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Healthcare Workers on the Frontline: A Conflict Analysis and the Potential for Transitional Justice in the Philippine COVID-19 Response

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The COVID-19 pandemic exposed entrenched structural inequalities in the Philippine healthcare system, as revealed through the experiences of frontline healthcare workers. During the crisis, they faced resource shortages, heightened risk, and institutional neglect rooted in bureaucratic corruption, opaque governance, and a securitized emergency response. This article examines how structural, cultural, and direct violence intersected under pandemic conditions within overarching patterns of governance and social inequality. Using qualitative methods, it draws on frontline narratives, civil society reports, and media accounts to analyze interactions among state authorities, healthcare institutions, and civil society actors. Anchored in Galtung's conflict triangle and conflict transformation framework, this article frames the pandemic as a site of unresolved social conflict and explores possibilities for accountability and structural reform toward equitable healthcare governance.

Keywords Philippine healthcare system, COVID-19, conflict studies, violence, transitional justice

Introduction

On the morning of July 22, 2020, following the completion of a mandatory fourteen-day quarantine after a COVID-19 diagnosis, I requested confirmatory testing from a local health office prior to returning to work. The request was denied due to the limited availability of test kits. I was advised that if I no longer had symptoms, I was fit to go back to work. Shortly thereafter, the death at Cainta Municipal Hospital of frontline nurse Maria Theresa Cruz—my mother—was reported. Her death sparked public discussions on delayed and misaligned hazard pay, reflecting the experiences of other healthcare workers across the country. Cruz, a public hospital nurse, had endured prolonged working hours,

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inadequate personal protective equipment (PPE), and delays in the release of benefits mandated under the Magna Carta for Public Health Workers and the Bayanihan to Heal as One Act (Ranada 2020). These events, occurring in different geographic locations yet personally affecting my mother and me, illustrate how the COVID-19 pandemic not only strained the Philippine healthcare system but also exposed a greater societal illness through various forms of structural violence rooted in chronic underfunding, bureaucratic corruption, and institutional neglect (Querri et al. 2018; Panao and Rye 2023).

Drawing on cases of delayed hazard pay, complaints arising from frontline experiences, and grievances raised in online spaces by healthcare workers between 2020 and 2024, small group discussions, and news reports, I argue that the Philippine COVID-19 response can be understood as a site of conflict that generated preventable harm to healthcare workers. I further consider how insights from conflict transformation and transitional justice may help raise questions and identify potential pathways for accountability and institutional reform for equitable healthcare and pandemic governance. From a peace and conflict perspective, the pandemic may be understood as a conflict insofar as it exposed incompatible interests between state priorities—particularly those related to maintaining order, border control, balancing virus containment with cost containment, and political legitimacy—and healthcare workers' demands for safety, adequate compensation, and dignified labor conditions, not only during the pandemic but before and beyond it.

Like in other conflicts, these tensions were further defined by pronounced power asymmetries. Frontline workers endured disproportionate risks, while decision-making authority, particularly within the Philippine government through the COVID-19 Inter-Agency Task Force (IATF), remained centralized and largely opaque. Shifting quarantine classifications, the policing of so-called "quarantine violations," unclear criteria for hazard pay eligibility, and delayed public disclosure of budget allocations, fund misuse, and benefit disbursements for healthcare workers reflect the low prioritization of a health-centered, evidence-based approach and a stronger reliance on a securitized pandemic response (Reuters 2021). The pandemic was not only a biomedical event or crisis but also a social struggle marked by structural inequalities and contested decision-making power, with consequences that disproportionately harmed frontline healthcare workers. This stands in contrast to official pronouncements emphasizing the fight against COVID-19 and the protection of public health as central priorities of the administration (Parrocha 2020).

The forms of violence compounded during the pandemic and examined in this article transformed administrative inefficiencies and corruption into life-threatening risks for frontline healthcare workers. Similarly, Hapal (2021) notes that the government's securitized and militarized approach prioritized discipline and control over public health system strengthening, reinforcing structural

weaknesses rather than resolving them. As Galtung (1969) explains, structural violence refers to conditions in which preventable harm arises from social and political arrangements that systematically disadvantage particular groups—in this case, healthcare workers. Arguably, understaffing, misuse of emergency funds, delays in hazard pay, failures in PPE procurement, and fragmented insurance coverage for healthcare workers were therefore not accidental shortcomings but manifestations of governance failures embedded within bureaucratic systems. In this regard, the International Committee of the Red Cross (ICRC) observed that the COVID-19 pandemic unfolded "in places like Iraq, the Philippines, Nigeria, Yemen, the Central African Republic, Colombia, Greece and Azerbaijan, where communities are already struggling with multiple crises and threats," reinforcing its observation that it was "as if war was not enough" (Muller 2021). Because systems of oppression are interconnected, the pandemic intensified unequal access to healthcare, deepened social and economic inequalities, enabled human rights violations, and fueled scapegoating, all of which have complicated efforts to sustain peace. These impacts have been particularly severe for the already marginalized groups who are already disproportionately affected by conflict and violence (Transformative Peace 2022).

The Philippine government relied heavily on the mobilization of security forces to enforce community quarantine measures, an approach scholars have described as the securitization and militarization of public health governance (Tapia 2024; Hapal 2021; Wicke and Bolognesi 2020). Chronic underfunding, labor precarity, delayed compensation, and inadequate occupational protections for healthcare workers persisted under emergency conditions, contributing to preventable suffering and loss of life on the front line. Stability and peace, in this context, were maintained through control rather than social justice, at the expense of human security, particularly for essential workers on the front line.

