Collaborative Care Model in Community Health Nursing: Bridging Healthcare Providers and Policymakers for Intersectional Care

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ABSTRACT

This study examined the collaboration between healthcare providers and policymakers in selected municipalities within the Bangsamoro Autonomous Region in Muslim Mindanao (BARMM), focusing on communication, coordination, resource allocation, and strategies to address health d isparities. Anchored in **Hildegard Peplau's Interpersonal Relations Theory**, the research explored how relational dynamics influence governance and service delivery outcomes in decentralized health systems. A mixed-methods design was used, combining quantitative survey data and qualitative interviews with healthcare workers, local government officials, and key stakeholders. Quantitative results showed moderate levels of collaboration, with communication and coordination remaining major challenges. Qualitative findings further emphasized the rise of adaptive relational governance, where stakeholders depended on informal networks, trust -building, and personal initiative to manage fragmented institutional structures. The integration of findings suggests that while formal mechanisms for collaboration exist, their effectiveness is often constrained by systemic limitations, including unclear policy guidelines, resource inequities, and weak inter-agency alignment. However, interpersonal relationships and localized strategies serve as critical enablers of functional collaboration in practice. The study concludes that strengthening healthcare governance in BARMM requires institutionalizing communication channels, enhancing the capacity of Local Health Boards, and developing policy frameworks that align formal systems with existing informal practices. A strategic roadmap is proposed to improve collaborative governance, promote equity in resource distribution, and ensure sustainable health outcomes in the region.

Keywords: Healthcare collaboration, BARMM, policy coordination, Peplau's theory, relational governance, health systems strengthening

INTRODUCTION

The broad range of healthcare services available in communities significantly influences individuals' well-being and overall quality of life. Ensuring these services are delivered effectively requires strong cooperation between healthcare providers and policymakers to develop a comprehensive, efficient, and high-quality healthcare system. Collaboration across different sectors has become increasingly vital in tackling complex healthcare challenges. According to Alderwick (2021), integrated efforts among healthcare systems, social services, and other sectors are crucial in addressing intersectional issues in care. These include ongoing health disparities, unequal access to healthcare services, and inefficiencies in resource distribution. Such collaborative approaches foster a more coordinated and inclusive system that better meets the diverse needs of the population.

The main goal of this study is to evaluate the extent of collaboration between policymakers and healthcare providers in addressing communication and coordination challenges in the delivery of healthcare services within Community Health Nursing. Effective collaboration is essential to ensuring that healthcare systems function efficiently and respond adequately to the population's needs. As noted by Indradjaja (2023), commitment among healthcare professionals—and even among stakeholders outside the health sector—promotes mutual understanding despite differing perspectives, ultimately leading to improved patient care outcomes.

This study is based on the Collaborative Care Model in Community Health Nursing, which provides its guiding

framework for addressing the intersectionality of care. The model emphasizes a team-based approach where multiple healthcare professionals work together to diagnose, treat, and manage patients, as defined by the American Board of Medical Specialties (2024). Although this model is primarily designed for coordination among healthcare providers, its application becomes more complex when extended to include external stakeholders, such as municipal policymakers. In this context, Abdeen (2022) identified interoperability and communication gaps as major barriers to effective collaboration.

REVIEW OF RELATED LITERATURE

This section presents the comparison between the past and the present studies conducted in a table form.

Aspect	Present Study Findings	Supporting / Contrasting Studies	Interpretation/Insight
Communication & Coordination	High extent of collaboration; active participation in joint activities and policy adherence	These findings support existing literature that interprofessional collaboration enhances communication, coordination, and shared decision-making in healthcare settings(Reeves et al., 2017; Sanborn, 2023)	Confirms that interprofessional collaboration strengthens communication and coordination in healthcare settings
Public Health Implementation	Strong involvement in vaccination, outreach, and community programs	Effective communication systems have been shown to improve service delivery in coordinated public health efforts (Sharkiya, 2023; Panjaitan, 2023).	Supports evidence that effective communication systems improve service delivery
Feedback & Evaluation Mechanisms	Lower participation in feedback sessions and evaluative processes	Effective interprofessional collaboration requires not only interaction but also structured mechanisms that support role clarity and sustained teamwork (McLaney et al., 2022).	Supports evidence that effective communication systems improve service delivery
Nature of Collaboration	Predominantly informal, relationship-based coordination feedback sessions and evaluative processes	This finding aligns with prior studies indicating that while collaboration may appear effective in structured assessments, it is often constrained by weak coordination systems, unclear roles, and reliance on informal practices (Moncatar et al. (2021)	Aligns with findings that informal systems sustain collaboration but limit consistency
Role Clarity & Structure	Unclear roles and reliance on key individuals	Furthermore, effective interprofessional collaboration requires not only interaction but also structured mechanisms that support role clarity and sustained teamwork (McLaney et al., 2022).	Indicates weak institutionalization despite strong relational ties
Mixed-Methods Insight	High quantitative scores but qualitative data reveal structural gaps	This supports mixed-methods research suggesting that strong quantitative indicators of collaboration may mask underlying structural constraints revealed through qualitative evidence (Kelly et al., 2025)	Demonstrates divergence between perceived effectiveness and actual system strength
Health Disparities	Collaboration exists but inequitable outcomes persist	In addressing health disparities, both quantitative and qualitative findings show strong collaborative efforts, but outcomes remain uneven, consistent with broader	Suggests that collaboration alone is insufficient without

		public health literature indicating that collaboration alone does not fully address structural determinants of health inequities (World Health Organization, 2021).	structural support
Overall Collaboration Model	Functionally strong but structurally fragile	refer to the multiple studies above	Emphasizes need to transition from informal to system-driven collaboration

Synthese and Research Gaps

The study found that collaboration in the community-based care model is strong but mostly informal, relying on personal relationships and communication rather than standardized systems. While these relational practices support coordination, significant challenges—such as geographic barriers, poverty, security concerns, and limited infrastructure and workforce capacity—continue to block fair access to healthcare. The findings also show critical gaps, including the lack of formal guidelines, fragmented governance structures, reactive resource allocation, and limited focus on isolated and disadvantaged areas (GIDA). These results highlight that communication is vital but not enough without structural support. Therefore, it is recommended to formalize collaborative practices through guidelines, strengthen health system resources, improve services in disadvantaged areas, and conduct more research on governance, resource capacity, and patient-centered outcomes to enable sustainable and fair healthcare. This aligns with evidence that collaboration is key in reducing health disparities (Briggs et al., 2019; CDC, 2022).

Theoretical Framework

This study is anchored on the theories of Hildegard Peplau's Interpersonal Relations Theory by Neese (2016), the Collaborative Approach to Nursing by Brar Navdeep Kaur and Rawat HC (2015), and the Nursing Center Model by Juiarti et al. (2019). All the theories mentioned are valuable for understanding this research.

The initial theory aligns with Hildegard Peplau's Interpersonal Theory of Nursing, which focuses on the nurse-client relationship and therapeutic communication. This theory considers intricate factors like the environment and attitudes, practices, and beliefs within the dominant culture. With the health complexities, the Journal of Safety in 2014, believed an astonishing 440,000 annual deaths from preventable medical errors is the third leading cause of death in the U.S. Consequently, Wright (2016) asserted that improving nursing communication could significantly reduce medical errors and enhance positive patient outcomes.

The second theory is from Brar Navdeep Kaur and Rawat HC (2015) which deals with the "Collaborative Approach to Nursing Care" (CAN-Care) Model. This theory is reflected on a notion that a patient is dependent on the collaborative practice of several care providers within the community, including physicians, nurses, and other healthcare workers. This theory is significant in bridging the gap between healthcare providers and policymakers when it comes to communication and coordination.

