Connecting gender and social networks to explore health service access and use in Negros Occidental, Philippines: A qualitative study

by

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AUTHOR'S DECLARATION

This thesis consists of material all of which I authored or co-authored: see Statement of Contributions included in the thesis. This is a true copy of the thesis, including any required final revisions, as accepted by my examiners.

I understand that my thesis may be made electronically available to the public.

STATEMENT OF CONTRIBUTIONS

The four chapters of this thesis were assembled by myself, Kathy Luu, under the supervision of Dr. Warren Dodd. I wrote Chapters 1, 2, and 4 of this thesis and these chapters were not written for publication, but for the purpose of completing my thesis requirement for my degree. Chapters 3 is a manuscript that was written for the intent of publication with the assistance of co-authors (Dr. Lincoln Lau and Dr. Jennifer Liu) who contributed to the preparation of this document.

Chapter 3:

Funding was obtained by Dr. Warren Dodd (principal investigator), Dr. Lincoln Lau (collaborator), and Dr. Jennifer Liu (co-investigator) through the Social Sciences and Humanities Research Council (SSHRC). This funding covered research expenses associated with the study that was conducted in Negros Occidental, Philippines and is detailed in Chapter three. This study was anchored on a collaboration with a Philippine-based NGO, International Cares Ministries (ICM). I would like to thank and acknowledge Beth Nicholson, Danilo Servano Jr, Charlott Torrebelanca, and Dolores Gagatam for their support and research assistance. In addition, we are grateful for the women and health staff who graciously participated in the study.

ABSTRACT

Background: In early 2019, the Universal Health Care Bill was signed into law in the Philippines with the intention of enabling all citizens to access a comprehensive range of health care services without bearing costs. To ensure the success of this reform, it is critical to understand how individual- and structural-level factors influence health system navigation among individuals that have historically had difficulty accessing and using health care services. Among Filipina women experiencing poverty, there is limited understanding of the social, cultural, and financial factors that enable and hinder health care access and use throughout the lifespan. By understanding how gender interacts with the by-products of social networks to shape health care access among women, there is an opportunity to inform programs delivered by non-governmental organizations (NGOs) in the context of Universal Health Coverage (UHC) implementation.

Research question: The purpose of this thesis is to 1) describe health care access and use among women experiencing extreme poverty, 2) investigate how gender and social networks interacted and influence health care access among young, middle-aged, and older adult women experiencing poverty, and 3) describe how health care providers accommodate and care for populations experiencing poverty in Negros Occidental, Philippines.

Methods: This project was built on a collaboration with a Philippine-based NGO, International Cares Ministries (ICM). Semi-structured interviews were conducted with participants (n=35) and health care providers (n=15) in seven communities in Negros Occidental, Philippines. Descriptive statistical analyses were performed to report basic demographic information. A

hybrid deductive-inductive thematic analysis was applied to identify and explore emerging themes. The Patient Centred Access to Health Care framework and Life Course Theory were used to guide the hybrid thematic analysis.

Results: Three main themes were identified to describe the stages that women encountered when accessing and using health care services: 1) characterizing pre-departure access factors; 2) identifying health care utilization factors; and 3) characterizing post-care health outcomes. Notably, health care access pathways varied among different age cohorts. Younger women prioritized the health of their children, and connected with their immediate families and relatives for social and financial support. Unlike other age cohorts, middle-aged and older adult women connected with governmental agencies and neighbours and had financial support from their children to cover their medical care costs. A fourth theme emerged which provided insights on how health care providers responded to the needs of their patients, and the challenges they encountered when delivering care.

Discussion and conclusion: Affordability acts as a persistent access barrier to reaching and engaging in health care services among women experiencing poverty in the Philippines. Findings indicate that women may have varying degrees of social support from their personal and external networks throughout their lifespan that can contribute to the availability of social and financial resources, which may enable or hinder their access to health care services. This information is important to consider in light of recent efforts in the Philippines and in other low- and middle-income countries to implement UHC that is equitable and gender-responsive.

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DEDICATION

I would like to dedicate this thesis to both of my grandmothers (Bà nội and Bà ngoại).

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LIST OF ABBREVIATIONS

UHC	Universal Health Coverage or Universal Health Care
NGOs	Non-Governmental Organizations
ICM	International Cares Ministries
LMICs	Low- and Middle-Income Countries
PCAHC	Patient-Centred Access to Health Care
L**CT**	Life Course Theory
WHO	World Health Organization
NHIP	National Health Insurance Program
OOP	Out-of-Pocket
SDG	Sustainable Development Goals
HICs	High Income Countries
SEA	South-East Asia
NBB	No-Balance Billing
MDGs	Millennium Development Goals
DOH	Department of Health
LGUs	Local Government Units
RHUs	Rural Health Units
BHSs	Barangay Health Stations
BHWs	Barangay Health Workers
BNSs	Barangay Nutrition Scholars
GDP	Gross Domestic Product
MMR	Maternal Mortality Ratio
ASEAN	Association of Southeast Asian Nations
PSA	Philippine Statistics Authority

CHAPTER 1: INTRODUCTION

1.1 Background

President Rodrigo Duterte of the Philippines signed the Universal Health Care Bill into law on February 20, 2019 (World Health Organization, 2019b). The Bill automatically registers all citizens into the National Health Insurance Program (NHIP), which enables citizens to access the comprehensive range of health care services without bearing financial hardship (Punongbayan, 2019; World Health Organization, 2019b). This effort to enhance NHIP coverage was made, in part, due to the recognition that individuals experiencing extreme poverty faced high out-of-pocket (OOP) expenditures on health services, and encountered social, structural, environmental, geographical, and economic inequities that impeded their ability to access quality care (Akita & Pagulayan, 2014; Boquet, 2017; Bredenkamp & Buisman, 2016; Chandra, McNamara, Dargusch, Caspe, & Dalabajan, 2017; Clausen, 2010; Dayrit, Lagranda, Picazo, Pons, & Villaverde, 2018; HILL, 2008; Kurita & Kurosaki, 2011; McDoom, 2019; McDoom, Reyes, Mina, & Asis, 2019; Mendoza, Beja, Venida, & Yap, 2016; Obermann, Jowett, & Kwon, 2018; Walch, 2018).

To successfully implement Universal Health Coverage (UHC) and achieve health-related Sustainable Development Goals (SDGs) in the Philippines, there is a need to understand how persistent health system challenges influence health system navigation among individuals and households that have historically had difficulty accessing and using health care services (Bredenkamp et al., 2014). In particular, it is important to examine factors that may act as barriers and enablers to accessing services among women experiencing extreme poverty to inform UHC implementation. The health inequities and barriers women encounter when accessing health care services may be exacerbated by the interaction of gender with broader

dimensions of inequality. For women experiencing extreme poverty in low- and middle- income countries (LMICs), there are specific gender-related, biological, sociological, and psychological factors that operate at both the individual- and structural-level that influence access to care throughout the lifespan (Alsan, Bhadelia, Foo, Haberland, & Knaul, 2016; Elmusharaf, Byrne, & O'Donovan, 2015; Finlayson & Downe, 2013; Hodge, Firth, Bermejo, Zeck, & Jimenez-Soto, 2016; Isangula, 2012; Knaul et al., 2012; Madjdian & Bras, 2016; Mendenhall & Weaver, 2014). Geographical, political, cultural, legal, and structural elements may shape gender roles, responsibilities, access to social networks and resources, and norms (e.g., within the household and society) that subsequently impact health seeking behaviours, decision making, and outcomes among women (Moss, 2002). With the changes in biological factors and health needs, women may experience changes in their social networks that may influence their health behaviours and decisions. The connection between social capital and health have been widely studied in High Income Countries (HICs); however, we have little understanding of changes in women's social networks impact their health needs, behaviour, and decisions throughout the life course in Low- and Middle-Income Countries (LMICs), and how these health care access and use experiences differ between age groups.

The legislation of UHC in the Philippines in 2019 offers an opportunity to examine health care access and use at a time of system transition to ensure that this transformation is responsive to gender and equity. Local attention from some non-governmental organizations (NGOs) has shifted towards understanding how household and community contexts, in addition to social connections (e.g., social networks), may positively influence health-seeking behaviour, decision making, and access and use of health care services among individuals experiencing extreme poverty (Agampodi, Agampodi, Glozier, & Siribaddana, 2015; Hagg, Dahinten, & Currie, 2018;

Labonne & Chase, 2011; Ng & Eriksson, 2015; Perkins, Subramanian, & Christakis, 2015; Story & Glanville, 2019). By examining these processes and mechanisms, there is an opportunity to consider the interaction of gender with other dimensions of inequality when developing policies and program interventions aimed at enhancing health care access among women experiencing extreme poverty.

1.2 Poverty and Livelihood in the Philippines

With a population of over 106 million people (World Bank, 2019e), the Philippines has one of the fastest-growing economies in the South-East Asia (SEA) region (OECD, 2018). In 2018, the Philippines experienced a 6.2% growth in GDP (OECD, 2018; World Bank, 2019a), and recorded a GDP per capita of $3,102.7 USD (World Bank, 2019d). Despite this recent national economic growth, the positive outcomes of the economic advancement have not been distributed equally among the population. Income inequality is higher in the Philippines than in most SEA emerging economies (World Bank, 2019b), and more than 90% of the people living under the poverty line in SEA reside in the Philippines and Indonesia (ASEAN, 2012). Moreover, the pace of poverty reduction in the Philippines has halted in comparison to other SEA countries. This means that the proportion of people experiencing extreme poverty remains high at 8.1% (Philippine Statistics Authority, 2016a; World Bank, 2019b), and more than 7% of the population are living under $1.90US a day (World Bank, 2019f).

Poverty is multidimensional, with social and economic dimensions operating at, and across, different scales. In terms of the economic dimensions, existing income poverty in the Philippines may be attributed to the low earning capacity among individuals experiencing extreme poverty (Ballesteros, 2010; Paqueo, Orbeta, & Lanzona, 2016; Pernia, 2008; Rutkowski,

2015). Also, there may be limited access to productive and consistent employment, which can exacerbate difficult living conditions (e.g., inadequate housing, and increasing occurrences of food insecurity) (Ballesteros, 2004, 2010; Cohen & Garrett, 2010; FAO, IFAD, 2017; Floro & Bali Swain, 2013; Gavilan, 2015; Melgar-Quinonez et al., 2006; Rutkowski, 2015). The national economic growth has not improved the status of low-paid workers, with some workers earning insufficient wages to meet basic needs (OECD/ADB, 2017). Another labour market challenge relates to the large informal sector in the Philippines, and the precarious employment arrangements within this sector (Rutkowski, 2015). Low-paid employment is often linked with informal employment, as about 90% of all low-paid jobs are informal (OECD/ADB, 2017; Rutkowski, 2015). Additionally, many young people are encountering challenges in finding jobs after school, as youth unemployment was 16% in 2018 (World Bank, 2019c).

In terms of housing, inequalities are observed across various income quintile groups, and geographic contexts (Ballesteros, 2010; World Bank, 2017). Only 33.5% of households of the lowest income quintile own their house, compared to 78.7% of households in the highest income quintile (Philippine Statistics Authority, 2018c). For access to drinking water, households with an income in the lowest quintile (83.7%) have poorer access to “improved sources” of drinking water than households with an income in the highest income quintile (99.5%) (Philippine Statistics Authority, 2018c). With respect to income groups and household sanitation facilities, almost all households from the highest income quintile reported having improved sanitation facilities, while less than half of the households from the lower income quintile had access to improved sanitation facilities (Philippine Statistics Authority, 2018c).

Food insecurity is extremely prevalent in the poorest regions in the Philippines. According to a 2017 review by the World Food Programme, borrowing food is the primary

mechanism to manage food shortages among the majority (79%) of the households from the poorest provinces (Briones, Antonio, Habito, Porio, & Songco, 2017). Most of this borrowing occurs between relatives and neighbours, or alternatively, through relying on credit from retail stores (Briones et al., 2017). Food insecurity may lead to malnutrition among individuals experiencing extreme poverty (Angeles-Agdeppa et al., 2019; Capanzana, Aguila, Gironella, & Montecillo, 2018), as 13.9 million Filipinos experienced undernutrition between 2014-2016 (FAO, IFAD, 2017).

Individuals experiencing extreme poverty are more likely to experience poor health outcomes due, in part, to their living conditions. However, financial constraints are also a critical barrier to accessing and using health care services in the Philippines (Gouda, Hodge, Bermejo, Zeck, & Jimenez-Soto, 2016; Hodge et al., 2016; O'Donnell, 2007; Obermann et al., 2018). Insufficient income may force households to prioritize and redirect income to cover basic needs, which reduces the amount of available income the household may have to meet the costs of accessing health care services (Alam & Mahal, 2014; Hodge et al., 2016).

1.3 Health Reforms in the Philippines

1.3.1 Past health reforms and national health insurance program in the Philippines

Major health reforms in the Philippines began in 1969 when the Philippine Medicare Care Commission was created to manage the Medicare Program (Dayrit et al., 2018). Limitations of this system prompted the creation of a National Health Insurance Program (NHIP). A NHIP is one approach to pursue UHC, as it involves national funds pooling, the development of a contribution scheme, and the purchasing of services for the entire population (Department of Health, 2012a; Kutzin, 2012; Lönnroth et al., 2014; Obermann et al., 2018; Obermann, Jowett,

Alcantara, Banzon, & Bodart, 2006; Tobe, Stickley, Del Rosario, & Shibuya, 2013). In 1995, the Philippine government created its NHIP, called PhilHealth, to establish criteria and rules to guarantee the quality of care, maintain health insurance funds, control the appropriate utilization of services, and consult payment mechanisms with health care providers (Department of Health, 2012a; Philippine Insurance Health Corporation, 2013). In the Philippines, people under the sponsored classification (i.e., indigents - individuals have no visible means of income, sponsored members, and lifetime members) are under the no-balance billing (NBB) policy and are not required to pay premiums to the NHIP (Department of Health, 2012a; Philippine Insurance Health Corporation, 2013). PhilHealth covers inpatient services in government hospitals for indigents, and the NBB policy is in effect; therefore, individuals are hypothetically not required to pay for services (Department of Health, 2012c). However, if an individual were to pursue services at a private hospital, they may encounter high out-of-pocket (OOP) expenses, even with PhilHealth and private insurance coverage (Dayrit et al., 2018).

Prior to the legislation of UHC in early 2019, the NHIP hypothetically had the potential to improve the financial protection of individuals experiencing poverty by ensuring that these individuals could obtain a full range of health services for no cost. The Aquino Health Agenda for UHC in 2010 aimed to (1) strengthen the NHIP to improve financial risk protection; (2) to sustain public health facilities; and (3) to offer public health services to achieve the Millennium Development Goals (MDGs) (Bredenkamp & Buisman, 2016; Cabral, 2016; Dayrit et al., 2018; Department of Health, 2016). In particular, subsequent reforms focused on diverse groups and specific targeted groups including infants and children, women, and the elderly: the preventive health care of infants and children (Infant and Children's Health Immunization Act); increasing revenues for health, and discouraging use of tobacco products and alcohol (Sin Tax Law);

increasing reproductive health services and family planning (Responsible Parenthood and Reproductive Health Act); increasing the enrolment of poor families in PhilHealth (National Health Insurance Act of 2013); providing mandatory health care coverage of all senior citizens (Republic Act No. 7432); and protecting households from health care expenditures (Philippine Health Agenda in 2016) (Dayrit et al., 2018). Each reform from 2010 onwards represented an incremental step towards the successful implementation of UHC in the Philippines.

1.3.2 Universal Health Coverage (UHC) in the Philippines: present day

Under Goal 3 of the Sustainable Development Goals (SDGs), sub-objective 3.8 aims "to achieve universal health coverage, including financial risk protection, access to quality essential health care services and access to safe, effective, quality and affordable essential medicines and vaccines for all" (Tangcharoensathien, Mills, & Palu, 2015; United Nations, 2019; World Health Organization, 2005). The World Health Organization (WHO) defines UHC as a measure that guarantees "all people obtain the health services they need without suffering financial hardship when paying for them" (World Health Organization, 2014). As previously mentioned, the Philippine government supported the use of its NHIP as a policy for attaining UHC to target health inequities impacting individuals experiencing poverty. With the recent movement towards UHC, the expansion of the PhilHealth benefit package and public health programs have improved (Bredenkamp & Buisman, 2016; Dayrit et al., 2018). PhilHealth beneficiaries can access inpatient care, outpatient care, emergency, and transfer services, and other services at government-owned and PhilHealth accredited hospitals (Dayrit et al., 2018; Department of Health, 2012b).

The increase in the range of services may be due to the implementation of the Sin Tax Law in 2012. The bulk (80%) of the revenue generated from this tax is devoted to UHC expenditures, and the remaining balance (20%) is diverted to medical assistance and health enhancement facilities program (Department of Health, 2018b). The Law has raised the health budget by five times, which increased the budget subsidies for PhilHealth premium payments, thus rendering 100% coverage for indigents (Department of Health, 2016). Despite these recent policy changes, household OOP expenditures on health care have remained high, which disproportionately affects income poor households (Dayrit et al., 2018; World Bank, 2012).

The newly signed UHC bill in 2019 marks the next phase of implementing UHC in the Philippines (World Health Organization, 2019b). With this forthcoming change, it is a critical period to investigate how individuals experiencing poverty are currently accessing health care services under PhilHealth coverage, and to examine the barriers associated with accessing care among this population.

1.4 Health Care System and Rural Health Units in the Philippines

The health system in the Philippines comprises both the public and private sectors (Dayrit et al., 2018; Department of Health, 2012a, 2018a). The Department of Health (DOH) is accountable for policy advancement, program devising, establishing standards, and supervision of support services, as well as assisting local government units (LGUs), monitoring and managing hospitals, and rehabilitation centres (Dayrit et al., 2018). In contrast, the LGUs are responsible for the provision of health services at the local level, and a local leader (mayor or *barangay* captain) maintains the decentralized municipal health system (e.g., rural health units

(RHUs) and *barangay* health stations (BHSs)) (Dayrit et al., 2018; Department of Health, 2012b).

