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Bridging the Gap: Reducing Health Inequities in Access to Preventive Health Care Services in Rural Communities in the Philippines

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Abstract

Introduction: We used an implementation science framework to investigate perceived health inequities in preventive health care initiatives in rural communities in the Philippines. We also identified health equity–focused quality improvement strategies.

Methods: Three health care providers and 12 barangay clinic patients were interviewed.

Results: Patient interviews showed that social determinants of health, respect, and attitudes toward health care providers affected patient empowerment to engage in self-management for noncommunicable diseases (NCDs). Health care providers identified six challenges in managing NCDs: (a) inefficient work processes; (b) staffing shortages; (c) insufficient access to low-cost medications; (d) inadequate primary preventive health education from the schools; (e) health care not considered a priority; and (f) lack of local government support.

Discussion: Inadequate preventive health care and education intensify health access and resource inequities in rural communities in the Philippines. A multi-sectoral plan may improve rural health infrastructure and education toward improving health care access and decreasing care disparities.

Keywords

diabetes; health disparities; public health policy; community health; transcultural health

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Disclaimer

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Introduction

Most deaths and illnesses in low- and middle-income countries (LMICs) are caused by heart disease, diabetes, cancer, and chronic lung disease (Checkley et al., 2014; Williams et al., 2018). LMICs have a higher noncommunicable diseases (NCDs) risk than industrialized nations due to less access to healthy food or choices and poor health care (Kaluvu et al., 2022). Prevention-focused health systems are the most inclusive, equitable, and cost-effective way to promote health (Checkley et al., 2014; Haque et al., 2020). NCD control systems need a nationwide preventive health care infrastructure to promote healthy behaviors, reduce early mortality, and enhance treatment access (Kruk et al., 2018; Williams et al., 2018).

Most NCD prevention occurs in primary care; however, this is challenging in the Philippines, where universal health coverage (UHC) is lacking. According to the early results of the Family Income and Expenditure Survey (FIES) done in July 2023, about 16.4% of households in the Philippines did not have enough money to cover their basic needs in the first half of 2023 (Philippine Statistics Authority, 2023). This means they struggled to afford both food and other essentials. At the same time, the poverty rate among individuals was 22.4%, which translates to roughly 25.24 million poor Filipinos during that period. In addition, around six out of every 100 Filipino families could not afford enough food to meet their basic nutritional requirements in the first half of 2023 (Philippine Statistics Authority, 2023). Similarly, about nine out of every 100 individuals faced food insecurity during the same time frame.

The Philippine health care system is decentralized, with much control from the local chief executive (e.g., governor, mayor). In the public health sector, a rural municipality with a population of 20,000 usually employs one physician, two nurses, and five midwives. This is particularly challenging for geographically isolated and disadvantaged areas where patients and health workers travel significant distances to reach a point of care. The rural health unit (RHU) has several barangay health stations (BHS), which often provide maternal and child health services, tuberculosis management, and general consultations (Dayrit et al., 2018). Although coverage from the National Health Insurance Program has improved and professional services at the RHU and BHS are free, diagnostics and medications are usually paid out of pocket. Unfortunately, attempts to increase human and material resources are constrained due to a lack of funds primarily derived from local income and allocation from the national government (L. M. S. Tejero et al., 2022).

Hypertension and diabetes account for 70% of all deaths in the Philippines. In 1979, a primary health care plan was developed to increase community control over local health care. The goal in 2000 was to ensure that all Filipinos were healthy. Priorities included preventing and controlling common health issues, promoting adequate food and nutrition, sanitation, water supply, maternity and childcare, immunization, managing and controlling endemic diseases, and delivering critical medications. The World Health Organization’s (WHO, 2020; Quimbo et al., 2018) Package of Essential Noncommunicable (PEN) Disease Interventions for Primary Health Care in Low Resource Settings consists of risk assessment, screening, prevention and management, follow-up care, and referral.

