

“Navigating Healthcare Frontiers: An In-Depth Examination of Challenges Faced by Public Health Nurses in Implementing Universal Health Services in San Carlos City, Pangasinan”

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ABSTRACT

This study explored the lived experiences of public health nurses in implementing universal health services in San Carlos City, Pangasinan. Specifically, it sought to describe the challenges encountered by public health nurses in delivering community-based health services, the effects of these challenges on service delivery and professional practice, and the strategies they used to manage difficult situations. A qualitative descriptive phenomenological research design was employed, guided by Giorgi’s phenomenological method. Seven public health nurses who had direct experience in implementing universal health services were purposively selected based on the established inclusion criteria. Data were gathered through individual, in-depth, semi-structured interviews conducted in English, Filipino, Pangasinan, and/or Ilocano. Interviews were audio-recorded with consent, transcribed, translated when necessary, and analyzed through the identification, transformation, and synthesis of meaning units until a general structure of the phenomenon was developed.

The findings revealed five major themes: (1) Demanding and Expanding Nature of Public Health Nursing, (2) Health-System and Resource Constraints Affecting Care Delivery, (3) Patient Engagement, Communication, and Cultural Determinants of Care, (4) Consequences of Interacting Health-System Challenges, and (5) Adaptation, Collaboration, and Professional Resilience. The findings showed that public health nurses managed multiple and competing responsibilities, including direct patient care, health programs, documentation, home visits, and community activities, which at times extended beyond regular working hours. Medication and supply shortages, limited facility capacity, and unavailable diagnostic services further constrained their ability to provide timely and complete care. Communication difficulties, health beliefs, traditional practices, and challenging patient interactions also influenced health education, treatment adherence, and patient engagement. These challenges interacted with one another, contributing to delayed or incomplete care, emotional and professional strain, and work-life spillover. Despite these difficulties, nurses demonstrated resourcefulness, strategic problem-solving, time management, collaboration, continuing professional development, patience, and resilience to sustain service delivery.

The study concludes that the implementation of universal health services is influenced not only by the commitment and competence of public health nurses but also by the organizational and health-system conditions in which they work. Individual resilience and adaptability help nurses manage challenges but cannot replace adequate staffing, reliable resources, sufficient facility capacity, accessible services, and supportive working environments. The study recommends strengthening workforce planning, improving the availability and management of medicines and supplies, enhancing facility and referral capacity, streamlining administrative requirements, promoting culturally responsive communication, and strengthening organizational support and continuing professional development for public health nurses. These measures may contribute to more accessible, timely, equitable, and sustainable universal health services in community settings.

Keywords: public health nurses, universal health services, lived experiences, phenomenology, rural health units, health service delivery, professional resilience

INTRODUCTION

Universal Health Care (UHC) is an important component of the Philippine health-care system because it seeks to ensure that every Filipino has access to appropriate, quality, and affordable health services without experiencing financial hardship. In the Philippines, Universal Health Care was formally institutionalized through Republic Act No. 11223, also known as the Universal Health Care Act, which was approved on February 20, 2019. The law establishes reforms intended to make health services more accessible, equitable, comprehensive, and responsive to the needs of the Filipino population.

Under RA 11223, the government is mandated to adopt an integrated and comprehensive approach to health care that includes health promotion, disease prevention, treatment, rehabilitation, and palliative care. The law emphasizes that health services should be provided in a manner that is people-oriented and responsive to differences in culture, values, and health needs. It also promotes a whole-of-government, whole-of-system, and whole-of-society approach, recognizing that achieving universal health care requires cooperation among government agencies, health-care institutions, health professionals, communities, and other stakeholders. (Republic of the Philippines. 2019)

One of the significant features of the Universal Health Care Act is the strengthening of primary health care. The law envisions that every Filipino should have access to a primary care provider who serves as a navigator, coordinator, and continuing point of contact within the health-care delivery system. It also provides for the financing of population-based health services by the national government and establishes mechanisms intended to protect individuals and families from financial risk associated with health-care expenses. The implementation of UHC is particularly important at the community level, where public health nurses serve as frontline health professionals. Public health nurses participate in health promotion, disease prevention, community assessment, health education, maternal and child health programs, disease surveillance, and other primary health-care activities. Their responsibilities place them in a crucial position to translate the objectives of the Universal Health Care Act into actual services for individuals, families, and communities. However, the implementation of UHC may also require nurses to manage increased workloads, limited resources, manpower concerns, administrative responsibilities, and changing health-care demands.

Public health nurses occupy a central position in translating health programs into actual services at the community level. Their work extends beyond direct patient care and includes health promotion, disease prevention, treatment, referral, coordination, documentation, and participation in public health programs. Consequently, the implementation of universal health services depends substantially on the conditions under which these nurses perform their responsibilities.

