Universal Health Care for All

Continuing the People's Conversations on the UHC

COLLATED NARRATIVE REPORT

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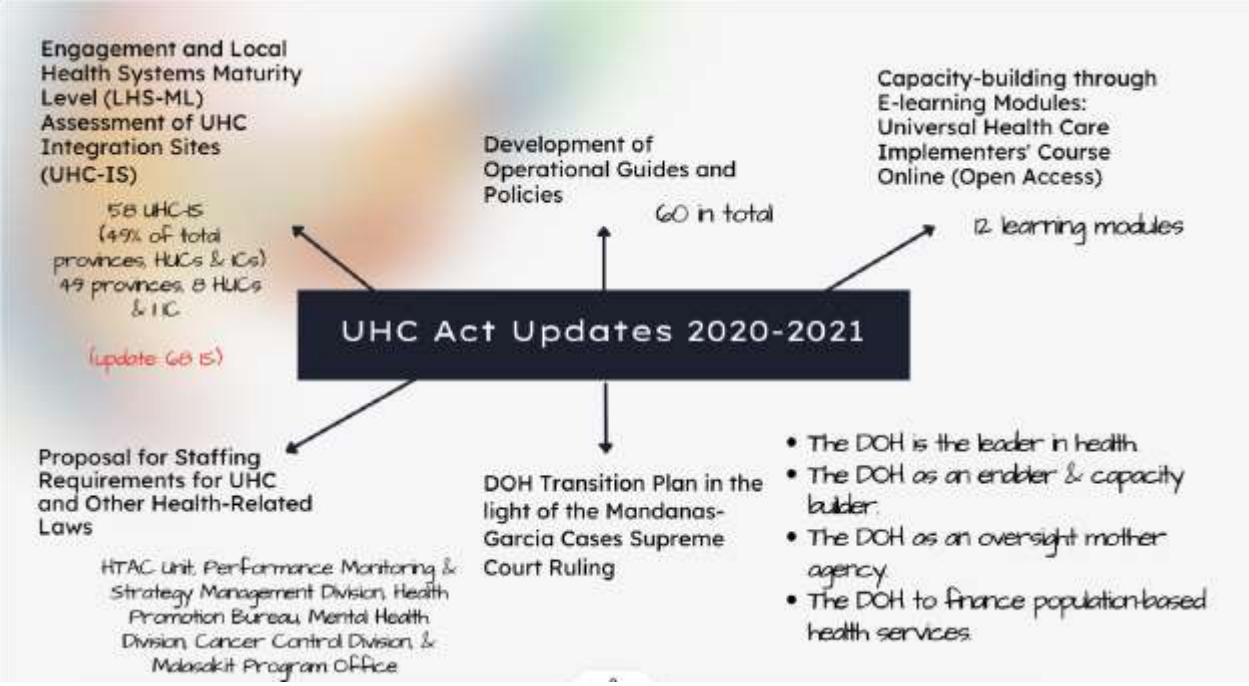
Executive Summary

The Universal Health Care (UHC) or Republic Act 11223 was passed into law in 2019. This mandates the State to have every Filipino receive equitable access to quality and affordable health care goods and services without facing financial hardships.

The law states that its implementation will be completed within 10 years given that it is a comprehensive mandate aimed at addressing systemic issues in health that were consequences of the devolution that happened in the early 90s.

Below is a slide containing the updates to the law:



In the UHC conversations organized, there were three Zoom/online sessions conducted, two face-to-face sessions with one conducted at a GeographicallyIsolated and Disadvantaged Area (GIDA) in the Province of Romblon, one of the Universal Health Care - Integration Sites (UHC-IS). These sites are those LGUs that have committed to integrating their health system into either a Province or City-wide Health System (P/CWHS) and implementing the UHC law.

Google forms were utilized to also encourage other interested groups who may not be able to join either the online or face-to-face sessions due to conflicts in schedules. The English questionnaire provided by APCASO were also revised to suit the Philippine context.

The sessions were recorded, organized into matrices and a collated narrative report with responses categorized according to the APCASO question categories with additional questions provided by the team and civil society organizations.

Most participant who joined came from marginalized and vulnerable populations. Some who also joined were development workers from various health and related civil society and non-profit organizations.

RESPONSES TO QUESTIONS ACCORDING TO CATEGORIES

The summary of responses per questions were organized by categories.

The additional preparatory questions were about the information they want to know more about UHC, the meaning of UHC to them and their immediate expectations after the law was passed. Below were their responses:

<u>On the information about UHC</u>

- Philhealth coverage and benefits
- The status of implementation of UHC

<u>On the meaning of UHC</u>

- It is a law that seeks to give all Filipinos social health insurance coverage.
- It means healthcare programs for children who are malnourished, adults who have hypertension, diabetes. It also means cleanliness of the surroundings, planting of vegetables and fruits that allow people to maintain good health.
- How do we fight against diseases, how do we strengthen people's immune system and how do we avail of the services that people do not have the capacity to pay for, and how can out-of-pocket expenditures be reduced.

<u>Expectations about UHC</u>

- Health systems and services become more accessible and inclusive.
- Rollout to the pilot areas can be felt.
- There are health policies, packages and protocols for all diseases.
- We will enroll in primary healthcare units within the radius of where we live.
    - Referral system in the integration
    - Patient navigation
    - Primary health care
- There will be initial structural reforms that can be felt/experienced.
- There is more focus on health promotion and prevention.
- Allow for citizen participation in every platform provided by the UHC.
- And that there is only one goal and understanding among implementation agencies

Category 1: Ensure Political Leadership Beyond Health

In the current mechanisms in place to realize UHC, the respondents have these to say:

- That the process of getting involved in the UHC law implementation should be well defined;
- The Philippine Charity Sweepstakes Office (PCSO) and the Department of Social Welfare and Development (DSWD) and other government agencies aided with the funding of health services and other health needs of the people.
- **Public health information campaign is critical and should predate the implementation, but:**
    - No agency seems to be willing to be involved in public health information campaigns
- There is COVID-19 coordination and navigation under the UHC with the use of Barangay Emergency Health Teams (BHERTS).

- Coordination with other sectors/national government agencies (NGAs) by CSOs:
    - *Department of Education (DepEd)* - the coordination on delivery of child and adolescent-related programs and services
    - *DSWD* - supplementary medical assistance, barangay daycare centers, social workers
    - *Department of Science and Technology (DOST), Food and Nutrition Research Institute (FNRI)* - Food and nutrition as a determinant of health
    - *Research Institute for Tropical Medicine (RITM)* - health technology and research (laboratories, vaccines)
    - *Department of Finance (DOF)* - discussions on fiscal space for health expenditures and sources of financing
    - National Economic Development Authority (NEDA) - development framework-setting
    - *DA* - Food and nutrition aspect of the determinants of health
    - *DBM* - for advocacies on budget allocation for health
    - *LGUs* - The delivery of health services in the Philippines has been devolved
- Malasakit Centers (though not part of the UHC) are able to help with medicine access.
- These are the offices and agencies in CM Recto that provide health-related services:
    - BHS in coordination with the Office of the Barangay Chairperson responsible for providing basic health services, daycare and nutrition programs for children
    - RHU is a secondary level health services
    - Provincial Hospital: Caters to cases that require a higher level of care.
    - DSWD, MSWDO: Provides supplemental financial support for medical needs
    - DepEd: Oral health, sexuality education
    - DA: aid for local farmers to be able to plant rice for local consumption.

On the prioritization of UHC over COVID-19, the respondents' answered two to five (agree to strongly disagree).

When the respondents were asked on what specific policies have changed the course of how UHC will be implemented, they identified the following:

- The Mandanas-Garcia SC ruling has changed the UHC implementation. DOH re-devolved more functions to the LGU.
- The Bayanihan Recover as One Act.
- The policies somehow have included health and safety components and engagement of people and creation of networks --- RA 11650 the ILRC (inclusive learner's resource center), which has a big component on the health and wellness of children at school, as it promoted 'inclusivity'.
- DOH has made a manual on Palliative and Hospice Care for rollout this July. This will impact integration of psychosocial for palliative and supportive care in the UHC.
- General Appropriations Act (the budget law): The budget law articulated priority expenditures for health during the pandemic, the way that the budget was directed to pandemic response in the past two years have affected the trajectory of UHC.
- Suspension of OFW premium payments. The OFWs had the capacity to pay; temporarily suspending their premium payments defeats the purpose of risk pooling in social health insurance where those who have the capacity to pay, pays for health services.
- The Antigen Test Protocol issued by the provincial government of Romblon had an impact on patients under emergency health situations as negative swab test results are required from

patients prior to admission. The lack of human resource and the health facility that has been under construction are seen to contribute to the challenge, as the limited number of triage stations slowed down the assessment process that identifies whether a patient should be directed to the COVID ward or the regular ward.

Category 2: Leave No One Behind

When asked what sectors and populations are mostly left behind in health, the following were identified: patients (including mental health patients, person with disability, children and adolescents (and those with disability), women and girls, informal sector workers, urban and rural poor including small food producers (farmers, fishers), indigenous peoples and those residing in GIDA.

Their barriers to care are namely: accessibility problems in economic (affordability), physical (proximity and absence friendly facilities) and information aspects of healthcare.

The underprioritized services include access to medicines, mental health, primary care, oral health and rehabilitation care.

The laws in place that protect the vulnerable population maybe classified as those inclusion policies in education, those for person with disability, children and adolescents, women, PLHIVs and healthcare workers.

Those policies that reduces out-of-pocket payments were the policies of Philhealth, PCSO, DSWD, Malasakit Centers, discounts given to person with disability and senior citizen, corporate social responsibilit of the Tribal Mining Corporation and the Ekonsulta of the Office of Vice-President Leni Robredo.

Category 3: Regulate and Legislate

UHC and other related laws are still to be adequately implemented in general. For some in the barangays, they think that UHC is being implemented because most are catered with health services at the primary cared units (BHS).

Respondents identified the following as the government-set accountability mechanisms:

- Performance monitoring within DOH
- Congressional Oversight
- Commission on Audit
- Civil Society Organzations (CSOs) as watchdog
- Barangay Development Council
- Kapit Bisig Laban sa Kahirapan–Comprehensive and Integrated Delivery of Social Services (KALAHI-CIDSS), a community-driven development project

The respondents also reiterated the role of CSOs and there are indeed laws that include participation in their provisions such as:

- The Local Government Code of 1991
- UHC
- HIV/AIDS Act (R.A. 11166)

In the barangay, they reached out to all constituents to inform them of important health information. Some are also not familiar with these platform of participation. At the national level, the Department of Budget and Management (DBM) requires CSO consultations.

It is another thing if these platforms are adequate and effective and if they indeed uphold the value of genuine citizen participation.

Category 4: Uphold Quality of Care

Those in the GIDA areas access their health services mostly at the primary care facilities (BHS, RHU). Most were satisfied with the health services provided by public facilities except for the shortages of medicines because supplies are not always enough.

While those patients in cities, they are able to access in private hospitals. However some respondents commended public health facilities like NKTI, PGH, East Avenue Medical Center because of the exemplary services and the healthcare professionals attending them, but they are mostly Metro Manila-centric. Patients heavily consider the proximity of health facilities in their residences.

On the adequacy of human resources for health (HRH), most members of the civil society groups and basic sectors were unanimous in their observation that despite of the HRH Masterplan, they are still inadequate and compensation is still less to be desired. On the other hand, community members from the GIDA seemed to be contented with the number of their health personnel for now but they provided ideal numbers. For the Municipality of Ferrol, they hope for two (2) physicians, while in Bgy. CM Recto, one midwife and one nurse is enough. However, they too agreed that compensation for healthcare workers should be increased.

Category 5: Invest More, Invest Better

According to the respondents, government spending should be focused more on:

- The personnel both in quantity and quality
- Infrastructure
    - Facilities
    - Roads
    - Information Technology / Digital Connectivity for Electronic Health Records and Telemedicine
- Medicines
- Primary Care
    - Expanded health benefits coverage (outpatient included)
- NCDs particularly Mental Health

- Health Promotion and Disease Prevention
- Filipino Traditional and Alternative Healthcare
- Knowledge, Management and Information Technology Services (KMITS)
- Citizen participation
- Emergency vehicle and driver
- Improved water supply/water source
- Agricultural financing programs

The respondents also claimed that funds and spending for health:

- Remained inadequate although the health budget has been increasing due to Sin Tax.
- Focused more on curative than preventive and primary care.
- Were irrational at times. They do not spend on the right things. Rational decision-making and handling of funds must be in place to reduce catastrophic disease spending on health services of conditions and diseases that are highly preventable.

The respondents also said that there is a problem in the DOH's absorptive capacity/utilization which also affects whether or not there will be an increase in the following year's budget. Hence, this should be addressed.

They also cited the following as reasons for the lack of funds:

- Procurement/budgeting concerns;
- Incomplete/inaccurate data, corruption, competing concerns, COVID; and
- Lack of HRH and citizen participation.

Category 6: Move Together

According to respondents, there are opportunities and spaces for CSO participation. Whether they are enough and effective or not is another matter. Most the time citizen participation is uneven at the local level in various LGUs. It also depends on the political will of the local chief executives (LCEs).

Patient groups are invited to sit in TWGs but most of the time it is to seek opinion on a crafted policy but not really involved in the co-creation of policies.

On the other hand, engagement of the above mentioned sectors especially children and youth and the working age is poorly graded, meaning there is minimal engagement of these sectors.

Another platform available is that CSOs participate at the local AIDS Council (R.A. 11166) including the Case Managers, etc.

It is very important to note the current context as of now:

- The civic space is shrinking
- Participatory spaces need to be claimed and/or created
- Civil society participation should be supported by government but allowing them to remain independent.

There is a hope though to improve these engagements and hopefully government listens and dialogue with CSOs to avoid token participation and not make activities just an FYI kind of event.

One example shared by respondents in the IP/GIDA area is that community members are invited to the State of Barangay Address being held twice a year so that members can listen to the projects and activities being implemented by the barangay. There are also emergency assemblies during urgent affairs.

The barangay in Ferrol also claimed that they are open and transparent with their funds. In fact, the barangay has a five-year development plan co-created with partners in identifying allocation of funds within the plan. E.g. augmentation of funds in medicine from partners. Still not enough despite help from NGO and private. Some of the barangay's partners: Rotary Club, Lions, Eagles help out in doing medical missions.

According to CSOs, there are citizen forums available to participate such as spaces in the:

- Cancer law and the Sin Tax law.
- Various political and policy dialogues where the Philippine Alliance of Patient Organizations (PAPO) is involved in
- Barangay Development Council and its Assemblies

Category 7: Gender Equality

The challenges of women and girls in their health service access are:

- Privacy (Philhealth card)
- Feeling of being unwelcome
- No consistent reproductive health policies.
- Stigma in accessing sexual and reproductive services.
- Insufficiency of information compounded by its inaccessibility for the blind, deaf and people with cognitive disabilities.
- **Teenagers themselves are the ones who choose not to access the services.**
- Lack of recognition of postpartum depression among women
- Lack of information about the available services for women and girls
- Specific age groups of young people are not covered in social health insurance if they are not yet employed and not considered dependent (i.e. unemployed 21 year olds)

The services that are most challenging to access for women and girls (adolescents included) are:

- Sex education and family planning.
- Maternal and Child Care.
- Safe pregnancy and childbirth.
- Contraceptives in some areas and teenage pregnancy counseling ● SRHR & rehabilitation.
- Tests specific to women.
- Health services for adolescents with disability
- Access of adolescents with disability (deaf) who are victims of violence
- Counseling for pregnant adolescents and VAC victims
- Adolescents who are pregnant usually conceal their pregnancy for fear of stigma.

For non-binaries, their challenges are centered on:

- Privacy.
- Stigma and discrimination.
- Financial constraints and inconsistent policies.
- Wellness, sex education and family planning.
- Lack of information to let them be engaged (how, why and what).
- Limited SOGIE-sensitive service providers.
- Lack of information on the use of do-it-yourself hormone replacement therapies that may cause harm, etc.
- Limited social hygiene facilities

Category 8: Emergency Preparedness

According to respondents, the COVID-19 affected the health systems in the aspects of:

- Primary health care, budget and resources because they were more focused on COVID-19 cases, which cause a lot of other non-COVID patients, particularly those with NCDs and chronic diseases, to be left behind. Their continuity of care was disrupted.
- Barangay budget (Kematu)
- Mobility restrictions made the disaster response more difficult and limited.

They recommended that to better prepare for the next emergency, there should be:

- Capacity-building of frontline personnel in disaster and emergency preparedness;
- Better community engagement;
- Investment and development of resilient and disability-inclusive DRRM for health systems; and
- Building of the digital connectivity and infrastructure of health facilites.

Category 9: Looking to 2023

In looking to 2023, the respondents would like to discuss more about:

- Compensation for the services to be rendered as well as the allocation of budget for staff. Source of funding for UHC;
- Health workers' conditions, decent pay and life;
- Right to health. No one must be left behind. Every Filipino, every disease must receive adequate health services and treatments;
- Patient Safety. Patient decision;
- More on disability and inclusion; youth and adolescent engagement; the concept of gatekeeping & electronic health records; and the
- Interoperability (centralized) of electronic health records (same records from the rural area to the provinces or cities.

Meeting with the current head of state, they will say to him:

- Add more budget to health, create services-based (essential health) packages and not only disease-based policies so everyone can have access to equitable health.
- Accessibility, Affordability, Availability & Quality of health services in both rural & urban setting.
- Strengthen priority over health.
- Invest in primary health care to control NCDs.
- Implement proper primary health care.
- And that the state of the Philippine health system is sick!
- That sick family member is a burden especially in GIDA. And that they hope for a better access to health without the hardships.

As representative of the country to the United Nations, they will each say to the UN:

- Be well informed and take action in providing adequate health services to ALL. Remember a Healthy People is a Healthy Nation.
- There is no Universal Health Care if there is no personnel to care for the health of the nation.
- Emphasize on the idea that "No one is left behind." ● Do no harm.
- "I would tell world leaders to look into the situation of the poor, sixth class municipality in the Philippines. The attention and support should be given to them. Our municipality has remained a sixth class municipality." – GIDA Barangay, CM Recto, Ferrol, Romblon

Communicating the UHC

The respondents shared their thoughts on how to communicate the UHC:

- In every opportunity possible, communicate UHC, to change the health seeking behavior of Filipinos.
- Involve the organizations of the poor.
- Go to grassroots, educate the people. Train people who will provide adequate knowledge. Look what is best in each locality.
- Social media and bite-size info everyday.
- Thru social media and tri-media at least twice a week.

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COLLATED NARRATIVE REPORT

BACKGROUND

The Status of UHC in the Philippines

The Universal Health Care (UHC) or Republic Act 11223 was passed into law in 2019. This mandates the State to have every Filipino receive equitable access to quality and affordable health care goods and services without facing financial hardships.

The law states that its implementation will be completed within 10 years given that it is a comprehensive mandate aimed at addressing systemic issues in health that were consequences of the devolution that happened in the early 90s.

According to the Medium Term Expenditure Program (MTEP) for UHC 2022-2026, A Multi-Year Spending Plan for the Department of Health (DOH), the following are some of the updates in the UHC Act implementation from 2020-2021:

1. Engagement and Local Health Systems Maturity Level (LHS ML) Assessment of UHC Integration Sites (UHC-IS). At the moment, there are a total of 58 UHC-IS (49%) - 49 provinces, eight (8) Highly Urbanized Cities (HUC) and one (1) Independent Component City. These provinces and cities have committed to implement the UHC and integrate their health systems into either a Provincewide or City-wide Health Systems (P/CWHS). All have been authorized to enter into a tripartite Memorandum of Understanding (MOU) with the DOH and the Philhealth via a Sanggunian Panlalawigan/Panglungsod Resolution or Executive Order (EO).

   The developed LHS ML tool will serve as a general framework for performance monitoring and evaluation among UHC-IS relative to their progressive realization of local health systems integration into P/CWHS. The results of each sites will inform the various stakeholders on the kind and level of assistance and support they will provide to the LGUs so as to achieve integration.

In recent meetings with DOH and partners, Ralph Degollacion of HealthJustice Philippines mentioned that the sites increased to 68, though no official document has been released yet to confirm this.

The following are the 58 UHC-IS per region:

- National Capital Region (NCR): Valenzuela and Parañaque Cities
- Cordillera Administrative Region (CAR): Baguio City and Benguet
- BARMM: Maguindanao
- Region 1 (Ilocos): Dagupan City
- Region 2 (Cagayan Valley): Isabela, Nueva Vizcaya, and Quirino

- Region 3 (Central Luzon): Bataan and Tarlac
- Region 4B (MIMAROPA): Oriental Mindoro, Marinduque, Romblon and Palawan
- Region 5 (Bicol): Masbate and Sorsogon
- Region 6 (Western Visayas): Aklan, Antique, Guimaras and Iloilo
- Region 7 (Central Visayas): Cebu
- Region 8 (Eastern Visayas): Biliran, Leyte and Samar
- Region 9 (Zamboanga Peninsula): Zamboanga del Norte
- Region 10 (Northern Mindanao): Cagayan de Oro and Misamis Oriental
- Region 11 (Davao): Compostella Valley and Davao del Norte
- Region 12 (Soccsksargen): Sarangani and South Cotabato
- Region 13 (CARAGA): Agusan del Sur and Surigao del Norte

To support these UHC-IS, a menu of technical assistance (TA) for the UHC-IS has been developed based on the national baseline assessment and other needs identified by DOH programs:

- Policy, standards and technical guidelines;
- Toolkits/templates/guides;
- Funding/logistic support;
- Orientations/capacity building/learning development intervention; and,
- Baseline assessment/performance monitoring tools and other technical input.

About PhP11.3 million and PhP15 million has been spent for the hiring of UHCIS support staff and other preparatory activities, respectively, were allocated. In addition, the LGU-Level UHC Project Management Teams were established to facilitate the localization and implementation of UHC and integration policies. Lastly, external health partners were tapped to provide direct assistance to these UHS-IS.

So far, the DOH has projected support for LGUs starting 2022 until 2026. Their support may be in the form of financial grants, performance awards, and technical assistance. Annual support is also given for LGUs such as human resources for health (HRH) deployment, health facilities enhancement program (HFEP), and public health commodities. There are also possibilities for funding in the line items of other DOH Bureaus (e.g., Health Promotion). Below is a table detailing these funding support for UHC-IS (DOH MTEP for UHC 2022-2026).

The UHC-IS will be monitored according to the progress of their integration and implementation of UHC provisions, specifically on the following characteristics and key result areas (KRAs)

Unified Governance of the LHS

- Strategic and Investment Planning
- Financial Management

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- Human Resources for Health Management and Development
- Information Management System
- Epidemiology and Surveillance System
- Procurement and Supply Chain Management
- Referral System
- Disaster Risk Reduction Management in Health System
- Health Promotion Programs and Campaigns

The main contention of the civil society and people's organization in these KRAs is that people's participation is entirely left out as an area to be included in the monitoring of performance of LGUs. This will be further discussed in the responses during the UHC Conversations.

2. Development of Operational Guidelines and Policies

From its passage in 2019, the DOH, in collaboration with various stakeholders, was able to have all 60 priority policies and operational guidelines approved by its Executive Committee. Fifty-seven (57) of these policies and guidelines have been issued and published, while the three are still undergoing process and concurrence from partner agencies. The DOH developed the UHC Policy Agenda that has been serving as its policy roadmap identifying the critical policies that had been issued and those that are still in the works.

