

Level of Acceptability of Roles and Performance of Barangay Health Workers in the Delivery of Basic Health Services

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Abstract

The Philippines experienced "brain drain" in 1987 due to the exodus of health workers which led to the training of BHWs to fill the gap. So, this study determined the level of acceptability of the roles and performance of barangay health workers in the delivery of basic health services.

This study was conducted with 1,332 respondents (245 BHWs and 1,087 residents) in Vigan City, Ilocos Sur in 2010.

The researcher used a questionnaire-checklist to gather data. The descriptive correlational method was used in this study.

The BHWs level of acceptability of their roles and performance was high.

The BHWs level of acceptability of their roles was significantly influenced by their socio-demographic profile except on their role as a teacher; but their level of performance was not significantly influenced by their socio-demographic profile.

There was a significant relationship between the BHWs' level of acceptability of their roles and their level of performance.

Based on the findings, the recommendations are drawn: the BHWs should be encouraged to attend trainings on basic health care services; a similar study be conducted but with wider scope; and the result would serve as a basis for future programs of the Department of Health (DOH) on BHWs' welfare.

Keyword Index: *acceptability, roles, performance, barangay health workers, delivery, basic health services*

INTRODUCTION

In 1978, the Philippines started to experience "brain-drain" due to migration of Filipino health workers abroad for greener pasture. The exodus of the doctors and nurses led to the training of BHWs to fill the gap vacated by these doctors and nurses. In 1979, former ex-President Ferdinand Marcos issued Letter of Instruction 949 (LOI) mandating the implementation of Primary Health Care. Initially, rural health midwives were oriented on the concept of PHC and trained in community organizations. Social preparations for the community were done through dialogues and assemblies and these paved the way for the community's awareness that it is "their responsibility to protect and maintain their own health." LOI 949 strengthens the promotion of health care through the training of barangay health workers. These trained barangay health workers were stationed in their own barangays. Republic Act No. 7883 (Barangay Health Workers Benefit & Incentive Act of 1995) states that: "the DOH shall be the one to determine the ideal ratio of BHWs to the number of households provided that the number of BHWs shall not exceed one percent of the total population." As of December 1985, the working ratio is one barangay health worker to every 20 household (Naido and Wills, 2000).

The barangay health workers were called by a variety of names but in this study the proponent used "Barangay Health Workers" (BHWs). The BHWs are the "persons who promote better life within their community through better health" (Reyala, et al., 2000). Some became barangay health workers after undertaking trainings conducted by organized programs of the Department of Health (DOH). Others were just members of the community whom the people respected as healers or leaders in matters of health. These were the people who studied health matters on their own.

From the Population Center Foundation brochure on Health Research Distribution Program Standards and Processes in Program Implementation (1990), the roles of the barangay health workers are three fold: a) primarily a leader- for he organizes his community towards health; b) a teacher- for he shares his knowledge as well as his ideas he learned about health with great emphasis to disease prevention; and c) as a service provider - for his responsibility is to attend to the immediate primary needs of the community. The BHWs' concern also is to form preventive medical services, monitor the community's health, identify patients at particular risks, act as liaison between the community and the health system, interpret the social climate as well as basic curative services. Realizing the importance of the different roles and functions of the BHWs as basic health providers in the community, the proponent was interested in finding out the BHWs' level of acceptability of their roles

by themselves, and their level of performance as Barangay Health Workers (BHWs) in the delivery of basic health services as perceived by the community respondents.

Objectives of the Study

The objectives of the study determined the BHWs' level of acceptability of their roles by themselves and their level of performance as Barangay Health Workers in the delivery of basic health services by the community respondents

The specific objectives were the following:

It determined the BHWs' level of acceptability in terms of their roles as leader, teacher, and service provider by the BHWs themselves; it determined the level of performance of the BHWs in the delivery of basic health services in terms of promotional and preventive care, case finding activities and curative services by the community respondents determined if the BHWs' level of acceptability of their roles as BHWs was significantly influenced by their socio-demographic profile; determined if the level of performance of the BHWs by the community respondents was significantly influenced by the BHWs' socio-demographic profile. It also determined if there was a significant relationship between the BHWs' level of acceptability of their own roles as BHWs and their level of performance as BHWs by the community respondents in the delivery of basic health services.

Review of Related Literature

Health has been a prime concern of humanity since the beginning of history. According to Dhillon & Philip (1994), man has the knowledge and tools to prevent many diseases. He knows how to improve his health and how to give ourselves, the families, and the communities the best possible chance of staying healthy. Unfortunately, that knowledge and those tools are not evenly distributed among humanity. Nor they are always used as well or given appropriate priority. Great advances have been made in health sciences. People now have a better understanding of risk factors for many conditions and better information on health status, ill-health and premature death at different levels of society. As a result many are more aware than ever before of inequities in health.

