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Bayanihan E-Konsulta: a volunteer-driven response to the COVID-19 pandemic in the Philippines

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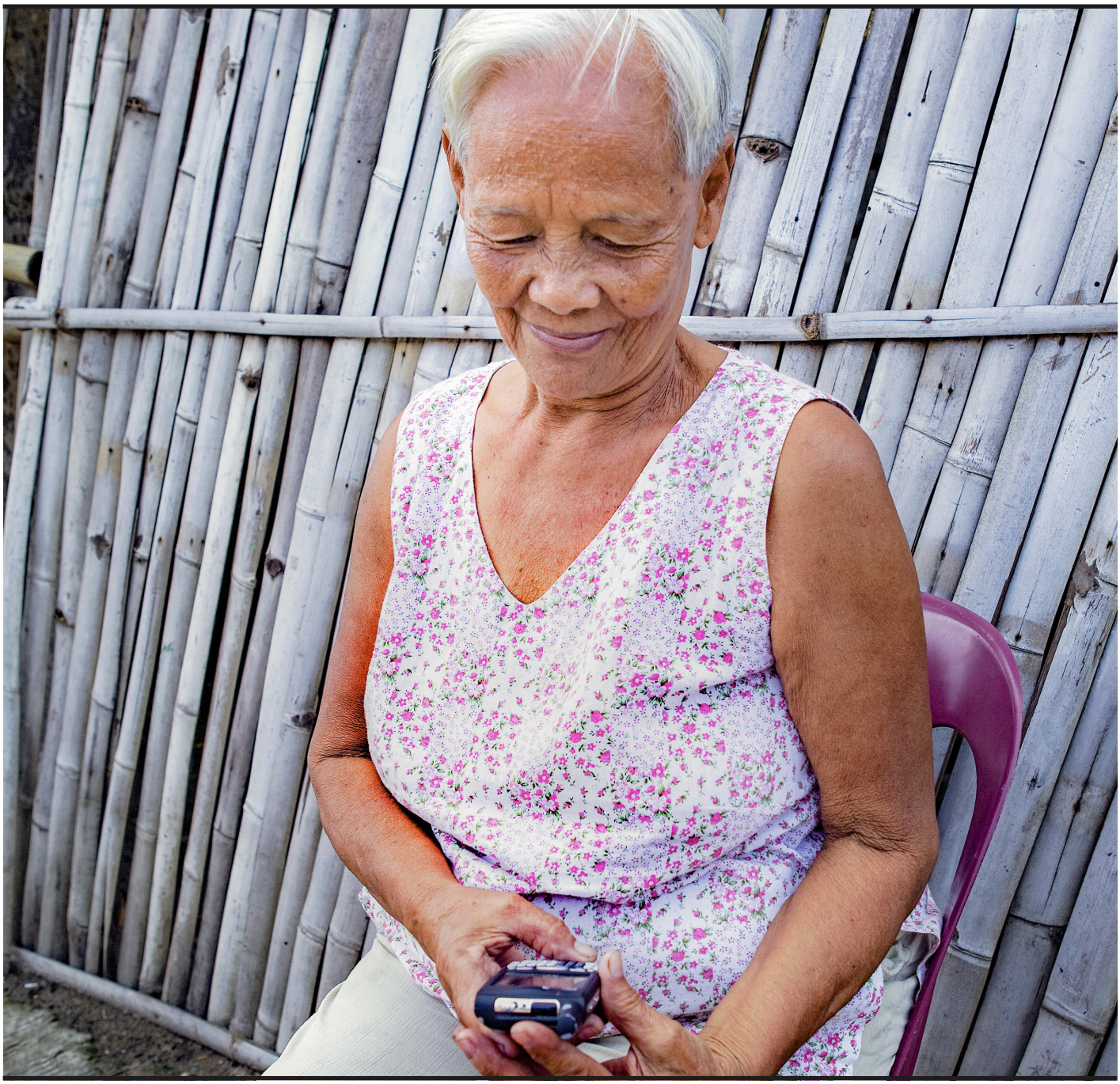

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THE HUMANITARIAN LEADER:
Bayanihan E-Konsulta: a volunteer-driven response to the COVID-19 pandemic in the Philippines

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Cover image: A Filipino woman looks at her mobile phone. © Art Phaneuf / Alamy Stock

Abstract

COVID-19 stretched health systems worldwide, but its deepest impacts were disproportionately felt across certain population segments. In the Philippines, a low-middle income country with one of the longest pandemic-induced lockdowns, the most marginalised communities suffered the most, and had little agency to afford and access care. Socioeconomic barriers, compounded by the misallocation of limited resources and the militarisation and overall mismanagement of the response, widened inequities, and resulted in poorer health outcomes for these groups.