NCDs persist in the Philippines, notwithstanding the 1979 health campaign and PEN's statewide implementation. Health care financing favors high-income individuals and families, delivery is fragmented, facilities are underequipped, and health human resources (e.g., health care providers, public health nurses, and educators) are unequally distributed (Banaag et al., 2019). Rural residents may use traditional practitioners, inadequately equipped or staffed RHUs, or not seek medical care except in acute sickness or medical emergencies due to socioeconomic circumstances (Kawi et al., 2024). This lack of health promotion infrastructure and resources shows Filipinos' health inequity attributable to social determinants (Flores et al., 2022).

The 2019 UHC Act guarantees health care access for everybody, especially in remote and impoverished places. Primary preventive health care in rural parts of the Philippines is essential to universal health care access due to inequities and the vast urban–rural health care delivery divide (De Vero et al., 2021). The COVID-19 epidemic and its aftermath have also harmed the country's socioeconomic stability, making health care access more challenging, creating health disparities, and increasing Filipinos' NCD prevalence (Berdida et al., 2022). Thus, not practicing preventive health care worsens NCD management access, resource allocation inequities, and poor health outcomes.

The Philippines' growing NCD rate has raised concerns about socioeconomic determinants of health (Yamaguchi et al., 2021). Transcultural nursing must link socioeconomic determinants of health to health care access gaps to lead and sustain quality improvement and create practical solutions to NCD-related health disparities. Identifying patient and health care provider barriers can help local governments be more responsive and eliminate health care fragmentation in rural areas with the most significant disparities in health. Patients' views, care facilitators, and barriers are essential to long-term NCD prevention.

Implementation science can be used to examine perceived health disparities in preventive health care outcomes in rural Philippines, accelerating the development, translation, and acceptance of evidence-based interventions (Shelton et al., 2021). Health equity necessitates addressing significant gaps and opportunities in implementation science, including the socioeconomic determinants of health. Research has focused on acute care facilities (Barr et al., 2021; McNett et al., 2020, 2021). Despite the growth of community-based care, research into evidence-based preventive health care remains sparse.

This study examines challenges and highlights barriers to preventive health care access that reduce health disparities in the Philippines. One must first understand the many layers of health care barriers to prioritize health equality in quality improvement programs. The research questions are as follows:

> **Research Question 1:** What challenges do patients perceive in getting NCD preventive health care in rural health clinics in the Philippines?
>
> **Research Question 2:** How do rural Philippine health clinic providers view NCD prevention barriers?

Theoretical Foundation

The Fundamental Cause Theory (Link & Phelan, 1995; Subica & Link, 2022) suggests that individual (patient), interpersonal (health care providers), community (programs, initiatives), and organizational (lack of supplies and protocols) barriers may reduce NCD risk in rural Philippines. Policy barriers impact NCD based on regional progressivity (Polonijo & Carpiano, 2013; Rydland et al., 2020). A primary sociocultural driver of health inequities has four key traits. First, socioeconomic status affects multiple health outcomes. Second, it is hypothesized that the fundamental causes of these health disparities operate through various risk-factor mechanisms, including awareness of health-related behaviors. Numerous risk factors affect these health outcomes. Third, disease prevention and treatment resources are essential societal causes. Finally, substituting intervening processes maintains cause-health relationships. The researchers identify them as “fundamental” because they affect health despite process modifications (Subica & Link, 2022). The researchers employ the Fundamental Cause Theory to study the complex social concerns prohibiting Filipinos from accessing preventive care. In addition, the theoretical framework used for this study does not imply that the risk of NCDs will be eradicated; instead, it offers a basis for understanding the significant burden of disease and insufficient infrastructure.

Method

Design

Using qualitative descriptive implementation research, the researchers examined possible reasons for health inequities in preventive health care access (Hamilton & Finley, 2019). Our research team used a participatory implementation science perspective to integrate insider perspectives (i.e., study participants) and current literature to develop solutions that reflected the study context, specifically the inequity in health care and resources in rural villages’ NCD prevention and control interventions. Qualitative techniques allow for varied data generation and evidence-based viewpoints to create real-world solutions (Ramanadhan et al., 2021).

