ORIGINAL ARTICLE

Teachers as Health Workers in the Philippines

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ABSTRACT

Objectives. While the chronically overburdened state of public school teachers in the Philippines is well-established, little is known about how they specifically provide 'care' and attend to their students' health in the workplace. This article addresses that knowledge gap by illustrating the many forms of 'health work' undertaken by public school teachers on a daily basis, and analyzing the concrete challenges they face in doing such work. In so doing, this article provides a qualitative construction of school teachers as 'health workers' in the country.

Methods. This article draws from two focus group discussions conducted in Southern Luzon and Eastern Visayas between November 2018 to May 2019, as part of a multi-sited study on the health-related challenges faced by low- and middle-income Filipinos. A total of 19 teachers participated in those two discussions. We used the principles of thematic analysis to code and analyze the discussion transcripts.

Results. Teachers regularly fulfill various tasks that can be considered health work, including measuring students' anthropometrics; supervising and administering government programs like deworming, feeding programs, and vaccinations; providing first-aid and various forms of immediate medical attention; addressing students' mental and psychological health concerns; and working with students' families in ways that resemble social work. However, the study participants largely considered themselves unqualified to do health work, often sacrificed their own personal health and interpersonal relationships to take on the additional burden of health work, and felt they received insufficient institutional support.

Conclusion. Doing health work not only takes away from actual teaching time, but also comes at the expense of teachers' own health. Hiring the appropriate personnel to conduct health work and improving legal safeguards are possible solutions to ameliorating the present working conditions of teachers. Yet, the larger and more long-term conversation demands the prioritiziation of teachers' well-being and overall quality of life, and recognizing the cruciality of a healthy work-life balance for them. Future studies should involve more diverse geographic sites and teacher populations, and utilize more focused forms of analysis (e.g., comparative, policy-driven).

Keywords: school teachers, healthcare workers, Philippines

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INTRODUCTION

Public school teachers in the Philippines are overworked and undercompensated—this much, the academic literature has established.[1-4] On top of their teaching load or actual classroom instruction, teachers are routinely made to fulfill a host of administrative and supportive tasks, from implementing government programs to manually accomplishing paperwork.[1,3] This chronically overburdened state of Filipino teachers is cause for concern, given that the quality of their teaching invariably affects students' learning outcomes.[5]

Our article zeroes in on a particular dimension of the dismal working conditions endured by teachers—specifically, 'health work', or work that relates to students' health. To be clear, it is not only in the Philippines where teachers have

dealt with such conditions: In countries like the United States and China,[6,7] primary and secondary school teachers have also been documented to be overburdened, contending with pressures akin to those faced by their Filipino counterparts. The reality of teachers being made to do health work has also been unpacked abroad. In Australia, scholars have framed teachers as 'health workers' on the basis of the considerable amount of time they devote to health work, ranging from the day-to-day and expected (e.g., teaching physical education or science courses) to the emotionally and psychologically demanding (e.g., counseling problematic students and liaising with students' families).[8-10] While health work has been hinted at in articles analyzing the plight of Filipino public school teachers,[2,3] it has yet to be explored qualitatively in detail.

Our objectives in this article are to illustrate the many forms of health work that Filipino school teachers undertake; understand the concrete challenges these teachers face in doing such work; and analyze the implications of these working conditions to the local educational system. We define 'health work' based on the pioneering conceptualization of McCuaig et al. as the spectrum of work involving various dimensions of students' health—physical, mental, social, psychological, clinical—and which are all 'peripheral' to the teachers' primary role in school as educators.[11] Through multi-sited discussions, we construct Filipino school teachers as 'health workers' by narrating the ancillary, health-related work they undertake, notwithstanding their limited time and resources. We also elucidate their ambivalences and apprehensions toward being made to do such work and what it says of their workplaces. While this article situates health work in relation to individual teachers' experiences, it also speaks more broadly of the state of the country's educational system and the neoliberal milieu within which it is entrenched.

In considering the plight of our teachers, it is useful to bear in mind that certain legal frameworks already exist that map out ideal scenarios as far as the school working environment is concerned. For instance, Republic Act No. 4670 or the Magna Carta for Public School Teachers limits a teachers' time for actual classroom instruction to a maximum of six hours a day and stipulates forms of renumeration for "co-curricula [and] other activities outside of what is defined as normal duties of any teacher"; however, the law conspicuously lacks any specific provision pertaining to ancillary tasks such as health work.[12] Separately, under the K-12 curriculum, the Department of Education (DepEd) has, at least on paper, standardized the allocation of school health personnel for standalone public senior high schools: one school nurse for every 5,000 students and one guidance counselor for every 500, both of which will be "deployed at a school or cluster of schools as deemed necessary by the schools division office."[13] As our article illustrates at length, the circumstances that teachers face in schools frequently deviate from those prescribed by the law and/or authorities—and the burden of finding solutions often falls squarely on the teachers themselves.

MATERIALS AND METHODS

This article draws from a multi-sited qualitative study on the health-related challenges faced by low- and middle-income Filipinos. That study was grounded on the understanding that many Filipinos are often deterred from fulfilling their life goals because of poor health care and catastrophic health events that drive them into debt.[14] To obtain a more realistic picture of the daily lives of Filipinos vis-à-vis their health, we emphasized the participation of low- and middle-income individuals who comprise an overwhelming majority of the country's population.

From November 2018 to May 2019, we conducted 33 focus group discussions (FGDs) involving 250 participants across 10 field sites in the Philippines. In selecting the sites and the participants per site, we used maximum variation sampling, a purposive recruitment technique used to capture the widest variety of possible perspectives—in our case, ensuring the involvement of heterogenous geographies and population and occupational sectors representative of low and middle-income Filipinos. For ease of access, we eventually selected sites where we already had previous contacts. Table 1 provides a geographic breakdown of our study sites. Table 2 categorizes the FGDs in terms of the participants' occupational sectors.

Our team was composed of researchers from the fields of public health, anthropology, public policy, and mass communications. We had no prior connection to the participants and vice versa; instead, we hired local facilitators to organize the FGDs, including arranging the venues in accessible community settings like barangay conference rooms and recruiting participants through personal and peer referrals. During the FGDs, however, only our team and the participants were allowed inside the venue. We obtained the participants' consent prior to participation and iteratively throughout the discussion. No repeat discussions or dropouts were noted.

Table 1. Geographic Distribution of FGDs

Region	Area type	Number of FGDs
National Capital Region	HUC 1	3
	HUC 2	2
	HUC 3	3
Region II	4th class municipality	4
Region III	3rd class municipality	2
Region IV-A	1st class city	3
Region V	3rd class city	4
Region VI	HUC	3
	5th class municipality	3
Region VII	5th class municipality	3

HUC – 'Highly urbanized city', as defined by the Philippine Statistics Authority.