Finally, the last theory represents a Team Nursing Model. In this model, a nurse is responsible for planning, delivering, and evaluating the care of one or more patients from admission to discharge. This model addresses issue of communication and coordination by fostering a collaborative environment where nurses work together, share information, and delegate tasks effectively, leading to improved patient outcomes and enhanced job satisfaction. According to Baek et al (2023), when nurses within a team can share opinions based on their expertise and work together on nursing care plans, care is well coordinated and patient focused. Furthermore, a culture of respect and open communication among nurses could influence communication with patients accordingly and could also influence policymakers from the Local Government Unit.

Conceptual Framework

Collaborative healthcare practice occurs when multiple health workers from various disciplines work together

to deliver the best care to patients, families, caregivers, and communities. While this model is effective for health workers alone, it highlights the importance of collaborating with policymakers in terms of communication and coordination. These dynamics influence the collaborative functions of healthcare providers and policymakers. When these variables are affected, it can lead to intersectional care issues such as healthcare disparities, unequal care delivery, and inefficient resource allocation. The following diagram illustrates how these variables relate to each other. As shown, the independent variables are considered preconditions for intersectional care issues and challenges in implementing a collaborative care model within a community setting.

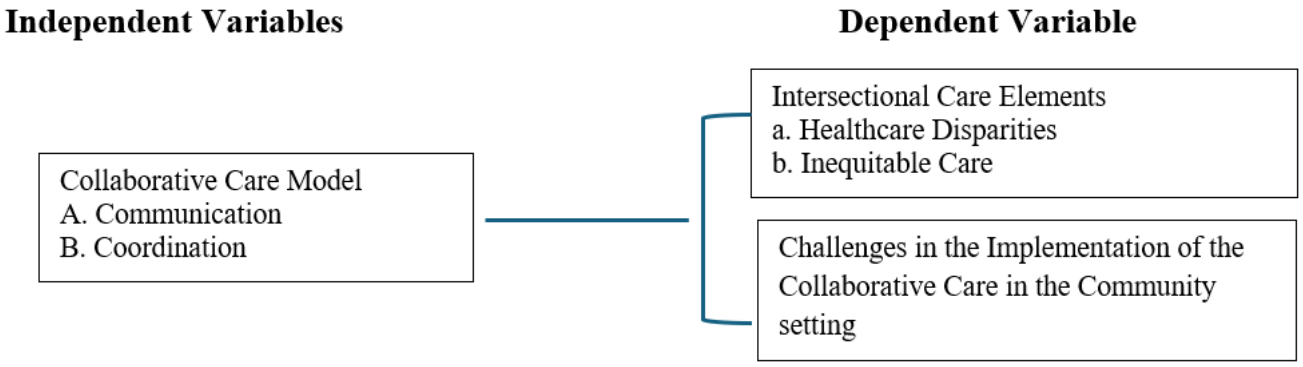

Figure1: Schematic Diagram showing the variables of the study

Statements of the Problem

The study aimed to determine the utilization of the collaborative care model in community health nursing to bridge the gap between healthcare providers and policymakers for intersectional care. Specifically, it sought to answer the following questions:

1. To what extent is the collaboration of healthcare providers and policymakers in the selected municipalities in the BARMM region in terms of:

A. A. Communication, and

B. B. Coordination?

C. 2. To what extent does the collaboration between healthcare providers and policymakers address the intersectional care elements in BARMM in terms of:

D. A. Health disparities

E. B. inequitable care; and

F. C. ineffective resource allocation strategies?

G. 3. What are the challenges encountered by healthcare providers and policymakers in the implementation of a collaborative care model in community health nursing?

H. 4. What are the potential steps and considerations for policy development to bridge the intersectional care between healthcare providers and policymakers?

Significance of the Study

The result of this study is significant in addressing the intersectionality of care elements such as healthcare disparities, inequitable care and ineffective resource allocation through the collaborative care model. In the collaborative care model, an integrated approach is being applied where communication and coordination in the delivery of health care services is very important. Moreover, it will contribute to local capacity building by orienting and training the RHU/LGU representatives on data collection ethics, instrument handling, and use of findings. Results and

recommendations will be shared to support evidence-informed decision-making at the local level. Finally, the result of the study is significant to the following:

Nursing Practice: The conduct of this study addresses the issues on healthcare team management on reducing the risk of committing errors in the medical practice such administering medications, carrying out of the doctors. It can be done through the patients' chart.

Nursing Education: The conduct of this study may benefit the nursing education through school nurses by how they strategized handling numbers of pupils and students to the ratio of their school nurse. Usually in schools, the only healthcare provider existing is nurse. There are doctors and dentists but not enough.

Nursing Research: The conduct of this study may contribute to the demand for health innovation, knowledge, and skills in the realm of nursing, considering the dynamics of the community where nursing is highly relevant. This research may pose further research to dig deeper into other factors in community health nursing. Future researchers may therefore consider the recommendations arising from this research.

Policymakers in BARMM: The conduct of this study may help address gaps and challenges that require policy, which policymakers at different levels of governance can investigate for legislation. The recommendations of this study are very good considerations for policy development, ensuring responsiveness, relevance, and sustainability.

Local Government Unit: The conduct of this study may help address gaps and challenges in the local government where health services are delivered. The gaps, challenges, and recommendations of this research are helpful for the local government units through the local health board. These may inform LGUs in improving service delivery mechanisms, budgeting, programming, and local health policies relevant to their contexts.

Community People: The conduct of this study involving the community people will be used as a basis for programming on how these stakeholders can be more relevant and engaged in the implementation of public health nursing. The education drive, advocacy, and other activities will be best informed by this research, explicitly and implicitly incorporated in the results and recommendations.

Health Care Providers: The conduct of this study may contribute to gaps and challenges among healthcare providers in the conduct of nursing research, for education and training, nursing practice, and innovative programs, activities, and projects in which different officers provide health programs and services.

Definition of Terms

The following terms are defined as they are used in the study.

Collaborative functions refer to the coordinated and joint activities of policymakers and healthcare providers aimed at addressing the intersectional needs of care delivery and improving overall healthcare outcomes.

Communication refers to the dissemination of information through memoranda, memorandum circulars, directives, and other digital platforms such as Messenger. These channels inform and guide health service campaigns to ensure implementation and minimize misconceptions.

Coordination is the process of arranging and aligning activities to achieve shared goals.

Health indicators are measurable characteristics of the population, gathered through research, that reflect the overall health of the population or the health system.

Healthcare providers include doctors, nurses, midwives, and pharmacists working together to deliver healthcare services.

Intersectionality differences explain how outcomes of services provided to clients can vary.

Policymakers are elected officials with the legal authority to establish policies related to healthcare services.

METHODS

This chapter presented the research design, study locale, respondents, sampling techniques, research instruments, validation and reliability of the research instruments, data-gathering procedures, and statistical treatment.

Research Design

The study employed a concurrent triangulation mixed-methods design, which involves the simultaneous collection of quantitative and qualitative data to examine the variables under study and provide a comprehensive understanding of the phenomenon (Creswell & Plano Clark, 2018). The quantitative component focused on measuring the extent of collaboration between healthcare providers and policymakers in communication, coordination, addressing health disparities, addressing inequitable healthcare, and resource allocation**.**

The qualitative component explored how these variables are experienced and operationalized in practice, particularly the dynamics of collaboration. Data were gathered through six focus group discussion sessions (FGDs) with Rural Health Unit (RHU)-based healthcare providers and fourteen key informant interviews (KIIs) with municipal mayors and vice mayors. Additional six (6) sessions of optional FGDs with municipal councilors and mothers of children under five years old were conducted to further strengthen triangulation.

