COMMUNITY HEALTH NEEDS ASSESSMENT OF BARANGAY ANTIPOLO OLD, NABUA CAMARINES SUR

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ABSTRACT

This descriptive study assessed the community health needs of Barangay Antipolo Old, Nabua Camarines Sur. This study determined the respondent's profile, family profile, health practices and health needs of the barangay constituents. A total of one hundred fifty heads of family were the respondents of the study. The study employed a self-made questionnaire formulated from the review conducted on the different needs assessment questionnaires. Percentage technique was used in the study. Results revealed that majority of the respondents were female, 30-39 years old, high school graduate and belonging to a nuclear family with farming as the main source of income. Results also revealed that perceive diseases are caused by microorganisms/pathogens and believes that good nutrition is important in disease prevention. Results further revealed that all of the respondents performs handwashing, daily bath and other hygienic practices. Pains (Back/Joints), high blood pressure/hypertension, depression, asthma, Tuberculosis, kidney, heart and lung diseases, diabetes and stroke are among the health challenges the respondents faced. Further, majority of the respondents avail the services of the PHC Clinics/RHUs, physician's clinics and hospitals. These findings served as the basis for the formulation of an extension program specifically designed for Barangay Antipolo Old.

Keywords: *community, health needs, Barangay Antipolo Old, prevention*

INTRODUCTION

A community health assessment, also known as community health needs assessment refers to a state, tribal, local, or territorial health assessment that identifies key health needs and issues through systematic, comprehensive data collection and analysis. Community health assessments use such principles as multisector collaborations that support shared ownership of all phases of community health improvement, including assessment, planning, investment, implementation, and evaluation; proactive, broad, and diverse community engagement to improve results.

Further, a community health assessment gives organizations comprehensive information about the community's current health status, needs, and issues. This information can help develop a community health improvement plan by justifying how and where resources should be allocated to best meet community needs. The benefits of a community health assessment include improved organizational and community coordination and collaboration; increased knowledge about public health and the interconnectedness of activities; strengthened partnerships within state and local public health systems; identified strengths and weaknesses to address in quality improvement efforts; baselines on performance to use in preparing for accreditation; benchmarks for public health practice improvements (CDC, 2015) 1.

The Public Health Accreditation board defines community health assessment as a systematic examination of the health status indicators for a given population that is used to identify key problems and assets in a community. The ultimate goal of a community health assessment is to develop strategies to address the community's health needs and identified issues. According to Jones and Bartlett, 2009 a variety of tools and processes may be used

to conduct a community health assessment; the essential ingredients are community engagement and collaborative participation. 2 Likewise, the Catholic Health Association (2013) defines a community health needs assessment as a systematic process involving the community to identify and analyze community health needs and assets in order to prioritize these needs, and to plan and act upon unmet community health needs.3

Needs assessment is a process of looking at many kinds of information about a target group or community, that includes a review of demographics or census data, surveys, and interviews of the population. Further, a health needs assessment is the process of systemically collecting information to enable the practitioner, team, and policy-makers to identify, analyze, prioritize, and meet the health needs of an individual, family or population. The design and implementation of health care programs and services are based on the information that as gathered in the process of health needs assessment which should be acceptable, affordable, accessible, and sustainable to all the community members. The health needs assessment can be done with the individual and family when planning for care and with the community or district when planning for health services and public health programs to improve the health of the population.

Furthermore, a community health needs assessment is a process that describes the state of health of local people, enables the identification of the major risk factors, cases of ill health, and identification of the actions or interventions that are needed. A community health needs assessment is a way of using information to plan healthcare and public health programs in the future. It will enable the health practitioners, NGOs, civic oriented societies, and policy makers to identify the members of the population who need health care services and resources the most and to ensure that these resources are used following the rule of equity. Thus it becomes a very important process in health care planning to identify priority health needs, utilize the internal and external resources of the community and develop community participation and involvement (Castro, 2012).[4]

With the view of formulating an extension program, the faculty extensionists conducted this study on the community health needs assessment of barangay Antipolo old, Nabua, Camarines Sur to identify its residents' needs and problems and to support the college's vision to assist in the sustainable development of the community, particularly its target clientele. Thus, empower them to improve their quality of life.

Barangay Antipolo Old is one of the barangays in the Municipality of Nabua, Camarines Sur. It is populated with 2,146 with a total number of 462 household with 507 families. The barangay has 184 elderly/senior citizen, 30 PWDs, 473 women of reproductive age, and with a considerable number of families without sanitary toilet facilities which are considered vulnerable (PHO CamSur, 2018).[5] The barangay is one of the partner barangays of the college where research-based extension programs implemented. There are also known cases of suicides and other medical conditions. In order to fully assess the needs of the constituents, specifically on health, this CHNA was conducted, hence, the extension program plan.