RHUs are the most attended public health facilities in the Philippines, as they provide primary health care for rural communities (Dayrit et al., 2018; Department of Health, 2012a). Each RHU is accountable for several BHSs that deliver services to communities in their catchment area. RHUs offer maternal and child health care, family planning and nutrition advice, health education, outpatient and dental care, preventative services and control of particular diseases, and hygiene and sanitation (Lieberman, 2002). The number of health care professionals vary per region; however, on average, there is one doctor, two nurses, five midwives, and several *barangay* health workers (BHWs) at each RHU (Dayrit et al., 2018).

Resources and services at RHUs also vary. When accessing and using health care services at RHUs, individuals may encounter challenges such as the geographic location of the RHU, a shortage of human resources and medical resources, and long wait times, which may deter some individuals from seeking care (Dayrit et al., 2018; Department of Health, 2012a; World Bank, 2012). Disparities in health care quality, equity, and access remain prevalent across the Philippines, which may also influence health care decisions including level (primary, secondary, tertiary) and type (public, private, traditional) of care accessed (Dayrit et al., 2018).

1.5 Barriers and Facilitators to Accessing and Using Health Services

The process of accessing health care remains a complex concept with broad dimensions and determinants that integrate demand- and supply-side factors (Levesque, Harris, & Russell, 2013). Barriers and facilitators to health care access can appear at any given point on the continuum of access, which includes: 1) “the ability to perceive” health care needs; 2) “the

ability to seek" health care services; 3) "the ability to reach" health care services; 4) "the ability to pay" for health care services; and 5) "the ability to engage" in health care services (Levesque et al., 2013, p. 5). In the Philippines, key barriers to health care access among individuals include geographic location, financial barriers, inability to perceive and recognize health care needs, differing personal, social, cultural and religious values, occupational inflexibility, lack of social support, lack of medical resources and facilities, poor quality facilities, lengthy wait times, and transportation costs (Cananua-Labid, 2017; Dayrit et al., 2018; Department of Health, 2012a; Development Bank & Son, 2009; Hou, Lin, & Zhang, 2017; S. Kim, Capeding, & Kilgore, 2014; Shimazaki, Honda, Dulnuan, Chunanon, & Matsuyama, 2013; Sobel, Oliveros, & Nyunt-U, 2010; Thind & Cruz, 2003). Key barriers to health care use among individuals in the Philippines include poor health literacy, mistrust and expectations of the health care system, and misunderstandings of how to navigate the pathways that facilitate an individual's 'right to health care' (Cananua-Labid, 2017; Dayrit et al., 2018; Department of Health, 2012a; Development Bank & Son, 2009; Hou et al., 2017; Shimazaki et al., 2013; Sobel et al., 2010; Thind & Cruz, 2003). These barriers may dictate the route of care individuals might select when they require medical attention, and it can pressure individuals to select options that may increase their OOP expenses or provide them with inadequate care.

1.6 Gender and Health Care Access Among Women in LMICs and the Philippines

Women experience notable variation in mental and physical changes throughout their lifetime, and their age can dictate the biological, psychological, and social factors that influence their health needs, behaviour, decisions and outcomes (Lund et al., 2010; Macintyre, 1994; Mishra, Hockey, & Dobson, 2014; Williams & Umberson, 2004). Current approaches to

understanding ageing among women may not acknowledge variations in culture, availability of economic resources, and distinct health needs (e.g., fertility, labour experiences, and menopause histories) that may amplify barriers women may encounter when accessing health care services (Hakim, 2003; Henrard, 1996; Lehman, David, & Gruber, 2017; Sommer, Chandraratna, Cavill, Mahon, & Phillips-Howard, 2016). In comparison to men, women of all ages experience different biological changes that require distinct health needs, and these health interventions can be unattainable due to the barriers created by gender inequality intersecting with socioeconomic status (Dev et al., 2019; Poomalar & Arounassalame, 2013; Poston et al., 2016; Wulifan, Brenner, Jahn, & De Allegri, 2016). Due to gender-based norms, young women in LMICs may be expected to bear children at an earlier age, and as a result, women from LMICs tend to have greater fertility rates. In some cultural contexts, early marriage contributes to this pressure for younger women to have children (Santhya & Jejeebhoy, 2015). In addition to the pressures from gender based-norms, women in LMICs have reported limited access to antenatal and postnatal care, and a higher number of miscarriages, abortions, and infant deaths compared to women in HICs (Chae, Desai, Crowell, Sedgh, & Singh, 2017; Decker, Kalamar, Tunçalp, & Hindin, 2017; Downe, Finlayson, Tunçalp, & Gülmezoglu, 2019; Leone, 2019; McGready et al., 2018). In contrast, older women in LMICs are experiencing a new disease pattern as the prevalence of non-communicable diseases, and chronic disease are increasing (Anderson, Ilbawi, & El Saghir, 2015; Irazola et al., 2016; Sousa et al., 2010). Therefore, unlike younger women, older women may be subjected to higher health care expenditures to cover the specialized care related to age-related conditions (Ginsburg et al., 2017, 2018; Jacobs, De Groot, & Fernandes Antunes, 2016).

Historically, women in the Philippines have possessed greater social status compared to other women in SEA, as they occupy leading senior positions in government, education, and

business sectors (Gipson & Upchurch, 2017). Despite the favourable conditions, women in the Philippines continue to face economic hardships, violence, and adverse health outcomes. Women are also subjected to intimate partner violence. According to the 2017 National Demographic and Health Survey, a quarter of ever-married women aged 15-49 suffered some type of violence from their partner (Philippine Statistics Authority, 2018b). Female representation in politics also remains low. As of 2018, 30% of seats were held by women in the national parliament in the Philippines (World Bank, 2018). Within the workforce, a larger proportion of women (37%) participate in low-paid employment compared to men (25%) (Rutkowski, 2015). The lack of secure income and employment may result in women not being directly covered by social health protection schemes and thus contributing to the increase risk of poverty from catastrophic health care expenditures. Families experiencing extreme poverty may redirect income to cover basic needs, which reduces the ability of these households to meet the costs of accessing health care services (Alam & Mahal, 2014; Gouda et al., 2016; Hodge et al., 2016; O'Donnell, 2007; Obermann et al., 2018).

Geography can intersect with gender to exacerbate access barriers. Access to reproductive, maternal and child health care services is progressing; however, many women and children living in rural areas of the Philippines may not be reaching health facilities where services are delivered. Sexual and reproductive health problems are responsible for a third of the health issues for women between the ages of 15 and 44 in the Philippines (Cudis, 2019). There has been an additional recent health concern is the growing trend in teenage pregnancy (Maravilla, Betts, & Alati, 2018; Natividad, 2014). Women need to obtain health interventions that target sexual and reproductive health as they impact individuals from their early fertility stages to childbearing years. These services may be more pertinent for Filipina women

experiencing poverty to receive as they may be more vulnerable to sexually transmitted infections (STIs), such as HIV/AIDS, than those from higher income households (Philippine Institute for Development Studies, 2008). As for maternal health, the maternal mortality ratio (MMR) remains high at 221 per 100,000 live births in 2015, which is considered one of the highest MMRs in the Association of Southeast Asian Nations (ASEAN) region (ASEAN, 2017). Mothers may be dying due to the delays in seeking care, their inability to reach appropriate facilities, poor transportation infrastructures, and the lack of high quality and appropriate services at health facilities (Dayrit et al., 2018). Women experiencing poverty and living in rural areas in the Philippines may have other factors influencing their inability to reach health care services, such as low educational attainment and socioeconomic status (Paredes, 2016; Sobel et al., 2010). Precarious employment may result in women being less inclined to attend health care facilities due to their lack of sick leave or paid leave (World Health Organization, 2019b).

Historical, geographical, political, cultural, legal, and structural elements may shape gender roles, responsibilities, and norms (e.g., within the household and society) that subsequently impact health-seeking behaviours, decision making, and outcomes among women (Moss, 2002). Women are seen as bearers of children and caretakers, and these gender roles may influence women in several ways (Singh & Venkatachalam, 2014). For example, Brickell and Chant (2010) reviewed research on gender norms in Cambodia, Philippines, the Gambia, and Costa Rica, and found that women may feel compelled to obey to "traditional feminine norms" such as practicing altruistic behaviour within the family setting (Brickell & Chant, 2010). Also, the Asian Development Bank reported that 84% of a woman's total household time is allocated to childcare in the Philippines (Asian Development Bank, 2013). In particular, young women disproportionately experience this caregiving role. Thirty-seven percent of women reported not

attending school because of marriage or family matters, compared to only 13% of men (Philippine Statistics Authority, 2018a). Additionally, adult-child caregivers are emerging as the population ages. A quantitative study completed in Davao City, Philippines, found that most adult-child caregivers were women living with their elderly parents (Varona, Saito, Takahashi, & Kai, 2007). These gender roles may act as a barrier to accessing health care. As the caregiver of the household, a woman may not want to be perceived as a financial burden to her family when health problems arise (Yamashita et al., 2014, 2015). For example, a qualitative study conducted in urban areas in Manila and Rizal, Philippines, explored the risk perception and screening behaviour of Filipina women, and found that perceived barriers such as financial barriers, and trouble allotting time caused participants to avoid accessing and using clinical breast examination (Lagarde et al., 2019). Indeed, health-seeking behaviour among women in the Philippines may be contingent on both individual- and structural-level factors that influence their perception of risk, availability of services, and how it will impact their household financial stability.

1.7 The Role of Social Networks in Health Care Access and Use

The by-products of social networks are social cohesion, social support, and social capital, recognized by the World Health Organization (WHO) as a crosscutting structural and intermediate determinant of health (Solar & Irwin, 2010). They are mediators of the association between income and health inequality; therefore, they play an essential role in creating health equity among individuals (Solar & Irwin, 2010). Consequently, it is vital to understand how direct and indirect informal supports can be a source of assistance for individuals when they are accessing health care in contexts where resources are limited (World Health Organization, 2017).

In LMICs, social networks, social support and capital are widely used concepts in health care access as they are integral to information sharing about health care access and use, which may increase an individual's awareness and access to care (Fadlallah et al., 2018; Hou et al., 2017; Story, 2013). Social networks are interpersonal bonds that "provide sociability, support, information, a sense of belonging, and social identity" (Wellman, 2005, p. 53). In these networks, social support and capital may be cultivated by both the relationships individuals foster within the space and the degree to which they are embedded in the system (e.g., social integration) (Ruiz, Prather, & Kauffman, 2013). Within these networks, trust can be manifested through the degree of closeness and quality of the social bonds among individuals, and it ultimately builds the foundation of trust among family members, friends, and community members. Social networks and trustworthiness are two components that form social capital, which is defined as "resources which are linked to possession of a durable network of more or less institutionalized relationships of mutual acquaintance and recognition" (Bourdieu, 1986, p. 248). Similar to social capital, social support is a construct that is determined by the "size, quality, and availability of one's social resources to moderate stress" (Ruiz et al., 2013, p. 1843). It is defined as the degree to which interpersonal relationships serve to provide physical, emotional, informational, or influential quality of life for the individual (Tang, Brown, Funnell, & Anderson, 2008). Social networks, specifically, social support and capital, can contribute to the available human and financial resources one may possess, which can be particularly crucial among individuals in low resource settings as these resources may facilitate health care access.

Social support may operate differently at different stages of the health care access pathway. According to previous health care access frameworks identified in the literature by Levesque et al. (2013), individuals must first perceive a need to seek care, and this perception of

need can be reliant and influenced by one's health literacy, beliefs, and trust and expectations (Levesque et al., 2013). Community-based social networks (e.g., relationships between individuals and households within and between communities) may be integral to information sharing about health care access and use, which may increase an individual's awareness and access to care (Fadlallah et al., 2018; Hou et al., 2017; Story, 2013). Community members can receive accurate information through social networks, as social capital all sustains broader dissemination of health-promoting information through various social and technological-based-mediums (Miyamoto, Iwakuma, & Nakayama, 2015). Acquiring relevant and accurate health information promotes positive health-related decisions, which include deciding on the appropriate physician or health facility (Paasche-Orlow & Wolf, 2007), and selecting and maintaining healthy behaviours (e.g., diet) (Kawachi, Subramanian, & Kim, 2008).

The ability to seek, reach and pay for health care services requires an abundance of financial resources as the path accumulates indirect, direct, and opportunity costs. Through social support and capital, individuals may have the means to tap into their networks to obtain monetary support to pay for the use of health care services. Social capital can produce various forms of social support that can be valuable during stressful events (Ehsan, Klaas, Bastianen, & Spini, 2019; Khazaeian, Kariman, Ebadi, & Nasiri, 2017). During times of financial need, communities with substantial social capital may readily borrow and loan money from neighbours to purchase basic necessities (Sun, Hartarska, Zhang, & Nadolnyak, 2018), and have a greater willingness to provide childcare support (Pitkin Derose & Varda, 2009). A qualitative study conducted in Quezon City in the Philippines examined health care-seeking experiences among poor women with tuberculosis (TB), and found that support from family members and peers encouraged women to seek TB care, and attend clinics (Hu, Loo, Winch, & Surkan, 2012). Some

neighbours were also willing to offer childcare and nutritional support if their peers were facing hardships (Hu et al., 2012). Furthermore, positive relationships between individuals and community health workers may stimulate greater trust in the health care system and facilitate health care access and use among households experiencing extreme poverty (Adebayo et al., 2015; Ballard & Montgomery, 2017; Bright, Felix, Kuper, & Polack, 2018).

The direct social support individuals receive from their networks can influence their physical and mental health outcomes. Among individuals taking antiretroviral treatment (ART) for HIV/AIDS, social, and community support have been linked to improved adherence and treatment outcomes (Igumbor, Scheepers, Ebrahim, Jason, & Grimwood, 2011). Similar results were found with TB treatment, where the support from nurses have notably improved TB treatment adherence and outcomes (Baniqued et al., 2020). Social support can also appear as active care (e.g., monitoring blood glucose, foot and eye care, encouraging a healthy diet) and emotional encouragement, which was found among individuals caring for people with diabetes (Pouwer, Snoek, Van Der Ploeg, Adèr, & Heine, 2001).

1.8 Connections between Gender, Social Networks, and Health Care Access

Higher levels for social support are reported among women compared to men, with an emphasis on reciprocal social support between women and family members, friends, adult children, and coworkers (Helgeson, 2003; Pittman & Lloyd, 1988; Umberson & Williams, 2005; Walen & Lachman, 2000; Williams & Umberson, 2004). Besides higher levels of social support, women are often more conscious of the significance of reciprocity, feeling loved and valued, and forming friendships as a form of emotional support (Coker et al., 2002; Rook, 1987; Sánchez-Ayéndenz, 1989; Tafere, 2015). Women may have strong ties to their friends and family, which

are beneficial when women rely on their social networks and capital to acquire social support, knowledge, and resources (Adjaye-Gbewonyo, Rebok, Gross, Gallo, & Underwood, 2019; Agampodi et al., 2015; Baheiraei, Bakouei, Mohammadi, & Hosseini, 2014; Chen & Meng, 2015; Ehsan et al., 2019; Mladovsky, Soors, Ndiaye, Ndiaye, & Criel, 2014; Palafox et al., 2017).

Bonds with immediate kin (e.g., parents, siblings, children, etc.) are reinforced and fostered by the understanding of long-term reciprocity, and this shared awareness has been supported by cultural norms, which promote family welfare and encourage kin to share resources among networks in the Philippines (Brandewie, 1973; Cruz, 2019; Hofferth & Iceland, 1998; Turgo, 2016).The importance of psychosocial resources, especially trust among family members and relatives, can promote positive health-seeking behaviour and access to health care services. For instance, a quantitative study completed in the Philippines explored social trust and its correlation with active case findings of tuberculosis and found that every unit increase of trust in relatives and family satisfaction was synonymous with the increased odds of the individuals attending an RHU (Lau et al., 2020).

Social networks may also encompass individuals outside of the family unit, and these external relationships can have similar and different effects in supporting health-seeking behaviours. Several studies demonstrate the importance of the context of community on reproductive and maternal health outcomes (Chiao, Yi, & Ksobiech, 2012; Firoz et al., 2016; Kaddour, Hafez, & Zurayk, 2005; Lassi, Das, Salam, & Bhutta, 2014; Pillai & Maleku, 2015). One quantitative study conducted in the Philippines using Demographic and Health Surveys investigated the importance of community factors on pregnancy intention among women of low socioeconomic status (Chiao et al., 2012). The results demonstrated that community social

capital, comprised of community-related variables (e.g., community religion, community education, female labor force participation, etc.), significantly predicted pregnancy intention (Chiao et al., 2012).

The gendered nature of employment, family obligations, and biological needs may influence women's life experiences and social networks throughout their life course (Fischer & Beresford, 2015; Harling, Morris, Manderson, Perkins, & Berkman, 2020). These social forces may lead to gender-based patterns of social support that may influence health care access and use among women. The health experiences of young-, middle-, and older- women have been explored in HICs, and there is a mix of evidence of how social capital varies across age groups (Boneham & Sixsmith, 2006). For instance, there is evidence of social capital accumulation and decline with age. One study conducted in the U.S. found that social resources from connections formed at the workplace tend to increase with age but ultimately level off amongst older individuals (McDonald & Mair, 2010). The connection between social capital and health have been widely studied in HIC with quantitative measures; however, we have little understanding of how changes in social networks among women impact their health needs, behaviour, and decisions throughout the life course in LMICs. In order to build a better understanding of social support and networks among women in LMICs, more context-specific, gendered qualitative research is needed to explore the processes and mechanisms linking social support and capital to health care access and use.

1.9 NGOs and their Role in Promoting Health Care Access and Use

Non-governmental organizations (NGOs) have been acknowledged as critical non-state actors to deliver, service, and reach vulnerable populations in need of health care services. A

study conducted in the Philippines in collaboration with International Care Ministries (ICM) investigated the role of trust in religious leaders and institutions as a mechanism to improve retention in a child malnutrition program offered in partnership between ICM and local religious leaders (Lau, Dodd, Qu, & Cole, 2020). The study found that an increase in trust in religious leaders and institutions among caregivers of children enrolled in the malnutrition program was associated with a decrease in program dropout. Overall, this study argues that leveraging pre-existing networks and strengthening social support among community members can contribute to improved social conditions, health outcomes, and access to resources and services.