Improvements in health can only be achieved if there's also an improvement of social and economic conditions. Azurin (1988) said that "poverty, poor living conditions, lack of education, illiteracy (including health illiteracy) and the lack of

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information or ability to make decisions about one's health are all impediments to health."

Maslow's (1954) famous hierarchy of needs suggests that human needs are in fact health needs. For a person to be "self-actualizing, physical, social and emotional needs must be met." In Primary Health Care, great importance is given to community participation and involvement of people in all aspects of health care. There had been numerous small-scale efforts to promote primary health care in the Philippines. Some of these efforts were coordinated by the government, while others were initiated by non-government organizations.

The World Health Organization (WHO) was created in 1948 with the ultimate aim of making possible the attainment by all people the highest level of health-" not merely the absence of disease but health as a state of complete physical, mental and social well-being." This is explicitly expressed in its preamble when it says, "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition" (Azurin, 1988).

The Alma-Ata conference identified primary health care as "the key to achieving an acceptable level of health throughout the world in the foreseeable future as part of social development and in the spirit of social justice." The heavy burden of sickness, the high cost of health technology and the inadequacy of health services coverage called for a bold new approach. Primary health care offers a rational and practical means for both developing and industrialized nations to work towards the health-for-all goal. Primary health care was endorsed as a strategy for making fundamental health services universally accessible to the world's population.

The objective of the first International Conference on Primary Health Care sponsored by the World Health Organizations and UNICEF is to promote primary health care through the training of barangay health workers. In the Philippines, this has been strengthened by Letter of Instructions (LOI) 949 by then President Ferdinand E. Marcos on October, 1979 (Reyala, et al., 2000).

Primary Health Care has been highlighted as a key setting in both international and national health promotion policies. The WHO "Health for All 2000" program called for a reorientation of health care services away from the tertiary hospital sector and towards the primary sector. "The focus of the health care system should be on primary health care – the basic health needs of each community through services provided as close as possible to where people live and work readily accessible and acceptable to all and based on full community participation" (WHO, 1988).

In Republic Act 1883, the term "barangay health worker" is defined as a "person who has undergone training programs under any credited 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."

The roles and responsibilities of BHWs vary considerably according to country and circumstances. In general, BHWs receive some kind of training from the formal health system to help them perform their tasks. "They may also be traditional healers such as traditional birth attendants who have received training in safe delivery practices." A definition confirmed by a WHO Study Group has been widely accepted: "BHWs should be members of the communities where they work, should be selected by the communities, should be answerable to the communities for their activities, should be supported by the health system but not necessarily a part of its organization, and have shorter training than professional workers" (Kahssay, Taylor and Burman, 1998).

The BHWs' roles specified in the Population Center Foundation brochure on Health Research Distribution Program Standards and Processes in Program Implementation (1990) are: as teacher, as leader and as service provider. A role is said to be the "position of the individual in social relations on the patterns of behavior." The BHW's role is geared towards the "attainment of health in the community."

Scope and Delimitation of the Study

This research study conducted during the Calendar Year 2010 determined the level of acceptability of the roles of the BHWs as perceived by themselves; and the level performance of the BHWs in the delivery of basic health services as perceived by the community respondents.

The socio-demographic profile of the BHWs such as age, sex, civil status, educational attainment, occupation, monthly income, family size, years of service, training programs attended, awards received, and incentives received was correlated with their level of performance on the delivery of basic health services such as promotional and preventive care, case finding activities and curative services; and with the BHWs' level of acceptability of their roles as teacher, as leader and as service provider.

This study was limited on the BHWs' roles as specified in the Population Center Foundation Brochure on Health Research Distribution Program Standards and Processes in Program Implementation (1990). The BHWs' roles specified were: as teacher, as leader and as service provider. The BHWs' responsibilities that were measured were along promotive and preventive care, case finding activities and curative services.

Research Design

This study used the correlation research design to describe the relationship between the socio-demographic profile of the BHWs such as age, sex, civil status, educational attainment, occupation, monthly family income, family size, years of service, trainings attended, awards received, and incentives received; and the level of acceptability of the BHWs' roles by themselves and the level of performance of the BHWs as perceived by the community respondents.