In an attempt to redress this, the Office of the Vice President of the Philippines sought to fill gaps in health delivery and access by launching Bayanihan E-Konsulta (BEK), a free telemedicine platform for indigent Filipinos. Through a Facebook messenger service that ran on free data, patients were given the opportunity to consult with health professionals regarding their medical concerns at no cost. Relevant social services, such as prescription delivery, laboratory assistance, and food and financial aid, were also streamlined in the platform. Recognising limitations in funding, the program banked on the mobilisation of health professionals and volunteers, and relied on capacity-building initiatives and the establishment of inter-agency collaborations.

Institutional credibility, intersectoral collaboration, and effective management of team dynamics were identified as enabling factors for the program's effectiveness. Transparency attracted partnerships, and trust in leadership inspired solidarity, volunteerism, and continued service. Inclusivity in different project stages improved engagement and encouraged shared participation and accountability, allowing for resilience and sustained action. Overall, BEK stands as a successful example of a low-cost public/private/volunteer health response in a time of crisis.

This paper discusses the critical challenges, considerations, and the iterations to the service implemented by the BEK team, providing insights for public health leaders and other low-to-middle income countries when tailoring responses to future public health emergencies.

Leadership relevance

Responsiveness to very dynamic situations like public health emergencies is an important characteristic of humanitarian leadership practice. In complex systems and disasters, collaboration is essential to gather diverse inputs, anticipate challenges and develop strategies to address them proactively and respond quickly and effectively. Participatory leadership can help leaders make informed decisions, gain buy-in from stakeholders, and mitigate risks, but over-reliance on consultatory processes may lead to delays. This required the BEK leadership team to strike the delicate balance between the need for speed and the need for thoughtful and ethical decision-making.

BEK provides a model of how a national government body with limited funding and technological capacity can comprehensively address the expansive needs of the communities it serves by effectively mobilising volunteers and engaging the private sector, government agencies, and local government units. It also serves as a testament to the value of balancing bureaucracy and flexibility in disaster situations. This program was a product of a combination of clear guidelines and procedures, flexible decision-making, and collaboration, which ensured a consistent but effective and timely responsive.

Introduction

The first COVID-19 case in the Philippines was detected on January 20, 2020. A state of public health emergency was declared on March 8, 2020, and the entire island of Luzon, where the National Capital Region (NCR) is located, was placed under enhanced community quarantine eight days later. All mass gatherings were prohibited and strict home quarantine was mandated (Government of Philippines, 2020). Travel was restricted, and movement was limited to accessing food and essential health services. Public transportation was suspended, businesses shifted to work-from-home, and only private establishments providing basic necessities were allowed to operate with a skeleton workforce. There was a drastic shift in health services, with hospitals struggling to respond to the pandemic. Health personnel and health resources were diverted towards the care of COVID-19 patients, and outpatient services ceased.

Given the lack of a structured nationwide telemedicine program, existing travel restrictions, and economic recession, accessing healthcare became even more challenging than it already was for many Filipinos, especially those residing in COVID-19 hotspots.

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Towards the end of 2020, there was a decrease in the number of COVID-19 cases in the Philippines, and hospitals were slowly able to resume other services. However, travel restrictions were lifted, and community quarantine guidelines were eased without the implementation of a comprehensive and efficient contact tracing system, a free mass testing program, or widespread vaccination against COVID-19. So, in March 2021, with the emergence of new COVID-19 variants, the Philippines suffered another surge in COVID-19 cases in NCR and its surrounding provinces (Cepeda, 2021). Hospitals were filled, healthcare worker infections rose, and many Filipinos seeking healthcare services had nowhere to turn to (Cortez, 2021).

