LCEs and other stakeholders who are interested in trying select GPPIs first before participating in the whole program.

Table 5. Leadership frameworks and approaches used in IHLGP

IHLGP Element	Framework or Approach	Main Idea
IHLGP's Theory of Change	Health Change Model (by ZFF)	Local health systems driven by responsive leaders with responsible leadership and governance will produce better health outcomes.
	Bridging Leadership (from Synergos Institute)	Bridging Leadership is a leadership style that focuses on promoting multi-stakeholder processes to address complex social, institutional, and environmental challenges.

Table 5. Leadership frameworks and approaches used in IHLGP		
IHLGP Element	**Framework or Approach**	**Main Idea**
Deep Dive	Theory U[41]	Deep dive sensing journeys pull participants out of their daily routine and allow them to experience the organization, challenge, or system through the lens of different stakeholders.
Roadmap	Health System Building Blocks[42]	The health system comprises six main building blocks, each with its own functions and elements that can be diagnosed, monitored, and improved.
Guiding Coalition	Leading Change[43]	Leading transformation in organizations is an eight-step process, which includes building a guiding coalition with people who have power, knowledge, credibility and leadership skills—since one leader cannot do it alone.
Others (Embedded in modules)	Adaptive Leadership[44]	Unlike technical challenges which can be solved by the knowledge of experts, adaptive challenges are complex and ambiguous in nature, requiring "leadership without easy answers."
	Systems Thinking	Problems happen not in linear one-way paths but in multidirectional systems with numerous moving and interconnected parts and are characterized by feedback loops, emergence, and surprises.
	Design Thinking	To design a solution to a problem, one must set aside one's expertise and instead learn to wear the shoes of—empathize with—the user.

[41] Scharmer, C. O. (2009). Theory U: Learning from the Future as it emerges. Berrett- Koehler: San Francisco. Chapter 21.
[42] World Health Organization (2001). Monitoring the Building Blocks of Health Systems. Geneva, Switzerland: World Health Organization. Retrieved from https://www.who.int/healthinfo/systems/WHO_MBHSS_2010_full_web.pdf
[43] Kotter, J. (2012). Leading change. Boston, Mass.: Harvard Business Review Press.
[44] Heifetz, R., & Linsky, M. (2002). Leadership on the line: Staying alive through the dangers of leading. Boston, Mass.: Harvard Business School Press.

Table 5. Leadership frameworks and approaches used in IHLGP		
IHLGP Element	**Framework or Approach**	**Main Idea**
	Social Determinants of Health Approach	People's health is shaped by the conditions in which they are born, live, learn, work, play, worship, and age, thus the need to think upstream.

6. ANSWERS TO LEARNING QUESTIONS

5.7 Sustainability

Sustainability has been an overarching theme of the GPPI assessment of IHLGP. This is not surprising, as sustainability presumably is implied with the "I" in IHLGP—institutionalization. In the last three years, IHLGP focused on institutionalizing the program throughout all levels of health governance and garnered many lessons to this end. For the purposes of this assessment, sustainability is defined as the ability for LGUs and other health system stakeholders to continue the implementation of IHLGP interventions, and to also maintain and potentially increase any improvements in health system outcomes. The other learning questions pertaining to change management, knowledge management, client satisfaction, and partnership building are all contributors to long-term sustainability as well.

The GPPI assessment identified several cases of LGUs demonstrating sustained improvements in targeted health outcomes over time (as earlier described in Figure 9) and specific sustainability plans to be implemented once IHLGP ends. For example, Region XII has allocated an official budget to ensure the program continues in the coming years. Several provinces increased their in health budget allocations, as shown earlier in Figure 8. In interviews and through the regional handover sessions, LCEs and their stakeholders consistently expressed interest in continuing IHLGP interventions, predominantly the deep dive, roadmaps, coaching, and team building components. In addition, several localities have sustainability plans to continue IHLGP activities or have informally expressed their desire to continue embracing this approach to strengthening their health system.

Case Study 8. Sustaining IHLGP interventions in Region XII

One exemplary example of IHLGP sustainability comes from Dr. Aristides Tan, DOH XII Regional Director. Out of the 48 municipalities in the region, 42 have ongoing IHLGP activities. As a sign of commitment to sustaining IHLGP's progress, the region has allocated an official budget to ensure the program can continue in the coming years.

Dr. Tan experienced his own personal development through his participation in IHLGP. He now plans to continue working to build the capacity of LCEs by applying IHLGP tools and principles such as coaching, use of roadmaps, and holding regular meetings with stakeholders to gather issues and concerns. Specifically, Dr. Tan mentioned that the culture of coaching will continue because his team already has the capacity to implement this project component without external input. In addition, the region plans to expand the activities to provinces that have not yet undergone IHLGP.

Region XII has gone beyond the initial curriculum and package of interventions and has developed regional innovations for motivating and mobilizing stakeholders, with support coming from the Guiding Coalition. For example, the region holds an annual award ceremony to recognize high performing municipalities and elevate the efforts of LCEs. The awards for health are based upon the results of their roadmaps. In addition, the region has instituted an information system to facilitate orderly management of human resources and procurement of goods, supplies, and services across the

region. Sustainability of interventions, approaches, and health progress is supported not only by the region's stakeholder commitment, but also through the innovative approaches that create an environment for IHLGP interventions and approaches to persist.

Case Study 9. Blast from the past: HLGP's gains sustained in Batangas City

Another example of sustained shift in health leadership mindset and behavior was seen in Batangas City, which participated in the City Leadership and Governance Program, IHLGP's predecessor project. ReachHealth, one of the activities under USAID's Health Project, had engaged with Batangas City and several other cities in developing a UHC Roadmap. ReachHealth described Batangas City as a success story, which they attributed to being able to continue working from the strong foundation that had been built by HLGP. The LCEs were deeply engaged and had an easier time understanding the complexity of UHC, as they were already familiar with health system concepts such as the six building blocks. During the initial technical assistance process, the early UHC implementation efforts were more province-driven and one-sided; however, LCEs voiced their concerns and improved the dialogue to ensure learning on both sides. In the end, they did not adopt the exact HLGP roadmap tool but structured the roadmap to meet their specific needs.

The main lessons learned by ReachHealth was that there was no need to reinvent the wheel; there were many areas to build upon and existing tools and approaches to adapt to meet their programmatic needs. The tools, such as the roadmap, were created to be generic to allow partners and other stakeholders to adapt them as needed to their particular context. Lastly, ReachHealth emphasized the importance of involving and engaging LCEs early to own the problem and ensure co-creation and co-ownership. Overall, principles such as systems thinking, adaptive management, and collaborative mindset that are the hallmark of HLGP were sustained years following LCEs' participation in the program—and now, other implementing partners such as ReachHealth are witnessing the fruits and leveraging on these previous gains.

The assessment also identified examples of localities that may struggle to sustain learnings, interventions, and any positive health outcomes. Areas with LCEs who are not fully bought in to the program and lack commitment led to poorer programmatic outcomes, including drop-out. In places like Tawi-Tawi and Sultan Kudarat, LCEs faced difficulties overcoming local political differences (LCEs having differing party loyalties), preventing the possibility of working together in a capacity building program such as IHLGP. In addition, challenges in Sultan Kudarat included a delay in appointing a PHO to support the governor's change management work as well as the election of a new governor during the election process. Stakeholders also explained that certain local governments, like Zamboanga Del Sur, were low performing due to the timing: these geographies were brought in later in the IHLGP cycle and did not receive the same amount of support from program staff and had more difficulty catching up to their colleagues.

