# The Politics of Localizing Health-related MDGS: A Case Study of Dolores, Abra

GHERALD P. EDAÑO
*Candidate for Master of Public Management major in Public Policy and Program Administration, University of the Philippines Open University*

***Abstract-*** ***This paper examines the efforts made by the Philippine government to bring about positive changes in rural areas, specifically in Dolores, Abra, Northern Philippines, regarding the three health-related MDGs on child mortality, maternal health, and the fight against HIV/AIDS and other diseases. The study discusses the localization of MDGs in terms of adequacy of health personnel, necessary infrastructure and facilities, implementation of aligned policies and programs, the budget allocation, and the political dynamics surrounding these areas. The research collected data through interviews with officials and residents, as well as an analysis of health reports, records, and field observations. The findings reveal that additional factors are needed to improve healthcare services. The study concludes that successful international agreements require a decentralized and coordinated national to local commitment, strong political will from local authorities, and political stability. These factors must work together to expedite the localization process and achieve these goals.***

***Indexed Terms-*** ***Localization, Health Governance, MDGS, Philippine Politics***

## I. INTRODUCTION

The concept of localization refers to the adaptation and implementation of global goals or targets at the national or local level. It involves designing and adjusting local development strategies to achieve the Millennium Development Goals (MDGs) in a manner that is relevant to the specific context of a region or locality (UN Habitat, 2004; Atienza, 2012). Localization is a crucial process that relies on the mechanisms outlined in the Local Government Code (LGC) of 1991, which decentralizes and devolves basic services, including health, to local government units (LGUs).

This process recognizes the need to bring down the MDG targets and indicators to the local context, ensuring accurate representation of national and global achievements. It acknowledges that addressing the disparities and deprivation in specific areas requires targeted interventions that vary depending on the local context. This flexibility allows for either modifying existing local development strategies to align with the MDGs or developing new strategies that reflect local priorities and realities, emphasizing a participatory and locally driven approach (UNDP, 2007).

Atienza's study (2004) stated that the devolution of power in the Philippines was influenced by multiple factors, not just democratization. While positive changes have resulted from devolution, not all reform goals have been met. People's participation and the socioeconomic-political environment play crucial roles in improving local health services. Sustaining achievements in health service delivery attracts external resources. Leadership commitment is also important for ensuring adequate services.

Atienza's further study in 2012 mentioned uneven progress of the MDGs in the Philippines and provided recommendations. The study identified two main factors: financial challenges and governance issues. Financial challenges resulted from the country's weakening fiscal situation and automatic debt servicing, leading to reduced expenditures for crucial services. Governance issues included political instability, ineffective governance, weak rule of law, and corruption. Recommendations included prioritizing budget allocations for social services, fostering partnerships, enhancing accountability, exploring debt conversions, and advocating for governance reforms. Local-level recommendations focused on poverty profiling, integrating MDG targets, promoting inter-local cooperation, and implementing the Community-Based Monitoring

System. The study also proposed stronger ASEAN involvement for MDG achievement and human security.

To further guide the localization process, the Department of the Interior and Local Government (DILG) has established a framework that outlines desired outcomes for MDG-responsive LGUs such as Circular No. 2004-152 and its amendment, Circular No. 2008-111. These circulars provide a guide for LGUs in localizing the MDGs and offer a menu of option-programs that LGUs can adopt to achieve their MDG targets, particularly in poverty-stricken provinces like Abra.

The province of Abra, located in the northern part of the Philippines, gained notoriety for its election-related violence (ERVs) during election seasons in the early 2000s. In 2007, power shifted from one clan to another when governor Vicente Valera lost the congressional race to Cecilia Seares-Luna. Additionally, Valera's wife, Ma. Zita, lost the gubernatorial race to Eustaquio Bersamin, the brother of the late congressman Luis Bersamin. Luis was assassinated in December 2006 at Mt. Carmel Church in Quezon City, and it was reported that Vicente was the mastermind behind the plot (Paredes, 2011b). This incident occurred after Vicente ssupected that Luis was being considered as a potential candidate against his wife in the upcoming elections (Felipe, 2006; Paredes, 2010). Vicente Valera was later convicted for the murder (Sauler, 2015).

Following the fall of the Valera couple, who had held power for over twenty years, the Valera-Bernos and Seares-Luna clans took over the political landscape in Abra (Paredes, 2011a). In the town of Dolores, the Valera-Guzman family, who were allies of Vicente Valera, managed to retain their post in 2007 but were eventually defeated in 2010. The matriarch of the Guzman family, who is Vicente's sister, attempted to succeed her husband as mayor in 2010 but was thwarted by their own nephew, Robert Victor 'JR' Seares, Jr. Seares, a political newcomer and ally of Bersamin, also happens to be the nephew of Cecilia Seares-Luna. Since Seares' election, Dolores has made significant improvements in its local government performance, particularly in the provision of healthcare services, and has received several awards and incentives, which was long neglected due to political rivalries.

