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The Politics of Collaborative Governance in Local Health Promotion in the Philippines: Determinants, Risks, and Institutional Reforms

Abstract

Public health promotion at the local level is a critical yet often overlooked aspect of health governance in the Philippines. While health promotion initiatives have been studied, there is limited empirical analysis on how local governance structures, political dynamics, and institutional coordination shape health promotion implementation at the local level. Given the decentralized nature of health governance in the country, frontline health workers, local officials, formal and informal institutions play a pivotal role in health promotion. Yet, their actions are often constrained by transaction costs and political disincentives.

Building on the Institutional Collective Action (ICA) framework and the Political Market Framework, this paper tackles the factors shaping collaborative governance in health promotion by local government units (LGUs). Specifically, it raises the questions: What are the factors impeding collaboration among health promotion stakeholders at the local level? How do coordination, division, and defection risks shape day-to-day implementation? What formal and informal reforms have been adopted to mitigate those risks?

A qualitative study is employed using Malabon City as a case study. Key informant interviews, focus group discussions, and policy document review provide qualitative insight into the governance dynamics across 21 *barangays* constituting the smallest administrative units in the Philippine governance system.

Findings reveal that: (i) ambiguous mandates and overlapping roles inflate negotiation, monitoring, and enforcement costs; (ii) partisan gatekeeping turns health promotion benefits into club goods, producing spatially and politically uneven service access; and (iii) informal networks and social capital of *Barangay* Health Workers (BHW) partially substitute for formal mechanisms but remain vulnerable to electoral turnover. Where transaction costs are minimized – e.g., through ordinances institutionalizing Health Promotion Units, pooled budgeting for multi-*barangay* health centers, and merit-based BHW tenure – collaboration gains stability and scale.

Keywords:
collaborative governance; local health systems; Barangay health promotion; Insitutional Collective Action (ICA); Transaction-cost politics; decentralization

Introduction

Health promotion is defined by the World Health Organization as "the process of enabling people to increase control over, and to improve their health" (Nutbeam & Muscat 2021, p. 1580). It is a population-based health service that hinges on the social, economic, and environmental determinants of health (Amit et al. 2022; DOH 2022). The Ottawa Charter situates health promotion within five interlocking action areas, two of which—i.e., "building healthy public policy" and "creating supportive environments"—demand a whole-of-government collaboration that extends well beyond the formal health sector (Kickbusch 2010; Wilberg et al. 2021). Because these domains intersect with other policy spheres, their success depends on sustained inter-sectoral cooperation (Allender et al., 2012). Collaboration may falter due to fragmented authority, resource constraints, uneven capacity, and competing bureaucratic or political agendas (Jansson et al., 2011).

These challenges are particularly acute in the Philippines. Since the enactment of the 1991 Local Government Code and the 2019 Universal Health Care (UHC) Act, primary care including health promotion has been devolved to more than 1,600 local government units (LGUs) and over 42,000 *barangays*, the country's smallest political jurisdictions (Diokno-Sicat et al., 2020; Liwanag & Wyss 2020). Although decentralization aims to localize decision-making, it has also generated high degrees of policy divergence, variable implementation, and multi-layered authority gaps (Capuno, 2012). *Barangays*, in particular, differ sharply in fiscal autonomy, technical capacity, and leadership quality, such that frontline health promotion is conditioned less by national standards than by local political dynamics (Langran, 2011; Layug et al., 2009; McCollum et al., 2018).

The Mandanas-Garcia Ruling of the Supreme Court in 2019, which enlarged LGUs' shares of national revenue, has intensified these dynamics. Larger fiscal transfers open the space for city- and *barangay*-led innovation, yet simultaneously magnify political discretion over health priorities, widening disparities in program reach and quality. Although technical guidance exists at national level, on-the-ground governance of health promotion remains precarious, shaped by discretionary leadership, informal arrangements, and shifting partisan alignments (Bertone et al., 2018; Leinonen & Syväjärvi, 2022).

At the frontline stand the *Barangay* Health Workers (BHWs), accredited community volunteers who connect residents to formal health services and spearhead local campaigns (Baliola et al. 2024; Fernandez, 2015; Mallari et al. 2020). Their effectiveness to perform these roles depends on dense, but often fragile, ties linking city health officers, elected officials, civil-society groups, and national regulators (Baliola et al., 2024; Taburnal, 2020). These ties can be compromised when there are coordination failures, disputes over the division of benefits and costs, and defection from commitments. Efforts to address these collaboration risks can be curtailed by transaction costs or hazards, such as information asymmetry, credibility gaps, and free-riding, thereby undermining the continuity and coherence of local health promotion programs (Curley et al., 2023; Dixit, 1998; Feiock, 2013, 2023; Kneale et al., 2019; Lacuesta, 2023; Lilly et al., 2023).