See http://202.78.94.78/index.php/ddibrowser/64/export/?-format=pdf&generate=yes.

Our FGDs lasted 45 to 90 minutes and averaged eight participants per session. We used either a Filipino discussion guide or its English translation, depending on participant consensus (Appendix). The discussions followed a three-part structure that started with the participants' health-related visions and goals, before exploring the challenges they encountered in attaining those goals and culminating in a wider discussion that situated the participants within the country's health system. The first and third authors alternated in leading the discussions, while the second author, along with other members of the research team, primarily served as a note-taker to supplement the FGD recordings. After each discussion, we gave the participants tokens and reimbursed them for ancillary costs such as transportation expenses.

This article is based on our analyses of the transcriptions of two FGDs conducted among public school teachers. As can be inferred from earlier paragraphs of this article, we did not set out to intentionally study the plight of Filipino teachers: The selection of the study sites, and the particular venues in each site involving these teachers, was thoroughly unplanned. However, even during the actual discussions, we already observed the predominant theme of health work in the conversations. The writing of this article is therefore entirely by choice. As with the three other articles that we have written and published out of our larger study—the first on health financing,[15] the second on the Dengvaxia controversy of 2017,[16] and the third on local politics and health devolution[17]—we deem the subject of teachers as health workers to be particularly unique and resonant to the contemporary Filipino context, and one that urgently demands to be written.

Like the rest of the FGDs in the study, the two FGDs on school teachers were audio-recorded and transcribed, and the transcriptions subsequently anonymized and coded via NVivo 11. To write this article, we revisited those two transcriptions and coded them using the principles of thematic analysis.[18] We began with an open reading of the texts, followed by a first round of coding that let us determine the two major themes of this article. We then proceeded to do a second round of coding to determine the sub-themes per major theme, and the relevant codes per theme. During coding and analysis, we regularly consulted each other to triangulate our findings and address the inherent subjectivities of our individual coding processes, given the biases brought about by our different academic backgrounds, as well as the logistical impossibility of conducting member checking (or returning to the participants to present our analysis for accuracy). We eventually settled on the themes and sub-themes of this article by consensus. All documents related to the study were kept in password-encrypted folders accessible only to our team. We obtained ethics approval for our study from Ateneo de Manila University Research Ethics Committee (AdMUREC 18-016).

The two aforementioned FGDs were conducted in Southern Luzon and Eastern Visayas. The study site in Southern Luzon (hereafter referred to as School A) was a provincial capital and economic center with an estimated population of 182,000. In contrast, the study site in Eastern Visayas (hereafter referred to as School B) was a fifth-class municipality with an estimated population of 15,000; where only a rural health center catered to the community's health needs and the nearest hospital was 10 kilometers away in the next town. The quotes presented in this article are either in the original English or have been translated into English from the original Filipino.

RESULTS

A total of 19 participants were involved in the two FGDs relevant to this article. All were public school teachers. Ten teachers participated in the FGD in School A, while nine participated in School B. Only one participant identified as male in School A, while three participants identified as male in School B; the rest were female. Table 3 further

Table 2. Distribution of FGDs according to the Participants' Occupational Sectors

Sector	Number of FGDs
Health workers	4
Youth	4
Government workers	4
Urban poor	3
Farming communities	3
Formal workers	2
Local migrants	2
(Families of) overseas workers	2
Caregivers of the sick or elderly	2
Fisherfolk	1
Disaster survivors	1
Persons with disabilities	1
Parents of children below seven years old	1

Table 3. Participant Characteristics in FGDs among Teachers

Characteristics	School A	School B
Gender		
Male	1	3
Female	9	6
Grade/Year Level Taught		
Pre-school	1	1
Grade 1-3	7	1
Grade 4-6	2	2
Junior High School		5
Subjects Taught		
English	All participants reported teaching a variety of subjects.	2
Science		2
Math		
MAPEH		3
Social Studies		1
No specific subject		1

breaks down the participants in terms of the grade or year levels they handled, and the subjects they taught.

In what follows, we present the multiple roles that teachers undertake as health workers. Subsequently, we narrate the challenges they identified in doing health work. Table 4 summarizes these findings.

The Multiple Health Care Roles of Teachers

Fundamentally, the teachers we interviewed could be considered health workers in their role as educators. After all, they taught science courses like biology, conducted physical education classes, and introduced students to crucial, health-related topics, from basic reproductive anatomy to more sensitive subjects like teenage pregnancy and sexually transmitted infections.

Teachers as anthropometrists and nutritional status assessors

But, besides formal teaching, our study participants related other responsibilities they carried out that could be clearly classified as health work. One such responsibility was the taking of anthropometric measurements. Those who handled elementary MAPEH (Music, Arts, Physical Education, and Health) classes were usually in charge of this, taking the students' measurements twice or thrice during the school year. According to our participants, being in charge of this task placed them in a unique position to monitor their students' nutritional status and look into their students' eating habits, both at school and at home. These teachers correlated poor academic performance with poor nutrition, and poor nutrition to poverty itself. They related how, almost always, students from farther-flung and/or more impoverished barangays were the ones who performed poorly in school. However, the teachers also expressed their 'powerlessness' to change their students' nutritional situation and often resorted to implementing simple, food-related classroom rules in an effort to improve their students' eating habits.

> *How about the ones who are severely wasted? What are we supposed to do with them? After measuring their weight, we can't do anything else… We teach them the food pyramid, but it's unavoidable that they won't be able to follow it. Most students are poor. (Participant 2, School B, female, high school MAPEH teacher)*

> *I've really become strict with the students' snacks. [I allow] nutritious food only; oily food and food that are too sweet should be avoided. I told them, you can have boiled plantains, sweet potatoes, fruits. (Participant 9, School B, female, high school teacher)*

Teachers as government program implementors

The taking of students' anthropometrics (and broad assessment of their nutritional status) was intimately tied to feeding programs. According to the participants, the statistics derived from the former would ideally inform the budget for the latter (i.e., more funding for schools with

Table 4. Summary of Findings

Themes	Sub-themes	Exemplification
1. The multiple health care roles of teachers	1. Anthropometry and nutritional status assessment	• measuring students' anthropometrics • observing students' eating habits • implementing food-related classroom rules
	2. Government program implementation	• implementing feeding programs • implementing deworming programs • implementing vaccinations • dealing with parents' apprehensions regarding said programs
	3. First-aid response	• administering first-aid to physical injuries • managing clinical manifestations of illness in the classroom
	4. Mental, social, and psychological health work	• identifying psychosocial 'trouble signs' among students • mediating between students' school life and their family life at home • providing psychosocial support to students • identifying and addressing mental health issues
2. The challenges of doing health work	1. Perceived lack of qualifications to be held accountable for students' health	• lack of qualified or trained personnel to handle health work (e.g., nurses, guidance counselors) • being held accountable for health programs gone awry (e.g., the Dengvaxia crisis)
	2. Insufficient institutional support	• insufficient material resources (e.g., malfunctioning weighing scales for anthropometry)
	3. Exposure to occupational health risks	• chronic exposure to chalk dust • chronic exposure to physical health risks (e.g., sun exposure) • reliance on unhealthy practices to preserve 'momentum' of teaching (e.g., skipping meals, holding one's bladder)
	4. Inability to strike a healthy work-life balance	• taking and finishing school work at home • sacrificing sleep and time for rest • neglecting familial responsibilities

more undernourished students). Yet, some schools did not even have sufficient budget to run these programs; in the case of School B, our participants said they carried out almost all of the tasks related to their program, from food preparation and actual feeding to the cleanup afterwards. As these participants related, since the program was held during class hours, it inevitably ate into time they could otherwise devote to actual teaching.