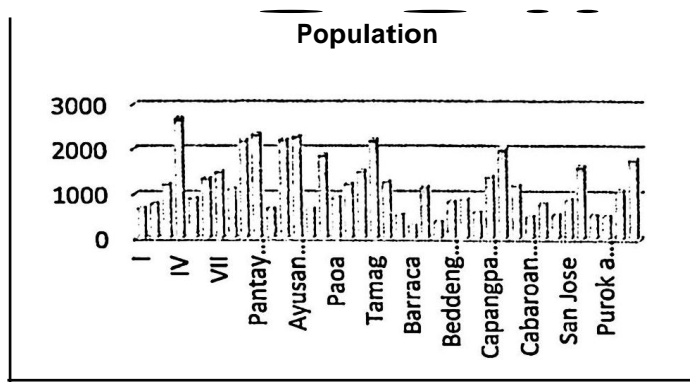


Figure 1. Distribution of Community Resident-Respondents

Sampling Design

The 46,005 residents from the 39 barangays of Vigan City, Ilocos Sur comprised the population of the study. The number of community resident-respondents per barangay was taken using the Slovin's formula. The sample size was 1087. All the 245 BHWs of Vigan City were included in the study.

METHODOLOGY

The researcher used a structured questionnaire-checklist based from the Population Center Foundation brochure on Health Research Distribution Program Standards and Processes in Program Implementation (1990) as the instrument in gathering data. The contents of the questionnaire-checklist were content validated by knowledgeable health professionals. This served as the questionnaire-checklist that was used in the data collection. The researcher tabulated the responses to determine out the frequency distribution, the mean and percentage.

Data Gathering Instrument/Data Collection Tools

The data gathering tool consisted of two sets for both the BHW and community respondents. For the BHW, Part I determined the socio-demographic profile (age, sex, civil status, educational attainment, occupation, monthly family income, family size, years in service, training programs attended, awards received and incentives received). Part II elicited the BHWs' level of acceptability of their roles. For the Community Respondents, Part I determined the socio demographic profile of the community respondents (age, sex, civil status, educational attainment, occupation, family income, and family size). Part II gathered information on the level of performance as perceived by the community respondents.

The BHWs' level of acceptability of their roles is measured by the Likert's Scale as follows:

- 5– Always
- 4 - Often
- 3- Sometimes
- 2- Seldom
- 1--Never

The level of performance of tasks is likewise measured by the Likert's Scale as follows:

- 5–Always
- 4- Often
- 3- Sometimes
- 2- Seldom
- 1–Never

Norms of Interpretation:

4.21--5.00 Very High

3.41–4.20 High

2.61–3.40 Moderate

1.81–2.60 Low

1.00-- 1.80 Very Low

Statistical Treatment of Data

The study used frequency count and percentage to describe the socio-demographic profile of the respondents; mean to determine the level of acceptability of the roles, and performance level of the BHWs in the delivery of basic health services. Multiple regression analysis was used to determine the influence of the socio-demographic profile of the BHWs on their acceptability of their roles and their level of performance as perceived by the community.

RESULTS AND DISCUSSION

Profile of the BHW Respondents

On Socio-Demographic Profile. Majority (143 or 58.4%) of the BHWs were middle-age (41-65 years of age), all (245 or 100 %) were females, majority (165 or 67.3%) were married, most (53 or 21.6%) reached high school level, majority (189 or 77.1%) were not gainfully employed, majority (148 or 60.4%) had a monthly family income of Php1000 to Php5000, most (101 or 41.3%) of them belonged to medium size families, most (64 or 26.1%) had 21-30 years of service.

On Training Programs Attended. On local training programs attended majority (133 or 54.3%) have attended 1-3 training programs; 22 (9.0%) have attended 4-6 training programs; 5 (2.0 %) have attended above 6 training programs; and 85 (34.7%) have not attend any local training programs.

On provincial training programs, only 44 (18.0%) BHWs have attended 1-2 training programs; 20 (8.2%) have attended 3-4 training programs; and one (0.4%) attended 4 and above training programs; and majority (180 or 73,5%) have not attended provincial training programs.

On regional training programs there were sixteen (6.5%) who have attended 1-2 regional training programs; two (0.8%) have attended 3-4 training programs and majority (227 or 92.7%) have not attend any regional training programs.