3. Capacity Building through E-learning Modules.

Implementing a comprehensive law like the UHC is no easy feat especially for local government units (LGUs) with many issues competing for its attention. Therefore to fast-track the LGUs implementation of the UHC and keep the healthcare workers and frontliners up to pace, the DOH launched the Universal Health Care Implementers' Online Course containing 12 modules. The modules and panel discussions provided an overview of the UHC Act and its IRR so that those taking the course from various LGUs and sectors can understand the vision of UHC.

- Module 1: Framework and mandates of the UHC Act;
- Module 2: Organization of Local Health Systems;
- Module 3: Local Health Systems Management Tools;
- Module 4: Basic Requirements for Primary Care Facilities;
- Module 5: Population-based Health Care Packages;
- Module 6: Individual-based Health Care Packages;
- Module 7: Financing Mechanisms for P/CWHS;
- Module 8: Human Resources for Health;
- Module 9: Health Information Systems;
  Module 10: Regulation on Safety, Quality and Equity of Health Goods and Services;
- Module 11: Regulation on Affordability of Health Goods and Services; and, ● Module 12: Health Governance and Accountability.

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The course can be accessed along with other health courses through the DOH E-learning Academy platform https://learn.doh.gov.ph.

4. Proposal for Staffing Requirements for UHC and Other Health Related Laws.

With a comprehensive law such as the UHC Act addressing the fragmentation of the health system, naturally, there will be changes in the staffing requirements to reflect the needs in the implementation of certain sections of the law. Apart from the UHC, it was almost at the same time it was passed that the Supreme Court Ruling on the Mandanas-Garcia Cases was also released. This ruling increases the Internal Revenue Allotment (IRA) of LGUs by almost 30% following their call for years for a just share of all the national taxes.

The DOH submitted to the Department of Budget and Management (DBM) its proposed revised staffing patterns. And in accordance with the UHC Act and other health laws namely the Mental Health Act, Cancer Law, and the Malasakit Program, the following offices were created with corresponding plantilla positions approved:

- Health Technology Assessment Unit;
- Performance Monitoring and Strategy Management Division;
- Health Promotion Bureau;
- Mental Health Division; ● Cancer Control Division; and ● Malasakit Program Office.

5. Re-devolution of functions in the light of the Mandanas-Garcia Supreme Court Ruling

Apart from the UHC Act provisions of reorganization and reintegration, the ruling in the Mandanas-Garcia cases mandated the DOH to create its Transition Plan to re-devolve, not the funds, but the functions according to the Local Government Code of 1991 performed by the national government agencies (NGAs) to the LGUs. Particularly affected is the National Nutrition Council (NNC). However, the rest of the DOH attached agencies, its corporations, hospitals and national health facilities will not be affected by this movement.

The re-devolution of DOH programs, activities, projects (P/A/Ps) basically considers the LGUs income classification, poverty incidence, capacity, availability of services or commodities in the local market, the National Allocation Framework. Also, the re-devolution is being mandated by the UHC Act and other pertinent laws. However, even if the re-devolution of functions is

on its way to implementation, some key functions have to be retained with the DOH and its Regional Offices based on EO no. 102 series of 1999 and the RA 11223 UHC Act. The DOH and the policies it has issued, reiterates the following:

- The DOH as the leader in health;
- The DOH as an enabler and capacity builder;
- The DOH as an oversight mother agency; and
- The DOH to finance population-based health services.

Based on Section 17 of the LGC, the following are the expenditure assignment of health functions per level of government in the table below (DOH MTEP for UHC 20222026).

Province	Health services which include hospitals and other tertiary health services
Municipality	● Health services which include the implementation of programs and projects on: ○ Primary Health Care, ○ Maternal and Child Care, and ○ Communicable and Non-communicable Disease Control Services ● Access to secondary and tertiary health services; ● Purchase of medicines, medical supplies, and equipment ● Rehabilitation programs for victims of drug abuse; ● Nutrition services and family planning services ● Clinics, health centers, and other health facilities necessary to carry out health services
City	All the services and facilities of the municipality and province, and in addition thereto, adequate communication and transportation facilities
Barangay	Health services which include the maintenance of barangay health facilities

And the summary of the transition plan of DOH to the LGU (DOH MTEP for UHC 20222026).

DOH Budget Line Item (P/A/Ps)	DOH Recommendation		LGU Role	Basis for Re-Devolution
	Transition Period (2022-2023)	End Result of Devolution (2024)		
Health Facilities Enhancement Program (HFEP)	Gradually and Partially Devolved by CY 2022	Partially Devolved	Procurement of Capital Outlay	National Allocation Framework in the Philippine Health Facility Development Plan (PHFDP) 2020-2040
Epidemiology and Surveillance	Gradually and Partially Devolved by CY 2022[3]	Partially Devolved	Hiring of Disease Surveillance Officers (DSOs)	RA no. 11332: At least 1 trained DSO per Epidemiology and Surveillance Unit (ESU)
Human Resources for Health (HRH) Deployment	Gradually and Partially Devolved by CY 2023	Partially Devolved	Hiring of nurses and midwives	Low possibility of market failure
Public Health Commodities				
Family Health, Immunization, Nutrition, and Responsible Parenting	Gradually and Partially Devolved by CY 2022	Partially Devolved	Procurement, warehousing, storage, and distribution of commodities to target recipients	With PhilHealth package, individual-based health services (best optimized by public and private service delivery) for PhilHealth benefit development and financing, available in the local market, low cost, population- based services which LGUs have the capacity to implement
Prevention and Control of Communicable Diseases	Gradually and Partially Devolved by CY 2022	Partially Devolved		
Prevention and Control of Non-Communicable Diseases	Gradually and Partially Devolved	Partially Devolved		

Apart from the recently passed health laws, the government's shift to prioritize health further came in during the victorious passage of the Sin Tax Reform Act or R.A. 10351 in 2013. Due to this law, the health sector's annual budget increased gradually from two to four percent at this time. Below is a table illustrating the increase of the DOH budget over the years (DOH Sin Tax Annual Report on Incremental Revenue for Health 2021).

Table 1. Sin Tax Incremental Revenue for Health in the DOH-OSEC and PhilHealth Budget 2014-2021, in Billion PhP

Year (t)	Amount in the GAA (a)	Incremental Revenue for Health[5]				Counterpart Funding from National Government or "Natural Increase" f = a - (d + Baseline)	Adjusted Balance[6]
		Projected (b)	Actual (c)	Attributed Amount in the GAA $d_t = (b)_{t-1} + (c - b)_{t-2}$	% e= d/a x 100		
2013[7] (Baseline)	**53.23**	33.96	44.72	-	-	-	-
2014	**83.72**	42.86	42.60	**33.96**	*40.56%*	-	3.47
2015	**86.97**	50.63	62.69	**53.62**	*61.65%*	-	19.88
2016	**122.63**	56.87	59.23	**50.37**	*41.08%*	19.03	-
2017	**148.50**	64.18	71.24	**68.92**	*46.41%*	26.35	-
2018	**160.73**	66.75	90.90	**66.55**	*41.40%*	40.95	-
2019	**165.01**	69.42	102.92[8]	**73.81**	*44.73%*	37.97	-
2020	**171.91**	N/A[9]	N/A[10]	**93.57**	*54.43%*	25.12	-
2021 (Transition Year)	**205.81**	N/A[11]	N/A[12]	**33.50**[13]	*16.28%*	119.08	-

However despite these increases in revenues and health budget allocation, the DOH has failed to utlize its funds. The DBM several times called the attention of the department on this issue of low absorptive capacity. These were the responses of the DOH, specifically in two areas that considerably should eat-up huge funds:

Program	**Reasons for non/delayed utilization of funds**
Health Facilities Enhancement Program	● Issues on implementation readiness (e.g. lot issues, DENR requirement, peace & order situation) ● The mode of payment is progress billing [late submission of billing by external clients, incomplete submissions] ● Bid failure [no bidders in GIDA; lack of quantification & forecasting skill for equipment] ● Implementation of COVID-19 quarantine restrictions

Public Health Program Commodities	Procurement concerns (e.g., no local suppliers, cancellation of procurement because of overlaps of commodities, global shortage in supply, delayed compliance, distribution problems; delayed liquidation of previous funds)

COVID-19 and the UHC

Globally, countries ravaged by the novel coronavirus (COVID-19) struggle to withstand its unprecedented toll to healthcare and socio-economic systems. The pandemic laid bare the weaknesses of our public governance systems in health and other areas, in both developed and developing countries alike, as governments strive to respond to a humanitarian crisis that has now unfolded. While the pandemic indiscriminately affects all countries, its negative impact is disproportionately heavier on countries such as ours. Within the Philippines, the pandemic has further laid bare the fault lines of inequality as the life of the poor, vulnerable and socially excluded are expected to exponentially deteriorate.

Despite the bleak situation that Filipinos have gone through, the same civil society groups and organizations that pushed the UHC in 2018, issued a three-part position paper at the onset of the pandemic. These sectors and vulnerable populations continued to voice their demands on using UHC as a foundation for pandemic response, the need to sustain healthcare services especially for non-COVID but NCD patients, to care for the frontliners (e.g., healthcare workers, local and small food producers, workers and riders) and provide adequate budget and prioritize the needs of the vulnerable.

One of the victory of these demands was when additional budget was allocated for this year for COVID-19 health care workers' benefits and compensation, including those non-healthcare workers but are also exposed to the virus and considered frontliners.

People's Conversations on the UHC

From 2018 to 2019, a network of 70 civil society groups and organizations comprising the basic sectors [children and youth, older persons, persons with disabilities, patients,

indigenous peoples and workers gathered in a series of consultations, discussions and workshops on the UHC. This was the peoples and the basic sectors' way of participating in the legislative process, when the UHC was just an impending law.

For these groups, the UHC may not be perfect and is still a work in progress but for them, the UHC ensures equal health care access for all, resolves the fragmentation of the health system, bridges the gaps and thoroughly reduces the steepness of the health gradient within, between and among groups, sectors and classes to achieve equity. It is one that works towards the progressive transformation of the health system while at the same time taking immediate affirmative actions to address each and everyone's distinct needs at different points in one's life course. This means pursuing a delicate balance of integrative, blended (targeted universal and/or proportionately universal, whichever is appropriate) approaches of ***'health equity action'*** (Carey, Gemma 2015) and services for both individual and public health, cohesively achieving total human development (SWP 2018).

When the law was passed in 2019, the civil society who have been active in the process of the push, have the following victories in terms of the mandate's provisions:

- Social insurance coverage for every Filipinos;
- Expanded benefit coverage;
- Integration into province/city-wide health systems;
- More funds for health at the local level where the action is;
- Refocus and support for health promotion allocating 1% of the total health budget and strengthening it through the now Health Promotion Bureau;
- Implementation of the Health Technology and Health Impact Assessments;
- Guaranteed employment and competitive salaries for healthcare workers;
- Continuous trainings and return service agreements for health professionals; and
- Creation of health ethics committee.

Three (3) years later, the same groups are now eager to know and ask how much of this comprehensive mandate has really been implemented thus far given that the COVID-19 pandemic entered into the picture? Do people feel the immediate benefits of the law? Some updates need to be shared including observations based on the lived experiences of the people in the grassroots, thus, conversations need to continue to renew and deepen further their commitments to the cause of UHC in the Philippines.

METHODOLOGY

For these conversations to happen, two networks of organizations collaborated – The Healthy Philippines Alliance (HPA) and Social Watch Philippines (SWP) Foundation, Inc. through its Alternative Budget Initiative (ABI) Health Cluster. The former is a coalition of NCD patients/survivors while the latter is a group of 70 civil society organizations comprising the basic sectors [children and youth, older persons, persons with disabilities, patients, indigenous peoples and workers]. As mentioned earlier, both have been involved in the active development and push for what had become the current UHC law in the Philippines.

However apart from the members of these networks, the UHC team together with Health Justice Philippines found it necessary to include in the conversations other hard to reach groups such as the T'Boli and Blaan indigenous communities from South Cotabato in Mindanao and a community from a sixth (6th)

class municipality known as a geographically-isolated and disadvantaged area (GIDA) in the province of Romblon. Most that joined these FGDs were primary care health workers and barangay (village) officials who are themselves members of these communities.

The UHC team utilized focus group discussions (FGD) as the primary data-gathering method with an exception of one key informant interview in preparation for the GIDA area session. While the originally-given questionnaires with nine categories were used, the team had to rephrase some of the questions based on the suggestions and recommendations during pilot FGD held. The questionnaire was also translated to Filipino language for better understanding. Both were inputted in a Google form for easy access of the participants.

See the table below on how the sessions were divided:

FGD Sessions	**Format**	**Participants (with link to the attendance)**
Pilot FGD June 17, 2022	Online/Zoom PM Session	Member patients of various groups (HPA)
FGD with HPA & SWP-ABI – June 24, 2022	Online/Zoom PM Session	Basic sectors & patients
FGD with the T'boli Community – July 1, 2022	Online/Zoom PM Session 3 hrs	Indigenous peoples who are barangay officials & primary care health workers
FGD with Blaan Community – July 4, 2022	Online/Zoom 2.5 hrs	Indigenous peoples who are barangay officials & primary care health workers
FGD with SWP-ABI Health Cluster members – July 6, 2022	Face-to-Face 9 AM – 2 PM	Basic sectors & patients
FGD with members of the community of Barangay CM Recto, Municipality of Ferrol, Province of Romblon – July 8, 2022 ● Key Informant Interview (KII) with a doctor to the barrio (DTTB) and the Municipal Health Officer (MHO) of Ferrol – July 7, 2022	Face-to-Face 9 AM – 12 PM 4 – 7 PM	Basic sectors, barangay officials & primary care health workers

Also, some participants opted to submit the Google form with their answers instead of joining any of the online/offline sessions.

Invitations and questions to participants were sent two weeks prior. The team highly encouraged them to register in advance. In the far-flung communities where Internet is sketchy, it was harder for them to access the registration form and even the questionnaires prepared but the team still sent the forms/questionnaires anyways.

The UHC team prepared the following objectives for the sessions:

- Provide a venue for the marginalized and vulnerable sectors to be updated with the current UHC implementation;
- Share their observations and experiences in accessing UHC-related prevention/promotion, therapeutic, rehabilitative and palliative services and those beyond health and hospital care;
- For those who opted to join the face-to-face FGD, the discussion also served as a "kumustahan" and wellness session because of the two (2) years absence of interaction among network members;
- Capture stories, live experiences, challenges, and achievements in Universal Health Care from the perspectives of civil society and vulnerable populations at the country level;
- The results to serve as inputs to the SoUHCC report as well as broader advocacy for UHC ahead of the 2023 United Nations High-Level Meeting on UHC.

All sessions were recorded via Zoom and using an actual recorder for the face-to-face sessions with photos.

The UHC team also prepared a simple program to run the sessions:

Time	**Session Particulars**	**In-Charge (with link to their BIO)**
9:00-10:00	Kumustahan/Wellness session	Ginhawa Team
10:00-10:15	Introduction & Rationale of the Conversations	Jofti Villena
10:15-11:00	UHC Implementation Updates	
11:00-14:00	UHC Conversations / Actual FGD Session	Jofti Villena Rosheic Sims Documenter: Geomarie Tumamao
14:00	End	

The Questionnaire

In the pilot FGD held last June 17 (Friday) attended by HPA members, comments and recommendations were provided to the UHC team. These comments and recommendations were heavily considered, thus, rephrasing and reformulating some of the questions:

Original Questions	**Comments**	**Revised Questions**
Preliminary (Addt'l Question from CSOs)		
What would you like to know more about the UHC?	Initially placed at the end of the questionnaire. Should be asked first since tackling questions/expectations.	What would you like to know more about the UHC?
What are your immediate expectations from the UHC?	Initially placed at the end of the questionnaire. Should be asked first since tackling questions/expectations.	What were your immediate expectations when the UHC was passed and now that it is being implemented?
Category 1: Ensure Political Leadership Beyond Health		
Does your government have a coordination government agency/mechanism/depa rtment that engages across sectors for the specific purpose of improving health or advancing UHC? If so, how well is this mechanism or department functioning?	Intimidating question. Can't be asked for those who have no knowledge about the nitty-gritty of the UHC, so rephrase/revise/make it in Filipino language or laymanize. The two comments apply for all questions. Should not be a yes or no question. Can be "how well the current mechanisms are working", what ways does the DOH work with other	Given your organization's involvement in health advocacy, would you be able to tell and describe to us how well the current mechanisms of the government engage across sectors for the specific purpose of improving health or advancing UHC? If so, how well is this mechanism or department functioning? Are the roles and

	agencies, who have clear accountabilities, etc. It has to highlight what DOH, PHILHEALTH, DILG are doing, which connects the question to the second one so possibly merge the two. DOH & PHIC usually do not coordinate with each other.	accountabilities of agencies clear?
If you primarily conduct health advocacy, have you engaged with other government ministries or departments beyond health in your advocacy efforts? How so? [For example, briefings with Ministers of Finance, Welfare, Labor, Water, and Education, Agriculture, etc.]	In asking "how so", highlight in the question their experiences - give their bad or good experiences and what agencies they had these experiences with	Given your organization's health advocacy efforts, can you share with us your experiences in engaging with other government ministries or departments beyond health, if there are, good or bad? If possible, please share with us what agencies are these. [For example: briefings with Ministers of Finance, Welfare, Labor, Water and Education Agriculture, etc.]
During the COVID-19 pandemic, has your government made UHC a high priority?	Should utilize a Likert Scale with even distribution of numbers (ex: scale of 1-5) to have a range. Perhaps create a separate category for all COVID-19 related questions.	Using the Likert Scale, provide a rating for the government, whether it was able to give UHC a high priority during this COVID-19 pandemic? 1 - Strongly Agree 5 - Strongly Disagree Please explain your answer with your examples/experiences.

How have new health policies and programmes during the pandemic changed the path towards UHC?	Introduce a line-up of policies and programmes that were passed during the pandemic. Choose 5 but also allow the participants to add other policies that they know. Ask the participants first if they are aware of these policies and programs.	Below are some of the new health policies and programmes passed during the pandemic. 1. Bayanihan to Recover As One Act 2. Emergency Use Authorization for Drugs & Vaccines for COVID-19 3. Corporate Recover & Tax Incentives for Enterprises Act (CREATE) Law 4. Guidelines on the Proper Use and Promotion of Active Transport During and After the COVID-19 Pandemic 5. Guidelines on the Registration of Filipinos to a Primary Care Provider 6. Other policies from DOH & other agencies: [https://doh.gov.ph/COVID-19-policies] [https://pcw.gov.ph/covid-19-programsand-services/] How have these new health policies and programmes during the pandemic changed the path towards UHC?
Category 2: Leave No One Behind		

Which groups of people in your country struggle to	Generally OK.	Which groups of people in your country struggle to
gain access to health services? What are the main barriers for them to access health services? [Barriers to care can include: affordability; social, political and cultural determinants of health care access]		gain access to health services? What are the main barriers for them to access health services? [Barriers to care can include: affordability; social, political and cultural determinants of health care access.]
Considering the needs of the groups identified above, what are the specific health services that are underprioritized? [Groups of people could include: vulnerable populations like children and caregivers, persons with disabilities, people living with NCDs, people with mental health conditions, etc.]	Generally OK.	Considering the needs of the groups identified above, what are the specific health services that are underprioritized? [Groups of people could include: vulnerable populations like children and caregivers, persons with disabilities, people living with NCDs, people with mental health conditions, etc.]

Are there laws and frameworks in place in support of vulnerable groups accessing essential health services they need? How well do they work in practice? [For example, the Affordable Care Act in the US includes that it is illegal to discriminate on the basis of "race, color, national origin, sex, age or disability in certain health programs"]		Are there laws and frameworks in place in support of vulnerable groups accessing essential health services they need? How well do they work in practice? [For example, these are mostly Magna Carta laws; laws for persons with disabilities; human rights to health, etc. that it is illegal to discriminate on the basis of "race, color, national origin, sex, age or disability in certain health programs"]

Does your country have a policy or program to reduce or eliminate patient fees (out-ofpocket spending on health)? [Examples include: public insurance schemes, free health care policy]	Ask about experiences with patients (cite clear cut examples), how well did these policies/program perform. Should extract their experiences, whether or not out-of-pocket expenses were lowered and if the programs truly helped them. Should show questions of equity and should be answered by each of the patient groups.	Cite clear-cut examples or experiences of how certain policies or programs reduced or eliminated patient fees (out-of-pocket spending on health)? Are these reductions enough for the needs of the patients and those accessing the services? Are there invisible/indirect costs related that are not covered by these policies/programs? [Examples include: public insurance schemes, free health care policy; It is highly encouraged that each patient group answers this question]

Who is most impacted or what health services are most negatively impacted by out-of-pocket payments?	e.g. chemo, dialysis...	Who is most impacted or what health services are most negatively impacted by out-of-pocket payments? [Examples of these health services: chemotherapy, dialysis, blood transfusions, etc.]
Category 3: Regulate and Legislate		
Do you feel that UHC laws/policies/strategies that exist in your country are being adequately implemented?		Do you feel that UHC laws/policies/strategies that exist in your country are being adequately implemented?

Do you know of any accountability or monitoring mechanisms for UHC in your country? If yes, please explain your answer.	Make it clear that what is being asked are gov't mechanisms for UHC.	Do you know of any government-set accountability or monitoring mechanisms for UHC in your country? If yes, please explain your answer.
Are there laws and policies in place to ensure that people can engage in planning, budgeting and monitoring of health plans and budgets?	Not institutionalized or embedded yet; token engagement; only for compliance	Are there laws and policies in place to ensure that people can engage in planning, budgeting and monitoring of health plans and budgets?
Category 4: Uphold Quality of Care		

Do you think that health services in your country are of good quality? Can you elaborate and give examples?		As citizens/patients, where do you primarily access your health services - public [BHS/RHU/district], private [tertiary hospital], or others [what are they]? Are the health services you receive in your facility of choice of good quality? Can you elaborate and give examples?
What health services and what communities/population groups experience the gaps in quality? [Components of quality could include cleanliness of facilities, adequate time spent with provider, provider knowledge and responsiveness to questions/concerns,		Are the health services you receive in your facility of choice of good quality? Can you elaborate and give examples? [Components of quality could include cleanliness of facilities, adequate time spent with provider, provider knowledge and responsiveness to questions/concerns,
adequate drugs/supplies/equipmen t, short wait times, , etc]		adequate drugs/supplies/equipmen t, short wait times, etc.]
Does your country have adequate health workers, especially at the primary health care level? Are community health workers part of the health staff roster and are they paid adequately?		Does your country have adequate health workers, especially at the primary health care level? Are community health workers part of the health staff roster and are they paid adequately?
Category 5: Invest More, Invest Better		

Where do you think your government should be spending more in terms of achieving UHC? [Examples might include: primary health care, health worker training, increasing the number of hospitals, health promotion and prevention]		Where do you think your government should be spending more in terms of achieving UHC? [Examples might include: primary health care, health worker training, increasing the number of hospitals, health promotion & prevention]
Is the government spending enough on health services and is this increasing? [“It is recommended that governments spend at least 5% of its GDP or at least 15% of its annual budget on health]		Is the government spending enough on health services and is this increasing? ["It is recommended that governments spend at least 5% of its GDP or at least 15% of its annual budget on health"]
If the government is not increasing its spending on health services, what is preventing your government from investing more in health services?	PhP250B is the DOH’s current budget, but PhP150B have not yet been utilized; Every year PhP80B isn’t being utilized. DOH has weak absorptive capacity.	Since the start of 2014 when the Sin Tax was passed, the DOH budget steadily increased because of the tax revenues. However, it was reported several times

	Utilization is low. Why despite the increasing budget in health, how come they are not being utilized? In the PH context, it has to be rephrased.	that the department had low absorptive capacity [low utilization of the budget]. With this, what do you think are the hindering factors why the department is having a hard time utilizing its additional budget from the Sin Tax?