Many *barangays* lack the institutional mechanisms, incentives, or strategic guidance required for sustained collaboration (Manuel, 2024). Responsibility often overlaps or blurs across actors, particularly where mandates are not clearly institutionalized or legally codified. This ambiguity creates a *de facto* need for both functional and inter *barangay* coordination, yet cooperation remains largely ad hoc, brokered through personal ties, political discretion, or short-lived agreements that shift with electoral cycles (Layug et al., 2009). In this vacuum, local health promotion is frequently delivered through informal workarounds driven more by visibility or administrative convenience than by public health logic.

These tensions are vivid in Malabon City, a politically complex LGU in Metro Manila with roughly 365,525 residents, 21 *barangays*, and a corresponding network of *barangay* health centers, including four "super health centers" located in the city's largest *barangays* that function as expanded primary-care hubs rather than standard health centers (Malabon CPDD, 2020). Although each *barangay* technically has a designated health center, the city's

governance dynamics—ranging from inter-office bargaining and resource asymmetries to political alignment and institutional weaknesses—shape the actual implementation capacity at the community level. Actor dynamics across city offices and *barangays*, together with uneven technical support, discretionary leadership, and fragmented accountability structures, impose a structural imperative for coordination. In the absence of standardized coordination mechanisms, duplication, uneven implementation, and partisan gatekeeping proliferate, producing wide disparities in preventive health delivery. City-level decisions on budget allocation, personnel deployment, and program prioritization cascade into *barangay* operations, intensifying the misalignments between formal mandates and on-the-ground practice.

This study uses Malabon as a case to explore how collaboration in health promotion is shaped by political incentives, administrative structures, and the transaction-cost logics embedded in *barangay*-level governance. Combining the Institutional Collective Action (ICA) framework with the Political Market Framework, the paper shows how fragmentation, electoral incentives, and inter-office bargaining constrain collaborative health promotion at the local level. The ICA framework highlights how risks of coordination, division, and defection escalate in fragmented and politically autonomous settings, whereas the Political Market Framework explains why both elected and technical actors, facing low-powered incentives and agency constraints, often eschew long-horizon, low-visibility investments in local health promotion (Bae and Feiock, 2013; Deslatte et al., 2016; Feiock, 2023; Feiock and Kim, 2021; Kim et al., 2022). Accordingly, this paper raises the following questions: What are the factors impeding collaboration among health promotion stakeholders at the local level? How do coordination, division, and defection risks shape day-to-day implementation? What formal and informal reforms have been adopted to mitigate those risks?

By examining the political, institutional, and relational dynamics underlying collaborative health promotion, this study contributes to the evolving discourse on decentralized health governance, particularly in low- and middle-income country contexts. It also enriches theory-building by embedding political-market dynamics and informal institutions into the ICA framework, demonstrating how coordination costs are not merely administrative but evidently political. Empirically, it examines the organizational, fiscal, and electoral barriers to institutionalizing prevention while identifying reform pathways emerging from within the system. Recentering the *barangay* yields three contributions: elucidating how transaction costs and ICA dilemmas shape inter-*barangay* cooperation; integrating political-market logic into ICA analysis; and distilling pragmatic reforms for politically adaptive, administratively realistic collaboration.

The next section presents the analytical framework guiding this analysis and the study's methodology, followed by six theory-driven propositions grounded in empirical evidence from the Malabon case study. The final sections discuss policy and institutional implications and conclude with directions for further research.

Analytical Framework

This study employs a theoretical lens that integrates the ICA Framework and Political Market Framework to analyze collaborative governance challenges in local health promotion. It situates collaboration risks and political dynamics within the broader context of health governance.

Structural Determinants of Health Governance

The structural determinants of health governance help explain why collaboration is not only difficult but also necessary (Trounstine and Goldman-Mellor, 2024). According to the World Health Organization (2022), structural determinants include the institutional and political conditions that shape health equity, access, and delivery (Marmot et al., 2008). In a devolved system, decision-making authority rests not only with the Department of Health of the national government but also with local executives, councils, and frontline implementers (Ruiz and Brillantes, 2020).

When local governance structures are weak, unclear, or heavily politicized, health promotion becomes vulnerable to fragmentation and episodic

implementation. Structural determinants theory thus illuminates the power struggles and institutional bottlenecks, and rule-based constraints that shape actors' capacity and willingness to collaborate on preventive health initiatives (Carr, 2015; Carr & Karuppusamy, 2008). It provides the backdrop against which ICA dilemmas and transaction costs play out, demonstrating that collaboration failures are embedded in broader governance architectures, not merely in interpersonal mistrust or individual reluctance.

Health promotion exhibits the characteristics of a public good. Its benefits, such as reduced disease incidence, improved health behaviors, and better community well-being, are non-excludable, especially in the long term. However, in resource-constrained settings like Malabon, health promotion also exhibits partial rivalry: limited manpower, funding, and airtime for campaigns can mean that one *barangay*'s access may reduce another's.