As the largest pandemic in contemporary history, COVID-19 created significant challenges for medical emergency response globally and exposed the limitations of existing public health policies and systems in managing unfamiliar and extreme conditions (Rodríguez Reveggino and Becerra-Bolaños 2022). Constrained by insufficient testing capacity and fragile contact tracing systems, the Philippine public health infrastructure was ill-prepared to contain viral transmission through a sustained, health-centered strategy (Hapal 2021). In this context, the Philippine COVID-19 response can be understood as reflecting a condition of negative peace rather than positive peace. Negative peace, as conceptualized by Galtung (1969; 1996), denotes the absence of overt armed violence without addressing the structural and cultural forms of violence that generate harm and inequality. Although the pandemic did not involve armed conflict, responses to it were driven by persistent structural harms that can be traced to governance arrangements, particularly in procurement deals, policy decisions and pronouncements, and institutional neglect.

A securitized approach to the pandemic was not unique to the Philippines but was also observed across Southeast Asia and globally, where policing and militarized enforcement were implemented (Hapal 2021; Baysa-Barredo 2020). Moreover, the Duterte administration's portrayal of COVID-19 as a *war* against an invisible enemy legitimized the deployment of military and police forces to enforce public health measures, often sidelining health-centered governance and medical expertise (Hapal 2021; Heydarian 2020; Tapia 2024). Existing structural dynamics were further reinforced by forms of cultural violence embedded in the government's framing of the pandemic. War metaphors normalized coercive practices, obscured institutional accountability, and justified the marginalization of healthcare workers and vulnerable populations, thereby sustaining conditions characteristic of negative peace. This underscores the importance of treating health crises such as the COVID-19 pandemic not merely as symptoms of existing crises but as sites of conflict in their own right, raising urgent questions about how their impacts may be prevented or mitigated as a matter of moral and policy concern, particularly through a peace and conflict lens.

In parallel with conventional armed conflicts, violence is most visibly manifested through direct physical harm, cultural narratives that reinforce and normalize coercion, and the militarization of everyday life, often silencing dissent and disproportionately affecting civilians. During the pandemic, these structural and cultural forms of violence similarly translated into direct harm experienced by healthcare workers, including extreme exhaustion, heightened exposure to infection, psychological trauma, harassment at checkpoints, and possible repressive disciplinary measures for speaking out against unsafe working conditions. Rather than improving health outcomes, the securitization of the pandemic reinforced top-down governance, weakened public trust, and left frontline healthcare workers inadequately protected (Tapia 2024; Kirk and McDonald 2021). While not constituting a violent armed conflict, Galtung's typology of violence is applied here metaphorically to illustrate how preventable suffering was sustained and endured on the front line in ways that were systemic and structurally embedded.

Building on qualitative materials, including personal narratives, frontline testimonies, civil society reports, and news sources, this article examines how structural, cultural, and direct forms of violence intersected in the Philippine COVID-19 response. The discussion begins by outlining the relevant theoretical frameworks, then situates the Philippine healthcare system and pandemic governance context, analyzes the empirical manifestations of harm experienced by healthcare workers, and concludes with implications for conflict-informed reform and a human rights-based approach to transforming responses to health emergencies.

Theoretical Framework

This section outlines the key theoretical frameworks that guide the analysis of violence and the relationships among actors in the conflict. As Quijano, Fernandez, and Pangilinan (2020) argue, the large-scale migration of Filipino health professionals had already weakened the country's capacity to respond to public health crises even before the onset of COVID-19. Analyzing the Philippine COVID-19 response through a peace and conflict lens therefore requires theoretical tools capable of capturing multiple forms of harm, power relations, and governance practices, as well as the lived experiences of the crisis. The pandemic exposed securitized governance, health system fragility, and broader social inequalities—conditions that significantly influenced both the design and enforcement of emergency measures. Drawing on Galtung's concept of structural violence, Singer and Rylko-Bauer (2020) demonstrate how the COVID-19 pandemic revealed and intensified pre-existing systemic inequalities, underscoring the need to move beyond purely biomedical explanations and incorporate broader socio-political analyses of health emergencies.

Johan Galtung's (1969; 1996) typology of violence, which distinguishes among direct, structural, and cultural forms of harm, provides the primary analytical foundation for examining how violence manifested during the pandemic beyond the immediate threat of the virus. Three interrelated modes of conflict analysis, adapted from Galtung's (1996) conflict model, are employed. First, conflict actor analysis identifies key actors in the pandemic response, including national and local government institutions, hospital management, healthcare workers, and civil society organizations, along with their interests, power relations, and sources of contention. Second, violence triangle analysis traces how structural and cultural violence translated into direct harm in the everyday experiences of healthcare workers, revealing how policy choices and governing narratives produced concrete forms of suffering. Third, conflict triangle analysis examines the interaction of attitudes, behaviors, and underlying contradictions between the state and healthcare workers and their advocates, highlighting patterns of coercion, negotiation, compliance, and resistance that emerged during the crisis. The article also incorporates the Thomas-Kilmann Conflict Model, which conceptualizes conflict-handling styles along the axes of assertiveness and cooperativeness, enabling further analysis of how state institutions and healthcare workers navigated competing interests under crisis conditions (Thomas and Kilmann 2008).

Drawing on John Paul Lederach's (1998; 2003) conflict transformation framework, this analysis shifts attention from short-term crisis management to the transformation of the underlying relationships, institutions, and power structures that rendered healthcare workers vulnerable in the first place. Rubenstein and Simmons (2021) emphasize that conflict resolution efforts

that prioritize stability or "peace" without addressing injustice, accountability, and harms suffered during the pandemic are unlikely to be sustainable. They caution against treating the post-pandemic period as a temporary disruption and returning to pre-pandemic governance arrangements that had already produced inequality and conflict, as doing so risks reproducing the structural injustices the pandemic exposed. This critique underscores the analytical value of Lederach's (1998; 2003) conflict transformation framework, which moves beyond resolving discrete disputes to addressing the relational, structural, and systemic conditions that generate and reproduce conflict over time.