In response to this surge of COVID-19 cases in the metro area and the resulting congestion of hospitals and other health facilities, the Office of the Vice President (OVP) launched the Bayanihan E-Konsulta program (BEK) on April 7, 2021.

BEK is an online-based telemedicine platform developed to cater to both COVID-19 and non-COVID-19 patients in the NCR+ bubble, particularly those unable to access existing telemedicine platforms due to high costs, poor internet connections, or the lack of advanced equipment.

Doctors, healthcare providers, and public health specialists from public and private institutions were consulted to understand what was happening in hospitals and local communities and to help develop stop gap measures that BEK-OVP could take on. Telecommunications companies were also approached to explore possible partnerships that would increase accessibility, especially for Filipinos with limited resources.

An operational framework was constructed after meetings with various stakeholders, and technical requirements were subsequently identified. Facebook (now Meta) Messenger was utilised to receive requests, and free medical teleconsultations were provided via mobile phone calls. Without cellular data requirements, this platform was the most popular and most user-friendly application for many Filipino users.

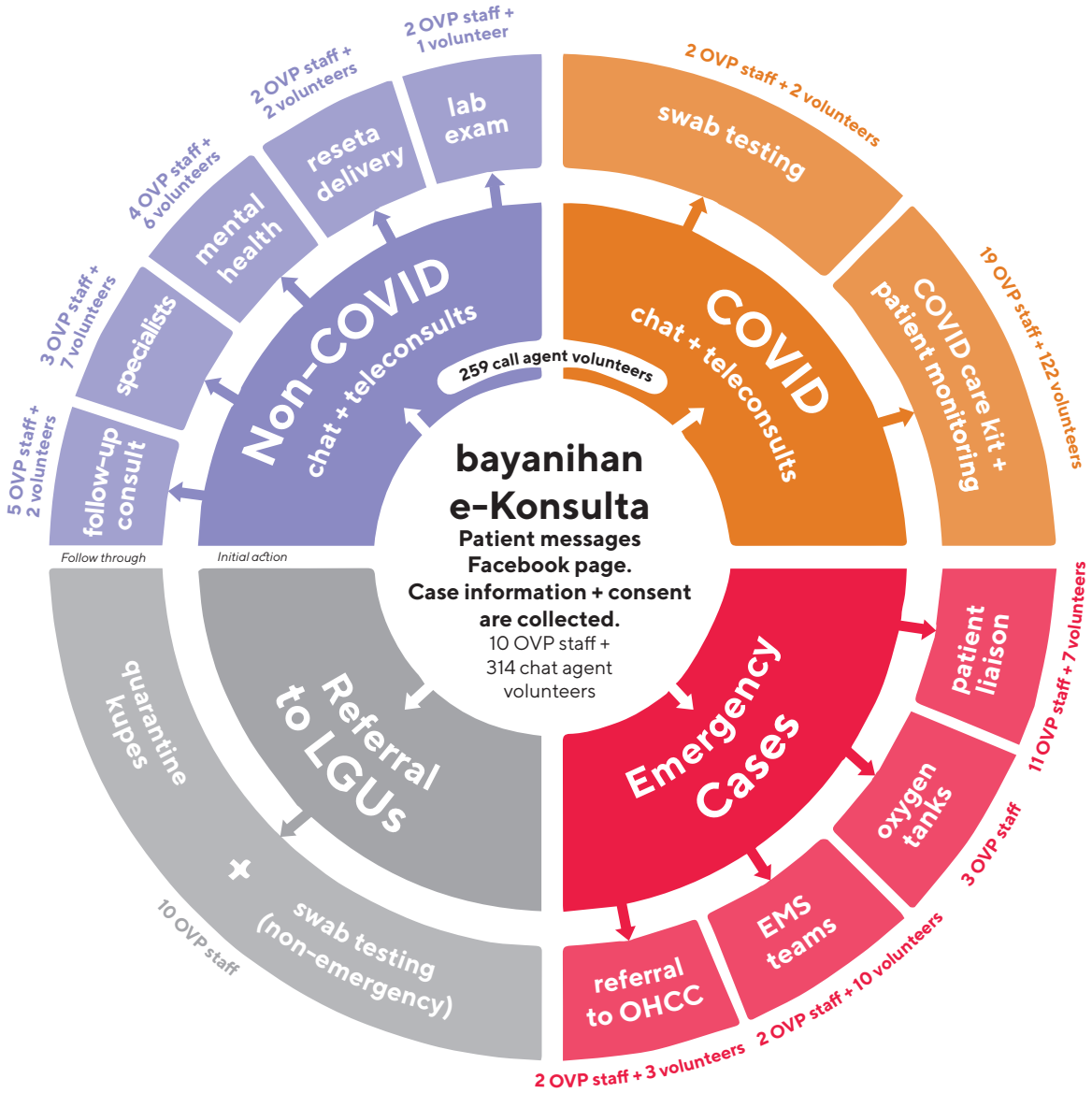
Human resource needs were concurrently assessed. Current capacity was determined, and administrative tasks were delegated to available OVP staff members. A public call for medical and non-medical volunteers was then made to complete the taskforce. This was met with an overwhelming response by professionals, organised volunteer groups, and private individuals, which allowed for the creation of multiple teams, and the provision of a wide array of healthcare services.