These conditions generate significant externalities (Feiock & Kim, 2021). When *barangays* operate independently, efforts may be duplicated, messages fragmented, and city-level resources overstretched. The absence of formal mechanisms for pooling resources, sharing information, or synchronizing schedules produces inefficiencies that affect not only campaign effectiveness but also public trust in health services (Feiock, 2013; Kim, 2021).

Because the benefits of health promotion are collective and accrue over long horizons, there is a persistent incentive to free-ride. A *barangay* may delay or downscale its own initiatives, anticipating spillover benefits from campaigns led by neighboring units or the city government. In the absence of institutionalized rules or incentive systems that reward contribution and penalize defection, voluntary cooperation becomes the exception rather than the norm.

Public goods theory therefore strengthens the rationale for coordinated action in health promotion. It underscores the need for institutional designs such as shared funding pools, joint planning platforms, and cross-*barangay* performance metrics, that mitigate free-riding, align incentives, and internalize positive spillovers across *barangays*. In a setting like Malabon, where institutional capacity and political dynamics vary sharply across communities, such designs are central to moving health promotion from discretionary, episodic activity toward a more stable and equitable system of collaborative governance.

Institutional Collective Action (ICA) Framework

The Institutional Collective Action (ICA) framework, developed by Feiock (2009; 2013; 2023), provides a lens for understanding the fragmentation of authority and coordination dilemmas among local governments. ICA Framework explains how collaboration becomes difficult when institutions and actors—such as *barangays* in the Philippines—are institutionally independent, have overlapping mandates, and lack an effective enforcement structure. In the context of *barangay* health promotion, each unit operates semi-autonomously, often without standardized policies or formal channels for inter-*barangay* coordination and *barangay* health promotion implementation. Fragmented authority leads to coordination risks (mismatched goals and timelines), division risks (unequal sharing of costs and benefits), and defection risks (withdrawal from commitments) (Feiock, 2013; Kim et al., 2022; Song, 2020; Steinacker, 2010). These risks are magnified in dense urban systems, such as Metro Manila, where some LGUs have multiple *barangays* sharing a single health center but operating under different leaderships and political alignments, or where local health promotion remains heavily dependent on the political discretion and direction of city-level officials.

In the absence of shared accountability platforms, informal mechanisms such as personality-driven agreements or campaign-based alliances, tend to substitute for institutionalized collaboration(Manuel, 2024). While these arrangements can temporarily bridge gaps, they are fragile and highly sensitive to leadership turnover and partisan shifts. This institutional fragility limits the sustainability, equity, and coherence of health promotion, particularly when collaborative efforts depend on voluntary compliance rather than codified obligations.

Political Market Framework

While the ICA framework explains collaboration risks inherent in fragmented governance, it pays

limited attention to the political economy shaping actor incentives and behaviors. The PMF addresses this gap by emphasizing that political actors navigate a marketplace where power dynamics, strategic uncertainty, and electoral payoff play a crucial role (Curley et al., 2023; Dixit, 1998).

Originating from the work of Dixit (1998) and further developed by Steinacker (2004) and Curley et al. (2023), transaction-cost politics posits that actors, whether elected or technical, make governance decisions under conditions of bounded rationality, incomplete information, and strategic uncertainty. Moreover, transaction costs in the political realm—such as lobbying for support, negotiating contentious policies, ensuring credible commitment, and managing reputational risks—heighten the complexity of effectuating governance reforms (Steinacker, 2004; Cruz, 2015). Political alliances, patronage, and competition influence collaboration opportunities, leading to selective service provision based on partisan lines (Feiock, 2009).

In *barangay* governance, collaboration incurs high transaction costs: actors must identify reliable partners, negotiate agreements, and monitor compliance, often without institutional support (Cruz, 2015; Williamson, 1985). For elected *barangay* officials, health promotion offers limited electoral payoff: its outcomes are long-term, diffuse, and difficult to attribute (Dixit, 1998; Frant, 1996; Horn, 1995). Unlike infrastructure or relief goods, its visibility is low, reducing its value in patronage-based and personality-driven political competition.

Integrated Theoretical Lens

The analytical framework is used conceptually to organize relationships among governance, political market dynamics, collaboration risks, and collaborative outcomes. Figure 1 below shows that collaborative governance of local health promotion is affected by systemic and localized factors. The structural determinants are contextual factors that create the backdrop for fragmented authority and governance challenges in local health promotion. These factors likewise affect the incentives, electoral fortunes, and transaction costs that local actors face. Overall, these structural determinants shape the collaborative governance outcomes of local health promotion; however, collaboration risks and political dynamics can play a critical role in defining that relationship.