While the preconditions for full conflict transformation were neither entirely absent nor fully present in the case under analysis, future interventions in emergency health crises may nevertheless draw on the transformative insights generated through this inquiry. Following the argument advanced by Rodríguez Reveggino and Becerra-Bolaños (2022), it approaches transitional justice not as a prescriptive set of mechanisms but as an analytical and normative lens. Although transitional justice has conventionally been applied in post-conflict or post-authoritarian settings, its core principles—truth-seeking, accountability, reparations, and guarantees of non-recurrence—remain relevant to large-scale social harms produced by systemic neglect.

Background of Conflict

How did the COVID-19 pandemic transform existing social and healthcare governance conditions in the Philippines into sites of conflict? The pandemic did not create crisis conditions so much as it exposed and intensified long-standing structural weaknesses in the country's social and healthcare governance systems. Even prior to 2020, the Philippine health system was characterized by chronic underfunding, shortages of healthcare personnel, fragmented service delivery, and persistent inequities in access between urban and rural populations, which limited its capacity to respond effectively to large-scale health emergencies (Dayrit, Dolea, and Dreesch 2011). These vulnerabilities have been documented in comprehensive health system assessments, including the World Health Organization (WHO)'s Philippines Health System Review (WHO 2022). When COVID-19 arrived, ongoing socioeconomic disparities, including widespread poverty, dependence on informal livelihoods, and uneven access to healthcare, intensified the social impacts of prolonged community quarantines, as millions of Filipinos struggled to meet basic needs during extended lockdowns (Bekema 2021; World Bank 2022). At the same time, differential regional capacities in testing, contact tracing, hospitalization, and later vaccine rollout underscored pre-existing inequalities in health infrastructure and service delivery across local government units, despite official pronouncements emphasizing a public health

focus for low- and middle-income families.

In March 2020, the WHO declared COVID-19 a global pandemic, prompting governments worldwide to adopt urgent public health measures. In the Philippines, Congress enacted *Republic Act No. 11469, or the Bayanihan to Heal as One Act* (Republic of the Philippines 2020b), granting President Duterte limited emergency powers to reallocate budgets, implement pandemic response measures, and provide cash subsidies and healthcare worker allowances (Tigno 2020; Hapal 2021). However, the implementation of the 2020 enhanced community quarantine and the Bayanihan Act was hindered by vague operational provisions and uneven administrative capacity, leaving key components of the response—particularly healthcare workers' hazard pay—largely dependent on disparate local resources and subsidies (Alliance of Health Workers 2022).

The Duterte administration's pandemic response was widely criticized for weak inter-agency coordination, unreliable data systems, and inconsistent policy directives, which contributed to public confusion and heightened health risks (Punongbayan 2020; Joaquin and Biana 2020). Divergent institutional capacities across local government units further compounded these challenges, resulting in uneven protection for healthcare workers and vulnerable populations. Scholars note that these implementation gaps exposed governance weaknesses in pandemic preparedness and execution, particularly in crisis coordination and policy coherence (Thompson 2022; Hapal 2021). Despite the invocation of emergency powers, logistical, political, and socioeconomic constraints continued to undermine effective pandemic governance. By May 2021, the Philippines had recorded over 1.1 million confirmed COVID-19 cases and more than 18,000 deaths, highlighting the severity of the public health crisis (WHO 2021). These developments unfolded against long-standing structural weaknesses in the healthcare system, including chronic underfunding, a decline in hospital bed capacity from 14.4 per 10,000 population in 1990 to 9.9 in 2014, and persistent shortages of healthcare personnel (Lim 2020).

Healthcare workers bore the brunt of these systemic failures. Despite legal protections and incentives under the Bayanihan Act, including hazard pay and COVID-related coverage, implementation remained uneven and often dependent on local resources (Alliance of Health Workers 2022). Administrative fragmentation, delayed fund releases, and bureaucratic bottlenecks resulted in delayed benefits, inadequate personal protective equipment, and increased exposure to the virus among healthcare workers (Seddik et al. 2023; Mulaudzi et al. 2021). Under these circumstances, civil society organizations and grassroots movements, including the Healthcare Professionals Alliance Against COVID-19 and the Alliance of Health Workers, mobilized to support healthcare workers and advocate for systemic reforms (Macaraan 2022; Rappler 2020). Thus, the pandemic transformed pre-existing structural vulnerabilities, governance failures, and coercive enforcement practices into sites of social and institutional conflict,

disproportionately affecting healthcare workers and marginalized populations while exposing the limits of centralized, securitized approaches to public health governance.

Methodology

This article adopts a qualitative, interpretive research design based exclusively on secondary data to examine governance failures, conflict dynamics, and forms of violence experienced by healthcare workers during the COVID-19 pandemic. It does not involve primary data collection or human subject research. The analysis draws on peer-reviewed literature, government policy documents, civil society reports, and news coverage from 2020 to 2023 concerning the Philippine pandemic response. It also draws on anonymized healthcare worker testimonies submitted to and published on the online platform Kami Naman, whose name is derived from the phrase *sana kami naman*, which translates to "we hope it's our turn" or "we hope we will be prioritized this time." On September 2, 2021, we launched the #KamiNaman Movement through the Ma. Theresa Cruz Initiative. The Kami Naman Movement is a grassroots, digitally driven advocacy campaign that amplifies the voices of healthcare workers (HCWs) in the Philippines, particularly in demanding accountability and the timely provision of pandemic-related benefits such as the Special Risk Allowance (SRA). Through an online platform and sustained advocacy efforts, we gathered reports, stories, and petitions, amplifying the calls and lived experiences of HCWs. These materials were later compiled and submitted to the Senate Blue Ribbon Committee as part of its investigation into pandemic-related corruption issues. The Kami Naman Movement also provided a nationally accessible public archive of frontline accounts from 2020 to 2021. These testimonies were translated from Filipino into English for the purpose of data presentation, with the recognition that some linguistic nuances may not be fully preserved. News reports and testimonial materials are treated as situated narratives that reflect policy developments, institutional practices, and public discourse, rather than as representative empirical samples. The analysis is further informed by the author's reflexive positionality, which shapes interpretation and is treated as a source of contextual insight rather than as primary empirical evidence.