Table 1. Socio-Demographic Profile of the BHW Respondents

Socio Demographic Factors	Frequency	Percentage
Age		
Young Adult (below 20-40 years of age)	51	20.8
Middle Adult (41-65 years of age)	143	58.4
Old Adult (66 years old and above)	51	20.8
Total	245	100.0
Sex		
Male	-	-
Female	245	100.0
Total	245	100.0
Civil Status		
Single	17	6.9
Married	165	67.3
Widowed	56	22.9
Separated	7	2.9
Total	245	100.0
Educational Attainment		
No Formal Schooling	2	0.8
Elementary Level	25	10.2
Elementary Graduate	43	17.6
High School Level	53	21.6
High School Graduate	32	13.1
College Level	40	16.3
College Graduate	40	16.3
Vocational	10	4.1
Total	245	100.0
Occupation		
Gainfully Employed	56	22.9
Not Gainfully Employed	189	77.1
Total	245	100.0
Monthly Family Income		
Ph 1,000-5,000	148	60.4
Php 5,001-10,000	30	12.2
Php 10,001 and above	67	2.4
Total	245	100.0

Level of Acceptability of Roles and Performance of BIW

Table 1 continued

Socio Demographic Factors	Frequency	Percentage
Family Size		
Small (0-2 children)	91	37.1
Middle (3-4 children)	101	41.3
Larae (5 or more children)	53	21.6
Total	245	100.0
5 and below	61	24.9
6-10	34	13.9
11-20	62	25.3
21-30	64	26.1
Above 30	24	9.8
Total	245	100.0
Training Programs Attended		
<i>Local</i>		
Above 6	5	2.0
4-6	22	9.0
1-3	133	54.3
None	85	34.7
Total	245	100.0
<i>Provincial</i>		
Above 4	1	0.4
3-4	20	8.2
1-2	44	18.0
None	180	73.5
Total		
<i>Reaional</i>		
Above4	-	-
3-4	2	0.8
1-2	16	6.5
None	227	92.7
Total	245	100.0
<i>National</i>		
1-2	3	1.2
None	242	98.8
Total	245	100.0
Awards Received		
<i>Local</i>		
3	1	0.4
2	-	-
1	6	2.4
0	238	97.1
Total	245	100.0
<i>Provincial</i>		
1	4	1.6
0	241	98.4
Total	245	100.0

Table I continued

Socio Demographic Factors	Frequency	Percentage
<i>Regional</i>		
3	1	0.4
2	-	-
1	1	0.4
0	243	99.2
Total	245	100.0
<i>National</i>		
0	245	100.0
Total	245	100.0
Incentives Received as BHW		
Above Php 600	23	9.4
PhD 401-600	26	10.6
PhD 201-400	29	11.8
PhD 200 and below	58	23.7
None	109	44.5
Total	245	100

On national training programs, three (1.2%) have attended 1-2 training programs; and majority (242 or 98.8%) have not attend any national training program.

On Awards Received. On local awards, there were six (2.4%) who received one award; only one (0.4%) received three awards; and majority (238 or 97.1%) have not received any local award.

On provincial awards, there were four (1.6%) who received one provincial award; and 241 (98.4%) have not received any provincial award.

On regional award, there was one (0.4%) who received three regional awards; one (0.4%) had a regional award; and majority (243 or 99.2%) have not received any regional award.

National Award. Nobody has (100%) received any national award.

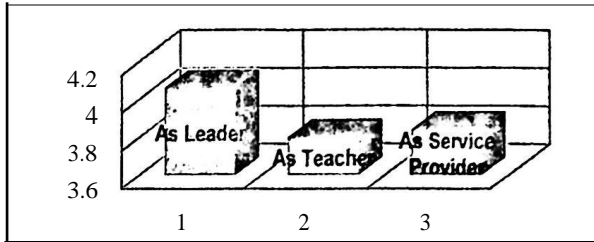
On Incentives Received. Twenty three (23 or 9.4%) have received incentives of more than Php 600 per month, 26 (10.6%) have received Php 401- Php 600/month, 29 (11.8%) have received Php 201-Php 400; 58 (23.7%) received at most Php 200/month; and 109 (44.5%) have not received any incentive.

Profile of the Community Respondents

Table 2. Socio-Demographic Profile of the Community Respondents

Socio-Demographic Factors	Frequency	Percentage
Age		
Young Adult (below 20-40 years of age)	682	62.7
Middle Adult (41-65 years of age)	362	33.3
Old Adult (66 years old and above)	43	4.0
Total	1087	100.0
Sex		
Male	155	14.3
Female	932	85.7
Total	1087	100.0
Civil Status		
Single	101	9.3
Married	881	81.0
Widowed	84	7.7
Separated	21	1.9
Total	1087	100.0
Educational Attainment		
No Formal Schooling	21	1.9
Elementary Level	34	3.1
Elementary Graduate	102	9.4
High School Level	156	14.4
High School Graduate	244	22.4
College Level	204	18.8
College Graduate	303	27.9
Vocational	23	2.1
Total	1087	100
Occupation		
Gainfully Employed	224	20.6
Not Gainfully Employed	863	79.4
Total	1087	100.0
Occupation of those employed		
Professional	23	2.1
Skilled	128	11.8
Semi Skilled	73	6.7
Monthly Family Income		
PhD 1,000 -5,000	866	79.6
Ph 5,001-10,000	155	14.3
Pho 10,001 and above	66	6.1
Total	1087	100.0
Family Size		
Small (0-2 children)	540	49.7
Middle (3-4 children)	389	35.8
Large (5 or more children)	158	14.5
Total	1087	100.0