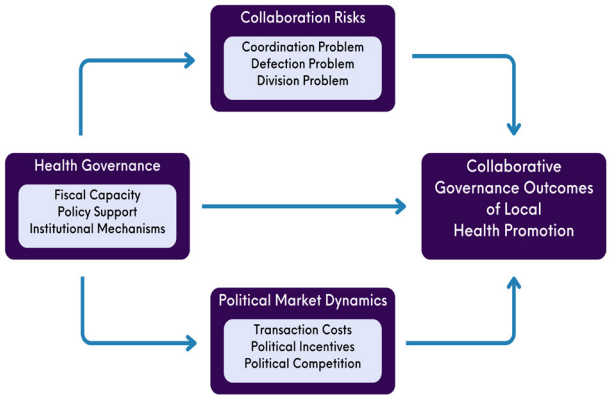

Figure 1. Analytical Framework

Source: Author

Method

The study collected data from key informant interviews, focus group discussions, and policy document analysis in Malabon City, using the *barangays* as units of analysis. Respondents were selected using a combination of purposive and snowball sampling to ensure a diversity of perspectives across political actors, technical personnel, and frontline health workers. These included *Barangay* Health Workers (BHWs), Health Education and Promotion Officers (HEPOs), *barangay* officials, City Health Office personnel, and former program implementers.

Interviews and discussions were transcribed verbatim and coded thematically using MAXQDA. Coding followed a two-tiered strategy: an initial open-coding process to identify emergent themes, followed by theory-driven axial coding aligned with the Institutional Collective Action (ICA) and Political Market Framework. Particular attention was given to quotations that illustrated governance behaviors, collaboration risks, and incentive structures.

Discussion and Analysis

The implementation of collaborative health promotion at the *barangay* level in Malabon City reveals a complex interplay of institutional, political, and administrative forces that shape how local actors engage in, or withdraw from, collective action.

Drawing on the Institutional Collective Action (ICA) framework and Political Market Framework, this section presents six propositions that illuminate the specific barriers, risks, and enablers encountered by health actors in their attempts to operationalize inter-*barangay* cooperation and program continuity. Each proposition reflects an empirically grounded insight into how collaboration dilemmas, incentive structures, and institutional ambiguity influence day-to-day decision-making, revealing both the adaptive strategies of local actors and the systemic constraints they must navigate. Through these propositions, the paper unpacks how health promotion, as a public good with diffuse benefits and low political visibility, becomes vulnerable to institutional inertia, selective participation, and governance fatigue, yet also offers avenues for reform through localized innovation and relational leverage.

Proposition 1. Informal networks and social capital compensate for the absence of formal collaborative mechanisms in *barangay*-level health promotion. However, these networks are politically contingent and vulnerable to exclusion.

In the absence of institutionalized structures to coordinate health promotion across *barangays*, local implementation often depends on informal collaboration among health workers, local officials, and community actors. These informal networks —rooted in shared social capital, neighborhood proximity, and mutual trust—form the *de facto* infrastructure of collaboration in many parts of Malabon City. BHWs, in particular, leverage their embeddedness in the community to sustain health initiatives despite limited technical and political support. Their intrinsic motivation, which is grounded in their other-regarding care for their neighborhoods and grassroots credibility, sustains continuity in health teaching and community engagement. As one BHW noted:

> *"Usually kasi ang BHW, nakatira doon sa community na 'yun. So may thinking na aayusin ko 'yung trabaho ko kasi community ko 'to... hindi lang 'yung mga kamag-anak ko pati 'yung mga kasama ko sa community."*
>
> (Usually, the BHWs reside within the communities they serve. So, they wanted to do their jobs well because they are serving their community. Working well would mean it would benefit not just their relatives, but also the rest of the community.)

Yet while these networks reduce coordination costs and enable spontaneous collective action, they are also highly contingent on political alignment. Informal systems lack protection from political interference. In *barangays* where BHWs are perceived to be allied with a former *barangay* captain or opposing political faction, they may be removed or replaced after elections. Political realignments thus fragment the informal governance landscape, undermining trust and continuity. As one respondent put it:

> *"Kapag hindi kaalyado, tatanggalin."*
>
> (If an employee is not a crony or does not politically align with the current administration, he/she will be removed from service.)

This vulnerability reflects the absence of credible commitment mechanisms, where there are no institutional safeguards to prevent the politicization of collaboration (Cruz, 2015). What initially appears as flexible and low-cost coordination becomes fragile in the face of electoral shifts and adversarial local politics. Moreover, from the perspective of transaction-cost politics, these dynamics generate relational costs: actors cannot predict whether today's collaborators will be tomorrow's rivals. Informality may reduce entry barriers for cooperation, but it provides no protection from exclusion when political priorities change (Langran, 2011; Liwanag and Wyss, 2018). Thus, while informal community networks serve as essential substitutes for institutional collaboration, their long-term viability is undermined by the volatility and factionalism of *barangay*-level politics.

Proposition 2. Collaborative governance is undermined by steep transaction costs produced by unclear mandates, overlapping roles, and weak institutional scaffolding.

In Malabon, the implementation of health promotion faces persistent structural ambiguity.

