Job performance of health center staff in brgy. apas, cebu city essay sample

Rationale

The first declaration of Primary Health Care was held in Alma, Alta, USSR on September 6-12, 1978 by the World Health Organization (WHO). This was subsequently implemented by the Philippine Government under the administration of the late President Ferdinand E. Marcos. As of today it is still in effect and continues to serve many people. Normally in the Philippines, the provision of Primary Health Care composes of a team which includes a physician, nurse, midwife, and barangay health worker. These are the important individuals who execute health care functions in accordance with their job description. Over the past years, the provision of primary health care in the Philippines has been an important service into the lives of every Filipinos, much especially in Cebu City wherein it is considered as the 2nd highly urbanized city in the country, and the manner of the health care team serve their patients. We pointed out three important health care staff and their individual job performance that is vital in the provision of primary health care which takes upon in a barangay setting; these are the nurse, midwife, and barangay health worker. It is expected therefore that the above-mentioned personalities should create a good relationship with each other that every constituents in the barangay feel comfortable of their services. For if nurses, midwives, and BHW will radiate a spirit of accommodating, being approachable and have a soft spoken personality will somehow give a comfortable feeling to every individual patient in the barangay. Such a practice will enhance a fulfillment of what is being stated in the primary health care provision. For it is a common knowledge that unhealthy persons should feel ease towards someone whom they think could

help them. The World Health Organization (WHO) created the components of primary health care that should be constituted in a barangay, these are: 1) Environmental Sanitation, 2) Control of Communicable Diseases, 3) Immunization, 4) Health Education, 5) Maternal and Child Health and Family Planning, 6) Adequate Food and Proper Nutrition, 7) Provision of Medical Care and Emergency Treatment, 8) Treatment of Locally Endemic Diseases, and 9) Provision of Essential Drugs (Cuevas et al., 2007). The above-mentioned components of primary health are the programs in the barangay health center

that modestly be implemented with the health center staff. These will become the basis or parameters of their performance in the community with their authorized role in the primary health care provisions. In this manner, we may be able to identify how each health care staff carry out the said programs into the community, and the effects of their performance with their individual personality, the environment they are in, or the organization they belong. Hence, the provision of primary health care will only function through the collaborative work of each named health center staff, as they are the ones whose function is ready available in the community.

The Theoretical Background

We merely believe that an organization will be effective in their services if the individual workers are efficient in performing their duties. Accomplishing tasks and performing at a high level can be a source of satisfaction, with feelings of mastery and pride. Low performance and not achieving the goals might be experienced as dissatisfying or even as a personal failure. Moreover, performance—if it is recognized by others within the organization

—is often rewarded by financial and other benefits. Performance is a major—although not the only—prerequisite for future career development and success in the labor market. Although there might be exceptions, high performers get promoted more easily within an organization and generally have better career opportunities than low performers (VanScotter, Motowidlo, & Cross, 2000). There is a saying that we reap what we saw, therefore if an individual performance will receive awards and recognition it will be an eye opener of their good performance in line of their duties and responsibilities. Promotions and attractive incentives shall only be given to the high performing individuals and of course the low performing individuals shall not receive the same opportunity.

Performance of an individual is an important aspect for it derives a good perception to the community of an organization. Individual performance is a core concept within work and organizational psychology. Moreover, according to Campbell et al. (1993), job performance is a commonly used, yet poorly defined concept in industrial and organizational psychology, thus the performance of every organization would somehow depend upon the efficiency of every individual performance.

Authors agree that when conceptualizing performance one has to differentiate between an action (i. e., behavioral) aspect and an outcome aspect of performance (Campbell, 1990; Campbell, McCloy, Oppler, & Sager, 1993; Kanfer, 1990; Roe, 1999). The behavioral aspect refers to what an individual does in the work situation. It covers manners such as assembling parts of a car engine, selling items in a grocery store, teaching basic algebra

to high school students, or performing heart surgery. Not every behavior is included under the performance concept, but only behavior which is relevant for the organizational goals: " Performance is what the organization hires one to do, and do well" (Campbell et al., 1993). Thus, performance is not defined by the action itself but by judgmental and evaluative processes (Ilgen & Schneider, 1991; Motowidlo, Borman, & Schmit, 1997). Moreover, only actions which can be scaled, i. e., measured, are considered to constitute performance (Campbell et al., 1993).

Campbell (1993) asserts that, outcomes are the result of an individual's performance, but they are also the result of other influences. In the same way, there are more factors that determine outcomes than just an employee's behaviors and actions.

The outcome aspect refers to the consequence or result of the individual's behavior. The above-mentioned behaviors may result in outcomes such as numbers of engines assembled, sales figures, student's proficiency in algebra, or number of successful heart operations. In many situations, the behavioral and outcome aspects are related empirically, but they do not overlap completely. Outcome aspects of performance depend also on factors other than the individual's behavior. For example, imagine a teacher who delivers a basic algebra lesson (behavioral aspect of performance), but one or two of his pupils nevertheless do not improve their number skills because of their intellectual deficits (outcome aspect of performance). Or imagine a sales employee in the telecommunication business who shows only mediocre performance in the direct interaction with potential clients (behavioral aspect

of performance), but nevertheless achieves high sales figure for mobile phones (outcome aspect of performance) because of a general high demand for mobile phone equipment.

In practice, it might be difficult to describe the action aspect of performance without any reference to the outcome aspect. Because not any action but only actions relevant for organizational goals constitute performance, one needs criteria for evaluating the degree to which an individual's performance meets the organizational goals. It is difficult to imagine how to conceptualize such criteria without simultaneously considering the outcome aspect of performance at the same time. Thus, the emphasis on performance being an action does not really solve all the problems.