Figure 2
Summary of the BHWs' Level of Acceptability of their
Roles as BHWs in Vigan City



The BHWs' Level of Acceptability of their Roles by Themselves

As Leader. The BHWs assessed their level of acceptability of the role as leader in the delivery of basic health services as "High" ($X=4.06$). The BHWs "always" motivate mothers to bring their children for immunization on scheduled dates ($S=4.43$); encourage mothers to breastfeed their babies for the first six months ($C=4.42$); encourage pregnant mothers to go to the health center on the dates that they are expected to have their pre-natal check-up ($X=4.35$); and encourage mothers to extend breastfeeding up to two years ($C=4.33$). Also, they "often" supervise implementation of proper disposal of garbage and other household wastes ($S=4.33$).

As Teacher. The BHWs assessed their level of acceptability of their role as teacher in the delivery of basic health services as "high" ($G=3.80$). The BHWs "often" teach new mothers on the proper technique of breastfeeding, young child feeding ($C=4.19$). They "sometimes" conduct mother's classes ($X=3.32$).

As Service Provider. The BHWs assessed their level of acceptability of the roles as service provider in the delivery of basic health services as "High" ($C=3.84$). The BHWs "always" identify pre-schoolers for weighing during Operation Timbang ($C=4.37$).

Overall. The overall level of acceptability of the BHWs' roles in the delivery of basic health services as perceived by themselves was "High" ($X=3.90$). The BHWs' level of acceptability of their role leader ($S=4.06$), as teacher ($C=3.80$), and as service provider ($C=3.84$) in the delivery of basic health services were assessed as "High" by them.

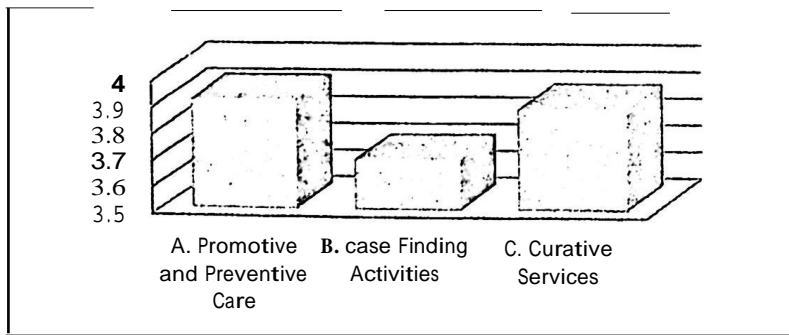
Level of Performance of the BHWs As Perceived by the Community Resident-Respondents

Promotive and Preventive Care. The level of performance of the BHWs in the delivery of basic health services along promotive and preventive care was assessed to be "High" (X=3.91). All activities along promotive and preventive care were "often" done by the BHWs. But the activity that they performed with the highest mean was "encourages mothers to breastfeed their babies up to twelve months even after supplementary food have been introduced" (=4.16); followed by "mobilizes the community to clean the environment" (C=4.14); "enforces the maintenance of proper disposal of garbage" (=4.12); "encourages pregnant mothers to go to the health center on the dates that they are expected to have their pre-natal check-up" (C=4.11) and the least that they performed was to "conduct mother's classes" (S=3.54).

On Case Finding Activities. The level of performance of the BHWs in the delivery of basic health services along case finding activities was assessed to be "High" (=3.69). All the case finding activities were "often" done by the BHWs, except "collects sputum from symptomatic cases of TB and immediately submits this to the nearest health center" (C=3.34) which was only sometimes done. This could be because they are not knowledgeable in collecting sputum.

Figure 3

Summary of the Level of Performance of BHWs in the Delivery of Basic Health Services, Vigan City as Perceived by the Community Resident-Respondents



On Curative Services. The level of performance of the BHWs in the delivery of basic health services along curative services was assessed to be "High" ($\bar{X}=3.88$). All curative services were "often" done by the BHWs. "Initiates mass feeding of malnourished children" ($\bar{X}=4.15$) was the most often done by the BHWs. The least ($\bar{X}=3.68$) that they performed was "follows-up chronic cases such as TB, hypertension, and leprosy in the community and make necessary referrals and/or plan of care with families of patients."