Roles and responsibilities are loosely defined across multiple actors, including *barangay* captains, local health personnel, City Health Office staff, and Health Education and Promotion Officers (HEPOs). While the Universal Health Care (UHC) Act widened the mandate for health promotion, it failed to codify clear governance arrangements at the *barangay* level, leaving the responsibility to the cities and municipalities. This institutional vagueness generates coordination breakdowns, delays, and strategic avoidance behaviors. As one HEPO recalled in an interview:

> *"Hindi pa malinaw sa amin 'yung aming trabaho bilang mga HEPO… nagulat na lang kami, HEPO na kami."*
>
> (Our job responsibilities as HEPOs were not clear to us. We were surprised that we were suddenly part of the HEPO team.)

This lack of clarity has led to overburdened workloads and blurred chains of command. A medical officer from the City Health Office expressed frustration with the sudden expansion of tasks:

> *"Sobrang dami na naming ginagawa, pati pala 'yun, mapupunta din sa amin."*
>
> (We were already doing so much, and we did not expect that we also have to handle HEPO matters.)

In some cases, HEPO roles are treated as informal add-ons to existing duties, with no additional compensation or training. Technical actors, including health education and promotion officers, city health officers, and *barangay* health workers, operate under multiple constraints: they face unclear mandates, lack of compensation for cross-*barangay* work, and political pressures from superiors. In such an environment, they frequently choose token compliance or symbolic participation over substantive engagement (Cruz, 2015). Rather than resolve role ambiguity, many actors deflect responsibility to subordinates or frontline volunteers. Political alliances, rather than program logic, often dictate who collaborates with whom, as actors weigh risks of failure, blame, and reputational damage (McCaffrey & Salerno, 2011).

This reflects what the ICA framework identifies as a defection risk, where the absence of formal rules and enforceable mandates deters actors from assuming responsibility (Feiock, 2013). The problem is further compounded by the strategic behavior of technical actors navigating their overspilling responsibilities. As one doctor observed:

> *"We're doctors… Ubos oras 'yan for us, instead of doing our jobs saving lives."*
>
> (We are doctors… That [taking on HEPO responsibilities] would take too much of a time for us, instead of doing our jobs saving lives.)

Here, the implementation burden is pushed downward, especially when performance metrics prioritize clinical service over preventive work (Storm et al., 2011). According to Dixit's (1998) theory of transaction costs, low-powered incentives disincentivize public actors from engaging in long-term, high-coordination efforts like health promotion. From the vantage point of actors navigating a complex political marketplace, health promotion becomes a "hard sell": it requires high effort, has low visibility, and is highly exposed to blame when outcomes are disappointing. Therefore, what appears as administrative dysfunction is a rational response to uncertain mandates, weak incentives, and punitive political contexts. Until institutional scaffolding is strengthened—through formal role delineation, performance-linked incentives, and cross-level coordination protocols—*barangay* health promotion will remain fragmented, personality-driven, and prone to governance drift.

Proposition 3. The politicization of agenda-setting distorts health promotion priorities, favoring visible service delivery over institutional reforms that are harder to politicize.

One of the most significant constraints to institutionalizing health promotion at the *barangay* level lies in the nature of local political incentives. In practice, elected officials, including city councilors, *barangay* captains, and even some department heads, are more likely to support programs that yield

immediate, visible returns to their constituencies (Frant, 1996). Community outreach events, medical missions, or distribution drives offer short-term visibility that can be translated into votes, whereas more systemic reforms, such as formalizing BHW roles, funding HEPOs, or institutionalizing *barangay*-level health units, remain neglected (Dixit, 1998). A health staff member recounted:

> *"Kung masipag talaga ang City Councilor for Health, marami sanang maipapasok na ordinansa kaso wala e… ramdam mo agad sa simula pa lang na hindi susuportahan kasi walang pakinabang politically for them."*
>
> (If the City Councilor was hardworking for Health, there would have been many Ordinances passed. Sadly, she was not…you can feel from the start that she would not be supporting the sponsorship of ordinances as she would not get anything from it, politically.)

This reflects what the Political Market Framework (PMF) describes as a situation of low voter salience: institutional reforms are less likely to influence electoral outcomes because citizens do not directly perceive or attribute value to back-end governance improvements. As a result, rational political actors deprioritize these reforms, focusing instead on programs that maximize their political capital (Curley et al., 2023; Deslatte et al., 2016; Feiock and Kim, 2021).

Moreover, health promotion policies often fail to reach the *Sanggunian* (council) floor, not due to opposition in substance, but due to the transaction costs of political lobbying, the absence of policy champions, or the reluctance of actors to expend effort on issues that do not have political payoffs (North, 1990). The lack of resolutions to institutionalize BHW Ranks, to support the implementation of the Special Health Fund, or assign dedicated HEPOs at the *barangay* level reflects these political disincentives (Carr, 2015). As another informant noted:

> *"S'yempre uunahin mo [ang] political, 'di ba? Kahit iniisip mong work lang ito... hahaluan mo ng politika."*
>
> (Of course, you will always choose and prioritize the needs od the political and elected officials. Even if you think that this is just work, at the end of the day, everything about LGU work is political.)