Setting and Participants

Health care providers and NCD patients were questioned in three rural, poor Northern Philippines villages. All participants were barangay members from rural Philippines. The Philippines’ lowest administrative division is a barangay, like a village, district, or neighborhood. Local governance and public health services, including medical care, fall under the barangay (Reyes et al., 2023).

Health care providers had to be Philippine-licensed physicians and leaders in local clinics. Patients had to be ≥ 18 years old, diagnosed with hypertension and diabetes within 12 months, and receiving care from rural health care clinics. Hypertension was operationally defined as patients with systolic/diastolic blood pressure of 140/90 mmHg or more significant. Type 2 diabetes was characterized by glycated hemoglobin below 6.5% or fasting plasma glucose below 126 mg/dL. Pregnant participants were excluded. Three health care providers were recruited, each responsible for three to five rural health care clinics in

their local government units. In addition, 12 patients (aged 45–70 years, six male and six female) participated in the study. Seven patients completed high school or less, and five completed college education.

Data Collection

A semi-structured interview guide for health care providers was based on the Consolidated Framework for Implementation Research (Damschroder et al., 2020) and Promoting Action on Research Implementation in Health Services (PARIHS) frameworks (Harvey & Kitson, 2016). Health care providers were asked about clinical context and characteristics, such as staffing (inner setting), facility or system priorities and changes (outer setting), and preventive health care service effectiveness (evidence). They were asked to describe their preventive health care implementation and which parts were easy or hard to accomplish. A senior researcher (L.S.E.) with qualitative interviewing experience conducted all interviews.

Participants in semi-structured interviews provided NCD information and if a health care provider had prescribed a treatment plan. Their opinions on their medical conditions' causes and prevention, therapy, food, exercise, and medications were also asked. Participants were then asked to describe their self-management level, including barriers and facilitators, stressing the health care system's participation (clinic, providers, staff). Finally, participants were asked whether family, friends, and community influences empowered them to self-manage their disease, follow their treatment plan, and achieve the best health results. All interviews ($N = 15$) were face-to-face and lasted 30 to 45 min. The researchers conducted face-to-face member-checking interviews within 3 months after their initial interviews to clarify emerging themes from our qualitative data analyses.

Data Analysis

The researchers used thematic analysis (Braun & Clarke, 2014; Braun et al., 2022) to find reoccurring themes in the data. Data saturation resulted from recurrent and concurrent NVivo data gathering and analysis. After repeated data inspection, familiarization, code development, and theme identification, recorded and transcribed data were independently analyzed. Participants' interview guide responses (e.g., preferences and opinions) were classified similarly. Aggregating codes yielded data themes. The research team then worked together on theme review, description, naming, and report preparation. Recursive steps were used to reach consensus on emergent ideas. Analytical quality was assessed using Braun and Clarke's (2014) 15-point checklist. Data were summarized and confirmed with participants after each interview, and members were checked for 3 months. Research reflexivity, written notes, and audit trails were also maintained. Data reliability was ensured by consulting a qualitative methodological specialist.

The researchers integrated interview and literature data using quality improvement methods in the implementation science framework, identified root causes, and made recommendations using root cause analysis. The researchers used the socioecological model to interview barangay health care workers about health care access barriers (Reyes et al., 2023). This study enhances that survey. The researchers describe study findings using the Consolidated Criteria for Reporting Qualitative Research (Buus & Perron, 2020).

Ethical Considerations

The study was approved by the Institutional Review Board of the University of California Irvine and the Ethics Review Board of the University of the Philippines (IRB approval number: UPMREB #2016-496-01). Before initiating any interviews, the researchers ensured that every participant was duly apprised of the study's objectives and that they provided written informed consent. Furthermore, local endorsement via a memorandum of understanding was secured at each site location.

Results

The thematic analysis of patient and provider interviews revealed two themes. The first collection of themes concerns rural patients' barriers to NCD preventive health care, whereas the second group concerns health care providers' barriers (Figure 1). Patient perspectives on NCD (the center) motivate health care practitioners to offer care. In contrast, provider perspectives focus on quality improvement techniques for individual, organizational, and policy change.