Based on the ideas of Motowidlo et al. (1997), performance is a multi-dimensional concept. On the most basic level, they distinguish between task and contextual performance. Task performance refers to an individual's proficiency with which he or she performs activities which contribute to the organization's ' technical core'. This contribution can be both direct (e. g., in the case of production workers), or indirect (e. g., in the case of managers or staff personnel). Contextual performance refers to activities which do not contribute to the technical core but which support the organizational, social, and psychological environment in which organizational goals are pursued. Contextual performance includes not only behaviors such as helping coworkers or being a reliable member of the organization, but also making suggestions about how to improve work procedures.

Three basic assumptions are associated with the differentiation between task and contextual performance (Borman & Motowidlo, 1997; Motowidlo & Schmit, 1999): (1) Activities relevant for task performance vary between jobs whereas contextual performance activities are relatively similar across jobs; (2) task performance is related to ability, whereas contextual performance is related to personality and motivation; (3) task performance is more prescribed and constitutes in-role behavior, whereas contextual performance is more discretionary and extra-role.

Task performance in itself is multi-dimensional. For example, among the eight performance components proposed by Campbell (1990), there are five factors which refer to task performance (Campbell, Gasser, & Oswald, 1996; Motowidlo & Schmit, 1999): (1) job-specific task proficiency, (2) non-job-specific task proficiency, (3) written and oral communication proficiency, (4) supervision—in the case of a supervisory or leadership position—and partly (5) management/administration. Each of these factors comprises a number of subfactors which may vary between different jobs. For example, the management/administration factor comprises subdimensions such as (1) planning and organizing, (2) guiding, directing, and motivating subordinates and providing feedback, (3) training, coaching, and developing subordinates, (4) communication effectively and keeping others informed (Borman & Brush, 1993). In recent years, researchers paid attention to specific aspects of task performance. For example, innovation and customer-oriented behavior become increasingly important as organizations put greater

emphasis on customer service (Anderson & King, 1993; Bowen & Waldman, 1999).

Researchers have developed a number of contextual performance concepts. On a very general level, one can made a distinction between two types of contextual performance: behaviors which aim principally at the smooth functioning of the organization as it is at the present moment, and proactive behaviors which aim at changing and improving work procedures and organizational processes. The ' stabilizing' contextual performance behaviors include organizational citizenship behavior with its five components altruism, conscientiousness, civic virtue, courtesy, and sportsmanship (Organ, 1988), some aspects of organizational spontaneity (e. g., helping coworkers, protecting the organization, George & Brief, 1992) and of prosocial organizational behavior (Brief & Motowidlo, 1986). The more pro-active behaviors include personal initiative (Frese, Fay, Hilburger, Leng, & Tag, 1997; Frese, Garst, & Fay, 2000; Frese, Kring, Soose, & Zempel, 1996), voice (Van Dyne & LePine, 1998), and taking charge (Morrison & Phelps, 1999). Thus, contexual performance is not a single set of uniform behaviors, but is in itself a multidimensional concept (Van Dyne & LePine, 1998).

Task and contextual performance can be easily distinguished at the conceptual level. There is also increasing evidence that these two concepts can also be separated empirically (e. g., Morrison & Phelps, 1999; Motowidlo & Van Scotter, 1994; Van Scotter & Motowidlo, 1996; Williams & Anderson, 1991). Additionally, task performance and contextual performance factors such as job dedication and interpersonal facilitation contributed uniquely to

overall performance in managerial jobs (Conway, 1999). Moreover, contextual performance is predicted by other individual variables, not only task performance. Abilities and skills tend to predict task performance while personality and related factors tend to predict contextual performance (Borman & Motowidlo, 1997; Hattrup, O'Connell, &Wingate, 1998; Motowidlo & Van Scotter, 1994). However, specific aspects of contextual performance such as personal initiative have been shown to be predicted both by ability and motivational factors.

Campbell (1993) hypothesized that, individual performance is not stable overtime. Variability in an individual's performance over time reflects (1) learning processes and other long-term changes and (2) temporary changes in performance. Individual performance changes as a result of learning. Studies showed that performance initially increases with increasing time spent in a specific job and later reaches a plateau. Moreover, the processes underlying performance change over time. During early phases of skill acquisition, performance relies largely on ' controlled processing', the availability of declarative knowledge and the optimal allocation of limited attentional resources, whereas later in the skill acquisition process, performance largely relies on automatic processing, procedural knowledge, and psychomotor abilities.

To identify the processes underlying changes of job performance, Murphy (1989) differentiated between a transition and a maintenance stage. The transition stage occurs when individuals are new in a job and when the tasks are novel. The maintenance stage occurs when the knowledge and skills

needed to perform the job are learned and when task accomplishment becomes automatic. For performing during the transition phase, cognitive ability is highly relevant. During the maintenance stage, cognitive ability becomes less important and dispositional factors (motivation, interests, and values) increase in relevance.

Performance changes over time are not invariable across individuals. There is increasing empirical evidence that individuals differ with respect to patterns of intra-individual change (Hofmann, Jacobs, & Gerras). These findings indicate that there is no uniform pattern of performance development over time.

Campbell (1993) pointed out that, researchers have adopted various perspectives for studying performance. On the most general level one can differentiate between three different perspectives: (1) an individual differences perspective which searches for individual characteristics (e. g., general mental ability, personality) as sources for variation in performance, (2) a situational perspective which focuses on situational aspects as facilitators and impediments for performance, and (3) a performance regulation perspective which describes the performance process. These perspectives are not mutually exclusive but approach the performance phenomenon from different angles which complement one another.

The individual differences perspective focuses on performance differences between individuals and seeks to identify the underlying factors. It should be understood that every person is different from each other in terms of ability,

personality and motivation therefore we have to note that we cannot compare one person to the other for individually there is always a difference. The head of the staff should not expect that his subordinates can serve a same level of performance as he is. Likewise, the subordinates should avoid thinking that he can serve a same line of performance with his superiors. Therefore, to understand this perspective an organization should determine the individual differences of their members. The core question to be answered by this perspective is: Which individuals perform best? The basic idea is that differences in performance between individuals can be explained by individual differences in abilities, personality and/or motivation.