Participant 8: Teachers should only assist in [implementing] the feeding program. But what happens is, we end up doing everything: We have to leave the classroom, go to the kitchen, let the children eat, and wait for them to finish—when they finish. Our teaching hours get cut.

Participant 1: Sometimes, we [teachers] even do the cooking—

Participant 8: And buying the food and ingredients at the market! We also do the dishes afterwards.

Apart from feeding programs, our participants also implemented—to varying degrees—the deworming programs of the Department of Health. In School B, the participants said they had a more peripheral role: They would be directly involved in implementation (i.e., directly overseeing the taking of deworming tablets) only with students who missed the scheduled date overseen by government authorities. In contrast, the participants from School A said the implementation of their program was left almost entirely in their hands, from giving the students and parents preparatory instructions and advice on possible side effects, overseeing the actual taking of medicine, to following up on the students after administration.

In both schools, the participants expressed their apprehensions toward and lack of qualifications in administering a program that involved making their students take a certain substance. A teacher from School B said she would rather not give her students the deworming tablet on her own, since she felt ill-equipped to attend to unexpected aftereffects that might result from the drug-taking. For that same reason, "I don't even make my own children take it," that teacher said. As in the following exchange, the participants from School A were likewise apprehensive toward dealing with the effects of deworming tablets among children (e.g., stomach upset, actual excretion of worms) and felt neglected by the government as far as being prepared to implement this program was concerned:

Participant 1: All the teachers would be panicking the next day. Why? Every now and then, [you would hear the students farting]. What could we do? We wouldn't know how to treat them. We could only count [how many worms were in the toilet bowl after a student finished defecating]. It would be scary to enter the CR then.

Participant 9: I experienced handling a grade 2 class, and when one student said, 'Ma'am, ma'am, something came out already!' [referring to their seatmate], I couldn't look. I couldn't bear to go near.

Interviewer: So, totally no orientation [from the government]?

Participant 1: The only orientation to us was to instruct students to take the tablets on a full stomach. And that if a student refused to take the tablet, we shouldn't force them. No other trainings.

While administering deworming programs, our participants also had to deal with apprehensive and fearful parents. The teachers attributed the parents' apprehensions to the Dengvaxia (dengue vaccine) controversy of 2017,[16] which had supposedly eroded people's trust toward school-based, government health programs, including those that predated the controversy and had long been part of the government's annual health campaigns. In the aftermath of the controversy's high-profile media coverage that highlighted the pediatric deaths ascribed to the vaccine, parents were now reportedly refusing to have their children dewormed and/or immunized even against vaccine-preventable diseases like measles. On many occasions, parents would supposedly provide prior consent, only to retract it or have their children be absent from school on the day of the actual program. Moreover, some of our participants said they, too, no longer fully trusted these programs.

They really refuse [the vaccinations or deworming]. Sometimes the parents would intentionally make their children skip school on the scheduled date [of vaccination or deworming]. Very few students would be in school during those days, usually the ones whose parents are really intent [on having their children vaccinated or dewormed]. Or the parents would go to school and no longer allow their children to receive the vaccines. (Participant 3, School B, female, grade 3 MAPEH teacher)

I myself no longer allowed my child to participate in any school program involving injections. (Participant 2, School A, female, grade 1 teacher)

Teachers as first-aid responders

Our participants also viewed themselves as first-aid responders. They spoke of attending to health emergencies as their students sustained injuries from accidents or fights, or fell ill in the classroom or complained of ailments ranging from headaches to toothaches to stomachaches. Many participants said they often felt inadequately prepared to handle these situations but, as the lone adults in the room, were forced to improvise, rely on their own knowledge, and use whatever resources were within reach. To quote a participant from School A, "sometimes you don't even know what to do with

the student." As shown by the last of the following three quotes, sometimes the teachers even used their personal resources to provide the needed care for the student:

> *I had a student who came to school visibly injured. The tricycle he was riding had gotten into an accident. I told my co-teacher to get the first-aid kit. I dressed his injuries myself. I'm also a first-aider, apparently. (Participant 2, School B, female, high school MAPEH teacher)*

> *I once had a student who suddenly complained of a stomach ache and feeling very faint. I was panicking because she had become very pale. I didn't really know what to do, so I rushed to get a glass of warm water as a first-aid measure. Afterwards, I asked her, 'What did you eat?' 'Ma'am, I didn't have breakfast,' she said. (Participant 8, School B, female, grade 6 science teacher)*

> *One of my students sustained a sizable wound from a playground fall, so I called for the parents. But the mother got mad. She didn't come; instead, she told the sibling to tell my student to go home already. '[Mother said you should] crawl home,' the sibling said. So, even though it was five o'clock already, my co-teacher and I really insisted that the parents came. 'We'll bring your child to the hospital and shoulder all expenses,' I said over the phone, 'so long as someone came with us.' We knew the family was really financially strapped. The father came; the mother couldn't face us. We brought the student to the hospital. My co-teacher and I shared the expenses and bought the medicine. We knew the student was our responsibility since we witnessed the accident. (Participant 1, School A, female, grade school teacher)*

Teachers as mental, social, and psychological health workers

The two preceding quotes illustrate how teachers often found themselves in a position to know about their students' lives beyond school (i.e., at home or in their communities). Our participants' narratives showed that this positionality essentially made them social workers or, in a sense, substitute parents who could reconcile their students' behavior in school with the students' home, family, and community dynamics; who could contextualize a student's academic performance based on that student's living conditions. This positionality provided our participants a profound understanding of observable 'trouble signs' among students—for example, why an elementary student would have lagging basic competencies, or why a high school student might be indulging in vices. Expectedly, poverty and the lack of familial support were often identified by our participants as the culprits behind these 'trouble signs'. Occasionally, the teachers provided some form of intervention; many times, however, they found themselves limited in terms of concrete and far-reaching measures they could enact to help their students. In some instances where they attempted to 'parent' the problem students themselves, the participants even encountered backlash or hostility from the actual parents.