Discussion and Analysis

It is important to note that the COVID-19 pandemic in the Philippines was not only a public health emergency but also a prolonged social and institutional crisis in which healthcare workers became primary bearers of systemic strain.

Positioned between state authority, institutional constraints, and public need, healthcare workers experienced overlapping forms of harm that were frequently normalized or justified in the name of crisis management. Examining the pandemic through a peace and conflict lens highlights how government responses, bureaucratic practices, and societal attitudes interacted to produce structural harm, cultural legitimization of inequity, and direct risks to healthcare workers' safety and dignity.

Tensions between national institutions, including the IATF, local government units (LGUs), hospital administrations, and healthcare advocates became particularly visible in the implementation of benefits such as the Special Risk Allowance (SRA). Healthcare workers, positioned at the frontline of pandemic response, were directly affected by administrative discretion, fragmented accountability, and inconsistent policy execution. One nurse from San Jose del Monte, Bulacan, described how internal hospital decisions influenced access to legally mandated benefits:

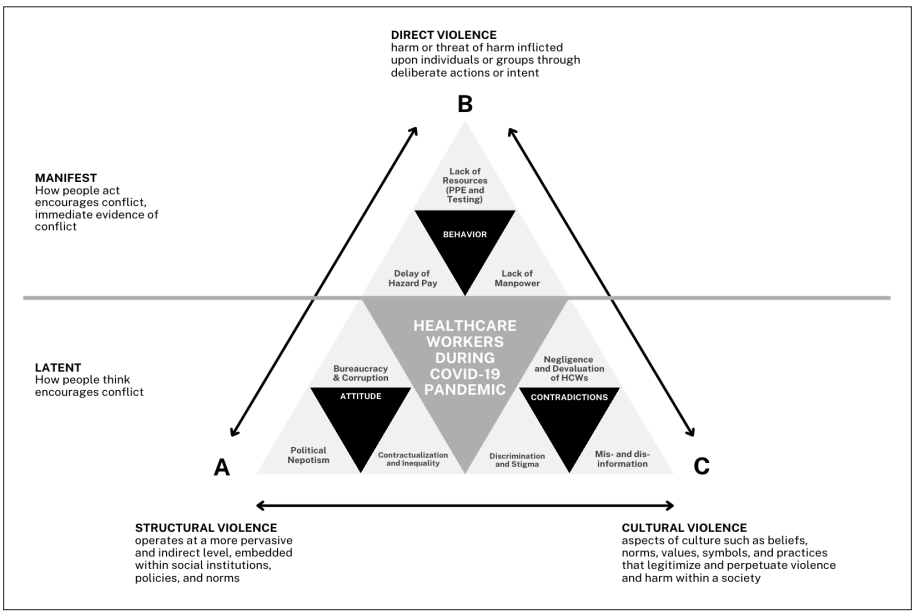
> The HR of our hospital did not process the SRA of all its employees. They are blaming the DOH for not giving us our SRA, but they are the ones we should blame. Instead of requesting a standard SRA for all employees, they made their own computation and decided that it should be our worth. We are all exposed to this pandemic. Stop favoring specific employees. (Kami Naman Movement 2021e)

This account shows how structural and bureaucratic practices produced institutional inequities, reinforcing perceptions of exclusion and arbitrariness in benefit distribution. The frustration expressed reflects not only delayed compensation but also deeper concerns about recognition, fairness, and professional dignity.

Nurses and other essential healthcare workers possess fundamental rights related to occupational safety, well-being, and the delivery of quality care (WHO 2020b). While healthcare workers may raise concerns or protest unsafe working conditions (Mulaudzi et al. 2021), they also carry professional obligations to provide care during emergencies. International labor standards, including those articulated by the International Labour Organization (2020), recognize certain limitations on strike action during public health emergencies, while WHO guidance emphasizes safe working conditions, access to PPE, fair compensation, and protection from discrimination (Mulaudzi et al. 2021; WHO 2020a). Despite these international frameworks, healthcare workers in the Philippines encountered persistent gaps between formal protections and actual frontline working conditions.

Applying Galtung's (1969) violence triangle, the following sections categorize the harms experienced by healthcare workers into three interrelated dimensions, as illustrated in Figure 1. Manifest violence refers to the visible and immediate

Figure 1. Violence Triangle Analysis Based on Filipino Healthcare Workers' Experiences during the COVID-19 Pandemic



Source: Author's illustration, adapted from Galtung (1996).

harms encountered during the COVID-19 pandemic, including inadequate personal protective equipment, delayed hazard pay, chronic understaffing, and unsafe working conditions that directly threatened healthcare workers' lives and well-being. In contrast, latent violence operates less visibly through persistent systems, institutions, and norms, such as bureaucratic inefficiency, contractualization, stigma, and misinformation, which normalize neglect and create the structural conditions under which direct harm becomes possible and recurrent (Galtung 1969; 1996).

Structural Violence

Bureaucratic inefficiencies and allegations of corruption impeded the Philippines' COVID-19 response, contributing to delays in the distribution of critical resources and undermining frontline worker safety and patient care (Heydarian 2020). Although the Universal Health Care Act of 2019 marked an important step toward systemic reform (Bayani and Guan Tan 2021), the pandemic exposed persistent structural weaknesses within the health system. Public investigations into the alleged misuse of funds by PhilHealth raised concerns about its capacity to support healthcare workers and the broader population (Baleña 2021). Similarly, procurement contracts awarded to Pharmally Pharmaceutical

Corporation prompted legislative scrutiny over governance and accountability, with reported delays and financial losses linked to these transactions (Tomacruz 2021). Together, these controversies deepened public dissatisfaction and reinforced existing financial and social inequalities.