OBJECTIVES OF THE STUDY

This study assessed the community health needs of barangay Antipolo Old, Nabua Camarines Sur. Specifically this study determined the profile of the respondents in terms of; a. Respondent's Profile, including the a.1 Sex, a.2 Age, a.3 Level of education and a.4 Religion; b. Family Profile including the b.1 type of family, b.2 source of income, b.3 combined family monthly income and b.4 total number of family members; perceptions of the respondents on disease causation, prevention and health maintenance and promotion; health practices of the residents of the barangay in terms of: a. Sanitation and hygiene (environment and water), b. Nutrition and Elimination (Food safety, Urination/defecation practices), c. Rest and sleep and d. Comfort and safety (type of housing, environmental hazards); health needs and challenges of the residents of the barangay; and propose an extension program to address the assessed health needs of the residents of Antipolo Old, Nabua, Camarines Sur.

MATERIALS AND METHODS

The study employed a descriptive survey design. This involves collecting numerical data to answer questions concerning current status which is then conducted through self-reports collected through questionnaires. According to Shuttleworth (2008), a descriptive research design is a scientific method which involves observing and describing the behavior of a subject without influencing it in any way.[6] Salaria (2012), stated that descriptive survey does not only concern the characteristics of the individual respondents but also the characteristics of the whole sample.[7]

The target population is the entire constituents of barangay Antipolo Old in Nabua, Camarines Sur. The reserachers utilized random sampling. They decided to choose this particular barangay for the main reason of formulating an extension program based on the assessed needs as it is one of the partner barangays of the College of Health Care Technology.

After obtaining the administrative clearance from the head of the partner barangay, the questionnaires were personally administered by the researchers. The data gathering procedure was done by zone to have ease in the flow as it is well-coordinated with the Barangay. Each zone has a designated chair from the council and they served as a guide and facilitated the distribution and retrieval of the questionnaire. There were 7 zones in the barangay and each zone was represented by 20-22 household respondents with a total of 150 households (one respondent/household). The gathered data were tallied and tabulated. After the assessment, the data were consolidated, analyzed, and interpreted using the percentage technique. Findings were drawn which served as the blue print of the extension program plan. The assessed needs were prioritized according to the frequency of its occurrence as perceived by the respondents. The formulated extension program was formulated by the researchers together with the department's extension coordinator. It was then submitted to the Dean for endorsement to the college through the extension division. Once approved, the implementation phase will be carried out alongside with subsequent monitoring and evaluation.

RESULTS AND DISCUSSIONS

A. PROFILE

1. Respondent's Profile

Majority of the respondents were female, which are usually mothers, between the ages of 30-39 though there were considerable number of ages between 40-49 years old. Age is a strong determinant of health. It can be noted that the higher the respondents gets, the lower the number of respondents. Middle adulthood yielded a significant number. Only a total of 17 respondents came from ages 60 and above. The life expectancy of Filipinos is estimated at 66-67 for male and 72-73 for female or an average of 69.3 which are affected by several factors (world life expectancy, 2018).[8] The data further shows that only very few reaches old age in the respondent barangay.

Almost 98% were Roman Catholic which is a strong manifestation of Catholicism in the province. This data shows that a very insignificant number of other religions are present in the barangay. This information is supported by the fact that of the nearly 100 million of the Philippine population, 80.6% are Roman Catholics. In Camarines Sur, which is populated with more or less 1.8 million Bicolanos, more or less 1.7M or 93.86% are Roman Catholics making Camarines Sur as Top 13 among the Top 15 Philippine Provinces with high Catholicism (Rappler, 2015). Religion plays a significant role in health as tradition and culture are mainly influenced by religion.

Most of them are high school graduate with a significant number of college graduate. These findings are supported by the study of Zimmerman, Woolf and Haley (2014) which emphasized the link between education and health. They claimed that education is critical to social and economic development and has a profound impact on population health. The health benefits of education accrue at the individual level (skill development), community level (health-related characteristics of the environment in which people live) and the larger social/cultural context (policies).[9] It is also important to consider the impact of health on educational attainment and vice versa. All other factors can impact both health and education.

2. Family Profile

2.1 Type of Family

Figure 1 shows the respondents according to the type of family. It was shown that of the total respondents, 93 (62%) are nuclear and 57 (38%) are extended. The type of family is significant in meeting the needs of the individual member of the family. The larger the family members, the more mouths to feed.

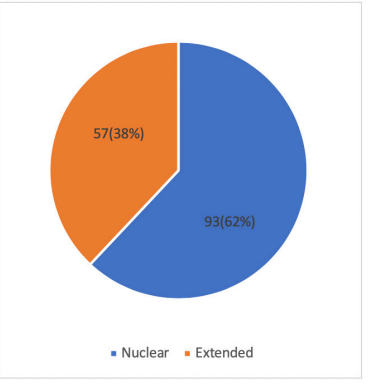

Figure 1. *Type of Family*

Large percentage of the respondents belongs to a nuclear family. The type of family is significant in meeting the needs of the individual member of the family. The larger the family members, the more mouths to feed.