Findings from both data sources were compared and synthesized to examine the relationship between communication and coordination (independent variables) and health disparities, inequitable healthcare, and resource allocation (dependent variables)**,** thereby generating evidence-based insights to inform policies to improve equitable and collaborative health service delivery in BARMM.

Participants

The participants in this study consisted of healthcare providers, policymakers, and key stakeholders drawn from the 23 municipalities of the Bangsamoro Autonomous Region in Muslim Mindanao (BARMM), specifically within the mainland provinces of Maguindanao del Norte, Maguindanao del Sur, and Lanao del Sur.

There are two hundred fifty (250) healthcare providers who participated in the study. Inclusion criteria are government-employed (RHU) personnel who were directly involved in delivering healthcare services to clients. They answered the survey questionnaires. There are thirty-eight (38) participants in the focus group discussions coming from the six (6) municipalities in BARMM who are not part of the quantitative data collection. To ensure adequate experience and contextual understanding, only those with at least one (1) year of continuous service in community health nursing were included in the study.

There are fourteen policymakers who were part of the study referred to as elected or appointed officials who were members of the Sangguniang Bayan, including mayors, vice mayors, and municipal councilors, with a minimum of two

(2) years of service who underwent the KII, an additional three FGD were added from councilors and mothers with under-5 children. This criterion ensured that participants possessed sufficient experience in local governance and policy implementation and stakeholders included care recipients—specifically mothers of children under five (5) years old—who were selected through random sampling to provide community-level perspectives on healthcare delivery.

Exclusion criteria included hospital-based staff because the study focuses on community-level collaboration between healthcare providers and policymakers. Since hospital nurses are primarily involved in facility-based clinical care and have limited roles in inter-agency coordination, including them would not directly support the objectives of the study and policymakers who were not members of the Sangguniang Bayan, as the study focused specifically on primary care providers and local legislative actors involved in municipal-level health governance. The participants' profiles will be presented in the Annex of the paper.

Setting

The study was carried out in the Rural Health Units (RHUs) and Municipal Halls of Parang, Barira, Buldon, Sultan Mastura, and Northern Kabuntalan in Maguindanao del Norte Province. For Maguindanao del Sur, the municipalities included are Talayan, Guindulungan, Datu Anggal Midtimbang, Datu Saudi, Datu Piang, and Buluan. In Lanao del Sur

Province, the study took place in Malabang, Kapatagan, Balabagan, Wao, Picong, Marogong, Pualas, Calanogas, Pagayawan, Balindong, and Sultan Domalondong, where sufficient staff, private consultation rooms, and meeting areas are available to facilitate the survey and interview procedures.

Sampling Techniques/Sample Size

The minimum required sample size was determined using Cochran's formula for proportions under simple random sampling, assuming a 95% confidence level, 5% margin of error, and maximum variability (). Cochran's initial formula for large populations is:

Substituting the study assumptions:

Because the target population of RHU staff was finite (), the finite population correction was then applied:

Thus, the minimum required sample size was 218 respondents. The actual survey sample of 250 respondents exceeded this minimum requirement, thereby providing adequate statistical precision for the study. The formula for estimating sample size for proportions and its finite population correction are discussed in *Sampling Techniques* (Cochran, 1977), particularly in the section on sample size determination.

For the qualitative phase, 6 FGDs (6–10 participants each) and 15–20 KIIs are recommended, following Guest et al. (2006) and Krueger & Casey (2014), who note thematic saturation is typically reached with these numbers. All sample sizes were validated in consultation with a statistician.

Instrument

The research tools used included survey questionnaires, a focus group discussion (FGD) guide, and key informant interview (KII) questions.

SOPs 1 and 2 were addressed using survey questionnaires prepared and tested for reliability. Ten respondents were excluded from the final study. Their responses were processed and analyzed with the split-half method. All items were improved, revised, or removed based on the results of item analysis before they were finalized as research instruments.

The reliability testing results indicated good internal consistency, with a mean of 4.50, an SD of 0.289, and a Cronbach's α result of 0.865. It assessed the level of collaboration among healthcare providers in the selected municipalities in BARMM, focusing on communication and coordination, as well as on collaboration between healthcare providers and policymakers to address health disparities and inadequate care. The questions were adapted from the Philippine Health Insurance Corporation's Bench Book for Non-Hospital Facilities, which serves as a reference for evaluating and identifying facilities as Centers of Excellence (COEs). For the resource allocation questionnaires, the study used the Universal Health Care framework, the Local Government Code of the Philippines, Section 30.12 of RA No. 112, and the United Nations Office for Disaster Risk Reduction's Local Government Self-Assessment Tool for Disaster Resilience. Regarding the questionnaire on health disparities and inequitable care, these addressed routine health activities in the RHU related to maternal and child health. To explore collaboration challenges, the researcher employed KIIs and FGD to gain a deeper understanding of the obstacles faced by policymakers and healthcare providers.

Measures

The quantitative data were analyzed using descriptive statistics, such as the mean and standard deviation, to assess the level and extent of collaboration between healthcare providers and policymakers. Since these SOPs focus on general trends rather than differences between groups, inferential tests (e.g., t-tests or ANOVA) are not required at this stage. For qualitative data gathered from FGDs and KIIs, transcripts were coded thematically using content analysis. Findings from both data strands were integrated through triangulation to develop a deeper understanding of collaborative practices and their implications for community health in BARMM. The survey questions were interpreted using a Likert scale.

Part I. Collaborative Functions of Healthcare Providers and Policymakers in the selected municipalities in BARMM in terms of Communication and Coordination. Below is the Likert scale used to interpret data for the collaborative care model.

Scale	Range	Interpretation	Description
5	4.21-5.00	High Extent	This indicates collaboration among healthcare providers and policymakers are consistent in terms of coordination and communication
4	3.41-4.2	Extent	This indicates collaboration among healthcare providers and policymakers are regular in terms of coordination and communication
3	2.61-3.4	Moderate Extent	This indicates collaboration among healthcare providers and policymakers are occasional in terms of coordination and communication
2	1.81-2.6	Low Extent	This indicates collaboration among healthcare providers and policymakers are infrequent in terms of coordination and communication
1	1.0-1.81	Very Low extent	This indicates collaboration among healthcare providers and policymakers. are not existing terms of coordination and communication

Note. *N=240. Mean scores were interpreted using the following scale: 4.21–5.00 = High Extent (consistently collaborating); 3.41–4.20 = Extent (regular collaboration); 2.61–3.40 = Moderate Extent (occasional collaboration); 1.81–2.60 = Low Extent (infrequent collaboration); and 1.00–1.80 = Very Low Extent (collaboration not practiced).*

Part II. Collaborative Functions of Healthcare Providers and Policymakers in addressing health disparities, equitable health care, and effective resource allocation in the community.