1.10 Study Rationale

To successfully implement UHC and achieve health-related SDGs in the Philippines, there is a need to understand how persistent health system challenges influence health system navigation among households that have historically had difficulty accessing and using health care (Bredenkamp et al., 2014). PhilHealth reportedly covers 92% of the population, 40% of which is the poor population and subsidized by the government for premium payments (Dayrit et al., 2018). However, the accessibility and usage by the most disadvantaged sub-group within that population determines whether national health policies and programs are truly effective at reducing inequities in health. For women experiencing extreme poverty in LMICs, there are specific supply- and demand-side factors that operate at both the individual- and structural-level that influence access to care throughout the lifespan (Alsan et al., 2016; Elmusharaf et al., 2015; Hodge et al., 2016; Madjdian & Bras, 2016). Failure to adequately address these barriers may result in health disparities among the most disadvantaged women. Social factors (e.g., social support and capital) may influence decisions about and perceptions of health care among women.

It is important to understand how social networks may encourage greater trust in services, and facilitate access and use among women experiencing extreme poverty in low resource settings. However, how these relationships may influence health care access and use among individuals with different demographic (e.g., age and gender) and socioeconomic characteristics remains understudied in the Philippine context.

1.10.1 Study objectives

The goal of my research was to apply qualitative methods to explore the associations between individual- and structural-factors along the health care access pathway by exploring the perspective of both female participants and health care providers. This study was anchored by a collaboration with ICM. To achieve this goal, this project had three objectives:

1) To describe health care access and use among women experiencing extreme poverty in low resource settings.

2) To explore how gender and social networks interacted and shaped health care access among young, middle-aged, and older adult women experiencing poverty in Negros Occidental, Philippines.

3) To explore the experiences of health care providers in delivering care for income poor individuals in this context.

1.10.2 Research questions

The qualitative research study was guided by the following questions:

1) What are the individual- (e.g., responsibilities, interpersonal relationship, social networks, and roles etc.) and structural-level (e.g., geographical, health systems, and decentralization, etc.) factors that influence health-seeking behaviour, health care access,

and health care use among women experiencing extreme poverty in Negros Occidental, Philippines? How do these factors shape the ability of women to navigate health care access and use?

2) What challenges do health care providers encounter when providing care for individuals experiencing extreme poverty in Negros Occidental, Philippines? How do health care providers accommodate their patients?

1.11 Positionality Statement

I would like to share and acknowledge my positionality and how it has influenced the development, interpretation, and overall process of this study. I am aware that my personal identity, opinions, socio-cultural biases and lived experiences influenced my research engagement, and it is vital to note these in this space. Throughout this thesis process, I tried to acknowledge my limitations and stayed open and engaged wholeheartedly with the individuals who supported me in conducting this study.

As a novice researcher at the time of starting the Public Health and Health Systems program at the University of Waterloo, I was privileged to be supervised, mentored, and trained by Dr. Warren Dodd. Before embarking on this academic journey, I completed an undergraduate degree in Health Sciences. I was immersed in quantitative and qualitative work surrounding access to health care services among people living with HIV/AIDS, people who inject drugs, and men who have sex with men in Ontario, Canada. This training provided me with a background in health care access among marginalized populations, specifically, barriers and facilitators that hinder or enable access to services. However, I had no previous knowledge or research experience in global health, and a limited understanding of conducting qualitative studies. I was

fortunate to have had the training and supervision from Dr. Warren Dodd and my committee members, who bestowed upon me the knowledge that guided me throughout this intense learning curve.

I am a 24-year-old cisgender woman of colour born and raised in Canada. As a daughter of parents who immigrated to North America from Vietnam, I identify as a first-generation Vietnamese-Canadian. I am university educated and relatively financially stable. As a woman of colour, I experience intersecting forms of discrimination perpetuated across multiple settings. As an Asian person, I have encountered racism, and as a woman, I am subjected to sexism in structural, community, and individual levels. Therefore, my intersectional identities allow me to empathize with other individuals who are a part of a marginalized population. I recognized that I am a settler and non-Indigenous person, and I have privileges due to my social identity and location. As a settler, I have encountered privileges in a multitude of social settings, including accessing health care services without the fear of discrimination. I believe that it is my responsibility to constantly educate myself and my peers about colonization and Indigenous issues, encourage others to challenge their biases, and recognize their privilege, and promote local community initiatives to show solidarity.

Growing up with dual cultural identities, I questioned my identity quite frequently because I partook in East Asian traditions at home, but in the external context, I found myself undertaking Western cultural practices and perspectives. With the exception of travelling to the Philippines, I have not travelled outside of North America and have not had first-hand experiences engaging in Filipino culture. I made efforts to participate and educate myself on South-East Asian cultures through various mediums, including publicly available information (e.g., newspaper articles, videos, and films) and speaking to individuals who have travelled and

lived aboard to further my understanding. My knowledge was not first-hand; however, I tried my best to be open-minded and welcomed all perspectives. When I arrived in the Philippines, I was not a noticeable foreigner at first glance due to my East Asian appearance. However, when having conversations with me, individuals were able to identify me as a foreigner due to my inability to speak the native language and limited understanding of the social and cultural contexts. When conducting this study, I actively tried to address and stay mindful of my knowledge gaps and limitations. I am beyond grateful for the members from the research team, International Care Ministries (ICM), and participants from the study as they were my source of guidance and information.

When I engaged in conversations with my participants about access to health care, I was cognizant that all of my encounters with the health care system have been within North America. These occurrences shaped my conceptualization of the health care pathway, interactions with health care providers, and available treatment options. Being privileged to live in Canada where health care is universally funded and involved with research within this context, I could have overlooked the financial burdens associated with accessing health care and diverted my attention to access barriers beyond the economic spectrum. In several instances, during semi-structured interviews and engaging in conversation with my participants, I noticed my differing gendered and socio-cultural subjectivities. While I am an Asian woman who was similar in age to some of my participants, I had a socio-cultural bias as a woman growing up in North America, and endured different social norms and expectations. My experiences may not mirror the ones my participants encounter, and therefore, at times, my position placed me as an 'outsider.' Also, the interviews were conducted using real-time translation in English or Ilonggo based on the participants' preference, and as I speak multiple languages, I am aware of the challenges with

communicating and translating from one's native language into another. Also, this limited my ability to probe and ask questions that emerged from the interviews. I relied heavily on my interpreters and members from ICM who facilitated these discussions. I am incredibly thankful for the community members, members of ICM, and my participants for educating, welcoming and having me in their spaces. Furthermore, I acknowledged that my socio-cultural biases may have transferred over to my analysis as there was an attempt to understand how gender-based norms may have influenced my participants' experiences when accessing health care services. I tried my best to stay aware of these personal biases and often revisited literature to understand the socio-cultural differences and gender expectations women in the Philippines encountered throughout their lifetime.

CHAPTER 2: METHODS

2.1 Overview of Research Design and Approach

This qualitative study was part of a larger SSHRC-funded research project that examined how households experiencing poverty navigate the social service and health care systems in Negros Occidental, Philippines. Semi-structured interviews were used to gain an in-depth understanding into the factors that influence health care access and use among women experiencing poverty. In addition, the study investigated the challenges health care providers encounter when delivering services to individuals in low-resource settings in the Philippines. Mainly based in Bacolod City, Negros Occidental, this thesis project builds on a collaboration with a Philippine-based non-governmental organization (NGO), International Cares Ministries (ICM), which operates poverty alleviation programs throughout the Philippines. A modified hybrid deductive-inductive thematic analysis was utilized to identify emergent and final themes.

2.2 Theoretical Approaches

2.2.1 Patient-Centred Access to Health Care (PCAHC) Framework

The PCAHC framework considers how different determinants influence the dimensions of supply, demand, and access to health care from a cumulative perspective (Levesque et al., 2013). When examining the dynamic nature of health care access, "access" should be observed as the "the possibility to identify health care needs, to seek health care services, to reach the health care resources, to obtain or use health care services, and to actually be offered services appropriate to the needs for care" (Levesque et al., 2013, p. 8). Therefore, the conceptualization of access to health care depends on the complex and broad dimensions that unite demand- and

supply-side elements, and include both aspects of access and utilization of health services, which can facilitate or hinder the process of completing an episode of care (Levesque et al., 2013).

Using, Levesque, Harries, and Russell's (2013) synthesis of access to health frameworks, they found that historically, access has been conceptualized in numerous ways and was acknowledged as important in health care services. Several authors consider the characteristics of health care resources as a prominent factor that influences one's utilization of services (Levesque et al., 2013). For example, Aday and Andersen (1974) perceived utilization as access, which is defined by population and health care systems' characteristics. Penchansky and Thomas (1981) imagined access in terms of the features of providers and health services, combined with the expectations of service beneficiaries. Mooney (1983) viewed both the supply and demand components of access to health care. All of these models continue to be frequently used in health care access research to identify individual, social, environmental, physical, and structural barriers and enablers to achieving treatment and care (Levesque et al., 2013). However, these conceptual frameworks and theories have limitations and weaknesses that may restrict the exploration of the interrelation interactions between factors occurring at segments of the access to health care pathway. The Aday and Andersen health care utilization model groups social and cultural elements as independent predisposing factors, and this classification has been critiqued for the lack of recognition of the potential interactions between the two components (Andersen, 1995; H. K. Kim & Lee, 2016). Penchansky and Thomas definition of access was criticized for the lack of acknowledgement of the technical factors and characteristics of the health provider that may influence the patient-provider interaction (McLaughlin & Wyszewianski, 2002), and the omission of the dimension of the patients' awareness of health services (Saurman, 2016). Other previous models of access to health care were scrutinized for the lack of integration of both

macro- and micro-level factors. For example, the Health Behavioural Model primarily focused on patient beliefs as the key component motivating health-seeking behaviours, and overlooked how structural factors (e.g., health care reform) might impact beliefs and behaviours (Davidhizar, 1983; Janz & Becker, 1984; Koh et al., 2018).

With these critiques in mind, it is important to consider how prospective models can be adapted, modified, and improved to better reflect the interrelated relationships between different factors, and how factors act differently during the stages of accessing health care to understand the complex interactions that may influence an individual's ability to access health care services. Specifically, the PCAHC framework recognizes that the concept of access requires both patient-centered perspectives and system-level approaches, as patients engage with different stages in the health care pathway. Thus, access is seen as the interaction between the attributes of an individuals' social and geographic environments, and their engagement with the health systems and providers (Levesque et al., 2013).

Levesque, Harris, & Russell (2013) included five dimensions of accessibility of services: approachability, acceptability, availability and accommodation, affordability, and appropriateness. In addition, they suggested five corresponding abilities of individuals to interact with the dimensions of accessibility, which entail: the ability to perceive, the ability to seek, the ability to reach, the ability to pay, and the ability to engage. Full descriptions of the dimensions of accessibility of services and abilities of individuals to interact with the dimension of accessibility are contained within Table 1 (Levesque et al., 2013).

Table 1. An overview of the PCAHC framework's dimensions of health care service access and the abilities of individuals to interact with the dimensions of accessibility (Levesque et al., 2013).

Dimensions of accessibility of services		**Abilities of individuals to interact with the dimensions of accessibility**	
Approachability	Ability of an individual who requires health needs to recognize, reach, and obtain existing services.	Ability to perceive need for	Influenced by health literacy, beliefs, and knowledge.
Acceptability	Cultural and social elements that could dictate ones' acceptance of the structure of the services and the judgment of the appropriateness of the services.	Ability to seek health care	Encompasses autonomy, rights, and ability to seek knowledge, and care.
Availability	Geographic location and existence of physical and human resources offered at health facilities that are accessible to the population.	Ability to reach health care	Personal mobility, transportation, knowledge about services that allow individuals to reach the services physically.
Affordability	Individual financial ability to the allocate time and capital to obtain services.	Ability to pay for health care	To produce funds that can be used to pay for services without succumbing to catastrophic expenditures.
Appropriateness	The assessment and determination of health issues, treatment, and the interpersonal relationships offered by the existing services.	Engage in health care	Ones' ability to make decisions on their course of treatment, which is dictated by the individuals' ability to commit to the chosen care.

Various studies have adapted the PCHAC framework to understand the sequential steps in the process of accessing health care services. The PCHAC framework is employed to explore gender equitable health programs and interventions (Mercer, Lyons, & Bassett, 2019), to identify

the interplay between barriers and enablers to accessing (Vedio, Liu, Lee, & Salway, 2017) and using health care services (Vora, Cottagiri, Saiyed, & Tailor, 2019), to complete an economic evaluation about infectious diseases control efforts in low- and middle- income countries (LMICs) (Vassall, Mangham-Jefferies, Gomez, Pitt, & Foster, 2016), and to study the provision of equitable treatments for chronic health conditions (Carrero, Hecking, Ulasi, Sola, & Thomas, 2017; Hailemariam et al., 2016).

2.2.2 Life Course Theory (LCT)

Life Course Theory (LCT) acknowledges how an individual's lifespan is influenced by their relationships with their networks, life transitions and events, historical and social change, and human agency (Elder, 1994; Elder, Johnson, & Crosnoe, 2003; Hutchison, 2011). The LCT can be applied to explore how health is shaped by biological, cultural, behavioural and social factors that operate independently and accumulatively throughout the lifespan, and across generations (Cheng & Solomon, 2014; Elder, 1994; Elder et al., 2003; Hutchison, 2011; Mishra, Cooper, & Kuh, 2010; Sahoo et al., 2015).

The historical roots of the LCT are found in sociology and social psychology, with contributions from other areas of study such as developmental life span psychology, anthropology, demography, public health, and social history (Elder, 1994; Elder et al., 2003; Hutchison, 2011). LCT emerged as a developmental theory that considered and integrated the potential influences of historical effects (e.g., urbanization, industrialization, migration, and conflict) on individual and family development (Elder et al., 2003). Central themes of the LCT paradigm include 1) "the interplay of human lives and historical times", 2) "the timing of lives", 3) "linked or interdependent lives", and 4) "human agency in choice making" (Elder, 1994, pp.

10-13; Elder et al., 2003). Full descriptions of the central themes of the LCT are contained within Table 2 (Elder, 1994, pp. 10-13; Elder et al., 2003).

The LCT has advantages in comparison to long-established theories of human development (Hutchison, 2011). When studying dynamic societies, LCT is considered an appropriate conceptual framework for culturally sensitive studies as it examines the diversity of life course trajectories and acknowledges the change individuals encounter throughout their lifespan (Haas, Oi, & Zhou, 2017; Tafere, 2015). For example, the LCT enables the exploration of cultures and social institutions and how those elements subsequently inform the mechanisms and patterns of individual and family lives (Garcia, 2009; Park, 2014; Qian & Qian, 2015; Wethington, 2005; Yoo & Kim, 2010).

Also, the LCT assesses the collective advantages and disadvantages individuals encounter throughout the lifespan, thus enabling the exploration of power, agency, and privilege among different cohorts (Hutchison, 2011). For example, the LCT has been employed to study individuals during a specific historical event, aspects of transition in one's life (e.g., motherhood and reproductive health) (Mishra et al., 2010), gender-specific public health interventions (Sahoo et al., 2015), assessing health disparities (Cheng & Solomon, 2014; Pearlin, Schieman, Fazio, & Meersman, 2005), understanding the dynamics of parenthood, and the interactions and relationship development among children and adults (Umberson & Gove, 1989).

Table 2. An overview of the four dominant and interrelated themes in the Life Course Theory (adapted from Elder et al., 2003; Hutchison, 2011).

Central themes from the LCT	Description
Interplay of human lives and historical time	Individuals are "embedded and shaped by the historical times and places they experience over their lifetime" (Elder et al., 2003, p. 12).
Timing of lives	The "developmental antecedents and consequences of life transitions, events, and behavioural patterns vary according to their timing in a person's life" (Elder et al., 2003, p. 12).
Linked or interdependent lives	Human lives are "lived interdependently, and socio-historical influences are expressed through this network of shared relationships" (Elder et al., 2003, p. 13).
Human agency	People create their life course through the "choices and actions they take within the opportunities and constraints of history and social circumstance" (Elder et al., 2003, p. 11).

2.3 Application of the Theoretical Approaches

2.3.1 Application of the PCAHC framework

Within this thesis, the PCAHC framework was applied in three ways: 1) to guide the semi-structured interview questions; 2) to form deductive codes for the codebook; and 3) to organize the final codes and themes.

First, the five dimensions from the PCAHC framework were used to inform the themes of the interview questions and guided the development of the interview guide to develop a series of questions that captured the "pathway" of accessing and delivering health care. The PCAHC framework was suitable as it acknowledges the connections among the health system, structural factors (e.g., social, environmental, and economic), and individual patient-related factors. Thus, the application of the framework was suitable for this study as we collected two data sets to

explore the interactions between the health care providers and patients' perceptions and ability to access health care services.

Second, the PCAHC framework was used to conduct a hybrid inductive and deductive thematic analysis on the primary qualitative data to search for themes and organize data. The five dimensions that specify the five demand- and supply-side components associated with health care access assisted in developing a coding framework and, subsequently, a deductive codebook.

Third, the framework was used to analyze the dataset, describe the participants' experiences of accessing health care services, and structure the results. Data and direct quotations were organized to illustrate the different consecutive phases of seeking and obtaining care.

2.3.2 Application of the LCT

The LCT was utilized to deepen the understanding of health disparities and challenges women may face when accessing health care services in low-resource settings by focusing mainly on how age, interpersonal relationships, and agency may influence their behaviour and decision-making processes (Cheng & Solomon, 2014; Mishra et al., 2010). Within this study, the LCT was applied solely at the data analysis stage 1) to form deductive codes for the codebook; and 2) to organize the final codes and themes.