B. SOURCE OF LIVING

Table 1 shows the family's source of living. Of the total respondents, 153 (82%) derives their income from farming; 76 (50.67%) from employment; 57 (38%) from hard labor; 23 (15.33%) from small business enterprise; and 12 (8%) from serving as housemaids. The data revealed information that farming is the respondents' main source of living. This result is supported by the data from Food and Agriculture Organization of the United Nations' Philippines at a glance (2015) which contributes to the 31 percent labor force.[10] Further, agriculturegoods.com (2017) says, 70% of people directly rely on agriculture.[11]

Table 1. *Respondents' Source of Living*

Source of Living	Frequency	Percentage (%)
Farming (Agriculture)	123	82.00
Employment	76	50.67
Small Business Enterprise	23	15.33
House Labor	57	38.00
Housemaids	12	8.00
Total	**150**	**100.00**

Table 2 shows the combined family monthly income (FMI). Of the total respondents, 21 (14.0%) has a combined FMI of 32500-37499; 20 (13.33%) has a combined FMI of 7499 and below; 17 (11.33%) has 22500-27499; 15 (10.00%) with 12500-17499; 14 (9.33%) with 27500-32499 and 17500-22499 respectively; 13 (8.67%) with 37500-42499; 10 (6.67%) with 42500-47499 and 7500-12499 respectively; Nine (6.00%) with a FMI of 47500-52499; and only Seven (4.67%) with a FMI of 52500 and above.

Table 2. *Combined Family Monthly Income*

Combined Family Monthly Income (Php)	Frequency	Percentage
52,500 and above:	7	4.67
47,500 - 52,499	9	6.00
42,500 - 47,499	10	6.67
37,500 - 42,499	13	8.67
32,500 - 37,499	21	14.00
27,500 - 32,499	14	9.33
22,500 - 27,499	17	11.33
17,500 - 22,499	14	9.33
12,500 - 17,499	15	10.00
7,500 - 12,499	10	6.67
7,499 and below	20	13.33
Total	**150**	**100.00**

The combined family monthly income (FMI) of the respondents plays between 32500-37499 which is closer to the number of those with 7499 and below. This results revealed that there is a large variance between those who can afford the basic needs and those who can only spend for their food. In the 2015 poverty statistics in the Philippines, 29.9M were poor that yields one in every five persons is poor. Each individual needs at least Php1,813 to meet his basic food and non-food needs which implies that a family of five needs to have an average monthly income of Php9064.00 to meet their food and non-food needs or Php6329 to meet their food needs. In the present study, significant numbers are below the poverty line. Thus this gives an implication that their state of health is at stake owing to not meeting the needs for food for each family member.

Table 3 shows the number of family members. A total of 691 (32.19% of the total population of 2146) individuals from 150 respondents/ households. This gives an average of 4-5 members in one household. Among the groups were: 268 (38.78%) adults; 261 (37.77%) older children; 96 (13.89%) under five years old; and 66 (9.55%) were elderly. These comprises the total number of individuals from the 150 households surveyed.

Table 3. *Number of Family Members*

Members	Frequency	Percentage (%)
Elderly (Senior Citizen)	66	9.55
Adults	268	37.77
Older Children	261	38.78
Under 5 Years Old	96	13.89
Total No. of Members:	**691**	**100.00**

It can be noted that adults dominate the population, which may lighten the financial burden of those who are in the lower level of family monthly income. This claim is supported by the data from the NSO that says the adult population in the Philippines is estimated at 60.72 million from the current population of 104.256 as of July 2017 (NSO,2017). This data displays a very significant role in the economic status of the family as they are the strongest workforce. These demographics profile supports the findings of this study as adults are the largest in number and pose a large percentage among the families covered in this study.

C. WATER SANITATION

Table 4 shows the source of water among the

respondents. Among the 150 respondents, 90 (60%) utilize water from the water district; 40 (26.67%) from deep well; 15 (10.00%) from water refilling stations and five (3.33%) use commercial bottled water. Maslow's hierarchy of human needs states that among the physiologic needs of man, there are top 3 priority needs which include air, water, and foods. It is a fact that water sanitation prevents the occurrence of environmentally acquired communicable diseases. It is to be ensured that the people consumes potable water in order to prevent them from contacting water-borne diseases.

Table 4. *Source of Water*

Source of Water	Frequency	Percentage (%)
Deep well	40	26.67
Commercial Bottled Water	5	3.33
Water refilling station	15	10.00
Water District/Pipeline	90	60.00
Total	**150**	**100.00**

It was revealed in the study that the respondents avail of the water services from the water district pipeline. According to WASH (2018), global water, sanitation and hygiene, global access to safe water, adequate sanitation, and proper hygiene education can reduce illness and death from diseases, leading to improved health, poverty reduction and socio-economic development.[12]

D. ENVIRONMENTAL SANITATION

Figure 2 shows the number of respondents with sanitary toilets. It was revealed in the study that (147) 98% of the respondents are utilizing sanitary toilets. There is a negligible number of respondents without sanitary toilets. Proper sanitation facilities toilets and latrines promote health because they allow people to dispose of their waste appropriately. Absence of basic sanitation facilities can result in an unhealthy environment contaminated by human waste. Without proper sanitation facilities, waste from infected individuals can contaminate a community's land and water, increasing the risk of infection for other individuals.