Patient Themes

The patient interviews revealed two main themes: (a) social determinants of health affect preventive health care availability and (b) mutual respect between patients and providers affects health care quality. Figure 1 shows the interconnectedness of social determinants of health and respect in rural Philippine health clinics' availability and quality of health care.

Social Determinants of Health Influence the Availability of Preventive Health Care Services.—The first central theme shows how social determinants significantly affect access to health clinics in rural areas. In most low- and middle-income nations like the Philippines, lack of education and distance to health facilities are major socioeconomic determinants of health. Education and distance to rural health clinics affect the patient's impression of the importance of preventive treatments, resulting in only severe cases of accessing care there:

> Our blood pressure is high, and we've both been taking medicine for it for over ten years. The only time we go to the clinic is when we're sick. When we go to the clinic, we have to wait hours and aren't seen because there are too many people.
>
> (Patient 1)

Poor people in the Philippines have trouble getting NCD prevention services. Families focused on food and less on healthy habits (e.g., diabetes prevention):

> We don't have time to go to the clinic because we have to work in the fields, and by the time we're done, it's already closed. We don't have time to exercise and eat. It's more of a problem to get food on the table than to worry about what we can and can't eat.
>
> (Patient 2)

> No one told me how to take care of my diabetes. They just told me to eat less rice and sweets. I wanted to know how bad my diabetes was and if I was going to die faster.
>
> (Patient 3)

Culture and folk medicine are critical social determinants of health in rural Philippine health clinics' NCD prevention. Families employ folk and Western medicine systems simultaneously, but lifestyles, education, geography, and the lack of rural health clinics affect their culturally connected health-seeking behaviors. Some of these families also utilized folk medicine, which can be influential and culturally significant. However, if not adequately evaluated, it may sometimes interact with medications prescribed by rural health clinics. Due to other societal issues, families have restricted access to rural health clinics' preventive services:

> Along with the maintenance medications we get from the clinic, our albularyo (herbalist) gives us supplements to take. Sometimes, when we ran out of medications, we only have herbal supplements, which seem to be working.
>
> (Patient 7)

Respect Between Patients and Providers Affects Health Care Quality.—Patients emphasized the value of being respected in rural health clinics. Patients suggested how their experience of being respected by their health care providers influenced their impression of the quality and availability of care. This sense of respect also predicted whether the patients would return to the rural clinic for additional services:

> When we see the doctor, there is no private space to discuss our issues.
>
> (Patient 1)

> A nurse in the clinic is very supportive of providing us with maintenance medications when she knows we cannot afford them—she is very caring and sensitive.
>
> (Patient 5)

The patient's experience of being respected showed structural constraints, such as a staff deficit and a scarcity of rural health clinics in specific catchment areas. Despite these institutional barriers, patients underlined the significance of maintaining a respectful patient–provider relationship when seeking NCD preventive interventions:

> The doctor isn't in the clinic regularly, and the barangay healthcare workers will tell us to return. They don't know what to do and are always short-staffed.
>
> (Patient 6)

> Sometimes, when I go to the clinic, I wave at the doctor and staff, and they wave back and ask me how I am doing, but they don't examine or talk to me.
>
> (Patient 8)

These two essential themes on rural health clinic patients' views of preventive services activate broader variables affecting health care quality and availability. Patients' economic

situations and the need to devote more time to work than to visit clinics for preventive health care services limited their visits to the clinic, and they perceived the lack of personal benefits of broader factors affecting their care. These broader issues affecting their treatment also influenced social determinants of health and mutual regard. Thus, the researchers contacted health care practitioners to identify these broader characteristics.

Provider Themes

Six primary themes emerged from our rural health clinic provider interviews: (a) lack of standardized procedures for evaluating and managing NCD; (b) staffing shortages; (c) inadequate supply of low-cost medications and medical supplies; (d) school system neglects primary preventive health education; (e) preventive health care access and needs are not valued; and (f) lack of local government support. These themes show the challenges of offering NCD preventive care.