The source research focused on the often-overlooked challenges faced by public health nurses in implementing universal health services in San Carlos City, Pangasinan. It examined the challenges encountered by nurses, the effects of these challenges on the effectiveness and sustainability of services, the coping mechanisms used to address them, and the advice nurses could offer to those considering rural health practice.

According to the study by Rombaoa et. al, (2025), "Public Health Nurses' Provision of Primary Healthcare Services in the Context of Universal Health Care," examined the experiences and practices of public health nurses in delivering primary health-care services under the Universal Health Care (UHC) framework in the Philippines. The study focused on understanding how public health nurses perform their responsibilities and the challenges they encounter as they participate in the implementation of UHC. The researchers used a qualitative research design and conducted interviews with 12 public health nurses working in rural health units in Tarlac Province. Through the participants' narratives, the researchers explored their day-to-day experiences, responsibilities, and difficulties in providing health services to communities.

The results of the study revealed several important themes concerning the role of public health nurses in UHC implementation. Public health nurses were found to perform diverse responsibilities, including health promotion, disease prevention, community assessment, patient care, program implementation, health education, and coordination with other health professionals and community stakeholders. However, despite

their important contribution to primary health care, the nurses experienced several challenges. These included heavy workloads, insufficient manpower, limited resources, multiple program assignments, administrative concerns, political issues, and technological limitations. The study also indicated that the increasing responsibilities of public health nurses require them to become more adaptable and capable of performing both clinical and administrative functions.

The findings further demonstrated that public health nurses play an essential role in bringing health services closer to communities, particularly in rural and underserved areas. However, the effectiveness of their services may be affected when there are inadequate human resources, equipment, supplies, and institutional support. The researchers emphasized that addressing these challenges is necessary to strengthen the capacity of public health nurses and improve the implementation of Universal Health Care in the Philippines. The study concluded that public health nurses are essential to the successful delivery of primary health-care services and the achievement of Universal Health Care, but their effectiveness is influenced by the availability of resources, organizational support, adequate staffing, and appropriate training. The researchers recommended strengthening the public health nursing workforce, improving resources and infrastructure, providing continuous professional development, and establishing stronger organizational and policy support for nurses working in primary health-care settings.

Other Study by Posadas et. al. (2024), “Leadership Development Program for Public Health Nurses: An Evaluation of Workplace Application,” examined how public health nurses applied competencies gained from a leadership development program to their actual workplace, particularly in addressing challenges related to the implementation of the Universal Health Care (UHC) Act of 2019. The researchers recognized that public health nurses are important frontline workers in the local implementation of UHC but need adequate competencies in health-systems approaches, leadership, advocacy, and program management to effectively respond to the changing demands of public health practice.

The study employed a multi-method research design guided by Kirkpatrick’s Model of Evaluation. Data were obtained from the participants’ Workplace Application Plans, questionnaires assessing the implementation of their capstone projects, interviews, focus group discussions with selected participants and their supervisors, and observation visits. The study evaluated how nurses transferred the knowledge and skills gained from the leadership development course into their workplace and how these competencies contributed to strengthening health systems and addressing UHC-related concerns. The results showed that 61.9% of participants reported partial implementation of their capstone projects, while 16.7% reported full implementation. The implementation of projects was facilitated by support from supervisors and local chief executives. However, participants also encountered significant barriers, particularly the demands associated with the COVID-19 pandemic and challenges surrounding the 2022 Philippine national elections. These circumstances affected the ability of public health nurses to implement planned programs and interventions in their respective communities.

Despite these challenges, the findings demonstrated that the leadership development program helped improve the nurses’ capacity to lead, innovate, advocate for health programs, and apply acquired competencies in their work settings. Participants reported improved abilities to advocate for their projects and transfer their newly acquired skills to actual public health practice. Supervisors also observed improvements in the nurses’ ability to deliver health services, lead programs, and perform supervisory responsibilities. The researchers concluded that public health nurses can contribute significantly to health-systems strengthening and the implementation of Universal Health Care when they are provided with adequate training, workplace support, and opportunities to apply their competencies. However, external and organizational barriers may interfere with the successful implementation of UHC-related programs. The study therefore emphasized the importance of strengthening nurses’ leadership capabilities while ensuring adequate institutional support and opportunities for professional development.

The experiences reported by the nurses may be understood as an interaction between professional responsibility and health-system capacity. When nurses face heavy workloads, extensive documentation, limited medications, communication difficulties, and competing patient demands, the consequences may

extend beyond individual work stress and influence continuity, quality, and sustainability of healthcare delivery.

OBJECTIVES OF THE STUDY

The study aimed to conduct an in-depth examination of the challenges faced by public health nurses in implementing universal health services in San Carlos City, Pangasinan.