The regional handover sessions were critical opportunities for regions to highlight their sustainability plans and strategies to continue the work done through IHLGP. While almost all regions stated that

they would like to continue components of IHLGP, a majority requested continued technical support and possibly funding support to continue with these activities. This sentiment may suggest that while IHLGP and its GPPIs are viewed as beneficial and worth retaining, some of the interventions, such as the deep dive or the use of roadmaps, may require limited or focused external help after the program ends.

In terms of long-term sustainability, IHLGP has made progress in not only shifting the mindset of LCEs but also of communities. The constituents of the participating geographies now have higher expectations of their health system and services. The hope is that longer-term sustainability and social change will manifest in the voting behaviors of communities. People will be more demanding and desiring of better leaders who are more responsive to local health concerns because they are accustomed to good local health governance that was first planted by IHLGP.

5.8 Change Management

Change management is a collective term referring to all tactics, strategies, and approaches for preparing, supporting, and aiding individuals, teams, and organizations in making positive change in terms of operations, structure, or policies. In social institutions such as health systems, change is constant but is usually not welcomed, especially if it is seen as a threat to the status quo. Therefore, strategies for rallying stakeholders around the need for change are critical for the success and sustainability of health system reform efforts.

Among the GPPIs, the most visible tool for change management is the deep dive, as it triggers an immediate attitudinal change at the level of the individual, in particular, the LCE. LCEs' leadership blind spots are a common source of challenges around public health due to their broad scope of responsibilities and a limited understanding of their role in local health system governance. Their raw and emotional encounter with index patients and their families during the deep dive—one even described it as "staring right at the face of poverty and disease"—serves as a 'Eureka' moment for the LCE. The governor or the mayor immediately realizes the enormity of the unmet health need and the constituents who are unable to access the local government's health programs. The design of the deep dive, which includes a post-dive debriefing and development of a personal vision for local health, ensures that LCEs immediately process their recent epiphany and converted it into a tangible initial step—what ZFF would consider as a "leadership act"—and this early commitment documented in deep dive reports can be later used to hold the LCEs accountable. In all the stories obtained through this GPPI documentation activity, all LCEs have made the health issue they encountered through the deep dive—ranging from malnutrition to teenage pregnancy to limited access to blood transfusion—an urgent health priority and called for a multi-stakeholder convening to further investigate the issue and generate potential solutions. This move is what the transition from ownership to co-ownership under the Bridging Leadership Framework is all about.

Beyond personal leadership change, IHLGP is also valuable for effecting change at the level of the workplace and across offices and sectors. In addition to the deep dive, which has a strong participatory component (from dry run to debriefing), the roadmap is also a transformative tool in terms of creating shared understanding of the complex building blocks and dynamics of the local health system. Because it is a tracking tool, stakeholders using it are also able to describe the change that they want, memorialize

the change that they see, and identify the desired change that is not happening. Finally, because it has an accountability function, the roadmap is also used to remind everyone—from LCEs to health staff—about the change in health outcomes that is still needed and the change in policies and programs that they need to enforce to make large-scale and long-term change happen.

The embedding of IHLGP interventions, particularly the roadmap and coaching, in everyday health governance and management can also be viewed as signs of openness to change. In the pre-HLGP era, these tools for diagnosis, monitoring, and accountability did not exist in the same way. Rigid organizations that are resistant to change may deem these new tools and activities as an additional burden, distraction, and disruption to their operations. Because these management tools were introduced as part of an intentionally designed package that is the IHLGP, it became much easier to introduce these tools to politicians and civil servants and to train them on how to use them.

Today, when asked about the ease of use of these tools, LCEs and other stakeholders describe them as being integrated as habits and routines and no longer *ad hoc* activities that are part of a capability development program. There is widespread acknowledgement that the roadmap is here to stay, and that it will be customized to suit different health issues and contexts. Meanwhile, even if the more formal coaching sessions will be less frequent because of IHLGP's close-out, leaders and staff are now trying to embed "coach-like" questions into their everyday dealings.

Finally, IHLGP in general and the GPPIs have prepared the local health system for the introduction of larger and more long-lasting institutional reforms such as UHC. Achieving the vision of UHC requires a whole-of-government and whole-of society approach. Because of the openness to change, better understanding of the workings of a health system, and good relations built by IHLGP and the GPPIs among the different stakeholders, it became much easier to spark a conversation about UHC and mobilize diverse stakeholders to support its realization in the province or city.

Case Study 10. Making UHC happen at the local level

In February 2019, the UHC Law was signed, which automatically enrolls Filipino citizens into the National Health Insurance Program administered by the Philippine Health Insurance Corporation. The law also enacts complementary health system reforms related to filling health workforce gaps, health technology assessment, and health promotion, among others. One of the major reforms related to provincial and city governments is the integration of health systems into health care provider networks (HCPNs), which are composed of public and private providers (such as hospitals and clinics) that will deliver primary, secondary, and tertiary services. Such networks are hoped to address the fragmentation of service delivery and move toward providing comprehensive and integrated care supported by a facilitated referral system.

The integration of fragmented local health systems clearly presents a challenge in change management. Due to institutional "stickiness" or inertia, various stakeholders often see major reorganization efforts as an inconvenience or threat, which then leads to resistance to change. Nonetheless, the LCEs and other stakeholders who participated in the IHLGP state that the program has prepared them for this

major institutional reform. For instance, the roadmaps, which depict the various building blocks of the health system, provided a visualization of UHC's different component reforms. The relationships built by IHLGP among stakeholders within (*e.g.,* between the governor and other members of the Provincial Health Leadership Team) and across levels of government (*e.g.,* between provinces and cities) allowed for more collaborative discussions on establishing province- and city-wide HCPNs. IHLGP played a pivotal role in supporting UHC implementation efforts at the provincial and city levels by engaging LCEs—the main decision makers—and obtaining their buy-in for this political reform.

Meanwhile, the IHLGP team from ZFF acknowledges the UHC Law, including the multi-year deliberation prior to its passing into law, as having provided an important push for the positive reception toward IHLGP by participating LCEs. The momentum built by the UHC Law deliberations served as an anchor for IHLGP's activities and raw material for discussion, particularly during coaching sessions (Figure 26). The experiences of local governments that participated in the IHLGP illustrate a bidirectional relationship between the program and the UHC Law: IHLGP prepared LCEs for UHC, and IHLGP implementation was further enhanced by the impetus coming from UHC in return.

Figure 26. Provincial dialogue on UHC in Sarangani Province

5.9 Knowledge Management

Knowledge management refers to the intentional process of defining, structuring, retaining, and sharing the knowledge and experience of stakeholders within an organization or system. The premise is that organizations can successfully achieve their objectives if they are able to make the best use of knowledge. A well-functioning knowledge management system is also key to long-term program sustainability.

Even in local health systems, a tremendous amount of knowledge needs to be stored, organized, processed, and shared: from policy decisions and stakeholder engagement norms; to program outputs and health outcomes; to adaptations made and lessons learned. In addition to setting up robust health

information systems which, as a health system building block, has received greater attention in recent years, knowledge management in local health systems means building collective awareness and understanding of what matters to health system operations and reform and creating a culture of continuous learning and sharing among leaders and stakeholders.