Campbell (1990) proposed a general model of individual differences in performance which became very influential. In his model, Campbell differentiates performance components (e. g., job specific task proficiency), determinants of job performance components and predictors of these determinants. Campbell describes the performance components as a function of three determinants (1) declarative knowledge, (2) procedural knowledge and skills, and (3) motivation. Declarative knowledge includes knowledge about facts, principles, goals, and the self. It is assumed to be a function of a person's abilities, personality, interests, education, training, experience, and aptitude-treatment interactions.

Individual differences in motivation may be caused by differences in motivational traits and differences in motivational skills. Motivational traits are closely related to personality constructs, but they are narrower and more relevant for motivational processes, i. e., the intensity and persistence of an

action. Kanfer and Heggestad (1997) described achievement and anxiety as two basic work-relevant motivational traits. Vinchur et al.'s meta-analysis provides evidence for the need for achievement to be related to job performance (Vinchur et al., 1998). Motivational skills refer to self-regulatory strategies pursued during goal striving. In contrast to motivational traits, motivational skills are assumed to be more domain-specific and influenced by situational factors as well as learning and training experiences. Motivational skills comprise emotional control and motivation control.

Moreover, professional experience shows a positive, although small relationship with job performance. Additionally, there are interactions between predictors from several areas. For example, high achievement motivation was found to enhance the effects of high cognitive ability. Some practical implications follow from this individual differences perspective. Above all, the individual differences perspective suggests a focus on personnel selection. For ensuring high individual performance, organizations need to select individuals on the basis of their abilities, experiences, and personality. The individual differences perspective also suggests that training programs should be implemented which aim at improving individual prerequisites for high performance. More specifically, training should address knowledge and skills relevant for task accomplishment. Furthermore, exposing individuals to specific experiences such as traineeships and mentoring programs are assumed to have a beneficial effect on individuals' job performance.

The situational perspective refers to factors in the individuals' environment which stimulate and support or hinder performance. The core question to be answered is: In which situations do individuals perform best? The situational perspective encompasses approaches which focus on workplace factors but also specific motivational approaches which follow for example from expectancy theory or approaches which aim at improving performance by reward systems or by establishing perceptions of equity and fairness. Precisely, environmental influence and background will help someone make a good or a bad performance, that of what kind of community or family that a person is influence to will determine his desire to perform good and push him to act accordingly or block his capacity to perform. With respect to workplace factors and their relationship to individual performance two major approaches can be differentiated: (1) those that focus on situational factors enhance and facilitate performance and (2) those that attend to situational factors which impede performance (Campbell, 1993). Situational constraints include stressors such as lack of necessary information, problems with machines and supplies as well as stressors within the work environment. Situational constraints are assumed to impair job performance directly.

For example, when a machine breaks down one cannot continue to accomplish the task and therefore performance will suffer immediately. Moreover, situational constraints, as other stressors, can have an indirect effect on performance by requiring additional regulation capacity (Greiner & Leitner, 1989). Additional regulation capacity over and above the one needed for accomplishing the task is required for dealing with the

constraints. Because human regulatory capacity is limited, less capacity is available for accomplishing the task and, as a consequence, performance decreases. However, empirical support for the assumed detrimental effect of situational constraints and other stressors on performance is mixed (Jex, 1998). Recently, Fay and Sonnentag (2000) have shown that stressors can even have a positive effect on personal initiative, i. e., one aspect of contextual performance. According to Campbell (1993), within a situational perspective, the performance enhancing factors (e. g., control at work, meaningful tasks) play a more important role than stressors.

Framed differently, the lack of positive features in the work situation such as control at work threatens performance more than the presence of some stressors. In terms of practical implications, the task and situational perspective suggests that individual performance can be improved by job design interventions. For example, empirical job design studies have shown that performance increases when employees are given more control over the work process. The performance regulation perspective takes a different look at individual performance and is less interested in person or situational predictors of performance. Rather, this perspective focuses on the performance process itself and conceptualizes it as an action process. It addresses as its core questions: ' How does the performance process look like?' and " What is happening when someone is ' performing'?" Typical examples for the performance regulation perspective include the expert research approach within cognitive psychology (Ericsson & Lehmann, 1996)

and the action theory approach of performance (Frese & Sonnentag, 2000). Most of these approaches focus on regulatory forces within the individual.

Roe (1999) suggested a very broad approach to performance regulation, in which he incorporated the action theory approach as one of five perspectives. The other four components of performance regulation are: energetic regulation, emotional regulation, vitality regulation, and self-image regulation. Roe assumes that all these five types of regulation are involved in performance regulation.

According to Campbell (1993) the process regulation perspective is closely linked to specific performance improvement interventions. The most prominent interventions are goal setting and feedback interventions. The basic idea of goal setting as a performance improvement intervention is that setting specific and difficult goals results in better performance than no or 'do-your-best' goals. Goal-setting theory assumes that goals affect performance via four mediating mechanisms: effort, persistence, direction, and task strategies. The benefits of goal setting on performance have been shown in virtually hundreds of empirical studies. Meta-analyses showed that goal setting belongs to one of the most powerful work-related intervention programs. The performance regulation perspective suggests that an improvement of the action process itself improves performance. For example, individual should be encouraged to set long-range goals and to engage in appropriate planning, feedback seeking, and feedback processing.