1. Describe the typical experiences and work-related challenges of public health nurses.
2. Identify physical, emotional, social, communication-related, and resource-related challenges encountered during implementation.
3. Examine the effects of these challenges on the effectiveness and sustainability of universal health service programs.
4. Explore the coping strategies and support mechanisms used by nurses.
5. Identify lessons and advice derived from the nurses' experiences in rural and community health practice.

METHODOLOGY

Research Design

This study employed a qualitative phenomenological research design to explore and describe the lived experiences of public health nurses in implementing universal health services in San Carlos City, Pangasinan. A phenomenological approach was appropriate because the study sought to understand how public health nurses experienced, interpreted, and gave meaning to the challenges encountered in delivering health services within the community. The inquiry focused on their experiences in providing accessible and equitable health services, managing workload and available resources, communicating with individuals and communities, addressing barriers to service delivery, coping with challenges, and deriving insights from their experiences in public health practice.

The study was guided by a descriptive phenomenological approach, with the analysis informed by the Giorgi phenomenological method. This approach was selected because it provides a systematic process for identifying and describing the essential meanings of participants' lived experiences while maintaining close attention to their descriptions. The analysis involved reading the interview transcripts as a whole, identifying meaning units, transforming participants' everyday descriptions into research-relevant meanings, synthesizing the transformed meanings, and developing a general structure that represented the phenomenon under investigation.

Research Setting

The study was conducted among selected **public health nurses working in San Carlos City, Pangasinan, Philippines**. The research setting included community-based health facilities and public health service areas where public health nurses were directly involved in the implementation and delivery of universal health services.

The setting was selected because public health nurses play an important role in bringing health services closer to individuals, families, and communities. Their work involves health promotion, disease prevention, community assessment, health education, coordination of services, and other activities intended to improve access to essential health services. The community setting therefore provided an appropriate context for examining the challenges experienced by public health nurses while implementing universal health services.

Participants

The participants were public health nurses who were directly involved in the implementation and delivery of universal health services in San Carlos City, Pangasinan. The participants were selected because their

professional roles and direct experiences enabled them to provide first-hand accounts of the challenges associated with implementing universal health services in the community.

Recruitment Procedure

Participants were recruited through non-probability sampling, with consideration given to their accessibility, availability, and direct involvement in the implementation of universal health services. Potential participants were initially identified based on their professional role as public health nurses and their experience in providing health services within the community of San Carlos City, Pangasinan.

The researchers approached eligible public health nurses and explained the purpose, scope, procedures, and voluntary nature of the study. Those who expressed willingness to participate were provided with an informed consent form and were given sufficient opportunity to ask questions before deciding whether to participate. Participation was entirely voluntary, and refusal to participate did not result in any penalty or adverse consequence.

Because phenomenological research requires participants who have direct experience of the phenomenon being investigated, only public health nurses who met the established eligibility requirements and could provide substantive descriptions of their experiences were considered for participation.

Inclusion and Exclusion Criteria

Participants were included in the study if they:

1. Were currently employed as a public health nurse in San Carlos City, Pangasinan;
2. Had direct experience in the implementation and delivery of universal health services;
3. Had encountered challenges related to the provision or implementation of universal health services;
4. Were willing and able to describe their experiences related to the phenomenon;
5. Were willing to participate in an individual, in-depth interview;
6. Provided written informed consent; and
7. Were willing to have the interview audio-recorded.

Individuals were excluded if they:

1. Were not currently working as public health nurses in the study setting;
2. Did not have direct experience in implementing or delivering universal health services;
3. Had no direct experience of the challenges associated with the phenomenon under investigation;
4. Were unable to participate in an in-depth interview;
5. Declined audio recording; or
6. Withdrew their consent before or during the data-collection process.

Data Collection

Data were collected through individual, in-depth, semi-structured interviews using an interview guide consisting primarily of open-ended questions. The interview guide focused on the participants' experiences in implementing universal health services, including challenges related to workload, availability of resources,

accessibility of services, communication with clients and communities, coordination with other health workers, community participation, service delivery, coping strategies, support systems, and lessons or realizations gained from their experiences.

The semi-structured format allowed the researchers to maintain consistency across interviews while providing participants with sufficient opportunity to elaborate on experiences that they considered important. Probing and follow-up questions were used when clarification or deeper descriptions were necessary.

Each interview lasted approximately 30–60 minutes and was conducted in a private and appropriate location within the participants' workplace or another mutually agreed setting that promoted confidentiality and minimized interruptions. Interviews were scheduled at a time convenient to the participants and were conducted in a manner that allowed them to freely describe their experiences.

With the participants' permission, interviews were audio-recorded. The researchers also maintained field notes to document contextual information, non-verbal observations when appropriate, notable statements, and reflections arising during the interview process.

Language and Translation Procedures

Participants were allowed to communicate in the language in which they could most comfortably and accurately express their experiences, including English, Filipino, Pangasinan, and/or Ilocano, as applicable.