Lack of Standardized Procedures for Evaluating and Managing NCD.—Health care providers stated that insufficient application of standardized diagnostic tools and best practice standards for NCD management slowed documentation, case management, and referral processes:

> Sometimes, when I go to the rural health clinic, I expect the barangay health worker to attend to some simple tasks and then discover they were not completed. This frustrates me because I cannot attend to the patients if these simple tasks are not completed. I am frustrated because I supervise multiple clinics.
>
> (Healthcare Provider 1)

Staffing Shortages.—Health care providers claimed that due to staffing constraints, they limit clinic hours. Rural health facilities were sometimes only open on particular days and times of the week, forcing patients to wait outside in the stifling heat while others received inadequate care. This is especially problematic for patients who only visit the clinic when severely ill or in emergencies:

> Too many patients are lining up outside, and we cannot attend to all of them. Some of them have illnesses that only the nurse can advise, and she could only come at least once a week. What can we do? We are always short of staff.
>
> (Healthcare Provider 2)

Inadequate Supply of Low-Cost Medications and Medical Supplies.—Health care providers reported that patients commonly indicated that they could not afford the medications needed to control their NCD. They claimed that patients who visit their clinics already have serious ailments that require medications. However, they described being caught between their desire to serve their patients and the scarcity of low-cost medications:

> We have a lot of patients with diabetes and hypertension. However, they could not afford to buy medications for their illnesses. We don’t have those medication supplies in our clinics. Sometimes, I feel sad because I am recommending these

> medications to them, but they don't have ways to obtain them anyway. So, what's the use?
>
> (Healthcare Provider 3)

The School System Overlooks Primary Preventive Health Education.—Health care providers expressed concern about a lack of preventive health education on NCDs in schools. They described how the school system was a key contributor to rural health clinics' health care services. However, they stated that programs connecting health promotion and education were promoted nationally but were rarely implemented at the grass-roots level, such as barangay-level programs. They expressed concern that the municipal health offices remained separate from the public education system; health promotion and disease prevention receive less attention in school curricula:

> The public-school administrators have different priorities. They don't see the importance of health education for children and families. If schools educate their students and the students' families on diseases like high blood pressure and diabetes, we probably will see patients when their diseases are not that severe yet.
>
> (Healthcare Provider 2)

Preventive Health Care Access and Needs Are Not Considered a Priority.—Health care providers said that while their mandate at the barangay level was health promotion and disease prevention, their rural health clinics' limited resources forced them to prioritize other activities. They noted the difficulties of educating people about NCD prevention and providing health care services, which exceeded their health knowledge. Social determinants of health affect patients' access to preventive health care, making it difficult to aid them:

> It is just difficult to tell our patients about maintaining a healthy lifestyle. Our patients have other needs, such as necessities like food and shelter. So, it is just like a revolving door. We teach them, but they don't follow through. It becomes frustrating, and we have other health issues like immunizations and communicable diseases.
>
> (Healthcare Provider 1)

Lack of Support From the Local Government Leaders.—Health care providers claimed that inadequate pharmaceuticals and medical supplies, staff shortages, low salaries, and staff training demonstrated a lack of government support. Program implementation was financially dependent on current municipal leadership; therefore, shifting municipal administrations often hampered long-term strategic planning. Some providers said they frequently rely on private organizations to fund their programs:

> We lack doctors and nurses because they go to the city as they are better paid there. We don't have the medications that the patients need, and we have to tell them they must get them at the local pharmacy, which they could not afford anyway.

> I feel hopeless in helping them because we do not get much support from the government.
>
> (Healthcare Provider 3)

Multiple root causes affecting stakeholders have been identified (Figure 2). These include patients not having time to come to the clinic, not having money to buy their medications, limited outpatient support, staff lacking evidence-based and implicit bias training, being overworked and not having time to see all patients, protocols lacking standardization, fragmented social and medical services, and irregular support from the Philippine Department of Health and local government units. Thus, our root cause analysis identified critical areas allowing stakeholders from barangay, municipal, provincial, professional regulatory, and national program implementation levels to prioritize solutions that yield the best, most beneficial, and extensive results. These include training barangay health workers to manage patients, implementing standardized NCD protocols, collaborating with the Philippine Department of Health to provide free or low-cost medications, working with school officials to integrate preventive education into the curriculum, and providing regular follow-up care.