Scale	Range	Interpretation	Description
5	4.21-5.00	High Extent	This indicates collaboration among healthcare providers and policymakers are consistent in addressing health disparities, equitable healthcare and effective resource allocation
4	3.41-4.2	Extent	This indicates collaboration among healthcare providers and policymakers are regular in addressing health disparities, equitable healthcare and effective resource allocation
3	2.61-3.4	Moderate Extent	This indicates collaboration among healthcare providers and policymakers are occasional in addressing health disparities, equitable healthcare and effective resource allocation
2	1.81-2.6	Low Extent	This indicates collaboration among healthcare providers and policymakers are infrequent in addressing health disparities, equitable healthcare and effective resource allocation
1	1.0-1.81	Very Low extent	This indicates collaboration among healthcare providers and policymakers are not existing in addressing health disparities, equitable healthcare and effective resource allocation

Note. *N=240. Mean scores were interpreted using the following scale: 4.21–5.00 = High Extent (consistently collaborating); 3.41–4.20 = Extent (regular collaboration); 2.61–3.40 = Moderate Extent (occasional collaboration); 1.81–2.60 = Low Extent (infrequent collaboration); and 1.00–1.80 = Very Low Extent (collaboration not practiced)*

Data Gathering Procedure

Prior to data collection, the researcher secured approval from the Dean and the panel. The research instruments underwent expert validation to establish content validity, and reliability testing was conducted using Cronbach's alpha to ensure internal consistency. Subsequently, the validated instruments were submitted to the Research Ethics Committee for protocol evaluation. Data collection commenced only after ethical clearance was granted.

Following approval, formal request letters were sent to local government unit (LGU) officials, including barangay chairpersons and mayors, to seek permission to conduct the study among healthcare providers, mothers of children under five, and local chief executives. Upon receiving approval, the researcher conducted an orientation to inform participants about the study's objectives, procedures, and ethical considerations.

Consistent with the concurrent triangulation approach, quantitative and qualitative data were collected within the same data collection period across selected municipalities in BARMM. Survey questionnaires were distributed to two hundred fifty (250) healthcare providers across twenty-three (23) rural health units (RHUs), with each respondent completing the instrument in approximately 45 minutes.

At the same time, qualitative data collection was conducted through focus group discussions (FGDs) and key informant interviews (KIIs). FGDs were conducted among healthcare providers, with six (6) participants per group in each RHU. These participants were not part of the survey respondents to ensure independence of data. A total of six (6) FGDs were conducted per municipality, each lasting no more than 30 minutes, and were held in separate rooms to maintain confidentiality and minimize disruption. Additionally, optional FGDs were conducted among caretakers of children under five to further enrich the qualitative data.

Following the FGDs, Key Informant Interviews (KIIs**)** were conducted with fourteen (14) policymakers, including local chief executives, with each interview lasting approximately 30 to 60 minutes. Additional optional FGDs were also conducted with policymakers, particularly councilors, to provide further perspectives. Data collection activities—survey distribution, FGDs, and KIIs—were implement concurrently across municipalities. While surveys were being administered in some RHUs, FGDs and KIIs were simultaneously conducted in others, ensuring that all data were gathered within the same timeframe. This approach ensured that both quantitative and qualitative data reflected a consistent context.After data collection, quantitative data were analyzed using appropriate statistical methods, while qualitative data from FGDs and KIIs were analyzed using thematic analysis. The results from both datasets were then compared and integrated to identify convergence, complementarity, or divergence of findings, thereby strengthening the validity and reliability of the study.

All procedures were carefully implemented to ensure that the research instruments were clear, concise, and well understood, resulting in the collection of accurate and reliable data and contributing to robust and meaningful research outcomes.

Limitations of the Study

This study is limited to determining the utilization of the collaborative care model in community health nursing. First, the study was conducted only in selected municipalities, which may limit the generalizability of the results to other areas with different governance structures, resources, or health system capacities. The context-specific nature of local health systems means that findings may not fully represent all regions. Second, the study relied on a combination of qualitative and quantitative data**,** with qualitative insights drawn from participants' self-reported experiences. This may introduce response bias, as participants might have provided socially desirable answers or withheld critical perspectives. Third, the sample size and participant selection were limited to key stakeholders, including healthcare providers and policymakers, as well as caregivers of children under 5. Fourth, due to time constraints, the researcher was not able to interview one participant of the KII. Other relevant actors—community leaders or non-governmental organizations—were not included, which may have limited the diversity of perspectives.

Ethical consideration

An official letter formulated by the researcher, signed by the adviser, and approved by the Dean of the graduate school was submitted to all concerned authorities to ensure and gain their cooperation. Written informed consent was presented and thoroughly explained to each participant before data collection began. The researcher was able to speak in the vernacular dialect. Consequently, participants had voluntarily signed the consent and answered the prepared questionnaire. All data gathered information had been treated with utmost confidentiality. Hence, the researcher ensured positive relationships with the participants, people, and institutions involved in this study.

Risk Assessment

This research poses minimal risk, as it may cause discomfort in sharing opinions, fear of judgement, or may talk about confidentiality. It may ask questions that are usual issues in the workplace such budgeting or resource allocation, but it can be handled, finally it will abide protocols of the institutions. Likewise, the researcher observed respect, openness, patience, friendliness, and politeness when gathering the participants' data.

Benefits

Although, the study may include mild discomfort from discussing organizational issues, the benefits include insights that could lead to improved healthcare delivery and more effective LGU–health sector collaboration. Findings may inform more equitable policy formulation and resource use. Participants may withdraw at any time without penalty. If requested, their data will be deleted and not used in analysis. No services or benefits will be withheld. The researcher declares no conflict of interest. No financial or institutional gain is expected. The research is conducted independently and solely for academic and policy-development purposes.

Procedures

This research study aims to examine collaboration between healthcare providers and local policymakers. The participation is voluntary and will contribute to policy development.

Withdrawal Criteria

Participants may withdraw at any time without penalty. If requested, their data will be deleted and not used in analysis. No services or benefits will be withheld.

Voluntary, Non-Coercive Recruitment of Participants

Recruitment will occur via formal invitation letters through RHUs and LGUs. Participation is entirely voluntary, with assurances that refusal or withdrawal will have no negative consequences for employment or access to services.

Disclosure of Potential Conflict of Interest

The researcher declares no conflict of interest. No financial or institutional gain is expected. The research is conducted independently and solely for academic and policy-development purposes.

Community Consultation

Prior to data collection, the research team consulted community leaders, RHU heads, and LGU representatives to validate instruments, coordinate logistics, and ensure local relevance. Findings will be disseminated back to the communities. There will be multiple community consultations since it covers a wide range of municipalities. First, during the distribution of survey questionnaires, focus group discussions and KII. Second, will be during data analysis and interpretation and finally, during dissemination of findings. This will also involve community members.

Contribution to Local Capacity Building

Findings may result to improvements in RHU service delivery, policymaking, and intersectoral coordination. RHUs and LGUs can use the insights to revise protocols, allocate resources efficiently, and reduce health disparities, especially in maternal and childcare services.

Benefit to Local Communities

Addressing gaps in health service coordination through identified in this study, will lead to a healthier community with easier access.

Sharing of Study Results

Results will be disseminated via LGU health board meetings, barangay dialogues, and printed summaries provided to RHUs and local governments. Short policy briefs and infographics will also be shared for public reference and implementation planning.

Data Confidentiality and Storage

All information provided were treated with the utmost confidentiality. The identity will not be revealed in any reports, presentations, or publications resulting from this study. Audio recordings from interviews will be transcribed and anonymized to remove any identifying details.

All data, including transcripts, audio files, and survey responses, will be securely stored in a password-protected digital folder accessible only to the researcher. These materials will be retained for five (5) years for potential future verification, after which they will be permanently deleted.