For interviews conducted in a language other than English, the recordings were first transcribed as accurately as possible in the original language. The transcripts were then translated into English for analysis and presentation of the findings. To preserve the participants' intended meanings, the researchers carefully compared the original-language statements with the English translations. Particular attention was given to culturally specific expressions, local terms, and statements for which a direct translation might alter the intended meaning.

Data Saturation and Sample Adequacy

The study did not establish a fixed sample size solely on numerical grounds. Instead, the researchers considered the adequacy of the sample based on the depth, richness, and redundancy of the information obtained from the participants.

Data collection continued until data saturation was reached, operationally defined in this study as the point at which subsequent interviews were no longer producing substantially new experiences, meanings, concepts, or themes relevant to the research questions. During the analysis, the researchers continuously compared emerging information from each interview with previously collected data. The final number of participants was determined when the narratives demonstrated substantial repetition and no significant new dimensions of the phenomenon were emerging.

Data Analysis

The interview data were analyzed using the Giorgi descriptive phenomenological method. Data collection and analysis occurred concurrently, allowing the researchers to become familiar with emerging meanings and to determine whether additional interviews were needed. The analysis proceeded through the following stages:

Stage 1: Establishing a Sense of the Whole

The researchers first read each transcript repeatedly and in its entirety to obtain a comprehensive understanding of each participant's account. At this stage, the researchers focused on the overall description of the participant's experience rather than immediately categorizing individual statements.

This process allowed the researchers to understand the context in which public health nurses experienced challenges in implementing universal health services, including their responsibilities, workload, interactions

with clients and communities, resource limitations, emotional responses, coping strategies, and perceptions of public health service delivery.

Stage 2: Identifying Meaning Units

After developing an overall understanding of each transcript, the researchers examined the narratives systematically and identified **meaning units**, or portions of the text that conveyed a distinct aspect of the participant's experience relevant to the research questions.

Meaning units were identified based on changes in meaning within the participant's narrative. Statements relating to workload, inadequate resources, accessibility of services, communication difficulties, community participation, coordination with health workers, service delivery concerns, coping strategies, organizational support, and professional commitment were examined according to their experiential significance.

Stage 3: Transforming Meaning Units

The researchers then examined each meaning unit and transformed the participants' everyday descriptions into research-relevant statements that captured the underlying meaning of the experience. The researchers remained grounded in the participants' accounts and avoided introducing interpretations that were not supported by the data.

For example, descriptions concerning limited resources and increasing workload were examined not simply as operational concerns but in terms of how these conditions were experienced by public health nurses while fulfilling their responsibilities and attempting to provide accessible and continuous health services to the community.

Stage 4: Synthesizing the Transformed Meanings

The transformed meaning units were compared across participants to identify similarities, differences, relationships, and recurring patterns. Related meanings were clustered together to develop categories and preliminary themes.

The researchers repeatedly returned to the original transcripts to ensure that emerging categories and themes remained grounded in the participants' actual narratives. Individual differences were retained when they provided meaningful variation in the phenomenon rather than being eliminated in favor of uniformity.

Stage 5: Developing the General Structure of the Experience

The final stage involved synthesizing the essential meanings identified across the participants' narratives into a coherent description of the phenomenon. The researchers examined the relationships among the categories and themes to determine the central structure of the **public health nurses' lived experiences and challenges in implementing universal health services**.

The analysis resulted in major themes and corresponding sub-themes that represented the common and significant dimensions of the participants' experiences. These themes described the challenges encountered by public health nurses, their effects on health service implementation, the strategies and support mechanisms used to manage these challenges, and the insights and professional meanings derived from their experiences.

Reflexivity

The researchers recognized that their professional experiences, assumptions, and perspectives could influence the collection and interpretation of qualitative data. To minimize the influence of pre-existing assumptions, the researchers practiced reflexivity throughout the research process.

Before and during data collection and analysis, the researchers reflected on their assumptions regarding public health nursing, universal health services, community health practice, workload, resource availability, and

service delivery. Reflexive notes were maintained to distinguish participants' descriptions from the researchers' personal interpretations. During analysis, the researchers repeatedly returned to the original transcripts and participants' accounts to ensure that themes were derived from the data rather than from preconceived expectations.

The researchers also remained attentive to their interactions with participants during interviews and avoided leading questions or statements that could influence participants' responses.

Trustworthiness of the Study

The trustworthiness of the study was established using the four criteria of credibility, transferability, dependability, and confirmability commonly applied in qualitative research.

Credibility

Credibility refers to the extent to which the findings accurately represent the experiences described by the participants. Credibility was strengthened through prolonged engagement with the interview data, repeated reading of transcripts, in-depth individual interviews, probing questions, and continuous comparison of emerging findings with the original narratives.