Figure 2. *Respondents Sanitary Toilets*

Proper waste disposal can slow the infection cycle of many disease-causing agents. It can also contribute to the spread of many diseases/conditions that can cause illness and death. Without proper sanitation facilities, people often have no choice but to live in and drink water from an environment contaminated with waste from infected individuals, thereby putting themselves at risk for future infection. Inadequate waste disposal drives the infection cycle of many agents that can be spread through contaminated soil, food, water and insects such as flies (WASH,2015).

Table 5 shows the methods of garbage disposal employed in the households. The respondents employs several methods of garbage disposal. Among these, 67 (44.67%) employ burning; 65 (43.33%) use composting; 55 (36.67%) employ burying; and 24 (16.00%) employ recycling/reuse.

Table 5. *Methods of Garbage Disposal*

Methods of Garbage Disposal	Frequency	Percentage (%)
Composting	65	43.33
Burning	67	44.67
Burying	55	36.67
Recycling/Reuse	24	16.00
Total	**150**	**100.00**

It was revealed that the respondents are utilizing several methods of disposing garbage. However, most of them still uses burning. When asked what kinds of garbage are being burnt, they specified that they burn those collected from the ground such as dried leaves, fallen twigs/driftwood and tree branches. Open burning of garbage poses health risks to those exposed directly to the smoke. It especially affects people with sensitive respiratory systems, as well as children and the elderly (Government of Canada, 2015).[13]

TYPE OF HOUSING

Table 6 shows the type of housing that

shelters the respondents' families. Of the total respondents, 84 (56.00%) have semi-concrete/ semi-permanent which is a combination of cement and wood; 55 (36.67%) have concrete/permanent housing and 11 (7.33%) have temporary housing which is made up of wood and light materials.

Majority of the respondents have semi-concrete/ semi-permanent which is a combination of cement and wood but significant numbers have concrete/permanent housing and few have temporary housing which is made up of wood and light materials. The type of housing ensures the safety and security of the family. The family's type of house affects the prevention of disease and promotion of health. Poor housing conditions are associated with a wide range of health conditions, including respiratory infections, asthma, lead poisoning, injuries, and mental health. Addressing housing issues offers public health practitioners an opportunity to address an important social determinant of health (Housing and Health: Time Again for Public Health Action, James Krieger and Donna L. Higgins 2002).[14]

Table 6. *Type of Housing*

Type of Housing	Frequency	Percentage (%)
Concrete/ Permanent	55	36.67
Semi-concrete/ Semi-permanent	84	56.00
Temporary	11	7.33
Total	**150**	**100.00**

Perception on disease causation, disease prevention, maintenance and promotion of health

Table 7 shows the respondent's perception on disease causation. Of the total respondents, 101 (67.33%) believe that disease is caused by microorganisms/pathogens; 25 (6.67%) believe that disease is a punishment from God; and 24 (16.00%) believe that disease is caused by evil spirit.

Table 7. *Perception on Disease Causation*

Perceptions on Disease Causation	Frequency	Percentage (%)
Disease is caused by evil spirit	24	16.00
Disease is caused by microorganism/ pathogens	101	67.33
Disease is a punishment from God	25	16.67
Total	**150**	**100.00**

In the context of disease causation, the triad factors are agents or the microorganisms, the host or the man being affected by illness/disease, and the environment which serves as the habitat of both the host and the agent. The study of Mesfin H. Kahissay, Teferi G. Fenta and Heather Boon on Beliefs and perception of ill-health causation: a socio-cultural qualitative study in rural North-Eastern Ethiopia (2017) supports the findings as it was revealed that natural and supernatural causations are the evident beliefs of the respondents.[15]

Table 8 shows the perception of the respondents on disease prevention, health maintenance and health promotion. The respondents manifested good perception that having good nutrition is important to disease prevention with 84 (56.00%); 55 (36.67%) perceive environment as a major player in disease prevention; and 11 (7.33%) believe that exercise and wellness activities help in the maintenance of health. It was revealed that good nutrition is a highly perceived contributor to disease prevention, health maintenance and promotion.

Table 8. *Respondents' Source of Living*

Perceptions	Frequency	Percentage (%)
Environment plays a big role	55	36.67
Good nutrition is important in disease prevention	84	56.00
Exercise and wellness in activities helps in the maintenance of health	11	7.33
Total	**150**	**100.00**

This result is supported by the fact that the best index for health is weight which is manifested from a good nutrition. All of the indicated perceptions however are important in disease prevention, health maintenance and promotion of health. This is supported by the ruralhealthinfo.org (2009) which says, health promotion and disease prevention programs focus on keeping people healthy.16 Health promotion programs aim to engage and empower individuals and communities to choose healthy behaviors, and make changes that reduce the risk of developing chronic diseases and other morbidities.

3. HEALTH PRACTICES AND HEALTH NEEDS

Household Health Practices

Table 9 shows the household Hygienic Practices. All of the respondents observe handwashing after use of toilets and proper dishwashing; 147 (98.00%) performs handwashing before and after eating; 141 (94.00%) perform handwashing before food handling; 140 (93.33%) perform daily bath; 105 (70.00%) use spoon/fork when eating; 85 (56.67%) use serving spoon; and 25 (16.67%) disinfect eating utensils.