Among the GPPIs, the roadmap, which acts as a physical and visual repository of health system data, has a clear knowledge management function. In the pre-HLGP era, information was housed in fragmented reports and often presented in forms that were hard to understand, especially for users lacking a health system background, such as LCEs. Roadmaps were used in Phase 1 of HLGP, and the roadmaps and coaching systems were further refined in IHLGP. Because the roadmap is a "one-stop-shop" of health system data, leaders and stakeholders can do a quick glance of its depiction of both numbers and colors and make an immediate diagnosis which can drive timely action. Coaching exercises also help in knowledge management by allowing knowledge to be processed in a collaborative dialogue, enabling the generation of lessons learned and proposed ways for moving forward. Relationship-building measures, particularly the formation of various teams that convene regularly, ensure that knowledge is processed, shared, and acted on by the collective (Figure 27).

Figure 27. Roadmap exercise allows for collective knowledge sharing

The participatory nature of the GPPIs, particularly the deep dive and roadmap, ensures that there is no single bearer of knowledge within the health system—as the adage says, knowledge is power. The more stakeholders who are aware of local problems and decisions, the greater the possibility of long-term sustainability and collective accountability. For instance, the multi-stakeholder team that prepares the deep dive activity—from the initial situational analysis and development of the province or city infographic to the dry-run and debriefing—along with the LCE, are also learning about the locality's health problems and together can discuss which priorities to set and solutions to consider.

Finally, in relation to IHLGP sustainability, there is some hope that the GPPIs will be continued by LGUs after the program because of the GPPIs' knowledge management aspects, which help build institutional memory. This is important for programs that have limited lifespan such as IHLGP and in situations where there is an expected change in top leadership.

Case Study 11. Building institutional memory amid leadership transitions

A typical challenge faced by institutions and organizations related to knowledge management is building institutional memory to allow for later use of knowledge and information, regardless of staffing or other changes. This task may be particularly challenging with leadership transitions, for instance when civil servants retire, or elected officials get replaced by new ones.

Among the different implementation sites of IHLGP, several have leaders that are close to leaving office: Dr. Monicimpo, who will retire from her post as Regional Director of DOH Region IX in 2021; and the governors of Guimaras, Misamis Oriental, and Zamboanga del Norte, who are all in their last term (out of three), which ends in 2022. While the governors have yet to announce their succession plans, all of them expressed confidence that the habits inculcated by IHLGP and the concomitant health system gains will be sustained and passed on to future administrations. In the previous case study, Dr. Monicimpo recounted the value of coaching in cultivating leadership among colleagues who will stay in office once she retires.

One of the main strategies that the governors identified is embedding IHLGP activities such as the use of roadmaps and coaching in the provincial government's management systems. The roadmap is particularly useful in documenting, in a written and visual manner, both the progress achieved and gaps that remain. Future governors and other health officials can easily refer to these documents, which were not present during the pre-IHLGP era. Meanwhile, both formal and informal coaching do not only aid in unleashing the leadership potential of officials and other staff; routine involvement in such activity also ensures that more people in the ecosystem have awareness and understanding of government's health programs and priorities. Together, IHLGP's GPPIs create an atmosphere of co-ownership, initiative, and accountability within government and ensure institutional memory, no matter who is in power.

5.10 Client Satisfaction

The primary clients of IHLGP were the regional directors and LCEs. This assessment defines client satisfaction as the level of LCE acceptance, happiness, and expectation with the overall experience, tools and strategies, practicum, and level of support provided. Client satisfaction is an important component of sustainability, serving as a predictor of whether the client will continue or discontinue with the IHLGP approach and strategy.

> *"The deep dive was the most wonderful experience during my journey, and one experience I will never forget."*
>
> *- Governor Yevgeny Emano, Misamis Oriental*

At the program level, some localities are fully or partially resourcing the continuation of the program. In addition, five out of the seven provinces have increased their annual health budgets, which can also be viewed as an indication of the satisfaction with the IHLGP approach and willingness to continue strengthening their health systems in this fashion. In addition, through interviews with LCEs, review of documents, and participation in regional handover sessions, there was a prominent theme of the intention to continue utilizing the deep dive, roadmap, and coaching interventions.

Overall, the clear message from LCEs is that the curriculum is complete with all of the necessary components, and LCEs' commitment and motivation is the only remaining need for program success. Although there were no major comments regarding the content of the program, there were some areas of feedback related to the execution and implementation. Areas for change, consideration, and improvement are the following:

- Consider using program facilitators with more local government experience to engage and motivate LCEs without becoming too technical.
- Given significant time limitations of LCEs, it would be useful to allow for a shorter course where LCEs can attend together with key stakeholders and potentially the health office as a whole.
- Create a mechanism to check in on program alumni to see how things are going and how best to sustain their work.
- Suggestions for the program should be given at the central level, specifically the DOH central office, to enhance alignment between local and national health governance.

Further evidence of the overall client satisfaction was the numerous offers from LCEs to support the IHLGP curriculum moving forward as a coach or mentor and for the program to expand and become universal for all new LCEs.

5.11 Partnership Building

Partnership and relationship building are clearly linked, and both emerged as key for success in implementing targeted health interventions. The promising intervention of this GPPI assessment would entail a more deliberate and structured approach to partnership and relationship building internally and externally through public sector convergence, public-private convergence, team building, and collaborative events (Figure 28). The assessment identified this loosely formed intervention as a promising intervention, as relationships and partnerships were called out as key components to IHLGP success stories and supported regions, municipalities, and barangays to respond to COVID-19 and achieve UHC.

Figure 28. Basilan Governor Hadjiman S. Hataman-Salliman, Dr. Emilia Monicimpo, DOH Region IX Director, and other health officials discuss roadmap findings

The findings from this assessment did not indicate any noteworthy efforts to strengthen community engagement and partnerships and empower community members to demand health system change. There are opportunities to engage community members in team building initiatives, such as including community representatives on the Guiding Coalition, Core Team, CHLT, and the like. Each team member should have a clear role and responsibility and power within the entity to ensure commitment from all stakeholders involved. This assessment did find that IHLGP effectively engaged civil society and the private sector to address targeted health areas, such as teen pregnancy, TB, and COVID-19. IHLGP's development of a coordinating committee and use of roadmaps supported the collaboration across sectors and provided a clear visual strategy for all parties involved. The program tapped academic partners to support the implementation of BLFP. The academic partners can also be tapped to provide more technical support through research and evaluation purposes.

Case Study 12. Partnerships reduce teenage pregnancy and enable response to COVID-19 in Guimaras

Governor Sam Gumarin of Guimaras relayed a success story related to the decrease in the teenage pregnancy rate from 2.4 percent in 2017 to 1.9 percent in 2019. When asked about the critical ingredient for this success, he identified the establishment of substantial cross-sectoral collaboration. A task force on teenage pregnancy was convened and included representatives from student councils, LGUs, religious groups, barangays, and health professionals.

Gov. Gumarin stated that the most critical piece is the co-ownership of the issue among everyone on the task force and council; all stakeholders knew that they must fully understand the issue. This approach, along with the requisite resources—Guimaras has maintained a health budget of 22-24 percent from 2017-2019—has supported the drop in teenage pregnancy rates.