Category 6: Move Together		
At the national level: are there opportunities for people, civil society organizations, and the private sector in your country to be engaged in planning, budgeting, monitoring and evaluating the health sector? [Examples of different groups of people engaged: adolescents and youth, children and caregivers, persons with lived experience, vulnerable and marginalized groups.]		At the national level: are there opportunities for people, civil society organizations, and the private sector in your country to be engaged in planning, budgeting, monitoring and evaluating the health sector? How about in the actual delivery of health services? [Examples of different groups of people engaged are adolescents and youth, children and caregivers, persons with lived experience, vulnerable and marginalized groups. Some examples of opportunities are open consultations with different groups of people/populations/ communities before developing major policies (ie. National Health Plan).

		Encourage discussion of how well they work in practice.]

If so, what are those opportunities and are they effective and efficient for the engagement of civil society, in particular, of the most vulnerable and marginalised populations and communities? [Some examples of opportunities: Open consultations with different groups of people/populations/communities before developing major policies (ie. National Health Plan)] Encourage discussion of how well they work in practice		If so, what are those opportunities, and are they effective and efficient for the engagement of civil society, in particular, of the most vulnerable and marginalized populations and communities? Are they being listened to and their proposals being integrated and carried?
At the community level: Are communities engaged in local level health planning, budgeting and accountability processes? If so, how are they engaged?		At the community level: Are communities engaged in local level health planning, budgeting and accountability processes? If so, how are they engaged? [Communities would mean real members/residents of target communities, people's groups, basic sectors, civil society, and members of the vulnerable populations [person with disability, patients living with NCDs/HIV, etc.].

At the community level: Are there civil society forums or constituencies in your country to engage with decision-makers on health-related issues? If so, how well does the existing civil society coordination function and what can be improved? [Examples: country coordinating mechanisms (i.e. for Global Fund), civil society alliances to influence national health budgets]		At the community level: Are there civil society forums or constituencies in your country to engage with decision-makers on health-related issues? If so, how well does the existing civil society coordination function and what can be improved? [Examples: country coordinating mechanisms (i.e. for Global Fund), civil society alliances to influence national health budgets]
Category 7: Gender Equality		
Can you identify some of the major challenges for women and girls in their access to health services?	Adolescent girls do not have the same access as women. We need teenager-friendly services. Include also access to information and education. Include also VAW, physical and mental.	Can you identify some of the major challenges for women and girls [including adolescents] in their access to health services?
What kinds of health services are most challenging for women and girls to access?		What kinds of health services are most challenging for women and girls [including adolescents] to access?
What are the primary challenges to access health care services for individuals who are nonbinary?	Non-binary are the LGBTQIAS2+	What are the primary challenges to access health care services for individuals who are nonbinary [e.g. LGBTQIA]?
Category 8: Emergency Preparedness		

How has the primary health care system been affected by the ongoing COVID-19 pandemic?	Combine with the other questions on COVID-19.	How has the primary health care system been affected by the ongoing COVID-19 pandemic?
How do you think that PHC can be improved/evolved to be better prepared for future pandemic and other health emergencies?		How do you think that PHC can be improved/evolved to be better prepared for future pandemic and other health emergencies?
Category 9: Looking to 2023		
Is there another element of UHC and the distribution of health services in your country that was not covered in the discussion today? [This may include: human rights, shrinking civic space, humanitarian settings, disability and inclusion, youth and adolescent engagement etc. Encourage discussion of specific examples of challenges and/or recommendations.]	If the participants are familiar with the concept of gatekeeping, private sector & hospital (integrate) Experience from Dr. Jimmy: They established their own network; indigenous peoples, island barangays/municipalities; business ethics of professional and private facilities; electronic health records	Is there another element of UHC and the distribution of health services in your country that was not covered in the discussion today? [This may include: human rights; shrinking civic space; humanitarian settings; disability and inclusion; youth and adolescent engagement; the concept of gatekeeping & electronic health records; private sector & hospital involvement- their business ethics; the communities in the GIDA areas (indigenous communities, island barangays/municipalities). Encourage discussion of specific examples of challenges and/or recommendations.]

What is the main request you have for your Head of State about the state of	Use the 1-minute elevator pitch exercise.	What is the main request you have for your Head of State about the state of
health care (access, quality, and cost) in your country?		health care (access, quality, and cost) in your country? Use the 1-minute elevator pitch exercise.
What is one message you would share with world leaders at the United Nations if you were the Head of State presenting the state of health care in your country?	Suggestion is for Xi Jin Ping, Putin, Biden to talk to a poor person with NCD for 15-minutes.	What is one message you would share with world leaders at the United Nations if you were the Head of State presenting the state of health care in your country?
		For you, what is best way to communicate the benefits of UHC to people? How often should they be communicated?

Presentation of the questions and answering them were also different between the online/offline sessions.

During the face-to-face session last July 6, the participants were asked to put into meta cards their answers and for the Category 9 [Looking into 2023] the questions on the messages to the Head of State and the United Nations were both photo and video documented.

While in the community of CM Recto, only select questions were asked due to the applicability of the questions in their context. The UHC team also employed a scenario type of questioning to the participants so they can describe the current primary care/health system in place in their village. This also helped surface the other problems in the community that are determinants to the health of the members [e.g., communication/Internet signal, transportation, roads, etc.].

Data Collation

The answers were grouped according to the categories provided by APCASO although some questions were added based on the recommendations of the pilot
FGD participants:

- Preparatory Questions: What do you want to learn about UHC? What were your immediate expectations after its passage?

- Category 1: Ensure Political Leadership Beyond Health
- Category 2: Leave One Behind
- Category 3: Regulate and Legislate
- Category 4: Uphold Quality of Care
- Category 5: Invest More, Invest Better
- Category 6: Move Together
- Category 7: Gender Equality
- Category 8: Emergency Preparedness
- Category 9: Looking to 2023
- Other country-specific questions

<u>THE PARTICIPANTS</u>

The priority participants for these conversations were those belonging to the marginalized and vulnerable sectors and groups. However, for the sessions conducted, the following are represented:

- Persons with disability
- Elderly and senior citizens
- Patients living with HIV/NCDs [including survivors and those with chronic conditions]
- Rural poor / farmers / fishers
- Indigenous peoples
- Professionals in civil society organizations working in policy advocacy and/or with basic sectors/communities
- Barangay (village) officials
- Primary healthcare workers [i.e., doctor to the barrio, midwives, public health nurse, sanitary inspector]

Profile of the Participants

T'boli Indigenous Community

[Reference from the article of Ms. Lourdes C. Manzano]

Photo credit: http://www.positivelyfilipino.com/magazine/tboli-its-better-to-weavethan-to-leave

The T'boli is an indigenous community residing in the mountain of Cotabato occupying an area of about 750 square miles where the Southern ends of the Southwest Coast Range and the Cordillera, also known as the Tiruray Highlands, merge. The center of their culture may be found more or less in the central part of a triangle whose points are the towns of Surallah, Polomolok and Kiamba. Within this triangle are three major lakes: Lake Sebu, Lake Lahit and Lake Selutan.

These indigenous peoples may be described as medium built, light in complexion and some are square-jawed. They also sport either curly or straight hair. T'bolis today normally go about in ordinary and plain clothing with only their sword on the side as their remaining piece of cultural clothing. However, the traditional clothing or dress of T'boli women is tight-fitting, long-sleeved, waist length and the blouse is collarless in plain black, dark or navy blue. The tubular skirt is ankle length.

A T'boli family is headed by the father. Depending on his economic resources, he can have several wives and they all live on the same roof. Their houses are spread sparsely over the entire T'Boli area. Since T'boli families have very close ties with their relatives, the houses come in isolated clusters of three or four. They live on hunting, fishing and cultivation like other hill people.

As for their governance structure, the community is ruled by a datu but this is not a position that is inherited and he also does not enjoy primary over others. He also has no jurisdictional control over specific areas or groups. A datu has several social, economic, religious and political functions.

In the T'boli belief system, death is not regarded as inevitable but rather a trick played by the busao or evil spirits, or punishment inflicted by gods. They believe that when one is asleep, his/her spirit leaves his/her body and when the spirit is not able to return, then death occurs. The *busao* may also wreak havoc on the lives of human beings, thus causing misfortune and illness. Propitiatory offerings of *onuk bukay* (white chicken) or *sedu* (pig) are made to gain the favor of these evil spirits.

For further understanding of the T'boli tradition, one must expose himself/herself to their literature because it reflects the typical beliefs, customs and traditions of their society. Every aspect of the life of a T'boli is governed by folk beliefs and sayings. Apart from the literature, the T'boli community is also sophisticated in the music and their variety of dances. T'Boli children learn these dances from old members of the household at a very early age.

The T'boli community, which was interviewed by the UHC team, were those residing in Bgy. Kematu. The municipality where the barangay is, is led by a T'boli himself, Bgy. Captain Benny.

The farthest sitio in Bgy. Kematu is Sitio Lagtaninag (population: 186). It is six (6) hours away from the barangay, but the BHERTs are able to reach them. Roads are only accessible by foot; even motorcycles cannot pass through. These are even more inaccessible during rainy seasons due to flooding.

In case the roads are built and maintained, the transportation of products by the community like abaca, coffee and kalawan would be possible and the community would benefit greatly economically.
Presently, the barangay has two nurses, two midwives, 10 BHWs, four BNS, and one sanitary inspector. There is no health education and promotion officer (HEPO), but
BHWs and the BNS engage in health promotion activities.
The barangay is already planning to add three more BHWs and one more BNS next year since the staff is currently not enough. Only one BHW is assigned to two puroks and two sitio each, so they are stretched thin. There are no doctors in the barangays but there are two doctors assigned to the RHU.

Blaan Indigenous Community

[Reference from the article of Mr. Antonio P. Kinoc]

Photo Credit: https://www.aswangproject.com/mythology-blaan/

The Blaans, another indigenous community in the South Cotabato area, came to the Philippines when it was still an unnamed archipelago, some seven thousand years ago. This community is more in number than the T'boli but less known. They are found originally in that vast plain that stretches from the shore of the Buluan Lake moving Southward to the Bay of Saranggani. They are found between the T'boli in the western side particularly the so-called Roxas mountain range.

Due to their large number, the Blaans cover a bigger area. They cover five municipalities namely: Magsaysay, Matanao, Kiblawan, Saranggani and Sulop; the province of Saranggani where they occupy ninety percent of the province except the town of Kiamba; the whole of General Santos City; the Province of South Cotabato except the towns of Lake Sebu, Surallah and Noralla; the towns of Columbio and Lutayan in Sultan Kudarat Province; the towns of Tulunan nakilala and Mlang in North Cotabato and a portion of the municipality of Datu Paglas in Maguindanao; and the so-called Allah Valley and Koronadal valley which are the traditional hunting grounds of the Blaan before the arrival of migrant Christian settlers in the 1930's.

The Blaan has some striking similarities with the T'bolis in terms of language. They have their own system of weaving using abaca fiber as materials. The superiority of their weaving is no match to any other indigenous group and this has been recognized. They also mastered the art of smelting brass and copper. These expert skills in weaving and art are shown in their clothing ornaments and weapons like the handle of their long knives known as "FAIS", which is an intricately designed brass work.

The life of a Blaan evolves around his family. A family usually resides in a compound together with its extended relatives. The husband may also have more than one spouse like the T'bolis. The men and women have very defined roles and chose in the home. The men does all the heavy work, while those of the women are less burdensome. The Blaan is considered clannish too since their marriages are, as much as possible limited to close relatives. This is done to protect property and to secure themselves from intrusions.

The Blaans are always on guard since the risk of combat is always present. During journeys, the men walk ahead of the group and carry only weapons of war. This indigeous group is a strong believer of interdependency with the environment. They believe that they are part of the grand design of creation and that everything evolve around the great creator of all things. They call the creator "Malu" or "D'wata". Blaans believe that despite being the more favored of the creatures, man must respect the will of the creator because they believe in his supremacy. He cannot touch or molest any creature or object without seeking permission from the creator through his guardians. Thus, Blaans have a lot of rituals for everything they do.

In the FGD, the team interacted with the primary care workers, frontliners and one chieftain from the Blaan. They are from Bgys. Kinilis and Landan. They shared that they have four doctors at the RHU level. In Bgy. Kinilis they have one nurse, one midwife, seven BHWs and one BNS, while in Bgy. Landan, there is one nurse, two midwives, two BNS and 13 BHWs.

Barangay CM Recto, Municipality of Ferrol, Province of Romblon

The Municipality of Ferrol in the province of Romblon, Philippines is classified as a Sixth Class Municipality, which means that it has an average annual income of less than Thirty Million Pesos (PhP 30,000,000.00). It has a population of 8,005 as of the 2020 Census and is politically subdivided into six barangays namely Agnooc, Bunsoran, Claro M. Recto, Poblacion, Hinaguman, and Tubigon.

Claro M. Recto is a Barangay with a population of 738 (as of 2020). CM Recto is included in the list of certified geographically isolated and disadvantaged areas (GIDA) of the Department of Health.

The people of CM Recto are mostly fishermen and farmers. Their main agricultural products are rice, abaca, dill, and common crops such as taro, sweet potato, banana, coconut, corn, and beans.

Aside from it being geographically isolated, there are currently no internet and telecommunication services in CM Recto. Local officials and health frontliners use handheld radios with a one-kilometer capacity to coordinate with the households.

Health Services

There are six Barangay Health Workers (BHWs) in CM Recto, which includes the daycare worker and the Barangay Nutrition Scholar (BNS). The BHWs voluntarily render primary health care services while the BNS monitors the nutritional status of children and links the community with nutrition and related service providers. The daycare worker also does height and weight assessment, daycare services including supplementary feeding, and participates in team monthly meetings. The Barangay Health Station serves as the primary care facility in the community.

The Ferrol Rural Health Unit provides preventive, regulatory medical care services in the municipality which includes general consultations, maternal and child health services, nutrition, immunization, among others. The RHU is led by a Doctor to the Barrio (DTTB) deployed by the Department of Health for three (3) years, who also serves as the Municipal Health Officer. The DTTB Program aims to ensure quality health care services to depressed, marginalized, and underserved areas through the deployment of competent and community-oriented doctors.

Medical cases that need higher level of care are referred to the provincial hospital for treatment.

Health Profile

- Top causes of death are Upper Respiratory and Lower Tract Infection and hypertension. These are lifestyle-related non-communicable diseases that can be traced to smoking, smoke inhaled from kainingin (slash and burn process of clearing the forests), climate, and nutrition.

- There are currently five (5) cases of malnutrition recorded, which includes the case of a child with disability that experiences late physical development which affects his/her food intake.
- Only about 25% have access to potable water, most households have access to Level I water supply. The health frontliners recommend that drinking water sourced from water pumps should first be boiled before consumption.

- Lack of regular supply of medicines for hypertension, fever, and vitamins. However, there are seasons when there is excess in medicines, there are also times when medicines are insufficient.

- Parental neglect, alcoholism (ie. alcohol as a risk factor, neglect as violence against children impacting the community) are viewed as one of the problems affecting the health of the community.

- Despite being an agricultural barangay, there are barriers among children in consuming food that are produced in the community farms and gardens.

- Lack of personal hygiene among children affects children's health and nutrition.

Access to nutritious food through agricultural programs and access to clean and potable water, roads and transportation, internet and telecommunication services are the key determinants of health in CM Recto.

Prior to the pandemic, Barangay Health Worker frontliners were able to do regular house visits to patients.

Other attendees from civil society [Age, Gender, Disability]
[Link to the attendance here]

THE RESPONSES

Preliminary/Context Questions from CSOs

On information about UHC

This question allowed the team to know the information that people would like to know about the UHC and its implementation:

- *On PhilHealth (national health insurance of the Philippines):* Updated comprehensive out-patient primary health package; membership coverage
- *Status of implementation:* Was there a review conducted on its implementation for the UHC-IS?
- Who are the beneficiaries of UHC?
- How does it affect the current TB and HIV situation in the Philippines?
- What are the programs and services it offers [service delivery network mechanism/pathway, community set up, affordability and accessibility]?
- When will people begin to feel the delivery of services?
- The bare minimum target for health services provided to all hospitals across the board
- The implementation of the services to older persons
- Matrix of health services provided/improved to be provided upon by UHC implementation
- How many benefits or health packages does UHC currently provide?
- What are the governance standard criteria/engagement?
- How can civil society organizations + people's organizations participate or access funds in support of a healthy community?
- Status of actual implementation of UHC (not only the issuance of guidance) ● The meaning of progressive realization
- How do we inform the public in general?
- How are the services under UHC felt by the public?
- Is there a UHC arbitrer or a monitoring team?
- Update on information dissemination

On the meaning of UHC mean to you (GIDA area participants)

- It is a law that seeks to give all Filipinos social health insurance coverage.
- It means healthcare programs for children who are malnourished, adults who have hypertension, diabetes. It also means cleanliness of the surroundings, planting of vegetables and fruits that allow people to maintain good health.
- How do we fight against diseases, how do we strengthen people's immune system and how do we avail of the services that people do not have the capacity to pay for, and how can out-of-pocket expenditures be reduced.
- It's a law that allows people's grievances about health to be addressed.
- Government program that gives services and health commodities to poor communities in 6th class municipality, to give them medical attention and medicines. This includes the Malasakit Program.
- Government initiative to uplift the economy through healthy citizens.
- It is enacted to benefit the poor. It is universal in a sense that it does not choose between the rich and the poor.
- It is established to help the poor, so that various government agencies can be approached by the citizens about health.
- Some people die without receiving medical attention, many people get sick without being treated.

On expectations about the UHC after its passage

Accessibility/inclusivity

- Its visibility in our local community.
- All Filipinos have a social health insurance
- All Filipino people will have fair, free, easy access and immediate care (if needed) to UHC and good health. And that no patient is left behind, especially the poor and the indigenous peoples (IPs).
- More facilities to provide better care for patients.
- The needs of **People Living with HIV (PLHIV)** will be addressed.
- Healthcare costs will be reduced or at least there are efforts to do so.
- Opposite of access despite UHC: Provincial hospital is lacking in facilities. Some patients are only held in tents outside the hospital [E.g. 24 hours after giving birth, the patient is relocated to stay in the tents instead. Both equipment and patients are suffering].
- Thus, Filipino patients are hoping to have better healthcare facilities for their health conditions
- There is an abundance of medicinal plants that can be used for first aid and home remedies that they are now trying to advocate for in place of conventional health services.

On implementation

- There is a question why UHC does not reach them and implementation may be a factor.
- Its rollout to the pilot areas.
  Health policies, packages and protocols for all diseases.
- We will enroll in primary healthcare units within the radius of where we live.
  - Referral system in the integration

-
    - Patient navigation
    - Primary health care
- Sadly no news yet regarding mandatory enrollment and roll out of comprehensive outpatient primary care benefits.
- Initial structural reforms
- Focus on health promotion and prevention
- Allow for citizen participation in every platform provided by the UHC
- Investment in Knowledge, Management and Information Technology Services (KMITS)
- Effective information system

On information and communication

- Included in the health agenda of politicians
- Only one goal and understanding among implementation agencies
- Sustainable and effective promotion of UHC

"Low-class" view, discrimination towards IPs makes them scared to approach health facilities."

Category 1: Ensure Political Leadership Beyond Health

Q: Given your organization's involvement in health advocacy, would you be able to tell and describe to us how well the current mechanisms of the government engage across sectors for the specific purpose of improving health or advancing UHC? If so, how well is this mechanism or department functioning? Are the roles and accountabilities of agencies clear?

Current government mechanisms engagement & function

- Primary health care programs still to be implemented
- The effort is not enough, but hoping that it will improve soon as the pandemic is slowly being managed
- The process of getting involved with the UHC law implementation should be well defined
- LGUs weren't trained on how to make a transition plan (which is a requirement for DILG to release funding); only accountants were trained, not GAD officers, mayor, etc.
- Philippine Charity Sweepstakes Office (PCSO) and the Department of Social Welfare and Development (DSWD) and other gov't agencies aided with funding.
  Department of Agriculture (DA): Fingerlings for fish pond, PhP5000, rice seedlings; swine dispersal (direct, being given without MOA) -- current mechanism opens possibility for program to die out; they would prefer to have it go through the barangay so they can redirect to those who can really benefit from the program.

-
- Mayor implements the DST Kariton program -- medical mission going per barangay (25 barangays under the umbrella of T'boli).
- DSWD: Social Amelioration Program (SAP) and the ones for the Pantawid Pamilya Program (4Ps) / Conditional Cash Transfer (CCT) and IPs. They enhance, evaluate and give health education to households or 4Ps members to make them aware about their health.
- Lack of available information/feedback
    - Cannot fully describe how gov't has been advancing UHC
    - The Philippine Association of Diabetes Educators is willing to assist the best they could but unfortunately they do not know with whom to coordinate with
    - Most patients don't know their entitlements (outpatient benefits) despite the abundance of health programs
    - **Public health information campaign is critical and should predate the implementation**
        - No agency seem to be willing to be involved in public health information campaigns
- Needs of certain groups and engagement with other sectors
    - Constituents from the informal sectors we are hoping to benefit the most from the UHC
    - No health policies are yet in place for psoriasis (and other NCDs/chronic conditions) both in the national and local levels
    - Include the monitoring of RA 11228 (Magna Carta for Persons with Disability) i.e. the Mandatory Coverage of PWDs as a complementary to UHC for PWDs
    - RA11166 (Philippine HIV and AIDS Policy Act) AIDS Medium Term Plan has not been implemented properly yet
- COVID-19 coordination and navigation under UHC with the use of Barangay Emergency Health Teams (BHERTS)
    - Allocate funds even to provide service like vaccination to remote areas and also promote projects that will benefit generation to generation. [E.g. funds of livelihood programs redirected to construction of concrete bridges for the benefit of students from remote areas to have safe crossing].
    - Unvaccinated and those who do not follow COVID safety protocols aren't allowed to enter the barangay.
    - Provides a 24/7 rescue vehicle with a driver.
- Aside from municipal and barangay health units redirecting severe cases to provincial hospitals, there is no actual hands-on help or health education from the provincial government.
- In Polomolok, South Cotabato, there are NGOs and private sectors that do interventions on health in order to reach areas that cannot easily access health

services.

- In Brgy. Kinilis, a *barangayan* happens – it is an activity of LGUs and Municipal Health Office (MHO) to do solidarity work with community members. None this year due to lack of budget in the barangay.
- The Mahintana Foundation (under the Department Labor and Employment or DOLE) -- used to help out the Brgy. Kinilis by giving PhP300 for food allowance during immunization and prenatal, specially in GIDA areas.
- Brought patients to Marbel (Koronadal) even though there is no ambulance in Brgy. Landan. Hoping that this will be remedied by the UHC for easier travel to provincial hospitals.
- Service provided by barangay sometimes can't be used because there's no available driver.