This paper therefore thematically seeks to track these improvements and how they localized and aligned these improvements to the health-related MDGs in terms of adequacy of health personnel, necessary infrastructure and facilities, implementation of aligned policies and programs, and the budget allocation. This paper then further examines the political dynamics surrounding these areas of localization.

The study used qualitative and descriptive research methods, including interviews, field observations, and documentary analysis. Ten respondents were randomly selected from four barangays, including key informants such as the Municipal Mayor, the Municipal Health Officer (MHO), several rural health unit (RHU) nurses, employees, and patients. Data supporting the adequacy of health personnel and building of necessary infrastructure and facilities was collected through interviews, documentary analysis, photo documentation, and field observations. Data regarding the implementation of aligned policies and programs were collected through documentary analysis of RHU’s quarterly and annual reports and triangulated through interviews and field observations. Budget allocations and trends were examined using financial health plans, budget plans, and investment programs.

Thematic categorization and analysis were then applied using relevant frameworks and studies. Ethical considerations were then followed throughout the research process, including obtaining written permission and assistance from the RHU, LGU, and private individuals.

## II. ADEQUACY OF HEALTH PERSONNEL

According to the World Health Organization (WHO), the recommended doctor-population ratio is one doctor for every 20,000 residents (Tubeza, 2012; Geronimo, 2016). In Dolores, with a population of 12,524 (as of 2015), there is currently one licensed physician available, meeting the WHO standard. The Rural Health Unit (RHU) in Dolores has five

midwives, three of whom are regular employees and two deployed by the Department of Health (DOH). The Provincial Health Office (PHO) has provided a dentist, and there is one Medical Technologist designated by the DOH. The number of Barangay Health Workers (BHWs) has increased over the years, reaching a total of 186 BHWs in 2016, along with 15 Community Health Teams (CHTs) consisting of five members each. These volunteers assist the BHWs in monitoring the health of residents in the barangays. The number of nutritionists decreased due to the RHU doctor taking on their responsibilities, resulting in cost savings for the local government.

Despite the absence of pharmacists and the lack of records regarding the number of RHU employees prior to 2013, the overall adequacy of health personnel in Dolores remains satisfactory. The local government has further focused on training and performance evaluation to enhance skills and ensure quality care. The presence of personnel in each barangay, including hard-to-reach areas, through BHWs and CHTs fosters community involvement and legitimizes the localization efforts of the government.

This inclusive approach aligns with the United Nations' objective of involving and benefiting the people directly in global development initiatives (UNDP, 2016). By fulfilling the healthcare goals, the local government strengthens its legitimacy and support from residents (ACSC, 2016).

## III. BUILDING NECESSARY HEALTH INFRASTRUCTURES, FACILITIES, AND EQUIPMENT

Before Mayor Seares took office, the healthcare sector in Dolores faced significant challenges, including a lack of infrastructure and limited access to services. However, Mayor Seares implemented various improvements to address these issues. Notably, cases of maternal and child deaths have been reduced to zero since the implementation of these changes. The Rural Health Unit (RHU) in Dolores serves as the main healthcare facility, and it has been expanded and repaired to accommodate more patients. These improvements were made using funds allocated for repairs, as well as funds from the Local Government's Internal Revenue Allotment (IRA) and the General Budget of the LGU.

The compliance of Dolores with healthcare infrastructure standards was assessed using the checklist provided by the *Sentrong Sigla* Quality Standards (DOH, 2000). The RHU in Dolores has consistently adhered to these standards, which aim to ensure quality services in healthcare facilities. The construction and provision of health infrastructure, such as Barangay Health Stations (BHSs), have been carried out to enhance accessibility to healthcare services in underserved areas. These efforts aim to provide primary care, maternal care, birthing services, and disease management closer to the residents, reducing the need for them to travel to distant towns with higher fees.

Figure 1. The Rural Health Unit of Dolores, Abra before Seares' term (left, downloaded from social media dated ) and during his term (right, captured by the author in 2017)

The physical structure of healthcare facilities plays an important role in promoting positive emotions and experiences among patients. The behavior of healthcare personnel, cleanliness, availability of amenities, and overall atmosphere contribute to patient satisfaction. These positive experiences within the

healthcare infrastructure foster trust in the Municipal Health Office and the local government of Dolores, highlighting the importance of investing in tangible spaces that create positive emotions and enhance the patient experience.

## IV. IMPLEMENTATION OF THE ALIGNED HEALTH SERVICES AND PROGRAMS

The third litmus test to the health performance of Dolores, Abra in localizing the health-related MDGs is the implementation of health services and programs that are specifically aligned with MDGs 4, 5, and 6. These MDGs focus on reducing child mortality, improving maternal health, and combating HIV/AIDS, malaria, and other diseases. Table 1 presents the health services and programs implemented by Dolores, primarily through the Rural Health Unit (RHU).