Statistical Treatment of Data

The collected data were tallied and analyzed accordingly. The extent of collaboration between healthcare providers and policymakers regarding communication and coordination, as well as its implications for addressing the intersectionality of care—such as health disparities, inequitable healthcare, and inefficient resource allocation—was assessed using weighted means and standard deviations. These statistical tools provided a summary or generalization of survey data, helping to understand the responses' distribution and identify outliers.

For the challenges encountered by the policymakers and healthcare providers, qualitative data gathered from FGDs and KII transcripts were coded thematically using content analysis. Findings from both data strands were integrated through triangulation to develop a deeper understanding of collaborative practices and their implications for community health in BARM.

RESULTS

This chapter presented the comprehensive results of the data gathered. The quantitative data and analysis were presented in tabular form. The results of the focus group discussion (FGD) and key informant interview (KII) were also included in the presentation, which contributed to the study.

Table 1 shows the results of "Collaborative functions between healthcare providers and policymakers in terms of communication. It consists of several items, most of which are in question form. The mean and standard deviation are provided. The collaboration was rated as High Extent, with an overall mean score of 4.54 (SD = 0.49). Specifically, the provision and issuance of memoranda and departmental orders by the Ministry of Health were considered helpful during mass vaccination. It received the highest mean score of 4.65 (SD = 0.59), which is interpreted as High Extent. This indicates strong adherence by the concerned stakeholders to official directives and effective communication channels between healthcare providers and policymakers. Similarly, approving blood donation activities conducted in the community (M = 4.61, SD = 0.64) and using social media platforms for health promotion (M = 4.58, SD = 0.65) were also rated as High Extent, demonstrating active engagement

in promoting public health programs. Among the indicators, participation in feedback sessions after health activities (M = 4.39, SD = 0.74) received the lowest mean but still falls within High Extent.

Table 1. Extent Of Collaborative Functions of Healthcare Providers and Policymakers in Terms of Communication

Statement	**SD**	**Mean**	**Interpretation**
a. 1. Acknowledge the memo and department orders coming from the Ministry of Health when conducting mass vaccination in the rural health units.	0.59	4.65	High Extent
a. 2. Support health advocacies that will be used in the community.	0.61	4.57	High Extent
a. 3. Involve in the feedback session after the launching of health activity.	0.74	4.39	High Extent
a. 4. Support the Rural Health Units on the online reporting system accessible to healthcare providers.	0.79	4.42	High Extent
a. 5. Approve blood donation activity conducted in the community.	0.64	4.61	High Extent
a. 6. Involve a social media page for health and promotion activities.	0.65	4.58	High Extent
Overall Mean	**0.49**	**4.54**	**High Extent**

Note. N=240. Mean scores were interpreted using the following scale: 4.21–5.00 = High Extent (consistently collaborating); 3.41–4.20 = Extent (regular collaboration); 2.61–3.40 = Moderate Extent (occasional collaboration); 1.81–2.60 = Low Extent (infrequent collaboration); and 1.00–1.80 = Very Low Extent (collaboration not practiced).

As reflected in Table 2, the extent of collaborative functions between healthcare providers and policymakers in terms of coordination was rated as High Extent, with the overall mean score of 4.41 (SD = 0.53). Among the indicators under coordination, ensuring that mass vaccination activities were coordinated with the municipality received the highest mean score of 4.64 (SD = 0.58), interpreted as High Extent. Similarly, inviting the local government to participate in health promotion and advocacy activities (M = 4.61, SD = 0.61) and informing the local government unit during clean-up drive activities (M = 4.60, SD = 0.62) were also interpreted as High Extent. However, two indicators were interpreted as Extent, and these include presenting proposed behavioral activities such as Zumba or Yoga with the mean of 3.93 and SD = 1.08 and "Present the annual operation plan to the local government.", with the mean of 4.13 and SD of 1.00.

Table 2. Extent of Collaborative Functions of Healthcare Providers and Policymakers in Terms of Coordination

Statement	**SD**	**Mean**	**Interpretation**
a. 1. Ensure the conduct of mass vaccination was coordinated to the municipality.	0.58	4.64	High Extent
a. 2. Inform the local government unit when conducting clean-up drive activities.	0.62	4.60	High Extent
a. 3. Invite the local government on health promotion and advocacies.	0.61	4.61	High Extent
a. 4. Present the proposed behavioral activities, such as Zumba or yoga, to the local government.	1.08	3.93	Extent

a. 5. Present the annual operation plan to the local government.	1.00	4.13	Extent
a. 6. Coordinate with the local government when addressing environmental hazards in the community.	0.67	4.57	High Extent
Overall Mean	**0.53**	**4.41**	**High Extent**

Note. *N=240. Mean scores were interpreted using the following scale: 4.21–5.00 = High Extent (consistently collaborating); 3.41–4.20 = Extent (regular collaboration); 2.61–3.40 = Moderate Extent (occasional collaboration); 1.81–2.60 = Low Extent (infrequent collaboration); and 1.00–1.80 = Very Low Extent (collaboration not practiced).*

As presented in Table 3, the extent of collaboration between healthcare providers and policymakers in addressing health disparities was rated High Extent, with an overall mean score of 4.62 (SD = 0.39). Notably, attending to clients' prenatal and postnatal care received the highest mean score of 4.83 (SD = 0.39), indicating High Extent. Similarly, ensuring client confidentiality (M = 4.82, SD = 0.39) and orienting clients regarding consultation processes (M = 4.75, SD = 0.48) were also rated as High Extent. However, screening couples for family planning packages (M = 3.90, SD = 1.08) was rated as Extent.

Table 3. Extent of collaborative functions of healthcare providers and policymakers in terms of addressing health disparities.

Statement	**SD**	**Mean**	**Interpretation**
a. 1. The clients have access to family care program of the government.	0.52	4.62	High Extent
a. 2. The clients receive ferrous sulfate or iron supplementation.	0.63	4.68	High Extent
a. 3. The newborn was vaccinated with BCG.	0.46	4.76	High Extent
a. 4. Couples who ask for family planning package are screened with hepatitis, syphilis, complete blood count, and urinalysis.	1.08	3.90	Extent
a. 5. Clients are not asked to pay or to put money on the donation box.	1.07	4.51	High Extent
a. 6. Clients' pre-natal and post-natal care are attended.	0.39	4.83	High Extent
a. 7. Children under 5 years old receive micronutrient supplementation.	0.61	4.64	High Extent
a. 8. The clients receive home visitation from healthcare providers when not showing for follow-up checkups.	0.51	4.65	High Extent
a. 9. The clients are treated with confidentiality.	0.39	4.82	High Extent
a. 10. The clients are oriented on the process flow of consultation in the Rural Health Unit.	0.48	4.75	High Extent
Overall Mean	**0.39**	**4.62**	**High Extent**

Note. *N=240. Mean scores were interpreted using the following scale: 4.21–5.00 = High Extent (consistently collaborating); 3.41–4.20 = Extent (regular collaboration); 2.61–3.40 = Moderate Extent (occasional collaboration); 1.81–2.60 = Low Extent (infrequent collaboration); and 1.00–1.80 = Very Low Extent (collaboration not practiced)*

As illustrated in Table 4, the extent of collaboration between healthcare providers and policymakers in addressing

healthcare inequities was rated as High Extent, with an overall mean score of 4.66 (SD = 0.34). Among the indicators, the use of common dialect when giving instructions to patients obtained the highest mean score of 4.84 (SD = 0.44), which is interpreted as "high extent." Similarly, the same interpretation was given to providing free tetanus toxoid vaccines for pregnant women (M = 4.83, SD = 0.55), providing free medicines to children under five years old (M = 4.83, SD = 0.44), and referring clients to higher healthcare facilities when necessary (M = 4.83, SD = 0.46); all were also rated as high extent. However, providing government subsidies for pregnant women delivering in lying-in clinics (M = 4.07, SD = 1.17) was interpreted as extent.