Transferability

Transferability was addressed by providing a sufficiently detailed description of the research context, participant characteristics, professional roles, sampling process, data-collection procedures, and phenomenon under investigation. Such contextual details enable readers and future researchers to determine whether the findings may be applicable to other community health settings or groups of public health nurses experiencing similar challenges in implementing universal health services.

Dependability

Dependability was established through systematic documentation of the research process. The researchers maintained records of participant recruitment, interview procedures, transcription, coding, development of categories and themes, and methodological decisions. Changes or refinements made during the research process were documented to provide an audit trail of how the findings were developed.

Confirmability

Confirmability was established by ensuring that the findings were grounded in the participants' actual narratives rather than solely in the researchers' assumptions or preferences. The researchers retained the interview recordings, transcripts, field notes, coding decisions, and thematic development records as an audit trail. Reflexive documentation was also used to identify and manage potential researcher biases.

Where appropriate, representative participant quotations were used in presenting the findings to demonstrate the connection between the themes and the original data.

Ethical Considerations

Ethical principles were observed throughout the study. Before data collection, participants were informed about the purpose of the study, the nature and procedures of the interviews, the voluntary nature of participation, potential risks and benefits, confidentiality measures, and their rights as research participants.

Written informed consent was obtained before each interview. Participants were informed that they could decline to answer any question or withdraw from the study at any point without penalty or negative consequences.

To protect confidentiality, participant names and other identifying information were removed from transcripts and replaced with participant codes. Audio recordings, transcripts, field notes, and other research materials

were stored securely and were accessible only to the researchers and authorized research personnel.

The information obtained from participants was used solely for academic and research purposes. The researchers also took appropriate measures to ensure that participation would not expose the public health nurses or their health facilities to unnecessary professional or organizational risks.

RESULTS AND DISCUSSION

The findings were organized into five major themes that describe the lived experiences of public health nurses in providing services within rural health units (RHUs). Rather than treating workload, resource limitations, communication difficulties, and cultural beliefs as isolated concerns, the findings show that these experiences are interconnected. High patient volume, extensive administrative responsibilities, inadequate resources, communication barriers, and culturally influenced health practices interact to affect the nurses' capacity to provide timely and comprehensive care. The themes further illustrate how nurses respond to these conditions through resourcefulness, time management, collaboration, continuing professional development, patience, and resilience.

I. Demanding and Expanding Nature of Public Health Nursing

This theme describes the demanding nature of public health nursing, where nurses simultaneously perform clinical, administrative, preventive, community-based, and coordination functions. The workload was intensified by high patient volume, multiple health programs, documentation requirements, home visits, referrals, and unexpected emergencies. These demands frequently extended beyond regular working hours and affected the nurses' ability to balance direct patient care with administrative responsibilities.

A. Managing Multiple and Competing Responsibilities

Participants described their daily work as involving numerous patients and several responsibilities that had to be performed simultaneously. Their work extended beyond admitting patients and providing direct care to include health education, specimen collection, medication administration, documentation, reporting, home visits, and program implementation.

PHN1: "A typical day is naturally filled with a lot of work, with many patients. It's busy because there are admissions of patients. And also, we have paper works, right"

PHN2: "Here at the RHU, we have many patients coming in. With the multitude of programs we have, we stay busy because our focus is on community health. We're not just admitting patients here. Sometimes we also conduct home visits, reaching out to our patients in their communities."

PHN3: "On a typical day, we're already here before 8 AM. Especially on Mondays, there are a lot of patients from sunrise to sunset. When you come in, there are really a lot of patients already. They come in for check-ups. There are different types of patients, so you need to be adaptable emotionally and mentally because they're all different."

PHN4: "As a public health nurse, our typical routine upon arriving at the office is usually admitting patients. We are responsible for admitting patients and carrying out the doctor's orders. I conduct patient interviews, collect specimens, provide health education to patients, administer medications, provide instructions, and follow up on patients' check-ups at the treatment center."

PHN5: "As a TB DOTS nurse, I handle the TB program. Usually, when a patient comes for a check-up with the doctor, the doctor will request a chest X-ray. Until the chest X-ray results are available, whether positive or not, it doesn't mean immediate treatment. They still need to undergo a sputum exam, and if it is positive, treatment is initiated automatically. We document all these procedures. We're not just dispensing medications; we also handle paperwork and submit reports."

PHN6: “Right from the start of our workday, patients are the first ones we encounter. After admitting a patient, the first thing we do is take their vital signs. Typically, they come to our center for consultation, vaccinations, and if available, we also provide medications.”

PHN7: “It can be stressful because we have many patients, and we need to manage our time efficiently. Especially when collecting sputum samples, we need to submit them before 11:00 in the morning because of my DOTS program responsibilities. We also give medications and educate them about what to do.”