Table 1. Assessment of aligned Health Services & Programs implemented by RHU Dolores

| MDGs & TARGETS | PROGRAM/ INDICATORS | GENERAL ASSESSMENT |
|---|---|---|
| GOAL 4: Reduce Child Mortality | REDUCE CHILDREN UNDER-FIVE MORTALITY | Implemented |
| TARGET: Reduce children under-five mortality rate by 67% by 2015 | IMMUNIZATION OF CHILDREN | Implemented |
| | PROMOTION OF BREASTFEEDING UP TO 6 MOS. CONTINUOUS UP TO 2 YRS. | Implemented |
| | PROVISION OF ONE DOSE VITAMIN A | Implemented |
| | PROMOTION OF NEW-BORN SCREENING FOR CONGENITAL METABOLIC DISORDERS | Implemented |
| | PROVISION OF DE-WORMING DRUGS FOR 2-5 YEARS OLD CHILDREN | Implemented |
| | OPERATION TIMBANG/ GROWTH MONITORING | Implemented |
| | COMPLIMENTARY FEEDING FOR INFANTS 6-8 MOS. | Implemented |
| | PROVISION OF IRON SUPPLEMENTS FOR LOW-BIRTH WEIGHT INFANTS AND ANEMIC CHILDREN | Implemented |
| GOAL 5: Improving Maternal Health | | |
| TARGETS<br>1. Reduce maternal mortality rate by 75% by 2015<br><br>2. Increase access to reproductive health services to 60% by 2005, 80% by 2010 & 100% by 2015 | | |
| | NATALITY – LIVEBIRTHS FACILITATED BY HEALTH WORKERS | Implemented |
| | PROMOTION OF FAMILY PLANNING | Implemented |
| | ESTABLISHMENT OF FUNCTIONAL COMMUNITY BASED MANAGEMENT INFORMATION SYSTEM (CBMIS) FOR FAMILY PLANNING AND OTHER RH SERVICES | Implemented |
| | PROMOTION OF MATERNAL CHILD HEALTH AND NUTRITION (PROVISION OF COMPREHENSIVE PRE-NATAL, NATAL AND POST- NATAL CARE FOR ALL PREGNANT WOMEN) | Implemented |
| | MEN'S REPRODUCTIVE HEALTH (RH) | Not Implemented |
| | EDUCATION AND COUNSELING ON SEXUALITY AND SEXUAL EDUCATION | Implemented |

| | | |
|---|---|---|
| | PREVENTION AND TREATMENT OF REPRODUCTIVE TRACT INFECTIONS/STD/HIV-AIDS | Implemented |
| | CAPABILITY DEV'T OF HEALTH WORKERS IN MATERNAL CARE, CHILDBIRTH, FAMILY PLANNING, PMAC, VAWC, AND OTHER SERVICES. | Implemented |
| GOAL 6: COMBAT HIV/AIDS, MALARIA, AND OTHER DISEASES | | |
| TARGETS<br>1. Prevent the spread and halt HIV/AIDS by 2015<br><br>2. Increase access to reproductive health services to 60% by 2005, 80% by 2010, and 100% by 2015 | | |
| | COMBATTING HIV/AIDS | Implemented |
| | COMBATTING TUBERCULOSIS | Implemented |
| | COMBATTING MALARIA | Implemented |
| | ESTABLISHMENT AND STRENGTHENING OF TB NETWORK | Implemented |
| | IMPLEMENTATION OF COMPREHENSIVE CLEANLINESS PROGRAM SUCH AS DE-CLOGGING AND MAINTENANCE OF CANALS. | Implemented |

Table 1 was divided accordingly with the three selected health-related MDGs. The indicators stated in the table are based on DILG Circular Memorandum No. 2004-152, which was issued on November 10, 2004. This memorandum serves as a guide for local government units (LGUs) in adapting the UN-MDGs to their specific contexts. It provides LGUs with various options for implementing services and programs that align with the UN-MDGs.

Table 1 presents the status of 22 health services and programs implemented by the LGU. Out of these, 21 were found to have been successfully implemented, while only one was labeled as "not implemented." This achievement can be attributed to the strong support and political will of the LGU's top management, led by Mayor Seares. According to Beck (1993), project management plays a vital role in translating the plans and goals of top management into practical implementation. However, it should be noted that the poor delivery of health services in Dolores is not solely attributed to the availability of necessary health personnel, infrastructure, and facilities. It also encompasses the effectiveness of health services and programs provided.

Most of the health services and programs discussed in this study were already planned and funded by the national government. These services are delivered by the DOH. The MHO, Dr. Darbie Madriaga, confirmed that the services were already in place as part of the national government's program. The MHO mentioned that they are mainly informed about the policies since they originate from the national government.