> *If they have poor diets, they would get sick easily and be absent from school. They'd miss the lessons. Some of them really just depend on the feeding programs. Maybe it's because at home, there really isn't enough food for everyone. (Participant 7, School B, female, preschool teacher)*

> *Some kids are really unmanageable, especially those who already smoke or drink alcohol. You can't manage them anymore. Even if you check on them regularly in their homes, they will still indulge those vices. And then you have those parents who would get mad at you for 'forcing' their children to actually study. (Participant 2, School B, female, high school MAPEH teacher)*

Lastly, apart from being informal 'social workers', the teachers also described themselves as "psychologists" or mental health workers. Beyond attending to students' physical injuries and ailments, our participants spoke of dealing with the growing prevalence of mental and psychological health issues among students, including bullying, depression, and suicidal ideations. Akin to the scenarios illustrated earlier, our participants also expressed their frustration at being unable to "do more" for their students; at their lack of relevant skills, as well as the lack of available human and material resources (e.g., guidance counselors), to address the situation. The following exchange from School B illustrates how the teachers often simply turned to one another for help in situations that they believed they were unqualified to tackle in the first place:

> *Participant 6: I had a student who almost… committed suicide. He felt neglected by his family. He was being bullied in school. So, we teachers also became psychologists in this sense.*
>
> *Interviewer: Do you refer these cases to the guidance counselor?*
>
> *Participant 1: We don't have one.*
>
> *Participant 2: We also had a case of a grade 7 student who tried to jump off the senior high school building.*
>
> *Interviewer: So, what do you do when there's no guidance counselor? Whom do you refer these students to?*
>
> *Participant 1: Our co-teachers.*
>
> *Participant 5: The class adviser.*
>
> *Participant 2: We really have to make do with our own strategies.*

'Binibigay lahat sa teachers': The Challenges of Doing Health Work

Discussing the many tasks they fulfilled as 'health workers', our participants clearly did not consider themselves qualified to do health work. In our discussions, they highlighted not only their perceived lack of competence, but also the need to actually have qualified people do health work in schools. As one teacher from School A put it, "Why are we [teachers] being left in charge of the pupils' health? We are not experts on health concerns."

Perceived lack of qualifications to be held accountable for students' health

Collectively, our participants lamented the lack of school nurses to handle health emergencies, the lack of guidance counselors to properly address mental health issues, and the lack of relevant personnel to carry out domestic tasks being relegated to them during feeding and deworming programs. In School B, the teachers expressed their dissatisfaction at having to "share" their school nurse with other schools in their division; on the other hand, the two times in the past decade that the school was able to fill the plantilla position for guidance counselor, one was only a certified—as opposed to licensed—counselor, while the other was actually a regular teacher on a "mismatched item" (i.e., hired using the item for guidance counselor). Even matters as seemingly simple as giving ailing students medicine should be handled by trained personnel, the teachers asserted, as shown by this quote from a participant from School A: "What if something happens after the student takes the medicine? We wouldn't know what to do then."

Related to the notion of accountability, the teachers shared how being the visible implementors of deworming and vaccination programs put them on the receiving end of parents' anger whenever anything happened to the children; parents would blame them even for expected side effects (e.g., stomach upset after deworming). These incidents of what one teacher described as "scapegoating" were most prominent during and after the Dengvaxia controversy, as teachers were the ones who oversaw the vaccinations back then. As the following quote shows, teachers in School A experienced being publicly blamed and shamed for supposedly allowing the vaccinations to push through:

> *It should have been the health center that [oversaw the vaccinations]. Because it was us teachers who were caught in the middle; who were made to explain; whom [the parents] complained about publicly over the radio. (Participant 5, female, grade 4 teacher)*

Thus, given the culture of blame, their perceived lack of qualifications, and the additional responsibilities piled on top of their daily jobs as educators, our participants were vocal about being unwilling to take on health work even with the promise of additional compensation. In these conversations, they once again highlighted the importance of qualified health workers who could be held accountable for the students' health, as well as the fact that being paid to do health work would still eat into the time they could devote to actual teaching in the classrooms. This exchange from School A is demonstrative:

> *Interviewer: What if you were given a bonus to do these jobs?*
>
> *Participant 7: You'd still think twice about that bonus, especially if you're not an expert. We are not experts.*
>
> *Participant 1: You'd say, 'I'm a teacher, not a health worker!' That's just a bonus.*
>
> *Participant 7: The accountability, even if you have a bonus, if you don't give the proper [treatment to the student]… because we are not health experts, we'd still be held accountable.*
>
> *Participant 5: Also, you don't know anything, you will still have to do research all day and night. [That time spent researching], it has equivalent teaching hours.*

Insufficient institutional support

Besides the lack of qualified personnel, our participants also felt they received insufficient institutional support, if at all, in being made to do health work. This sentiment manifested foremost in their narratives of contending with the scarcity of material resources that could otherwise allow them to do health work more efficiently. Those who measured students' anthropometrics in School B, for example, complained that the school did not even have functioning weighing scales. To quote Participant 2 from that school, "How can you get [correct] data when your weighing scale is already 10 years old and displays a different weight every time you measure the child?"

According to the teachers from School B, another notable manifestation of this lack of institutional support was the fact that their school still used traditional chalkboards (instead of modern whiteboards). For the participants, this reflected the lack of support not only at the school level, but also from local and even regional authorities.

> *Participant 1: The problem is that DepEd supposedly can't fund the replacement of chalkboards with whiteboards.*
>
> *Participant 2: We have newly constructed buildings, but the chalkboard is still there. It's always there.*

Exposure to occupational health risks

Constant exposure to chalk dust was in fact a major health concern among the teachers from School B. The participants recognized this exposure as a health risk, both in the immediate and long term, and cited certain medical conditions that they (or their colleagues) have experienced as a result, ranging from the manageable (e.g., asthma) to the fatal (e.g., lung cancer).

> *Participant 2: When I use chalk, just a few minutes after [being exposed to the dust], I'd get a runny nose and sore throat.*

> *Participant 8: Chalk is really a concern for us because we use it every day. We develop coughs and runny noses. So, respiratory problems.*

> *Participant 1: Especially for me as an asthmatic because it really triggers my asthma. Mostly, I only use the board for activities that [require] students to write on it. And also, the risk of developing lung cancer [from daily chalk exposure].*

This chronic exposure to harmful chalk dust appeared to be emblematic of the larger irony of being a teacher: While being made to do health work, the teachers themselves said they had a difficult time caring for their own health and setting an example for their students. Much of this had to do with the working conditions they tolerated in their respective schools. For example, a physical education teacher from School B drew attention to the fact that some of her classes would be held in late morning at the quadrangle—essentially exposing her and her entire class to harmful ultraviolet rays from the sun. Other teachers spoke of skipping meals during lunch breaks in order to finish their work for the day, or stressing out their voices from too much talking to the point of developing throat ailments. Another common experience was holding one's urine and waiting until the class ended to go to the bathroom so as "not to disrupt the momentum of teaching," to quote one participant. Concurring with this last point, one participant said she would intentionally lessen her water intake throughout the day to minimize the need to go to the bathroom: "I'd end up drinking just three to four glasses of water the entire workday. It's almost impossible to have a healthy lifestyle when you're a teacher."