The transaction-cost politics perspective explains how uncertain returns, complex negotiations, and diffuse accountability make institutional reforms particularly vulnerable to neglect. Instead of pursuing collective efficiency, actors respond to short-term political calculus, contributing to a persistent implementation gap in local health promotion.

Thus, the failure to institutionalize health promotion is not merely a matter of resource scarcity or technical oversight, but a rational outcome of political prioritization in a system where health promotion remains a low-powered incentive domain (Curley et al., 2023; Sullivan and Strach, 2025).

Proposition 4. *Barangay*-level health promotion is shaped by adversarial politics, where partisan alignment, patronage, and factions determine service access and resource distribution.

While *barangays* are often conceptualized as uniform frontline governance units, field evidence from Malabon reveals that inter-*barangay* dynamics and internal political divides significantly affect health promotion outcomes. The allocation of health promotion services, training access, and even staffing decisions is frequently mediated by political affiliation with the city administration or dominant factions within the LGU (Lubell et al., 2009). One informant recalled:

> *"May mga barangay kami na hindi pwede babaan. Hindi namin pwede bigyan ng bonggang health services kasi kailangan may approval ng admin at mayor's office… kung sino lang ang nakapanig sa administrasyon na 'yon, sila lang yung makakakuha ng health services."*
>
> (There are *barangays* where we cannot conduct health promotion services since the City Administrator and the Mayor's Office should approve it…only those who are aligned and politically-affiliated can avail of the services.)

This reflects an exclusionary access regime, where public health—ostensibly a non-rival public

good—is subject to selective provisioning based on political alignment (Brown, 2025). Within the PMF, this constitutes a distortion in the political marketplace: actors use selective benefit distribution to consolidate loyalty, while withholding services from perceived opponents. What should be population-based, universal services become club goods, contingent on political loyalty.

The ICA framework helps explain this through the lens of collaboration risks and jurisdictional fragmentation (Feiock, 2013). In settings where *barangays* share health centers, coordination becomes vulnerable to rivalries, informal veto points, and political retribution. *Barangay* captains who are not aligned with city hall report reduced program support and even deliberate exclusion from planning meetings or campaigns. Further, patronage politics plays out in BHW employment and tenure.

> *"Nandun din ung takot ng mga BHWs lagi 'pag election season. Pag natalo si Kap, wala na silang trabaho, automatic na 'yun."*
>
> (BHWs are also scared every election season. If their *barangay* captain loses, they will also lose their work. The consequence is immediate and automatic.)

Hiring and retention of BHWs are often at the discretion of *barangay* captains, leading to fragile employment, politicized turnover, and constrained autonomy in health work. These dynamics erode the institutional memory and program continuity essential for effective health promotion. This leads to a patchwork of unevenly empowered micro-governments, where health promotion is filtered through loyalty tests, turf protection, and partisan gatekeeping.

Proposition 5. Low-powered incentives, blurred mandates, and organizational risk-aversion among technical actors weaken collaborative health promotion at the *barangay* level.

While elected officials are often blamed for the politicization of health promotion, this study finds that technical actors themselves—department heads, physicians, and focal personnel—often create political dynamics through passive non-engagement, bureaucratic self-preservation, or unclear mandates. These actors are not apolitical functionaries. As Sullivan and Strach (2025) assert, technical personnel also organize themselves politically, exercising discretion over which initiatives to support, avoid, or delay. A program officer shared:

> *"To be honest, we did not even know how to split ourselves anymore… Minsan admin ka, minsan eto pala trabaho mo. Kapag dulutan na, magugulat na lang ako, aba trabaho ko pala yun…no incentive naman para sa'kin."*
>
> (To be honest, we do not even know how to split ourselves anymore…Sometimes, I am an administrator, sometimes, I'll be given extra work. If there are rush activities, I'll be surprised that those tasks will be passed on to me… but I don't have any incentive in finishing those.)

Such statements reflect the absence of high-powered incentives and the presence of transaction costs: ambiguity of responsibility, effort-intensive coordination, and low political or financial reward (Dixit, 1998; Frant, 1996). Even when collaboration is formally mandated, actors often withhold effort due to limited performance metrics, lack of evaluation mechanisms, or fear of overstepping (Cruz, 2015). These are classic coordination failures under ICA, where perceived costs of action outweigh benefits in siloed bureaucracies (Feiock, 2023).

Moreover, the HEPO role, central to *barangay*-level health promotion, is frequently left unfilled, misunderstood, or rotated informally among actors who do not receive dedicated support or training:

> *"Bago ako maging HEPO… merong ibang priority kesa unahin pa 'yan… Lubog na ko sa trabaho noon, pasan ko buong Health [Department] kahit hindi ako doctor."*
>
> (Before I became a HEPO…I have lots of other priorities…I have tons of work, it seems like I handle the Health Department single-handedly even though I am not a doctor.)