Table 9. *Respondents' Source of Living*

Hygienic Practices	Frequency	Percentage (%)
Daily bath	140	93.33
Performing handwashing before and after eating, use of toilets, and before food handling	147	98.00
Use of spoon/fork	150	100.00
Use of serving spoon	141	94.00
Proper dishwashing	105	70.00
Disinfecting eating utensils	85	56.67
Total	**150**	**100.00**

Hygiene is as important as nutrition. The role of nutrition in health promotion and chronic disease prevention is significant. In the article "importance of diet and nutrition to disease prevention at home care and hospice.com (2016), it was stated that it is undeniable that a well-balanced diet goes hand in hand with a healthy lifestyle. The respondent's knowledge on healthy foods is important in their food selection.

Food and Nutrition

Table 10 shows the practices of the respondents as to food and nutrition. All of the respondents include rice in their daily diet; 99 (66.00%) drink 8-10 glasses of water; 92 (61.33%) include vegetables in the daily diet; 80 (53.33%) take milk/coffee daily; 71 (47.33%) include fish in the daily diet; 37 (24.67%) eat eggs daily; 35 (23.33%) include fruits daily and only 23 (15.33%) include meat in the diet. The respondents' knowledge on the nutrition they derive from the food included in their daily diet is significant to disease prevention, health maintenance and health promotion.

Table 10. *Food and Nutrition*

Food included in the daily diet	Frequency	Percentage (%)
8 to 10 glasses of water	99	66.00
Fruits	35	23.33
Vegetables	92	61.33
Meat	23	15.33
Fish	37	24.67
Eggs	80	53.33
Milk/Coffee	150	100.00
Rice	25	16.67

Practices on Elimination

Table 11 shows the respondents' practices on elimination. Of the 150 respondents, 141 (94.00%) performs handwashing after use of toilets; 140 (93.33%) are urinating/defecating as the need arise; and only 10 (6.67%) are used on postponing the need to eliminate.

Table 11. *Household Practices on Elimination*

Practices on Elimination	Frequency	Percentage (%)
Urinating/defecating as the need arise	140	93.33
Performing handwashing after use of toilets	141	94.00
Postponing needs to eliminate	10	6.67

Rest and Sleep

Table 12 displays the respondents' practices to ensure rest and sleep. Of the total respondents, 93 (62.00%) sleep 8-10 hours a day; 78 (52.00%) take a nap of 30 minutes to one hour in 8 hours (of) work; while 72 (48.00%) take nap less than 30 minutes or not at all; and further, only 57 (38.00%) sleep less than 8 hours. These results are manifestations that the respondents are have enough rest and sleep. However, the number of respondents who have less than 8 hours of sleep ca not be neglected.

Rest and Sleep are vital in human health maintenance, disease prevention, and health promotion. The quality of sleep directly affects mental and physical health and the quality of life, including productivity, emotional balance, brain and heart health, immune system, creativity, vitality and even weight (HelpGuide.org, 2018).[17]

Table 12. *Rest and Sleep*

Rest and Sleep	Frequency	Percentage (%)
Naps 30 mins to 1 hour in 8hrs work	78	52.00
Naps less than 30mins or not at all	72	48.00
Sleeps 8 to 10hrs	93	62.00
Sleeps less than 8 hours	57	38.00

Practices that Affects Health

Table 13 shows the top 5 practices of the respondents that affect their health. Rank 1 is holding urine with 43 (28.67%); rank 2 is eating fruits and vegetable each day with 20 (20.00%); rank 3 is bathing daily with 28 (18.67%); rank 4 is smoking cigarettes with 23 (15.33%); and rank 5 is drinking 8 glasses of water per day and eating fast food more than once/week with 21 (14.00%) respectively.

Table 13. *Practices that affects one's health*

Practices on Elimination	Frequency N=150	Percentage (%)	Rank
Exercise at least three times per week	14	9.33	9.5
Smoking cigarettes	23	15.33	4
Eating fruits and vegetables each day	30	20.00	2
Chewing tobacco	1	.67	15
Eating fast food more than once/week	21	14.00	5.5
Using illegal drugs	3	2.00	13
Abuse or overuse of prescription drugs	2	1.33	14
Attending a wellness program	5	3.33	12
Having more than four alcoholic drinks	14	9.33	9.5
Taking meds without prescription	15	10.00	8
Handwashing	20	13.33	7
Drinking 8 glasses of water/day	21	14.00	5.5
Regular Bowel Elimination	11	7.33	11
Daily bathing	28	18.67	3

It can be noted that among the top 5 practices, eating fruits and vegetable each day, daily bathing and drinking 8 glasses of water are good practices which positively affects one's health. It can also be noted that there among the top 5 practices, there were also 3 practices included which negatively affects one's health, namely: holding urine, smoking cigarettes and eating fast food more than once/week.