Table 4. Extent of collaborative functions of healthcare providers and policymakers in terms of addressing inequitable healthcare

Statement	**SD**	**Mean**	**Interpretation**
a. 1. Healthcare providers use common dialect in giving instructions to patients.	0.44	4.84	High Extent
a. 2. Healthcare providers engage community, traditional, and religious leaders in discussions before conducting mass vaccinations.	0.43	4.76	High Extent
a. 3. Clients are being treated even without health insurance.	0.57	4.75	High Extent
a. 4. Healthcare providers conduct community awareness programs before implementing vaccination drives.	0.40	4.82	High Extent
a. 5. Clients are promptly attended upon arrival at health facilities.	0.57	4.66	High Extent
a. 6. "Buntis Congress" activities for pregnant women receive support from the government.	1.03	4.23	High Extent
a. 7. Pregnant women who give birth in lying-in clinics receive government subsidy through health insurance.	1.17	4.07	Extent
a. 8. Tetanus Toxoid vaccines are given free for pregnant women.	0.55	4.83	High Extent
a. 9. Children under 5 years old who seek consultation in rural health units are given free medicines.	0.44	4.83	High Extent
a. 10. Clients who are not manageable in rural health units are referred to higher facilities.	0.46	4.83	High Extent
Overall Mean	**0.34**	**4.66**	**High Extent**

Note. *N=240. Mean scores were interpreted using the following scale: 4.21–5.00 = High Extent (consistently collaborating); 3.41–4.20 = Extent (regular collaboration); 2.61–3.40 = Moderate Extent (occasional collaboration); 1.81–2.60 = Low Extent (infrequent collaboration); and 1.00–1.80 = Very Low Extent (collaboration not practiced).*

As shown in Table 5, the extent of collaborative functions of healthcare providers and policymakers in promoting effective resource allocation was rated as Extent, indicating that the collaboration between the two is regular, with an overall mean score of 3.80 (SD = 0.92). Among the indicators, access to government-provided ambulance services received the highest mean score of 4.33 (SD = 0.95), indicating High Extent. However, the payment of some health workers by the local government unit received the lowest mean score of 3.31 (SD = 1.48), indicating moderate extent.

Table 5. Extent of collaborative functions of healthcare providers and policymakers in terms of promotion of

resource allocation

Statement	SD	Mean	Interpretation
a. 1. LGU provides allocation for health facilities, advocacy, education, and training initiatives.	1.09	3.80	Extent
a. 2. LGU includes indigent patients in health insurance systems such as PhilHealth and other relevant healthcare institutions.	1.10	3.90	Extent
a. 3. LGU regularly measures, tracks, and monitors healthcare facilities in the implementation of cash subsidies.	1.20	3.59	Extent
a. 4. Health activities such as clean-up drive and medical missions in the barangay are supported by the LGU.	1.20	3.89	Extent
a. 5. BLGU allocates funds for Barangay Nutrition Scholars or Barangay Health Workers.	1.26	3.67	Extent
a. 6. Medications not available in the RHU are referred to other agencies that cater free medications for indigents.	1.00	4.12	Extent
a. 7. LGU provides funding in health centers so that treatments are free.	1.21	3.77	Extent
a. 8. Rural Health Centers have access to ambulance owned by government.	0.95	4.33	High Extent
a. 9. Some health workers in the Rural Health Units are paid by the local government unit.	1.48	3.31	Moderate Extent
a. 10. LGU augments financial assistance to RHU when there is conduct of mass vaccination in the community.	1.26	3.67	Extent
Overall Mean	**0.92**	**3.80**	**Extent**

Note. *N=240. Mean scores were interpreted using the following scale: 4.21–5.00 = High Extent (consistently collaborating); 3.41–4.20 = Extent (regular collaboration); 2.61–Moderate Extent (occasional collaboration); 1.81–2.60 = Low Extent (infrequent collaboration); and 1.00–1.80 = Very Low Extent (collaboration not practiced)*

As presented in Table 6, the findings from the Focus Group Discussions (FGD) and Key Informant Interviews (KII) reveal four major themes identified through thematic analysis. These themes collectively illustrate the dynamics shaping the implementation of the community-based collaborative care model.

The first theme, **Adaptive Relational Governance**, highlights how healthcare providers navigate the implementation process within fragmented formal systems. The findings indicate that, in the absence of fully institutionalized structures, providers depend heavily on informal networks, interpersonal trust, and relationship-based coordination. This adaptive approach allows stakeholders to maintain functionality despite systemic gaps, demonstrating the critical role of social relationships in sustaining collaboration.

The second theme, **Relational Health Equity**, underscores how access to healthcare services is shaped by multiple intersecting factors, including geographic location, socioeconomic conditions, and local security situations. Participants emphasized that proximity to healthcare facilities significantly affects service utilization, particularly in geographically isolated and disadvantaged areas. At the same time, trust-building and active community engagement emerged as essential mechanisms for mitigating barriers to access and promoting more equitable health outcomes.

The third theme, **Structural Systemic Depletion**, reflects the persistent limitations within the healthcare system. The findings reveal that inadequate infrastructure, shortages in healthcare workforce, and insufficient resources constrain service delivery. Participants consistently reported challenges related to limited supplies, understaffing, and overburdened facilities, all of which contribute to inefficiencies and reduced quality of care.

Finally, the theme **Relational Resilience in Systemic Dependency** illustrates how continuity of care is sustained despite structural weaknesses. The findings show that healthcare delivery often depends more on the resilience, adaptability, and commitment of providers than on formalized systems. Interpersonal relationships and informal coordination mechanisms serve as critical buffers, enabling providers to cope with systemic deficiencies and maintain service provision.

Table 6. Presentation of the Qualitative Result

Emergent Themes	**Sub-themes**	**Significant Statements**
a. 1. Adaptive Relational Governance	Informal, Relationship-Driven Governance of Collaborative Care, Fragmented Policy, and Multi-Level Governance Structures	FGD- P1: Policymaker verbalized, "Meron silang Local Health Board… dumarating sa barangay level."(*There is a Local Health Board that coordinates down to the barangay level* FGD-P2: Healthcare provider said: "Sa ngayon, wala po kaming sinusunod na guidelines… nakikipag-communicate kami kay Mayor… through letter naman."(*At the moment, we do not follow any guidelines… we communicate with the Mayor through letters.*) FGD-P3: Healthcare provider verbalized: "Masasabi namin na 5 po ito… si Doc Dada… minemake sure po nya na well-coordinated."(*We rate it 5 because Doc Dada ensures coordination.* KII-P4: Policymaker : Kulang pa ang localized implementation...may gap sa coordination." (*Localized implementation is lacking, and there is a coordination gap. ")*
a. 2. Relational Health Equity	Unequal Access Shaped by Geography, Poverty, and Security and Community Trust and Patient-Centered Care Practice	FGD- P1: Mothers with under 5 children verbalized the following: "Nakatira kami sa Sitio San Roque… malapit lang." (*We live in Sitio San Roque, which is near.*) Conversely, individuals in geographically isolated and disadvantaged areas (GIDA) experience barriers: FGD- P1:"Those who live from far- flung areas… they feel they are neglected… GIDA area." FGD-P2 :Security concerns further area."complicate