However, one specific health service, Men's Reproductive Health (item no. 14), was found to have not been implemented. There was no record of men's involvement in reproductive health programs from 2013 to 2016. No cases of male sterilization or vasectomy were reported during that period. The reason for this lack of participation remains unclear, despite the implementation of Family Development Sessions (FDS) specifically targeting recipients of the government's poverty alleviation program called *Pantawid Pamilyang Pilipino* Program (4Ps), which is a conditional cash transfer scheme.

MDG 4 measures child mortality rates. In the span of three years (2013-2016), there was only one recorded infant death in Dolores. However, the cause of death was not health-related but resulted from an accident. There was also one case of neonatal death, but the mother was not from Dolores, and the delivery took place at a provincial hospital. The Rural Health Unit (RHU) of Dolores was not involved in monitoring this

case since they were not the primary consultant or health service provider for the patient.

The overall number of deaths in Dolores decreased from 75 in 2013-2014 to 65 in 2015-2016. The single recorded infant death accounted for only 1.53% of the total deaths in the same year. This accounted Dolores as a child-friendly town and was awarded the Seal of Child-Friendly Local Governance in 2014. However, the Government Assessment Report of Dolores from 2014-2016 revealed that there was no accredited care facility for children at that time. Nonetheless, a state-of-the-art National Child Development Center has been recently constructed by the local government unit (LGU) as a care facility for children.

Regarding the immunization of children, it was implemented in Dolores, although there was a slight decrease in the number of children receiving immunization. The MHO expressed concerns during the interview about the conflicting goals set by the DOH, which aims to increase both family planning access and the number of fully immunized children. The MHO also highlighted the disparity in figures due to fixed rates set by the DOH for the eligible population of pregnant mothers and children to be immunized. This approach does not reflect the actual population in the area. The MHO emphasized the importance of basing the recipients of services on the real number of eligible cases instead of a fixed rate.

This study further uncovered an important issue regarding the DOH's approach to determining the eligible population for pregnant mothers and children to be immunized. The DOH uses a fixed rate which does not accurately reflect the actual situation on the ground. It is crucial to calculate the recipients of services based on the real number of eligible individuals in the population, rather than relying on a predetermined rate.

For instance, the number of pregnant mothers in Dolores is not determined by the actual number of pregnancies but by a fixed rate set by the DOH, which is 2.7% of the population. The MHO raised concerns about this approach as it, first, the RHU cannot expect 2.7% of the population to be pregnant, and second, it is contradicting to the government's policy of promoting contraceptive family planning. The MHO expressed a strong stance on the matter. The aim is to address this concern since relying on projected population figures rather than actual population figures may hinder the achievement of the goals.

In terms of low-birth infants, there were no cases in 2013-2014, but the number increased to 2 in 2014-2015 and doubled to 4 in 2015-2016 despite efforts to address the issue. Anemic children were not reported in Dolores. The promotion of breastfeeding was also emphasized, with mothers being educated and prohibited from bringing milk bottles or pacifiers when visiting the RHU to encourage breastfeeding.

The data on MDG 4 in Dolores align with the national data in the Philippine Progress report on MDGs. According to the Philippine Statistics Authority MDG Watch Report as of May 2016, the under-five mortality rate decreased from 80 in 1990 to 31 in 2013. The proportion of one-year-old children immunized also increased from 77.9% in 1990 to 91% in 2013.

In order to further ensure the well-being and protection of children in Dolores, a Municipal Ordinance was introduced by Councilor Sesy Seares, who is also the mayor's mother. This ordinance, known as Municipal Ordinance No. 4, Series of 2016, was signed and executed by the Mayor on March 28, 2016. Its purpose is to establish the Children's Code of the Municipality of Dolores, Abra. One of its key provisions is Section 2 (b) of the ordinance which guarantees children's rights to assistance, including provisions for their health, nutrition, education, and protection against abuse, neglect, cruelty, exploitation, discrimination, and other harmful conditions. The ordinance also includes provisions for imposing sanctions against those who violate these rights. Additionally, Section 5 of the ordinance mandates the creation of a Municipal Council for Children, with the Municipal Mayor serving as the Chairman and the Municipal Social Welfare and Development Officer as the Vice Chairman.

For MDG 5, the given indicator was the proportion of women who died due to pregnancy related causes. According to the data provided in Table 1, there were no reported maternal deaths due to pregnancy-related causes from 2013 to 2016. The majority of livebirths occurred in 2013-2014, with 69 deliveries performed

by doctors and 23 deliveries conducted by midwives at home. However, in 2014, a Municipal Ordinance No. 03 was enacted to prohibit homebirths, resulting in a significant decrease to only one homebirth during that period.