Healthcare providers from various practices and specialties, including doctors, nurses, dentists, and therapists, freely shared their expertise, enlisted for shifts, and offered to be on call for teleconsultations at designated times of the day. Advocacy groups, especially mental health societies, also extended their services to complement existing efforts and accommodate more patients.

When the program ended on May 31, 2022, some 1,109 medical volunteers had been verified and onboarded. Through the assistance and in-kind donations of its partners, BEK was also able to assemble its own COVID Care Package Kit for patients isolating at home without health kits and basic medical paraphernalia in their households. Each kit included: (1) a 14-day symptom monitoring sheet, (2) over-the-counter medicine and instructions for use, and (3) medical gadgets, such as digital thermometers, pulse oximeters, face masks, disinfectants, alcohol, and waste disposal bags.

Non-medical teams were just as essential in the program's daily operations. There were 1,678 volunteers who were assigned various tasks, including: (1)

Figure 1. BEK-OVP Operational Chart as of May 2021



98 *OVP staff activated*

748 *volunteers activated**

* Number of volunteers who already went on duty; onboarding of others who signed up continues

Volunteer management (doctors)
8 OVP staff + 2 volunteers

Volunteer management (non-doctors)
6 OVP staff + 4 volunteers

Monitoring & evaluation
3 OVP staff + 5 volunteers

IT support
2 volunteers

Referral for outside NCR+ bubble
3 OVP staff

Overall management
13 OVP staff

contacting patients, discussing confidentiality and data privacy terms, obtaining consent, and bridging calls to volunteer doctors for teleconsultation, and (2) acting as chat support, by attending to inquiries and screening requests. Patients flagged for consultation were triaged by medical doctors, while those needing other forms of assistance were directed to appropriate teams.

Non-medical volunteers also staffed the teams that acted on post-teleconsultation recommendations, including: (1) e-prescription delivery, (2) doorstep delivery of COVID care kits, (3) daily monitoring of BEK-OVP patients under quarantine, (4) assistance for basic diagnostics and swab tests through a commissioned mobile laboratory, (5) non-medical assistance, such as

financial aid, food packs, and referral to local government units, and (6) referral to the in-house Emergency Medical Service (EMS) for immediate response. Some of the program's medical volunteers also helped out with the other post-teleconsultation recommendations, such as one volunteer doctor who delivered COVID care kits to patients on his bicycle on his days off from hospital duties.

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Several patients benefited from the COVID care kit and patient monitoring service of the program. Some COVID-positive patients who did not have symptoms of breathing difficulties were identified to be experiencing low blood oxygen levels through the pulse oximeter provided and regular monitoring by the non-medical volunteers. Once patients with distorted vitals were flagged, the emergency response arm of the program was immediately activated.

Issues and evolution

Issues encountered in the earlier stages of BEK's operations were due to the sheer volume of patient requests received daily.

An online spreadsheet service was initially used to store information, but this began to lag with the increasing number of patients. Information technology specialists were invited to develop a database and a net-based system tailored to the BEK's needs and process flows. This increased data capacity and improved data management allowed for easier patient record retrieval for follow-up teleconsultations.