Gov. Gumarin also attributed the province's nimble response to COVID-19 to the preparation and capacity built through IHLGP. Through the learnings, collaboration, and networking, Guimaras was able to create an executive committee which allowed for sharing of human and financial resources to respond to the pandemic.

"If they did not undergo the program, it would have been much more difficult to mobilize the entire province to work together on the pandemic."

- Governor Sam Gumarin, Guimaras

7. LESSONS LEARNED

IHLGP provides a strategy for direct LCE engagement intended to build local capacity to address priority health issues. IHLGP's premise is that building such local capacity for leadership and governance will lead to better health outcomes. While the specific GPPIs implemented under IHLGP may not directly or immediately result in improved health outcomes, especially in the short-term, they build the foundation for community health improvement by developing positive attitudes, mindsets, and behaviors among LCEs and other local stakeholders—a key enabling condition for good health governance and decision making.

Ownership, co-ownership, and co-creation—the three segments of the Bridging Leadership Framework that underpins the IHLGP process—are vital in strengthening local leadership and the LCE engagement process. IHLGP's component GPPIs are designed in a structured, sequential, and synergistic way to mirror the process of transitioning from a traditional "top – down" leadership framework to a model of collective leadership development, which is better suited to address complex and varied public health challenges of the communities in which IHLGP is working.

This GPPI documentation and assessment activity has found that IHLGP has three good practices: deep dive, roadmap, and coaching. Based on a holistic review of documents, stakeholder accounts, and insights from learning sessions, the three good practices effectively deliver their intended immediate results such as attitudinal change and execution of concrete leadership acts. Moreover, while the health improvements gained during the IHLGP period cannot definitively be attributed to specific GPPIs, these early successes occurred alongside the implementation of these interventions.

- The **deep dive** is an activity where a participant is directly exposed to the challenges of a system from the perspective of other stakeholders, such as an "index patient." The deep dive activity helps LCEs correct leadership blind spots (such as lack of recognition of a particular public health problem), develop a more profound sense of ownership of the issue at hand, and enhance their personal vision for the health of their locale.

- The **roadmap** is a visual tool for identifying gaps in the health system and monitoring progress in addressing them. Patterned after the health system building blocks framework, the roadmap provides a structure for diagnosing health system problems and planning interventions. It also can be used as coaching tool to engender motivation and accountability among stakeholders.

- **Coaching** pertains to engagement strategies for changing mindsets and perspectives, unlocking potential, improving performance, and enabling learning. Experiences in IHLGP indicate that coaching aids in inculcating a sense of ownership of and accountability for health decision making among LCEs. Both leadership and technical coaching, whether structured or informal, are vital in helping build the capacity of LCEs and other stakeholders for local health system governance.

Relationship-building measures are an essential foundation for the successful implementation of IHLGP's good practices, and they are worth considering as promising interventions for improving local health leadership and governance. While IHLGP did not have an explicit intervention for building relationships, it nonetheless did so formally and informally throughout the program, such as through the formation of core teams and activity "pre-work," which is critical to obtain LCE buy-in to participate in other activities under IHLGP.

Relationship building is an important precondition for, input to, and an outcome of implementing health leadership programs. The need for this derives from the fact that addressing complex social challenges such as public health problems is beyond the capacity of one leader or sector alone, relying instead on enhanced collaboration and coordination that can only be realized through strong relationships among all stakeholders.

While individual GPPIs can be executed as stand-alone interventions, the IHLGP experience demonstrates that they are best implemented as a package to maximize their synergistic effect. Each GPPI plays an important function, and their simultaneous or sequential implementation will likely support more holistic leadership development. The deep dive allows for self-discovery and visioning; the roadmap provides structure for diagnosis, action planning, and monitoring; coaching engenders motivation and accountability; and relationship building serves as the "glue" binds all interventions.

The experience of IHLGP also showed the flexibility of the GPPIs: they can be adapted to suit a variety of public health problems, different types of LCEs, and diverse local contexts. The deep dive activity has been used to highlight a neglected yet pressing local health problem which varied by location. The roadmap has been customized for use in diagnosing gaps and monitoring progress not only in health system-wide actions but also in responses to specific public health issues like TB and family planning.

IHLGP as a whole, as well as the specific GPPIs, has contributed to the sustainability of leadership gains in several ways. IHLGP also contributed to the achievement of other institutionalization goals such as change management, knowledge management, client satisfaction, and partnership building. Early signs indicate that IHLGP and its GPPIs have laid the groundwork for long-term change in health systems and communities; the challenge is to ensure that these positive outcomes are retained and advanced beyond the lifespan of the IHLGP.

While it is still early to conduct an impact evaluation, there is some indication that IHLGP in general and the GPPIs in particular helped set the stage for introducing UHC reform efforts and for timely, quick, and coordinated COVID-19 response. As a whole, LCEs feel that their experience with IHLGP or its specific GPPIs such as deep dive and coaching has prepared them to easily convene stakeholders and coordinate resources around big transformation efforts such as institutionalizing UHC or mounting an unprecedented response to a pandemic.

8. OVERALL RECOMMENDATIONS

GPPI-specific recommendations have been presented in the respective sections in this report. The key overall recommendations are found below.

The identified GPPIs—the deep dive, roadmaps, and coaching—should be implemented as a package of interventions to maximize synergistic effect. As outlined in the key findings, the assessment found the most effective approach to implementing the identified GPPIs is in a sequential order that allows for compounding and additive effects on the program—through relationship building, change management, knowledge management, and the like. The GPPIs can be implemented individually but will not yield the same impact as if executed as a package.

Additional technical assistance and potential funding may be needed to sustain the implementation of GPPIs post-IHLGP. In handover sessions, LCEs and other stakeholders clearly expressed both interest and intention to continue implementing specific components of the IHLGP, particularly the deep dive, roadmap, and coaching. However, despite several years of support, various stakeholders also said they would like continued technical assistance, and possibly also funding, to ensure sustained implementation in the medium term.

Government agencies responsible for developing local capacity for health governance should leverage these GPPIs and harness the lessons learned from IHLGP. Agencies such as the DOH, Department of Interior and Local Government, Development Academy of the Philippines, and Commission on Population can adopt these GPPIs in their LCE engagement activities and incorporate them in trainings they offer to LCEs and other local stakeholders.

Other USAID Health Project implementing partners can use these GPPIs in their own activities. Whether for family planning (ReachHealth) or community-based drug rehabilitation (RenewHealth), GPPIs such as deep dive and roadmap can be useful in engaging LCEs and other stakeholders, encouraging them to take ownership of different public health concerns and catalyze multi-sectoral responses to these problems. IPs can also tailor the GPPIs to diverse public health problems and local contexts.

Certain other sectors, such as agriculture, fisheries, and other industries, should consider using the IHGLP approach, as they are integral to good health and the success of health outcomes. One of the key findings within the GPPI assessment was the need for intersectoral collaboration to address complex health issues, as seen with teenage pregnancy and nutrition. IHLGP tools and approaches, such as the deep dive and roadmap, can be applied in sectors such as sustainable farming and fishery operations, and others that are peripheral to the health sector but still are key to positive health outcomes.

Build in flexibility to adapt IHLGP to local contexts and different types of LCEs. The assessment found that LCEs came to the program with different levels of experience, and specific geographic, political, and community contexts. The curriculum and approach ideally should be tailored

to meet individual LCEs and LGUs where they are, as opposed to adopting a one-size-fits-all approach. ZFF and IHLGP staff, as well as LCEs, have suggested the possibility of developing a more intensive program and a "lite" version for LCEs who may not be available for intensive engagement.