Discussion

Social determinants of health affect the availability of preventive health care and patient utilization of ongoing care in rural Philippine health facilities. Several perceived constraints impede the Philippines from providing preventive health care. Health care facilities and providers are scarce, especially in rural areas where geography and infrastructure make preventive care challenging (Reyes et al., 2023). Financial constraints restrict preventive health care access. Preventive screenings and vaccines are expensive for many Filipinos. The lack of UHC leaves a large percentage of the population without preventive care, adding to this expensive burden (Lim et al., 2023; Serafica et al., 2023). Health care provider and patient-perceived barriers are illustrated in Figure 2. Improved access to health care facilities, health education and awareness, UHC, and culturally responsive preventive health care services are needed to reduce barriers. Addressing these constraints can enhance Philippine health care delivery and results.

Health care access depends on social factors like income, education, and location (Cacciata et al., 2021; Soberano et al., 2021). These social variables can significantly affect rural health care access due to inadequate resources and infrastructure. Underserved populations may be unable to afford health care or transportation, delaying or forgoing care. In addition, poor preventive health care education and awareness can affect utilization rates in specific populations. These societal determinants must be addressed to ensure rural health care equity. Improved infrastructure, financial aid, and health education can reduce these discrepancies and improve health outcomes for all, regardless of social status.

Patients' opinions of care quality and health care system confidence depend on their relationship with clinicians, particularly regarding mutual respect and biases. Patients trust their doctors and follow treatment regimens better when they feel appreciated and valued. Disrespect and discrimination can damage trust and care views. Conscious or unconscious

biases might affect care quality and cause treatment inequities. Promoting cultural awareness and sensitivity among health care providers and creating a respectful and inclusive health care environment is necessary to address these concerns. Health systems can increase patient satisfaction, care adherence, and results by eliminating biases.

Interviews with health care providers show the challenges of providing preventive care in rural Philippines. The lack of NCD assessment protocol standardization is a significant issue. Therefore, a care delivery strategy emphasizing well-defined procedures and rules must provide consistent and efficient care for chronic illness patients. First, a thorough and universal screening approach for socioeconomic determinants of health should connect people with support services to improve their well-being and reduce morbidity and mortality. Without standardized screening, support services were lacking, limiting patients' capacity to self-manage their disease, follow prescription regimens, attend regular checkups, and participate in health-promoting activities. Developing standardized NCD management practices, including regular clinic visits, would assist in building personalized care regimens and assessing patients' illness management.

Another issue was staffing, which hindered rural health clinics' ability to serve their communities. Staffing shortages reduce service availability and patient wait times, which may delay diagnosis and treatment. Creative methods such as assigning staffing responsibilities improved implementation (Aytona et al., 2022; Tamayo & Reyes, 2023). These positions were paid and voluntary, with regular responsibilities. A paid nurse staff member is named a champion with devoted time and clear responsibilities, improving regional operational processes. Barangay health workers also assist health care providers and connect potential users to innovations. These creative techniques show that nurse leadership and involvement are crucial to adopting health care innovation.

Another option is that rural health care clinics are vital to poor rural communities but are underutilized for nursing clinical education. Clinics and nursing schools working together can improve patient care and student education. Students learn about rural populations' health care needs and the importance of interprofessional teamwork in providing services. Students can attain clinical goals and address rural people's health care requirements through practical experience. Supporting PhilPEN training, risk assessments, screening, medication management, health education, and referrals requires collaboration with municipal health officials, barangay leaders, and residents.

Rural providers face challenges due to a shortage of affordable medications and supplies, which can impair care quality and NCD prevention and management. UHC and Sustainable Development Goal 3.8 emphasize access to affordable medications to prevent and manage NCD (Beran et al., 2019; Lambojon et al., 2020). By eliminating taxes, profits, and tariffs, medication prices can drop. Value-added tax for medications ranges from 0% to 19% worldwide, with the Philippines at 12% (Bangalee & Suleman, 2017). On January 1, 2019, the Philippines passed Section 109-AA of Republic Act 10693, the "Tax Reform for Acceleration and Inclusion Law" (Lambojon et al., 2020), reducing the value-added tax for Food and Drug Administration (FDA)-approved drugs NCD. Philippine laws and regulations must be reviewed to increase medication accessibility.