		healthcare delivery: KII-P3:"Priority… yung rido settlement." (*Peace and rido settlement are prioritized.*) Despite these challenges, local leaders play an important role in facilitating access as verbalized by the respondents. FGD-P4: Mothers with under 5 children verbalized: "Si Brgy Chairman, action agad." (*The barangay chairman acts immediately.*)
3. Structural Systemic Depletion	Leadership-Centered Service Delivery and Crisis Management and Chronic Resource and Infrastructure Constraints	KII-P1- "Currently, our resources… are insufficient to fully implement the Collaborative Care Model… still not enough to meet all the needs." Although some infrastructure is available: KII-P2: "Meron na tayong basic infrastructure… RHU building… ambulance… ngunit kailangan pa natin ng maayos at kumpletong RHU facility." (*We already have basic infrastructure… but still need a complete RHU facility.*) Human resource constraints are also evident: KII-P3: "Additional medical administrative personnel… overloaded na rin ang existing staff…" (*Additional staff are needed because existing personnel are overloaded.*) FGD-P4: "Kulang ng staff" *We lack staff.*
4. Relational Resilience in Systemic Dependency	Dependency-Oriented Health Service System and Adaptive Coping and Professional Resilience among Frontliners	FGD-P1: "Gamot… hygiene kits… per request." (*Medicines and hygiene kits are provided upon request.*) 1. FGD-P2: "When informed, LGU supplies medicines and equipment. 2. FGD-P3: "Nasasanay na kami… pag hindina kaya humihinge kami ng help." *(We are used to it; we ask for help when needed.)*

After presenting the results, the researcher developed a set of policy recommendations as practical steps to bridge the intersectional care gap between healthcare providers and policymakers. These suggestions are meant to be concise, actionable, and easy for LGU and BARMM to implement, with each addressing a specific issue identified in the study.

First, establishing a Local Health Coordination Mechanism (LHCM) is proposed to create a formal structure for collaboration, ensuring that coordination efforts are institutionalized rather than reliant on informal relationships.

To support this, it is recommended to map existing coordination practices to identify current strengths, gaps, and overlaps in collaboration.

Building on this, clearly defining roles and responsibilities among stakeholders is essential to reduce confusion and enhance accountability in service delivery. Supporting this, assigning coordination focal persons in each municipality or health unit is recommended to ensure consistent communication and follow-up of collaborative activities.

Finally, the development of standard coordination protocols is emphasized to guide interactions, streamline processes, and promote consistency across different levels of governance.

The detailed version of these policy recommendations is provided in Appendix A presented as a memorandum for ease of adoption and implementation.

DISCUSSION

This study examined collaboration between healthcare providers and policymakers in selected BARMM municipalities by integrating quantitative and qualitative data to explain how communication, coordination, resource allocation, and efforts to reduce health disparities function in practice . Quantitative findings indicate a high extent of collaboration, particularly in communication and coordination, as reflected in active participation in joint activities, adherence to policies, and engagement in public health initiatives. These findings support existing literature that interprofessional collaboration enhances communication, coordination, and shared decision-making in healthcare settings (Reeves et al., 2017; Sanborn, 2023). Similarly, effective communication systems have been shown to improve service delivery in coordinated public health efforts (Sharkiya, 2023; Panjaitan, 2023).

Despite these strengths, lower ratings in feedback participation and preventive or lifestyle programs highlight gaps in evaluative and long-term coordination processes . Qualitative findings provide further explanation, revealing that collaboration is largely sustained through informal networks and personal relationships rather than formalized systems. This finding aligns with prior studies indicating that while collaboration may appear effective in structured assessments, it is often constrained by weak coordination systems, unclear roles, and reliance on informal practices (Moncatar et al., 2021; Abdeen et al., 2021). Furthermore, effective interprofessional collaboration requires not only interaction but also structured mechanisms that support role clarity and sustained teamwork (Reeves et al., 2017; McLaney et al., 2022).

Anchored in Peplau's Interpersonal Relations Theory, the findings suggest that collaboration is strong at the relational level but remains limited in its progression toward institutionalization. Trust and familiarity enable cooperation, consistent with the working phase; however, the absence of formal systems constrains movement toward more structured and sustainable collaboration . This explains why collaboration appears effective in practice but remains inconsistent and dependent on individual actors.

The integration of quantitative and qualitative data highlights a key insight: collaboration is functionally strong but structurally fragile. While interpersonal trust sustains coordination, the lack of formalized systems limits scalability, accountability, and long-term sustainability. This supports mixed-methods research suggesting that strong quantitative indicators of collaboration may mask underlying structural constraints revealed through qualitative evidence (Kelly et al., 2025). These structural limitations also contribute to persistent health disparities, where collaborative efforts do not consistently translate into equitable outcomes.

To address these gaps, the study introduces Adaptive Relational Governance (ARG) as a complementary framework. ARG bridges relational strengths with institutional structures by embedding trust, communication, and participation into formal governance mechanisms. This approach enables collaboration to become more consistent, accountable, and sustainable. Overall, the findings demonstrate that effective healthcare collaboration requires both strong interpersonal relationships and structured governance systems to achieve equitable and lasting health outcomes .

In response to various challenges, this study proposes a strategic roadmap that shifts collaboration from a primarily relationship-based approach to a more organized, system-oriented one. The roadmap focuses on reducing reliance on informal relationships, strengthening collaborative resilience through institutional support, preventing structural inefficiencies by clarifying roles and processes, and promoting health equity through inclusive governance. Moreover, the roadmap aims to strengthen relational resilience by embedding interpersonal trust within institutional support systems. This ensures that existing collaborative strengths are preserved while being reinforced through formal mechanisms. To further enhance system efficiency, the roadmap focuses on preventing structural depletion by clearly defining roles, responsibilities, and coordination processes, thereby minimizing confusion and improving accountability among stakeholders.

In addition, it advances relational health equity by promoting inclusive governance, ensuring that collaboration is not only efficient but also responsive to the diverse needs of communities. By aligning governance structures with the relational phases of Hildegard E. Peplau, the roadmap ensures that collaboration evolves from informal, trust-based interactions into a sustainable, efficient, and accountable system of care delivery.

Table 7. Strategic Roadmap for Collaborative Care Framework

Strategic Phase	**Key Actions**	**Timeframe**	**Expected Output**	**Peplau Phase Alignment**
a. **1.Foundation Building**	• Map existing informal networks and communication flows• Strengthen Local Health Board functionality• Conduct trust-building and stakeholder alignment workshops	Short-term (0–6 months)	Documented coordination structure; strengthened trust among stakeholders	Orientation
a. **2.System Structuring**	• Establish formal coordination and communication protocols • Create a Technical Working Group (TWG) on health disparities and resource allocation • Define roles, responsibilities, and reporting mechanisms	Short-term to Medium-term (6–12 months)	Formalized coordination mechanisms; operational TWG	Identification
a. **3.Operational Integration**	• Institutionalize joint planning, budgeting, and resource allocation processes • Integrate culturally responsive and community-based approaches into programs • Strengthen monitoring and feedback systems	Medium-term (1–2 years)	Integrated plans and budgets; improved service delivery coordination	Exploitation (Working Phase)
4.Sustainability and Scaling	• Enact local policies or ordinances supporting coordination mechanisms • Scale best practices across municipalities • Establish continuous evaluation and adaptive governance systems	Long-term (2–3 years)	Institutionalized, sustainable collaboration systems	Resolution