- Coordination with other sectors/nation government agencies (NGAs)
  - *Department of Education (DepEd)* - the coordination on delivery of child and adolescent-related programs and services
  - *DSWD* - supplementary medical assistance, barangay daycare centers, social workers
  - *Department of Science and Technology (DOST), Food and Nutrition Research Institute (FNRI)* - Food and nutrition as a determinant of health
  - *Research Institute for Tropical Medicine (RITM)* - health technology and research (laboratories, vaccines)
  - *Department of Finance (DOF)* - discussions on fiscal space for health expenditures and sources of financing
  - National Economic Development Authority (NEDA) - development framework-setting
  - *DA* - Food and nutrition aspect of the determinants of health
  - *DBM* - for advocacies on budget allocation for health
  - *LGUs* - The delivery of health services in the Philippines has been devolved

Case Study: Bgy. CM Recto, Municipality of Ferrol, Province of Romblon (GIDA)

A **barangay health station (BHS)** is the local government health facility that is closest to the community. This is the first point of contact for primary care or basic health needs. Cases that need further medical attention are brought to the **rural health unit (RHU)** in Ferrol or in Odiongan.

There was a particular case when an older patient who was being closely monitored died before reaching the health facility due to the distance of his residence in an uphill area and the lack of appropriate medical vehicle.

The FGD participants were asked to collectively analyze the situation and the gaps that led to the demise of the patient. The participants listed the following:

- The health condition of the patient was already **catastrophic**, the **worsening of the diseases should have been prevented** had the family **communicated** the condition with the barangay health station frontliners. There was a **lack of communication** between the patient's family and the frontliners.
- The lack of communication was the outcome of the **lack of mobile and internet connectivity** in the barangay. The sole device that is being used for coordination between and among the frontliners, the handheld radio, could only be used within one kilometer radius.

- There was a **lead time needed** to arrange for medical transportation and this service may not always be readily available during emergency situations.
- Even when the patient reaches the higher level of facility in the next municipality which is closer to the barangay, the Municipality of Odiongan, there is a **province-initiated policy that requires swab testing** before a patient could be admitted to the hospital. The **waiting time** for the COVID test result could also have led to the death of the patient.

Recommendations

- Continuous seminars from different sectors of gov't regarding the benefits of UHC is a good way to make more Filipinos understand the importance of UHC

"It is good that the gov't is engaging the communities to participate in such a mechanism, but not many people know about this. I think as an NGO we also have the responsibility to share the information to the public in our capacity so that the people will be aware & be engaged too, especially the end-user of the services
(children & youth with disabilities). For our org, it helps us a lot in planning for our advocacy activities (strategic plan) better. For the NGAs, some of the other agencies need to be on board at all times not just DOH, because this needs active collaboration from them & must be part of each of the dept's planning to have some representative who can relay it back for genuine actions re: UHC's implementation."

Q: Given your organization's health advocacy efforts, can you share with us your experiences in engaging with other government ministries or departments beyond health, if there are, good or bad? If possible, please share with us what agencies are these. [For example: briefings with Ministers of Finance, Welfare, Labor, Water and Education Agriculture, etc.]

Experience by agencies

- Collaboration with agencies that we approached have gone smoothly.

"Their engagement could be graded, 'poor to fair'. Many of them seem to not understand deeper their role in the implementation of UHC, how important HEALTH is in all areas of the government, which we all have experienced in this PANDEMIC; indeed an understanding of 'HEALTH

IN ALL POLICIES' principle must be shared to these departments too."

- DOH: Efforts of ANG NARS to make contractuals permanent in the DOH Deployment Program.
    - Only engaged DOH, PhilHealth and FDA.
- Malasakit Centers (though not part of the UHC) are able to help with medicine access.

Non-DOH Agencies

- They sometimes cannot see the benefit of UHC to their departments.
- DOLE OSH (Occupational Safety and Health Center) always has dialogue for Social Protection.
- Monitoring of the Department of Trade and Industry (DTI) regarding intellectual patents on drugs and medicines. In trade agreements, economic and trade aspects are prioritized over public health, as evidenced by the lack of push for the TRIPS waiver, which waives the restrictions on accessibility of vaccines, diagnostics and treatment. This causes the economy to be sick as well.
- World Trade Organization (WTO) has policies/laws on drugs and medicines affecting why only vaccines from the US, UK, Russia, etc. were approved and other vaccines from India and Bangladesh were not, effectively driving up prices of vaccines.
- Municipal DRRM and DSWD helped with construction of the hanging bridge and concrete bridge.
- LGUs - generally open to UHC
- DILG - More engagement is needed
- Department of Public Works and Highway (DPWH) - agencies that are not generally considered health agencies are not used to being engaged by health groups
- These are the offices and agencies in CM Recto that provide health-related services:
    - BHS in coordination with the Office of the Barangay Chairperson: responsible for providing basic health services, daycare and nutrition programs for children
    - RHU is a secondary level health services
    - Provincial Hospital: Caters to cases that require a higher level of care.
    - DSWD, MSWDO: Provides supplemental financial support for medical needs
    - DepEd: Oral health, sexuality education
    - DA: aid for local farmers to be able to plant rice for local consumption.

With CSOs

- Representatives of organizations are only able to attend seminars and give recommendations

GIDA Experience

The Malasakit Center is also considered a helpful office. It is a one-stop shop where indigent patients can efficiently access financial medical assistance from agencies such as PhilHealth, Philippine Charity Sweepstakes Office, and the Department of Social Welfare and Development.

There is a need to ensure that the food for supplemental feeding for children, in partnership with the DSWD and MSWD, are healthy and nutritious. There were experience in the past when instant noodles were given to children.

Q: Using the Likert Scale, provide a rating for the government, whether it was able to give UHC a high priority during this COVID-19 pandemic?

1 - Strongly Agree
5 - Strongly Disagree

Please explain your answer with your examples/experiences.

2 - Agree

- Nobody was prepared for the pandemic but we have fared well compared to other countries. Because the Filipino people took part in its implementation of protocols, we developed a better "family leadership" – wherein there should be a leader in each of the families – which is the essence of PHC and one of the key components of a successful (future) UHC implementation.

  ABI's engagement with the gov't has also helped people become more vigilant of health advocacies.

  Though late in responding the first time, as time went by the gov't has somehow improved in its ways & strategies.

  Agreeing that UHC should help in the time of COVID-19.

- Five (5) participants from GIDA agrees that government was able to prioritize UHC.

3 - Neutral

- Personally didn't feel the presence of UHC during the pandemic.

  Though the response to COVID is satisfactory, some other health conditions were left behind.

  DOH was able to create policies based on the IRR and online learning modules on UHC.

  Many hospitals were converted into COVID wards.
  The UHC is being abused by the private health provider and the government is not taking any actions to stop it .
- There were fair efforts.
- UHC is being implemented, but the national government has to further prioritize this to allow for better accessibility and for lesser known programs under the UHC to be enjoyed by the general populace.

  Local LGU is constantly taking action within the barangay, but they are also looking to see more action from the national government.

- Relief goods given during the pandemic are not sufficient. Doesn't contain medicines. Residents in mountainous areas are not satisfied.

4 - Disagree

- The government concentrated on the Covid efforts.

  Because of the pandemic, the gov't saw the need to provide accessible health care for all.

- Polomolok has ongoing telemedicine services. Delayed arrival of medicines.

  Difficulties in implementing Resbakuna due to lack of doctors to explain the benefits of the vaccine.

- UHC was not given a high priority

5 - Strongly disagree

- The poor response to the health crisis shows the poor implementation of UHC.

GIDA Experience

In the course of the pandemic, there were not a lot of patients that were admitted to the hospital due to medical emergencies, the Rural Health Unit was able to slowly get back to its regular work immediately while following health protocols, in coordination with Barangay officials.

Patients were allowed to go to the health centers during the lockdown. Primary care was provided based on the needs of the patient, including COVID-19 vaccinations.

One challenge was that patients would be reluctant to go to the provincial hospital for check-up due to the COVID cases. The other challenge cited above, which is the required COVID-19 swab test result before a patient could be admitted to the hospital.

Q: How have new health policies and programmes during the pandemic changed the path towards UHC? You may see a list of laws and policies above [Category 1] or you may have a policy/program passed/implemented during the pandemic that you think may have changed the path towards UHC.

Not well-implemented

- In my opinion UHC during the pandemic is not well implemented.
- The focus on UHC was not fully seen.
- The UHC must be reviewed for the benefit of the really needy.

Effective

- It was effective for the COVID-19 situation. Still to be seen how effective it is across the board of all health conditions now that we are slowly moving forward away from covid.
- It made the people ready to listen to what UHC can do in the community (benefits & impact).
- Yes, especially for PLHIV, the DOH together with development partners and CSOs were able to develop a program on providing ARVs to all PLHIV.

Specific policies that change the course of how the UHC is implemented

- The Mandanas-Garcia SC ruling has changed the UHC implementation. DOH devolved more functions to the LGU.
- The Bayanihan Recover as One Act.
- The policies somehow have included health & safety components & engagement of people & creation of networks --- RA 11650 the ILRC (inclusive learner's resource center), which has a big component on the health & wellness of children at school, as it promoted 'inclusivity'.
- DOH has made a manual on Palliative and Hospice Care for rollout this July. This will impact integration of psychosocial for palliative and supportive care in the UHC.
- General Appropriations Act (the budget law): The budget law articulates priority expenditures for health during the pandemic, the way that the budget was directed to pandemic response in the past 2 years have affected the trajectory of UHC
- Suspension of OFW premium payments. The OFWs had the capacity to pay; temporarily suspending their premium payments defeats the purpose of risk pooling in social health insurance where those who have the capacity to pay, pays for health services.
- The Antigen Test Protocol issued by the provincial government had an impact on patients under emergency health situations as negative swab test results are required from patients prior to admission. The lack of human resource and the health facility that has been under construction are seen to contribute to the challenge, as the limited number of triage stations slowed down the assessment process that identifies whether a patient should be directed to the COVID ward or the regular ward.

On COVID-19 and UHC: Mobility Restrictions

- In other barangays, emergency ambulances are being used instead as personal vehicles.
- Emergency vehicle of Brgy. Kematu is even able to service other barangays.
- For four (4) years (including the time of the pandemic), they didn't have a rescue vehicle. Used the personal vehicle of a kagawad or rented another vehicle instead to fetch return OFWs or local stranded individuals.
- Currently has one (1) rescue vehicle for barangay use. Pickup was given by the provincial government but they were asking for an actual ambulance.
- **Lockdown and quarantine restrictions** have the disadvantage of people being trapped in their homes -- **mental stress** due to being locked in, patients cannot freely visit the hospital.

Category 2: Leave No One Behind

Q: Which groups of people in your country struggle to gain access to health services? What are the main barriers for them to access health services? [Barriers to care can include: affordability; social, political and cultural determinants of health care access.]

Identified vulnerable groups

- Children and adolescents - There is a gap of service provision to this age group and young people's health seeking behavior is low.
- Pregnant adolescents that need proper counseling and child-friendly accommodations in the barangay health stations

- Children, youth & elderlies with some form of disability ● Person with disability, as caring for them require transportation ● Low to middle class workers. Workers in informal sectors.
- IPs, people living in the GIDA and rural areas with no hospital in their municipality. Areas where high quality health services, from primary to tertiary, are hardest to reach; most tertiary care are Manila-centric
- People living with NCDs, rare diseases, chronic illness and mental health problems. Cancer patients. Patients who are bed-ridden. Those who have mental health problems (Brgy Landan).
- Informal settlers and farmers/fisherfolks.
- Persons with disability : accessibility of health facilities and services
- Poor communities
- Older persons

Barriers to care

- Not well disseminated implementation rules and regulations.
- Affordability, service delivery network and access to medicine.
- Financial hurdles due to expensive medicines and treatment.
- Specific to T'boli and Blaan IPs both in the sitio and remote/GIDA
    - The farthest is Sitio Lagtaninag (population: 186) under Brgy. Kematu. It is six (6) hours away from the barangay, but BHERTs are able to reach them. Roads are only accessible on foot; even motorcycles cannot pass through. These are even more inaccessible during rainy seasons due to flooding.
    - Ululandan and Bukayel are remote areas. Roads to the remote areas of the barangay are rough and steep, taking one to two (1-2_ hours of travel time. Polomolok 3 is a GIDA area.
    - The elderly will only get checked up once their symptoms are severe.

On Accessibility

- Stakeholders are able to help out when short on funds (economic access).
- Transportation of products like abaca, coffee and kalawan would also benefit from better roads. It is the hope that more bridges and roads under the Build, Build, Build program will be built.

Q: Considering the needs of the groups identified above, what are the specific health services that are under-prioritized? [Groups of people could include: vulnerable populations like children and caregivers, persons with disabilities, people living with NCDs, people with mental health conditions, etc.]

Some participants said that generally their LGUs are able to respond to their health needs, but to some, they have listed the following services they think are underprioritized by government:

- Rehabilitation is often an "after-thought" and often available at the secondary & tertiary level of the health system. It must be a part of the health promotion, prevention & intervention.
- Health and wellness and physical therapy
- Oral health services
- Primary healthcare, screening, laboratory/diagnostics
- Education regarding health and illness. How to prevent and control especially NCDs.
- Access to HIV services including treatment.

- UHC is supposed to allow for general practitioners to examine patients prior to referral to specialists.
- Specifically on access: financial and transportation assistance / Medical Vehicle for the Barangay
- Food and nutrition services
- Mental health services
    - Brgy Landan: There is a problem of mentally ill pregnant women who wander around the barangay. Barangay kagawad were asked to assist them to a mental hospital but no response. The barangay health worker (BHW) refers mental health problems to the RHU.
    - Assistance can be requested from the DOH since both the Mental Health Law and UHC are supposed to cover this.
    - Trauma counseling
    - Only Davao City has a mental hospital. Hopefully South Cotabato can also have this facility.
    - There are free medicines in the Polomolok RHU, but due to the number of mental health problems not everyone is able to avail.
    - LGU has programs for mental health awareness but information isn't disseminated in every barangay.
    - In Brgy. Kinilis, information is disseminated but the people do not have the financial capacity to avail services.
- Medicine Access
    - There is a 1% budget allotted to medicines from barangay funding.
    - Shortage of medicines. If medicine is unavailable at the barangay level, patients are referred to the RHU (e.g. hypertension, diabetes).
    - Free medicines for older persons (maintenance medicine)
    - Medicines for mental health patients
    - Botika sa Barangay
- Needs of person with disability are not being adequately serviced since they need to be examined by specialists.

Specifically on mental health

The participants of the FGDs and the national strategy for mental health developed, due to the mandate of the Mental Health Act, have identified as one of the gaps, the **community-based mental health services**. These could be implemented through the establishment and strengthening of a psychosocial network of mental health services preventing, treating, and promoting the social inclusion of people suffering from mental illness. The law itself, under Sections 15-16, supports the establishment of community-based mental health services.

"Stigma serves as one of the primary barriers of mental health services utilization among Filipinos [Martinez et.al., 2020]. As long as there is a big institution like the

National Center for Mental Health (NCMH) identified as a go-to hospital for people with mental and psychosocial concerns, the stigma will always be there. Service points should be integrated in health facilities to address quick referral. Community-based mental health care facilities are still like NCMH just on a smaller scale." – Doc Jun Bernardino, LifeHaven Independent Living

On poverty, its different aspects as a determinant of health

- Need to improve the lives of their constituents through better livelihood programs.
- More benefits for GIDA areas (e.g. solar lights were given). ●

DSWD is supposed to allocate PhP300k for *corn sealer* or *palay sealer*· Paperworks have been submitted but this still hasn't been implemented.

New services

- The COVID-19 pandemic led to the rise and innovation of telemedicine for counseling and consultations. There have been advantages and disadvantages, but the gains **cannot be maximized without the prerequisite infrastructure and internet connectivity**.

On primary care providers

- Ensuring health benefits for Healthcare workers/Barangay Health Workers, such as allowances and PhilHealth coverage
- Regular nurse on-duty in the Barangay Health Station
- Visiting psychiatrist for two (2) patients with mental health conditions. These two patients are currently controlled and uncontrolled.

Q: Are there laws and frameworks in place in support of vulnerable groups accessing essential health services they need? How well do they work in practice? [For example, these are mostly Magna Carta laws; laws for persons with disabilities; human rights to health, etc. that it is illegal to discriminate on the basis of "race, color, national origin, sex, age or disability in certain health programs"]

Specific laws to support the vulnerable population

- Magna Carta for Disabled Persons (R.A. 7277 amended by R.A. 9442)
- Creation of the National Council on Disability Affairs or NCDA (R.A. 10070) / Philippine Disability Affairs Office (PDAO) creation
- Philippine Disaster Risk Reduction and Management (DRRM) Act of 2010 (R.A. 10121)
    - Should be Disability Inclusive Disaster Risk Reduction & Management of the Health System (DI-DRRM H)

- Instituting A Policy of Inclusion and Services for Learners with Disability in Support of Inclusive Education Act or ILRC (R.A. 11650)
- An Act Providing the Mandatory Philhealth Coverage for All Persons with Disability (R.A. 11228) - Philhealth membership for person with disability & elderlies, but rehabilitation service package is still not developed especially for adults.
- An Act Expanding the Benefits and Privileges of Person with Disability (R.A.10754)
- The mandated one (1) percent IRA allocation for Senior Citizen and Persons with Disability under RA 7277 or the Magna Carta for People with Disability

- EO 437 re: Community Based Rehabilitation
- First 1000 days Law (R.A. 11148): seeks to scale up the national and local health and nutrition programs through a strengthened integrated strategy for maternal, neonatal, child health and nutrition in the first 1,000 days of life.
- Early Childhood Care and Development (ECCD) Law (R.A. 8980)
- Sexual and Reproduction Health Rights (R.A. 10354)
- Gender and Development Budget allocating five (5) percent of the total LGU budget for gender programs (for women and girls)
- Philippine HIV and AIDS Policy Act (R.A. 11166)
- Health Emergency Allowance (R.A. 11712)
- Mental Health Law
- Cancer Law
- Framework on patient rights: data information management showed abuse of healthcare workers/ healthcare workers' human rights violation (Medical Action Group or MAG has a documentation of human rights violations)
- The programs of the DSWD that help citizens access supplemental financial aid for medical use.

How well do they work

- There are laws and they have a big impact on vulnerable groups. However, implementation of almost all of them remain a challenge.
- There should be clear rules and regulations in the implementation of any laws. Massive information and literacy campaign drives for the public regarding these laws should be conducted.
- For the disability sector, the law is still outdated and does not adhere to the United Nations Convention on the Rights of Persons with Disabilites (UNCPRD). A lot are still left behind and excluded from this sector.
- Community-based mental health services that need to be scaled up and institutionalized
- They ask who can recommend or request the construction of a big hospital in their area (coordination problem)
- Advocacy or campaigns for health organized/led by local/primary health workers are important because they can be the voice to argue their case and health at the local level regarding budget.
- They emphasized that the problem is financial because BHWs are doing their best to disseminate health information (on paying BHWs higher allowances or salaries)

For primary care workers, they service all their constituents to the best of their abilities

- From the farmers from the farthest sitios to the most successful business owners at the center of the barangay, they are all provided with basic health and social welfare needs.
- Over 70% of the barangay constituents are vaccinated against Covid.
- Ninety (90) percent of infants and babies are fully immunized babies
- All constituents requiring basic medicines are assisted by nurses. When necessary, refer to higher medical facilities.

  Ensure that every senior citizen can receive their first pensions by deploying people to list those above 60 years old and inform them of their schedule.
- Has a list of person with disability, including those with mental health problem, for easy contacting.

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- Almost all 4Ps are able to receive their financial assistance.

Q: Cite clear-cut examples or experiences of how certain policies or programs reduced or eliminated patient fees (out-of-pocket spending on health)? Are these reductions enough for the needs of the patients and those accessing the services? Are there invisible/indirect costs related that are not covered by these policies/programs? [Examples include: public insurance schemes, free health care policy; It is highly encouraged that each patient group answers this question]

On person with disability and senior discounts/insurance

- Supposedly the RA 11228, but it's not yet available for the out-patient category.
- Twenty (20) percent discount for people living with cancer.
- Discounts due to insurance are helpful in alleviating financial problems of patients; however, there are instances that patients have to choose between
  using their PWD ID or senior ID in availing these benefits
- Senior Citizen discount at 20%

With Malasakit (Concern in English) Center

- A lot of patients are able to access services from Malasakit Centers but only limited to basic services. Some treatments are still inaccessible due to high costs.

Other agencies that provide financial assistance for health to reduce out-of-pocket

- PhilHealth
- PCSO
- DSWD
- E-Konsulta by the OVP (providing free COVID-19 consultation and medicines)
- One Romblon (formerly Sulong Romblon), a provincial initiative. The booklets given to qualified indigent patients can be used in public hospitals, ultrasound, laboratory requests (up to worth 5,000 PhP)

For PLHIV

- It is stated in R.A. 11166 that Anti-retroviral Therapy (ART) should be free for PLHIV.
- PhilHealth has Outpatient HIV/AIDS Treatment (OHAT) Package.

What needs to be improved

- The regulation of fees for professionals; engagement of the professionals esp. the allied medical professionals engaged in rehabilitation; availability of the rehabilitation services. These three things have not changed yet.
- Need to improve access.
- No balance billing.
  Lack of information on free services: There is an issue of uniformity. Health services that are provided for free are often given to those who have knowledge of these services and those who can assert.

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For indigenous people

- When there are problems/disputes/complaints, there is supposed to be a filing fee. But these is free for their barangay (Bgy. Kematu, T'boli).
- PhP100k health budget intended for one year. All services for both IP and nonIP are given for free.
- BHERTs assist constituents (specially senior citizen) to avail PhilHealth membership. ● *Mining*
    - Tribal Mining Corporation -- has been approached to help IP through their Social Development Management Program (SDMP), 1% royalty share, 1% surface owner rights. Coordinating with Indigenous Political Structure (IPS).

      The corporation is at its exploration and development stage. Assisted in medical missions and interventions during the pandemic.

      Normal Corporate Income Tax (NCIT) law indicates that those who will use whatever natural resources (mining/water) will have to lease.

      All shares from the company is deposited into the account of Indigenous People Organization (IPO). IP leaders decide on the priority programs.

      South Cotabato is an awardee of Galing Pook for most cleanest and regulated mining -- which is being done within Brgy. Kematu.

      Barangay makes sure that budget for Mine Rehabiliation Program is being utilized. To mitigate environmental risks, they implemetn continuous tree-planting.

      Plant is being monitored by Mines and Geosciences Bureau (MGB).

- South Cotabato provincial hospital services are free. However, Brgy. Landan is 14.5km (1.5 to 2 hours) away from Polomolok. This is made even worse by the lack of an ambulance. *Assistance during COVID-19*
- PhilHealth coverage on COVID testing for pregnant women (however, this is not applicable when there is no doctor's order)
- Free antigen test in some LGUs, in coordination with PhilHealth

Q: Who is most impacted or what health services are most negatively impacted by out-of-pocket payments?

- Patients and families are greatly affected by the high cost of medicines,

treatments and medical procedures.