Inability to strike a healthy work-life balance

Even without the added responsibilities of health work, our participants already found it challenging to strike a good work-life balance. Overload, or going beyond the prescribed teaching load for a day, and taking the unfinished day's work home figured frequently in the teachers' narratives. One teacher from School A said, "Many days I find myself spending more time in school than in my own house." Juggling school-related tasks with house and family-related work, our participants also talked of sacrificing sleep and time for themselves—issues that rang truest for those who had children. The following quote provides a glimpse into the hectic lives our participants led as they juggled the combined responsibilities of being teachers *and* parents:

> *You're really supposed to finish all your work in school. But sometimes you can't; while teaching, you may have to attend to this and that. Before you know it, it's already five [dismissal time]. You now have to bring the unfinished work home so you'd be prepared the next day. But when you arrive home, the unfinished school work isn't all you have to do, especially when you have kids. You have to see to your kids, feed them. Then, when the children are asleep, that's when you can start working on the unfinished school work again. And what time would you finish? 12 a.m. or 1 a.m. You go to sleep, but soon enough, you have to wake up and go to work again. (Participant 4, School A, female, grade 3 teacher)*

It is easy to see, then, why our participants would rather not do health work or be identified as health workers, even as their present circumstances left them with no other option. In both schools, the collective sentiment was that teachers simply have too much on their plates. It is not only that teachers have too much work, but that a lot of work are being delegated to teachers now: "*Binibigay lahat sa teachers* [Everything's being given to the teachers]," Participant 2 from School A lamented. A passing description by another participant from that school could not be more apt: Teachers have indeed become "jacks of all trades."

DISCUSSION

Our findings validate the construction of teachers as 'health workers', illustrating the many tasks they fulfill in school that can be classified as health work. These include measuring the students' anthropometrics; supervising and administering government programs like deworming, feeding programs, and vaccinations; providing first-aid and various forms of immediate medical attention; addressing students' mental and psychological health concerns; and working with students' families in ways that resemble social work.

In undertaking health work, teachers are granted extraordinary access into their students' health, personal lives, and family and home dynamics. They are placed in a unique position to evaluate how students are faring at home—nutritionally, psychologically, socially—based on the physical and mental manifestations of a students' health in school. By measuring anthropometrics, for example, teachers not only get to assess a student's nutritional status, but also gain insight into a student's socio-economic status and family life. Exemplified by our participants' narratives of shouldering their poorer students' hospital costs, teachers also find themselves situated at the crossroads of school, family, and community life, bestowed with the best vantage point

to witness how students are faring in and outside of school. Put this way, teachers are essentially carers; to do health work is to deliver care, be it physically, emotionally, even manually and administratively.[19-21]

The idea that being a teacher constitutes a "special duty of care"—one that necessitates going above and beyond mere instruction to address a student's needs holistically—appears not to be lost upon our participants.[22] However, their narratives of imparting care through health work—oftentimes, without the choice not to do so—teases out two paradoxes to being a public school teacher in the Philippines. The first relates to perceived competence and qualification. While teachers find themselves tasked with taking care of students' health, and while they recognize that, in terms of students' health, more must be done, they are often unable to commit completely to the job, if at all, mainly because they believe they are not competent enough to do so. This was evident in our participants' narratives of fear and apprehension toward conducting deworming and vaccination programs; providing immediate medical attention to ailing students; and attempting to address students' mental health issues. These narratives echo Rossi et al.'s study among Australian primary and secondary school teachers, where the participants also considered themselves insufficiently equipped to handle health work, even as they acknowledged the necessity of the work for students for whom school was "perhaps the 'only place' where [they received] any health care."[9]

The second paradox pertains directly to teachers' health: In doing health work, teachers end up sacrificing 'health' and 'care' in many senses of each word. Teachers end up sacrificing actual teaching time—clearly a loss for the students—as they apportion part of their working hours to fulfilling health work and its ancillary responsibilities. More significantly, in doing health work, teachers sometimes end up sacrificing and neglecting their own physical health, as well as their emotional health in the form of their relationships with loved ones. Health work, in this way, becomes a means to committing 'unhealthy' work, and the environment of care that teachers strive to build ultimately becomes, for them, an environment of 'uncare'.

Considering these paradoxes, the effects of neoliberalism and the market economy upon our teachers and their workplaces are rendered quite stark. The long-unpacked systemic nature of the problem becomes undeniable: The extreme commodification of teachers reflects a lack of care for their health and well-being, which in turn reflects a lack of care for students' health, well-being, and performance in school.[23] The neoliberal system, to paraphrase San Juan, demands that teachers work harder at incommensurate incentives[24]; to borrow from Guerrero-Nieto and Quintero, who investigated the plight of elementary school teachers in Colombia, nowadays teachers are "not there [in school] to think but to do."[25] Consequently, as shown by Pereira's study among Singaporean teachers, the hypercompetitive, performance-oriented, and results-driven milieu engendered by the market economy in schools only end up diminishing the delivery of care by teachers to their students, while at the same time making the delivery of such care more laborious.[26] Going about the twofold labor of being a teacher—the physical, as well as the emotional—teachers are often left to their own devices in doing health work, forced to make do with "micro-practices" that include resorting to band-aid solutions for structural problems and utilizing whatever little resources they have to address students' health issues.[25,27]

The environment of 'uncare' endured by our participants is further magnified in the ways they have found themselves caught up in controversy—for example, as "scapegoats" during the Dengvaxia controversy, or as the target of parents' and even entire communities' aggression. It is, in other words, an environment that engenders feelings of danger and aligns with broader, global discourses on the ways teachers frequently find themselves working in violent ecologies.[28,29] Additionally, this 'uncare' also takes the form of a lack of institutional support in ways big and small—for instance, in the lack of material resources that would make doing health work easier (e.g., unavailability of working weighing scales) or the persistence of structural resources that only expose the teachers to certain health risks (e.g., exposure to chalk dust).