Kimhi et al. (2022) compare societal coping mechanisms across different crises. The study suggests that the pandemic, much like armed conflict, generated conditions of prolonged uncertainty that required individuals and communities to draw upon various forms of psychological and social resilience. For healthcare workers, these governance failures translated into material and psychological strain. A nurse who had served for five years in a public hospital in Rizal province shared:

> I hope Kami Naman, healthcare workers, will be valued... I just want to share my story. In my almost five years as a nurse in a public hospital, it is only now that I have experienced feeling extremely drained and losing motivation at work. Benefits that are supposed to be for healthcare workers are going to greedy individuals. (Kami Naman Movement 2021a)

Such accounts make evident how prolonged institutional strain and perceived corruption contributed not only to delayed or uneven benefits but also to emotional exhaustion and moral injury. From a conflict perspective, these experiences reflect structural violence, in which governance arrangements and administrative decisions produced preventable forms of suffering. These tensions unfolded within existing legal and professional frameworks, even as healthcare workers remained bound by ethical commitments to prioritize patient care above all else. The influence of political authority over hospital operations further illustrates this dynamic. A nurse from Manila described the pressures experienced at the institutional level:

> I hope Kami Naman, those who run our institution, will listen... I know that almost all hospitals are already at full capacity. But what I cannot accept is that we continue admitting patients simply to please the politicians who have authority over us—we keep accepting and accepting. In truth, we are run by the local government, supposedly for the people of Manila, yet you would be surprised that we have COVID patients from Cavite, Las Piñas, Caloocan, Laguna, and other areas. What is worse is that COVID and non-COVID patients are placed together in one area. What separates them? A thin green drape. It is exhausting because, in reality, those running our institution do not truly care about us. (Kami Naman Movement 2021b)

This account demonstrates how political interference and administrative discretion shaped hospital practices in ways that compromised safety. Within Galtung's framework, such institutional arrangements constitute structural violence, as governance decisions generated preventable risks for healthcare

workers while constraining their ability to challenge unsafe conditions.

Importantly, many of these vulnerabilities predated the pandemic and were intensified by its demands. A significant number of nurses were employed under contractual arrangements that limited job security and benefits (*Philippine Daily Inquirer* 2022). Chronic understaffing and low compensation contributed to fatigue, burnout, and workforce attrition (Stodolska et al. 2023), while lower-tier health workers and relief nurses were often subjected to "no work, no pay" conditions (Garcia and Daño 2019). Reports of administrative mismanagement, political interference in quarantine enforcement (Maria Theresa Cruz, personal communication, various dates in 2020), and concerns about preferential vaccine access further highlighted accountability gaps that strained health facilities and undermined public trust (Usman et al. 2022). As Rahman et al. (2021) argues, these conditions substantiate the need for stronger accountability mechanisms and institutional reform to safeguard healthcare workers and strengthen health system resilience.

Cultural Violence

Health workers responding to COVID-19 faced significant risks, including infection, physical exhaustion, psychological strain, stigma, and even violence (WHO 2020a). In the Philippines, these risks extended beyond the immediate threat of the virus to encompass the pervasive effects of cultural violence. Cultural violence, as reflected in prevailing norms, narratives, and symbolic systems, manifested in the social devaluation of healthcare labor, experiences of stigma, and discriminatory attitudes directed at healthcare personnel both within and outside the health system (Dey, Hay, and Raj 2022).

Healthcare workers experienced significant stigma and violence. Reports documented cases in which nurses were forced out of their residences due to fears of contagion, while an ambulance driver was fatally shot after being accused of endangering a residential community. These incidents highlight the severity of harm directed at healthcare workers, which remains profoundly unacceptable, especially when it results in the loss of life (Eala et al. 2022). Such conditions contributed to heightened psychological distress, anxiety, and stress-related symptoms (Alnazly et al. 2021; Sachdeva et al. 2022). Societal expectations that nurses and other frontline workers perform their duties in self-sacrificial ways reinforced normative assumptions that obscured their rights to safety, rest, and adequate protection (Ramaci et al. 2020). These expectations normalized overwork and risk exposure as inherent to their professional identity rather than as issues of labor rights and state obligation. Cultural violence was likewise evident in discrimination within healthcare workplaces. As one nurse from Mandaluyong City recounted:

> No to discrimination! Our workplace has become so toxic, and we are handling an overwhelming number of patients, so we asked our supervisor for additional manpower. But instead of properly addressing the shortage, they are planning to remove my Muslim co-workers and replace them with non-Muslims. They said Muslims are "difficult to work with." In times like this, we should be prioritizing teamwork and listening to one another so we can get through this pandemic together. (Kami Naman Movement 2021c)

This account illustrates how religious prejudice intersected with workplace precarity, compounding stress and undermining solidarity at a time when collective cooperation was essential. Such discriminatory attitudes not only violated principles of equality and non-discrimination but also weakened institutional responses to the crisis. Moreover, the circulation of misinformation about COVID-19, coupled with gaps in clear and consistent public communication, intensified fear and distrust, further contributing to stigmatizing and discriminatory responses toward healthcare workers (OpenGov Asia 2021). The widespread reliance on war metaphors and securitized discourse—advanced by government and media institutions amid limited scientific, data-driven communication—obscured institutional accountability and contributed to a wider climate of fear and impunity, facilitating public acceptance of coercive measures.

The Philippine government's sanction-based approach to COVID-19 governance was further reinforced through the deployment of the *pasaway* (undisciplined or non-compliant citizen) narrative, which framed viral transmission primarily as a consequence of individual irresponsibility. By individualizing blame, this discourse—as a form of cultural violence—legitimized repressive measures and positioned public non-compliance as the principal cause of perceived failures in the pandemic response (Lasco 2020; Hapal 2021). In doing so, it deflected attention from structural inadequacies in public health infrastructure and labor protection while deepening stigma and social division at a moment of collective vulnerability.