- The people - those below the poverty line, near-poor, low-middle class
- PLHIV, specially OFWs living with HIV. Minors diagnosed with HIV are unable to use their parents' PhilHealth since they don't want to inform their parents of their HIV status.
- The poor and indigenous peoples in far-flung areas

What services/treatments

- Implants
- Dev ped fees
- Genetic tests
- Outpatient diagnostics and laboratories
- COVID-19 tests and treatments
- Physical therapy
- Medicines. This 2022 Election season affected the procurement of medicines
- PPE/sanitation fees have been added to healthcare costs

Category 3: Regulate and Legislate

Q: Do you feel that UHC laws/policies/strategies that exist in your country are being adequately implemented?

Most participants' answers range from NO, not enough, poor implementation, there are lapses and needs improvement. Only a few affirmed that the implementation of UHC and related laws are adequate.

As a response to these inadequacy, primary care and frontliners in various barangays – BHWs, nurses, councilors – all go to the field to encourage people to enroll into PhilHealth. At the moment, 70% of the Bgy. Kematu is currently enrolled.

"We cannot claim Universal Health Care if we are not yet able to cover and provide benefits to all and every indigenous community in the Philippines." – Dr. Jaime Galvez-Tan

Implementation may be ongoing but those people residing uphill, upland and near mountains are not aware or do not feel yet the impacts/benefits.

In Bgy. CM Recto, primary care frontliners said yes that UHC is being felt through the BHS since those who come are being catered.

Q: Do you know of any government-set accountability or monitoring mechanisms for UHC in your country? If yes, please explain your answer.

As far as the CSO/FGD participants know, the following are the monitoring mechanisms set-up within government:

- Performance monitoring (within DOH)
- Congressional oversight at the legislative branch of government (House and Senate)
- Commission on Audit (COA)
- At the barangay, the council and the BHWs conduct survey or profiling/household in every sitio and purok in order to list all those without PhilHealth membership and pass it to LGU to help enroll them.

There were also some who answered that they lack the information on these mechanisms, thus, were not able to answer.

They also reiterated the important role of citizens and civil society organizations to monitor and partner with the government to better implement and improve existing policies. Critical engagement with government like what ABI-Health is doing should continue, especially those public consultations.

Q: Are there laws and policies in place to ensure that people can engage in planning, budgeting and monitoring of health plans and budgets?

There are currently no specific laws to mandate/require citizen participation in different governance political arenas or public spheres. However, there are laws like the Local Government Code of 1991 (LGC) that include in its provision the involvement/representation of the private sector, to which civil society is considered a part of. There were several laws filed before to strengthen this but they failed to pass.

In the UHC Law, it is mandated that the HTA process involves patients in the process. Likewise, the HIV/AIDS Act (R.A. 11166), does have a platform for involvement from patients. However, the main question is can one or two representatives from the citizens/civil society/patient groups be enough to carry the voice of the vulnerable populations, who most of the time are not consulted. Are the necessary mechanisms of action, platforms friendly for citizen participation? Do information of these processes disseminated so that more can practice their responsibilities as citizens and participate in the political arena? These were most of the questions of active civil society groups. If they are clueless, what more ordinary citizens who want to know how to be involved.

According to one of the communities interviewed, during their Annual Investment Planning (AIP), they gather data from the community through the BHWs and Barangay Nutrition Scholars (BNS) to determine what programs should be prioritized by the Barangay LGU. The participation of the community is 100% through sitio leaders, purok leaders, IP members, farmers and women's association, fishpond owners and Sangguniang Kabataan (SK). Partners in development are also tapped to join and input what else needs to be included in the P/A/Ps.

In the other barangay (Blaan), they are not familiar with who is the point person that can do interventions regarding the budget. Only the barangay council or the kagawad on health helps out on this front. It would be good if there are NGOs to help them.

At the national level, the DBM require agencies to consult with CSOs (National Budget Memorandum/Budget Call requiring the submission of budget preparation form D) As mentioned, the LGC of 1991 has some participatory processes and mechanisms within its provisions, however, the implementation of these is often uneven.

In recent years, the COA also launched a project on Citizen Participatory Audit but the groups interviewed are not aware if it is still ongoing. The Kalahi-CIDSS poverty alleviation program implemented by the DSWD also has some platform for participation.

In Bgy. CM Rector, the Barangay Development Council (BDC) includes civil society organizations and other associations in their processes. Senior citizens and persons with disabilities are invited to BDC meetings so that they can suggest and request programs.

Category 4: Uphold Quality of Care

Q: As citizens/patients, where do you primarily access your health services - public [BHS/RHU/district], private [tertiary hospital], or others [what are they]? Are the health services you receive in your facility of choice of good quality? Can you elaborate and give examples?

General feedback

- **Good.** Whether public or private, generally, health providers are easy to deal with in the facilities we accessed. We have good experiences with the doctors, health workers, the medicines provided and facilities.

For those accessing services at public health facilities [BHS/RHU/district hospital]

- Valenzuela – Fair to good at the RHU level, vaccination and medicine provision is well-implemented. Facilities are clean and staff are "welcoming" in treating clients. Poor in relation to "rehabilitation".
- Fairly graded. Rehabilitation services are still not included.
- Some public hospitals and rural health centers still lack some expertise in certain fields and have no capacity for providing needed diagnostics, treatments or operations.
- Some participants say that the health services are of good quality with adequate facilities and specialist doctors, including sufficient medicine supply. One example of this is the National Kidney Transplant Institute (NKTI) and the East Avenue Medical Center. They said that public health doctors and professionals in these facilities are really good. However, while they are exemplary, these facilities are often too crowded.
- Barangay health station (IP communities)
    - Good services, however the midwife (Tboli), can be hard to find at times. ○ Services are okay. The problem is the lack of commodities.
    - BHW, BNS, nurses and midwives stationed within the health station of the barangay while nurses decide on necessary actions. The private hospital is 20 minutes away while the provincial hospital is one hour away and the regional hospital is three to four (3-4) hours travel.

- The referral system then is from the barangay to the municipal RHU, then referred to the provincial hospital, then the regional hospital in Davao.
- At Polomolok, the health referral system assigns emergencies at private hospitals. BHS does the initial assessment, then a BHW assists them in going to the RHU. If RHU is unable to help, the doctor will contact the affiliated hospital.
- The BHW and the Blaan midwife are readily available to provide service.
- No discrimination since BHWs are all friendly.
- There are feedback/suggestion boxes.
- Shortage of medicine supply is also common in primary care facilities such as BHS.

- There is a lack of healthcare staff in the provincial hospital.

For those accessing health services at private health facilities

- Those who said yes that health services are of good quality at private health facilities and those who said fair are even. However, they are of good quality due to having fees and higher cost of service.
- Patients and citizens said that for convenience and complete medical services, private and tertiary hospitals are adequate.

Accessibility to either public or private facilities is due to its proximity to the patient's residence. Specialized centers in the Philippines are Metro Manila-centric.

One of those in the online discussion said that good feedback about the quality of health services were not representative of the majority. Respondents may personally have good experience but in general, people probably do not have the same experience, especially with regards to availability, accessibility and affordability.

Check-ups of NCDs and chronic diseases such as psoriasis and other major diseases are available in public facilities and they are good. However, the paper works and processing of documents take time.
It was emphasized that no data yet is available from DOH that confirms the effectivity of the UHC accurately. It was also mentioned the importance of capacitating CSOs at
the LGU level to know the true face/phase of the UHC implementation.
On claims for Philhealth, there have been inconsistencies in the roster of indigent beneficiaries that affect their benefit claims in both private and public health facilities. Those who know their benefits/entitlements and are able to assert them are the ones who can claim their benefits.

Q: Does your country have adequate health workers, especially at the primary health care level? Are community health workers part of the health staff roster and are they paid adequately?

Lack of human resources for health (HRH)

- Inadequate staff and they are not well compensated.

It is also important to have permanent positions for healthcare personnel rather

than temporary positions as BHWs play a big role in the grassroots.

- There is a lack of health workers in all levels of care, most especially primary health care. ●
- [T'boli] Each barangay has one to two (1-2) midwives, one (1) nurse, two (2) BNS and up to 13 BHWs. This is enough. It would also be good if they could have a doctor assigned to the community to respond to their needs, or to have a doctor visit them at least twice a week.
- The Municipality of Ferrol currently has a population of 7,000 and one municipal health officer or MHO (a DOH, national government-deployed physician / doctor to the barrio). The ideal would be to have two (2) physicians on duty to sustain the work in the whole municipality.
- One midwife and one nurse would be ideal for a GIDA like CM Recto. While the population of the barangay is relatively small, the distance from one house to another is quite far, which requires ample transportation and communication means in order to deliver the services efficiently and effectively.
- [Blaan] As per experience, they are adequate - each purok of every barangay has an assigned BHW but they are NOT well-compensated and their budget & tenure is at times co-terminous with the mayor or chairman.

Inadequate compensation

- The community health workers are enough for the barangays interviewed but sadly not well compensated.
- Salary wise, there's still a big room for improvement to encourage them to work here locally rather than to move to other countries for job opportunities.
- While the number of barangay frontliners is enough for CM Recto for the time being, incentives and allowances that are given to the Barangay Health Workers (BHW) should be increased. Currently, the BHWs receive a total of around PhP5,500/year: PhP100/monthly from the allocation of Bgy. CM Recto; From the municipality, PhP1,000-2,000/year (based on assessment), and PhP2,400 from the provincial budget.

Category 5: Invest More, Invest Better

Q: Where do you think your government should be spending more in terms of achieving UHC? [Examples might include: primary health care, health worker training, increasing the number of hospitals, health promotion & prevention]

- Personnel both quantity and quality
    - Continuous training and increasing the number of staff to focus more on the health promotion and prevention of diseases and disabling conditions, sexual reproductive health rights (SRHR)
    - Permanent positions for health workers hiring (deployment)
- Infrastructure (including roads and its proper maintenance, lights, accessibility facilities, etc.)
- Upgrade hospital facilities
    - Increase capacity in terms of beds
    - Medical equipment such as oxygen tanks

- Access to medicines. For the GIDA, the PhP100k budget is not enough based on area population. While anemia and hypertension medicines are available at the primary care facility, they are still not enough
- Health promotion and disease prevention
- Primary Care
    - Expanded out-patient benefits
    - Blood pressure monitor for older persons
- Electronic records
    - ICT infrastructure
    - Digital and Internet connectivity should be funded by the UHC for maintaining electronic records and telemedicine
- NCDs, particularly Mental Health
- Improve means of communication (apart from Internet) - handheld radios with extended reach
- Filipino Traditional and Alternative Healthcare
- Knowledge, Management and Information Technology Services (KMITS)
- Citizen participation
- Emergency vehicle and driver
- Improved water supply/water source
- Agricultural financing programs

On the issue of mental health financing, since all areas mentioned the presence of mental health patients, the community-based mental health services including the prescribed medicines should be given ample attention and funding.

In the FGDs conducted with the health advocates, the participants saw the advantages and opportunities for increased mental health services, particularly mental health awareness and psychosocial counseling, during the COVID-19 pandemic. Telemedicine/online sessions and counseling as means to deliver the services is also seen as a factor that broadened the reach of mental health services.

Q: Is the government spending enough on health services and is this increasing? ["It is recommended that governments spend at least 5% of its GDP or at least 15% of its annual budget on health"]

- Spending on health has been inadequate although the health budget has been increasing due to sin tax.
- The health budget should be commensurate to the needs of the community, while also consulting key stakeholders and vulnerable groups.
- Those in charge of health, especially the health workers, are at the receiving end of complaints, whenever the commodities are lacking.
- The focus of government spending is more on curative than preventive and primary care. Rational decision-making must be in place to reduce catastrophic disease spending on health services of conditions and diseases that are highly preventable.
- Government's absorptive capacity/utilization also affects whether or not there will be an increase in the following year's budget. Hence, this should also be addressed.

Q: Since the start of 2014 when the Sin Tax was passed, the DOH budget steadily increased because of the tax revenues. However, it was reported several times that the department had low absorptive capacity [low utilization of the budget]. With this, what do you think are the hindering factors why the department is having a hard time utilizing its additional budget from the Sin Tax?

Lack of DOH resources or irrational spending

- Lack of clear directive people working in each DOH unit/office/bureau.
- They do not have enough human resources for monitoring & evaluation inside DOH. This is where NGOs should take part even in the budget, like publicprivate partnership (PPP) engagement.
- Majority of funds went to PhilHealth, when the resources should have gone to health promotion and prevention (there should be spending on the right things/needs (low cost but high impact programs/activities/projects).

Procurement/budgeting

- The need to amend the procurement law and some of the antiquated COA rules that prohibits the use of funds efficiently. There is also the lack of foresight and projection skills.
- No utilization plan.
- Budget is not well prepared. Stakeholders are not well informed on how to submit their budgets at the Barangay/Municipal/Provincial. A thorough assessment of the needs of the community should be done.
- Due to bureaucracy which hampers the implementation of policies.

Others

- Due to incomplete/inaccurate data.
- Lack of real people's participation in local decision making bodies. Need to beef up the local health board with CSOs.
- Fund for health is from LGU only, not from DOH.
- Additional funds from DOH would be helpful.
- Politically-speaking, the funds were used to finance the health agenda of politicians
- Lack of health human resources who will deliver the programs and health services, including ample incentives and benefits.
- Violation of laws.
- Irregularities and corruption: There are health facilities that are still unfinished, affecting service delivery in the barangay and municipality.
- COVID-19: The pandemic which reduced the usual expenses on seminars and meetings.

Category 6: Move Together

Q: At the national level: are there opportunities for people, civil society organizations, and the private sector in your country to be engaged in planning, budgeting, monitoring and evaluating the health sector? How about in the actual delivery of health services?

[Examples of different groups of people engaged are adolescents and youth, children and caregivers, persons with lived experience, vulnerable and marginalized groups. Some examples of opportunities are

open consultations with different groups of people/populations/ communities before developing major policies (ie. National Health Plan). Encourage discussion of how well they work in practice.]

- There are opportunities and spaces for CSO participation. Whether they are enough and effective or not is another matter. Most the time citizen participation is uneven at the local level in various LGUs. It also depends on the political will of the local chief executives (LCEs).
- There are also long-time NGOs and CSOs that are filling-in the gap in actual health services provision in the communities that are seldom recognized by government.
- There are a lot of consultations and discussions happening between DOH, PhilHealth and CSOs. There are opportunities like in ABI, but not many people in the community know about it. NGOs must also take part in advocating or spreading the information to the community.
- Patient groups are invited to sit in TWGs but most of the time it is to seek opinion on a crafted policy but not really involved in the co-creation of policies.
- Engagement of the above mentioned sectors especially children and youth and the working age is poorly graded, meaning there is minimal engagement of these sectors.
- CSOs are also participating at the local AIDS Council (R.A. 11166) including the Case Managers, etc.

Very important:

- The civic space is shrinking
- Participatory spaces need to be claimed and/or created
- Civil society participation should be supported by government but allowing them to remain independent.

Q: If so, what are those opportunities, and are they effective and efficient for the engagement of civil society, in particular, of the most vulnerable and marginalized populations and communities? Are they being listened to and their proposals being integrated and carried?

- Healthcare policy dialogues / Public hearings
- Consultation and assistance in preparing documents needed through the help of the Philippine Alliance of Patient Organizations (PAPO).
- The DOH Pharmaceutical Division has regular consultations with patient groups but this process has no follow-through.
- Both the NGAs and NGOs should facilitate such engagements even at the barangay level. The communities need an opportunity to be heard. Community organizing is important.
- There is hope to improve the engagements and hopefully government listens and dialogue with CSOs to avoid token participation and not make activities just an FYI kind of event.
- NGO work should be directed to LGU capacity building in health service delivery.
- In Philippine National AIDS Council (PNAC), council members are not engaged in the development of the Work and Financial Plan (WFP).

Q: At the community level: Are communities engaged in local level health planning, budgeting and accountability processes? If so, how are they engaged? [Communities would mean real members/residents of target communities, people's groups, basic sectors, civil society, and members of the vulnerable populations [person with disability, patients living with NCDs/HIV, etc.].

- No. They are poorly engaged.
- Some LGUs include CSOs but not many are knowledgeable about this.
- There are local citizen councils and federations who are continuously engaging their LGUs. But this is uneven across LGUs.
- There are some progressive-thinking local chief executives (LCE) who make it a point to involve members of the community in local level health planning.
- Continuous attendance and engagement is effective.
- In Bgy. Kematu, South Cotabato a private sector, the Trade Mining Corporation, is involved.
    - E.g. ENFRA project. If sitio leaders say that dryer should be part of priority projects, the barangay allots 20% of development fund.
- In the community, the sitio leaders, purok leaders, IPs, farmers' association, women's association, fishpond owners and SK.
- Community members are invited to the State of Barangay Address being held twice a year. to listen to the projects and activities being implemented by the barangay.
    - There are also emergency assemblies during urgent affairs.
- The barangay leadership is open and transparent with their funds.
    - The barangay has a five-year development plan is co-created with partners in identifying allocation of fund within the plan. E.g. augmentation of funds in medicine from partners. Still not enough despite help from NGO and private.
- Rotary Club, Lions, Eagles help out in doing medical missions.

Q: At the community level: Are there civil society forums or constituencies in your country to engage with decision-makers on health-related issues?

If so, how well does the existing civil society coordination function and what can be improved? [Examples: country coordinating mechanisms (i.e. for Global Fund), civil society alliances to influence national health budgets]

- Yes, there are opportunities for civil society to engage decision-makers on health related issues e.g., the Cancer law and the Sin Tax law.
- PAPO are well involved in various political and policy dialogues.
- So far with the experience of ABI and its partners, NGAs respect their views and proposals. Some but not all. It should be improved.
- Very few opportunities, such as fora must be available on "ground zero", the work of the NGO and the LGU must be in place. Community development and organizing is one of the strategies that can help (WHO's CBR strategy) to strengthen engagement with non-state actors.
- House rule of the barangay: legislators have respective committees, each kagawad being assigned to that committee mean that they he/she is interested in the particular issue, should be efficient and have delivered the needed outputs/outcomes.
- The Barangay Development Council is the mechanism for barangay-level discussions between officials and organized groups.
    - One example is the one (1) percent allocation for the projects, activities, and programs of older persons/senior citizens.
    - There is a need for organized groups, including sectoral groups, to have capacity-building on planning their activities and programs.

Category 7: Gender Equality

Q: Can you identify some of the major challenges for women and girls [including adolescents] in their access to health services?

- Accessibility
    - Accessibility and privacy.
    - The feeling of being welcome.
    - Access to their own PhilHealth Card.
- Reproductive health services on
    - Safe pregnancy and childbirth, difficulty in maintaining low mortality rate and teenage pregnancy is on the rise
    - No consistent reproductive health policies.
    - Stigma in accessing sexual and reproductive services.
- Lack of information
    - Insufficient information on how to access health services. Seminars can help make them more aware.
    - Information not accessible for the blind, deaf and people with cognitive disabilities.

Teenagers themselves are the ones who choose not to access the services.

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- Lack of recognition of postpartum depression among women
- Lack of information about the available services for women and girls
- Specific age groups of young people are not covered in social health insurance if they are not yet employed and not considered dependent (i.e. unemployed 21 year olds)

- Stigma against girls and adolescents who are pregnant hinder their access to services
- Programs for adolescent who are pregnant are uneven
- Lack of a "from womb to tomb" services disenfranchises specific age groups from the health system

At the moment, there are programs at the barangay aiding women and girls:

- Mainly doing IECs to inform the community of their social responsibility.
- Orientation for R.A 9262 for women. Adolescent symposium for adolescents.
- Strengthen programs anti-VAWC.
- Discourages early marriage despite the tradition of the tribe to marry early, in cooperation with IPS. Encourage them instead to approach government agencies to avail of the many education programs in order to stay in school.
- Methods and health education are available at the barangay health center. Nurses and midwives are able to cater to their needs.

Q: What kinds of health services are most challenging for women and girls [including adolescents] to access?

- Sex education and family planning.
- Maternal and Child Care.
- Safe pregnancy and childbirth.
- Contraceptives in some areas and teenage pregnancy counseling ● SRHR & rehabilitation.
- Tests specific to women.
- Health services for adolescents with disability
- Access of adolescents with disability (deaf) who are victims of violence
- Counseling for pregnant adolescents and VAC victims
- Adolescents who are pregnant usually conceal their pregnancy for fear of stigma.

In Bgy. Kematu, the maternal and neonatal services in the barangay and RHU are vibrant. Maternal and child health classes are held on an annual basis and monthly check-ups and family planning are available in the barangay health centers.

According to the respondents, their reproductive health information and services are mainly addressed through information-education campaign materials (IECs). This help inform women of their rights so that they won't be abused.

"Women in Brgy. Kematu are already empowered." – Bgy. Captain Benny

There is also an existing and active women's desk to handle VAW complaints.

Prior to the pandemic, the National Commission on Population (PopCom) and the DepEd, together with the midwives, used to hold lectures for grades 10-11 on sexuality education.

Q: What are the primary challenges to access health care services for individuals who are non-binary [e.g. LGBTQIA]?

- Privacy.
- Stigma and discrimination.
- Financial constraints and inconsistent policies.
- Wellness, sex education and family planning.
- Lack of information to let them be engaged (how, why and what).
- Limited SOGIE-sensitive service providers.
- Lack of information on the use of do-it-yourself hormone replacement therapies that may cause harm, etc.
- Limited social hygiene facilities

No discrimination and human rights violation based on gender in Brgy. Kematu.

Other services offered at the barangay level in partnership with other groups:

- HIV Testing: They partner with SK to conduct reproductive health and HIV testing. Recently, there was an HIV testing done for pregnant women two months ago but results still haven't returned.
- No discrimination. They even provide these individuals with condoms. ● They secure the privacy of their patients.
- There is an existing counselor in the social hygiene clinic in Odiongan.

Category 8: Emergency Preparedness

Q: How has the primary health care system been affected by the ongoing COVID-19 pandemic?

- The primary health care, budget and resources were more focused on COVID19 cases, causing a lot of other non-COVID patients, particularly those with NCDs and chronic diseases, to be left behind. Their continuity of care was disrupted
- Valenzuela City: They are greatly engaged, but there's too much work.
- Healthcare workers were directly affected. So much work on the ground and they need protection.
- Private health providers overprice their billings. ● RHUs were closed.

Barangay Funds

Greatly affected the barangay, especially in terms of its funds.

- Allocation of funds for rescue vehicles.
- Provided for returning OFWs and locally stranded individuals. The barangay has isolation units. Food and medicine for quarantined individuals were from the barangay budget.
- BHERTs monitor Covid-positive individuals.

●

    - Barangay also uses its funds to help certain families in need. [E.g. If a husband is unable to provide for pregnant wife, the BLGU assists in acquiring baby milk, PhP500 aid for their expenses in a lying-in clinic, etc.]
- The mobility restrictions made the disaster response more difficult and limited.

Q: How do you think that PHC can be improved/evolved to be better prepared for future pandemic and other health emergencies?

Trainings

- Strengthen the primary health care by continuous training & surveys that are relevant to preparedness; training needs assessment (TNA) to the people.
- Information, Education and Communication (IECs).
- Continuous training of trainers (TOT) & community engagement.

Better community engagement

- Raising awareness and better community engagement.
- Identify leaders in the community. People must be engaged in the planning of LGUs and other government devolved programs.
- Clearer and stronger border controls and quarantine protocols through community mobilization.
    - Plan for implementation.