PREVENTIVE PROCEDURES THE RESPONDENTS HAVE HAD FOR THE LAST 12 MONTHS

Table 14 shows the preventive procedures the respondents have had for the last 12 months. The top 5 preventive procedures are as follows: Rank 1 is blood pressure check with 91 (60.66%); rank 2 is vision screening with 29 (19.33%); rank 3 is blood sugar check with 20 (13,33%); rank 4 is dental cleaning/x-rays with 18 (12.00%); and rank 5 is cholesterol screening with 13 (8.67%).

Table 14. *Preventive procedures for the last 12 months*

Preventive procedures	Frequency	Percentage (%)	Rank
Mammogram (if woman)	4	2.67	8
Pap smear (if woman)	3	2.00	9
Colon/rectal exam	1	.67	10
Blood pressure check	91	60.66	1
Blood sugar check	20	13.33	3
Cholesterol screening	13	8.67	5
Vision screening	29	19.33	2
Cardiovascular screening	10	6.67	7
Physical exam	12	8.00	6
Dental cleaning/ X-rays	18	12.00	4

HEALTH CHALLENGES

Table 15 shows the health challenges identified by the respondents. Seventy-seven (51.33%) are challenged with pains (Back/Joints) as rank 1; 64 (42.67%) consider a high blood pressure/hypertension as rank 2; depression with 14 (9.33%) as rank 3; asthma as rank 4 with 13 (8.67%); rank 5 are tuberculosis and kidney disease with 11 (7.33%) respectively; rank 7 are heart and lung disease with 10 (6.67%) respectively; six (4.00%) are challenged by diabetes which placed rank 9; and four (2.67%) are challenged by stroke which is rank 10.

These results were confirmed by the Top 10 leading diseases in the Philippines (2016) which ruled out that are the leading illnesses in the Philippines especially those in the rural areas. It was revealed that 8 of the 10 leading illnesses in the Philippines are experienced by the respondents.

Table 15. *Health Challenges*

Health Challenges	Frequency	Percentage (%)	Rank
High BP/Hypertension	64	42.67	2
Diabetes	6	4.00	9
Stroke	4	2.67	10
Heart Disease	10	6.67	7.5
Lung Disease	10	6.67	7.5
Tuberculosis	11	7.33	5.5
Kidney Disease	11	7.33	5.5
Pains (Joint/Back)	77	51.33	1
Asthma	13	8.67	4
Depression	14	9.33	3

AGENCY AVAILED FOR ROUTINE HEALTH CARE

Table 16 shows the agency being availed by the respondents for routine health care. Of the total respondents, 82 (54.67%) avail the services of the PHC Clinics/RHUs; 31 (20.67%) goes to physician's clinics; 25 (16.67%) avail hospitals; 24 (16.00%) prefer herbularyos/faith/natural healers; and 20 (13.33%) do not seek health care. Filipinos are highly cultural/traditional. Being in the barrio, (the respondents are) is affected by their culture and traditions especially on matters about health. It can be observed that there is a significant number of respondents who submit for professional health care but the number of those who submit to herbularyos/faith/natural healers are not negligible.

Table 16. *Agency for Routine Health Care*

Venue for Routine Health Care	Frequency	Percentage (%)	Rank
Primary Care Clinic/RHUs	82	54.67	1
Herbularyo/Faith/ Natural Healers	24	16.00	4
Physician's Clinic	31	20.67	2
Hospital	25	16.67	3
I would not seek health care	20	13.33	3

AGENCY BEING AVAILED BY THE RESPONDENTS FOR EMERGENCY MEDICAL SERVICES

Table 17 shows the agency the respondents may avail for emergency medical services. Of the total respondents, 96 (64.00%) would go to the hospital for emergency medical services; 29 (19.33%) to the PHC Clinic/RHUs; 19 (12.67%) to physician's clinic and six (4.00%) would go to Herbularyo/Faith/ Natural healers. These preferences are affected by different factors such as the financial capability of the respondents. The study of Michelle E. Olah, Gregory Gaisano and Stephen W. Hwang, on The Effect of SES on access to Primary care: an audit study (2013) supports this specific finding. It was revealed in the study that people of low socio-economic status encounter many barriers in obtaining health care.[18]

Table 17. *Agency for Emergency Medical Services*

Venue (Emergency Health Care)	Frequency	Percentage (%)	Rank
Primary Care Clinic/RHUs	29	19.33	2
Herbularyo/Faith/ Natural Healers	6	4.00	4
Physician's Clinic	19	12.67	3
Hospital	96	64.00	1
Total	150	100.00	3

ISSUES/CONCERNS THAT PREVENTS THE RESPONDENTS FROM ACCESSING PROFESSIONAL CARE

Table 18 shows the issues/concerns that prevents the respondents from accessing professional care. The fact that there are those who do not seek professional care, it is a must to rule-out their reasons of not doing so. Of the total respondents, 90 (60.00%) are unable to pay for the care; 23 (15.33%) are hindered by the transportation; 13 (8.67%) are fearful (not ready to face/discuss concerns; five (3.33%) are hindered by their cultural/religious beliefs; and three (2.00%) do not understand the need to see a doctor.