First, the foundations of the LCT were used to identify and extract the individual factors (e.g., age and gender), distinctive contexts (e.g., social networks), and conditions that influence health care decision making among women in the study. Also, the theory was employed to describe the differences among linked lives, health-seeking behaviours and decisions, and agency among age cohorts and therefore was deemed appropriate to use in the analysis to form

deductive codes. The LCT provided a focus on how social networks and support may be characterized differently among women across various age cohorts, and how these elements subsequently impacted women's health care access and use that the broader PCAHC framework inadequately considered. The authors of the PCHAC suggested that the constructs included within the framework should be considered as interrelated since they can influence each other and operate at different times during the consecutive phases (Levesque et al., 2013). However, the PCHAC does not adequately interrogate the complexity of age (e.g., biological, social, and psychological) and how relationships may influence each phase of health care access and use. Therefore, the LCT was viewed as an appropriate framework to apply to the dataset and explore how social influences, especially, social networks, impact health care access among women.

Second, the LCT was used to identify the final themes that emerged from the data. Data and direct quotations were organized to illustrate the differences in the social relationships among the age cohorts, and how those elements influence the pathway of accessing health care.

2.4 Study Location

Negros Occidental is a province located in the Western Visayas, in the Philippines. It is known as the "Sugarbowl," as it produces more than half the country's sugar output (Department of the Interior and Local Government, 2019). With nearly 2.5 million people, it is the most-populous province of the Western Visayas (Department of the Interior and Local Government, 2019). Negros Occidental generated an income of 2.2 billion Philippine-Pesos (PHP) in 2013, making it one of the wealthiest provinces in the country (Department of the Interior and Local Government, 2019).

Despite the economic growth, poverty reduction remains a challenge. According to the 2015 full-year poverty statistics of the Philippine Statistics Authority (PSA), Negros Occidental had a higher poverty incidence among its population (29.0%) compared to the entire Western Visayas (22.4% of its population) and the national incidence of poverty (21.6%) (Philippine Statistics Authority, 2016b). NGOs are active in this area and offer poverty-alleviation and community development programming initiatives to address barriers to services and resources.

Bacolod City (also referred to as Bacolod) is the capital city of Negros Occidental. It is the most urbanized centre in the province of Negros Occidental with a total of 61 *barangays* (41 urban and 20 sub-urban) and 729 *puroks* (Bacolod City Government, 2018). A *barangay* refers to the smallest political unit in the Philippines. *Barangays* are comprised of *puroks* which are smaller zones that are informally divided and considered as the sub-village level (Matthies, 2017). With a population of more than half a million in 2015, Bacolod makes up approximately one quarter of the total population of the province of Negros Occidental (Bacolod City Government, 2018). Bacolod is highly urbanized with infrastructure and resources to support transportation, sanitation, and power systems (Bacolod City Government, 2018). Despite the availability of resources, facilities and economic opportunities, 22.6% of households in Bacolod have an income below the poverty threshold (Bacolod City Government, 2018).

In terms of health outcomes in this urban setting, a combination of infectious diseases and chronic illnesses are present in Bacolod. According to one report, in 2017, upper respiratory tract infection (URTI) was the leading cause of morbidity, with 2,311 cases. Additionally, dengue H-fever (1,965 cases), tuberculosis (1638 cases), hypertension (1,266 cases), and pneumonia (1,089 cases) are common illnesses in this setting (Lambatin, 2018). In terms of

health care facilities, there is one government hospital, six private hospitals, and 29 *barangay* health stations (BHSs) serving the population in Bacolod (Bacolod City Government, 2018).

2.5 Partnership with International Care Ministries (ICM)

International Care Ministries (ICM) was the collaborating organization for this research, as well as a key target audience for the outcomes of the study. Operational in the Philippines since 1993, ICM works exclusively with ultrapoor households (less than $0.50 USD or 22 Philippine Pesos per person per day) to provide health and livelihood interventions. At the time of data collection, ICM operated across 10 bases in 21 provinces across Central and Southern Philippines (including Negros Occidental, which was the study site for this research). These bases act as hubs of coordination for local operations, as ICM works with approximately 30,000 new households per year through its core strategic 15-week program called 'Transform' that includes health promotion and education (International Care Ministries Foundation Inc, 2020).

ICM was enthusiastic about collaborating with this study as the organization values accountability and desires to continuously improve its interventions. ICM granted institutional support and informed the development of the research tools (questionnaires and semi-structured interview guides). I also worked through ICM's existing networks to recruit study participants. For example, the health care beneficiaries included in this study were current Transform participants (at the time of data collection), and this selection enabled a fairly homogenous group in terms of socioeconomic characteristics. As a result, I was able to explore additional factors that shape this particular group's experiences accessing health care services such as age, gender and social network dynamics. In addition, health care providers were recruited through ICM's

pre-existing connections with individual providers and *barangay* health stations (BHSs) to assess the challenges health professionals and administrators encounter when delivering care.

2.6 Research Ethics Approval

Ethics approval from the University of Waterloo Research Ethics Board (ORE#40797) was approved on April 15, 2019. Please refer to Appendix A for a copy of the research ethics approval.

2.7 Questionnaire and Semi-structured Interview Guides

Prior to the development of data collection tools, I increased my familiarity with ICM's operations and programming by reviewing internal research projects and notes on discussions between Dr. Warren Dodd and the ICM team. Using these resources, the research team (led by Kathy Luu with feedback from Dr. Warren Dodd and Beth Nicholson [research associate]) developed preliminary data collection tools (two brief questionnaires and two semi-structured interview guides) to present to the staff at ICM (including Dr. Lincoln Lau). There were a total of four data collection tools developed for this project: 1) a participant questionnaire that collected a range of individual-level socio-demographic information including, age, educational attainment, occupation, and the presence of acute and chronic illnesses; 2) a health care provider questionnaire that asked similar socio-demographic questions regarding age, educational attainment, occupation, and years of employment; 3) a participant semi-structured interview guide that explored the factors affecting individuals' access and use of health care services; and 4) a health care provider semi-structured interview guide that investigated the challenges health care providers encounter when delivering care to individuals in low resource settings.

Initially, the semi-structured qualitative interview guides were developed by the research team to elicit in-depth information about the relevant determinants that can have an impact on health care access from a diverse perspective through a vignette format. The vignette format was selected to mitigate the feelings of discomfort among the participants by centring the discussion on the experience of accessing and using health care and social services (Gourlay et al., 2014; Hughes & Huby, 2002). However, the vignette format was removed after the consultation with ICM. The vignettes were eliminated due to a concern that the participants may encounter challenges associated with shifting their focus from the fictional characters to their own perspectives and experiences. Revisions were incorporated and the questions were modified to explore the factors that influence participants' perceptions of illnesses, health-seeking behaviours, health care access and use when navigating the health care system, and health care providers' views on the challenges of health care delivery in low-resource settings.

Interview questions were semi-structured, but prompts were offered if an interviewee had trouble answering a particular question. The semi-structured questions provided a framework, but permitted the interviewer the flexibility to probe emerging topics and ask follow- up questions (Cohen, 2007), and enabled participants to share their health care experiences through narratives, descriptions, and explanations (Turner, 2010). The refined tools were piloted on May 3, 2019 with five individuals, and adaptations were made following the pilot phase based on feedback from interviewees and based on participant observation. Please refer to Appendix B for a copy of the participant questionnaire and semi-structured interview guide, and Appendix C for a copy of the health care provider questionnaire and semi-structured interview guide.

2.8 Participants

The target populations for this study were (1) individuals experiencing poverty across seven communities in Negros Occidental (referred to as participants), and (2) health care providers in the region. Participants over the age of 18 were purposively selected due to their location (urban, peri-urban, and rural). Participants were individuals who accessed health care services in the study location. Health care providers over the age of 18 who worked at *barangay* health stations (BHSs), rural health units (RHUs), private or private health care facilities, in Negros Occidental, were invited to participate in the interviews. Please refer to Appendix D for the full details of the inclusion and exclusion criteria.

2.9 Data Collection

In total, 36 participants were interviewed from a total of seven communities (combination of urban, peri-urban and rural) in and around Bacolod City (Iglau-an, Murcia; Humayan/Tubanan, Bago City; Barangay XIII, Victorias City; Carburihan, Estefania; Had. Mimi, Victorias City; San Lorenzo, Talisay; VistaAlegre) between May 3 – May 16, 2019 using face-to-face interviewing with semi-structured questions and translation assistance. An additional 15 health care providers were interviewed in six communities (Vista Alegre; Cabug; Barangay 25; Handomanan; Bago City; Banago) over the same time period. A range of health care providers were interviewed such as *barangay* health workers (BHWs), *barangay* nutrition scholars (BNSs), nurses, midwives, a public clinic physician, a private clinic physician, and a health and environment *barangay* official (elected local leader).

With the assistance from ICM's staff members, participants were selected purposively to allow for a broad cross-section of backgrounds and experiences (Etikan, 2016). To recruit

participants (current Transform participants), the research team attended various Transform programs in and around Bacolod City with the ICM trainer, local pastor, and other staff members. An ICM staff member who has worked for ICM for more than 20 years scheduled our interviews with the health care providers. Her pre-existing relationships with these individuals allowed us to quickly become aquatinted and gain the trust of the participants (Arcury & Quandt, 1999; Clark, 2011; Mulhall, 2003). On average, the research team visited at least two communities every day, and research team members conducted 1-3 semi-structured interviews at each location. The final sample size was reached following a determination of data saturation (Fusch & Ness, 2015). Data saturation was determined through the discussions among the research team, and the team's recognition of similar emerging themes, in other words, "informational redundancy" (Fusch & Ness, 2015; Sandelowski, 1995, pg 181-182; Saunders et al., 2018; Weller et al., 2018).

During each face-to-face interview, a research team member was accompanied by a translator who was trained by the research team members. The questions were delivered in either Ilonggo or English based on the preferred language of the participant. The choice of having a translator present at the interviews to do real-time translation was informed by van Nes, Abma, Jonsson, & Deeg (2010), who suggested using translators in earlier phases of the research study to reduce efforts to refine translations in subsequent stages. In addition, it allowed the research team member and interpreter to co-facilitate the interview to identify and address emergent themes. Informed verbal consent was obtained before each questionnaire and interview as not all participants were fully literate. This process involved each participant receiving a full description of the study and having the opportunity to ask questions. All interviews were audio-recorded with permission from the participants, and lasted 30 minutes to one hour. The participant's

response to each question was audio-recorded and translated in-real time to English by the translator.

To begin data collection, each participant or health care provider was verbally asked a series of socio-demographic questions found in the questionnaire. Following the completion of the questionnaire, a research team member reviewed the data to ensure completeness and clarity of information. At least one research team member was present during the administration of every questionnaire and semi-structured interview to ask follow-up questions, when relevant, and to guarantee quality and consistency across interviews. Finally, all participants were thanked for their time; however, participants were provided with a small grocery bag containing two noodle packets and three cans of sardines. At the end of the interviews, the interpreter and interviewer would summarize the participants' answers to confirm the interview findings. To better understand and interpret the experiences of access and use of health care services shared during each interview, I engaged in debriefing conversations with the research team to discuss the perspectives that transpired at the end of each day of data collection. Afterwards, I manually transcribed all of the interviews with help from Beth Nicholson.

2.10 Data Analysis

2.10.1 Pre-coding activities: quantitative analysis, transcriptions, and interview summary notes

For quantitative analysis, descriptive statistical analyses were performed on the data collected from the questionnaires to report basic demographic information about the participants. The original sample size was n=36 participants and n=15 health care providers. However, after reviewing the data, one participant was removed from the data set due to incomplete

demographic information. The demographic data were imported into QSR NVivo 12 (qualitative data analysis software), and assigned to the corresponding interview transcripts to generate cases and classifications. The cases and classifications made it possible to explore, code, and analyze the narratives of each participant while remaining cognisant of their assigned age cohort (18-30 years old; 31- 45 years old; 46-59 years old; 60 years and older) and other demographic characteristics.

Each interview was reviewed multiple times to increase familiarity with the data prior to coding, and to assess the preliminary themes emerging from the data. As a researcher, the process of familiarizing myself with the data required me to revisit the recordings to remind myself of the data collection process to fully understand the participants' narratives and prepare for coding. The purpose of familiarization with the data was to classify initial common experiences, individual events, and actions as general themes, clues and ideas. This was achieved by reading and listening to the data, highlighting themes, points, keywords, and emphasizing the experiences revealed in each participant's transcript (Fereday & Muir-Cochrane, 2006).

Afterwards, I reviewed the interview guide to understand the questions asked during the data collection process, and the elements from the PCAHC framework and LCT to prepare myself for the development of the code manual for the participant interviews.

2.10.2 Hybrid deductive-inductive thematic analysis process for the participant interviews: Coding

Following familiarization with the interview data (e.g., interview summary notes), the participant data were coded in QSR NVivo 12. An iterative process using theoretical frameworks (PCAHC framework and LCT) and a modified hybrid deductive-inductive thematic analysis was

applied to the data set to identify and explore emerging themes (Fereday & Muir-Cochrane, 2006). The six phases included: (1) creating the code manual, (2) testing the reliability of codes, (3) identifying initial themes, (4) applying deductive codes and adding inductive codes, (5) connecting codes and identifying themes, and (6) validating coded themes (Fereday & Muir-Cochrane, 2006).

This hybrid thematic approach combines polarizing philosophical standpoints (positivism and interpretivism), which allowed for the identification of key themes determined by the literature and themes cultivated by participants' experiences that answered the research questions from the semi-structured interview guides (Fereday & Muir-Cochrane, 2006). More specifically, deductive coding requires the selection of appropriate theoretical approaches that will allow the careful examination of the dataset (Fereday & Muir-Cochrane, 2006; Horsfall, Byrne-Armstrong, & Higgs, 2001). On the other hand, inductive coding preserves the participant's subjective perspectives and reflections (Fereday & Muir-Cochrane, 2006; Horsfall, Byrne-Armstrong, & Higgs, 2001). The hybrid approach demonstrates the formation of the overarching themes drawn from both literature informed codes and data-driven codes (Fereday & Muir-Cochrane, 2006).

2.10.2.1 Stage 1: Creating the code book

The code manual was created as a data management tool to identify and organize sections of similar texts to allow the ease of interpretation (Crabtree & Miller, 1992; Fereday & Muir-Cochrane, 2006). This systematic method contributes to the rigour of the study and data collected (Crabtree & Miller, 1992; Fereday & Muir-Cochrane, 2006). The preliminary manual was generated and informed by the research questions, interview guide, and elements from PCAHC framework. The five "access" elements were identified as five broad code categories

(approachability, acceptability, availability and accommodation, affordability, and appropriateness), and subsequently, collapsed and grouped into three code categories (pre-departure, health care utilization, post-care health outcomes). Please refer to Appendix E for a visual representation of the factors participants indicated that could act at various stages of the health care pathway. The reasoning behind this decision was solidified by the interview guide, as the guide detailed three specific stages to the health care pathway. After the discussions among the research team and ICM, to minimize confusion and overlapping questions, three phases of accessing health care services were derived. As well, the nature of the semi-structured interviews, and interview guide questions confirmed the appropriateness to use these three stages to conceptualize access to health care services for this study. Social support, capital, and gender were included within the PCAHC framework, but these elements were further analyzed using the LCT categories.

Fereday & Muir-Cochrane (2006) applied and referenced to the approach Boyatzis (1998) proposed to write their codes, and I used the identical approach. I identified by (1) the code name, (2) the definition of the theme, and (3) a description of when to apply the code and how to recognize the theme (Fereday & Muir-Cochrane, 2006). Afterwards, I developed the codes using the PCAHC framework, three elements from the LCT (timing of lives, linked lives, agency), and they were applied as broad code categories to offer an additional perspective to understand the complexities of age, gender, and social relationships and capital, and how these elements may influence health care access. The codes relating to the LCT are found in Appendix F.

2.10.2.2 Stage 2: Testing the codes

To perform the appraisal of the code manual, I scanned participant interviews and applied the predefined codes generated from the PCAHC framework (Fereday & Muir-Cochrane, 2006). Afterwards, I presented my predefined codes with corresponding quotations for review, feedback, and approval by thesis committee members (Drs. Warren Dodd and Jennifer Liu). This review and approval step was completed prior to subsequent coding, interpretation of the data and in-depth analysis of the data to maximise rigour and reliability (Fereday & Muir-Cochrane, 2006). Subsequently, I tested the reliability of the codes developed from the application of the LCT and completed the all the steps listed above. Throughout this process, I reviewed the data, theory-driven codes, and the code book on multiple occasions through regular meetings with my supervisor (Dr. Warren Dodd) to ensure agreement of the formation and reliability of the codes before subsequent coding, interpretation of the data, and in-depth analysis.

2.10.2.3 Stage 3: Identifying initial themes

To summarize the data and form initial themes, I read and listened to the raw interview data recordings to analyze patterns, and record and summarize collective sentiments from all age cohorts in a chart (Fereday & Muir-Cochrane, 2006). Disagreements and narrative conflicts were noted separately in a document to acknowledge the complexity of the participants' experiences accessing health care services. Afterwards, the identical technique was applied to each of the four age cohorts (18-30 years old; 31-45 years old; 46-59 years old; 60 years and older) to explore the experiences of accessing health care within each group. The most prevalent sentiments were recorded in a chart. The completed table had the four age cohorts with a

corresponding list of perspectives from each about the cohort's experiences accessing health care in their community.

2.10.2.4 Stage 4: Applying deductive codes and adding inductive codes

Using the template analytic technique, the deductive codes from the codebook were employed to the text to identify and classify segments of the data (Crabtree & Miller, 1992; Fereday & Muir-Cochrane, 2006). The deductive codes from the codebook were entered as nodes in QSR NVivo 12. During the coding process, the data were not restricted by the preliminary deductive codes, which permitted the identification of data-driven codes (Fereday & Muir-Cochrane, 2006). Inductive codes were classified and assigned to segments of data that illustrated themes that emerged from the text, and the node was organized separately from the deductive codes (Boyatzis, 1998; Fereday & Muir-Cochrane, 2006).

2.10.2.5 Stage 5: Connecting the codes and identifying themes

The codes assigned to the four sets of data (four age cohorts) were clustered under each heading that was directly associated with the theoretical frameworks (PCHAC framework and LCT). At this stage, the similarities and differences between separate groups of data were emerging and prevalent homogeneous experiences were noted. These patterns of agreement and conflicts among the age groups demonstrated that some experiences were common across cohorts, and some were isolated incidents (Crabtree & Miller, 1992; Fereday & Muir-Cochrane, 2006).