In a political market where incentives are low-powered and risks are asymmetric, it is rational for technical actors to adopt defensive stances: doing

the minimum, avoiding contentious reforms, and passing politically sensitive tasks downward. The unwillingness of technical superiors to back subordinate-led innovations, the fear of political backlash, and the lack of formalized incentives for initiating *barangay*-level health reforms reveal an invisible politics within the bureaucracy, where collaboration dies not from explicit resistance but from institutional neglect and calculated inaction. Thus, health promotion stalls not only because of political interference, but also because the bureaucratic system fails to incentivize proactive collaboration, creating a vacuum where responsibilities are passed down without empowerment and innovation becomes an organizational risk.

Proposition 6. Spatial, fiscal, and institutional disparities among *barangays* generate coordination asymmetries that hinder collective health promotion efforts.

Even within a single LGU like Malabon, the *barangays* vary significantly in geographic size, fiscal capacity, population density, and access to infrastructure. These disparities translate into uneven capacities for initiating and sustaining health promotion programs, creating deep coordination asymmetries, particularly in health centers that serve multiple *barangays*. According to City Health Office staff, more and higher-level services are concentrated in the super health centers located in a subset of larger *barangays*, compared with those available in the remaining *barangays*. While these super health centers *can* accept clients from other areas, priority is still accorded to residents of the host *barangay*. As one informant explained:

> *"Hindi lahat merong super health center sa per barangay…Kung saan pang barangay naka lagak [ang super health center], madalas sila 'yung napapaburan ng benefits."*
>
> (Not all *barangay* has the super health center… Usually, the *barangay*, where the super health center is located, residents often get the better benefits.)

In *barangay* clusters that are nominally served by the same super health center, spatial proximity therefore translates into service favoritism, especially when one *barangay* captain can wield political influence or exercise de facto control over the site, the technical actors serving the super health center, or even the regular health centers—or even the regular health centers. Access to health promotion services becomes a function of both geography and political bargaining power, undermining the principle of equitable distribution of public goods.

These patterns are embedded in broader power asymmetries between city hall and *barangays*. Political competition and the strategic use of political resources shape which *barangays* receive technical assistance, logistics, or inclusion in flagship campaigns. *Barangays* with stronger political ties to the city government are more likely to secure sustained support, while others operate at the margins. Under such conditions, the effectiveness of health promotion hinges less on the individual effort of BHWs or local staff and more on the institutional scaffolding that coordinates policy, resources, and cross-level support (Deslatte, 2018; Deslatte & Feiock, 2018). Where that scaffolding is weak or uneven, collective action problems are amplified.

Fiscal inequalities further reinforce these asymmetries. Before the recent move to institutionalize a modest monthly salary for BHWs, which is around ₱8,000 and still under job-order status, BHWs received only allowances, often in the range of ₱500 to ₱2,000, depending on *barangay* budgets and the discretion of the *barangay* captain. One respondent described the situation this way:

> *"Kahit ngayon, parang volunteers pa rin mga BHWs… Nakasalalay pa rin sa captain, at s'yempre sa mayor, kung irerenew sila. Job order pa rin, sobrang dali nilang tanggalin, wala pang benefits."*
>
> (Even now, BHWs still feel like volunteers… Their renewal still depends on the *barangay* captain, and of course the mayor. They are still under job order, very easy to remove, with no benefits.)

From a Political Market Framework perspective, this constitutes a selective reward regime, where political patrons retain discretionary control over frontline health workers as a source of leverage and loyalty. Such arrangements discourage long-term planning and professionalisation of health-promotion roles, while eroding inter-*barangay* trust

as BHWs and health personnel from under-resourced *barangays* perceive themselves as structurally disadvantaged in collaborative efforts. These spatial, fiscal, and institutional disparities make citywide coordination both less attractive and more costly. Better-resourced or politically aligned *barangays* tend to dominate planning processes and agenda-setting, while others become passive recipients—or, in some cases, are effectively excluded. In the absence of mechanisms to redistribute resources, standardized minimum service levels, or harmonized responsibilities across *barangays*, collective health promotion remains structurally uneven and politically stratified, reproducing precisely the inequalities it is meant to address.

Policy Implications and Institutional Reform

The study reveals that while health promotion is framed as a whole-of-society endeavor, it remains institutionally peripheral and is undermined by weak formal mandates, clientelistic incentives, and fragmented implementation across *barangays*. Despite its population-wide benefits, health promotion is vulnerable to direct and indirect political interference that weakens capacity without triggering immediate accountability. Over time, this fragility may yield severe consequences for public health, as indirect governance arrangements allow political actors to evade responsibility while deprioritizing upstream services.

To reposition health promotion as a strategic and protected public good, the following institutional reforms are proposed:

1. *Institutionalize Health Promotion as a Core Function of Local Governance*

   Health promotion must be elevated from a discretionary task to a formal governance function embedded in planning, budgeting, and performance management systems. This requires:

   a. Enactment of a local ordinance institutionalizing a Health Promotion Unit (HPU) at the city level, with dedicated *plantilla* positions, funding streams (e.g., from the Special Health Fund), and clear functional mandates;
   b. Mainstreaming of health promotion targets in City and *Barangay* Development Plans, Annual Investment Plans, and the Local Health Systems Operational Framework; and
   c. Integration of health promotion indicators into the Local Health Systems Maturity Level (LHS ML) Monitoring Tool and recognition of compliance in the Seal of Good Local Governance (SGLG) criteria.