An important point to consider is the idea of higher material compensation as key to retention, or at least, a means to alleviate the burden of health work among teachers. Advocacy groups in the Philippines have long lobbied for salary hikes, among many much-needed reforms in the education sector.[30] But, while quantitative and econometric studies done in neighboring Southeast Asian countries like Indonesia and Mynamar have shown that material incentive matters greatly to teachers as far as job satisfaction and stress reduction are concerned,[31,32] our findings show that such may not exactly be the case for the country. For our participants, no amount of financial reward will ever be enough to convince them that the extra work and additional hours are worth taking on at the expense of their own health and the health of their relationships with their loved ones.

Clearly, the legal safeguards supposedly meant to ensure reasonable working conditions for teachers have proven inadequate, or else, been ignorant of the reality that teachers actually face. The Magna Carta for Public School Teachers, for instance, has failed to account for all the other 'unofficial' responsibilities handed over to teachers all the time. And while the DepEd has issued memoranda stipulating perceivably acceptable nurse- and guidance counselor-to-student ratios, the reality is that one school division is still a fairly sizable and unmanageable student population to handle for a single health worker. In any case, these plantilla items do not even get filled all the time to begin with. In recent years, bills like the School Health and Safety Act of 2019—which seeks to "unburden public school teachers… of non-teaching responsibilities" by requiring the employment of various, dedicated health personnel—have been advanced

in government, but evidently, the full implementation of such legislation remains to be seen.[33]

In the end, any conversation on reforming teachers' working conditions should heed what teachers themselves say they actually need, with respect to what the ever-evolving educational system demands from them. This means working toward fulfilling recommendations that scholars have already identified in previous research, such as increasing plantilla items and salaries for the right personnel.[3] The issue of having competent and trained human resources to do health work was especially dominant in our participants' narratives, highlighting the importance of allotting resources toward getting the right people for the job, so to speak. At the very least, teachers themselves must be properly trained to do certain forms of health work (e.g., delivering first-aid) with adequate compensation and respect for both their working hours and days off work. After all, a sense of professional competence has been shown to be quite vital to teachers' well-being and their overall performance in the classroom.[23]

The larger and more long-term conversation, however, demands transitioning beyond discussions of proper allocation of human resources or adequate compensaton to a prioritiziation of teachers' well-being and overall quality of life; to a recognition of the cruciality of a healthy work-life balance.[34] In other words, a paradigm that cares for the carers, assuring them of non-violent working environments. As it is, teachers have to contend with a system that, in the process of forcing upon them myriad responsibilities concerning students' health, erodes their own.

CONCLUSION AND LIMITATIONS

Our article has provided a preliminary, in-depth glimpse into how public school teachers in the Philippines might be considered health workers. We have shown the myriad forms of health work that teachers undertake, including providing basic clinical care, addressing students' psychosocial health needs, monitoring their nutritional status, and promoting public health—all in addition to their primary roles as educators. We have also demonstrated how health work is something these teachers do not take lightly: They often feel unqualified to do the work, but are also left with no choice but to do them. In constructing teachers as health workers, we have teased out an unspoken paradox of the country's educational system: To provide 'care' for their students, the teachers themselves must also contend with environments of 'uncare'.

The limitations of our article—and the study upon which it is based—point to several avenues for future research. First, our article is evidently limited in terms of sample size (only 19 participants in two FGDs). Second, we covered only two study sites for this article, and none of the sites in our larger study were set in Mindanao. Finally, our article itself is derived from discussions that did not exactly intend to analyze health work on its own or in its entirety. Thus, it would be good for future studies to: 1) have more geographical diversity; 2) be more focused in terms of comparative, population-based analyses along vertical divisions of the educational system (e.g., among high school teachers only); 3) involve larger populations of teachers; 4) probe into the effects of the COVID-19 pandemic and how it has shaped health work and the working environments of public school teachers; and 5) aim for more policy-driven analyses to understand health work and the roles teachers fulfill in schools in relation to the law and school governance.

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All authors certified fulfillment of ICMJE authorship criteria.

Author Disclosure

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REFERENCES

1. Into CAD, Gempes GP. Untold stories of teachers with multiple ancillary functions: a phenomenology of fortitude. J Adv Humanit Soc Sci. 2018;4(1):13–25. doi: 10.20474/jahss-4.1.2.
2. Embang SI, Jumamil VB, Cabang L, Ceballos R. Teachers' workload and work environment: inference to NAT performance of senior high school learners in Misamis Occidental. Int J Early Child Spec Educ. 2022;14(3):3599–605.
3. David CC, Albert JRG, Vizmanos JFV. Pressures on public school teachers and implications on quality [Internet]. Philippine Institute for Development Studies; 2019 [cited 2023 May 17]. Available from: https://www.think-asia.org/bitstream/handle/11540/9702/pidspn1901.pdf?sequence=1
4. Mercado JO. Work life balance and level of satisfaction among women teachers assigned in the northernmost part of the province of Surigao del Sur, Philippines. Southeast Asian J Manag. 2019 Oct 30;13(2):140–50. doi: 10.21002/seam.v13i2.11344.
5. Generalao IN, Ducanes G, Yee KM, David CC. Teacher education in the Philippines: are we meeting the demand for quality? Philipp J Public Policy. 2022;5:1–65. doi: 10.54096/IENE4805.
6. Beckett G, Zhao J. Overworked and stressed teachers under the market economy: case study in Northwest China. In: Guo S, Guo Y, eds. Spotlight on China. Changes in education under China's market economy. Rotterdam: SensePublishers; 2016. pp. 137–52.
7. Hester OR, Bridges SA, Rollins LH. 'Overworked and underappreciated': special education teachers describe stress and attrition. Teach Dev. 2020 May;24(3):348–65. doi: 10.1080/13664530.2020.1767189.
8. Aydin G, Margerison C, Worsley A, Booth A. Australian teachers' perceptions and experiences of food and nutrition education in primary