Overall. The community respondents assessed the level of the BHWs performance in the delivery of basic health services as "High" ($\bar{X}=3.83$). The BHWs' performance along promotive and preventive care ($\bar{X}=3.91$), case finding activities ($\bar{X}=3.69$), and curative services ($\bar{X}=3.88$) were assessed as "High." They performed so well along promotive and preventive care ($\bar{X}=3.91$).

Influence of the Socio-Demographic Profile of the BHWs on the Level of Acceptability of Their Role as a Leader

As a Leader. The BHWs' level of acceptability of their role as a leader was significantly influenced by the socio-demographic profile ($F_{ratio}=2.746$, $p<.01$). The socio-demographic profile accounts for 30.7 percent ($R=0.307$) of the variance in the level of acceptability of the roles of the BHWs as a leader. Monthly family income ($t\text{-value}=2.367$, $t\text{-prob}<.05$), family size ($t\text{-value}=-3.071$, $t\text{-prob}<.01$), and training programs attended ($t\text{ value}=2.075$, $t\text{-prob}<.05$) were found to be significant predictors of the level of acceptability of the roles of the BHWs as a leader.

Table 3. Regression of BHWs' Level of Acceptability on their Role as Teacher

Socio-Demographic Factors	Beta	t-value	t-prob
Age	-0.226	-1.272	0.208
Civil Status	0.093	0.641	0.524
Educational Attainment	-0.130	-1.076	0.286
Occupation	-0.215	-1.757	0.084
Monthly Family Income	0.123	0.946	0.348
Family Size	-0.012	-0.089	0.929
Years of Service	0.051	0.327	0.745
Training Programs Attended	0.209	1.651	0.104
Awards Received	0.033	0.269	0.789
Incentives Received	0.205	1.562	0.123

Mult R= 0.409 R' =0.168 F-ratio= 1.248 F-prob= 0.280 (p > .05)

Monthly family income influenced the BHWs' role as leader for they always perform their role as leader like "participate in supplemental feeding activities of underweight children." When they perform this role they would also be included; they would not only feed the underweight children but also under weight children in their families of or even they have under weight children.

As a Teacher. The BHWs' level of acceptability of their role as a teacher was not significantly influenced by their socio-demographic profile ($F\text{-ratio}=1.248, p>.05$). The socio-demographic profile accounts for 16.8 percent ($R=0.168$) of the variance in the level of acceptability of the role of the BHWs as a teacher.

None among the socio-demographic factors significantly influences the level of acceptability of the BHWs role as a teacher.

As Service Provider. The BHWs' level of acceptability of their role as service provider was significantly influenced by their socio-demographic profile ($F\text{-ratio}=2.165, p<.05$). The socio-demographic profile accounts for 25.9 percent ($R=0.259$) of the variance in the level of acceptability of the role of the BHWs as service provider. Years of service ($t\text{-value}=2.240, t\text{-prob}<.05$) was found to be a significant predictor of the level of acceptability of the role of the BHWs as service provider.

Training programs attended, awards received and incentives received were not significant predictors on the level of the BHWs acceptability of the role as service provider. This was not found to be a significant predictor of the level of acceptability of the role of the BHW as service provider ($t\text{-value}=1.932, t\text{-prob}>.05$).

Awards received was not found to be a significant predictor of the level of acceptability of the role of the BHWs as service provider ($t\text{-value}=0.261, t\text{-prob}>.05$) for most of them did not receive an award. The same is true with incentives received ($t\text{-value}=1.874, t\text{-prob}>.05$).

The acceptability of the roles of the BHWs as service provides was not attributed to the training programs attended, awards received and incentives received by the BHWs; but by length of service.

Overall. The level of acceptability of the roles of the BHWs was significantly influenced by their socio-demographic profile ($F\text{-ratio}=2.029, p<.05$). The socio-demographic profile account for 24.7 percent ($R^2=0.247$) of the variance in the level of acceptability of the roles of the BHWs. Training programs attended ($t\text{-value}=2.084, t\text{-prob}<.05$) was found to be a significant predictor of the BHWs' level of acceptability of their roles as BHWs.

Training Programs attended was found to be a significant predictor of the overall level of acceptability of the roles of the BHWs (t -value=2.084, t -prob<.05); although it was not a significant predictor on their role as service provider. This implies that training programs elevated their competence in the performance of their roles as leader and as teacher. The training programs also boosted their morale and ultimately gave them self-confidence. Training programs also helped the BHWs attain personal growth. More so, most of them underwent training programs. The overall acceptability of their roles as BHWs could be attributed to the training programs they attended.