This perspective assumes that training interventions can be useful in achieving such changes. Additionally, job design interventions can help to improve the action. A rather different approach to performance regulation is the behavior modification perspective. Based on reinforcement theory this approach is not primarily interested in the processes within the individual which regulate performance but in regulative interventions from outside the individual, particularly positive reinforcement. Such reinforcements can comprise financial interventions, non-financial interventions such as performance feedback, social rewards such as attention and recognition, or a combination of all these types of reinforcements. Meta-analytic findings suggest that such behavior modification interventions have a positive effect on task performance, both in the manufacturing and in the service sector (Stajkovic & Luthans, 1997).

Fig. 1 Theoretical/ Conceptual Diagram of Job Performance

Statement of the Problem

The purpose of this study is to know the level of the Job Performance of health center staff in Barangay Apas, Cebu City for the class year 2013. Specifically it aimed to answer the following: 1. What is the level of Job Performance of health center staff in Barangay Apas as perceived by the community residents, when categorized into: 1. 1 Public Health Nurse

1. 2 Public Health Midwife

1. 3 Barangay Health Workers

2. Based on the findings of the study, what recommendations can be

proposed? Hypothesis

HO: There is no significant difference in the Job Performance of health center staff as perceived by the community residents. Significance of the Study

The study is significant to the following entities:

Nurse. Since the nurse is the team leader in the barangay health center staff, he/she should know the programs and services provided by the government and know what to do in times of emergency or severe cases. Midwife. He/she should know and put into correct explanation of the knowledge that the community should practice in terms of maternal and child health care and family planning for many sad experiences that the community did not understand what to do as it is not well explained. Barangay Health Worker. Even BHW are identified by the constitution as volunteered trained person yet he/she should understand the principle of channeling his/her duties and responsibilities that the head of their staff should be informed before doing an act to the community. Local Government. Barangay Captains in every barangay should understand their responsibilities as the local executive to help implementing, providing, and overseeing the health care of every individual in the community. They should also know the resources to provide the health care services in the barangay.

Department of Health. They should give proper training and seminar that will enhance knowledge of those who are involved in the barangay health care. The Researchers. They should gather datas, information, ideas and suggestion from the community that would help the health center staff learn

what the community needs in terms of health care. Future Researchers. They should overview the previous gathered datas of the previous researchers that will somehow guide them of where to improve and where to enhance the new research information. Scope and Limitations of the Study/

The scope of the study was focused on the job performance of health center staff in Barangay Apas, Cebu City. Training and seminars will help someone become effective of his/her responsibility in the barangay health care regardless of educational attainment for if he/she is willing to learn and putting into his/her heart the sacredness of their duty his/her duties will be performed well. The study and the gathered information are taken from one barangay, specifically barangay apas only. Definitions of Terms

This section defines the terms operationally to have a common understanding. The following terms are associated: Nurse. As used in this study, this is the person who is the team leader of the barangay health center staff, and the one who primarily monitors, mandates and oversee the function of the health center in providing health care to the community residents. Midwife. As utilize in this study, this is the person who is considered as the front line in the health center staff in the barangay. He/she assumes responsibility in obstetrical cases and child care of the community residents. Barangay Health Worker. As employed in this study, this is the person who voluntarily works in the health center with trainings and seminars provided by the government. They assume responsibility in the patient's record and appropriate recognition of the community residents. Job Performance. As used in this study, it is the action of an individual that will

be identified as excellent or poor, depending on the criteria set upon by the evaluator. This will determine if the individual is doing his/her job well. Health Center. As utilized in this study, it is the place or facility wherein it is located in the community or barangay where health center staff, like nurse, midwife and barangay health worker works in catering patient's needs. They only give primary health care and in emergency cases do a referral of patient's condition. Primary Health Care. As used in this study, it is important health care services given free of charge in the people in the community, local executives in the barangay and health center staff are the main personalities to which this will be implemented.

Chapter II

REVIEW OF RELATED LITERATURE AND STUDIES

The review of literature for this study focuses on the intent of the primary health care, the objective of community health care, the meaning and scope of a community, the functions of the health center, and the job description of barangay health center staff namely the public health nurse, public health midwife, and barangay health workers. The literature used in this study is worth reviewing for it will give us a common knowledge to the purpose and action of the barangay health center staff in the community. Related Literature

According to Crooks and Andrews (2009), there are seven (7) multiple framings of primary health care that should be considered in the community setting, these are the following; 1) PHC as a System – PHC is ' community-based health professionals and programs that are the first point of contact

with the health care system', 2) PHC as a Set of Qualities – Responsive, comprehensive, continuity, interpersonal communication, technical effectiveness, 3) PHC as a Range of Services – Emphasizing health promotion, chronic illness management, and integration of services within a continuum of care. Also includes basic emergency care, referrals, primary mental health care, palliative care, healthy child development, primary maternity care, and rehabilitation services, 4) PHC as an Approach – PHC ' refers to an approach to health and spectrum of services beyond the traditional health care system. It includes all services that play a part in health, such as income, housing, education, and environment. Primary care is the element within the primary health care that focuses on health care services, including health promotion, illness and injury prevention, and the diagnosis and treatment of illness and injury',

5) PHC as a Sector – ' The PHC sector contributes to health system equity directly through its responsibility for distribution of care within this sector, and indirectly through control over prescriptions, referrals and hospital admissions', 6) PHC as a Set of Components – Specific components of PHC are: (1) improved continuity and coordination; (2) early detection and action; (3) better information on needs and outcomes; and (4) incentives to support the adoption of new health care approaches, 7) PHC as a Group of Providers – Physicians, dieticians, home care workers, nurses, occupational therapist, physiotherapists, pharmacists, social workers, and other health care providers.

Reeves and Baker (2004), asserts that access to PHC is a critical determinant of population health in any context, regardless of the level of wealth and social development. It is well known that having regular contact with PHC providers confers all sorts of benefits to individuals and the wider societies to which they belong. These benefits include more attention to health promotion, earlier detection of health problems, and more efficient use of other health sectors and resources, such as emergency services and tertiary level acute care. PHC refers not only to a broad collection of health practitioners, but a more holistic approach to health care that emphasizes health promotion and wellness. Thus, while questions abound about the contribution of the curative sectors of health systems to the overall health populations, there is widespread support for policies that seek greater investments in PHC as a means to achieve better health and health care outcomes.