2.10.2.6 Stage 6: Validating coded themes

When interpreting data, it is usual to contrive evidence (Crabtree & Miller, 1992; Fereday & Muir-Cochrane, 2006); thus, interpretation required careful examination of the previous steps to ensure that the themes were representative of the initial data analysis. I shared several iterations of text, codes, and themes with Dr. Warren Dodd before subsequent interpretation, in-depth analysis, and finally, a framework that displayed the elements that emerged from the data. Three core themes were identified that explained the phenomenon of health care access among participants in this setting.

2.10.3 Inductive thematic analysis process for the health care provider interviews

For the health care providers data set, an inductive thematic approach from Boyatzis (1998) was employed to analyze the common sentiments expressed by the health care providers. An open coding method was applied to inductively identify initial categories. There was a diverse range of health care providers in the sample (n=15), and this inductive approach permitted flexibility to account for this diversity (Nowell, Norris, White, & Moules, 2017).

The transcripts were uploaded to QSR NVivo 12 and each interview was reviewed multiple times to increase familiarity with the data prior to coding, and to assess the preliminary themes emerging from the data. Afterwards, the coding process involved identifying rich text and assigning preliminary codes to the data to describe the content before interpretation (Boyatzis, 1998). The codes for the health care providers data set are found in Appendix G. Once the data were coded, the nodes were analyzed and organized to identify patterns in the information that illustrated the observations about health care providers' experiences of delivering care in low-resource setting to formulate themes. Throughout this process, I reviewed

the data with Dr. Warren Dodd on multiple occasions to ensure agreement concerning the formation of the themes. Three sub themes were identified and collapsed into one overarching theme that described how health care providers perceived access barriers, experienced challenges in providing services, and responded to patient needs.

CHAPTER 3: The interaction between gender and social networks: A qualitative study investigating health service access and use among women in Negros Occidental, Philippines

3.1 Introduction

Social networks, and the social cohesion, support, and capital that emerge from these networks, are important structural and intermediate determinants of health (Solar & Irwin, 2010). In low- and middle-income countries (LMICs), these concepts are used to examine both facilitators and barriers to health care access as they are integral to information sharing about health and building financial and social resources, which may, in turn, enhance the ability of individuals to maintain healthy behaviours, promote positive health-related decisions, and access health care (Agampodi et al., 2015; Fadlallah et al., 2018; Hou et al., 2017; Kawachi et al., 2008; Ng & Eriksson, 2015; Paasche-Orlow & Wolf, 2007; Perkins et al., 2015; Sun et al., 2018). Social networks have been hypothesized to be particularly beneficial for women in low resource settings to facilitate health care access, as gender inequalities and gender-related norms can amplify access barriers (World Health Organization, 2019a).

Women have distinct health needs during their lifetime that require specialized care (e.g., sexual and reproductive health, maternal care) (Mariani et al., 2017; Puchalski Ritchie et al., 2016; World Health Organization, 2019a). For women experiencing poverty in LMICs, expenses associated with specialized care may place women in a vulnerable position to accumulate greater health care costs, which can contribute to catastrophic health spending (Njagi, Arsenijevic, & Groot, 2018; Van Hees et al., 2019). Geography can also influence the availability of health care facilities and providers in some contexts, with women disproportionately impacted by these supply-side constraints (Dayrit et al., 2018; Johri et al., 2015; World Health Organization, 2019a). Additionally, cultural and religious beliefs may restrict participation in sexual,

reproductive, and maternal health care services among some women (McCauley, Abigail, Bernice, & Van Den Broek, 2019; Moreira, Ewerling, Barros, & Silveira, 2019; Panday, Bissell, Teijlingen, & Simkhada, 2019).

The Philippines has one of the fastest-growing economies in the South-East Asia (SEA) region (OECD, 2018). Despite this national economic growth, income inequality is higher in the Philippines than in most SEA emerging economies (World Bank, 2019b), with close to 25% of the population living under the poverty line (Philippine Statistics Authority, 2016c). In this context, Filipina women who experience poverty continue to endure economic hardships and adverse health outcomes (Philippine Statistics Authority & ICF, 2018; Rutkowski, 2015). Non-communicable diseases (e.g., cancer and ischaemic heart disease) are the leading cause of death among Filipina women (Cudis, 2019). Additionally, the Philippines has one of the highest maternal mortality (MMRs) rates in the Association of Southeast Asian Nations region with 221 deaths per 100,000 live births in 2015 (ASEAN, 2017).

According to the 2017 Philippines National Demographic and Health Survey (NDHS), women experiencing poverty frequently reported difficulty accessing health care, with young women (15-19 years old) reporting greater challenges with accessing care relative to other age cohorts (Philippine Statistics Authority & ICF, 2018). Delays in seeking care, limited transportation to reach health care facilities, and a lack of high quality and appropriate services at health facilities are all cited as critical barriers to health care access among Filipina women (Dayrit et al., 2018). In addition, financial barriers remain a persistent challenge among Filipina women, as 45% of the women from the 2017 Philippines NDHS reported difficulties securing money for medical treatment (Philippine Statistics Authority & ICF, 2018). Critically, underlying inequalities and gender norms may exacerbate barriers to health care access among

women who hold caregiving roles within their households (Philippine Statistics Authority, 2018a; Varona et al., 2007). Indeed, health care access among women in the Philippines may be dependent on both individual- and structural-level factors that influence their perception of risk, availability of services, and how their engagement with health care services will impact their social networks.

Psychosocial resources, including trust among family members and relatives, can promote positive health-seeking behaviour and access to health care services. For example, a study with data from the Visayas and Mindanao, Philippines explored associations between social trust within an active case finding program for tuberculosis (TB). The study found that each unit increase of trust in relatives and family satisfaction among individuals suspected of TB infection was associated with an increased odds of these individuals attending a Rural Health Unit (RHU) to obtain testing for TB (Lau, Hung, et al., 2020)[1]. Similarly, another study found that Filipina women who concurrently experienced poverty and TB were encouraged by their family members and neighbours to seek care, with some neighbours willing to provide childcare and nutritional support (Hu et al., 2012). Overall, these studies point to the importance of social networks in facilitating health care access among women experiencing poverty in the Philippines. However, further in-depth research that prioritizes the lived experiences of Filipina women is needed to better understand the strength, quality, and reliability of these social network among women at different life stages.

In February 2019, the Universal Health Coverage (UHC) Bill was signed into law in the Philippines to enroll all citizens into the national health insurance program (PhilHealth) (World

[1] Rural health units (RHUs) provide primary health care for rural communities in the Philippines, and each RHU is responsible for multiple *barangay* health stations (BHSs) that deliver services to catchment areas (Dayrit et al., 2018; Department of Health, 2012a).

Health Organization, 2019b). The UHC Bill in the Philippines builds on decades of health system reforms aimed at the provision of health care services to populations experiencing poverty and marginalization. Within this new health policy landscape, it is important to understand how Filipina women experiencing poverty experience and navigate health care challenges for themselves and their families. Thus, the objectives of this qualitative research study were 1) to describe health care access and use among Filipina women experiencing poverty; 2) to understand the role that social networks may play in accessing the health care services among women; and 3) to investigate the experiences of health care providers in delivering care to populations encountering poverty in Negros Occidental, Philippines.

3.2 Methods

3.2.1 Theoretical frameworks: Patient Centred Access to Health Care and Life Course Theory

This qualitative study was guided by two theoretical frameworks: the Patient Centred Access to Health Care (PCAHC) framework and Life Course Theory (LCT). The PCAHC framework considers how multilevel perspectives influence the determinants of the supply, demand, and access to health care (Levesque et al., 2013). Levesque, Harries, & Russell (2013) included five dimensions of health care accessibility: approachability, acceptability, availability and accommodation, affordability, and appropriateness (Levesque et al., 2013; Penchansky & Thomas, 1981; Peters et al., 2008). In this study, the PCAHC framework was used to inform the semi-structured interview questions (data collection), in addition to deductive codes and themes (data analysis). The LCT acknowledges that lifespans are influenced by relationships, life transitions, social change, and human agency (Elder, 1994; Elder et al., 2003; Hutchison, 2011). In this study, LCT was utilized in the data analysis phase to deepen our understanding of health

disparities and challenges experienced by women when accessing health care services. This application of LCT was completed by primarily focusing on how chronological age and relationships impacted the health-seeking behaviour and decision-making processes of participants (Cheng & Solomon, 2014; Mishra et al., 2010; Sahoo et al., 2015).

3.2.2 Study area

This study was conducted in and around Bacolod City, which is the capital city of the province of Negros Occidental, Philippines. In total, data was collected is seven *barangays* inclusive of urban, peri-urban, and rural settings. Despite its high level of urbanization, availability of public services, and economic opportunities, 22.6% of households in Bacolod City have an income below the country's poverty threshold (Bacolod City Government, 2018). In terms of health care facilities, there are 29 *Barangay* Health Stations (BHSs), one government hospital, and six private hospitals serving the population in Bacolod City (Bacolod City Government, 2018) [2].

3.2.3 Partnership

International Care Ministries (ICM) was the collaborating Philippine-based non-governmental organization (NGO) for this research study. ICM works with ultrapoor households (defined by the organization as a household with less than $0.50 USD or 22 Philippine Pesos per person per day) to provide health and livelihood interventions. At the time of data collection, ICM operated across 10 bases in 21 provinces across the Visayas and Mindanao, Philippines

[2] A *barangay* refers to the smallest political unit in the Philippines. *Barangay*s are comprised of puroks which are smaller zones that are informally divided and considered as the sub-village level (Matthies, 2017).

(including Negros Occidental). ICM's core strategic program is called Transform, which is a 15-week community-based curriculum that includes livelihood support and health promotion (International Care Ministries Foundation Inc, 2019). Each Transform program recruits 30 individuals at a time, with ICM reaching over 30,000 individuals annually. ICM granted institutional support for this project, informed the development of data collection tools, and guided participant recruitment.

3.2.4 Study participants and participant recruitment

Participants and health care providers were the target populations for this study. Participants were purposively selected due to their location (in and around Bacolod City), and participation in ICM programing (Transform), which provided a fairly homogenous group in terms of socioeconomic characteristics. Participants were over the age of 18 years old, current Transform participants, and accessed and used health services in the region. Health care providers were individuals who worked at BHSs (public), RHUs (public), or private health care facilities in and around Bacolod City. These health care providers often worked in the same settings where participants resided.

3.2.5 Data collection

Four data collection tools were developed for this project: 1) a participant questionnaire; 2) a health care provider questionnaire; 3) a participant semi-structured interview guide that explored experiences of accessing and using health care services; and 4) a health care provider semi-structured interview guide that investigated the challenges health care providers

encountered when delivering care to individuals experiencing poverty. Questionnaires and interviews were conducted in either Ilonggo or English based on the preferred language of the participant, with data collection co-facilitated by a member of the research team and a trained translator. The choice of having real-time translation was made to reduce the need to refine translations in subsequent stages of the study (van Nes et al., 2010). All interviews were audio recorded and lasted between 30 minutes and one hour.

3.2.6 Data analysis

For quantitative data collected through the questionnaires, descriptive statistical analysis was performed to report basic demographic information on the health care beneficiaries and providers.

For qualitative data, audio files were transcribed, with non-English portions of interviews translated prior to analysis. To facilitate qualitative analysis, participants were divided into four cohorts based on age (18-30 years; 31- 45 years; 46-59 years; 60 years and older). Demographic data were imported into QSR NVivo 12 (qualitative data analysis software) and assigned to the corresponding interview transcript to the generate cases and classifications. This process was completed to analyze the narratives of participants while remaining aware of each participant's assigned age cohort and other demographic characteristics.

An iterative process using the PCAHC framework, LTC, and a modified hybrid deductive-inductive thematic analysis was applied to the health care beneficiary data to identify and explore themes (Fereday & Muir-Cochrane, 2006). The first round of coding was informed by the research objectives, the interview guide, and elements from the PCAHC framework. During this initial round of coding, inductive codes were identified, classified, and assigned to

segments of data that illustrated emergent themes (Boyatzis, 1998; Fereday & Muir-Cochrane, 2006). The second round of coding acquired three elements (timing of lives, linked or interdependent lives, and human agency) from the LCT to explore how age, gender, social networks, and agency influenced health care access among participants (Elder, 1994; Elder et al., 2003; Hutchison, 2011). Then, the connections among the inductive and deductive codes were identified and arranged into themes (Crabtree & Miller, 1992).

For the health care provider interviews, an inductive thematic approach from Boyatzis (1998) was employed to analyze the sentiments expressed by the participants. With the diversity of roles held by health care providers included in the study (e.g., physicians, midwives, *barangay* health workers), the inductive approach permitted flexibility to account for this diversity (Nowell et al., 2017).

3.2.7 Ethical considerations

This study was approved by the Research Ethics Board at the University of Waterloo (ORE#40797). Prior to data collection, a description of the study was provided to all participants and written or oral informed consent was obtained. As some participants had low literacy levels, the option of oral informed consent was provided to participants in line with our ethics clearance from the University of Waterloo.

3.3 Results

3.3.1 Overview of demographic background of participants

Overall, 35 female participants (age range: 18-75 years) were interviewed from seven *barangays* in and around Bacolod, Negros Occidental. Across the four age cohorts, 10 women were in the youngest cohort (18-30 years), 11 women were in the second youngest cohort (31-45 years), 9 women were in the second oldest cohort (46-59 years), and 5 women were in the oldest cohort (60 years and older).

Twenty-four participants (68.6%) reported that they were PhilHealth beneficiaries. The majority of these participants were married (85.7%), did not work outside their household (60.0%), and had achieved a secondary school education (60.0%) (see Table 3). In terms of differences between age cohorts, women from the youngest age cohort (18-30 years) were less likely to be enrolled in the *Pantawid Pamilyang Pilipino Program* (4Ps; a national conditional cash transfer program) compared to the other three older age cohorts. Women from the youngest age cohort also had attained a higher level of education (often secondary school of college-level education) and had smaller household sizes compared to women in the other three older age cohorts.

In total, 15 health care providers from seven *barangays* were also interviewed. The participants included *barangay* health workers (BHWs) (n=5), *barangay* nutrition scholars (BNSs) (n=2), midwives (n=4), physicians (n=2), a nurse (n=1), and a *barangay* health official (n=1).

Table 3. Demographic characteristics of participants in Negros Occidental, Philippines (n=35)

Characteristics		**Overall (%)**
PhilHealth status	Beneficiary	24 (68.6%)
	Non-beneficiary	9 (25.8%)
	Missing	2 (5.7%)
4Ps status[a]	Beneficiary	13 (37.1%)
	Non-beneficiary	22 (62.9%)
Occupation	At home	21 (60.0%)
	Farm labourer	5 (14.3%)
	Other	9 (25.7%)
Educational attainment	No school	1 (2.9%)
	Primary school	12 (34.3%)
	Secondary school	21 (60.0%)
	College or vocational school	1 (2.9%)
Marital status	Married	30 (85.7%)
	Common law	1 (2.9%)
	Widow	2 (5.7%)
	Single	2 (5.7%)
Household members	0-5	16 (45.7%)
	6-10	17 (48.6%)
	11-15	2 (5.7%)

[a]4Ps = *Pantawid Pamilyang Pilipino Program*.

3.3.2 Characterizing pre-departure access factors

Overall, participants reported that their main source of health information came from family members, neighbours, and BHWs serving the local BHS. In particular, BHWs were often responsible for connecting individuals to available health services and providing information through their community outreach work.

When confronted with minor symptoms such as fever, cough, body pains, or headache, all women reported they did not seek care at a health facility, but rather purchased over-the-counter medication from a sari-sari store (i.e., corner store) or sought remedies from traditional healers (e.g., *helots*). A woman from the oldest cohort (60 years and older) explained that individuals in her community were reluctant to seek care at health facilities due to a lack of financial resources. She explained, "if you are feeling bad that's when you rush to the hospital but unless it's…bad then you don't have to go to the hospital because you don't have money." Additionally, several women indicated that over-the-counter medicines and traditional care were more affordable and convenient. More specifically, their geographic proximity to and trusting relationships with traditional healers relative to public health care providers facilitated care seeking from traditional healers.

Women used public and private health care facilities for more serious acute, chronic, and emergency health concerns. Public health care facilities were mainly used when participants perceived that the health concern could not be treated by over-the-counter medication and required medical attention, but lacked financial resources to access private care. A woman from the oldest age cohort (60 years and older) recounted an experience when one of her granddaughters was sick and explained, "if we have the money, we would prefer to go to a private doctor…because we are poor…then we just have the public." In contrast, women

gravitated towards accessing care at private clinics and hospitals if they perceived their health concern to be an emergency (e.g., tuberculosis, chest pains, fainting) and they had sufficient financial resources. Private health was preferred by some women due to the perception that private care was more efficient and higher quality than public health care. For example, a participant from the youngest age cohort (18 – 30 years) explained that for her goiter, "I prefer private [care] because I [get] checked thoroughly...and I have not been checked thoroughly in the public [health facility]."

Younger women commonly reported experiences of seeking prenatal care or antenatal care or care for their children at both public and private facilities. In recounting experiences of seeking care for their children, some younger women described instances where they delayed care for themselves in order to prioritize the health of their child. As one woman from the youngest age cohort (18 -30 years) explained:

> "I have [previously] been to a check-up [for my toxic goiter], but when I got pregnant with my youngest [child] I haven't been able to have a checkup…Two years ago [was] when I had my last check-up [for the goiter] but I have [more recently] gone to the [nearest BHS] for vaccines for the youngest [child]."

In contrast, older women frequently reported age-related health issues and more commonly described experiences of seeking care for themselves.

Transportation was a consistent barrier to accessing health care at both public and private health care facilities, especially for women who lived in rural and peri-urban *barangays*. For example, one woman from the second youngest cohort (31-45 years) stated, "it is hard to find

transportation …there's actually [a] scheduled tricycle so after 9:00 [in the morning] there are no more tricycles to serve you so you need to wait for 2:00 [in the afternoon]." Transportation costs were also a challenge for most participants, and these costs prevented some women from reaching health care facilities. In addition to these challenges, some participants, especially younger mothers, reported that they had trouble finding childcare support when they needed to access a health care facility. If women could not find childcare support, their children often accompanied them to the health care facility, meaning that these women incurred higher transportation costs.