Protocols

- Inform and push communities to mobilize and obey protocols set by the government. Better to develop and/or stay within our farms or gardens, stay healthy by planting and consuming vegetables.
- Continuous COVID-19 vaccination program

Resources/facilities

- Invest in primary health care human resources and improve primary health care facilities. Include primary health care in disaster preparedness plan.
- Have more sufficient and equal/fair access to facilities.
- Must have proper data of all private health providers and their rates.
- Sufficient funding per barangay. Enough health workers per barangay so that the need to refer to the RHU is minimized and all services can be provided at the barangay level.
- Strengthen referral system including baseline for disaster risk reduction services across national, regional, and local levels
- Develop an integrated 911-like system i.e., the one hospital command
- Readiness of infrastructure such as health facilities (quarantine facility), health equipment, transport for mobility, and internet and mobile connectivity are essential to being prepared for any future pandemic and health emergencies *Digital Connectivity*
- Engage the Department of Information and Technology or DICT (more efficient coordination and communication) in the development of the country's digital infrastructure
- Interoperable ICT. IT can also be used for referral system, e-trainings, and more efficient monitoring and evaluation

Category 9: Looking to 2023

Q: Is there another element of UHC and the distribution of health services in your country that was not covered in the discussion today?

[This may include: human rights; shrinking civic space; humanitarian settings; disability and inclusion; youth and adolescent engagement; the concept of gatekeeping & electronic health records; private sector & hospital involvement-their business ethics; the communities in the GIDA areas (indigenous communities, island barangays/municipalities). Encourage discussion of specific examples of challenges and/or recommendations.]

- Compensation for the services to be rendered as well as the allocation of budget for staff. Source of funding for UHC.
- Health workers conditions decent pay and a decent life.
- Right to health. No one must be left behind. Every Filipino, every disease must receive adequate health services and treatments.
- Patient Safety. Patient decision.
- More on disability and inclusion; youth and adolescent engagement; the concept of gatekeeping & electronic health records.
- Interoperable (centralized) electronic health records (same records from the rural area to the provinces or cities.

Health Infrastructures

- Looking to get a PhP5M budget from DBM to expand the barangay health center, especially to provide for pregnant women and infants/childrens being immunized.
- Lying-in clinic.

Q: What is the main request you have for your Head of State about the state of health care (access, quality, and cost) in your country?

Use the 1-minute elevator pitch exercise.

- Add more budget to health, create services-based (essential health) packages and not only disease-based policies so everyone can have access to equitable health.
  Accessibility, Affordability, Availability & Quality of health services in both rural & urban setting.
- Strengthen priority over health.
- Invest in primary health care to control NCDs.
- Implement proper primary health care.

"I hope that the Head of State should focus on the health of Filipino people not "lip service" only. ACTION is important. Assess the real health need of the entire country. Put in place people who have a "heart" is providing services to "ALL" : rich or poor, educated or not. Provide adequate compensation to those who are

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giving services. LISTEN to the needs of everyone. Be compassionate to the needy. Provide better services."

- “I am a kidney transplantee. Our wish is for the government to give priority for our medicines and organ donation in order to lengthen lives and provide better quality of life for fellow patients.”
- Provide better funding for health since the barangay budget is limited. Include livelihood to allow families to be provided with better nutrition.
- Use the ‘build build build’ program to provide farm-to-market roads, bridges to aid in the people’s livelihood.
- Improve facilities within the health center.
- Opportunity equality in terms of health. Regular employment and more benefits for health workers.
- Supplementation and implementation.
- Scholars of the IPs to become doctors, nurses and midwives.
- Form health response teams in each barangay. For example, provide at least one each of doctors, nurses, midwives, BHWs, MedTech and rescue teams.
- Also provide ambulances and telephones for easy access and referral to hospitals.
- Continue programs started by the outgoing president.
- Gov’t should fund all hospitals in order to help those that cannot afford to pay their bills.
- An improved health care service by having additional budget and professional proficiency of health workers.
- More Doctors to the Barrios (DTTB).
- Real, felt, adequate, and fully funded implementation of Universal Health Care
- Improve health services to modern technology and promote health prevention over curative services.
- Prioritize health!
- Include vulnerable groups in every aspect and have vulnerable groups driven programs with strong mechanisms for check and balance ● Make health your priority.
- Fast track UHC implementation.
- Ensure the law is properly funded. Make primary care the goal of all implementers and provide evaluation mechanisms with people’s participation
- We need to fully invest in health promotion and ensure that all agencies of government will help create a healthy society.

The State of Philippine Health System is Sick!

- Mabigyan kami ng sapat na pondo para makapagtayo ng isang malaking quarantine facility at multipurpose building at pondo para makabili ng lupa." - GIDA Barangay, CM Recto, Ferrol, Romblon *Translation: Give our barangay adequate funds so that we can build a quarantine facility that can also serve as a multipurpose building, and funds to be able to buy land for communityuse.*
- "Sana 'yung PhilHealth magagamit sa private o kaya sa public para hindi mambroblema ang mga pasyente kung saan kukuha ng pera." - GIDA Barangay, CM Recto, Ferrol, Romblon *Translation: We hope that PhilHealth (social health insurance) benefits can both be used in private and public facilities so that the patients will not problematize where to get money from to pay for the hospital bills.*
- "Taasan ang sweldo ng healthcare providers para hindi sila aalis ng bansa!" - GIDA Barangay, CM Recto, Ferrol, Romblon *Translation: Increase the compensation of healthcare providers so that they don't need to work overseas.*
- "Gawing priority ang pagbibigay ng regular na trabaho ang mga healthcare workers, hindi aalis ng bayan o bansa." - GIDA Barangay, CM Recto, Ferrol, Romblon *Translation: Make it a priority to give regular jobs to healthcare workers so that they do not need to work overseas.*
- "Sana pag-ukulan ng pansin 'yung kalusugan ng mga taga-Recto na kulang sa gamot, equipment, sa vehicles, at sana kung pwede mabigyan ng regular na doktor. Sapat na pondo para sa nutrisyon ang mga mamamayan ng Recto para mapanatili ang mas maayos na kalusugan. Equipment na pang-agrikultura para masuportahan ang aming barangay at karatig barangay." - GIDA Barangay, CM Recto, Ferrol, Romblon *Translation: We hope that the health needs of the people of CM Recto, specifically medicines, equipment, medical vehicles, and a permanent doctor can be addressed. We need funds for nutrition, so that the people of CM Recto will remain healthy. We also need agricultural support and equipment so that we can support the food and nutrition needs of our barangay, as well as other neighboring communities.*
- "Sa estadong pangkalusugan ng aming barangay, mahirap kapag nagkakasakit, sasabihin ko sa kanya, kapag may nagkakasakit, sana hindi kami mahirapang pumunta ng ospital. Sana asikasuhin kaagad at huwag pabayaan sa labas. Kapag humingi ng tulong, may malalapitan kaagad lalo na sa emergency cases. Hindi kami mahirapan sa facilities, nandoon na lahat ng kailangan." - GIDA Barangay, CM Recto, Ferrol, Romblon

"Due to the fact that our community is a geographically isolated and disadvantaged area, being sick or having a sick family member is a burden. We hope that we will not experience hardships in reaching hospitals anymore, and that we can access the facilities and be given medical attention with ease and everything we need is there. We hope that we can approach public services when we need help, especially during emergency situations."

- "Magkaroon ng budget para sa Municipal Health Officer, kasi every 3 years nagpapalit ng doctor dahil sa DTTB, binibigyan lang ng allowance ng LGU. Pag nagkaroon ng permanenteng doctor na, dalawa na ang doctor, mas mabuti po sa kanila 'yun!" - GIDA Barangay, CM Recto, Ferrol, Romblon

Translation: Currently, the national program of deploying Doctor-to-the Barrios only spans for three years. It will be for the good of the people to have a permanent municipal health officer and physician who can look after their health needs.

Q: What is one message you would share with world leaders at the United Nations if you were the Head of State presenting the state of health care in your country?

- Be well informed and take action in providing adequate health services to ALL. Remember a Healthy People is a Healthy Nation.
- There is no Universal Health Care if there is no personnel to care for the health of the nation.
- Better emphasize and implement the idea of “No one is left behind.”
- We are starting on a journey for health for all. We need your expertise. Help us realize this dream. No one must be left behind.
- Respect our way of providing & planning for a responsive health system that is culturally applicable but still using the principle of "no one should be left behind " & "do no harm"
- We want to fully implement UHC and we need your technical and financial assistance.
- Help us build quality hospitals in rural areas to allow easier access for all citizens of the country.
- Will bring all supporting documents to emphasize the needs of the barangay and the country -- total population, how many are in need, what services are needed, etc.
- Quality health service program through more budgeting. ● More global health assistance for third world countries ● Health for all in 2024, make it happen!
- Equity and inclusion for global health services.
- UN must give significant technical assistance for health care reform in the Philippines to make services accessible, affordable, and high quality
- Our health system is fragmented: access, quality, and cost. There is a need to address governance issues, have adequate health workers with good working conditions, and accountability. We need to put health in the hands of the people with information, education, and participation. Make health and wellness at the center of all policies and programs.
- Do not commercialize health!
- Dream of stronger/people driven health care
- A lot of things still need to be done. We need your help. Make us accountable

“We have very good laws but implementation is another story. Access to healthcare is still unequal and inequitable. We need to be on the same page with regard to our understanding of UHC and primary care and adopt a health lens/framework in all dealings and policies.”

- Prioritize investments in the prevention and control of NCDs.
- "Hanapin ang 6th class municipality – dapat sila ang unang bigyang pansin sa pangkalusugan. Ang 6th class nananatiling 6th class municipality." - GIDA Barangay, CM Recto, Ferrol, Romblon

"I would tell world leaders to look into the situation of the poor, sixth class municipality in the Philippines. The attention and support should be given to them. Our municipality has remained a sixth class municipality." – GIDA Barangay, CM Recto, Ferrol, Romblon

- "Hihingi po ako ng resolusyon na pwedeng magagawa sa lokal." - GIDA Barangay, CM Recto, Ferrol, Romblon *Translation: I'd ask for a resolution that can be used in our own community.*
- "Kahit nagka-COVID na, hindi pa rin naging priority ang healthcare at mga healthcare workers!" - GIDA Barangay, CM Recto, Ferrol, Romblon *Translation: We already have experienced the COVID-19 pandemic and yet healthcare and healthcare workers never became a priority.*

Q: For you, what is the best way to communicate the benefits of UHC to people? How often should they be communicated?

- In every opportunity possible, communicate UHC, to change the health seeking behavior of Filipinos.
- Involve the organizations the poor.
- Go to grassroots, educate the people. Train people who will provide adequate knowledge. Look what is best in each locality.
- Social media and bite-size info everyday.
- Thru social media and tri-media at least twice a week.
- Continuous seminars regarding the UHC.
- Each NGO with their covered communities (LGU to the Brgy) must also do the advocacy re: it's benefit and how it will impact our lives holistically. ABI health must continue to train the US in this aspect of strategizing for the implementation of UHC, even other NGOs who are not in Health are not aware of its "NON-Health" impact to the people.
- As NGOs we must conduct FORA in the community where we are engaged with, as often as possible so that people will be updated at all times, let the people feel that THEY are part of the success of its simple. not just the GOVT.
- Well-documented IECs through BHW and BHERTs in order to be transparent with the benefits and programs of the UHC.

- Utilize the barangay assemblies in order to share the status of UHC, funding of BLGU, etc.
- Conduct REKORIDA together with barangay council for information dissemination. Health workers themselves go to households to share information.
- Utilize social media to better reach people. Most purok have access to the internet due to the shift to online classes (Pisonet).
- Tap all LGUs, barangay and purok leaders to help convince people to participate in orientations.
- House-to-house campaigns. Transportation and food of health workers should be free to allow them to do more in engaging their communities.
- Raise salaries/honorarium of BHW since they are also the ones moving for data gathering. They are also important since they are most familiar with the grassroots.

END OF NARRATIVE COLLATED REPORT

ANNEXES

Annex 1: Questionnaire – English and Filipino

English Questions	**Filipino Questions**
Preliminary	
What would you like to know more about the UHC?	
What were your immediate expectations when the UHC was passed and now that it is being implemented?	Ano-ano ang iyong mga inasahan noong naisabatas ang Universal Health Care? Ano-ano naman ang iyong mga inaasahan ngayong ipinatutupad na ito?
Category 1: Ensure Political Leadership Beyond Health	
Given your organization's involvement in health advocacy, would you be able to tell and describe to us how well the current mechanisms of the government engage across sectors for the specific purpose of improving health or advancing UHC? If so, how well is this mechanism or department functioning? Are the roles and accountabilities of agencies clear?	Maaari mo bang mailarawan kung paano nag-uugnay ang iba't ibang mekanismo ng gobyerno upang mapainam ang kalusugan ng mga mamamayan o upang isulong ang UHC? Gaano kahusay ang mga ahensya o mekanismong ito? Malinaw ba ang mga gampanin ng mga ahesyang ito?
Given your organization's health advocacy efforts, can you share with us your experiences in engaging with other government ministries or departments beyond health, if there are, good or bad? If possible, please share with us what agencies are these. [For example: briefings with Ministers of Finance, Welfare, Labor, Water and Education Agriculture, etc.]	Maaari mo bang maibahagi ang iyong mga karanasan sa pakikipag-ugnayan sa ibang ahensya ng gobyerno bukod sa Department of Health, kung mayroon man? Naging mabuti ba ang karanasan mo? Bakit o bakit hindi? (kung maaari pakibahagi ang pangalan ng mga ahensyang ito hal. Department of Finance, DSWD, DepEd, atbp.)

Using the Likert Scale, provide a rating for the government, whether it was able	Gamit ang likert scale sa ibaba, bigyan ng rating ang iyong pag-sang-ayon kung nararapat bang bigyan ng mataas na

to give UHC a high priority during this COVID-19 pandemic? 1 - Strongly Agree 5 - Strongly Disagree Please explain your answer with your examples/experiences.	prayoridad ang pagsasapatupad ng UHC sa gitna ng COVID-19 pandemic. Ipaliwanag ang iyong sagot sa pamamagitan ng pagbabahagi ng iyong mga karanasan.
How have new health policies and programmes during the pandemic changed the path towards UHC? You may see a list of laws and policies above [Category 1] or you may have a policy/program passed/implemented during the pandemic that you think may have changed the path towards UHC.	Ano-ano ang naging epekto ng mga bagong polisiya at programang pangkalusugan sa pagpapatupad ng UHC? Maaaring sumangguni sa listahan ng mga batas at polisiya sa itaas (category 1) o maaari ring may naipasa at naipatupad na bagong batas pangkalusugan sa kalagitnaan ng COVID-19 pandemic na sa iyong tingin ay nagkaroon ng epekto sa daan patungo sa UHC.
Category 2: Leave No One Behind	
Which groups of people in your country struggle to gain access to health services? What are the main barriers for them to access health services? [Barriers to care can include: affordability; social, political and cultural determinants of health care access.]	Aling mga grupo ng mga mamamayan sa iyong bansa ang nahihirapang magkaroon ng akses sa mga serbisyong pangkalusugan? Ano ang mga pangunahing hadlang para ma-akses nila ang mga serbisyong pangkalusugan? [Maaaring kabilang sa mga hadlang sa pangangalaga ang: pagiging abot-kaya (affordability) panlipunan, pampulitika at kultural na mga determinants o nakakaimpluwensya sa pag-akses sa pangangalagang pangkalusugan (healthcare).

Considering the needs of the groups identified above, what are the specific health services that are underprioritized? [Groups of people could include:	Isinasaalang-alang ang mga pangangailangan ng mga grupong natukoy sa itaas, ano-ano ang mga partikular na serbisyong pangkalusugan na hindi nabibigyan ng priyoridad?

vulnerable populations like children and caregivers, persons with disabilities, people living with NCDs, people with mental health conditions, etc.]	(Maaaring kabilang sa mga grupo ng mga mamamayan ang: mga may mga bulnerabilidad tulad ng mga bata at kanilang mga tagapag-alaga, mga may kapansanan, mga nabubuhay na may mga non-communicable diseases, mga may kondisyon sa pag-iisip, atbp.)
Are there laws and frameworks in place in support of vulnerable groups accessing essential health services they need? How well do they work in practice? [For example, these are mostly Magna Carta laws; laws for persons with disabilities; human rights to health, etc. that it is illegal to discriminate on the basis of "race, color, national origin, sex, age or disability in certain health programs"]	Mayroon bang mga batas at sistemang sumusuporta sa mga bulnerableng grupo na nag-a-akses ng mahahalagang serbisyong pangkalusugan na kailangan? Gaano sila kahusay sa pagsasanay? (Halimbawa, ito ay karamihan sa mga batas ng Magna Carta; mga batas para sa mga taong may kapansanan; karapatang pantao sa kalusugan, atbp. na labag sa batas ang diskriminasyon batay sa "lahi, kulay, bansang pinagmulan, kasarian, edad o kapansanan sa ilang partikular na programang pangkalusugan")

Cite clear-cut examples or experiences of how certain policies or programs reduced or eliminated patient fees (outof-pocket spending on health)? Are these reductions enough for the needs of the patients and those accessing the services? Are there invisible/indirect costs related that are not covered by these policies/programs? [Examples include: public insurance schemes, free health care policy; It is highly encouraged that each patient group answers this question]	Magbanggit ng mga malinaw na halimbawa o karanasan kung paano binabawasan o inaalis ng ilang mga polisiya o programa ang mga bayarin sa pasyente (mula-sa-bulsang paggasta para sa kalusugan o out-of-pocket spending on health)? Sapat ba ang mga nababawas na gastusing ito para sa mga pangangailangan ng mga uma-akses sa mga serbisyo? Mayroon bang mga hindi nakikita o hindi direktang mga gasto na hindi saklaw ng mga polisiya/programa na ito? (Kabilang sa mga halimbawa ang: public insurance schemes, patakaran sa libreng pangangalagang pangkalusugan) *Lubos na hinihikayat na sagutin ng

	bawat pangkat ng pasyente ang tanong na ito*
Who is most impacted or what health services are most negatively impacted by out-of-pocket payments?	Sino ang pinakanaaapektuhan o anong mga serbisyong pangkalusugan ang pinaka-negatibong naaapektuhan ng mga pagbabayad namula-sa-bulsang paggasta para sa kalusugan ng mga mamamayan?
Category 3: Regulate and Legislate	
Do you feel that UHC laws/policies/strategies that exist in your country are being adequately implemented?	Nararamdaman mo ba na ang mga batas/polisiya/stratehiya ng UHC na umiiral sa iyong bansa ay ipinatutupad ng mabuti?

Do you know of any government-set accountability or monitoring mechanisms for UHC in your country? If yes, please explain your answer.	May alam ka bang mga accountability o monitoring mechanisms para sa UHC na itinakda ng pamahalaan sa iyong bansa? Kung oo, pakipaliwanag ang iyong sagot.
Are there laws and policies in place to ensure that people can engage in planning, budgeting and monitoring of health plans and budgets?	Mayroon bang mga batas at polisiya na nakalatag upang matiyak na ang mga tao ay maaaring makilahok sa pagpaplano, pagbabadyet at pagsubaybay sa mga plano at badyet para sa kalusugan?
Category 4: Uphold Quality of Care	
As citizens/patients, where do you primarily access your health services - public [BHS/RHU/district], private [tertiary hospital], or others [what are they]?	Bilang mga mamamayan/pasyente, saan mo pangunahing naa-akses ang mga serbisyong pangkalusugan? Pakitsek ang lahat ng naaangkop.
Are the health services you receive in your facility of choice of good quality? Can you elaborate and give examples? [Components of quality could include cleanliness of facilities, adequate time spent with provider, provider knowledge	Maganda ba ang kalidad ng mga serbisyong pangkalusugan na natatanggap mo sa iyong piniling pasilidad? Maaari mo bang idetalye ang karanasan mo at magbigay ng mga halimbawa?

and responsiveness to questions/concerns, adequate drugs/supplies/equipment, short wait times, etc.]	(Maaaring kabilang sa mga bahagi ng kalidad ang mga sumusunod: kalinisan ng mga pasilidad, sapat na oras na ginugol ng doktor at iba pang health provider, kaalaman ng health provider sa pagtugon sa mga tanong, sapat na gamot, supply, kagamitan, maikling oras ng paghihintay, atbp.)

Does your country have adequate health workers, especially at the primary health care level? Are community health workers part of the health staff roster and are they paid adequately?	May sapat bang mga manggagawang pangkalusugan sa iyong bansa, lalo na sa primary health care level? Ang mga community health workers ba ay bahagi ng listahan o roster ng mga opisyal na kawaning pangkalusugan sa inyong lugar, at sila ba ay nababayaran ng tama?
Category 5: Invest More, Invest Better	
Where do you think your government should be spending more in terms of achieving UHC? [Examples might include: primary health care, health worker training, increasing the number of hospitals, health promotion & prevention]	Sa iyong palagay, dapat bang maglaan ng mas malaking pondo ang iyong pamahalaan para sa pagkamit ng UHC? (Maaaring kabilang sa mga halimbawa ang: primary health care, training ng mga health workers, pagdadagdag ng bilang ng mga ospital, health promotion & prevention)
Is the government spending enough on health services and is this increasing? ["It is recommended that governments spend at least 5% of its GDP or at least 15% of its annual budget on health"]	Sapat ba ang pondong inilalaan ng gobyerno para sa mga serbisyong pangkalusugan? Nadaragdagan ba ito? (Inirerekomenda na ang mga pamahalaan ay dapat maglaan ng hindi bababa sa 5% ng GDP o hindi bababa sa 15% ng taunang badyet nito para sa kalusugan)
Since the start of 2014 when the Sin Tax was passed, the DOH budget steadily increased because of the tax revenues. However, it was reported several times that the department had low absorptive capacity [low utilization of the budget].	Simula noong maipasa ang Sin Tax Law noong 2014, unti-unting tumaas ang badyet ng DOH dahil sa mga kita mula sa buwis na ito. Gayunpaman, ilang beses nang iniulat na ang DOH ay may mababang kapasidad sa pag-absorb

With this, what do you think are the hindering factors why the department is having a hard time utilizing its additional budget from the Sin Tax?	(mababa ang "absorptive capacity" o hindi nagagamit ng buo ang badyet). Ano-ano sa palagay mo ang mga nagiging balakid at nahihirapan ang DOH na gamitin ang karagdagang pondo mula sa Sin Tax?
Category 6: Move Together	
At the national level: are there opportunities for people, civil society organizations, and the private sector in your country to be engaged in planning, budgeting, monitoring and evaluating the health sector? How about in the actual delivery of health services? [Examples of different groups of people engaged are adolescents and youth, children and caregivers, persons with lived experience, vulnerable and marginalized groups. Some examples of opportunities are open consultations with different groups of people/populations/ communities before developing major policies (ie. National Health Plan). Encourage discussion of how well they work in practice.]	Sa pambansang antas: may mga oportunidad ba para sa mga mamamayan, mga civil society organizations, at pribadong sektor sa iyong bansa na makilahok sa pagpaplano, pagbabadyet, monitoring and evaluation (pagsubaybay at pagsusuri) sa sektor ng kalusugan? May mga oportunidad din ba para sa pakikilahok sa aktwal na implementasyon o paghahatid ng mga serbisyong pangkalusugan? (Ang mga halimbawa ng iba't ibang indibidwal at grupong nakikilahok ay ang mga bata, kabataan at kanilang mga tagapag-alaga, mga taong may karanasan sa buhay, mga bulnerableng grupo gaya ng mga nakatatanda. Ang ilang mga halimbawa ng mga oportunidad ay mga konsultasyon sa iba't ibang indibidwal o grupo bago bumuo ng mga polisiya gaya ng National Health Plan at taunang badyet.)