Direct Violence

The lack of personal protective equipment critically undermined healthcare workers' safety, leaving them highly vulnerable to COVID-19 infection. WHO Director-General Tedros Adhanom Ghebreyesus (2020) characterized the severe risk posed by inadequate PPE, exacerbated by corruption in procurement and distribution, as preventable harm. Reports indicated that some hospitals experienced inadequate provisions of essential protective supplies, including face masks and gowns, exposing frontline workers to heightened risk (Impelli 2020). This situation further complicated the public health response (Hoernke et al. 2021). As such, Vicencio Dizon, Deputy Chief Implementer of the National Task Force against COVID-19, argued that mass testing alone is insufficient

for preventing COVID-19 transmission, emphasizing instead the need to follow minimum public health standards such as distancing and mask-wearing (Crismundo 2021).

PPE shortages heightened physical risks while also intensifying psychological stress, anxiety, and burnout among healthcare workers (Alnazly et al. 2021). Rising COVID-19 caseloads further overwhelmed healthcare facilities, resulting in overcrowded wards, extended shifts, and expanded responsibilities amid chronic nurse shortages and low salaries (Alibudbud 2023). Limited access to COVID-19 PPE and testing compounded these challenges by reducing opportunities for early detection and timely intervention. Despite the physical discomfort, practical constraints, and communication barriers associated with PPE, healthcare workers continued delivering care throughout the pandemic. In many cases, however, proper PPE practices were difficult to maintain due to shortages, leading to reuse and improvised use of protective gear (Hoernke et al. 2021). A nurse from Pasay City described these conditions:

> I hope Kami Naman will be treated as human beings. I hope you would come and join us on duty so you can understand how difficult it is to work in PPE inside a hospital that is extremely hot—where you are responsible for giving medication to forty patients, feeding bedridden patients, manually replacing oxygen tanks when they run out, and lifting patients on your own. We receive patients in the ER. We clean feces and urine. We change diapers. We dispose of waste. We insert IV lines and document the care of forty patients in a single day. It is heartbreaking when patients have no food or medicine because they cannot afford them. We wipe down patients while we are drenched in sweat inside our PPE. This is the dirtiest and most difficult work, yet we continue to do it. I hope it will be repaid, even in the smallest way. (Kami Naman Movement 2021d)

Financial constraints further worsened healthcare workers' vulnerabilities. Delays and shortfalls in hazard pay, such as the PHP7,000 received by the family of frontline nurse Maria Theresa Cruz, undermined morale and limited workers' ability to cope with the demands of the crisis (People's Health Movement Philippines 2020; Senate of the Philippines 2020). A news feature by Martinez (2020) documents that, despite battling pneumonia since March 2020, Nurse Cruz continued reporting for duty at Cainta Municipal Hospital without adequate PPE. She and her colleagues worked under deteriorating conditions marked by chronic shortages, which compelled nurses to purchase their own protective suits, facemasks, and shower caps, alongside persistent understaffing in critical wards.

Family accounts further indicate that Cruz experienced significant anxiety about taking sick leave, as the pediatric ward where she worked routinely operated with minimal nursing staff per shift, a situation that many healthcare workers nationwide had already been confronting even before the pandemic (Maria Theresa Cruz, personal communication, various dates in 2020). These

accounts also point to prolonged delays in the release of benefits and hazard pay mandated under the Magna Carta for Public Health Workers and the Bayanihan to Heal as One Act, highlighting the gap between formal legal protections and their implementation in practice (Ranada 2020).

Beyond healthcare institutions, state narratives and enforcement practices during the pandemic also produced direct harm. The scapegoating discourse advanced by government officials did not remain merely rhetorical. Citizens labeled as *pasaway* were subjected to punitive sanctions, particularly during militarized border lockdowns, where enforcement by police and military forces involved arrests, public shaming, and other coercive measures (Lasco 2020). These practices point to forms of direct violence embedded within pandemic governance and warrant separate and more critical examination.

To systematically analyze these dynamics, the conflict analysis model developed by Galtung (1996) provides a useful framework. By conceptualizing conflict as a triangle comprising attitudes (Table 1), behaviors (Table 2), and contradictions (Table 3), the model enables a structured examination of tensions among government agencies, healthcare advocates, and civil society organizations.

Zeroing in on the conflict through the Thomas-Kilmann Conflict Model illustrates how actors navigated pandemic tensions within unequal power structures. Tables 1, 2, and 3 collectively map the conflict between Philippine government units and healthcare advocates by examining their differing attitudes, behaviors, and underlying structural contradictions during the COVID-19 pandemic. These tensions are not merely abstract or ideological, but are actively expressed in practice and relationships.

Table 1. Summary of Attitudes in the Conflict Triangle Analysis between the Philippines Government and Healthcare Advocates during the COVID-19 Pandemic

(A) Attitudes (perceptions, beliefs, and feelings that individuals or groups hold toward each other in a conflict)	
PH Government Units (NGU, IATF, and LGUs)	**Healthcare Advocates and Civil Society Organizations (CSOs)**
• Authoritarianism and militaristic lockdown and response to pandemic • Aggression and indifference with dismissive or callous attitude towards the concerns and welfare of healthcare workers and the public • Progressive public officials are open for cooperation and empathize with healthcare workers • Misinformation and discriminatory attitudes	• Advocacy, empowerment, and demand for accountability • Believes in the importance of community engagement • Assertive of public's participation in decision-making processes • Critical but sometimes hopeless of government's pandemic response

Source: Author, adapted from Galtung (1996).