Some women reported that they had assistance from their social networks (e.g., family members, community members, or employers), to cover transportation costs, to provide childcare support, and to provide other non-financial supports when they experienced a health problem. Young women reported smaller perceived social networks, as most stated that they only had financial support from their parents or employers. As indicated above, women from the youngest age cohort were less likely to be enrolled in social protection programs (e.g., 4Ps) that could provide additional financial resources in the case of a health problem. In contrast, some women from the second oldest cohort (age 46 – 59 years) had their older children offer to pay for transportation costs. For example, when one participant from the second oldest cohort (age 46 – 59 years) was asked who she could reach out to if she required assistance for a health problem, she stated "when I need help, I usually go first to my relatives and family within the community…my children gave me money and food and fruits as well." Overall, older women reported a wider range of social connections compared to younger women, and more frequently mentioned their family members, communities, and social service agencies as sources of support to facilitate health care access.

3.3.3 Identifying health care utilization factors

RHUs and public hospitals were the most commonly utilized health facilities among participants and their families. Most women described quality issues at public health care facilities which included lengthy wait times and a shortage of available staff and resources. The anticipated long wait times prompted some women and their partners to take time off of work to claim an early spot in the queue. However, the experience of lengthy wait times was not shared among all women, as one participant over the age of 60 explained that she was prioritized at a RHU due to her senior status. In addition, a few women reported a shortage of health care staff and medical resources at some facilities, which negatively impacted their experience of health care utilization and resulted in them having to seek medical care elsewhere. These experiences prevented women from receiving timely care for themselves and their family members.

Despite these quality concerns, some health care beneficiary participants reported that their interactions with health care providers at public health care facilities were generally positive. However, other participants felt neglected and shared experiences of discrimination due to their socioeconomic status at public health care facilities. For example, one woman from the second oldest age cohort (age 46 – 59 years) expressed, “if you are very poor, poorest of the poor in the public you do not get attention… so I like private if I have money.” Thus, the quality concerns with public facilities and poor experiences with public health care providers caused some individuals to favour private health care options, which subsequently increased their health care costs. Women who utilized private health care facilities reported faster assistance from the staff, attentive health care providers, and the availability of medications.

For participants with PhilHealth coverage, these women mentioned that they used PhilHealth to settle all or a portion of their health care costs at public health care facilities.

Different participants described different scenarios whereby they were able to use PhilHealth to cover a portion of their public hospital stay, consultation with a physician, or the diagnostic tests that the physician ordered. However, the usage of PhilHealth appeared to be inconsistent among some participants who expressed uncertainty around what precisely was covered by the insurance under different circumstances. In addition, some women highlighted experiencing unexpected indirect costs such as the cost of food at the health facility during multi-day stays.

Following a preliminary diagnosis for a health problem, participants were often provided with a prescription for medication in addition to requisitions for further diagnostic tests (e.g., blood work, medical imaging, etc.). Despite a few participants explaining that medications and diagnostic tests for certain health problems were covered by PhilHealth, some of the participants indicated that they had to pay out-of-pocket to fill prescriptions or for further diagnostic tests. In these cases, many participants opted to fill the prescription and forgo diagnostic tests because filling the prescription was the more affordable option. However, one woman in the second youngest age cohort (age 31-45 years) shared an experience where she could not afford to obtain a biopsy for her cyst. Consequently, health care providers could not determine her diagnosis, and the woman explained, “they did not prescribe any medicine for me to take because they do not know.” Additionally, some women stressed that they could not afford the medication they were prescribed.

When PhilHealth coverage was insufficient, not accepted, or nonexistent, participants often approached their family members for financial support. Women in the youngest cohort (18 – 30 years) only reported reaching out to their relatives (e.g., parents and siblings) for financial support to cover health care expenses including laboratory tests, diagnostic imagining, and medication. A few women in the youngest age cohort were reluctant to borrow money from their

families as they did not want to appear to be a burden to their families. Consequently, these women often incurred loans or were required to save up money for anticipated health care expenses. In contrast, women in the other three age cohorts frequently received financial support from their family members, with some women explaining that they were not required to repay loans provided by family members. Some older women (46-59 years old; 60 years and older) also reported receiving remittances from their adult children who had migrated for work either within Negros Occidental or elsewhere in the Philippines.

In addition, most older women (46-59 years old; 60 years and older) were able to leverage their connections with local politicians and governmental agencies (e.g., Department Social Welfare and Development) to subsidize their health care costs. For example, several participants mentioned requesting financial assistance from municipal leaders when they experienced a large or emergency health expense. The older women (ages 46 – 59 years; 60 years and older) who had access to this financial support reported that they were able to seek appropriate treatment, adhere to treatment, and attend follow-up appointments. These women also explained that their existing social networks (e.g., family members, neighbours) were critical in informing them about these sources of financial support.

3.3.4 Characterizing post-care health outcomes

As previously mentioned, outstanding medical bills were a consistent concern raised in interviews among participants both with and without PhilHealth coverage. In particular, the ongoing burden of loans from health care expenses was highlighted among women in the youngest age cohort as a key consequence of health care access and use. Loans profoundly impacted the ability of these women to purchase basic necessities. As a consequence, many of

these women explained that they relied on food donations from family members or loans from the local sari-sari store to meet the food needs of their families.

A few women explained that if potential health emergencies arose, members within their social networks would be willing to provide financial assistance and food. Building a sense of reciprocity within social networks was mentioned as an important element to enhance the confidence among participants that they would be well-supported in case of a health emergency. For example, one participant from the second oldest age group (46 – 59 years) described her bond with her social network by explaining, “the feeling is mutual if they need something, if they have they can extend help, and for their family as well if I have something or anything and they need help I can extend the same.” Indeed, this assurance of reciprocity in the case of a health emergency was a source of security for some participants.

3.3.5 The role of health care providers in facilitating health care access and use

Among the health care providers interviewed, most providers recognized that indirect costs (e.g., transportation costs) and the geographic distance to health facilities discouraged individuals experiencing poverty from seeking care. Health care providers also mentioned that a lack of stable work or precarious employment (e.g., sugar cane farming), in addition to a lack of childcare, might create barriers to accessing health care. As one physician explained, “they will not come if they are too busy earning their money... I will ask them how come they [wait] this long to come to see the doctor and [they say] 'I have no money'.” Due to these indirect and opportunity costs, several health care providers acknowledged that patients would often seek out traditional health care or over-the-counter medications instead of accessing care at a formal health care facility.

In terms of direct health care costs, several health care providers explained that they ensured their patients were aware of government agencies and programs that could reduce or eliminate health care expenses. Some health care providers, especially private physicians, mentioned that they would also partner with local non-governmental organizations to provide free care to individuals experiencing poverty.

Community outreach work was primarily conducted by BHWs to assess the health of community members (e.g., prenatal care, child malnutrition care, and TB care), to provide health education, and to encourage community members to access local public health facilities. In some cases, BHWs reported paying out-of-pocket to cover transportation costs to health facilities for some community members experiencing poverty. However, BHWs also described the resource constraints (e.g., medications) they faced at their facilities and how this contributed to an inability to accommodate all patient needs. In addition, some BHWs also commented on how demand for health services was high and that they needed to work overtime and on weekends to meet patient demand.

3.4 Discussion

Many UHC policies eliminate financial barriers such as user fees and direct health care costs at the point of service (Quick, Jay, & Langer, 2014). Indeed, removing these direct costs can reduce financial barriers and encourage health care access and use; however, an exclusive focus on direct costs does not capture the other indirect costs individual may incur, such as transportation to the health facilities, costs associated with long-term illnesses, and opportunity costs (Saksena, Hsu, & Evans, 2014). Participants in this study expressed that incurring indirect costs, such transportation was a key barrier to reaching health care facilities. Furthermore, our

findings can offer a deeper understanding of why PhilHealth coverage and usage may differ across contexts. More specifically, a recent study found that women with PhilHealth coverage from rural communities would only access health care facilities to give birth, but not for other health problems, demonstrating that the elimination of direct health care costs does not automatically translate into improved health care access and use (El Omari & Karasneh, 2020). Similarly, our study showed that indirect health care costs were a significant barrier to accessing health care among participants with and without PhilHealth coverage.

In our study, a lack of financial resources often postponed health care access and use among participants, with younger women more likely to delay care than older women. This finding aligns with a study conducted in Mexico City that found that younger women of a low socioeconomic status who lived outside of Mexico City were most likely to delay care for breast cancer (Unger-Saldaña, Ventosa-Santaulària, Miranda, & Verduzco-Bustos, 2018). Similarly, our study demonstrated that gender could intersect with socioeconomic status and geography to prevent women from accessing timely care. Moreover, in our study, younger women reported they delayed seeking health care services as they prioritized their children's health, had caregiving responsibilities, and had difficulties finding childcare. Indeed, with caregiving responsibilities, a woman may be reluctant to be perceived as a financial burden to her family when health problems arise (Yamashita et al., 2014, 2015). This finding aligns with a qualitative study conducted in urban regions in Manila and Rizal, Philippines, that investigated the risk perception toward breast cancer and the corresponding health seeking-behaviour among women. Researchers found that some women avoided accessing and using clinical breast examinations due to a lack of financial resources and caregiving responsibilities (Lagarde et al., 2019). Overall, our results confirm that in the setting where our study was conducted, gender can

intersect with other individual and structural level factors to produce and amplify barriers to health care access and use among women experiencing poverty.

Access to quality health care services depends on the availability of health care providers, resources and infrastructure. In our study, appointment delays, lengthy wait times, and a shortage of health care providers were reported to be challenges participants encountered when using public facilities. In particular, long waiting times are considered to be an indicator of poorly distributed staff and equipment, as the demand of these services override the supply that is available (Jacobs et al., 2016). Importantly, in the setting where our study was conducted, the perception of poor quality public health care acted as a deterrent to public health care access and use, further exacerbating existing health care access barriers among women experiencing poverty.

We found that social networks may alleviate some of the barriers to accessing and using health care among women experiencing poverty in the context where this study was conducted. This finding is consistent with literature exploring the connection between social networks and health. A systematic review examining the relationship between social networks and health in LMICs found that network composition, individual network centrality, and network structure were associated with essential health behaviours (e.g., intervention use, and perception of health information and risk) and contribute to positive health and development outcomes (Perkins et al., 2015). Furthermore, social support can alleviate barriers to health care access and use. Results from a qualitative study conducted in Kenya reported that women often drew on their social networks when challenges or constraints impeded health treatment-seeking pathways for their children (Zakayo et al., 2020). Conversely, a lack of social support can result in delays in seeking health care. A study conducted in Uganda found that women that had no social support from

their spouses and family members were more likely to delay their care for breast cancer (Odongo, Makumbi, Kalungi, & Galukande, 2015). Similarly, participants in our study reported a lack of childcare support or financial support from their relatives and neighbours contributed to delays in seeking health care services.

In addition, our results provided some insights into how age and gender may interact with social networks to influence experiences accessing health care services among women experiencing poverty in the context where this study was conducted. In particular, due to the need for antenatal care and to address age-related health concerns, women in the youngest and oldest age cohorts were found to be more vulnerable to out-of-pocket health care expenditures and expected higher costs when accessing health care services. However, our study also demonstrated that older individuals had more support than younger individuals, which aligns with other literature that has explored the relationship between age and the quality of social networks. For example, a study conducted in Davao City, Philippines, found that elderly individuals were frequently well-supported by their female adult-child caregivers (Varona et al., 2007). Overall, these findings illustrate that life stage should be considered when assessing the size and strength of social networks among women experiencing poverty in the Philippines.

3.4.1 Limitations

Two limitations of the study should be noted. First, the LCT is most commonly used to conduct longitudinal studies to investigate the impact of historical, social, and biological age throughout the lifespan (Elder, 1994; Elder et al., 2003; Hutchison, 2011). Since there were limited examples of qualitive studies that have used the LCT in this context, there was a lack of consensus in adapting this theory for qualitative research that was conducted at one point in time.

As a result, we took an adapted approach that borrowed elements from the LCT to complete our hybrid thematic analysis for the participant data set. Second, due to the homogenous nature of participants and their involvement with programming offered by ICM, these participants were not necessarily representative of the broader income-poor population in the study context who may not have access to programs provided by NGOs or other civil society organizations.

3.5 Conclusion

In the context of recent UHC legislation in the Philippines, this study explored health care access and use among Filipina women experiencing poverty in and around Bacolod City, in addition to the experiences of health care providers providing care in this setting. We found that although existing health reforms in the Philippines (i.e., PhilHealth) have attempted to alleviate the financial burden at the point of care for individuals experiencing poverty, women relied on their social networks for financial support when health insurance coverage did not adequately address the direct and indirect costs along the healthcare access pathway (i.e., pre-departure, health care utilization, post-care). In addition, these findings demonstrated the importance of social networks in mitigating the social and financial burdens associated with accessing health care services among women at different life stages in this context. These findings suggest that supporting and strengthening social networks among women experiencing poverty can complement existing efforts to implement UHC in the Philippines.

CHAPTER 4: CONCLUSION

4.1 Research Contributions

4.1.1 Summary of key findings

Despite the existence of health financing reforms that target individuals experiencing poverty in the Philippines, this study contributes to the academic literature by providing evidence about persistent financial, social and cultural, organizational, and structural barriers Filipina women commonly encounter when accessing and using health services. Financial resources were considered one of the most important determinants of access and use as it functioned as a challenge at the 'pre-departure', 'health care utilization', and 'post-care' stages. Participants expressed that incurring indirect costs, such as out-of-pocket expenditures to cover transportation for themselves, their children, and companions, were challenging to acquire and therefore served as barriers to reaching health care facilities. Distances and location of health facilities have been identified to influence utilization of health services, and in rural regions in low- and middle-income countries (LMICs) poor road infrastructure contributes to a lack of available transportation (Agyepong et al., 2016; Cai et al., 2015; Kabia et al., 2019; Varela et al., 2019). Once participants arrived at a health care facility, they often experienced direct health care costs, which were not always covered by PhilHealth (national health insurance program). Other individuals residing in LMICs have reported similar experiences and challenges with national health insurance programs (Agyepong et al., 2016; Crosnoe & Elder, 2002; Kabia et al., 2019). In addition to direct costs, health care beneficiary participants in this study commonly encountered organizational barriers, appointment delays, lengthy wait times, and shortages of available staff members at public health facilities. Long waiting times are considered to be an

indicator of poorly distributed staff and equipment, as the demand for these services override the supply that is available (Jacobs et al., 2016). Commonly, participants engaged with midwives, *barangay* health workers (BHWs), nurses or doctors in public and private care settings. Some women reported interactions of adversity and experiences of discrimination at public health care facilities due to their socioeconomic status. This finding is consistent with the literature, which suggests that a lack of agency and power can leave individuals prone to discrimination by health care providers, which can contribute to unmet health care needs (Betron, McClair, Currie, & Banerjee, 2018; Gurung et al., 2017; Khatib et al., 2014; Sprague, Woollett, & Hatcher, 2020). This study also reinforced the growing body of academic literature that highlights the challenges health care providers encounter when delivering care to community members in low-resource settings. Health care providers emphasized the limitations they faced were caused by the lack of financial support they received from the government and their facilities. Health care providers often worked to meet the needs of their communities by engaging in outreach work. Many health care providers extended their work beyond their catchment areas through their connections with non-governmental organizations (NGOs) and other civil society organizations.

4.1.2 Contributions to academic literature

This study provided some insights into how age and gender may interact with social networks to produce advantages or disadvantages that may impact how women experience accessing health care services. For instance, younger women were more likely to seek prenatal and antenatal care for their babies than women who were 60 years and older. Unlike young women, older women in the study were more inclined to seek care for their chronic health issues or health-related concerns regarding ageing. Thus, older women may be subjected to higher

healthcare expenditures to cover the specialized care related to age-related conditions (Ginsburg et al., 2017, 2018; Jacobs et al., 2016). These results revealed that women in the younger and oldest age groups may be more vulnerable to out-of-pocket expenditures and expect higher costs when accessing health care services. Also, these findings highlighted that affordability was a persistent barrier that disproportionately affected the younger women included in this study as these individuals had smaller external social networks compared to other age cohorts. Women who were 60 years and older from the study reported similar challenges, as these individuals explained that their children migrated to other provinces and did not provide consistent support when a health issue or challenge emerged.

Overall, these findings demonstrate that age can influence the size and strength of social networks among women across their lifespan in the context where this study was conducted. Age can also interact with gender to shape social expectations that can influence health behaviour and decisions among women at different life stages. Additionally, these findings demonstrate the importance of social networks and informal relationships in mitigating the social and financial burdens associated with accessing health care services among women in this context. Although existing health insurance programs and health reforms in the Philippines have attempted to alleviate the financial burden associated with accessing health care for individuals experiencing poverty, this study demonstrates that women continued to rely on their social networks to access health care when these programs and reforms did not adequately meet their needs at different points along their health care access pathway (i.e., pre-departure, health care utilization, post-care). These findings encourage further investigation of the connections among age and the presence of social networks when exploring the relationship between gender and health care access and use.

4.1.3 Contributions to practice

As this study was conducted in collaboration with a Philippine-based NGO, it is important to reflect on how the findings from this study can inform the work of other NGOs and civil society organizations focused on facilitating health care access and improving health outcomes in populations experiencing poverty in the Philippines. First, this study demonstrates the need to design programs and interventions in a way that is sensitive and responsive to the unique experiences of women in meeting their health care needs and the health care needs of their families. Second, these organizations could consider how health care access among women changes across the lifespan and use the findings from this study to inform programs and interventions that account for the health care needs of women at different life stages. More specifically, organizations could consider altering programs and interventions to meet specific age-related needs in contexts where women experiencing poverty are the main beneficiaries. Third, this study demonstrates that importance of social networks in facilitating health care access and use among women experiencing poverty in the Philippines. Based on these findings, NGOs and other civil society organizations could create programs that support and strengthen social networks among women. Beyond facilitating health care access and use, supporting and strengthening social networks can empower women to achieve personal goals and growth (Osirim, 2001). Finally, this study serves as an example of collaborative research between Canadian academics and a Philippine-based NGO with the intention of informing both the academic literature and NGO operations. Through this approach, this study sought to balance academic rigour and organizational needs to produce an output that had relevance to both academic audiences and the partner organization.