Midwives and barangay health workers are the main health care professionals in rural areas. Health care providers are mainly at the RHU of the municipal center. Current efforts aim to formalize rural health care workers' duty delegation to improve efficiency and accessibility. Furthermore, the principle of "kapwa" (shared identity) in Filipino Psychology under-scores the significance of cultivating trust, particularly pertinent in rural contexts, wherein the dynamic between providers and recipients transitions from that of outsiders ("ibang tao") to insiders ("hindi-ibang-tao") (Enriquez, 1978; Pe-Pua & Protacio-Marcelino, 2000).

The lack of primary preventive health education in schools misses an opportunity to teach good habits and promote well-being early on. Preventive health education in the curriculum can help people make healthy choices and lower the long-term burden of NCD, especially cardiometabolic illnesses, which are common in rural regions (Cacciata et al., 2021). For example, comprehensive health education should be integrated into the school curriculum, covering nutrition, physical activity, mental health, reproductive health, and substance abuse prevention. Ensure that these topics are age-appropriate and culturally relevant. Collaboration among various stakeholders is essential to act on these recommendations in the Philippines. This includes government agencies responsible for education and health, school administrators, teachers, parents, students, and community organizations. Policies should be developed and enforced to support school health promotion initiatives, and resources should be allocated to ensure their successful implementation. Training programs for educators and health professionals can enhance their capacity to deliver effective health promotion interventions. In addition, monitoring and evaluation mechanisms should be put in place to assess the impact of these interventions and make necessary adjustments to improve their effectiveness over time.

To guarantee equitable access to preventive health care, health care providers, politicians, and communities must work together. A systematic approach is warranted to enhance access to health care facilities, health education and awareness, UHC, and culturally responsive health care services. These barriers can be overcome to improve the country's preventive health care services and health outcomes, reducing health disparities in rural areas. Finally, local government leaders' opposition prevents health care policy and program execution. Advocating for rural health care resources requires engaging with local leaders and stakeholders (Tejero et al., 2022).

Conclusion

Rural LMICs like the Philippines struggle to provide preventive health care. Insufficient health promotion and prevention infrastructure, a shortage of qualified health care workers, lack of health education focused on primary prevention strategies in schools, underestimation of primary health care training and supervision, and insufficient local government engagement contributed to study findings. Essential preventive health care in rural Philippines worsens NCD health access and resource inequality. A multi-sectoral plan may strengthen rural health infrastructure for preventive care.

Implications for Nurses

Nurses must go beyond clinical treatment to address rural health care's systemic issues. Nurses can lead and advocate for policy reforms that standardize NCD management and staff barangay health centers. Advanced practice nursing policies in the Philippines will help train nurse providers in remote and underserved areas or those with a physician shortage. Nurses can improve medicine and supply access by working with local health care facilities and groups to collect donations or funds. Nurses can also empower people to manage their health by promoting primary preventive health education in schools and communities. Nurses, school instructors, and health care providers can collaborate to overcome these difficulties and improve rural Philippine preventive health care by being watchful.

Implications for Policymakers

UHC is essential for LMIC health promotion and NCD prevention. Policymakers and stakeholders must emphasize sustainable policies and measures to alleviate LMICs' lack of preventive health care services. LMIC governments must also focus on socioeconomic determinants of health in NCD preventive health programs to reduce disease burden. Human resources, health facility development, service delivery, and health care finance require policy monitoring and assessments.

Implications for the Society

The current period of global public health is marked by enthusiasm as international leaders, politicians, and stakeholders work together to meet the health needs of countries with limited resources. The initiative is known as the UHC Agenda. Our study examined preventive health care, a vital component of this strategy. In addition to individual-level determinants, structural biases—established and accepted laws, practices, and attitudes—significantly affect Filipinos' access to preventive health care. The report encourages further discussion and highlights emergent research issues related to preventive health care in rural, underserved Philippines.