In 2014-2015, out of the 70 livebirths, 69 took place in health facilities, with 8 attended by doctors, 1 by a nurse, and 61 by midwives. This constituted 98.5% of livebirths attended by skilled birth attendants and safely delivered inside a health facility.

The Municipal Ordinance No. 03 not only imposed penalties for non-compliance but also acknowledged the role of Traditional Birth Attendants (TBA) in a supportive capacity before, during, and after childbirth. The ordinance emphasized the importance of protecting maternal health and preventing complications such as sepsis. The MHO further narrates that the ordinance almost did not pass the review of the *Sangguniang Panlalawigan,* Abra's provincial legislative board, but his team persisted in defending said provisions as it also aims to protect and promote maternal health. Its implementation contributed to the absence of maternal deaths.

To further promote maternal health and MDG 5, RHU Dolores has implemented the 4D2 program in partnership with the Inter-Local Health Zone (ILHZ) of DOLASAN. The program requires four mandatory pre-natal check-ups, one check-up upon delivery, and two post-natal check-ups, hence 4D2. Mothers are given a card that must be signed by the health attendant during each mandatory consultation. Upon completing all consultations, mothers and their partners receive incentives. This practice, along with providing Philippine Health Insurance Corporation (PhilHealth) coverage for pregnant mothers, is considered a significant accomplishment by RHU Dolores.

The promotion of family planning is another focus of Dolores. The number of mothers undergoing female sterilization (Bilateral tubal ligation) increased from 864 in 2013-2014 to 1,146 in 2015-2016. This may be attributed to the FDS conducted by the RHU as a means of information dissemination. Other family planning methods, such as contraceptive pills, have also been availed by Dolores' mothers. The number of times contraceptive pills were obtained from the RHU increased from 1,616 in 2013-2014 to 2,075 in 2015-2016. These figures indicate an increasing awareness among mothers in Dolores regarding family planning and their growing control over their reproductive health.

RHU Dolores also utilizes a functional Community-Based Monitoring and Information System (CBMIS) to monitor and promote family planning and other reproductive health services. The 4D2 program covers the promotion of maternal child health and nutrition by providing comprehensive pre-natal, natal, and post-natal care for all pregnant women.

For MDG 6, the implementation of health services and programs in Dolores has shown positive results in various areas. In terms of combating HIV/AIDS, there were no reported cases in Dolores due to the Mayor's ban on *videoke* bars and similar establishments. The connection between tourism and the prevalence of HIV/AIDS cases remains unclear, but previous studies (Herold & Van Kerkwijk, 1992) have shown that tourists seeking sexual gratification, particularly in these kind of locations, may contribute to the spread of the virus.

The tuberculosis cases in Dolores increased from 74 in 2013-2014 to 113 in the following year and 209 in 2015-2016. However, only a small number of cases were smear-positive, with 9 identified in 2013-2014, 11 in the following year, and 35 in 2015-2016. Despite this, the Cure and Detection Rate (CDR) remained high at 100% as of 2015-2016, concurred by our visit to the RHU's TB Directly Observed Treatment – Short Course (DOTS) facility.

In terms of access to safe water and sanitary toilets, the proportion of households with level 3 access to improved water supply increased from 670 in 2013-2014 to 717 in 2015-2016. The percentage of households with sanitary toilet facilities also improved, rising from 69.9% in 2013-2014 to 83.15% in 2015-2016. Additionally, the percentage of households with satisfactory solid waste disposal increased from 65.5% to 80.49% in 2015-2016.

The Mayor and the MHO utilized funds from the LGP (Local Governance Program) to provide toilet bowls and cement for selected households to construct their

own sanitary toilets. Other households took the initiative to establish their own facilities. The adequacy and professionalism of health personnel, as well as the role of PhilHealth accreditation, were identified as contributing factors to the successful implementation of services and programs.

The substantial implementation of health services and programs in Dolores promotes better health conditions for the community, aligning with the goal of the UN Millennium Declaration to alleviate extreme poverty and ensure development for all. Improved health conditions lead to increased productivity, income, and a stronger local economy. It also allows for more time with family, better education opportunities for children, and a vibrant community with active engagement in serving others.

## V. THE BUDGET ALLOCATION

Implementing health programs and projects requires a sufficient budget to ensure their development. Adequate financial capacity is crucial for promoting health, including providing necessary drugs, medical expenses, and other healthcare services. The budget allocation for achieving the Millennium Development Goals (MDGs) in Dolores municipality is summarized in Table 2. It reveals a decrease in the allocated funds over the years, which raises concerns among healthcare workers about the availability of essential resources such as clinical equipment and emergency vehicles.