Solheim et al. (2007) maintained that the realization of PHC's promise depends upon the degree to which the full range of PHC resources available is engaged in the pursuit of population health objectives. They also added that there is much often emphasis on PHC as the point of initial contact in a given health system, but should also be borne in mind that the sector plays an ongoing role in the patterning of care. This includes such things as the monitoring and management of chronic disease and degenerative conditions, rehabilitation from illness and injury, information and referral activities, and palliation.

Based on the ideas of Brameld and Holfman (2006), there is a widespread interest in the socio-spatial dimensions of PHC organization and delivery. They added that geographers are especially drawn to the fact that PHC is the aspect of formal health care systems where notions of distributional equity are most localized. That is, while no one would reasonably insist that specialist and sophisticated technologies are dispersed evenly across space, there is every reason to expect that PHC provision be distributed in a manner that is proportionate to the demographic and socio-economic structure of populations, but also sensitive to concerns of distance minimization for individuals in small and remote locations.

According to Carabeo (1994), the people's participation is the core principle of the community-based health program (CBHP) in the Philippines that differentiates it from the other health programs' approaches. He also added that without people's participation, a CHBP would be just another " band-aid solution". He explained that CHBPs give primacy to the organization of the local people before they are implemented. Organizing the people would include activities such as education or consciousness-raising and leadership formation. He added that it ensures the people's participation in the planning, implementation and evaluation of the program. He concluded that the success of any undertaking that aims at serving the people is dependent on the people's participation at all levels.

The CHBP is one of the methods to address the health needs of the people. It does not provide solution to health problems but assists and facilitates in laying the foundation of a health system that is governed by the people at

the community level. CHBPs are programs that aim to respond to the basic health needs of the people through education, training and services. It is a method or process of giving or transferring knowledge, skills and power to the people so that they become more responsible for their health. It strengthens the people's resolve to demand their basic right to good health. Therefore, CHBP is a method of health-care development with and for the people at the community level (Carabeo, 1994).

According to Quesada (2004), there are eight (8) elements of primary health, these are the following: 1) Education regarding prevailing health problems and the methods of preventing and controlling them, 2) Promotion of food supply and proper nutrition, 3) An adequate supply of safe water and basic sanitation, 4) Maternal and child health care including family planning, 5) Immunization against the major diseases, 6) Prevention and control of locally endemic diseases, 7) Appropriate treatment of common diseases and injuries, and 8) Provision of essential drugs.

He also pointed out seven (7) essential components of primary health care, and these are the following: 1) It should embrace the entire health system of the country and should be available to home, place of work, community, the hospital and research centers, 2) Active and responsible participation of the people individually and collectively at all levels of the health system, 3) Real health needs peoples' participation and the actual resources of the country. The communities should govern the type of technology to be used by the health system at different levels, 4) Appropriate technology should be scientifically sound, effective and acceptable to both who will use it and who

will get benefit from it, 5) Multisectoral approach has to be taken to improve the health status. The factors which are responsible for health and diseases are in absolute necessity for multisectoral action e. g., better education, proper nutrition, safe drinking water, sanitation, good food, suitable working environment etc., 6) Primary health care must be a component of and never be isolated from a national socioeconomic development strategy, and 7) There is an absolute necessity of gradually delegating the responsibility for health activities to various categories of health personnel.

He also added the distinguished ingredients from basic health services of primary health care, and these are the following: 1) Involves all related sectors and aspects of national and community development in particular, agriculture, animal husbandry, food, industry, education, housing, public works, communication and other sectors and demands the co-ordinated efforts of all the sectors, 2) It requires and promotes maximum communication and individual self reliance and participation in planning, organization and control of health care making fullest use of local, national and other available resources, 3) It has to be sustained by integrated functional and mutually supporting referral systems, and 4) It relies at local and referral level on health workers and community workers as applicable, as well as on traditional practitioners as needed socially and technically trained to work as health team and to respond to the expressed health needs of the community.

According to Galvez-Tan (2005) inclusion in the community health are the entire community organized efforts for maintaining, protecting and

improving the health of the people. The term has replaced the previous nomenclatures viz. public health, preventive medicine and social medicine because of the changing nature of public health which has entered an era of individual responsibility and community participation. He added that the entire community is considered a patient needing community diagnosis and community treatment. He emphasized that community diagnosis is based on collection and interpretation of various data such as (a) the age and sex distribution of the population (b) birth rate, death rate, infant mortality rate, maternal mortality rate etc. (c) the incidence, prevalence and attack rates of the more important diseases of the area. The focus is on identification of the basic health needs and health problems of the community.

The needs " as felt" by the community are investigated and listed accordingly to priority for community treatment. He pointed out that community treatment or health action is decided upon to meet the health needs of the community taking into account the resources available and the wishes of the people revealed by community diagnosis. He added that improvement of water supply, immunization, health education, control of specific diseases is examples of community health action. He also emphasized three (3) levels of actions that may be taken: (1) Individual, (2) Family and (3) Community. Community is defined as a collection of people who share some quality of their lives and intermingle with each other in some way. They may live in the same locale, attend a particular church, or even share a particular interest such as art (Allender & Spradley, 2004).