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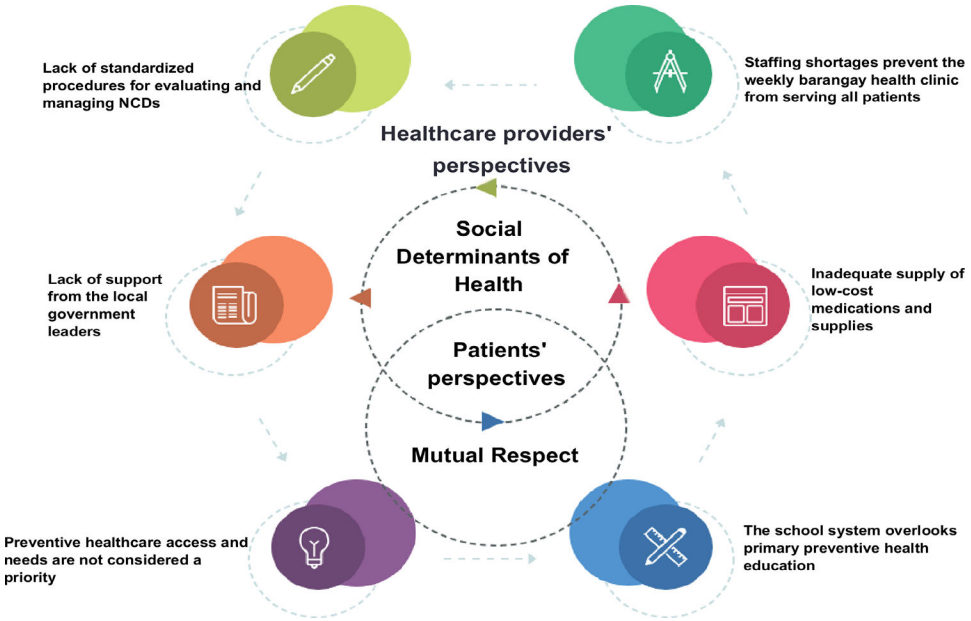

Figure 1.
Two Key Themes and Six Thematic Challenges.

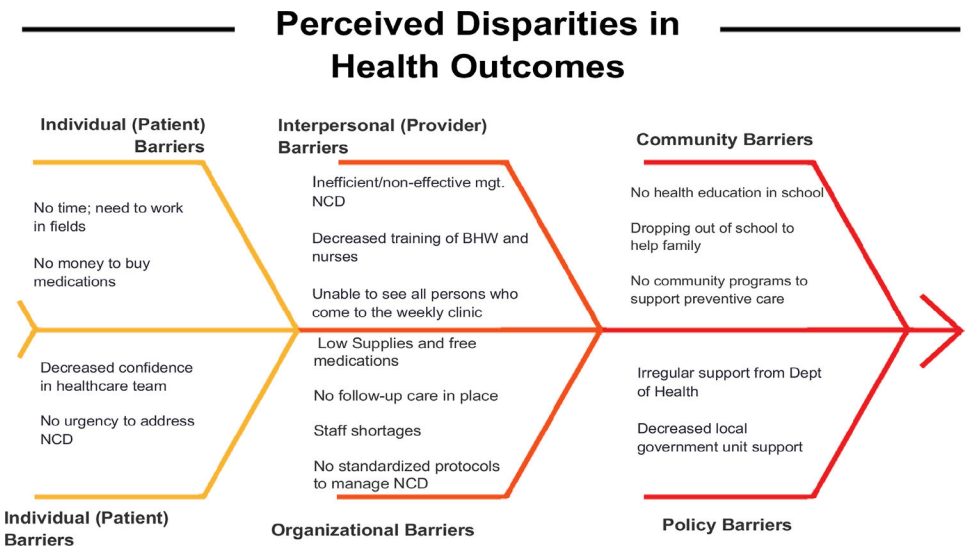

Figure 2.
Fishbone Diagram That Illustrates Multilevel Barriers to Preventive Services.