Awards received was not found to be a significant predictor of the overall BHWs' level of acceptability of their roles as BHWs (t -value=0.370, t -prob>.05). This was so because only a few received awards; and they accepted their roles as BHWs without waiting for rewards; but to help attain health in their own communities.

Incentives received was not found to be a significant predictor of the overall level of acceptability of the roles of the BHW (t -value=1.639, t -prob>.05). This implies that as volunteer barangay health workers, they accepted their roles in the call of service exercising the spirit of volunteerism without waiting for remuneration. They are contented with the honoraria that the government is giving them.

Influence of the Socio-Demographic Profile of the BHWs on their Level of Performance in the Delivery of Basic Health Services as Perceived by the Community Respondents

Along Promotive and Preventive Care. The level of performance of the BHWs along promotive and preventive care was not significantly influenced by the BHWs' socio-demographic profile (F -ratio=0.753, p >.05). The socio-demographic profile accounts for 10.8 percent ($R^2=0.108$) of the variance in the level of performance of the BHWs along promotive and preventive care.

It was observed that all the demographic factors of the BHWs did not influence their performance along promotive and preventive care including training programs attended (t -value=-0.197, t -prob>.05), awards received (t -value=0.027, t -prob>.05), and incentives received (t -value=0.361, t -prob>.05). The data shows that the performance of the BHWs along promotive and preventive care was not attributed to the training programs attended, awards received, and incentives they received.

Table 4. Regression of BHWs' Level of Performance Along Promotive and Preventive Care

Socio-Demographic Factors	Beta	t-value	t-prob
Age	0.048	0.260	0.795
Civil Status	0.021	0.139	0.890
Educational Attainment	-0.106	-0.851	0.398
Occupation	-0.129	-1.024	0.310
Monthly Family Income	0.178	1.321	0.191
Family Size	0.173	1.290	0.202
Years of Service	0.071	0.437	0.663
Training Programs Attended	-0.026	-0.197	0.845
Awards Received	0.003	0.027	0.979
Incentives Received	0.049	0.361	0.719
Mult R= 0.329 R ² =0.108 F-ratio= 0.753 F-prob= 0.672			

Table 5. Regression of BHWs' Socio-Demographic Level of Performance Along Case Finding Activities

Socio-Demographic Factors	Beta	t-	t-prob
Age	-0.042	-	0.818
Civil Status	0.024	0.160	0.874
Educational Attainment	-0.093	-	0.458
Occupation	-0.077	-	0.544
Monthly Family Income	0.101	0.749	0.457
Family Size	0.153	1.137	0.260
Years of Service	0.204	1.263	0.211
Training Programs Attended	-0.057	-	0.666
Awards Received	0.036	0.282	0.779
Incentives Received	0.	1.306	0.196
Mult R= 0.334 R ² =0.111 F-ratio= 0.778 F-prob= 0.650			

Along Case Finding Activities. The level of performance of the BHWs along case finding activities was not significantly influenced by the BHWs' socio-demographic profile (F-ratio=0.778, $p>.05$). The socio-demographic profile accounts for 11.1 percent ($R^2=0.111$) of the variance in the level of performance of the BHWs along case finding activities. Training programs attended (t-value= -0.434, $t\text{-prob}>.05$), awards received (t-value = 0.282, $t\text{-prob}>.05$), and incentives received (t-value=1.306, $t\text{-prob}>.05$) were not significant predictors on the BHWs' level of performance along case finding activities as perceived by the community respondents.

Table 6. Regression of BHWs' Level of Performance Along Curative Services

Socio-Demographic Factors	Beta	t-value	t-prob
Age	-0.027	-0.151	0.880
Civil Status	0.030	0.204	0.839
Educational Attainment	-0.145	-1.184	0.241
Occupation	-0.105	-0.845	0.402
Monthly Family Income	0.133	1.002	0.320
Family Size	0.174	1.320	0.192
Years of Service	0.176	1.106	0.273
Training Programs Attended	-0.011	-0.084	0.933
Awards Received	0.022	0.174	0.862
Incentives Received	0.196	1.463	0.149

Mult R=0.373 R' =0.139 F-ratio= 1.005 F-prob=0.450

Along Curative Services. As perceived by the community respondents, the level of performance of the BHWs along curative services was not significantly influenced by the BHWs' socio-demographic profile (F-ratio=1.005, $p>.05$). The socio-demographic profile account for 13.9 percent ($R^2=0.139$) of the variance in the level of performance of the BHWs along curative services.