Table 18. *Issues/concerns that prevent the respondents from accessing professional care*

Issues/Concerns	Frequency	Percentage (%)	Rank
Cultural/Religious beliefs	5	3.33	4
Don't understand the need to see a doctor	3	2.00	5
Unable to pay for the care	90	60.00	1
Fear (not/ready to face/discuss concern)	13	8.67	3
Transportation	23	15.33	2
Total	**150**	**100.00**	

These results are evidenced by the fact that many of the respondents are having a family monthly income just enough to suffice their needs for food and non-food, excluding the needs for medical care. There is a large percentage of unable to pay the probable expenses which causes them not to avail of hospital services. These findings reveal a consistent results in the factors considering the socio-economic status of the respondents as it was revealed

that there was a large percentage of respondents who consider payment to the facility as a major factor in accessing professional care. The study of Olah et al. (2013) supports this results as SES really affects the respondents' access to health services.

NEEDS TO IMPROVE THEIR PRESENT HEALTH STATUS

Table 19 shows the needs of the community for them to improve their present health status. Of the total respondents, 129 (86.00%) need healthier foods as they believe that it will improve their health status; 91 (60.67%) need good sanitation as they may have understood that sanitation is a large factor in the improvement and maintenance of health of the family and the community as a whole; 84 (56.00%) need jobs as they believe that having jobs will help them earn enough to suffice for their needs; 51 (34.00%) need wellness services; 29 (19.33%) need free health screenings; and three (2.00%) need to have a good transportation to improve health status.

Table 19. *Needs to Improve Health*

Need to Improve Family Health	Frequency	Percentage (%)	Rank
Healthier food	129	86.00	1
Transportation	3	2.00	6
Sanitation	91	60.67	2
Job Opportunities	84	56.00	3
Wellness services	51	34.00	4
Free health screenings	29	19.33	5

The data revealed a significant finding on healthy food being valued by the respondents. According to the World Health Organization's Food Water and Family Health: A Manual for Community Educators (1994) good food is important for good health; eating well can help prevent one from becoming ill.19 Good food means safe, nutritious food, not necessarily expensive food. Eating well means eating balanced mixture of food from all main food groups. The respondents have shown that they have enough knowledge on the relationship of healthy foods to health maintenance.

HEALTH SCREENING/SERVICES NEEDED BY THE RESPONDENTS

Table 20 shows the health screenings/services needed by the respondents. The top 5 health screenings/services reported by the respondents were: blood pressure as rank 1 with 59 (39.33%); mental health/depression as rank 2 with 34 (22.67%); nutrition as rank 3 with 33 (22.00%); childhood illnesses as rank 4 with 30 (20.00%); and prenatal care as rank 5 with 29 (19.33%).

Table 20. *Health Screenings/Services Needed (Top 5)*

Health Issues Needing Screening/Services	Frequency	Percentage (%)	Rank
Blood Pressure	59	39.33	1
Cancer	5	3.33	18
Childhood Illnesses	30	20.00	4
Cholesterol	25	16.67	7
Dental Screenings	27	18.00	6
Diabetes	17	11.33	9
Disease outbreak prevention	16	10.67	10
Drug and alcohol abuse	2	1.33	20.5
Eating disorders	10	6.67	12
Emergency Preparedness	9	6.00	13.33
Exercise/Physical activity	7	4.67	15
Heart Disease	19	12.67	8
HIV/AIDS/STDs	2	1.33	20.5
Immunizations	11	7.33	11
Memory Loss	4	2.67	16.5
Mental Health/Depression	34	22.67	2
Nutrition	33	22.00	3
Parental Care	29	19.33	5
Quit Smoking	4	2.67	16.5
Routine Check-ups	9	6.00	13.33
Suicide prevention	3	2.00	19
Weight-loss help	9	6.00	13.33

ADDITIONAL HEALTH SERVICES NEEDED TO ADDRESS HEALTH ISSUES IN THE COMMUNITY

Table 21 shows the identified additional health services needed to address health issues in the community. Rank 1 is the importance of fruits and vegetables in the diet with 54 (36.22%); rank 2 is the importance of exercise/physical activity with 51 (34.00%); rank 3 is the ill-effects of self-medications with 41 (27.33%); rank 4 is drug addiction/substance abuse with 27 (18.00%); and rank 5 is ill-effects of smoking with 25 (16.67%).

Table 21. *Additional Health Services Needed to Address Community Health Issues*

Additional Health Services	Frequency	Percentage (%)	Rank
Drug Addiction/ Substance abuse	27	18.00	4
Ill-effects of Alcohol	19	12.67	8
Ill-effects of eating "Fast Food"	23	15.33	6
Ill-effects of self-medications	41	27.33	3
Ill-effects of smoking	25	16.67	5
Importance of Exercise/Physical activity	51	34.00	2
Importance of Fruits and Vegetables	54	36.22	1
Importance of Wellness Programs	22	14.67	7

The respondents were asked on what additional services are needed to address community issues. They were able to identify at least 8 health issues needing to be addressed. These health issues are all contributory to the prevention of diseases, maintenance and promotion of health. These can be addressed through the formulated extension program plan for implementation.