The narratives demonstrate that public health nurses perform multiple roles within a limited period. Patient care, health programs, documentation, and community activities compete for the same time and personnel. Thus, workload is not merely a matter of having “many patients”; it is produced by the simultaneous demands of clinical care, program implementation, documentation, and community outreach. The nurses’ experiences suggest that workload management in RHUs requires attention to staffing, workflow, delegation, and administrative systems rather than relying solely on individual efficiency.

B. Extending Work Beyond Regular Duty Hours

The participants further described how competing responsibilities and unexpected service demands frequently extended their work beyond the regular eight-hour schedule.

PHN1: “Our working hours here at the RHU are fixed at 8 hours. We start at 8 am and finish at 5 pm, which is our regular schedule. However, there are times when we have an overwhelming amount of paperwork to handle, so sometimes we extend our time, to the point where we bring some of the paperwork home to continue there. Sometimes, it can be tiring because we also have household chores to do, and at the same time, we have paperwork that needs to be taken care of.”

PHN2: “For example, during a typhoon, when work is suspended for others, we're still required to report for duty even on Saturdays or Sundays just to accommodate patients in need. On other days, even on our days off, we might be called in if there's a shortage of available nurses, or if there are seminars they need to attend, and they can't handle accommodating all the patients who come in for check-ups. So, sometimes, we have to sacrifice our days off.”

PHN3: “There are times when we're swarmed by patients, especially during the pandemic when we started administering vaccines. There were so many people getting vaccinated. Originally, we would start at 8 am and leave at 5 pm. But during the pandemic, we started at 7 am, and sometimes we wouldn't finish until 10 pm because of the implementation of the anti- COVID vaccine, which sometimes reached over a thousand individuals due to the high demand. So, that's when we had irregular shifts, particularly during the pandemic.”

PHN4: “One of our physical challenges is the workload, especially with the numerous TB cases. Before March, I had 31 pending cases of TB patients that I hadn't admitted yet. When the TB medications arrived, I was overwhelmed with tasks. Instead of just working our regular 8-hour shifts, we had to extend our hours, and on top of that, there were additional cases to handle, so we had to be responsible for those as well. We had no choice but to extend our time to at least get our work done.”

PHN5: “In the RHU, we conduct house-to-house visits, reaching every neighborhood or barangay. Particularly during the time of Covid, we go out, and sometimes we don't get home until 11 pm. Usually, the government mandates an 8-hour working day, so I don't often work overtime unless there's a disaster like a flood, and we need to respond to emergencies. Our overtime is seasonal. As for transportation, it's not much of a problem because you're usually assigned to the RHU closest to where you live.”

PHN6: “Our problem sometimes is that even though our work is supposed to be just 8 hours, we often exceed the desired hours because sometimes patients flood in. There are times when our meal times are delayed because even though it's almost 12 pm, there are still many patients, so we need to accommodate them. Especially during the time of COVID, there were really a lot of patients, and we ended up eating very late.”

PHN7: “I’ve experienced a lot during the time of COVID regarding work hours. Nowadays, of course, you’ll extend, especially if the patients are there, then you extend your hours. You have to finish what needs to be done. Once the patients are there, you shouldn’t leave them until they’re taken care of. When they’re there, you should attend to them so they won’t have any complaints. We’re public servants after all. That’s why our meal times are sometimes delayed.”

This finding is strongly supported by the Philippine study of Aytona et al. (2022), which examined staffing requirements in 89 primary healthcare facilities, including rural health units (RHUs), barangay health stations, and city health offices. The study found that nurses in RHUs experienced workload pressures and that primary care workers devoted a substantial portion of their available working time to support and additional activities. It also documented overlapping and shifting responsibilities among health workers, demonstrating that workload in primary care is influenced by the range of services and activities assigned to personnel rather than patient volume alone. Similarly, a more recent Philippine study involving geographically isolated and disadvantaged communities found that public health nurses were required to perform both clinical and administrative functions. In one Rhu, a single public health nurse was responsible for preparing reports for several barangays while also assisting in birthing services, dispensing medications, managing the Rhu when the physician was unavailable, and performing other duties. Some nurses reported working during weekends to complete their outputs. These findings closely correspond with the present participants’ accounts, particularly PHN4 and PHN5, who described the simultaneous management of patient care, disease programs, documentation, and reporting.

II. Health-System and Resource Constraints Affecting Care Delivery

This theme captures the structural conditions that limited the nurses’ ability to provide complete and timely services. Participants described shortages of medicines, limited facilities, unavailable laboratory services, inadequate supplies, and the need to refer patients to other facilities. These constraints interacted with workload and contributed directly to delays in treatment and unmet patient needs.

A. Medication and Supply Shortages

Medication shortages emerged as one of the most significant barriers to continuity of care. Nurses described situations in which patients could not receive medicines because supplies provided by the local government were insufficient or delayed.