Volunteer-driven operations were highly dependent on the availability of personnel, who had commitments outside the program as well. It was particularly challenging when volunteers cancelled shifts that they had originally signed up for at the last minute. Coupled with the overflow of teleconsultation requests, such limitations resulted in missed expectations, delays in service delivery, and even compromised continuity of care for patients on follow-up. This called for a review of the program's staff capacity and overall scope of service.

Workstreams were re-evaluated to identify which steps of the operations were labour-intensive and which ones could be automated. Calls for additional volunteers were made, and a surge hiring of staff on a job-order basis became necessary to keep up with the workload and influx of patients. Daily teleconsultation caps were set based on available human resources, while still ensuring that urgent cases received immediate attention through an adjusted triaging system.

BEK further organised its referral system with local government and health units to coordinate the care of patients outside the NCR+ bubble, after redefining the geographic limits of its services. It also strengthened its partnership with the One Hospital Command Centre (OHCC), which provided health systems capacity analytics and coordinated facility referrals in metro Manila, to properly endorse critical patients that required hospitalisation or in-person intervention. In one encounter, a pregnant, COVID-positive patient had difficulty finding a hospital to accommodate her as she was about to give birth. Through close coordination with the OHCC and the program's own emergency medical services, the patient was referred to and brought to one of the largest government hospitals in the metro area. She was able to deliver the child safely, and they were discharged without complications a few days later.

Finally, additional medics and basic equipment for emergency response, such as ambulances, oxygen tanks and IV fluids, were procured for interim management of urgent and emergent cases. Partnerships with other ambulance service providers were also established to cope with the increasing number of emergency service requests to the program.

Lessons

Sustained patient-provider engagement has been proven to improve health literacy, health outcomes, and patient experience by allowing individuals to become more active participants in their care (Bombard, 2018). Although moderate to severe COVID cases were referred to hospitals, a significant number of BEK patients were managed at home. Probable, suspected and mild COVID cases were provided with care kits, quarantined, and monitored twice daily. Patients who received this service took more responsibility for their care and were empowered to be stewards of their own health, with a significant number even proceeding to volunteer for the program. Some patients even willingly took on shifts during isolations. Recovered patients provided unexpected additional resources, which was instrumental in sustaining operations.

BEK ran daily for a little over a year and continues to operate, albeit in a modified form, to this day. It has served many patients through continued volunteerism, especially from the Filipino youth. This highlights the potential of youth involvement in disaster response (United Nations, 2020), and underscores the role of credibility and trust in leadership in inspiring service, and the role of program management in sustaining engagement.

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While motivations varied, person-environment fit and similarities in attitudinal characteristics (e.g. political preference and trust) (Bekkers, 2012) were key to attracting volunteers. Self-fulfillment and job and workplace satisfaction were also critical in sustaining action. Apart from non-monetary incentivisation (Abduljawad & Al-Assaf, 2011), it was crucial to clearly define tasks, and to thoroughly orient and manage the expectations of volunteers. Communication lines with team leads were kept open, allowing for quick troubleshooting of technical and personal issues. This was a critical component as emergency responses are highly time-sensitive in nature.

Given the nature of the service, it was important to ensure the emotional and psychological well-being of the volunteers as well. There were reports of over-identification, compassion fatigue, and emotional exhaustion, which are common in health- and disaster-related response operations (Gonzalez-Mendez & Diaz, 2021). Regular debriefing and feedback sessions were then conducted to bolster resilience among volunteers, provide adequate organisational support, and delegate and reshuffle tasks as needed. Regular onboarding sessions were also conducted to increase the pool of volunteers and ensure adequate human resources to cater to the increasing number of patients.

Intersectoral collaboration and private partnerships were also essential components to service delivery. As an agency, the OVP had a very limited budget and mandate to run the program independently, so it required additional resources and support to broaden its reach and sustain its operations. Mutual commitment and reciprocity (Joudyian et al, 2021) were crucial in strengthening relationships with local government units and health departments, while transparency attracted benefactors and companies to extend their assistance.