If so, what are those opportunities, and are they effective and efficient for the engagement of civil society, in particular, of the most vulnerable and marginalized populations and communities? Are they being listened to and their proposals being integrated and carried?	Kung gayon, ano ang mga oportunidad na iyon? Epektibo at episyente ba ang mga iyon para sa pakikipag-ugnayan sa CSOs, partikular na ang mga pinakabulnerableng grupo at komunidad? Pinakikinggan ba sila at ikinokonsidera at ipinatutupad ba ang kanilang mga panukala?

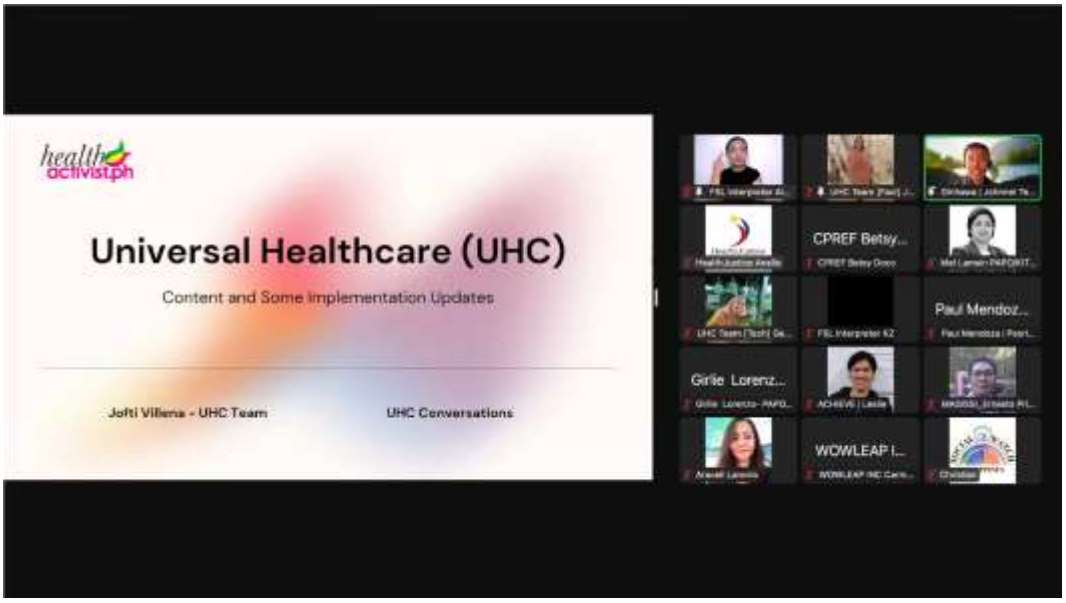
At the community level: Are communities engaged in local level health planning, budgeting and accountability processes? If so, how are they engaged? [Communities would mean real members/residents of target communities, people's groups, basic sectors, civil society, and members of the vulnerable populations [person with disability, patients living with NCDs/HIV, etc.].	Sa antas ng komunidad: Ang mga komunidad ba ay nakikilahok sa lokal na pagpaplanong pangkalusugan, pagbabadyet, at mga prosesong nagsisiguro ng accountability/pananagutan? Kung oo, paano sila nakikilahok? (Ang komunidad ay maaaring mga miyembro/residente ng isang tukoy na komunidad, people's groups, basic sector, civil society at mga miyembro ng bulnerableng populasyon gaya ng mga may kapansanan, mga pasyenteng nabubuhay na may mga NCD/HIV, atbp).
At the community level: Are there civil society forums or constituencies in your country to engage with decision-makers on health-related issues? If so, how well does the existing civil society coordination function and what can be improved? [Examples: country coordinating mechanisms (i.e. for Global Fund), civil society alliances to influence national health budgets]	Sa antas ng komunidad: Mayroon bang mga pagtitipon ng mga mamamayan o CSOs sa iyong bansa upang makipagugnayan sa gobyerno tungkol sa mga isyu na may kaugnayan sa kalusugan? Kung gayon, gaano kahusay ang mga ito at paano ito maaaring mapag-buti? [Mga halimbawa: country coordinating mechanisms (i.e. para sa Global Fund), mga alyansa ng CSOs upang maimpluwensyahan ang mga pambansang badyet para sa kalusugan]
Category 7: Gender Equality	

Can you identify some of the major challenges for women and girls [including adolescents] in their access to health services?	Matutukoy mo ba ang ilan sa mga pangunahing hamon para sa mga kababaihan at mga batang babae (kabilang ang mga kabataan) sa kanilang pag-akses sa mga serbisyong pangkalusugan?
What kinds of health services are most challenging for women and girls [including adolescents] to access?	Ano-anong mga uri ng serbisyong pangkalusugan ang pinakamahirap para sa mga kababaihan at mga batang babae (kabilang ang mga kabataan) na ma-akses?

What are the primary challenges to access health care services for individuals who are non-binary [e.g. LGBTQIA]?	Ano ang mga pangunahing hamon sa pag-akses sa mga serbisyong pangkalusugan para sa mga indibidwal na non-binary (hal. lesbian, gay, bisexual, transgender, queer, intersex, asexual)?
Category 8: Emergency Preparedness	
How has the primary health care system been affected by the ongoing COVID-19 pandemic?	Paano naapektuhan ang Primary Health Care System ng COVID-19 Pandemic?
How do you think that PHC can be improved/evolved to be better prepared for future pandemic and other health emergencies?	Paano sa palagay mo maaari pang pagbutihin/paunlarin ang Primary Health Care upang maging mas handa para sa hinaharap na pandemya at iba pang mga hindi inaasahang mga krisis pangkalusugan?
Category 9: Looking to 2023	

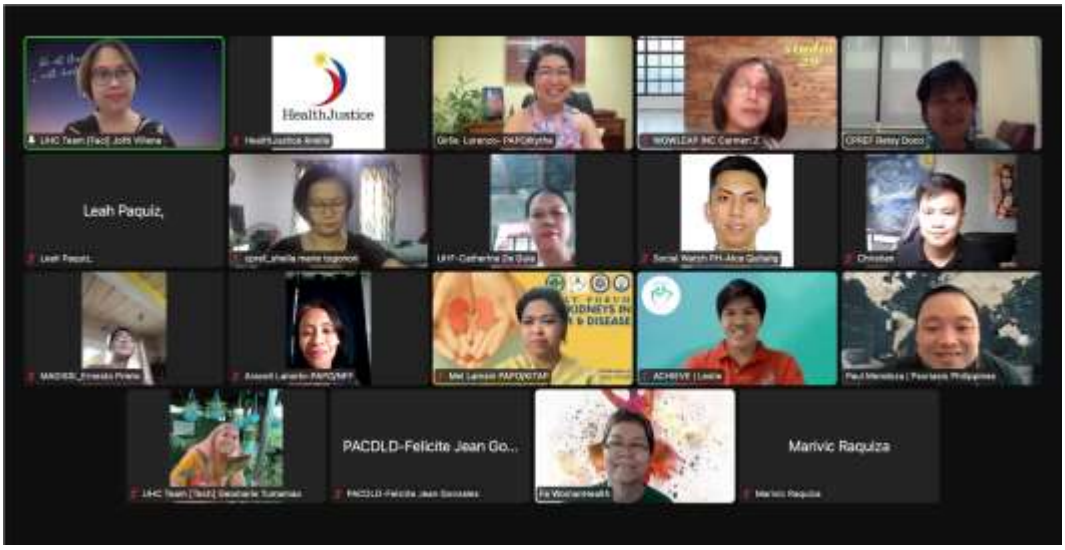
Is there another element of UHC and the distribution of health services in your country that was not covered in the discussion today? [This may include: human rights; shrinking civic space; humanitarian settings; disability and inclusion; youth and adolescent engagement; the concept of gatekeeping & electronic health records; private sector & hospital involvement-their business ethics; the communities in the GIDA areas (indigenous communities, island barangays/municipalities). Encourage discussion of specific examples of challenges and/or recommendations.]	Mayroon bang iba pang elemento ng UHC at distribusyon ng mga serbisyong pangkalusugan sa iyong bansa na hindi nasaklaw sa talakayan ngayon? [Maaaring kabilang dito ang: karapatang pantao; lumiliit na civic space; humanitarian setting; disability and inclusion; pakikilahok ng mga bata at kabataann; ang konsepto ng gatekeeping at elektronikong mga rekord ng kalusugan; pribadong sektor at kanilang business ethics; ang mga komunidad sa lugar ng GIDA (mga katutubo at komunidad sa mga islang barangay/munisipyo). Talakayin ang partikular na mga halimbawa ng mga hamon at/o iyong mga rekomendasyon.]
What is the main request you have for your Head of State about the state of health care (access, quality, and cost) in your country?	Ano ang kahilingan mo sa iyong Pangulo/Pinuno ng Estado para sa kalagayan ng pangangalagang pangkalusugan sa iyong bansa (akses,
Use the 1-minute elevator pitch exercise.	kalidad, at gastos)? Gumamit ng 1-minute elevator pitch.
What is one message you would share with world leaders at the United Nations if you were the Head of State presenting the state of health care in your country?	Ano ang isang mensahe na nais mong ibahagi sa mga pinuno mula sa iba't ibang bansa sa United Nations kung ikaw ay isang Pangulo/Pinuno ng Estado na nagpapaliwanag ng kalagayan ng pangangalagang pangkalusugan sa iyong bansa?
For you, what is the best way to communicate the benefits of UHC to people? How often should they be communicated?	Para sa iyo, ano ang pinakamahusay na paraan upang maipaalam ang mga benepisyo ng UHC sa mga mamamayan? Gaano kadalas dapat itong dapat gawin?

Annex 2: Photo Documentation



Starting off the online (Zoom) session with a wellness activity % GINHAWA (June 24, 2022)

Discussing the UHC Act and updates on its implementation (June 24, 2022)



Participants of the online FGD session held on June 24, 2022

Participants of the online FGD session with the T'boli group from Barangay Kematu, T'boli, South Cotabato (July 1, 2022)

Participants of the online FGD session with the Blaan group from Polomolok, South Cotabato (July 4, 2022)

KII with Romblon Former Doctor to the Barrio and Municipal Health Officer, Jebbick de Guzman (July 5, 2022)

Balai Diwata - venue for the face-to-face session of the FGDs

FGD participants in front of Balai Diwata's rooftop mural (July 6, 2022)

Settling in for the face-to-face FGD session (July 6, 2022)

GINHAWA heads the wellness activity to start off the program (July 6, 2022)

Participants sharing things they are grateful for (July 6, 2022)

Torch surrounded by individual blessings from participants (July 6, 2022)

Movements facing North (July 6, 2022)

Stepping movements towards the East (July 6, 2022)

Breathing exercises facing South (July 6, 2022)

Stretching towards the west (July 6 , 2022)

Using elements of nature to exchange blessings with others (July 6, 2022)

Traditional Filipino instruments representing music for each of the four directions (July 6, 2022)

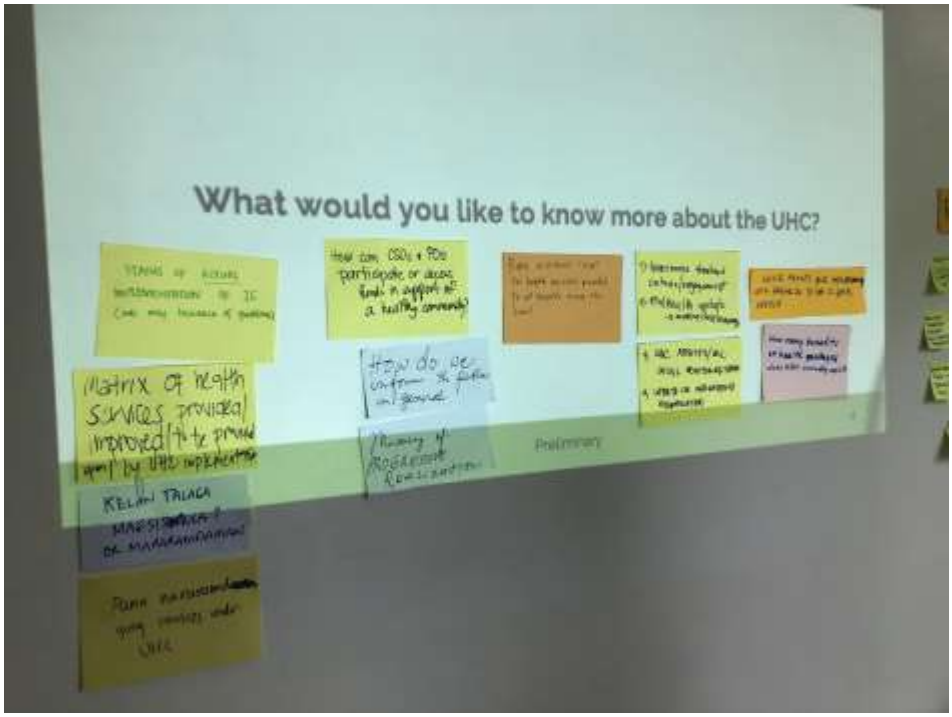
Using elements of nature to exchange blessings with others (July 6, 2022)

HealthJustice gives an introduction of the UHC Conversations to start off the program (July 6, 2022)

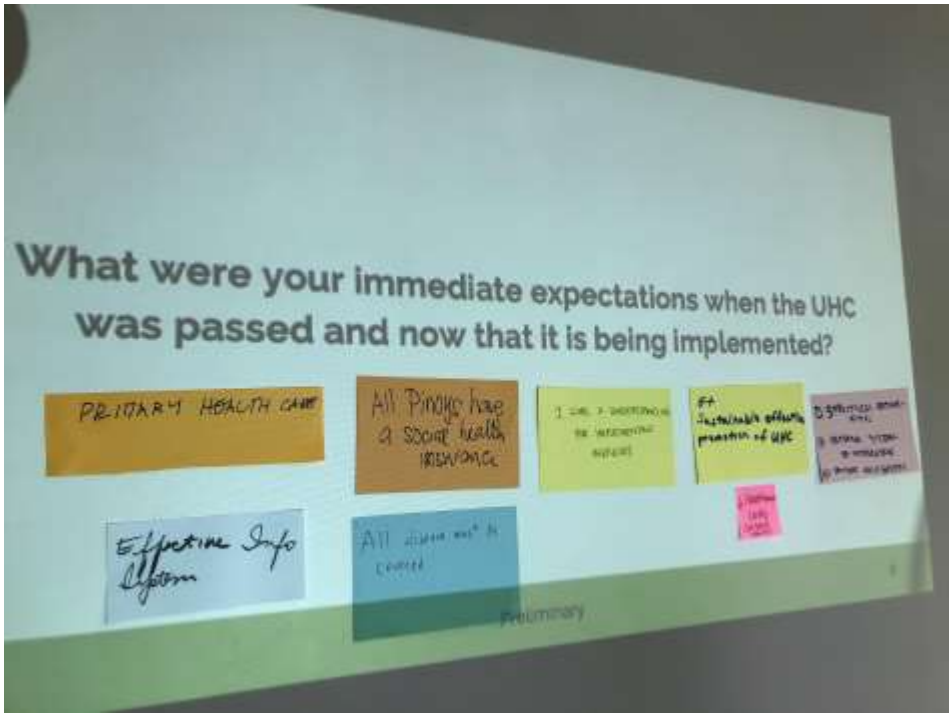
Participants listening to the updates on the UHC implementation (July 6, 2022)

Ms. Jofti Villena sharing updates on the UHC implementation (July 6, 2022)

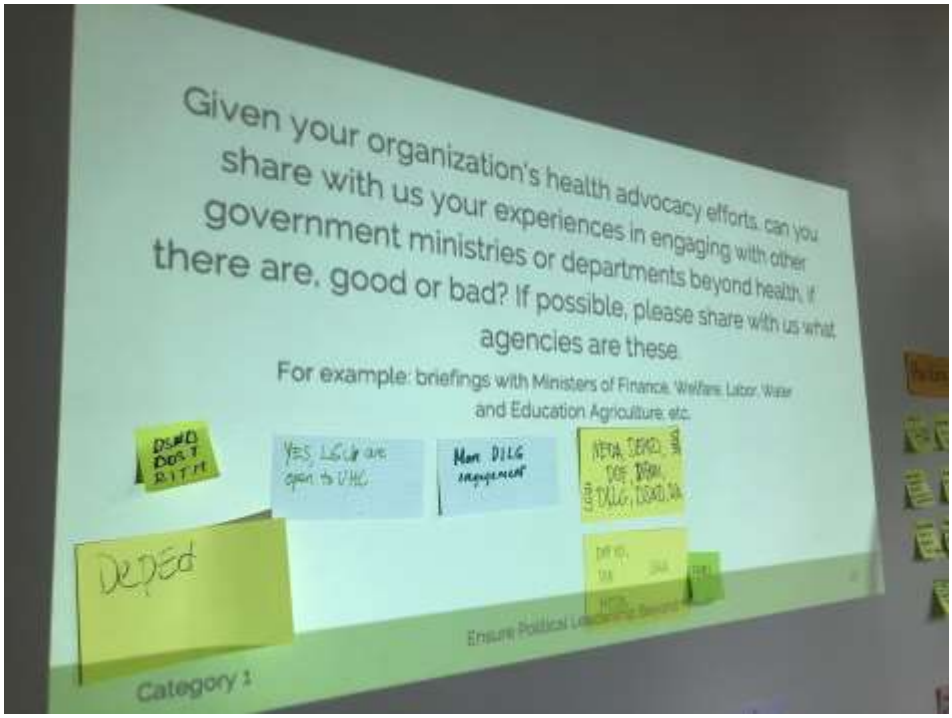
Inputs regarding the UHC updates (July 6, 2022)



Participants' questions regarding the UHC (July 6, 2022)



Immediate expectations regarding the UHC (July 6, 2022)

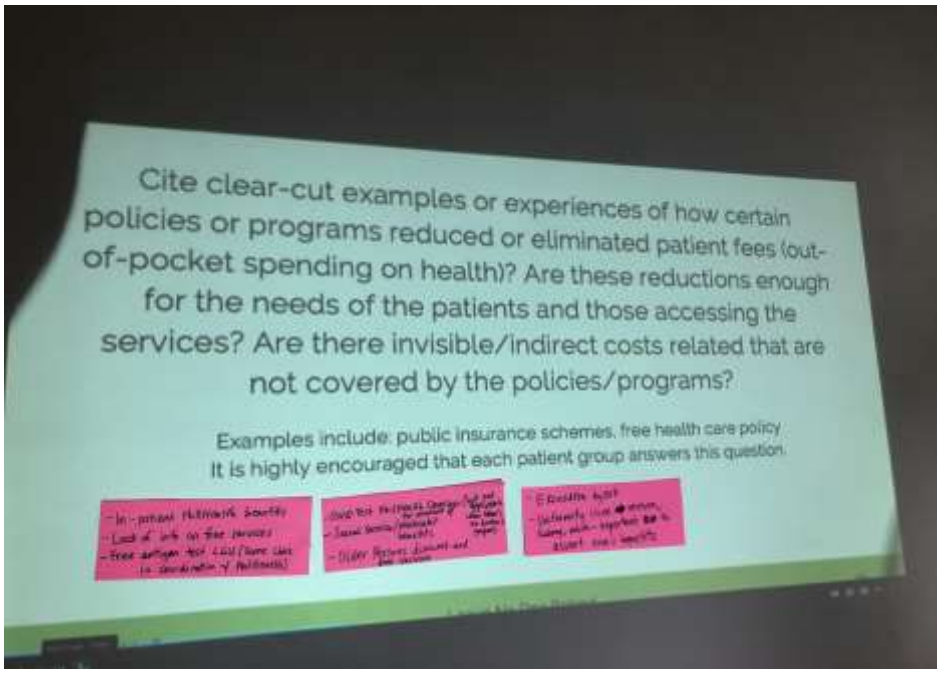


Experiences with government agencies (Ensure Political Leadership Beyond Health)

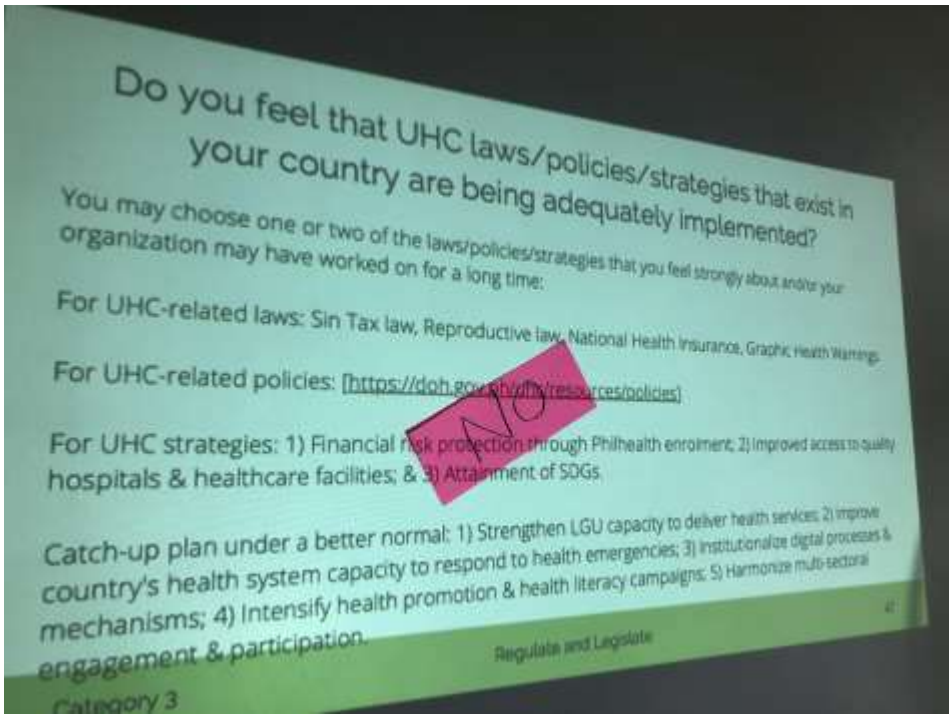
Strongly disagreeing that the government has made UHC a priority during the pandemic

Disagreeing that the government has made UHC a priority during the pandemic

Neither agreeing nor disagreeing that the government has made UHC a priority during the pandemic