Table 2. Source of Funds for Health Budget of LGU Dolores

| PROGRAMS / SOURCE OF FUNDS | 2013-2014 (Php) | 2014-2015 (Php) | 2015-2016 (Php) | NON-LOCAL BUDGET SOURCES (one-time grant; estimated in Php) |
|---|---|---|---|---|
| Goal No. 4 | 459,500 | 432,000 | 410,000 | DOH PhilHealth, JICA, ILHZ |
| Goal No. 5 | 105,000 | 96,500 | 96,500 | DOH, PhilHealth, JICA, ILHZ |
| Goal No. 6 | 599,000 | 405,000 | 345,000 | DOH, PhilHealth |
| Health Facilities & Development | 1,930,000 | 190,000 | 190,000 | DOH-NFEP (P 1.5 M; P 1M) PhilHealth (P 1.712 M), JICA (P 1M), PCSO (P 990,000) |
| Other Programs | 57,000 | 33,500 | 33,500 | - |
| | 3,150,500 | 1,157,000 | 1,075,000 | - |
| Municipal Budget for Health | 3,176,727 | 2,941,878 | 1,460,469 | PHO (240,000), DOH (P 1.15 M; P 192,000) |
| Annual Investment Program | 80,750 | 58,817 | 24,775 | - |
| GRAND TOTAL | 6,407,977 | 4,157,695 | 2,560,244 | 9,846,000 |

However, despite the budgetary decrease, the quality of services and programs in Dolores has remained consistent and even improved. This is due to the support received from non-governmental organizations (NGOs) like Japan International Cooperation Agency (JICA) and other government agencies such as the DOH, PhilHealth, and Provincial Health Office (PHO). These external sources of funding have helped to sustain the healthcare initiatives in Dolores.

Table 2 also highlights the agencies that have assisted the local government unit (LGU) in each specific area of the MDGs. For instance, the DOH has played a

significant role in immunization programs and the provision of medical supplies. JICA has contributed birthing equipment, while PhilHealth has provided insurance coverage for medical costs. These collaborations have greatly supported the attainment of MDGs 4, 5, and 6.

The DOH and other organizations have also contributed to the development of health facilities in Dolores. Funding has been allocated for the rehabilitation of the RHU building, as well as the procurement of equipment and vehicles. The Philippine Charity and Sweepstakes Office (PCSO) and PhilHealth, for example, have donated an ambulance and a service vehicle for the RHU. These investments in infrastructure and resources amount to a total of PHP9,846,000.

To ensure that health receives sufficient funding, the DILG has set a standard requiring at least 15% of the LGU's general budget to be allocated for health. However, it seems that the Annual Budget Plan for Health in Dolores contradicts this requirement, as indicated by the MHO.

Furthermore, the national government, in accordance with the Constitution, has the responsibility to protect and promote the right to health of the people. Article 13 emphasizes the need for an integrated and comprehensive approach to health development, with essential goods and services made available at affordable costs. LGU Dolores, with the support of the national government, has established equitable access to health services for its constituents through the Universal Healthcare program and the accreditation of the RHU.

The partnership between Dolores LGU and private/public agencies, such as JICA, has also contributed to the implementation of health programs. This collaboration has resulted in the availability of necessary equipment and resources. Additionally, the involvement of the community through organizations like the Tricycle Operators Drivers Association (TODA) has enhanced the provision of emergency transport services.

The funding of the health programs in Dolores have had positive outcomes. Child mortality has been reduced, with no reported deaths due to lack of medicines or health services. Maternal health has improved through the provision of equipment and incentives for pregnant mothers. The prevention and treatment of diseases like tuberculosis and HIV/AIDS have been prioritized, leading to zero cases in Dolores. These achievements have not only benefited the health of the community but also have potential economic advantages.

## VI. THE POLITICS OF THE LOCALIZATION

Executive-Legislative Relations. The Local Government Code of 1991 was somehow already clear about the mandate of the local governments in delivering healthcare services for their constituents. However, the execution of these mandates does not solely rely on budget allocations but also in the political will and support of the Local Chief Executive. In 2010, the people of Dolores placed their faith in a young candidate named JR Seares, who, despite coming from a political clan, brought a fresh perspective to the table. Having previously studied medicine in Manila, Seares emerged victorious in a landslide victory against his own uncle, the incumbent mayor. With his election, a new era began for Dolores, one that held the promise of transformative change in the healthcare sector.

Seares assumed office with limited resources at his disposal. The Municipal Health Office, led by a midwife, operated out of a cramped space, underscoring the pressing need for improvement. Undeterred by these constraints, the young mayor made a solemn commitment to prioritize the development of the local health center. However, it soon became apparent that the power to effect change in the local government system did not rest solely in the hands of the mayor.