BEK played an important role in the pandemic response, especially during the surges in April 2021, August 2021 (Delta) and January 2022 (Omicron). It was able to follow through on its commitment to provide a more accessible platform for healthcare for indigent Filipinos and implement measures that aided in the decongestion of hospitals to support an already overworked formal health unit. As of May 31, 2022, it has been able to process 56,262 patient requests, conduct 20,917 teleconsultations, respond to 2,978 emergency cases, and deliver 13,494 COVID Care Package Kits.

BEK-OVP was a product of interagency coordination, collective action, and volunteerism. It was an embodiment of *bayanihan*, a Filipino word for communal unity and cooperation. We encourage people in other resource-constrained settings to consider the measures taken by BEK-OVP in crafting their own disaster-response programs and policies.

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Leadership relevance

BEK provides a model for effective humanitarian leadership in disasters and crises as devastating as COVID-19.

The teleconsultation platform was originally intended to complement the ongoing response initiatives of the OVP at the time. These included the provision of transportation and temporary lodging for health workers, manufacturing and distribution of locally sourced personal protective equipment, testing services, and vaccination drives. Non-medical but essential measures, such as food drives and the formation of community learning hubs and markets, were likewise launched.

Although these interventions contributed significantly, there was an urgent need to augment service provision in a flailing health system during the height of the pandemic. Humanitarian leadership was essential in efficiently recognising gaps, identifying opportunities and organisational limitations, and rapidly mobilising resources to address any crisis situations.

There are many different variations in definitions of humanitarian leadership, but we find adaptive leadership to be the most encompassing reference in the literature. Heifetz et al (2009) refer to adaptive leadership as "the practice of mobilising people to tackle tough challenges and thrive". Bolletiono et al (2019) add that it is about providing a clear objective and overall goal, and motivating others to work towards it despite and within a changing environment.

These characteristics were instrumental in the success of BEK, but an important component was also participatory leadership. This approach involved relevant stakeholders—both medical and non-medical professionals—throughout the development and implementation of the health innovation to ensure the responsiveness of the service, empower individuals and catalyse a sustainable response.

OVP acknowledged its technical limitations in developing a health-related platform, so it sought experts in relevant fields to understand public health realities as they happen on the ground. Although it was important to appreciate complexities, fast action was critical, and analysis paralysis was deliberately avoided. Strategic vision allowed for the design of workstreams aligned with swiftly but thoughtfully identified goals and objectives, and leadership and decisiveness translated these into results-driven action.

The direct participation of the top leadership in the backend and the day-to-day tasks of the program (e.g., processing patient requests, call bridging, and collaborating with working teams and partners, among others) grounded the key decision-makers in the operations of BEK.

The direct participation of the top leadership in the backend and the day-to-day tasks of the program (e.g., processing patient requests, call bridging, and collaborating with working teams and partners, among others) grounded the key decision-makers in the operations of BEK. This birthed deep insights and practical recommendations for further improving and refining the system. Coordination across the board—from top management down to the volunteers—allowed for resilience and iterative action that was backed up by data from daily monitoring and quality assurance reports. The collective culture of task ownership and accountability also facilitated efficient processes and created responsible and empowered team members.

Despite constraints, OVP capitalised on its ability to build networks, partnerships and a community of nation-builders. This supports the idea that while humanitarian leaders are not always fully equipped to address emerging crises, the ability to establish trust, productively engage partners, and rapidly translate recommendations into concrete process changes is crucial in addressing multifaceted challenges in situations.

Compassion, resilience, and the conscious decision to consider different voices, especially those directly involved in the project, were also instrumental to success. As the program progressed, the staff and the volunteers, through their constant exposure to diverse cases, identified relevant non-health-related needs of the community—such as food packs, financial assistance and legal support. The needs were discussed among volunteers in post-shift huddles and were raised to the management committee as needed. Old partnerships were tapped and new ones were built to supplement the resources necessary to integrate these additional services into the operations. This contributed to the gradual expansion and transformation of the platform into a more holistic service that addressed many overlooked structural and societal barriers to achieving good health. This highlights the importance of working beyond the silos when engaging in humanitarian work and being proactive in anticipating the various needs of the community in very dynamic situations.