   By giving legal permanence to health promotion through ordinances rather than executive orders, LGUs reduce vulnerability to political transitions and promote program continuity across electoral cycles.

2. *Professionalize the Barangay Health Promotion* Ecosystem

   BHWs, who form the backbone of local health promotion, continue to operate under conditions of low remuneration, unstable tenure, and politicized deployment. A recalibration of incentives is essential:

   a. Institutionalize BHWs as *Barangay* HEPOs, with Salary Grades (SG) 1-3 plantilla positions after ten years of service and merit-based hiring mechanisms for new hires;[1]
   b. Clarify that HEPO is one function of BHWs, preserving their rights under the Magna Carta while protecting them from exploitative contracts or task-dumping; and
   c. Establish mandatory training programs, allow flexible roles for elderly BHWs, and pursue national legislation for the Magna Carta of BHWs to secure tenure and benefits.

   These reforms will professionalize the field, reduce, reduce collaboration risks arising from turnover and ambiguity, and insulate public health delivery from electoral interference.

3. *Enable Inter-Barangay Collaboration and Resource Pooling*

   In settings where health centers serve multiple *barangays*, fragmented authority and resource asymmetries generate high coordination costs. LGUs should:

[1] In the Philippine civil service, Salary Grade (SG) refers to a standardized national pay classification system used for government positions. Each plantilla position is assigned a salary grade (e.g., SG 1–33), which corresponds to a fixed base salary range set by law and adjusted periodically through Salary Standardization Laws. Higher salary grades generally reflect greater responsibility, technical complexity, and seniority, rather than individual negotiation.

a. Create *barangay* health clusters with joint planning bodies, pooled funds, and shared accountability mechanisms;
b. Institutionalize multi-*barangay* coordination boards for health promotion; and
c. Offer city-level matching grants for inter-*barangay* health campaigns.

These mechanisms reduce collective action dilemmas and align fragmented incentives across *barangays* that share both risks and benefits of public health outcomes.

4. *Build Institutional Resilience Against Electoral Volatility*

Patronage-based appointments of BHWs, short-lived executive orders, and politically driven budget reallocation erode the long-term gains of health promotion. To buffer against these disruptions:

a. Pass local ordinances defining minimum standards for HEPO employment, tenure, and compensation;
b. Institutionalize the Local Health Board and Local Health Promotion Committee with detailed provisions on composition, duties, and mandatory consultation with technical actors;
c. Empower *Barangay* Health Boards to handle BHW hiring and grievance mechanisms, reducing direct political discretion; and
d. Strengthen implementation of the Special Health Fund, with dedicated books of account, a clearly mandated Management Support Unit composition, and robust accountability protocols.

These institutional safeguards ensure the continuity of public health functions independent of political cycles or changing priorities.

5. *Elevate Political and Strategic Capacity of Technical Actors*

Health promotion focal persons often lack the political capital and institutional knowledge to influence decision-making in a politicized LGU environment. To build their capacity:

a. Conduct regular capacity-building on policy making, budgeting, and inter-agency navigation;
b. Provide coaching and mentoring systems between HEPOs/BHWs and senior LGU officials;
c. Develop standardized toolkits and policy templates for ordinances, resolutions, and health promotion planning;
d. Institutionalize internal health promotion campaigns within City Hall (e.g., Zumba, health lectures, Adopt-a-*Barangay*), not only as wellness initiatives but also as opportunities to normalize and internalize health promotion as a shared bureaucratic value.

Moreover, the Department of Health and the Department of the Interior and Local Government should jointly issue an Administrative Order mandating compliance with the Local Health Systems Maturity Level Tool at the level of City Mayors, thereby aligning political accountability with technical responsibilities. Sister-city programs and DOH-led regional consultations can further support technical actors in navigating complex policy and implementation environments.

Conclusion

The consequences of neglecting health promotion are likely to manifest in indirect but far-reaching public health failures over time. The diffuse, upstream nature of health promotion makes it easy to overlook, yet its absence will be deeply felt in rising disease burdens, fractured service delivery, and unsustainable community systems. Unless safeguarded from political volatility and institutional fragmentation, health promotion will remain an easy target for budget cuts, labor exploitation, and symbolic compliance.

Thus, public health governance must confront a difficult truth: health promotion is not merely a technical or sectoral issue—it is a political good. Embedding it into the architecture of local governance, professionalizing its actors, and aligning incentives for cooperation are not just administrative choices, but political imperatives. The sustainability of public health in the Philippines depends on whether these imperatives are met, not only by those within the health sector, but also by the broader machinery of local government.

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