The decentralization of democratic reforms to local governments following Martial Law introduced a separation of powers between the local *Sanggunian* (municipal council) and the local chief executive. However, a potential issue arises when the Sanggunian and the mayor's office are occupied by individuals from rival political parties. In an interview, the mayor explained his approach:

*"When I ran for Mayor in 2010, I asked my mother to run as well so that I would have an ally. She was a unifying force. In the 2007 election, two of my allies were successful. In 2010, we had four allies, followed by seven in 2013, and six in 2016. Although they retired after each election, we still maintain a strong relationship with the legislative body. Our processes run smoothly, which surprises other areas that struggle to secure funding due to a lack of like-mindedness between the Vice Mayor and Councilors. Fortunately, we don't have such problems here. Even if the councilors are not our allies, we engage in open communication with them.. If they refuse to sign an ordinance, I am prepared to [expose] them to the public..."*

This was mentioned in the previous discussions how the mayor's mother, Councilor Sesy Seares filed one of the pieces of legislation needed to localize these goals. In order to implement the desired reforms, the mayor recognized the need for a positive relationship with the local *Sanggunian* counting on his own mother as an ally thus running for councilor. The mayor believed that a stable working relationship between the mayor's office and the local *Sanggunian* was crucial for the success of the reforms.

A study conducted by the Health Evidence Network (HEN) in 2005 emphasized the importance of political support in terms of resources and public backing for public health interventions. This support included enacting legislation and ensuring its enforcement.

Establishing a harmonious relationship with the local *Sanggunian* allowed the LGU and Seares' leadership to develop key frameworks, policies, and ordinances to support their programs and achieve the MDG targets. Some of the ordinances passed by the *Sanggunian* included the Anti-Home birthing Ordinance, aligned with MDG 4 to reduce child mortality, and the Children's Code of Dolores, aligned with MDG 4 as well.

To discourage home births, the LGU not only prohibited such practices but also provided incentives to encourage mothers to deliver their babies in a sterile and safer environment, such as the RHU. The LGU closely monitored the locations and status of pregnant mothers with the help of local gossipers, enabling municipal nurses to track, monitor, and assess their conditions. It was mandatory for the RHU to arrange for ambulance transportation for mothers close to their expected delivery date and provide nursing care during childbirth. This commitment was part of the LGU's 4D2 program, which included four mandatory prenatal check-ups, one delivery check-up, and two mandatory postnatal check-ups. Mothers were provided with a handbook containing essential information on maternal health and child care, as well as a 4D2 card to be signed by attending healthcare professionals during the consultations.

Local-Provincial relations. To create an institutionalized primary healthcare requires not only political support from the municipal level but also from the provincial government. The provincial government was headed by then Governor Eustaquio P. Bersamin, who was a former ally of the Seares-Luna clan from 2007 until their political breakaway 2010. The alliance was broken with the emergence of the Valera-Bernos clan which the Bersamins shifted alliance with, however, the Seares of Dolores maintained amicable political alliance with the Bersamins. Mayor Seares of Dolores and Governor Bersamin were able to maintain professional relationship.

The Inter-Local Health Zone (ILHZ) was sought and lobbied by LGU Dolores to coalesce an aggregate of the local health systems of Dolores with its two neighbors, the municipalities of San Juan and Lagangilang forming DOLASAN. However, its creation required support from the provincial government, either through a provincial ordinance or an Executive Order signed by the governor. In this case, the provincial government opted for the latter and created the first ILHZ in the province through Executive Order No. 12, series of 2012. The ILHZ Board, chaired by Seares and co-chaired by the mayors of San Juan and Lagangilang, was subsequently formed. The ILHZ serves as a cooperative agency among the three municipalities and collaborates with the provincial government to implement health policies, services, and programs in the area. Board members do not receive compensation, and the ILHZ's funding is derived from contributions of P100,000 from each of the three member-municipalities, with an

additional annual allocation of P100,000 from the provincial government to support its operations.

According to the ILHZ Secretary, Mr. Jason Celeste, the inspiration for creating the ILHZ came from his training sponsored by the LGU and the Japan International Cooperation Agency (JICA) in Japan. He explained that the concept of an Inter-local Health Zone had existed since the 1980s but was not fully realized until JICA revived it. JICA provided equipment and funded trainings for the RHUs in exchange for the formation of an ILHZ. The Secretary emphasized that the ILHZ's focus initially centered on achieving MDGs 4 and 5, particularly in maternal and child health. Activities unrelated to these goals were set aside. The collaborative effort and non-partisan approach of the LGUs, disregarding political affiliations, were key factors in the ILHZ's progress and success, showcasing their decisive political will.

In the official website of the DOH, an ILHZ is defined to be a coordinated arrangement of health providers and facilities, including primary health providers, referral hospitals, and end-referral hospitals, working together to serve a specific population within a local geographic area that falls under the jurisdiction of multiple local governments. ILHZs are established to protect the collective health of communities, ensure access to necessary healthcare services, and manage limited health resources more effectively and fairly. It is important for existing ILHZs in the country to strengthen their operations and maintain their functionality. Regardless of their organizational structure, whether formal, informal, or initiated by the DOH, the ultimate goal is to make each ILHZ functional so that it can fulfill its purposes and tasks. One of the main programs of the ILHZ that was cascaded and is being practiced by Dolores is the 4D2 program. A program that is not only enjoyed by Dolores but by its neighboring municipalities.