Consider developing a structured relationship-building intervention, based on the existing successful relationship-building measures in IHLGP, that IPs can easily adopt and replicate. The IHLGP curriculum had numerous existing mechanisms for building teams, relationships, and partnerships woven into its design. These should be distilled into one document showing the different options for engaging and building relationships with LCEs, between and across sectors, for use by implementing partners and other stakeholders working in health.

When replicating GPPIs, embed research from the start. Parties planning to implement IHLGP's GPPIs should incorporate elements of learning and research to further understand whether and how health systems strengthening and health outcome gains can be directly attributed to specific GPPIs.

Leverage the interest of HLGP/IHLGP alumni to coach, mentor, and train new LCEs. Several LCEs expressed interest in participating in a community of HLGP/IHLGP alumni to allow for cross learning across regions, provinces, cities, and barangays, and in supporting new incoming LCEs. As previous program participants with extensive experience serving their communities, alumni are an untapped resource for sustaining the gains of HLGP/IHLGP.

ANNEX 1. GPPI EVALUATION CRITERIA

Table A. GPPI evaluation criteria with main and sub-questions		
Criterion	**Main Questions**	**Sub-questions**
Effective	Is the practice or intervention **measurably effective**, per the defined aim or objective?	1. Is there a useful framework, outlining the specific context and practice/intervention and making the link to improved health outcomes and learning questions? 2. Is there clear program documentation of the aim or objective? 3. Is there a clear understanding of the aim or objective across beneficiaries and implementers? 4. Is there well-documented, high-quality, robust, and consistent quantitative and qualitative evidence that the practice will have or has already had a positive effect on the immediate programmatic outputs and longer-term health outcomes? (Preferably real-time documentation, to ensure the appropriate data is being collected.) 5. From a qualitative perspective, how effective has the intervention been in general terms and specifically in terms of benefiting groups or communities where it was implemented?
Replicable	Is the practice or intervention **replicable**, requiring expertise and resources that may be generalized or adapted?	1. What is the level of complexity of the intervention? (*i.e.*, what are the financial and human resources required to implement effectively?) 2. Does the intervention allow for flexible adaptation to new contexts and settings? 3. Currently, what is the coverage and reach of the intervention over time? 4. Given financial and human resource requirements, is the intervention feasible in other local settings?
Commitment	Is there a strong **commitment** for the practice or intervention at the local, sub-regional, and/or	1. Does the health system have key stakeholders who have the capacity to implement the intervention without technical support? If yes, explain how, where, and by whom. 2. What are the specific commitments to the intervention, and how did you get the commitments?

Table A. GPPI evaluation criteria with main and sub-questions		
Criterion	**Main Questions**	**Sub-questions**
	national levels, demonstrating the potential for sustainability and scale up?	3. What were the obstacles to obtaining commitments? 4. Does the health system have key stakeholders who champion the intervention? At what level?
Aligned	Is the practice or intervention **aligned** across stakeholders?	1. Is the practice or intervention aligned with national-level priorities (*i.e.*, Philippine government and USAID priorities) 2. Is the practice or intervention aligned with current local needs and priorities? (*i.e.*, identified from community needs assessments)
Integrated	Is the practice or intervention **integrated** (horizontally and vertically), to the extent possible, with existing health system structures?	1. If the practice is not currently integrated, are there plans to integrate the intervention? 2. Is the practice or intervention integrated across the following categories? ● Technically integrated with the existing health system (considering evidence-based clinical and public health interventions)? ● Managerially integrated? (Streamlined internally and across administration levels) ● Financially integrated? (budgets and financial forecasting documents)
Inclusive	Is the practice or intervention **inclusive** (involving, collaborating with, and empowering key stakeholders in all phases of intervention)?	1. Who was involved in the design, implementation, monitoring, and evaluation of the intervention, and what was is their role (extent of their involvement)? ● At the national level ● Sub-national level ● Community level ● Private sector ● Civil society 2. Is the intervention ensuring the participation of specific vulnerable and affected groups? 3. Is the intervention using a participatory approach in involving the community/clients? If so, describe the approach.

Table A. GPPI evaluation criteria with main and sub-questions		
Criterion	**Main Questions**	**Sub-questions**
Resourced	Are there **sufficient resources** to support the practice or intervention, including financial, physical, human, and technical resources?	1. Is the intervention resourced appropriately (*i.e.*, budgeting, staff allocation)? ● Are there national and local finances and resources for the intervention? ● Does the system have the capacity to implement the intervention without technical support? If yes, explain how, where, and by whom. ● Are clear and specific commitments included in the intervention (policies, MOAs, partnerships)? How did you get the commitments? What were the obstacles to obtaining commitments?
Accountable	Are there **accountability** measures built in within the intervention?	1. Are processes in place to ensure the utilization of intervention results? 2. Are staff and programs reviewed on the performance of the intervention or practice? 3. Does the intervention include reporting structures that are connected to higher leadership bodies? 4. Is this practice routinized? How?

ANNEX 2. SEMI-STRUCTURED INTERVIEW GUIDE FOR LCEs AND HEALTH OFFICERS

General Questions

1. What were the components of the IHLGP that you participated in?

2. How would you describe your overall experience with IHLGP?

3. How did your experience with IHLGP change your mindset towards governance and your local health system?

4. How do you think the IHLGP helped your local health system/province or city?

5. What are the factors that made the implementation of IHLGP in your province/city successful? How can these be enhanced?

6. What are the barriers or challenges that you faced during the implementation of IHLGP? How are these overcome?

7. Which elements or interventions of the IHLGP do you find most important and useful? Why?

Specific Questions

For this study, we are focusing on a particular set of interventions or elements of the IHLGP. We have specific questions pertaining to these interventions.

1. **Story:** Let's talk about Intervention X. Can you tell us about your personal experience of Intervention X? Please share your story.

2. **Effectiveness:** What was the purpose or objective of Intervention X in your own words? Do you think the objective was achieved? How? Also, please share a story from your community that demonstrates or indicates Intervention X's effectiveness.

3. **Replicability:** Was Intervention X easy to implement and even replicate? Why or why not?

4. **Commitment:** Has your province/city already planned the continuation of Intervention X's implementation once IHLGP is finished? What capacities are being built or preparations made for the transition?

5. **Alignment:** Do you think Intervention X is aligned with or feeds into higher level priorities, for instance the objectives and priorities of the Department of Health? Why and how?

6. **Integration:** Do you think Intervention X is integrated or seeks to integrate with existing governance systems and structures, for instance the mechanisms in your office? Why and how?

7. **Inclusivity:** Do you think Intervention X is inclusive or encourages the inclusion of different stakeholders, especially vulnerable and affected groups? Why and how?

8. **Resources:** What are the resources required to implement Intervention X? Are these resources manageable or too much? What resources have you already allocated for the continued implementation of Intervention X?

9. **Accountability:** Do you think Intervention X inspires accountability among different stakeholders, including yourself? Why and how?

10. What are the factors that made the implementation of Intervention X in your province/city successful? How can these be enhanced?

11. What are the barriers or challenges that you faced during the implementation of Intervention X, and how are these overcome?

12. How else do you think Intervention X can be improved, especially if it will be sustained and even replicated in other settings?