Government agencies typically rely on the implementation of bureaucratic processes for efficient delivery of public services. However, when the system experiences shocks like a sudden skyrocketing demand for services or when the current resources cannot keep up with the demands on the system, extensive bureaucracy may serve as hindrance to immediately addressing the needs. This requires leaders to go beyond the traditional ways of governance and implement a mix of social and technical innovations without undermining the necessary checks and balance mechanisms of government. The highly adaptive staffing patterns in the OVP, partnerships with the private sector, engagement of health and non-health volunteers, and the development of an integrated patient information system, are examples of innovations that augmented the capacity of the OVP to respond to increased demand for services.

Moving forward

Recognising the continued threats from COVID-19 and the challenges in accessing health services for many Filipinos in general, BEK has continued beyond its original terms of reference. It has now transitioned from an initiative supported by a government agency to a flagship project completely run by Angat Buhay, an anti-poverty non-profit organisation headed by the former OVP leadership.

As in many other non-profit organisations, Bayanihan eKonsulta-Angat Buhay (BEK-AB) faces challenges, including funding sustainability, inadequate human resources, and limited scale of interventions. The organisation has been extending support and assistance to local government units that are looking to develop similar interventions in their respective communities but is largely dependent on private funding for its own operations. Changes in staffing have also been observed.

Currently, BEK-AB is overseen by a Technical Officer for Public Health and Nutrition assisted by a volunteer team that is responsible for managing medical and non-medical volunteers and the day-to-day operations of the program. Some 269 medical and 431 non-medical volunteers have been onboarded and deployed since the transition in July 2022. Given these circumstances, the program temporarily limited its services to teleconsultations for outpatient cases and other basic medical services. Financial assistance, food packs and medicine distribution, and emergency ambulance services have been discontinued, and COVID care kits are being distributed in limited amounts.

Despite these challenges, BEK-AB is maintaining its commitment to improving access and delivery of health care, especially for resource-challenged populations. In fact, it has now crossed geographic borders and expanded its reach to the whole of the Philippines. Because of the decrease in COVID cases, the platform can now entertain patient requests for a more diverse set of concerns and conditions. These include basic health information (e.g., medications, reproductive health services), specialist services (e.g., OB-GYN, dermatology, internal medicine, paediatrics), and mental health consultations.

BEK-AB has the capacity to meet such demands because of the sustained engagement and active participation of the volunteers from its early days at the OVP. It also seeks and welcomes invitations for partnerships with organisations looking to collaborate.

Conclusion

In its continued operations, BEK-AB aims to expand its services by establishing referral networks with different health agencies and facilities. However, the program ultimately hopes to widen its reach and impact by forging meaningful partnerships with local government units across the country that would prioritise health in their respective local agendas. As in any non-profit organisation, resources are limited, and sustainability is better achieved in coordination with institutions that could integrate the model into a bigger delivery network and public healthcare system. In the long term, this could not only improve responsiveness to crisis situations but also offer a potential solution in enhancing the delivery of promotive and preventive primary healthcare services.

Although trends in medical challenges are dynamic, the greater problem of health inequity remains. Innovative measures are proposed to bridge these gaps, but the success of implementing any of these solutions is highly dependent on the quality of leadership involved in the process.

The value of humanitarian leadership in initiatives like BEK has been well-stated. However, its relevance extends beyond disaster mitigation and response. It is critical for leaders to work with a deep understanding of the challenges faced by vulnerable communities and the underlying structural issues that perpetuate inequalities. Adopting a human-centered approach throughout the project cycle helps ensure that needs are appropriately identified and that outcomes are sustainable and impactful. Creating a space that allows for communities to be co-designers and co-creators of solutions also builds trust and fosters a culture of commitment, ownership, and continuous adaptation. This allows for resiliency and gives individuals agency.

Empathy and empowerment are at the core of this brand of leadership, and it serves as a blueprint for how governments can work to provide more holistic solutions instead of stop-gap measures and address root causes instead of mere symptoms of inequality.

Empathy and empowerment are at the core of this brand of leadership, and it serves as a blueprint for how governments can work to provide more holistic solutions instead of stop-gap measures and address root causes instead of mere symptoms of inequality. The COVID-19 pandemic highlighted the significant and disproportionate impacts of pressing global challenges on vulnerable populations, and never has it been more urgent for sectoral leaders to adopt a humanitarian approach.

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