schools: a qualitative study. Aust J Teach Educ. 2022 Feb;47(2):61–75. doi: 10.14221/ajte.2022v47n2.5.
9. Rossi T, Pavey A, Macdonald D, McCuaig L. Teachers as health workers: patterns and imperatives of Australian teachers' work. Br Educ Res J. 2016 Apr;42(2):258–76. doi: 10.1002/berj.3197.
10. McCuaig L, Rossi T, Enright E, Shelley K. Schools, student health and family welfare: exploring teachers' work as boundary spanners. Br Educ Res J. 2019 Oct;45(5):1001–20. doi: 10.1002/berj.3548.
11. McCuaig L, Enright E, Rossi T, MacDonald D. Teachers as health workers: a critical understanding of the health-education interface. New York: Routledge; 2022.
12. Congress of the Philippines. The Magna Carta for Public School Teachers [Internet]. Republic Act. No. 4670 Jun 18, 1966 [cited 2023 May 18]. Available from: https://lawphil.net/statutes/repacts/ra1966/ra_4670_1966.html
13. Department of Education, Republic of the Philippines. Guidelines on the organizational structures and staffing patterns of stand-alone and integrated public senior high schools (SHS). DepEd Order No. 19, s. 2016 [Internet]. 2016 [cited 2023 May 18]. Available from: https://www.deped.gov.ph/wp-content/uploads/2016/04/DO_s2016_19_0.pdf
14. David CC, Dumdum OO. Vision 2040: the Filipino. Public consultations: discussions with the Filipino youth [Internet]. National Economic Development Authority, Republic of the Philippines; 2017 [cited 2023 Aug 3]. Available from: https://2040.neda.gov.ph/wp-content/uploads/Vision2040_final.pdf
15. Lasco G, Yu VG, David CC. The lived realities of health financing: A qualitative exploration of catastrophic health expenditure in the Philippines. Acta Med Philipp. 2022;56(11):5-15. doi: 10.47895/amp.vi0.2389
16. Yu VG, Lasco G, David CC. Fear, mistrust, and vaccine hesitancy: narratives of the dengue vaccine controversy in the Philippines. Vaccine. 2021;39(35):4964-72. doi: 10.1016/j.vaccine.2021.07.051
17. Yu VG, Lasco G, David CC, Baysic IS. 'Kontra-partido': untangling oppositional local politics and health care devolution in the Philippines. Health Policy Plan. 2023;38(7):840-50. doi: 10.1093/heapol/czad039
18. Braun V, Clarke V. Using thematic analysis in psychology. Qual Res Psychol. 2006;3(2):77–101. doi: 10.1191/1478088706qp063oa.
19. Noddings N. Caring: a feminine approach to ethics and moral education. Berkeley, CA: University of California Press; 1984.
20. Goldstein LS. Reclaiming caring in teaching and teacher education. New York: Peter Lang; 2002.
21. Acker S. Carry on caring: the work of women teachers. Br J Sociol Educ. 1995 Jan;16(1):21–36. doi: 10.1080/0142569950160102.
22. Barber T. "A special duty of care": exploring the narration and experience of teacher caring. Br J Sociol Educ. 2002 Sep;23(3):383–95. doi: 10.1080/0142569022000015427.
23. Acton R, Glasgow P. Teacher wellbeing in neoliberal contexts: a review of the literature. Aust J Teach Educ. 2015 Aug;40(8):99–114. doi: 10.14221/ajte.2015v40n8.6.
24. San Juan DMM. Neoliberal restructuring of education in the Philippines: dependency, labor, privatization, critical pedagogy, and the K to 12 system. Asia Pac Soc Sci Rev. 2016;16(1):80–110.
25. Guerrero-Nieto CH, Quintero A. Elementary school teachers in neoliberal times: the silent voices that make educational policies work. Profile: Issues Teach Prof Dev. 2021 Jan - Jun;23(1):27–40. doi: 10.15446/profile.v23n1.83052.
26. Pereira AJ. Caring to teach: exploring the affective economies of English teachers in Singapore. Chin J Appl Linguist. 2018 Nov;41(4):488–505. doi: 10.1515/cjal-2018-0035.
27. Isenbarger L, Zembylas M. The emotional labour of caring in teaching. Teach Teach Educ. 2006 Jan;22(1):120–34. doi: 10.1016/j.tate.2005.07.002.
28. McMahon SD, Reaves S, McConnell EA, Peist E, Ruiz L, the APA Task Force on Classroom Violence Directed Against Teachers. The ecology of teachers' experiences with violence and lack of administrative support. Am J Community Psychol. 2017 Dec;60(3–4):502–15. doi: 10.1002/ajcp.12202.
29. McMahon SD, Peist E, Davis JO, McConnell E, Reaves S, Reddy LA, et al. Addressing violence against teachers: a social-ecological analysis of teachers' perspectives. Psychol Sch. 2020 Jul;57(7):1040–56. doi: 10.1002/pits.22382.
30. Marcelo E. Teachers demand higher salaries. The Philippine Star [Internet]. 2023 May 2 [cited 2023 May 23]. Available from: https://www.philstar.com/headlines/2023/05/02/2263087/teachers-demand-higher-salaries
31. de Ree J, Muralidharan K, Pradhan M, Rogers H. Double for nothing? experimental evidence on an unconditional teacher salary increase in Indonesia. Q J Econ. 2018 May;133(2):993–1039. doi: 10.1093/qje/qjx040.
32. Blevins BK. Revealing preferences for teachers in rural Myanmar. Asia Pac J Teach Educ. 2020 Oct;48(5):538–54. doi: 10.1080/1359866X.2019.1684435.
33. Tutor KAB. School Health and Safety Act [Internet]. 4232 Aug 28, 2019 [cited 2023 May 17]. Available from: https://hrep-website.s3.ap-southeast-1.amazonaws.com/legisdocs/basic_18/HB04232.pdf
34. da Silva JP, Fischer FM. Understudied school teachers' work/life balance and everyday life typologies. Chronobiol Int. 2020 Sep-Oct;37(9–10):1513–5. doi: 10.1080/07420528.2020.1808010.

APPENDIX

FGD Discussion Guide *(updated as of November 2018)*

I. FGD preparatory steps

Before the discussion proper, each discussion group will be prepped by doing the following:

1. Ensure completeness of signed consent forms, give participants a chance to ask clarificatory questions on the consent form.
2. Each participant will fill out (by interview) a background questionnaire form
3. Participants will be provided snacks/lunch and drinks
4. All team members will be introduced to the group, and a round of introductions of participants will start the discussion
5. Reiterate anonymity of participants, ask for permission to audio record for documentation purposes, remind that they can leave the group if they feel uncomfortable, that they are not compelled to answer questions if they do not want to

II. FGD Guide Questions

Maganda umaga/hapon/gabi po. Kami ay mga mananaliksik sa Ateneo de Manila University. Itong interview na ito ay ginagawa bilang bahagi ng pag-aaral namin tungkol sa mga ambisyon, pangarap, at mga limitasyon na nararanasan ng mga Pilipino hinggil sa kanilang kalusugan. Gagamitin namin ang mga resulta ng pag-aaral na ito upang ipaalam sa gobyerno kung ano ang ating mga layunin para sa sarili at para sa bansa, partikular. Kami ay umiikot sa iba't ibang bahagi ng bansa at kumakausap ng maraming mga tao. Kami ay nagpapasalamat sa inyong pagdalao sa diskusyong ito.

May mga itatanong ako sa inyo at sana ay komportable kayo na i-bahagi sa grupo ang inyong mga sagot. Ito po ay diskusyon bilang grupo kaya't puwede kayong magtanong sa isa't isa kung may naiisip kayong itanong. Puwede rin ninyo akong tanungin kung may mga gusto kayong linawin.

Lahat ng mga sagot ninyo dito ay confidential, hindi namin ipababasa sa iba ang mga sagot ninyo habang may mga kasamang pangalan ninyo ang datos. Kung may publikasyon na lumabas at may gagamitin kaming sinabi ninyo, papalitan namin ang pangalan ninyo para hindi kayo makilala.