Table 2. Summary of Behaviors in the Conflict Triangle Analysis between the PH Government and Healthcare Advocates during the COVID-19 Pandemic

(B) Behaviors (manifestations of underlying attitudes and structural factors, reflecting the ways in which conflicts are expressed and perpetuated in society)	
PH Government Units (NGU, IATF, and LGUs)	**Healthcare Advocates and CSOs**
• Negligence and failed implementation of policies from national to local level • Inadequate and corrupted funds for healthcare • Regular press conferences to address the public but has censorship on scientific, data-driven facts on COVID-19 • Repression to dissent and critics	• Advocating and lobbying for policy change • Mobilizing grassroots movements and donation drives for PPEs and other medical supplies • Conducting independent research and information drives • Organizing protests or strikes to demand better working conditions and resources for healthcare workers

Source: Author, adapted from Galtung (1996).

Table 3. Summary of Contradictions in the Conflict Triangle Analysis between the PH Government and Healthcare Advocates during the COVID-19 Pandemic

(C) Contradictions (the underlying sources of tension or conflict within a society or between groups)	
PH Government Units (NGU, IATF, and LGUs)	**Healthcare Advocates and CSOs**
• Lack of transparency in decision-making and non-cooperation with non-government bodies • Lack of accountability and command responsibility • Unequal enforcement of regulations • Failure to address underlying socio-economic disparities among healthcare workers and the public	• Tensions between cooperation and confrontation in engaging with government units • Challenges in balancing the need for immediate action with the long-term goal of systemic change

Source: Author, adapted from Galtung (1996).

Table 1 shows a clear divergence between a predominantly securitized and top-down government response, characterized by authoritarianism, militaristic enforcement, and at times dismissive or indifferent attitudes, and a rights-based, participatory stance among healthcare advocates, who emphasize accountability, community engagement, and public involvement in decision-making. This contrast reflects a divide between a state-led, securitized approach and citizen-driven advocacy that calls for a more holistic healthcare response centered on participation and the welfare of frontline health workers and the public. Despite

these differences, the presence of progressive officials across local and national levels suggests that these positions are not monolithic but internally contested. These dynamics indicate that pandemic responses are influenced by competing and overlapping belief systems among various actors in the pandemic response (Table 1). These attitudes are translated into contrasting behaviors. State practices, marked by negligence, inconsistent policy implementation, and the repression of dissent, contrast sharply with civil society's advocacy, grassroots mobilization, and independent knowledge production (Table 2). Although the government maintained formal communication through regular press briefings, these were often undermined by censorship and limited transparency, widening the gap between official narratives and lived realities. This points to a divide between control and containment, on the one hand, and participation and accountability on the other, where state actions and response tend to restrict civic space while healthcare advocates seek to expand it.

Structural sources of tension underpin these patterns. The gap between government claims of a coordinated pandemic response and the realities of weak transparency, limited accountability, and uneven enforcement has undermined public trust and hindered effective collaboration among actors, including government agencies, healthcare workers, and civil society (Table 3). These contradictions show that the conflict is sustained not only by opposing positions but also by institutional limitations and competing pressures on both sides, even where shared goals exist.

Government agencies and many local government units adopted competitive, securitized approaches, prioritizing enforcement and regulatory compliance over the welfare of healthcare workers. In contrast, civil society organizations and healthcare advocacy groups pursued more collaborative strategies through dialogue, policy advocacy, and public campaigns on occupational safety and compensation (Table 2). Hospital management often occupied intermediary positions, balancing national directives with workforce constraints, while many healthcare workers adopted avoidant or accommodating strategies to sustain care and manage risk without direct confrontation. Read alongside Galtung's framework, the model highlights how institutional power shapes conflict behavior and influences whether responses reproduce or mitigate harm.

Authority-driven state responses constrained collaboration and eroded public trust, whereas cooperative advocacy efforts demonstrated how conflict could be redirected toward reform (Tables 2 and 3). Initiatives such as the Kami Naman Movement translated frontline grievances into public engagement and policy dialogue, generating scrutiny, mobilizing resources, and prompting partial institutional responses. This suggests that conflict transformation in health crises depends not only on institutional capacity but also on the willingness of state actors to engage dissent, professional expertise, and the lived experience of workers on the front line.

Advocacy efforts such as SHAPE-UP Defeat COVID-19, the Cure COVID-19 Alliance, and the Kami Naman Movement, alongside organizations including the Alliance of Health Workers, Health Action for Human Rights, and Filipino Nurses United, played visible roles in demanding safer working conditions, addressing labor and rights concerns, and improving access to essential resources. Additional stakeholders further influenced the conflict landscape. Media institutions acted as intermediaries by reporting on PPE shortages, delayed benefits, and frontline working conditions, contributing to public scrutiny of pandemic governance (Sachdeva et al. 2022; Dey, Hay, and Raj 2022). International organizations and humanitarian actors provided technical guidance and articulated normative standards that informed rights-based approaches to health governance (WHO 2020c; Muller 2021). Local communities and the broader public influenced pandemic governance through solidarity initiatives, advocacy, and protest, pressing for more responsive and humane policies.

The question of what has been achieved in the post-pandemic period, however, remains unresolved. Rubenstein and Simmons (2021) caution that recovery efforts risk reproducing injustice when reduced to technical fixes or elite-driven negotiations that sideline social justice, lived experience, and grievances intensified by the pandemic. Given COVID-19's disproportionate impact on marginalized groups, treating the crisis as uniformly experienced is analytically insufficient and politically limiting. This concern is particularly relevant when examining national recovery policies such as *Republic Act No. 11494*, or the *Bayanihan to Recover as One Act* (Republic of the Philippines 2020c), which aimed to mitigate pandemic impacts but has also raised questions about the inclusiveness of government policy responses and the equity of recovery measures.

Pathways to Conflict Transformation and Transitional Justice

Public health emergencies such as COVID-19 intensify structural and state-facilitated violence, particularly when crisis governance prioritizes securitization over care. In the Philippines, prolonged lockdowns, militarized enforcement, and centralized decision-making, justified as necessary for disease control, often exacerbated existing inequalities and deepened the vulnerability of healthcare workers and marginalized communities (Hapal 2021; Muller 2021). When healthcare workers were expected to absorb disproportionate risk without adequate protection, compensation, or meaningful participation in decision-making, violence was reproduced under the rationale of crisis management.