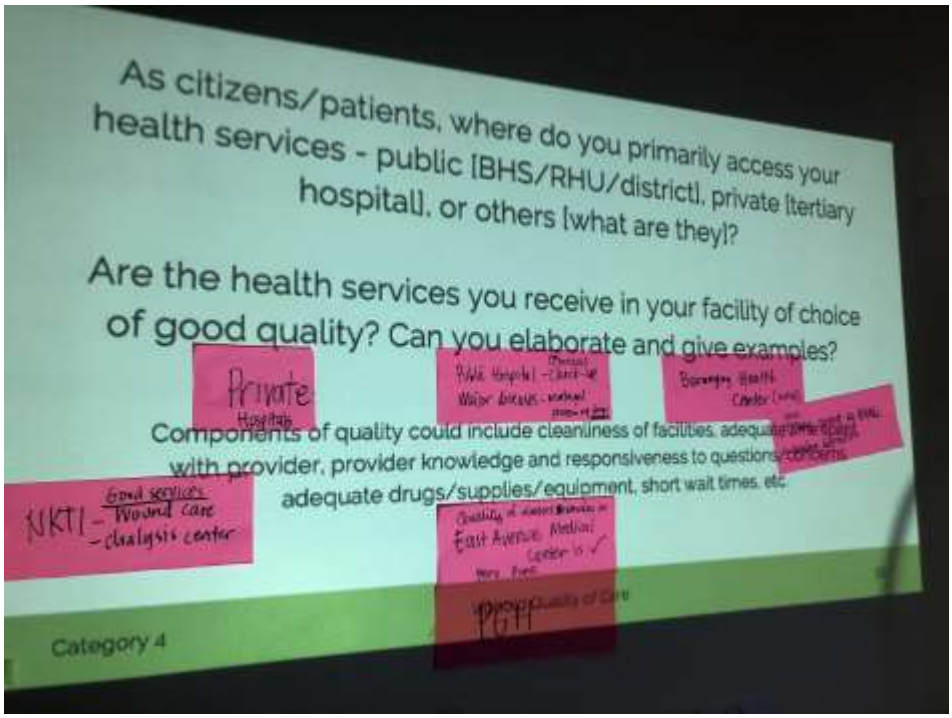


Examples of programs reducing out-of-pocket fees (Leave No One Behind)

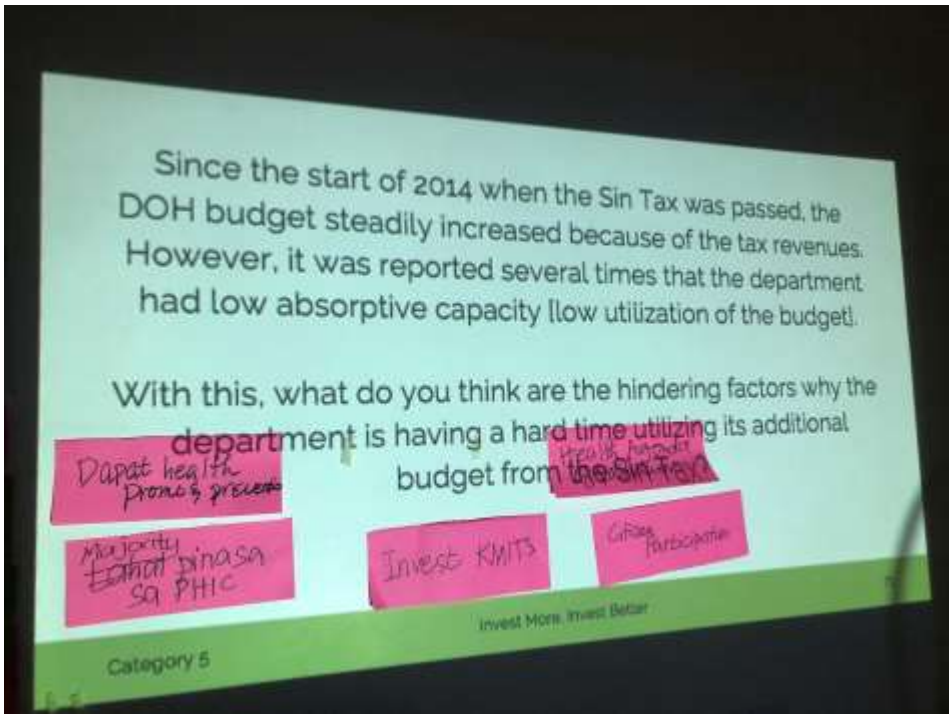


Participants answer with a resounding NO on whether or not they feel that the UHC is being adequately implemented (Regulate and Legislate)

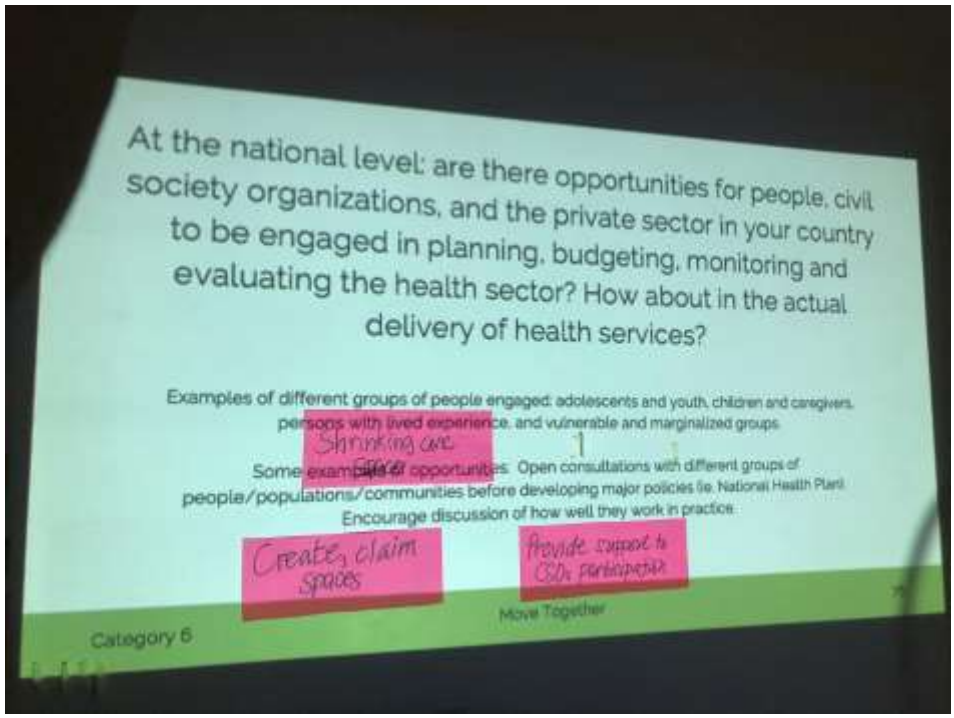
Face-to-face session of the UHC Conversations held at Balai Diwata (July 6, 2022)



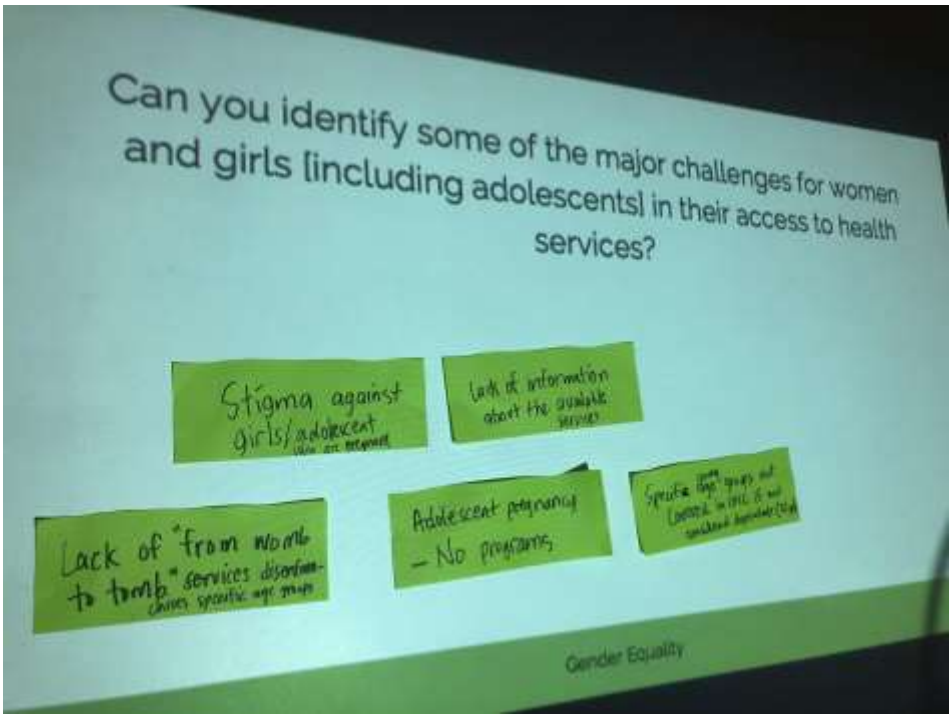
Where participants access their health services (Uphold Quality of Care)



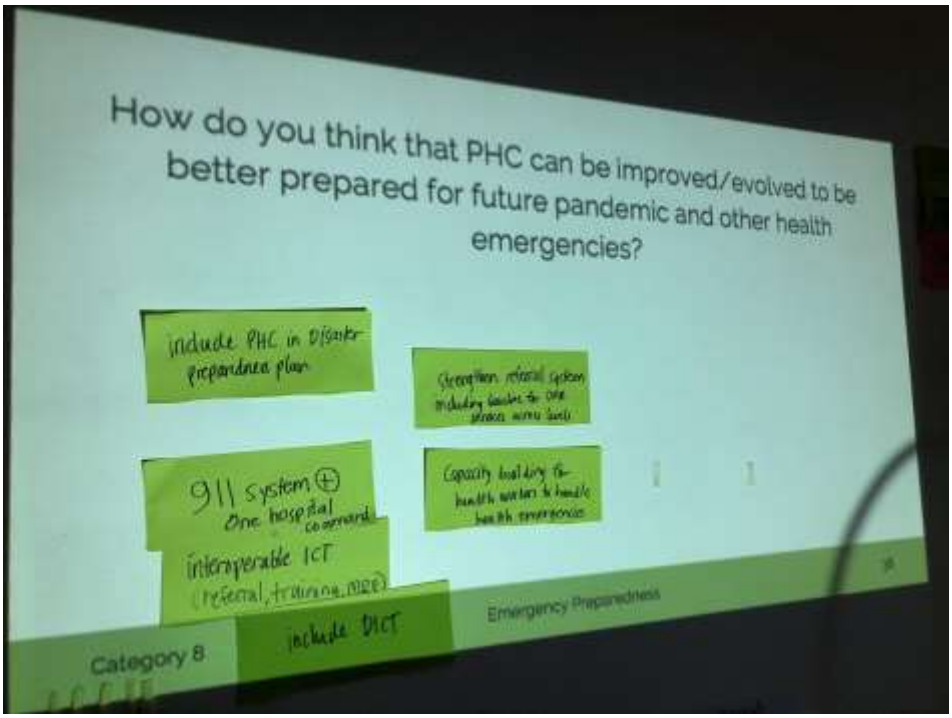
Participants weigh in on hindering factors and where the government should invest instead



Remarks on the shrinking civic space and the need to create and claim spaces



Challenges for women (and adolescents)

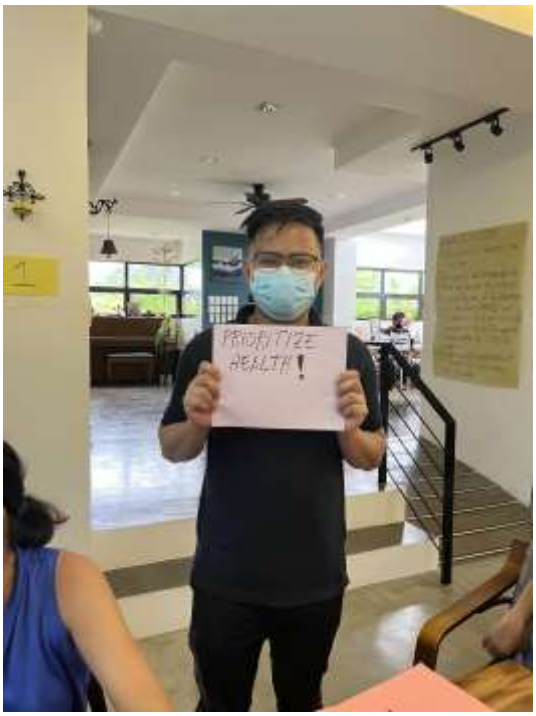


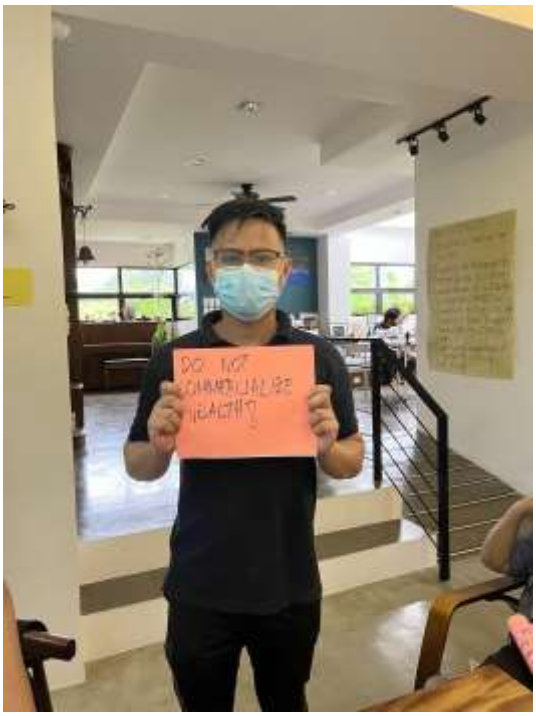
How they think primary health care can be improved for future emergencies

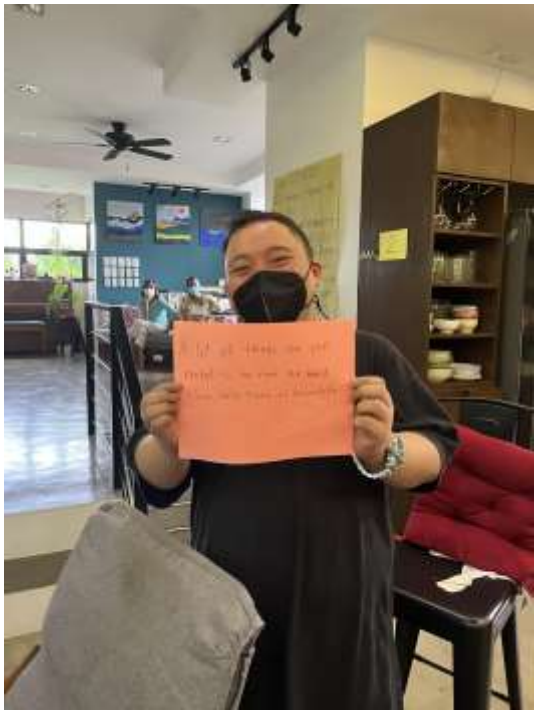
What the GINHAWA team would say to the head of state

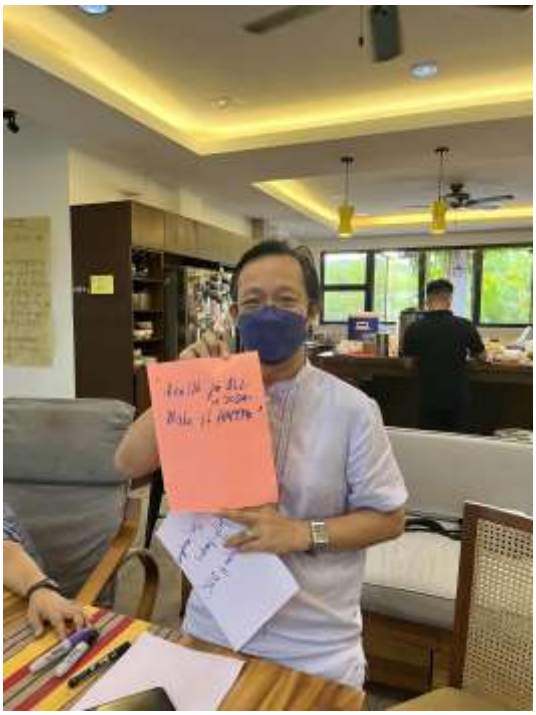
Messages to the head of state and the UN

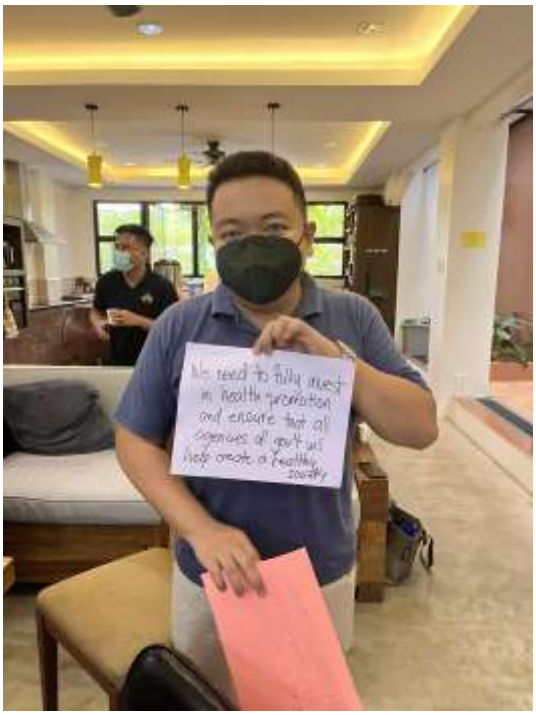

NO FEAR USA
Equity and inclusion for global health services


PRIORITIZE HEALTH!

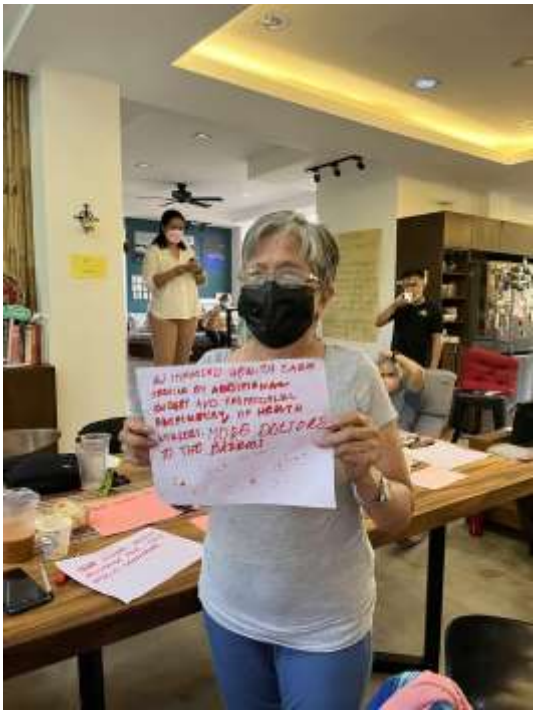

DO NOT

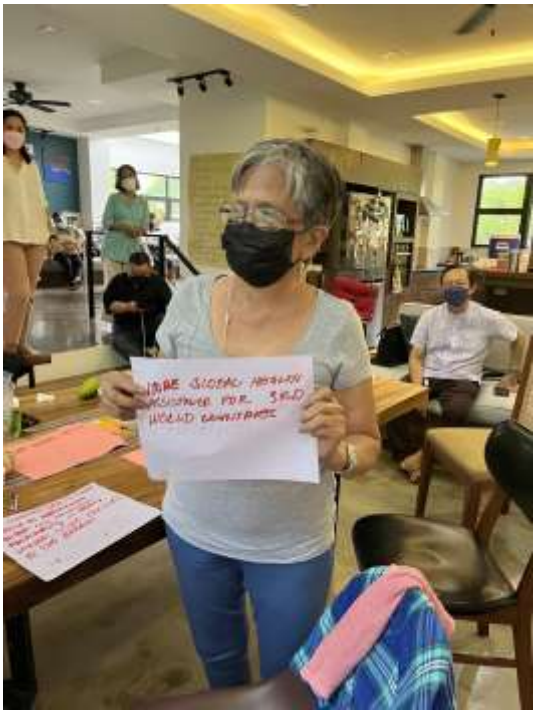





We need to fully invest in health promotion and ensure that all expenses of govt will help create a healthy society


Prioritize investments in the prevention & control of NCDs


MORE DOCTORS



Courtesy call at the Office of the Mayor, Christian Ll. Gervacio together with the current Ferrol Municipal Health Officer and Doctor-to-the-Barrio, Gerald Lyndon Felix

Rural Health Unit, Ferrol, Romblon

Community focus group discussion in GIDA Barangay, Claro M. Recto, Ferrol, Romblon

Community focus group discussion in GIDA Barangay, Claro M. Recto, Ferrol, Romblon

Group photo with FDG participants at the Barangay Hall of CM Recto

Annex 3: Bio of the UHC Team

Maria Fatima A. Villena [Jofti]: Team Leader

Jofti has been in the development field for more than 20 years and has been working in health advocacy for eight (8) years. She focuses on empowering people to take action over their health through budget and policy advocacy. She does this by doing collaborative work with other civil society organizations, paid or free.

Ms. Villena is a patient living with NCD (PLWNCD), a health activist and policy advocate. She also works as a freelance health writer and technical consultant for health for health-related CSOs/NGOs.

She is one of the board members of Center for Policy Studies and Advocacy on Sustainable Development [The Policy Center]. At the moment, she is finishing her graduate studies on Health Policy [Health Science track] at the College of Public Health, University of the Philippines Manila.

Rosheic Sims [Sheic]: Associate

Sheic has been doing advocacy work for 10 years now. For three years, she served as a program officer in a regional child rights coalition and focused on program implementation focused on child participation, children's right to health health, and communications. For seven years, Sheic worked on advocacy, campaigns, research, and coalition work on public health finance and policy, participatory governance, and children and adolescent health and development. She is a member of the Young Women Collective of WomanHealth Philippines and of the Health Cluster of the Alternative Budget Initiative-Social Watch Philippines.

Sheic holds a Bachelor's Degree in Development Studies from the University of the Philippines – Manila and is currently pursuing a Master's Degree in Public Administration at the University of the Philippines Diliman.

Geomarie [Geom] Tumamao: Staff Assist

Geom is an electronics engineering student from the University of the Philippines Diliman. She has been working with several organizations to learn more about how to use her studies to help the people, with environmental advocacy being her initial interest.

She previously worked as a Personal Research and Technical Assistant for Ms. Villena. During this, she was able to assist in the preparation and documentation of events for a number of NGOs.

The Ginhawa Team

GINHAWA, Inc. (or COMFORT in English) is an onsite and online space whose thrust is integrating creativity and spirituality at the service of wellbeing. Ms. Leah Tolentino is the founding director who has been facilitating and developing programs for wholistic renewal, healing and transformation for three decades. Ms. Mini Gavino, who is part of the team is the board member of GINHAWA, a senior GINHAWA facilitator, artist-teacher and sacred space artist.

Annex 4: Organizers with logos – HPA, SWP-ABI Health

Healthy Philippines Alliance (HPA)

The Healthy Philippines Alliance is a coalition of health and patient organizations that have come together to address health inequities in the prevention and control of noncommunicable diseases (NCDs)

Social Watch Philippines (SWP) - Alternative Budget Initiative Health Cluster (ABI Health)

The Alternative Budget Initiative Health Cluster – Social Watch Philippines (ABI Health-SWP) is a broad network of more than 70 civil society and peoples' organizations engaging itself in the formulation of the national health budget since 2006 and representing the basic sectors on children and youth, older persons, persons with disabilities, indigenous peoples, labor rights and groups working on health concerns such as health promotion and integrative health, reproductive health, social policy and access to medicines. Our

position paper on COVID-19, is the result of a series of consultations on the pandemic situation based on our long-standing advocacies.