ANNEX 3. MEETINGS AND EVENTS ATTENDED

Table B. Summary of meetings and events attended	
Date	**Event**
September 1, 2020	Endline Assessment Presentation
Regional Hand-over Ceremonies	
September 14, 2020	Region IX
September 15, 2020	Regions VI
September 22, 2020	Bangsamoro Autonomous Region in Muslim Mindanao (BARMM)
September 23, 2020	Region XII
September 24, 2020	Region X
September 29, 2020	National Handover Ceremony
October 7, 2020	Internal Learning Session between ZFF-IHLGP and USAID Implementing Partners

ANNEX 4. BRIDGING LEADERSHIP FRAMEWORK[45]

Table C. Bridging Leadership competencies and their core behavioral elements		
Competency	**Definition**	**Core Behavioral Element**
Ownership		
Modeling personal mastery	The ability of a leader to demonstrate and display self-direction or self-motivation as well as engage in ongoing personal and professional development, keeping in mind his/her personal core values, and organization's values, respectively. It is a demonstration of courage to do what is right regardless of the circumstances or consequences.	Developing, articulating, and aligning a personal vision for health
		Resilience in ambiguous situations
		Commitment to the truth
Thinking strategically on health inequities	The ability to see the "big picture" and think multi-dimensionally and identify connections between situations that are not obviously related.	Demonstrates systems thinking
		Exercises strategic agility
Problem solving and decision making on health challenges	The ability to resolve deviations and exercise good judgment by using fact-based analysis and generating and selecting appropriate courses of action to produce positive results (making a personal response)	Finds and identifies nature of the problem
		Gathers, organizes, and analyzes data
		Considers alternatives or options for solutions
		Comes up with recommendations and selects appropriate solutions
Co-Ownership		
Leading change	The ability to generate genuine enthusiasm and momentum for organizational change. It involves building a shared sense of commitment to a common goal and utilizing interventions to help close gaps or improve competence of staff to	Creates a shared vision for change
		Engages and enables the organization
		Implements and sustains change
		Exercises strategic agility

[45] Source: Zuellig Family Foundation

Table C. Bridging Leadership competencies and their core behavioral elements		
Competency	**Definition**	**Core Behavioral Element**
	achieve that goal. Furthermore, it means engaging and enabling groups to understand, accept, and commit to the change agenda	
Leading multiple stakeholders	The ability to identify who needs to be part of the conversation, build and maintain high trust, develop synergistic working relationships across relevant sectors necessary to implement the change agenda	Facilitates development and co-ownership of shared goals
		Creates and enables a culture of dialogue that sustains learning
		Manages resolution of conflict for multiple stakeholders
Leadership coaching and mentoring for results	The ability to create an enabling environment, which will nurture and sustain a performance-based coaching culture.	Applies appropriate coaching and mentoring techniques
		Sets performance-based culture
		Commits to continuous learning and improvement
Co-Creation		
Championing and sustaining social innovations	The ability to challenge, champion, and sustain conventional practices and approaches, generate new ideas and fresh perspectives, craft creative solutions and strategies aligned with goals and directions that lessens social inequities.	Explores novel ideas, concepts, or strategies from relevant fields based on current trends and research
		Seeks to improve or modify processes, methods, and services
		Creates innovative solutions that result in the reduction of inequities
		Influences and inspires the organization and its stakeholders towards new institutional arrangements
		Empowers citizens or constituents to generate demand to health access

ANNEX 5. DEEP DIVE PROGRAM DESIGN FOR PLGP[46]

Table D. Outputs, objectives, and participants for the Deep Dive activity		
Step and Outputs	**Objectives**	**Participants**
Step 1: Deep Dive Pre-Work—Gather, Process, Analyze Data Outputs: Provincial prioritization of health outcomes; quick victories for the provincial team	• Discuss the assessment of the provincial health system and its connection with health data • Explain the strengths and weaknesses of the elements of the provincial health system–provincial hospital, municipal RHUs, continuity of care, and leadership and governance • Articulate the impact of current health system for the poor constituents	HLGP Team Provincial DOH Officer Provincial stakeholders (Governors, PHO, Chiefs of Hospitals)
Step 2: Deep Dive Pre-Work—Perform a dry run of the deep dive activity Outputs: Provincial prioritization of health outcomes; quick victories for the provincial team; explicit permission from the target participants	• Perform a dry run of the deep dive • Identify the risks that would be taken • Prepare the team to address the risks identified	Provincial DOH Office (PDOHO) Provincial stakeholders (PHO)
Step 3: Deep Dive Pre-Work—Pre-Dive Orientation of Governor Outputs: List of expectations by the	• Articulate the expectations of the governor • Explain the expected learning from the deep dive	ZFF Team PDOHO Provincial stakeholders (PHO)

[46] The detailed program can be found in the facilitator's manual for conducting the deep dive activity for LCEs produced by ZFF. To obtain a copy, contact: communications@zuelligfoundation.org.

Table D. Outputs, objectives, and participants for the Deep Dive activity		
Step and Outputs	**Objectives**	**Participants**
Governor addressed; list of anticipated learning from the deep dive	• Discuss and provide comments on the expected itinerary	
Step 4: Deep Dive Proper Outputs: Reflection journal; activity report	• Deepen governor's understanding of the current health inequity in the province by applying active listening and dialogue skills • Enhance Bridging Leadership competencies of governor on ownership • Practice listening and dialogue skills • Create a sense of urgency from the governor to support the provincial health system	Province: Governor; Provincial Health Officer; Chief of Provincial Hospital DOH: Regional Director; Assistant Regional Director; HLGP team; PDOHO ZFF Team: Cluster Manager; PLGP Manager; Provincial Account Officer
Step 5: Deep Dive Post-Work—Debriefing of Governor Outputs: Personal vision of the governor; additional priority directions for the governor's plans; list of stakeholders needed for the governor to execute their plan	• Articulate what they have learned from the activity • Articulate their vision for the province • Identify additional priority directions for the plans • Identify the stakeholders who would be needed for the governor to execute their plan	Governor ZFF Team PDOHO Provincial stakeholders (PHO)

ANNEX 6. SAMPLE ROADMAPS FROM HYPOTHETICAL PROVINCIAL HEALTH SYSTEMS[47]