Conflict transformation emerged through organized collective action seeking recognition of harm and the creation of dialogic spaces. Consistent with Lederach's (1998; 2003) view of conflict transformation as addressing relational

patterns and structural injustices—not merely resolving discrete disputes—healthcare workers and advocates worked to make frontline experiences visible to state institutions and the public. In 2022, the Kami Naman Movement and other civil society actors mobilized nonviolent, dialogic strategies to highlight occupational risks and structural neglect while minimizing reprisals. Through online forums, media engagement, and public discussions, they documented anonymized testimonies and advanced policy demands. The recurrence of grievances across regions revealed systemic governance failures rather than isolated lapses.

Advocacy-driven transformation efforts produced partial and uneven policy outcomes. Sustained pressure from healthcare unions and civil society organizations, including the Alliance of Health Workers and Filipino Nurses United, contributed to the passage of the Bayanihan to Heal as One Act (2020), which allocated resources for pandemic response and risk allowances. Although some benefits were released, labor groups documented persistent delays and gaps in implementation, particularly affecting private-sector healthcare workers (UNI Global Union 2024). Senate inquiries and investigative reporting further raised concerns about procurement practices and the management of public health funds, highlighting continuing accountability challenges (Gotinga 2020; Cepeda 2021).

Despite formal guarantees under the *Magna Carta of Public Health Workers* (Republic Act No. 7305) (Republic of the Philippines 1992) and subsequent compensation reforms such as the *Salary Standardization Law* (Republic Act No. 11466) (Republic of the Philippines 2020a), uneven implementation has normalized labor precarity, especially among contractual, rural, and lower-ranking healthcare workers (People's Health Movement Philippines 2020). Chronic underfunding, limited hospital capacity, supply shortages, and insecure labor arrangements predated COVID-19 and magnified its impact (Lim 2020). Governance weaknesses, including challenges within PhilHealth and procurement systems, exposed long-standing inequities during the crisis (Gotinga 2020). Addressing pandemic harms therefore requires confronting historical policy choices that rendered healthcare workers structurally vulnerable. War metaphors and enforcement-driven approaches further sidelined medical expertise and limited consultation with frontline workers.

No one has been truly held accountable for the COVID-19 crisis we experienced. It is high time to demand accountability and uncover the truth about the structural inequalities exposed by the pandemic. I suggest that exploring the potential of transitional justice in post-COVID-19 context is therefore warranted. Transitional justice can help prevent forms of violence from happening again and address pandemic-induced trauma and shocks, not only for healthcare workers but also for the public. Transitional justice mechanisms offer a platform to acknowledge pandemic-fueled injustices, hold those responsible for mishandling

the crisis accountable, and address structural inequalities (Rodríguez Reveggino and Becerra-Bolaños 2022). In light of the current challenges, it is understandable that many individuals have sought inspiration, ideas, and guidance from the field of transitional justice (Mazzucato 2020; Parmentier 2021).

Transitional justice principles provide lens for identifying patterns of harm, accountability gaps, and reform pathways. Truth-seeking processes can institutionalize documentation of frontline experiences, while independent audits and transparent investigations may address governance failures that amplified preventable suffering. Reparative measures, including timely compensation, mental health support, and stronger protections for contractual workers, acknowledge frontline sacrifices and reduce long-term inequities. Institutional reforms that embed standardized emergency protocols and evidence-based policymaking remain essential to preventing the recurrence of crisis-induced structural violence. Recognition of harm and commitments to non-repetition are particularly critical, as unresolved injustices risk generating long-term insecurity and intergenerational vulnerability among healthcare workers and their families. Following recognition of harm and the identification of accountability gaps, reparative measures serve both to acknowledge frontline sacrifices and to mitigate long-term inequities. With processes adapted from transitional justice, it may be possible to co-create a resilient post-COVID-19 society and a more prepared, reliable healthcare system in the country.

Although not universally generalizable, the frameworks applied here are relevant to other low- and middle-income countries confronting health emergencies amid inequality and contested governance. The realization of such reforms, however, remains contingent on sustained political will, institutional capacity, and the willingness of state actors to engage in accountability and cooperative governance, conditions that have been uneven in the Philippine context.

Conclusion

We are not helpless in the face of the unseen. Considering the countless others who have suffered and lost loved ones to this pandemic, I cannot help but wonder: What will become of the many children left behind, seeking answers and justice in the aftermath of such profound loss? Without justice, without accountability for the failures and injustices of this crisis, what hope is there for a future free from cycles of violence and vengeance? Public health crises, like protracted social conflicts, do not emerge in institutional vacuums. The Philippines' COVID-19 pandemic response exposed how long-standing governance weaknesses, social inequalities, and fragmentation within the health system intensified under emergency conditions, producing preventable harm to frontline healthcare

workers. These dynamics demonstrate that frontline experiences are not merely technical failures of health policy but manifestations of structural and relational breakdowns in the state's fulfillment of its obligations.

The experiences of healthcare workers during the pandemic underscore the need for a governance model and rights-based policymaking grounded in transparency, participatory decision-making, and coordinated multi-actor engagement. Conflict-informed and transitional justice perspectives foreground questions of harm, responsibility, accountability, and reform. While these frameworks cannot substitute for political will or sustained public health investment, they demonstrate how emergency responses may reproduce entrenched patterns of exclusion while also creating openings for transformation toward peace grounded in social justice. Only then can we meaningfully speak of a genuine "new normal."

Future research may further examine the structural determinants of healthcare worker vulnerability, including chronic underfunding, labor precarity, and administrative fragmentation, as well as comparative applications of conflict transformation and transitional justice frameworks in pandemic responses and governance across Southeast Asia and other regions.

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