4.2 Strengths and Limitations

First, the study sample size was both a strength and a limitation. The 35 participants and 15 health care providers achieved informational redundancy according to qualitative research methodology (Boddy, 2016; Dworkin, 2012; Malterud, Siersma, & Guassora, 2016; Mason, 2010; Sandelowski, 1995; Weller et al., 2018). The sample size is also comparable to other qualitative studies that explored health care service access in LMICs (Atif et al., 2016; Brenman, Luitel, Mall, & Jordans, 2014; Chang et al., 2019; Hunter-Adams & Rother, 2017; Jafar et al., 2020). Thematic saturation of the sample size was determined by the lack of new emergent themes and topics among the interviews with the participants (Boddy, 2016; Dworkin, 2012; Malterud et al., 2016; Mason, 2010; Sandelowski, 1995; Weller et al., 2018). The thematic saturation confirmed that the sample size allowed us to collect sufficient information that described the experiences among women accessing health care services in the context where the study was conducted.

Additionally, purposive sampling was used as I understood that intersecting socioeconomic inequalities may differentially influence health care access among individuals experiencing poverty compared to individuals who do not experience poverty (Guarte & Barrios, 2006; Klar & Leeper, 2019; Robinson, 2014). This type of sampling enabled me to control for the socioeconomic status among the participants, and therefore, allowed me to explore a broad cross-section of experiences that may influence health care access including gender and social network dynamics. The participants' commonalities allowed me to identify barriers and enablers that were expressed among individuals living in similar socioeconomic conditions. Purposive sampling has been employed in studies where the participants may offer unique insights and

experiences on the explored phenomenon (Abiiro, Mbera, & De Allegri, 2014; Auerswald et al., 2004; Lempp et al., 2018; Mehmood, Wadhwaniya, Zziwa, & Kobusingye, 2019). However, due to the homogenous nature of participants and their involvement with programming offered by International Care Ministries (ICM), these participants were not necessarily representative of the broader income-poor population who may not have access to programs offered by NGOs or other civil society organizations. More specifically, the connection with ICM programming among participants in this study may have influenced levels of social support and experiences accessing health care services.

During data analysis, I decided to categorize the participants into four age cohorts. Each age cohort had 5-11 participants, which may be considered a small sample size. Despite the smaller cohorts, the data collected within each age cohort of participants detailed their experiences and described similar challenges that individuals encountered when accessing health care services. Also, employing the hybrid thematic analysis allowed me to explore the many experiences that emerged from the data. More specifically, this iterative process enabled me to use both theoretical frameworks and an inductive approach to identify patterns and analyze the data from different perspectives. Additionally, despite the smaller health care providers sample size, the heterogeneous nature of the data and experiences captured offered a comprehensive understanding of the challenges that health care providers encounter when delivering care to populations experiencing poverty in urban and peri-urban setting in the Philippines.

The Life Course Theory (LCT) is most commonly used to conduct longitudinal studies to investigate the impact of historical, social, and biological age throughout the lifespan (Elder, 1994; Elder et al., 2003; Hutchison, 2011). Since there were limited examples of qualitive studies conducted in LMICs that have used the LCT, there was a lack of consensus in adapting this

theory for qualitative research that was conducted at one point in time. As a result, I took an adapted approach that borrowed elements from the LCT to complete my hybrid thematic analysis. Furthermore, since the LCT traditionally requires longitudinal research to identify cohort effects, I could not determine whether the social networks among these age cohorts changed throughout their lifespan and could only report on the present experiences each cohort. Despite this limitation, in some cases, participants were able to reflect on how health care access has evolved over time, while other participants focused more on their present experiences. Also, the data set did have individuals from all age groups to provide a fulsome representation of the potential experiences women may encounter when accessing care at different life stages in the settings where the study was conducted.

Finally, as the majority of interviews were conducted using an interpreter, some interview content may have been incorrectly translated. However, this limitation was mitigated through extensive debriefing and follow-up with interpreters to confirm interview content and a thorough review of key findings and themes among research team members.

4.3 Future Research

This study benefited from the inclusion of both participants and health care providers in order to better understand the supply and demand dynamics that can create barriers to accessing health care among populations experiencing poverty in the Philippines. Future qualitative research should continue to include the perspectives of both participants and health care providers to identify areas of convergence and divergence among these various actors in understanding health care access and use in low resource settings. In addition, the use of the LCT in combination with the PCAHC framework offered more depth and understanding of how

participants at different life stages navigated the health care system along the health care access pathway (i.e., pre-departure, health care utilization, post-care). Future research that combines these two theoretical frameworks could provide greater insight into how health care access is shaped by and evolves across the life course. Finally, further research is needed on the possible role of NGOs and other civil society organizations in supporting and strengthening social networks among individuals experiencing poverty in low resource settings. In particular, research is needed to evaluate programs and interventions by these organization to determine the extent to which supporting and strengthening social networks can facilitate health care access and use. This type of applied research is critical in a context like the Philippines where much of the focus of the public health system is focused on improving the 'supply' side dimension of health care (e.g., through operationalizing universal health coverage (UHC)). Thus, there are opportunities to further investigate how supporting and strengthening social networks may enhance health care 'demand' among individuals experiencing poverty.

4.4 Conclusions

The objective of this study was to explore how gender and social networks can influence various stages of health care access among young, middle-aged, and older adult women in Negros Occidental, Philippines. Almost all women among the different age cohorts reported financial constraints and a lack of funds at the pre-departure, health utilization, and post-care stages. Financial, social, and emotional support from families, relatives, and communities may permit women to access services more easily. However, the degree of social support was not consistent among all age groups. In response to the barriers women encountered when accessing health care services, health care workers and providers extended their outreach operations to

accommodate their community members, and partnered with local NGOs to reach beyond their catchment areas. Health care providers operating at different levels of delivery and care reported challenges including a lack of funds to support staff members and to purchase the necessary equipment. Based on the conclusions drawn from this study, women of all ages may experience barriers to health care access due to gender-based norms intersecting with socioeconomic factors and other inequalities rooted in poverty. Social support networks may alleviate some of these barriers; however, these networks are not reliable and consistent across age groups.

For UHC to be successfully implemented in the Philippines, equitable and gender-responsive health reforms and programs should account for the interaction of gender with broader dimensions of inequality, such as socioeconomic status, geography, and sociocultural factors (World Health Organization, 2019a). This approach is especially critical when developing social protection schemes that aim to shield individuals across the life course from the financial burden of health care costs (World Health Organization, 2019a). Furthermore, public health care delivery and operations should look beyond offering care at the facilities, invest resources in health care outreach, and participate in multisectoral collaboration to ensure that services are equitable (World Health Organization, 2019a). Overall, this study demonstrates that qualitative research can provide rich information about the challenges and lived experiences among women in accessing and using health care that can be used to inform health care policy and practice in the context of UHC implementation in the Philippines.

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APPENDICES

APPENDIX A: University of Waterloo Research Ethics Board – Ethics clearance

UNIVERSITY OF WATERLOO

Notification of Ethics Clearance to Conduct Research with Human Participants

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Principal Investigator: Warren Dodd (School of Public

Health and Health Systems) Principal Investigator: Lincoln

Lau (International Care Ministries)

Student investigator: Kathy Luu (School of Public

Health and Health Systems) Co-Investigator: Jennifer

Liu (Anthropology)

Co-Investigator: Siwon Lee (International

Care Ministries) Research assistant: Beth

Nicholson (International Care Ministries)

File #: 40797

Title: Exploring individuals' experiences of accessing and using social and health services in a low resource setting: a qualitative study in Negros Occidental, Philippines

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The Human Research Ethics Committee is pleased to inform you this study has been reviewed and given ethics clearance.

Initial Approval Date: 04/15/19 (m/d/y)

University of Waterloo Research Ethics Committees are composed in accordance with, and carry out their functions and operate in a manner consistent with, the institution's guidelines for research with human participants, the Tri-Council Policy Statement for the Ethical Conduct for Research Involving Humans (TCPS, 2nd edition), International Conference on Harmonization: Good Clinical Practice (ICH-GCP), the Ontario Personal Health Information Protection Act (PHIPA), the applicable laws and regulations of the province of Ontario. Both Committees are registered with the U.S. Department of Health and Human Services under the Federal Wide Assurance, FWA00021410, and IRB registration number IRB00002419 (HREC) and

IRB00007409 (CREC).

This study is to be conducted in accordance with the submitted application and the most recently approved versions of all supporting materials.

Expiry Date: 04/16/20 (m/d/y)

Multi-year research must be renewed at least once every 12 months unless a more frequent review has otherwise been specified. Studies will only be renewed if the renewal report is received and approved before the expiry date. Failure to submit renewal reports will result in the investigators being notified ethics clearance has been suspended and Research Finance being notified the ethics clearance is no longer valid.

Level of review: Delegated Review

Signed on behalf of the Human Research Ethics Committee

Joanna Eidse, Research Ethics Officer, jeidse@uwaterloo.ca, 519-888-4567, ext. 37163

This above named study is to be conducted in accordance with the submitted application and the most recently approved versions of all supporting materials.

Documents reviewed and received ethics clearance for use in the study and/or

received for information: file: REB revisions - notes and other

comments_answers_April 9.docx

file: REB REVISIONS 2 - Notes and Other

comments_Answers_ April 11.docx file: 5. REB -

interview guide -service providers-APRIL 9.docx

file: REB - Interview guide - service users.docx

file: REB - Questionnaire - service users-APRIL 11.docx

file: 2. REB - Recruitment - verbal scripts - Service

users - APRIL 9.docx file: 2. REB - Recruitment -

verbal scripts - service providers-APRIL 9.docx file:

REB - Appreciation Letter - service providers-APRIL

11.docx

file: 3. REB - Information and informed consent letters - service providers - APRIL 11.docx

file: 3. REB - Information and informed consent letter and oral consent script - service

users-APRIL 11.docx Approved Protocol Version 4 in Research Ethics System

This is an official document. Retain for your files.

You are responsible for obtaining any additional institutional approvals that might be required to complete this study.

APPENDIX B: Participant questionnaire and interview guide

Questionnaire and semi-structured interview guide used in Negros Occidental

QUESTIONNAIRE: PARTICIPANT

Helping with research is voluntary, you do not have to do it. You can even start the study and still change your mind and stop at any time. You may also decline to answer any questions that you prefer not to.

Date: **Name of Interviewer:** **ID#:**
1. Age: **2. Sex (M/F):** **3. Name of community:**
4. School level achieved: **5. Occupation:** **6. Number of individuals in household:**
7: Literary level: **8. Marital status:**

9. Relationship to interviewee	**9a. Sex** (M/F)	**9b. Age**	**9c. Literacy** 0 = Illiterate 1=only write name 2=Can read, not write 3=Can read and write	**9d. Currently in school** (Yes/no)	**9e. Most recent occupation**	**9f. Acute health problem in last 14 days (specify)**	**9g. Chronic health issue (specify)**

Social services related questions:

10. Does your household currently owe anyone money?

□ Yes □ No

10a If YES, how many people do you owe money to? _____

11. Do you have outstanding loans for any big items?

	Approximate monthly payment
11a. Housing	
1b. Motorcycle	
11c. Tricycle	
11d. Appliance	
11e. Entertainment	
11f. Other (Specify)	

12. Do you currently receive support from the following services or programs?

□ Old age pension □ School supplies

□School feeding program □ Unconditional cash transfer

□ Other NGO program(s) (specify)_____

□ Other _____

13. Do you currently receive money from (select all that apply):

□ 4Ps (Conditional cash transfers) □ Microfinance

□ ⅝ □ Community lender

□ Relatives □ Politicians

□NGO programs □ Remittances

□N/A

14. How important is this money to meeting your family's needs?

	1 – Not important	2 – Somewhat important	3 – Neutral	4 – Important	5 – Very important (main source of income for family)	N/A
26a. 4Ps (Conditional cash transfers)						
26b. Microfinance						
26c. 5/6						
26d. Community lender						
26e. Relatives						
26 f. Politicians						
26g. NGO programs						
26h. Remittances						

INTERVIEW GUIDE – PARTICIPANT

Introduction

Interviewer (I): Hello and thank you for making the time. My name is XXX and I'm a [role, eg. research associate] from the International Care Ministries (ICM). This is XXX, a [role eg. interpreter] We will be facilitating this interview and taking notes. We thank you for agreeing to participate in this interview.

Topic overview

I: The results from these discussions will be used to help researchers and ICM understand what are the factors affecting individuals' access and use of healthcare and social services and also comprehend the lived experience of individuals living in low resource settings. This will help us learn how current healthcare and social services can be improved. You have been asked to participate in this study because you are a current Transform participant.

Ground rules

I: I will be asking you a series of questions, and you are encouraged to talk to about and share your opinions and experiences. There are no right or wrong answers here so please feel free to share your point of view.

I: I will remind you that my role is not to provide any medical advice or information. However, at the end of the interview, there will be the opportunity to ask general questions. More specific questions should be directed to your doctor. In addition, we can provide you with the contact information of the closest RHU and social service organizations.

I: This session is being recorded, because although XXX will be taking notes, it's difficult to write down everything that is said. We will be using first names only here, and names will not be used in the report, so you can feel confident that your identity will remain anonymous. The report that results from this session will become part of a larger document that will help us understand a better way to improve healthcare and social services access and use among individuals in low resource settings.

I: Are there any questions? [If the participant wants to withdraw from the study, he/she may.] Ok then, before we begin, we ask that you please fill out the questionnaire (socio-demographic questionnaire) in front of you.

A. Healthcare	
Service users, Access to and/or use of Healthcare Services/Providers including **RHU, Public hospital, Private provider (clinic), Private hospital, Traditional provider**	
1.0 Have you ever sought health attention at a(an)_____? Can you tell me about your last experience?	
1. Pre-departure; Travel	1.1 How did you recognize you had a health problem that was needing medical attention
	1.2 Did you wait to go get care? How long? Why? (e.g., work, family responsibilities, no time) Were there any delays outside of your control? (weather events)
	1.3 How did you find transportation?
	1.4 How did you pay for transportation?
	1.5 Was childcare necessary? What did that look like?
	1.6 Did you take a day off work? Were you concerned about the lost income? What did that mean for your family?
	1.7 When you get sick does your community offer support? What kind? Did you bring a support person with you? Who was it?
	1.8 How long did it take you to get to the RHU?
2.0 Do you have PhilHealth coverage? What is your understanding of the PhilHealth coverage? Where did you get this information?	
2. Once you are there; During appointment	2.1 Was it open?
	2.2 Was there a doctor there? If not, what did you do?
	2.3 How long did you wait in line?
	2.4 When you saw the doctor, did you feel like you were treated well? Did they listen to your concerns?
	2.5 Did you understand what the doctor told you?
	2.6 Did you have to do any test? What was this like?
	2.7 Was the test available?
	2.8 Were there clear instructions about what your diagnosis was and what appropriate treatment was (if applicable)?
	2.9 Were you prescribed medication
	2.10 Did you use your PhilHealth coverage (if applicable)
3. Diagnosis; Treatment; Medication; Follow-up	3.1 Was there medication available? If not, what did you do?
	3.2 Was there a plan for follow-up?
	3.3 Did you received any support from your BHW? How often did the BHW check in?
	3.4 Did you have to go back to the RHU?
	3.5 At any point along your journey, did you have to spend money (where, when, and why) E.g. transportation, staying overnight, diagnostic test, medication?

	3.6 Are there any barriers that you experienced that we have not discussed?

Assessing Health Care Use Satisfaction & Preferences	
1) Actual experiences obtained	1. See Healthcare pathway above Experience A)_____eg. Baby with fever gone to Centro Experience B)_____eg. Husband with chest pain gone to Provincial Hospital Experience C)_____eg. Grandma with diabetes check up at RHU
2) Rank actual experiences	2. "One, two, three, four, five... One is not satisfied at all, Five is the most satisfied with your experience at A)_____B)_____C)_____
3) Hypothetical experience preferences	3.1 Where would you have preferred to receive care for Experience A)...B). C) Where would you prefer to go for treatment for (any category that has not been captured by actual experiences): 1) Chronic disease management (eg. diabetes, hypertension "high blood") 2) Urgent sickness (acute infection, etc.) 3) Pregnancy 4) Child ill 5) Terminal illness (eg. cancer)

APPENDIX C: Health care providers interview guide

Questionnaire and semi-structured interview guide used in Negros Occidental

INTERVIEW GUIDE: Health care providers (public/private)		
Date:	Interviewer:	ID#:
A. Demographic Data		
1. Age:	2. Sex (M/F):	3. Name of community:
4. School level achieved:	5. Job title/occupation:	6. Years working in job:
	1.0 Can you tell me what a typical day looks like in your work?	
	2.0 Can you tell me about the services and/or programs that are available to families experiencing poverty (in this baranguay, area, etc.)	
B. Access/ Barriers of Users	3.0 From your experience, what are the key barriers for families experiencing poverty in accessing your healthcare services? How do these barriers operate in the lives of poor families?	
Prompts	3.1 Transportation	
	3.2 Money	
	3.3 Time	
	3.4 Childcare	
	3.5 Gender differences between women and men	
	3.6 Lack of knowledge/understanding of how to navigate the system	
C. Provider Challenges	4.0 What is your patient load like (How many patients are in your catchment area)? How many patients serve on a daily basis? How does that impact your ability to provide care (e.g. time spent with each patient?)	
	5.0 How do you in your role work to meet the needs of families experiencing poverty?	
	6.0 How does your facility/clinic/hospital work to meet the needs of families experiencing poverty? Are there any special measures put in place or things that your facility does to address the barriers that families experiencing poverty face that may prevent them from accessing healthcare?	
	7.0 What are the barriers that your facility/clinic/hospital faces in meeting the needs of families experiencing poverty?	
Prompts	7.1 Funding	
	7.2 Space	
	7.3 Staffing	
	7.4 Lack of political support	

	7.5 Is there anything specific you would like to see your facility/clinic/hospital do to address the needs of families experiencing poverty?