Iri-rekord namin ang diskusyong ito para lamang sa amin, para may mabalikan kami kung may hindi kami naisulat. Pero hindi po namin ito iparirinig sa ibang tao na hindi kasama sa pag-aaral namin.

Mayroon po ba kayong tanong para sa amin bago tayo magsimula?

Introductions (10 mins)

Mag-umpisa po tayo sa pagpapakilala para alam namin kung sino-sino tayo dito sa diskusyon. Pakisabi sa amin ang inyong palayaw/pangalan, ilang taon na kayo, kung may trabaho kayo saan kayo nagtatrabaho, kung may asawa kayo at mga anak, at kung may iba pa kayong gustong ikwento sa amin tungkol sa inyong buhay.

Ako muna ang magsisimula: Ako si Clarissa David, nagtuturo ako sa UP Diliman, may asawa ako na may sariling negosyong gumagawa ng mga website, at may dalawang anak isang 4 years old at isang six years old. Ako ay lumaki sa probinsya sa Laguna at lumipat sa Maynila noong kolehiyo. (do round of intros)

Part 1: Ambition/Vision on quality of health in the future (30 mins)

1. Ang una kong gustong pag-usapan ay ang mga ambisyon at plano ninyo sa buhay, lalo na sa inyong kalusugan at kalusugan ng inyong pamilya, kasama na rin maging ang kalusugan o mga dinaramdam ng mga nakatatanda sa inyo sa pamilya. Mag-isip tayo ng 20 taon sa hinaharap (in the future), ano ang nakikita ninyong estado ng inyong buhay? May mga asawa o anak ba kayo, at sa tingin nyo ba ay mananatili kayong malusog at walang sakit?

   Kung sa tingin ninyo ay wala kayong magiging problema: Bakit po kayo may kumpyansa na maayos ang inyong kalusugan hanggang sa inyong pagtanda?

   Sa inyong pananaw, kayo ba ay may sapat na kaalaman tungkol sa mga bagay na pwede ninyong gawin upang manatili kayong malusog at walang sakit hanggang sa inyong pagtanda? Bakit meron/bakit wala?

Getting participants to imagine the future:
   a. Isipin niyo po muna, ilang taon na kayo sa 2040?
   b. Ilang taon na ang mga anak ninyo?
   c. Kung iimagine ninyo ang buhay sana ninyo sa 2040, ano iyon? Ano ang lagay ng inyong kalusugan? Ng inyong pamilya? Ng inyong anak?

Probes
   a. Sa edad ninyo sa 2040, nagtatrabaho pa ba kayo? Ano ang trabaho ninyo? Anong oras
   ninyo gustong nakakauwi sa bahay, gaano kadalas kayo magtrabaho?
   b. Ano sa tingin ninyo ang inyong magiging estado ng kalusugan? Nakakapag-ehersisyo ba kayo? Mayroon ba kayong makakain na mga pagkain na mabuti para sa inyo?
   c. Makakabili ba kayo ng mga gamot na kakailanganin ninyo kapag tumanda na kayo?
   d. Saan kayo nakatira? Anong klaseng bahay? Gaano kalaki?

e. Magkakaroon ba kayo ng pera o insurance na kasya sa pambayad sa ospital at doktor kung kayo man ay magkasakit nang malubha?
f. Paano ang pangangalaga ninyo sa kalusugan at kapakanan ninyo at ng pamilya?

2. Bukod sa inyong sariling kalusugan, mayroon bang mga ibang "health threats" dito sa inyong lugar? Kasama dito ang mga problema hinggil sa kalusugan na dulot ng mga disaster tulad ng baha at bagyo, o kaya mga threat o banta sa seguridad ninyo tulad ng karahasan (violence) o mga trabaho na nakaka-dulot ng mga pinsala (injuries) at sakit?

Part 2: Current situation and constraints (30 mins)

3. Salamat sa pagpahiwatig ninyo ng inyong mga pinapangarap at inaambisyon. Ngayon naman po ay pag-usapan natin ang inyong kalusugan ngayon at ang access ninyo sa mataas na kaledad ng health care (pangangalaga sa kalusugan). Base sa kalagayan ninyo ngayon, sa tingin niyo ba ay kaya ninyo bilang pamilya na makamit ang mga pinahiwatig ninyong ambisyon para sa inyong kalusugan sa inyong sarili at sa inyong pamilya?

   Ano ang mga kailangan mangyari upang makamit ninyo ang mga ambisyon na ito? Ano po ba ang mga balakid ninyo sa inyong pagprotekta sa inyong kalusugan at kalusugan at seguridad ng inyong mga anak? Mayroon po bang mga bagay o sitwasyon sa inyong paligid na nagpapahirap sa inyong pagtrabaho upang makamit itong mga ambisyon ninyo para sa isang mahaba at malusog na buhay?

   Kayo ba ay nababahala o di nababahala na baka mahirapan kayong mabuhay nang mahaba? Ano ang inyong mga kinababahala tungkol sa pangangalaga ninyo sa inyong kalusugan?

Sources of constraints, for directional probes:

a. Sa abilidad ninyong magbayad kung sakaling magkasakit
b. Sa mga kakulangan o kasapatan ng facilities sa komunidad tulad ng doktor, nurse, ospital, health center, specialist, pharmacy
c. Sa kakulangan ng kaalaman tungkol sa paano panatilihin ang kalusugan ng sarili at pamilya
d. Sa abilidad ng health care system ng Pilipinas na pangalagaan ang kalusugan ng mga tao sa komunidad.
e. local governments

Part 3: Broader health goals for country and countrymen (20 mins)

4. Pinag-usapan natin ang sarili ninyong kalusugan at pamumuhay, ngayon naman ay pagusapan natin ang mga Pilipino bilang mamamayan at bahagi ng bansa natin. Ano sa inyong palagay ang dapat nating makamit na estado ng health care system sa bansa? Anong kaledad? Anong klaseng relasyon dapat ang mayroon ang mga mamamayang Pilipino sa kanilang health care system?

   May alam o napuntahan na ba kayong ibang bansa na sa tingin ninyo ay magandang maging modelo ng Pilipinas para sa isang health care system? Aling bansa ito?

5. Ano ang pinaka-importanteng mga problema sa health care system ng Pilipinas na kailangan maayos upang umunlad ang mga Pilipino? Sino dapat ang nag-aayos nito?

6. Ano ang pinaka-importanteng mga problema o isyung pangkalusugan sa inyong komunidad? Ano ang mga problema o isyu na sa tingin ninyo ay makakabagal sa pag-unlad ng inyong buhay o di kaya ay magdudulot ng kapakanan sa inyong kalusugan?