Training programs attended (t-value= -0.084, t-prob>.05), awards received (t-value = 0.174, t-prob >.05), incentives received (t-value=1.463, t-prob>.05) were not significant predictors of the level of performance of the BHWs along curative services in the delivery of basic health services because the BHWs are not actually involved in the curative services of the Department of Health (DOH).

Table 7. Regression of BHWs' Level of Performance

Socio-Demographic Factors	Beta	t-value	t-nrob
Ape	-0.011	-0.060	0.95
Civil Status	0.026	0.178	0.86
Educational Attainment	-0.116	-0.937	0.35
Occuation	-0.105	-0.834	0.40
Monthlv Familv Income	0.139	1.036	0.30
Familv Size	0.170	1.270	0.20
Years of Service	0.157	0.974	0.33
Training Programs Attended	-0.030	-0.231	0.81
Awards Received	0.021	0.169	0.866
Incentives Received	0.148	1.090	0.280

Mult R= 0.343

R' =0.117

F-ratio = 0.824

F-prob = 0.607

Overall. As perceived by the community respondents, the level of overall performance of the BHWs was not significantly influenced by the BHWs' socio-demographic profile (F-ratio=0.824, p>.05). The socio-demographic profile accounts for 11.7 percent (R²=0.117) of the variance in the level of overall performance of the BHWs.

The overall performance of the BHWs as perceived by the community respondents was not attributed to the training programs attended, awards and incentives received. The community respondents were not able to see these in the BHWs' level of performance because of the fact that BHWs were performing well. The BHWs were rated high (M = 3.83) on their performance as perceived by the community respondents

Table 8. Correlation Coefficients Showing the Relationship Between the BHWs' Level of Acceptability of their Roles and their Level of Performance as BHWs in the Delivery of Basic Health Services

ACCEPTABILITY	PERFORMANCE			
	Promotive & Preventive Care	Case Finding Activities	Curative Services	Overall
Leader	0.240	0.226°	0.303	0.279
Teacher	0.235	0.224	0.319	0.283
Service Provider	0.241	0.210	0.318	0.279
Overall	0.243	0.224	0.320	0.286

• - significant at .05 level of probability

There was a significant relationship between the BHWs' level of acceptability of their roles as BHWs by themselves and their level of performance by the community respondents in the delivery of basic health services. Each of the dimensions of performance was significantly related to each of the dimensions of acceptability of roles. This implies that the performance of the BHWs in the delivery of basic health services was attributed to the acceptability of their roles. The BHWs' level of performance as perceived by the community respondents was high because the level of acceptability of their roles as perceived by them was also high. The data show that the BHWs perform efficiently because they accept and do perform their roles well.

CONCLUSIONS

Majority of the BHWs were middle age (41-65 years of age), females, married, most were high school level, not gainfully employed, with a monthly family income of Php 1000 to Php 5000, of middle family size (3– 4 children), who were BHWs for 21-30 years, majority didn't attend provincial, regional and provincial training programs, and most did not receive awards and incentives. Majority of the community respondents were young adults (below 20-40years old), married, females with small family size (0-2 children), mostly college graduates, skilled workers but not gainfully employed, and with a monthly family income of Php 1000-Php 5000. The BHWs assessed themselves as high in the acceptance of their roles as a leader, teacher and service provider in the delivery of basic health services. The community respondents assessed the BHWs' level of performance in the delivery of basic health services as high along promotive and preventive care, case finding activities and curative services. The BHWs' level of acceptability of their roles as leader, teacher, and service provider was significantly influenced by their socio-demographic profile; although, their role as teacher was not influenced by their socio-demographic profile. Trainings attended had greatly influenced their acceptability of their roles. Monthly family income, family size, and training programs attended had greatly influenced their acceptability of their role as leader; and their being service provider was greatly influenced by their years in the service. The BHWs' demographic profile did not significantly influenced their level of performance as perceived by the community respondents. There was a significant relationship between the BHWs' level of acceptability of their roles as perceived by them and their level of performances perceived by the community respondents in the delivery of basic health services.

RECOMMENDATIONS

The BHWs should be given more trainings on teaching basic health care services to be better prepared and equipped in performing their role as teacher. A similar study should be conducted and the coverage should be wider in scope to have a better perception on the performance of the BHWs. The result of the study would serve as a basis for future programs of the Department of Health (DOH) on the welfare of the BHWs like extending R.A. 7883, otherwise known as the "Barangay Health Workers' Benefit and Incentives Act of 1995" to all BHWs.

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