SOURCES OF HEALTH INFORMATION

Table 22 shows the sources where the respondents derive health information. Rank 1 is health facility with 78 (52.00%); rank 2 is radio with 43 (28,67%); rank 3 is social media and TV with 40 (26.67%) respectively; and rank 5 is hospital with 34 (22.67%). The source of information may impact the decision of the community as to where they would avail health services.

Table 22. *Sources of Health Information*

Source of Health Information	Frequency	Percentage (%)	Rank
Church group	1	0.67	11
Workmates	5	3.33	9
Family or Friends	29	19.33	6
Health Facility	78	52.00	1
Health Professionals	7	4.67	8
Hospital	34	22.67	5
Internet	24	16.00	7
Newspaper/mag	4	2.67	10
Radio	43	28.67	2
Social Media	40	26.67	3.5
TV	40	26.67	3.5

PROPOSED EXTENSION PROGRAM PLAN

Recipient: Barangay Antipolo Old Nabua, Camarines Sur

Rationale

Health needs when not met results to problems. The conducted assessment provides a concrete data and information regarding the perceived health needs of the barangay which served as basis for this proposed extension program especially designed to help meet the identified health needs.

Objective

To provide measures to the identified health needs which will focus on disease causation, nutrition/ elimination, environmental sanitation, health challenges and health care system/facilities orientation in order to raise awareness and promote self-reliance among the constituents through health education (participative discussion), demo-return demonstration of basic household emergencies, production of IEC materials and focus group discussions (FGDs) for children, women, mothers, elderly).

Areas of Concern	Specific Objectives	Strategies	Persons Involved	Expected Output
Health Challenges	To raise the level of awareness in terms of health conditions that challenges the constituents	Health Education (Participative discussions) Role Playing	Key Leaders Household heads CHCT Faculty Extensionists Extension Coordinator Extension Director and Staff	Raised level of awareness on different health challenges
Disease Causation	To be able to impart scientific knowledge on disease causation and scientifically influence people on health beliefs with negative effects	Health Education Workshop College Making Interactive/ SLA	Key Leaders Household heads CHCT Faculty Extensionists Extension Coordinator Extension Director and Staff	In-depth understanding and Behavioral Change among participants
Nutrition/ Elimination	To properly inform the constituents on the benefits of proper nutrition and the need for elimination	Evocative discussion Experiential Sharing	Key Leaders Household heads CHCT Faculty Extensionists Extension Coordinator Extension Director and Staff	Better understanding on the importance of good nutrition and proper elimination
Environmental Sanitation	To increase awareness on the proper environmental sanitation, water and garbage disposal and its influence to health promotion and maintenance, disease prevention and promotion of well-being	Evocative discussion Experiential Sharing	Key Leaders Household heads CHCT Faculty Extensionists Extension Coordinator Extension Director and Staff	Healthy practice on water sanitation, maintenance of clean environment and mitigation of unhealthy environmental practices
Health care system/ facilities	To educate the constituents on the present health care system of the country and orient them about the facilities they can avail in case of need	Evocative discussion Experiential Sharing	Key Leaders Household heads CHCT Faculty Extensionists Extension Coordinator Extension Director and Staff	Better understanding on the health care system in the country and proper orientation on available health facilities

CONCLUSIONS

From the findings, it can be concluded that majority of the respondents were female, between ages of 30-39, Roman Catholics and are high school graduate. Majority belongs to a nuclear family with farming agriculture as the main source of living owing to a combined family monthly income of 32,500-37,499 with an average of 4-5 members in one household which are mainly composed of adults. Majority have sanitary toilets and employs several methods of garbage disposal. Respondents perceives that diseases are caused by microorganism/pathogens while significant numbers believe that it is caused by supernatural phenomenon. Majority believes that good nutrition is important to prevent diseases. Majority of the respondents claim that they have fair health status and that all of them perform handwashing, daily bath, and other hygienic practices. Respondents include rice, fruits and vegetables in their daily diet and sleep and rest regularly. The respondents believe that their practices affect their health. Pains (Back/ Joints), high blood pressure/hypertension, depression, asthma, tuberculosis and kidney, heart and lung diseases, diabetes, and stroke are considered as the health challenges of the repondents. Majority of the respondents avail the services of the PHC Clinics/ RHUs; physician's clinics; hospitals; some prefers herbularyos/faith/natural healers; and a certain number do not seek health care. The respondents recognize their health needs and that they are capable of identifying their own needs which can be provided by the CHCT Cares as an extension program.

RECOMMENDATIONS

Based on the findings and conclusion mentioned, it can be recommended to educate the community on proper waste and garbage disposal especially the advantages and disadvantages of the methods employed. Since there is a significant number of those who believe on supernatural phenomenon on disease causation, it is recommended to extend and share the knowledge based on scientific basis. Further, enrich the community's knowledge on hygiene, food and nutrition and the significance of good health practices vis a vis the disadvantages of other practices that would affect health negatively. The proposed plan maybe recommended for implementation through an extension program by the college as it covers comprehensively all the identified health needs of the respondents with emphasis on the health challenges the respondents are facing. The adoption of the proposed plan is recommended to the CHCT Cares committee for future implementation.

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