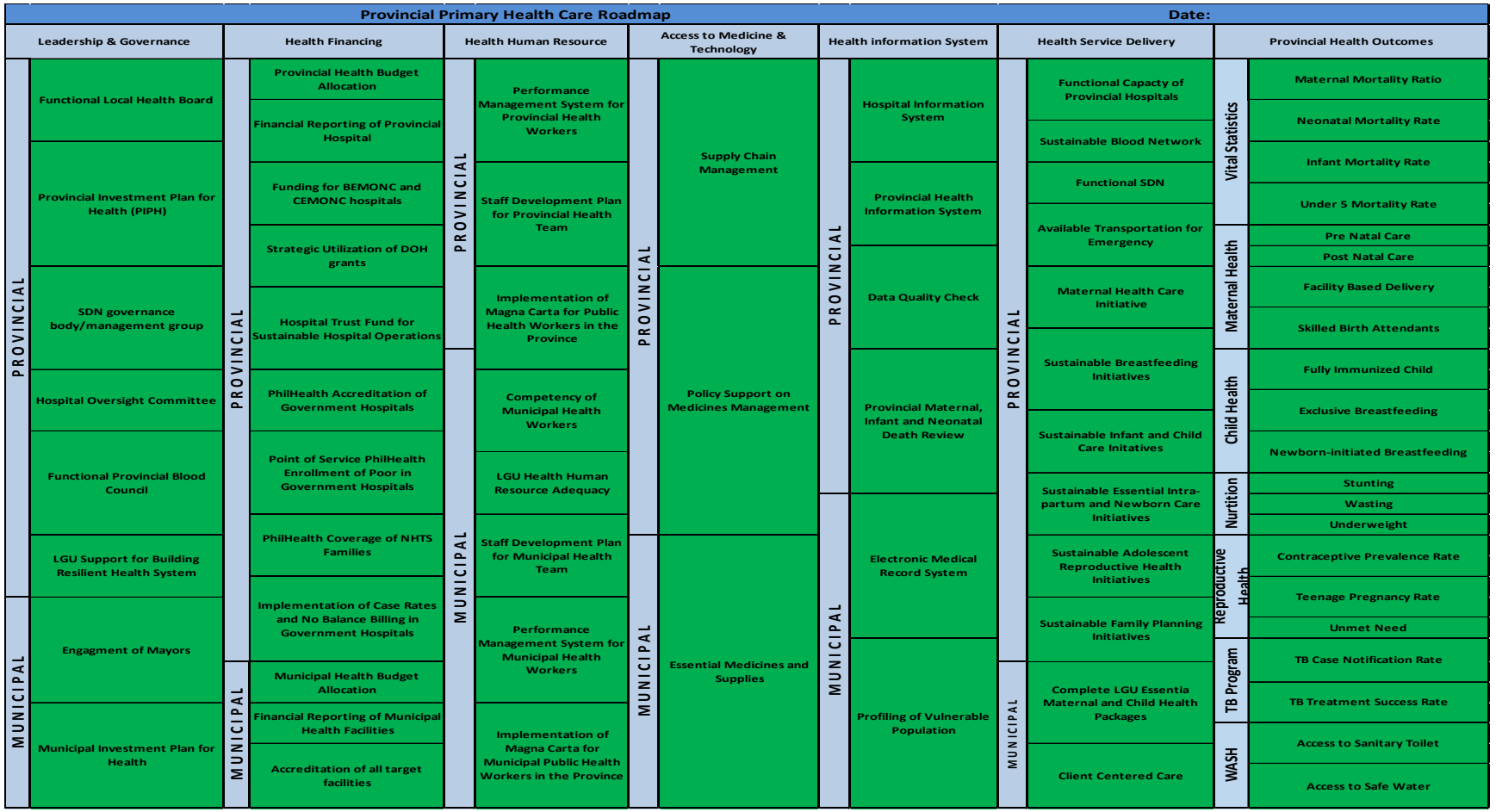


Figure A. Strong and functional provincial health system, and needs to be sustained

[47] Source: PLGP Technical Roadmap User's Guide developed by ZFF-IHLGP. To obtain a copy, contact: communications@zuelligfoundation.org.