According to Davis et al. (2005) there are five major functions of a community. 1) Production, distribution, and consumption of goods and services – These are the means by which the community provides for the economic needs of its members. This function includes not only the supplying of food and clothing but also the provision of water, electricity, and police and fire protection and the disposal of refuse. 2) Socialization – It refers to the process of transmitting values, knowledge, culture, and skills to others. Communities usually contain a number of established institutions for socializations: families, churches schools, media, voluntary and social organization, and so on. 3) Social control – It refers to the way in which order is maintained in a community. Laws are enforced by the police; public health regulations are implemented to protect people from certain diseases. Social control is also exerted through the family, church, and schools. 4) Social interparticipation – It refers to community activities that are designed to meet people's needs for companionship. Families and churches have traditionally met this need; however, many public and private organizations also serve this function. 5) Mutual support – It refers to the community's ability to provide resources at a time of illness or disaster. Although the family is usually relied on to fulfill this function, health and social services may be necessary to augment the family's assistance if help is required over an extended period.

According to Maurer & Smith (2004), there are ten characteristics of a healthy community. 1) Is one in which members have a high degree of awareness of being a community. 2) Uses its natural resources while taking

steps to conserve them for future generations. 3) Openly recognizes the existence of subgroups and welcomes their participation in community affairs. 4) Is prepared to meet crises. 5) Is a problem-solving community; it identifies, analyzes and organizes to meet its own needs. 6) Possesses open channels of communication that allow information to flow among all subgroups of citizens in all directions. 7) Seeks to make each of its systems' resources available to all members. 8) Has legitimate and effective ways to settle disputes that arise within the community. 9) Encourages maximum citizen participation in decision making. 10) Promotes a high level of wellness among all its members. According to Anderson and McFarlane (2004) there are eight subsystems of the community for analysis. These are communication, economics, education, health and social services, physical environment, politics and government, recreation, and safety & transportation.

The subsystems are illustrated around a core, which consists of the people and their characteristics, values, history, and beliefs. According to Veneracion (2003), the primary health centre occupies a key position in the nation's health system. The primary health center is defined as an " institution for providing comprehensive (i. e., preventive, promotive and curative) health care services to the people living in a defined geographic area. It seeks to achieve its purpose by grouping under one roof or co-ordinates in some other manners all the health works of that area." He also emphasized nine (9) functions of the primary health centre, and these are as follows: 1) Medical care, 2) Maternity, child health and family welfare, 3)

Improvement of environmental sanitation with priority for providing safe drinking water and disposal of human excreta, 4) Control of communicable diseases, 5) Collection and reporting of vital statistic, 6) Health education, 7) National health programmes, 8) Referral services, and 9) Training of village health guides, health assistants and health supervisors. The public health nurse is a member of the health center staff

in the barangay and has the following functions: 1) Planner/Programmer – Identifies needs, priorities, and problems of individuals, families, and communities; Formulates municipal health plan in the absence of a medical doctor; Interprets and implements nursing plan, program policies, memoranda, and circular for the concerned staff personnel; Provides technical assistance to rural health midwives in health matters, 2) Provider of Nursing Care – Provides direct nursing care to sick or disabled in the home, clinic, school, or workplace; Develops the family's capability to take care of the sick, disabled, or dependent member,

3) Community Organizer – Motivates and enhances community participation in terms of planning, organizing, implementing, and evaluating health services; Initiates and participates in community development activities, 4) Coordinator of Services – Coordinates with individuals, families, and groups for health related services provided by various members of the health team; Coordinates nursing program with other health programs like environmental sanitation, health education, dental health, and mental health, 5) Trainer/Health Educator – Identifies and interprets training needs of the RHMs, Barangay Health Workers (BHW), and hilots; Conducts training for

RHMs and hilots on promotion and disease prevention; Conducts pre and post-consultation conferences for clinic clients; acts as a resource speaker on health and health related services; Initiates the use of tri-media (radio/TV, cinema plugs, and print ads) for health education purposes; Conducts pre-marital counseling, 6) Health Monitor – Detects deviation from health of individuals, families, groups, and communities through contacts/visits with them, 7) Role Model – Provides good example of healthful living to the members of the community, 8) Change Agent – Motivates changes in health behavior in individuals, families, groups, and communities that also include lifestyle in order to promote and maintain health,

9) Recorder/Reporter/Statistician – Prepares and submits required reports and records; Maintain adequate, accurate, and complete recording and reporting; Reviews, validates, consolidates, analyzes, and interprets all records and reports; Prepares statistical data/chart and other data presentation, 10) Researcher – Participates in the conduct of survey studies and researches on nursing and health-related subjects; Coordinates with government and non-government organization in the implementation of studies/research (RNPedia, 2013). Public health nurses assimilate community participation and knowledge about the entire population with personal, clinical understandings of the health and illness experiences of individuals and families within the population. They transform and articulate the health and illness experiences of varied, often susceptible individuals and families in the population to health planners and policy makers, and support members of the community to voice their problems and objectives. Public

health nurses are well-informed about numerous strategies for intervention, from those appropriate to the entire population, to those for the family, and the individual. Public health nurses translate facts from the health and social sciences to individuals and population groups through targeted interventions, programs and advocacy (American Public Health Association, 2013)

Public health nursing may be applied by one public health nurse or by a group of public health nurses working collaboratively. In both instances, public health nurses are straightforwardly engaged in the inter-disciplinary activities of the interior public health functions of appraisal, assertion and policy development. Interventions or strategies may be targeted to multiple levels depending on where the most efficient outcomes are potential. They consist of strategies aimed at whole population groups, families, or individuals. In any setting, the role of public health nurses focuses on the prevention of illness, injury or disability, the encouragement of health, and prolongation of the health of the populations (American Public Health Association, 2013). According to the World Health Organization (WHO), a midwife is a person, who, having been regularly admitted to a midwifery educational programme, duly recognized in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery (Sherratt, 2010).