PHN1: “Our problem sometimes is the lack of facilities to accommodate the patients. Like here, we have many catchment barangays but our center is small so we can’t cater to patients as much as we can.”

PHN2: “The problem we have here at Rhu is the shortage of medicine stocks. Although it was provided by the LGU there is a time that is really running out due to the number of patients who need free medicine.”

PHN3: “The difficult thing here is that when the vaccine is used up like for example flu vaccine, it will be too long before it is available again. Usually, the stocks are only once a year and then again next year, so instead of giving people free vaccines, we can’t give them. At the end, if the patient has nothing, they will not get vaccinated.”

PHN4: “In our TB dots program, every month patients get their medicines here. But there are times when the supply is really low due to the number of TB cases, we can’t give them all.”

PHN5: “Sometimes, the LGU’s supply allotment is not consistent. With the large number of patients to be catered for, the supply of medicines provided by the government does not fit.”

PHN6: “Apart from the drug supply running out, we also have a problem with the printing of paperwork since coupons and printer ink are running out. We cannot print all the paperwork and cases that are our quota.”

PHN7: “(I think the challenge here with us when it comes to finances is about the supply of medicine. It is the LGU that supplies the medicine to the Rhu. Now when the supply they gave runs out, you have to wait again

to have it. Sometimes, because the stocks take too long to arrive, we are unable to provide free services to our patients.”

The narratives indicate that resource shortages are not merely logistical inconveniences. They directly influence whether nurses can implement prescribed interventions. When medicines, vaccines, laboratory services, or even documentation supplies are unavailable, nurses are placed in a position where professional responsibility exceeds institutional capacity. This creates a gap between what nurses intend to provide and what the RHU is practically able to deliver.

B. Limited Facility Capacity and Referral Dependence

Resource constraints were also evident in the physical capacity and service availability of the RHUs.

PHN1: “Look at our health center, it's small. With the number of catchment barangays that we have, we cannot cater to all the patients because they are quite crowded and the services available are less.”

PHN2: “Due to the lack of medicine supply, we cannot provide free medicine to those in need. Ending that, instead of continuing the treatment, it stops especially if the patient doesn't buy medicine.”

PHN3: “When the vaccines run out, instead of being able to implement immunization especially for children, we are not able to fully implement it because there is a lack of supply.”

PHN4: “Communicable diseases like TB, don't you need to take care of them so that they don't get worse and don't get infected. But sometimes we run out of medicine at the center, we can't give them. Instead of starting the treatment immediately, we need to refer them to another facility because we cannot provide their specific needs.”

PHN5: “Due to the lack of services provided at the RHU, we cannot cater to all patients who need free treatment. For example, the laboratory requests, we cannot carry them out here because they are not available.”

PHN6: “When the supply of medicine runs out, we get piled up with tasks because the paperwork and reports become pending. Because sometimes the patient cannot buy anything, the progress of their recovery is delayed.”

PHN7: “Our clinic is only for prevention not all services are available. Even if you want to provide the patient with their needs, we cannot do it because that service is not available here. They need to be referred to a bigger facility.”

These accounts demonstrate that the nurses' capacity to respond to patients is shaped by the resources and services available within the RHU. When services are unavailable, referral becomes necessary. However, referral can also introduce additional delays and burdens for patients, particularly those who depend on free or locally available services. Therefore, accessibility is influenced not only by the presence of healthcare personnel but also by the availability of medicines, equipment, laboratory services, facilities, and functional referral systems.

The findings of the present study are further supported by Kanamori et al. (2026), who examined access to diagnostic services in a rural health unit in the Philippines. Their study found that although the RHU was required to provide a range of laboratory and diagnostic services, several tests were not available on-site and had to be obtained through external laboratories in other municipalities. Patients consequently had to travel approximately one to two and a half hours and incur additional transportation expenses to access these services. The authors emphasized that formal availability of a primary care package does not necessarily guarantee functional access when facilities lack adequate laboratory infrastructure and resources. This finding closely reflects the experience of PHN5, who reported that laboratory requests could not be performed in the RHU because the necessary services were unavailable. Similarly, PHN7 explained that patients had to be referred to larger facilities because not all services were available in their clinic. These accounts demonstrate that referral is sometimes not based primarily on the complexity of the patient's condition but on the limited

service capacity of the primary healthcare facility. Consequently, patients may experience additional travel, expenses, waiting time, and possible delays in receiving appropriate care.

III. Patient Engagement, Communication, and Cultural Determinants of Care

This theme illustrates how patient behavior, communication difficulties, health beliefs, and culturally influenced practices interact with the nurses' capacity to deliver effective health education and treatment. Rather than viewing patients simply as "noncompliant," the findings indicate that adherence is influenced by language, understanding, beliefs, trust, and previous health practices.