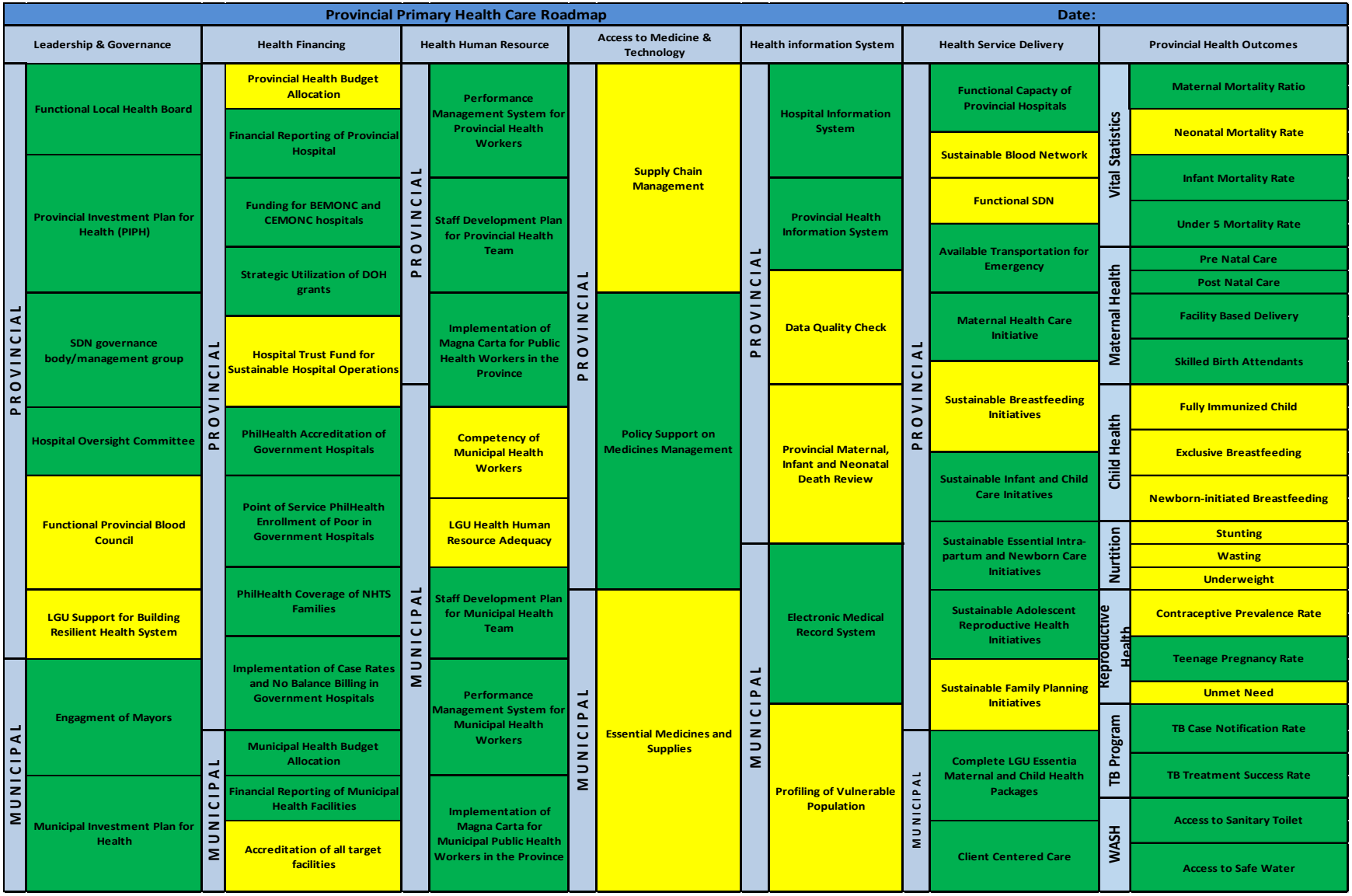


Figure B. Functional provincial health system but needs to be strengthened

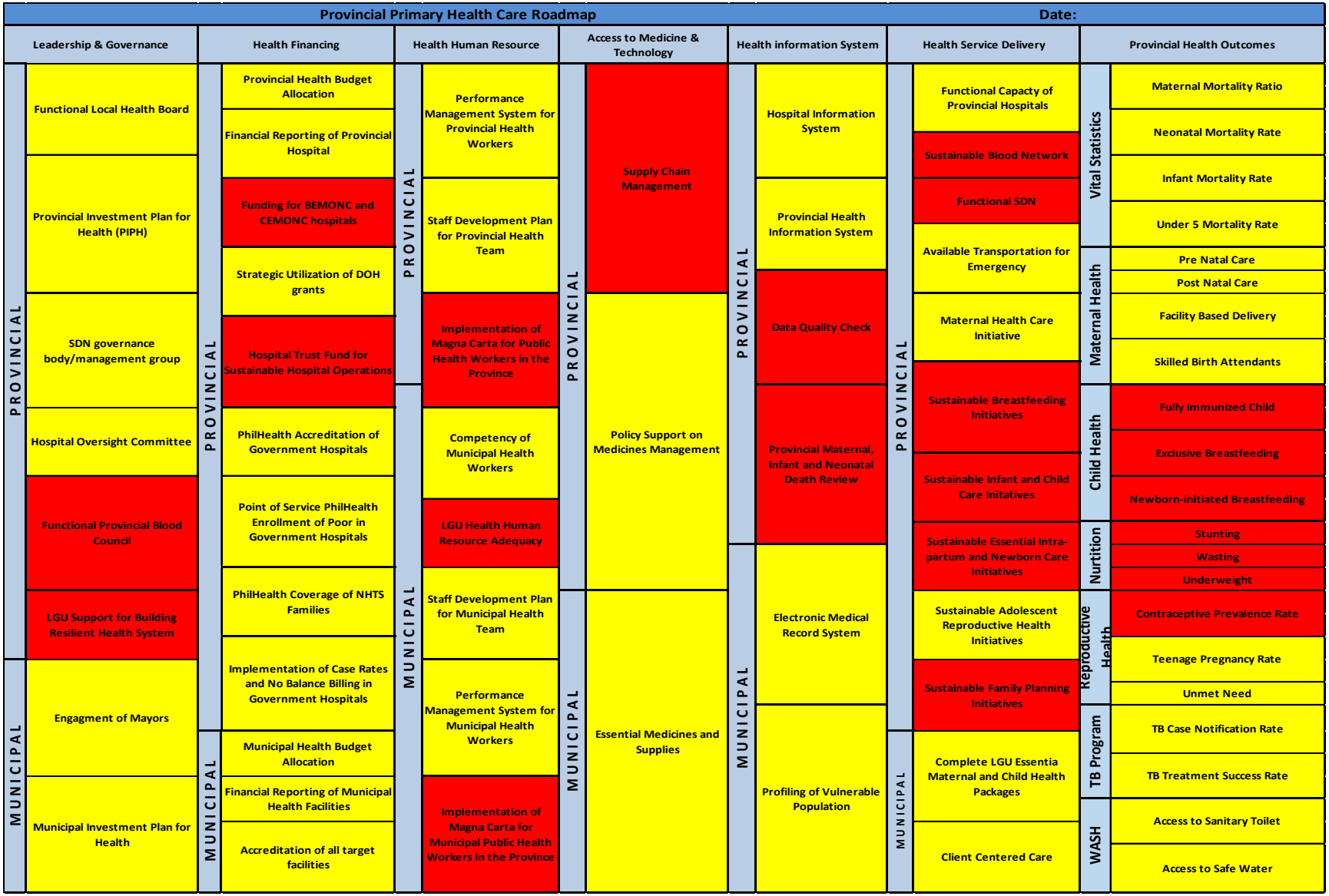


Figure C. Weak provincial health system, and gaps need to be prioritized

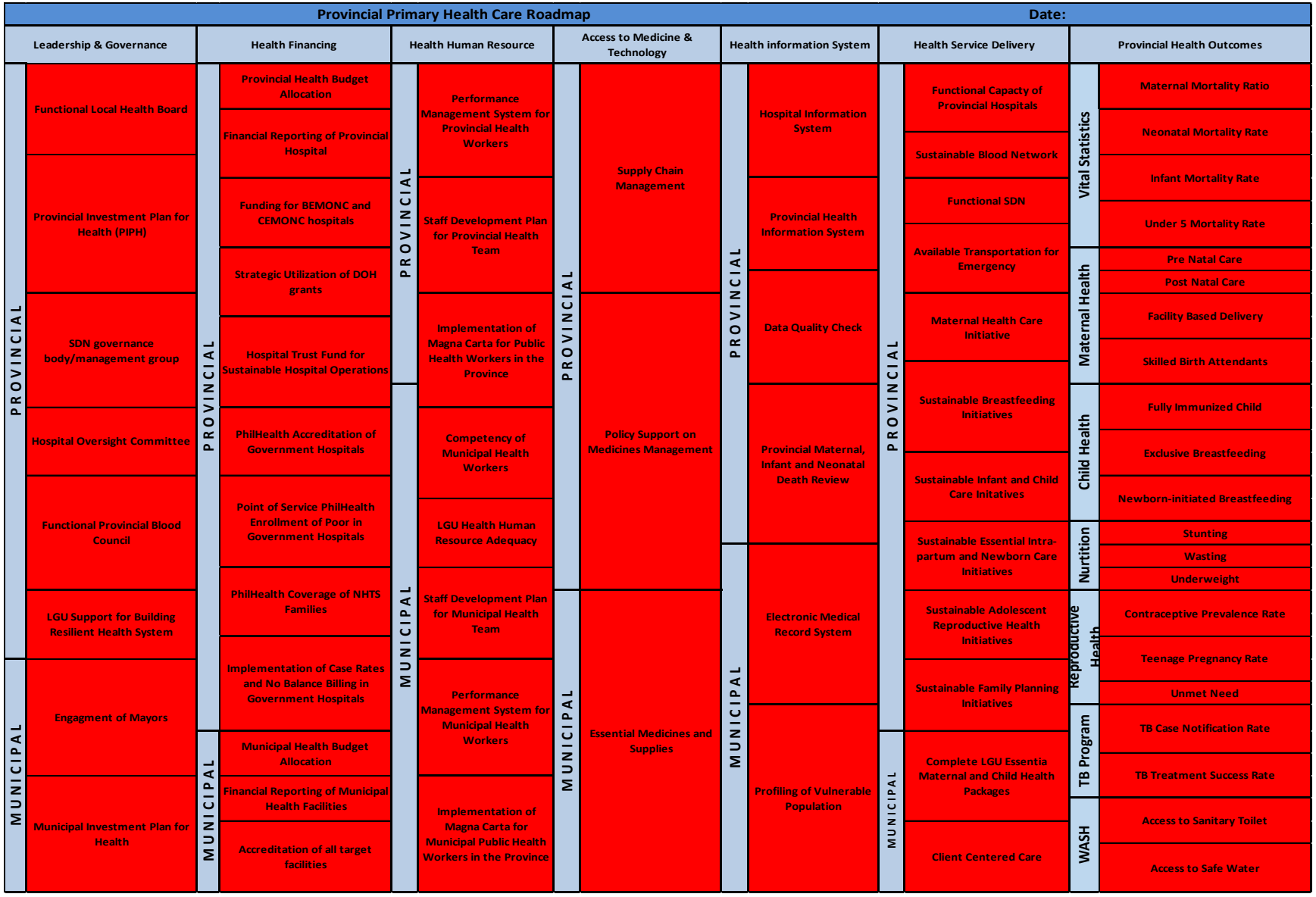


Figure D. Absent functional health system