Sherratt (2010) emphasized that a midwife must be able to give the necessary supervision, care and advice to women during pregnancy, labor

and post partum period, to conduct deliveries on her own responsibility and to care for the newborn and the infant. This care includes preventive measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help. She also added that the midwife has an important task in health counseling and education, not only or the women, but also within the family and the community. The work should involve antenatal education and preparation for parenthood and extends to certain areas if gynecology, family planning and child care. The midwife may also practice in hospitals, clinics, health units, domiciliary conditions or any other service. According to the Department of Health (2011) the midwives are the frontline healthcare providers that serve as the link between health service delivery and the community in the reduction of maternal and neonatal morbidity and mortality. The role of the midwife is much diversified.

They are exceedingly trained professional and carries out clinical examinations, provides health and parent education and supports the mother and her family all the way through the childbearing process to help them amend to their parental responsibility (Nursing and Midwifery Council, 2004). The midwife also works in partnership with other health and social care services to meet individual mother's need, for instance, teenage mothers, mothers who are socially excluded, disabled mothers, and mothers from diverse cultural background. Midwives work in all health care settings; they work in the maternity unit of a big general hospital, in smaller stand-alone maternity units, in private maternity hospitals, in group practices, at

birth centers, with general practitioners, and in the community. The midwives provide counsel, care and support for women and their parents and families before, during, and after birth. They help women make their own choice about the care and services they access. They care for newborn children, providing health education and parenting support for the first 28 days, after which care transfers to health visitor. Midwives are personally responsible for the health of both mother and child and only refer to obstetricians if there are medical complications. They work in multidisciplinary teams in both hospital and, increasingly, community healthcare settings (Prospects, 2012). A midwife has a range of responsibilities, including the care of mother and baby, adhering to hospital policy and maintaining of issues such as health and safety. Typical work activities include:

1) Diagnosing, monitoring and examining women during pregnancy; 2) Developing, assessing and evaluating individual programmes of care; 3) Providing full antenal care, including screening tests in the hospital, community and the home; 4) Identifying high risk pregnancies and making referrals to doctors and other medical specialists; 5) Arranging and providing parenting and health education for the woman, her partner and family members; 6) Encouraging participation of family members in the birth to support the mother and enhance both mother/baby bonding and family relationships; 7) Providing counseling and advice before and after screening; 8) Offering support and advice following events such as miscarriage, termination, still birth, neonatal abnormality and neonatal death; 9)

Supervising and assisting mothers in labor, monitoring the condition of the fetus and using knowledge of drugs and pain management; 10) Giving support and advice on the daily care of the baby, including breast feeding, bathing and making up feeds; 11) Providing advice and guidance on a safe and timely transfer home; 12) Liaising with agencies and other health and social care professionals to ensure continuity of care; 13) Engaging in professional development to meet PREP (post-registration education and practice) requirements; 14) Participating in the training and supervision of junior colleagues (Prospects, 2012). According to R. A. 7883 Sec. 3 (1995), Barangay Health Worker is a person who has undergone training programs under any accredited government and non-government organization and who voluntarily renders primary health care services in the community after having been accredited to function as such by the local health board in accordance with the guidelines promulgated by the Department of Health.

Barangay health workers are created as an important part of the community-based programmes that would serve as a link between professional health staff such as the doctors, nurses and midwifes into the community, and would help the communities identify and address their own health necessities. They added that the barangay health workers are considered as the main instrument of community-based treatment, education, and counseling that takes upon in a home visitation. In line with this, the BHW's are frequently the key participants in dispensing essential services and promoting better caring practices (UNICEF, 2007). Barangay Health Workers have been less effective in identifying and managing complications during

childbirth. Reducing maternal mortality rate thus requires the scaling up of skilled attendance at birth with referral systems for emergency obstetric care. Effective referral systems are an essential accompaniment to thriving community-based programmes to ensure a continuum of care. In relation, hospitals provide services that cannot be safely replicate somewhere else, such as Caesarian sections and other emergency obstetric care. On the other hand, the poorest countries with the highest maternal and child mortality rates, health care resources are often inadequate and access to referral hospitals are often low. In these circumstances, millions of children can be assisted very hastily by scaling up of established, cost-effective interventions in primary health care, mainly those that are community-based (UNICEF, 2007).

A report by Dr. Henry Perry and Rose Zulliger of the Johns Hopkins Bloomberg School of Public Health estimates that using community health workers (CHWs) to provide health services to families can significantly improve health outcomes and potentially save the lives of 3. 6 million children per year. These important findings support the urgency of the One Million Community Health Workers Campaign (MDG Health Alliance, 2013). The new report finds that the services delivered by CHWs that hold the most promise for reducing maternal and child mortality are: family planning, distributing misoprostol (for reducing the risk of post-partum hemorrhage in women who give birth at home), essential neonatal care at home, promoting exclusive breastfeeding during the first six months of life, integrated community case management of childhood illnesses (pneumonia, diarrhea

and malaria), and promoting and providing immunizations (MDG Health Alliance, 2013). According to the Cebu City Health Department (n. d.) there are 10 (ten) functions of a barangay health worker, and these are the following: 1) Obtaining OPT Results which is weight for age, height for age and weight for height; 2) Weighing of 0-71 months old children and is classified into new and old cases both determined by underweight or severely underweight; 3) Provision of Micronutrient Supplementation which includes Vitamin A and Iron;

4) Deworming of 12-71 months old children, underweight, severely underweight, children referred/provided with feeding and agency providing feeding; 5) Case Finding of pregnant women during the first trimester (up to 12 weeks), pregnant women above 12 weeks, TT2-TT5 plus, postpartum home visits (within 24 hours/within 1 week), FIC, family planning acceptors buying/ receiving FP commodities from other agencies and women of reproductive age encourage/ brought to health center for a method; 6) Referral of Cases of 0-4 Y. O. children for cough, 0-4 Y. O. children for diarrhea, 15-49 Y. O. women for family planning, TB symptomatic for sputum examination, sputum positive for treatment, leprosy suspects for consultation, fever, hypertensive cases and diabetic cases; 7) Follow-up of Defaulter Cases which includes on immunization (OPV, DPT, Pentavalent, Hepa B, AMV/MR and MMR both in 2nd and 3rd dosage) and seen cases both in health center and hospital (Dengue, Diarrhea, Measles, Typhoid Fever, Hepatitis, Influenza, Pneumonia and others); 8) Record clinic attendance; 9) Updating of Records (Monitoring of Malnourished Children); 10) Submission

of Reports (BHW Monthly Accomplishment Report, OPT Form 1A Summary of Preschoolers Weighed by Age Group and Weight Status, and others). Related Studies

This part relates the summary method, findings and conclusion of studies like dissertation, unpublished thesis and other studies viewed. The study with the current issues and problems compromise of collected research study.