SUMMARY, CONCLUSION, RECOMMENDATION

Summary of Findings

This section contains the summary of results, recommendations, and conclusions. The following results were evident:

a. 1. Many of the participants revealed there is a great extent of collaboration between healthcare providers and policymakers in terms of communication, with an overall mean score of 4.54 (SD=0.49). In terms of coordination, the participants reported a high level, with a mean score of 4.41 (SD=0.43), indicating consistent collaboration when carrying out a task. On the other hand, the results of the data gathered from FGD and KII imply personal networks rather than institutionalized systems. It gives the idea that a great extent of collaboration exists in the system through personal networks.

b. 2. In terms of addressing health disparity, the participants revealed a high extent meaning there is a consistent collaboration between healthcare providers and policymakers in addressing health disparities with an overall mean score of 4.42 (SD=0.53). Based on this data, when the two collaborates there will be reduction of cases. On the other hand, it will give another meaning to the theme gathered when talking about disparity, in which it is said there are structural inequalities that continue to shape service utilization.

c. 3. In terms of addressing inequitable healthcare, the participants revealed a great extent, which means there is a consistent collaboration between healthcare providers and policymakers in addressing inequitable healthcare, with a mean score of 4.66 (SD=0.34). On the other hand, the integrated themes gathered indicated persistent human resources and capacity gaps arising from the integration (KII 4, 8 + FGD 3, 4, 5), which were interpreted as workforce shortages and uneven training, thereby weakening service delivery.

d. 4. In terms of the promotion of resource allocation, the participants reported a moderate result, indicating regular collaboration between healthcare providers and policymakers, with a resource allocation score of 3.80 (SD=0.92). On the other hand, the integrated themes gathered indicated that there are chronic resource and infrastructure constraints.

   This was obtained through the integration (KII 2, 3, 9 + FGD 2, 7, 10), which was interpreted as resource provision remains reactive, fragmented, and insufficient. In the survey conducted on promotion of resource allocation, the results were extent which means there is a regular collaboration between healthcare providers and policymakers but are not consistent compared to other indicators.

Conclusion

In conclusion, collaboration between healthcare providers and policymakers in BARMM is built on strong relational foundations but lacks sufficient structural support. Peplau's Interpersonal Relations Theory explains the current reliance on informal, trust-based interactions and emphasizes the need to develop more structured and goal-oriented relationships.

However, systemic dependency on informal networks, coupled with structural systemic depletion, limits this progression. While relational resilience enables stakeholders to sustain collaboration, it is insufficient for long-term system strengthening. Persistent gaps in relational health equity further indicate the need for more inclusive and structured engagement.

Adaptive relational governance provides the integrative solution, enabling the institutionalization of relational strengths while maintaining flexibility and responsiveness. By aligning governance systems with Peplau's relational phases, ARG facilitates the transformation of informal, person-dependent collaboration into sustainable, equitable, and system-driven partnerships.

Recommendations

Based on the findings and their theoretical integration, the following recommendations are proposed to strengthen collaboration between healthcare providers and policymakers and improve health service delivery in BARMM municipalities:

A. For Action

1. Institutionalize Adaptive Relational Governance (ARG) Mechanisms by establishing a formal Local Health Coordination Mechanism **a**nchored in the Local Health Board. This mechanism should combine structured coordination processes with relational practices like trust-building, open communication, and ongoing feedback. Implementing ARG institutionally will help transform collaboration from informal networks into sustainable, system-driven partnerships.

2. Reduce reliance on informal networks within the system. Develop and implement standardized protocols for communication, coordination, and decision-making. Clearly define roles and responsibilities to ensure collaboration is built into institutional systems rather than depending on specific individuals.

3. Strengthen Relational Resilience through Capacity Building: Invest in leadership development, team-building activities, and inter-agency training programs that enhance trust, mutual understanding, and conflict resolution skills among stakeholders. These initiatives will reinforce Peplau's "working phase" and sustain effective collaboration even in challenging contexts.

4. Address Structural Systemic Depletion: Improve institutional capacity by ensuring adequate staffing, clarifying organizational roles, and reducing workload imbalances among key actors. Establish formal coordination units or focal persons to distribute responsibilities more equitably and prevent over-reliance on informal coordinators.

5. Promote Relational Health Equity: Strengthen inclusive and culturally responsive governance by actively engaging marginalized and geographically isolated communities in planning and decision-making processes. Utilize local languages, culturally appropriate strategies, and community-based approaches to ensure that relationships between institutions and communities are equitable and meaningful.

6. Enhance Coordination in Resource Allocation: Establish participatory and transparent processes for planning, budgeting, and resource distribution. Integrate iterative decision-making mechanisms that allow stakeholders to collaboratively identify priorities and adjust allocations based on emerging needs, consistent with adaptive relational governance principles.

7. Institutionalize Community Engagement and Feedback Systems: Create formal platforms for community feedback, such as regular consultations, public forums, and grievance mechanisms. This will strengthen accountability, improve trust, and ensure that health services are responsive to community needs.

8. Strengthen Political Commitment and Policy Support: Encourage elected officials and policymakers to prioritize health governance reforms by allocating sufficient resources and ensuring continuity of programs across political cycles. Strong political will is essential for sustaining institutionalized collaboration mechanisms.

9. Establish a Technical Working Group (TWG) on Health Equity and Governance: Form a multi-sectoral TWG that focuses on addressing health disparities, improving coordination, and operationalizing adaptive relational governance. This group should monitor implementation, evaluate outcomes, and recommend policy adjustments.

10. Integrate Relational and Governance Frameworks into Policy and Practice**.** Incorporate principles from Peplau's Interpersonal Relations Theory and adaptive relational governance into local health policies, guidelines, and training programs. This ensures that both relational dynamics and institutional systems are aligned in promoting effective collaboration.

B. For Further Study

Future research should build on the identified gaps by examining how formal governance structures and

standardized guidelines can strengthen collaborative care beyond informal, relationship-driven practices. There is a need for longitudinal studies to assess the sustainability and long-term impact of collaborative care models, particularly in resource-constrained and conflict-affected settings. Further investigation is also recommended on healthcare access in geographically isolated and disadvantaged areas (GIDA), focusing on the interplay of geography, poverty, and security in shaping health outcomes. Studies exploring strategies to improve resource allocation, infrastructure development, and workforce capacity are essential for addressing the systemic limitations identified in this research. In addition, future research should incorporate patient-centered perspectives to better understand experiences, satisfaction, and trust in healthcare services. Overall, these areas of inquiry will help bridge the gap between strong relational collaboration and weak structural systems, ultimately contributing to more equitable and sustainable healthcare delivery (Briggs et al., 2019; Centers for Disease Control and Prevention [CDC], 2022)

APPROVAL SHEET

The Faculty of the Graduate School of Notre Dame University accepts and approves the thesis entitled:

"Collaborative Care Model In Community Health Nursing: Bridging Healthcare Providers And Policymakers For Intersectional Care"

submitted by **Johaira M. Ali**, in partial fulfillment of the requirements for the degree of **Master of Arts in Nursing**.

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Certificate Of Authentic Authorship

I hereby declare, to the best of my knowledge, that this is my own work and that it contains no materials previously published or written by others, nor material that has been substantially accepted for a degree or diploma at Notre Dame University or any other educational institution unless proper acknowledgment is made. Any contributions made to the research by others, whether at NDU or elsewhere, are explicitly mentioned in this paper.

I also declare that the intellectual content of this paper is the product of my own work except to the extent that assistance from others in the design or style and conception of the study, presentation, and linguistic expression is acknowledged.

JOHAIRA MACACUA-ALI, RN

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Curriculum Vitae

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a. III.TRAININGS AND SEMINARS ATTENDED

Achievements: None

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