APPENDIX D: Inclusion and exclusion criteria

Criteria was used in project to recruit participants in Spring 2019

The target populations for this study are:

(1) Participants across 7 communities in Negros Occidental to explore health care access and use; and
(2) health care providers in the region (Negros Occidental) to explore their perspectives on the challenges of healthcare delivery to income poor populations.

Participants fitting the following inclusion criteria will be invited to participate in the study:

(1) must be over the age of 18 years old;
(2) must be a current Transform participant;
(3) living under $0.50 US/day,
(4) speak the language of local ICM staff;
(5) access and/or use healthcare services at the rural health unit.

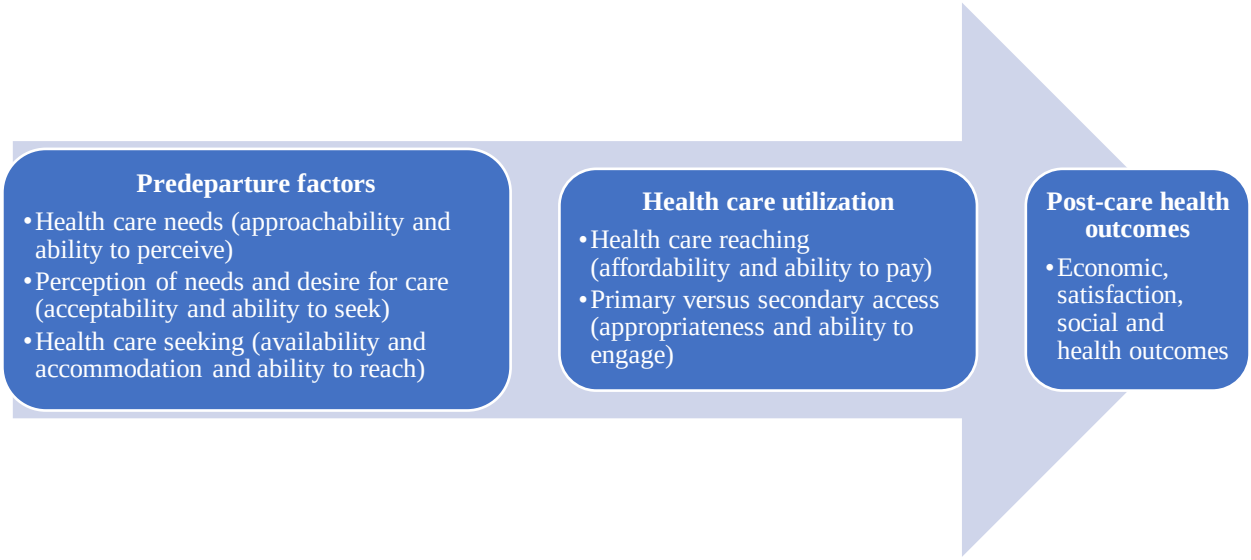
The exclusion criteria are as followed:

(1) under the age of 18, and
(2) is not a current Transform participant.

Health care providers fitting the following inclusion criteria will be invited to participate in the study:

(1) must be over the age of 18;
(2) work at an RHU, hospital, clinic, or provide traditional medicines in Negros Occidental; and
(3) provide care to individuals living under $0.50 US/day.

APPENDIX E: A visual representation of the factors participants indicated that could act at various stages of the health care pathway using the patient-centred access to health care (PCAHC) framework (adapted from Levesque, Harries, & Russell, 2013)



APPENDIX F: Participant codebook

Theme / Parent node/ sub-nodes and codes	Description[3]
1. Pre-departure factors	Comprised of elements/factors that inform service beneficiaries' of existing health services, conceptualize their perception of the need to access care, and subsequently, determine their course of action to seek the appropriate health facility or services.
Health care needs	This parent node describes individuals' awareness, recognition, and understanding of existing available health services in their community.
Approachability	Describes the distribution and availability of information circulated to service beneficiaries', and subsequently, assist them to identify forms of health services that can impact their health and well-being.
	Transparency: Information is available to the public, in a reliable and understandable manner (e.g., availability, outreach schedule, referral systems, efficiency and consumer experience).
	Outreach: The type of services/information/support barangay health workers and NGOs offer to marginalized populations.
	Information: The sources and type of information available to service beneficiaries.
Ability to perceive	To recognize the need for care, and it is comprised of health literacy, health and beliefs related to health and sickness, and trust and expectations in the existing health care services.
	Health literacy : Individuals' capacity to obtain, process, and understand health information and services (e.g., PhilHealth) to make the appropriate health decisions.
	Health beliefs: Individual beliefs about health conditions and treatment options, which may predict individual health-related behaviours and decisions (e.g., recognizing and understanding the symptoms and signs; emergencies versus regular check-up).
	Trust and expectations: The belief in the reliability, truth, ability of the health provider or facility (e.g., trusting and expectations of public care or private care; individuals relying on their previous experiences to assist them in making subsequent decisions).
Perception of needs and desire for care	This parent node describes the combination of external- (professional beliefs, norms, culture, gender), and individual- (personal beliefs, values, gender, and autonomy) factors that influence individuals' judgement of the health services, and subsequently, determine their perception and desire to seek health care services.
Acceptability	Describes the cultural and social factors that determine people's acceptance of the existing services (e.g. the sex or social group of providers, the beliefs associated to systems of medicine), and judgement of its appropriateness.
	Professional values, norms, culture, gender: Core principles and ideals developed within societies, communities, and households (e.g., acceptability of traditional services) about the health facilities, providers, and treatment options available.
Ability to seek	Relates to the concepts of personal autonomy and capacity to choose to seek care, knowledge about health care options and individual rights that would determine expressing the intention to obtain health care.
	Personal and societal values, and culture: Core principles and ideals developed within societies, communities, and households (e.g., expectations to seek/use traditional services and local alternatives) that dictate one's capacity to decide the appropriate time to seek care, and type of service.
	Gender (In the framework, this factor is deemed to only impact the ability to seek, however, I will be exploring gender throughout the pathway of care.): The norms, roles and relations that exist over a course of a person's life and how they influence health seeking behaviour (e.g., Delaying health care appointments due to caregiving responsibilities).

[3] Codes and descriptions were informed by the theoretical frameworks used in this study (PCAHC framework and LCT) (Bourdieu, 1986; Elder et al., 2003; Levesque et al., 2013)

	Autonomy : Individuals' right to make decisions about their medical care.
Health care seeking	This parent node describes the degree of accessibility of the health facility based on its physical geography, commodities, and accommodations, and the individuals' ability to seek the facilities based on their personal mobility, work flexibility, and access to transportation.
Availability and accommodation	Refers to ease of accessing the health care facility based on its physical location, available staff, and hours of operation.
	Geographic location: The road infrastructure, inaccessible/difficult terrain, and available transportation surrounding the health facility.
	Accommodation: The availability of staff to accommodate the number of service users, and the supply of resources at the facilities.
	Hours of opening: The hours of operation and health provider's availability.
	Appointments mechanisms : The formal referral systems existing in both the public and private sector.
Ability to reach	Relates to the notion of personal mobility and availability of transportation, occupational flexibility (e.g., formal and informal (housework and childcare), and knowledge about health services that would enable an individual to physically reach the health care facilities.
	Living environments: The distance (travel time) to the health facilities.
	Transport: Individuals' access to transportation, and ability to afford transportation fees.
	Mobility : Individuals' perception of travelling time, and the distance modified by organizational flexibility of the clinic, and their occupational inflexibility/flexibility.
	Social support (In the framework, this factor is deemed to only impact the ability to reach, however, I will be exploring social support throughout the pathway of care.): The perception and actuality that an individual is cared for, has assistance available from other people, and is part of a supportive social network (e.g., child support, connections with NGOs and agencies, availability of a companion).
2. Health care utilization experiences	Describes the factors that shape individuals' experiences at the health appointment and facilities, which include their interactions with health care professionals, emotional responses towards their experiences, and engagement and commitment to the course of diagnosis and treatment.
Healthcare reaching	This parent node describes an individual's ability to interact with different channels of income and support networks to withstand the economic costs of obtaining health services.
Affordability	Reflects the economic capacity for people to spend resources and time to use appropriate services.
	Direct costs: All expenses due to the use of a health care services, diagnosis, treatment, and/or interventions to treat the disease or illness.
	Indirect costs: Expenses incurred from costs that are not directly related to patient care (e.g., the reduction of work productivity, transportation, etc.).
	Opportunity costs: The loss of potential gain from other alternatives when one alternative is chosen.
Ability to pay	Describes the capacity to generate economic resources through income, savings, borrowing or loans to pay for health care services without incurring catastrophic expenditure of resources, and still have ability to obtain necessities.
	Income: Individuals' ability to generate income to cover medical expenses.
	Assets: Individuals' access to savings, borrowing, and valuables.
	Social capital(In the framework, this factor is deemed to only impact the ability to reach, however, I will be exploring social capital throughout the pathway of care.): The networks of relationships among people who inhabit in a community.
	Health insurance : Type of insurance coverage that pays for medical expenses incurred by the insured.
Healthcare decision making	This parent node describes the factors impacting the choice of care (e.g., primary versus secondary care, and public, private, and traditional care), and subsequently, the individuals' capacity to engage with the diagnostic or/and treatment plan.
Appropriateness	Denotes the fit between services and service beneficiary's needs which is based on the treatment of the health provider, amount of care spent in assessing the health problems, and determining the correct treatment plan.
	Technical and interpersonal quality: The effective communication between health care provider and service user to improve the user's satisfaction, compliance and health outcomes.
	Adequacy: The degree of appropriateness and quality of the services.
	Coordination and continuity : Describes the providers' administering follow-up appointments, and the service users' willingness and successful attendance.

Ability to engage	Relates to the participation and involvement of the service beneficiary in decision-making and treatment decisions, which is in turn strongly determined by their capacity and motivation to participate in care, and commit to its completion.
	Empowerment: Individuals having the control to act and navigate health issues that they themselves define as important.
	Information: Health information and instructions communicated by the health care provider and/or other members in an individuals' social network.
	Adherence to treatment: Individuals ability to participate in care and commit to its completion.
	Caregiver support: Support given to a service user that from someone other than a health care professional.
3. Health care consequences	Describes the outcomes that transpire from the individuals' health care decision, and how it subsequently, influence their perception of health care services and determine their future health-behaviour and decisions.
Economic	The economic burden and ramifications of out-of-pocket expenditures on healthcare services.
Satisfaction	The degree of which the service users' expectations are fulfilled by their health provider/services (e.g., effectiveness of the care or the degree empathy they received from their health provider).
Health outcomes	An individual's health and wellness after committing to the specific health care treatment.
Social outcomes	Describes the potential changes to an individual's behaviour, social environment, interactions, and networks after interacting and/or committing to health care treatments.
Agency	The capacity of the individual to act and decide on the course of treatment.
Acquiring basic needs	Individuals' ability to acquire the minimum resources necessary for long-term well-being (e.g., consumption goods) for themselves and their family members.
Resiliency	The capacity to recover from hardships and consequences, adapt to adverse circumstances, and developing methods to cope with limited resources available.
4. Timing of lives	The age-graded perspective to social roles and events that includes the incidence, duration, and sequence of roles, and to relevant expectations and beliefs based on age.
Biological age	Person's level of biological development and physical health, as measured by the functioning of the various organ systems.
Psychological age	Behaviourally, psychological age refers to the capacities that people have and the skills they use to adapt to changing biological and environmental demands.
Social age	Age-graded roles and behaviors expected by society, the socially constructed meaning of various age. Including: gender, race, ethnicity, and social class within a given time and society.
	Gender: The norms, roles and relations that exist over a course of a person's life and how they influence health seeking behaviour (e.g., Delaying health care appointments due to caregiving responsibilities).
	Transitions : Individual's transition into new roles (e.g., mother) and how it impacts their behaviour and decisions.
	Caregiver roles: Unpaid and informal work/support/help individuals provide and offer to their social network (e.g., family) .
5. Linked lives	Refers to the interaction between the individual's social worlds and social relationships with kin and friends across the life span.
Social support	The perception and actuality that an individual is cared for, has assistance available from other people, and is part of a supportive social network (e.g., child support, connections with NGOs and agencies, availability of a companion).
	Link between family members : The ways that individuals and their multigenerational families are interdependent.
	Links with the wider world : The ways between individuals and families and other groups and collectivities are interdependent.
Social capital	The networks of relationships among people who inhabit in a community.
	Bonding : Connections formed between individuals and their immediate family members or/and extended family members.
	Bridging: Connections formed between individuals' and their friends or/and neighbours.
	Linking : Connections formed between individuals' and service organizations.
6. Agency	Agency is based on the assumption that humans are not passive recipients of a predetermined life course but make decisions that determine the shape their lives. The capacity of the individual to act and decide on the course of treatment.
Personal agency	Personal agency is exercised individually, using personal influence to shape environmental events or one's own behaviour.

Proxy agency	Proxy agency is exercised to influence others who have greater resources to act on one's behalf to meet needs and accomplish goals.
Collective agency	Collective agency exercised on the group level when people act together to meet needs and accomplish goals.

APPENDIX G: Health care providers codebook

Theme / Parent node/ sub-nodes and codes	Description
1. Health care providers awareness of access barriers	
Awareness of conditions of poverty	Health care providers describing challenges their patients encounter when they access services
Awareness of traditional services	Health care providers knowledge and awareness of existing traditional services and providers in the community.
Gender	Health care providers recognizing the norms, roles and relations that exist over a course of a person's life and how they influence health seeking behaviour
Lack of financial help for users	Health care provider acknowledging that their patients have financial restrictions, and they may lack financial assistance to cover health care costs
Lack of PhilHealth	Health care providers acknowledging that some of their patients may not have PhilHealth
Miscommunication and lack of coordination	Health care providers recognizing that there are gaps within coordinating and delivering to their patients
Perceived barriers users encounter	Health care provider acknowledging that their patients have barriers beyond financial limitations that can restrict their ability to access health care services
2. Challenges health care providers experience	
Accommodation	The availability of staff to accommodate the number of service users, and the supply of resources at the facilities.
Climate change impacts	Concerns surrounding the health of the population due to climate change
Concerns about non-communicable diseases	Recognizing the factors that may increase in non-communicable disease in the population
Health records and information	Systems used to keep and maintain health information
Improvements and criticisms	Health care providers reflecting on their challenges and offering their opinions on the potential improvements they would like to integrate into their practice
Lack of resources	Health care providers expressing the lack of resources they have at the medical facilities
Limitations to authorized care	Health care providers describing the limitations they encounter when providing care to their patients
Medication as treatment	Health care providers offering prescriptions to their patients
Providers' challenges when offering care	Overall challenges health care providers encounter working in low-resource areas
Systematic issues	Health systems issues
Underpaid	Health care providers expressing that they are not fairly compensated for their work
Understaffed	Health care providers explaining that they are understaff
Mistrust	Health care providers acknowledging that their patients may mistrust the formal health care system

3. Health care providers responsiveness to the needs of patients	
Committed	Health care providers expressing their commitment to work in their communities
Direct patient-care addressing social determinants of health	Health care providers offering programming and education for their communities, alleviating the impacts of poverty, and addressing the needs beyond health care
Educating patients	Health care providers offering educational programming
External financial support for patients	Health care providers offering financial donations to their patients
Outreach work	Health care providers conducting outreach activities in their communities
Prenatal care	Health care providers focusing on prenatal care services
Priority health cases	Health care providers acknowledging and prioritizing certain health conditions
Working with organizations	Health care providers working with external organizations to reach patients beyond their catchment areas

APPENDIX H: Demographic characteristics of participants in Negros Occidental, Philippines organized by age cohort (n=35)

Characteristics		Overall (n=35)	18 - 30 years old (n=10)	31- 45 years old (n=11)	46 – 59 years old (n=9)	60+ years old (n=5)
PhilHealth Status	Beneficiary	24 (68.6%)	6 (60.0%)	9 (81.8%)	6 (66.7%)	3 (60.0%)
	Non-beneficiary	9 (25.8%)	4 (40.0%)	1 (9.1%)	3 (33.3%)	1 (20.0%)
	Missing	2 (5.7%)	0 (0.0%)	1 (9.1%)	0 (0.0%)	1 (20.0%)
4Ps Status	Beneficiary	13 (37.1%)	0 (0.0%)	7 (63.6%)	4 (44.4%)	2 (40.0%)
	Non-beneficiary	22 (62.9%)	10 (100.0%)	4 (36.4%)	5 (55.6%)	3 (60.0%)
Occupation	At-home	21 (60.0%)	7 (70.0%)	8 (72.7%)	3 (33.3%)	3 (60.0%)
	Farm Labourer	5 (14.3%)	0 (0.0%)	1 (9.1%)	3 (33.3%)	1 (20.0%)
	Other	9 (25.7%)	3 (30.0%)	2 (18.2%)	3 (33.3%)	1 (20.0%)
Educational Attainment	No School	1 (2.9%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (20.0%)
	Primary School	12 (34.3%)	0 (0.0%)	3 (27.3%)	6 (66.7%)	3 (60.0%)
	Secondary School	21 (60.0%)	9 (90.0%)	8 (72.7%)	3 (33.3%)	1 (20.0%)
	College or Vocational School	1 (2.9%)	1 (10.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Marital Status	Married	30 (85.7%)	8 (80.0%)	10 (90.9%)	8 (88.9%)	4 (80.0%)
	Common law	1 (2.9%)	0 (0.0%)	1 (9.1%)	0 (0.0%)	0 (0.0%)
	Widow	2 (5.7%)	0 (0.0%)	0 (0.0%)	1 (11.1%)	1 (20.0%)
	Single	2 (5.7%)	2 (20.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Household members	0-5	16 (45.7%)	6 (60.0%)	3 (27.3%)	3 (33.3%)	4 (80.0%)
	6-10	17 (48.6%)	3 (30.0%)	8 (72.7%)	5 (55.6%)	1 (20.0%)
	11-15	2 (5.7%)	1 (10.0%)	0 (0.0%)	1(11.1%)	0 (0.0%)