## ANALYSIS AND CONCLUSION

This study provides a general outlook of local health governance where goals are aspired globally but acted locally, where international commitments meet local results. Optimal outcome and results are only possible when politics function not for private interests but for common good. Based on the findings and lessons of this study, this study further concludes that it is possible for international agreements to be realized by the rural and remote areas of the world only if the following factors exist: (1) decentralized and coordinated national to local commitment; (2) strong political will and commitment by the local implementing bodies; and (3) political security of the leadership.

The discussions in this study focus on the decentralization of commitments from the national level to the local level. These commitments originated from the signing of the millennium declaration and were subsequently incorporated into national policies, which mandated the national government to implement and fulfill these commitments. The presence of both executive and legislative frameworks at the national level is a result of the institutional structure established by the government under the 1987 constitution, which ensured the transfer of health-related powers to local governments through the LGC of 1991. This framework has facilitated local governments in developing their strategies to fulfill these commitments. Therefore, there is a solid politico-legal foundation and guidelines in place for both national and local governments to adapt and implement these global goals at the local level.

This is aligned with the findings of Atienza in 2004, where she mentioned that the devolution of power in the Philippines was influenced by factors beyond democratization. While there have been positive changes resulting from devolution, not all goals of the reform have been achieved. People's participation and the socioeconomic-political environment are crucial for improving local health services. Sustaining the progress in health service delivery requires attracting external resources, which in the case of Dolores, are those from JICA, private partners, and governmental agencies like DOH, Philhealth, and PCSO. The commitment of local leaders, exemplified by Mayor Seares and his team, as well as the Municipal Health Officer (MHO) and Rural Health Unit (RHU), is vital in implementing effective and responsive health programs and services in Dolores.

While Atienza recognizes the improvements of local healthcare systems under devolution, she also recognizes that it is not a guarantee of improvement in

the delivery. She cited that the politico-legal framework of the national-local commitment to localize health-related MDGs lacks in form and substance in providing guidelines in terms of personnel, their benefits, facilities, and the politics, which this study has addressed. This study has proven Atienza's study and provided that these issues cannot be addressed by national-local politico-legal frameworks *per se* but requires strong political leadership and commitment (2004).

The commitment and determination of the local chief executive in Dolores, as well as their medical background, have proven that low-income municipalities can enhance their healthcare services. This aligns with Atienza's (2004) study in Irosin, Sorsogon province, which emphasized that financial limitations should not hinder healthcare improvement. Despite being a fifth-class municipality, Dolores has successfully achieved an adequate number of skilled health personnel, implemented and provided necessary healthcare infrastructure and facilities, and executed various health services and programs. This challenges the common notion among politicians that inadequate funding is a valid excuse for poor performance. The significant progress in Dolores' local health performance from 2013 to 2016 demonstrates that budgetary constraints cannot justify incompetence.

Atienza's (2012) recommendations emphasize the importance of addressing financial and governance issues to effectively localize MDGs. This can be achieved through innovative fiscal administration, involving non-governmental and private partners, and ensuring political stability in leadership. By establishing a secure executive-legislative alliance and fostering professional relationships between municipal and provincial politics, strong advocacy for governance reforms can be guaranteed.

Political will plays a crucial role in driving changes and implementing positive reforms. However, political security is necessary to establish and maintain political will. Former San Fernando City, La Union Mayor Maryjane Ortega supports this notion, stating that political will can only exist when there is political security (Aceron. 2007). This perspective is also evident in the case of Mayor Seares, who encouraged his mother to run as a councilor to ensure harmonious relations between his office and the local government and maintained professional working relations with governor Bersamin despite their families' political breakup. The Mayor understood that minimizing resistance was essential for achieving his goals in transforming Dolores. While this approach may raise concerns about misuse of power and undermine democratization, it is legally permissible and politically celebrated when used for positive reforms.

The case of Dolores highlights that amicable relations between executive and legislative departments accelerate efforts of the local government in localizing the goals. Political security precedes political will, and this requires securing alliance with provincial or even national patrons and along with it, a consistent shared agenda to guarantee results in each sphere

Finally, this study provides a perspective that the politics of localizing international goals is functionalist in nature, meaning, it requires all actors and factors to be synchronized and have to function in unison, uniformly with same approach and direction from global to local, from public to private, from formal institutions to civil societies, and to every branch of government and institutions, from policy to budget, from law to execution, from patient to doctor. Like one living organism, every actor have a role and everyone must function, and each function according to support or opposition, and that is how we can characterize and judge a functional, healthy, and good government.

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