The Canadian Public Health Association (2010) defines public/community health nurse as follows: 1) combines knowledge from public health science, primary care (including the determinants of health), nursing science, and the social sciences; 2) focuses on promoting, protecting, and preserving the health of populations; 3) links the health and illness experiences of individuals, families, and communities to population health promotion practice; 4) recognizes that a community's health is closely linked to the health of its members and is often reflected first in individual and family health experiences; 5) recognizes that healthy communities and systems that support health contribute to opportunities for health for individuals, families, groups, and populations; and 6) practices in increasingly diverse settings, such as community health centers, schools, street clinics, youth centers, and nursing outposts, and with diverse partners, to meet the health needs of specific populations.

According to the Canadian Public Health Association (2010) public/community health nurses must use advanced decision-making

strategies such as the nursing process, which combines judgment, action, responsibility, accountability and must take the time to inform themselves about current community health issues and new technologies, so they can properly apply public health science and epidemiological principles to their work.

The Canadian Public Health Association emphasized the role of public/community health nurse into the community and these are the following: 1) Role in Health Promotion – (a) encourages the adoption of health beliefs, attitudes, and behaviors that contribute to the overall health of the population through public policy, community-based action, public participation, and advocacy or action on environmental and socio-economic determinants of health, as well as health inequities, (b) supports public policy changes to modify physical and social environments that contribute to risk, (c) assists communities, families, and individuals to take responsibility for establishing, maintaining, and/or improving their health by adding to their knowledge or control over (and ability to influence) health determinants, (d) works with others and leads processes to enhance community, group, or individual plans that will help society to plan for, cope with, and manage change, (e) encourages skill building by communities, families, and individuals so they can learn to balance choices with social responsibility and, in turn, create a healthier future for all, and (f) initiates and participates in health promotion activities in partnership with others such as the community and colleagues in other sectors;

2) Role in Disease and Injury Prevention – (a) reduces the risk of infectious disease outbreaks; this includes early identification, investigation, contact tracing, preventive measures, and activities to promote safe behaviors, (b) applies epidemiological principles and knowledge of the disease process so as to manage and control communicable diseases using prevention techniques, infection control, behavior change counseling, outbreak management, surveillance, immunization, episodic care, health education, and case management, (c) uses appropriate technology for reporting and follow-up, (d) uses effective strategies to reduce risk factors that may contribute to chronic disease and disability; this may include changes to social and economic environments and inequities that increase the risk of disease, (e) helps individuals and families to adopt health behaviors that reduce the likelihood of disease, injury, and/or disability, and (f) encourages behavior changes to improve health outcomes; 3) Role in Health Protection – (a) acts in partnership with public health colleagues, government, and other agencies to: ensure safe water, air, and food, control infectious diseases, and provide protection from environmental threats (including delegating or carrying out delegated regulatory functions), (b) takes the lead in identifying issues that may need attention and offers public health advice to groups such as municipal governments or regional districts about the public health impact of policies and regulations, and (c) works with individuals, families, and communities to create or maintain a safe environment where people may live, work, and play;

4) Role in Health Surveillance – (a) is aware of health surveillance data and trends; applies this knowledge to day-to-day work, (b) integrates eco-social surveillance that focuses on broad, multi-level conditions that contribute to health inequalities, (c) mobilizes formal and/or informal networks to systematically and routinely collect and report health data for tracking and forecasting health events or health determinants, (d) collects and stores data within confidential data systems; integrates, analyzes, and interprets this data, and (e) provides expertise to those who develop and/or contribute to surveillance systems, including risk surveillance; 5) Role in Population Health Assessment – (a) uses health surveillance data to launch new services or revise those that exist, (b) contributes to population health assessments and includes community viewpoints, and (c) plays a key role in producing and using knowledge about the health of communities (or certain populations or aggregates) and the factors that support good health or pose potential risks (determinants of health), to produce better policies and services; 6) Role in Emergency Preparedness and Response – (a) contributes to and is aware of public health's role in responding to a public health emergency, (b) plans for, is part of, and evaluates the response to both natural disasters (such as floods, earthquakes, fires, or infectious disease outbreaks) and man-made disasters (such as those involving explosives, chemicals, radioactive substances, or biological threats) to minimize serious illness, death, and social disruption, and (c) communicates details of risk to population subgroups at higher risk and intervenes on their behalf during public health emergencies using a variety of communication channels and engagement techniques.

According to Dingfelder (2006), there are eight (8) components of public health nursing practice, and these are: 1) Focuses on entire populations; 2) Reflects community priorities and needs; 3) Establishes caring relationships with communities, families, individuals, and systems that comprise the population the public health nurse serves; 4) Grounded in social justice, compassion, sensitivity to diversity, and respect for the worth of all people, especially the vulnerable; 5) Encompasses mental, physical, emotional, social, spiritual and environmental aspects of health; 6) Promotes health through strategies driven by epidemiological evidence; 7) Collaborates with community resources to achieve those strategies, but can and will work alone if necessary; and 8) Derives its authority for independent action from the Nurse Practice Act.

Tracey Cooper in her research entitled " Perceptions