A. Communication and Health-Instruction Barriers

Participants experienced difficulties when patients did not understand or follow health instructions.

PHN1: "There are times when we have patients who understand the instructions but are unable to follow them, such as following the vaccination schedule for children or attending follow-up check-ups."

PHN2: "One challenge for me is that I'm not proficient in Pangasinan and not fluent because I'm really an Ilocano. Sometimes patients say, "Just speak in Tagalog, ma'am." Others may not understand even if I explain in the simplest way possible, so I repeat it. Here, we call someone who can speak the language to explain it in order for them to understand."

PHN3: "It can be frustrating when no matter how many times you explain, the patient still doesn't follow instructions. For example, with TB patients who are advised to quit smoking but still stubbornly continue. They can be defiant like that."

PHN4: "Perhaps it's their stubbornness, but I'm not sure if their religious beliefs play a role because they have certain beliefs. Before administering COVID vaccines or other vaccines, they refuse because of their personal beliefs."

PHN5: "Dealing with stubborn patients can indeed be challenging. No matter how many times you advise them, even with simple instructions, they just don't seem to grasp it in one go. You know how it is; sometimes, people find forbidden things tempting."

PHN6: "It can be tough when giving instructions, especially if some patients don't understand them. So, I really need to explain to them repeatedly."

PHN7: "It can be frustrating when patients are hesitant or resistant to follow our advice as nurses, especially when we warn them against certain actions, like advising a diabetic patient to avoid certain foods, but they still come back with high blood sugar levels because they've been disobedient."

These narratives suggest that communication is a two-way process rather than simply the delivery of instructions by the nurse. Language differences, health literacy, patient perceptions, and personal circumstances can affect whether health information is understood and acted upon. The nurses responded by repeating explanations, simplifying information, and seeking assistance from individuals who could communicate in the patient's preferred language.

B. Cultural and Traditional Health Beliefs

Cultural and traditional beliefs were closely connected with communication and adherence. Participants encountered patients who preferred traditional healers, questioned medical recommendations, or declined medications and vaccines because of personal beliefs.

PHN1: "It's difficult to advise them, especially when patients are more inclined to believe in traditional healers. Even after repeatedly explaining or providing health teachings to them, it's still challenging to convey because they don't believe in it. It's difficult to get them to adopt medical assistance. For example, there are

people with high blood pressure who refuse to take medicines, no matter what you say. There are situations like that.”

PHN2: “As a community health nurse, one of the challenges we face during home visits is when individuals are not easily encouraged. You know, we visit their homes, but they will hide or pretend to be absent, even though you know they're there. There are really situations like that.”

PHN3: “Sometimes, there are patients who are really difficult to talk to because of their various beliefs. You know, traditional healers. It's hard to explain things to them because you know they don't believe in you. For example, a patient with high blood sugar, we advise them on what foods to avoid, but they don't follow it.”

PHN4: “It can be challenging to explain sometimes because there's a conflict between the beliefs of the people here and our own beliefs. We're community nurses here, and it's our responsibility to provide them with health education, but sometimes it's just difficult because some are closed minded when it comes to medications or undergoing tests like that.”

PHN5: “Sometimes, it's tough when patients have opposing attitudes, like whether they're listening or not, because some patients doubt what we're saying. And there are also those who are persistent, asking the same questions, but when you see them, they're not really following our instructions.”

PHN6: “Sometimes I find it difficult to communicate with patients who don't believe, like when I prescribe medication, they don't take it because they believe more in traditional healers, thinking that a fever is caused by a curse.”

PHN7: “During the Covid pandemic, we encountered many VIPs, and we had to explain to them that they needed to follow the queue or line. There were many patients at that time, around 30% more than usual, and some were trying to cut in line. We explained with the help of barangay officials, and we clarified so they could understand. Because some of them wanted to go first, especially the officials. They wanted to be prioritized, especially when there was no vaccine yet. They wanted to be prioritized, especially the officials. As of now, we don't experience that anymore, except occasionally with medications when there's a shortage.”

The findings indicate that cultural beliefs influence healthcare-seeking behavior and acceptance of interventions. Importantly, the narratives show that nurses did not simply encounter “noncompliance”; they encountered differences in beliefs and expectations about illness, treatment, and health services. Consequently, culturally responsive communication becomes an essential component of public health nursing. The nurses’ experiences suggest that trust-building, respectful explanation, language adaptation, and collaboration with community members can facilitate acceptance of healthcare recommendations.

C. Difficult Patient Interactions and Emotional Demands

Patient interactions also created emotional demands for nurses, particularly when patients became angry, hostile, or unappreciative.

PHN1: “To me, you need to know how to set boundaries between your work and personal life. Of course, if you have a problem at home, you will bring it to work, of course you will not be able to act properly. Don't mix personal problems with work because you won't be able to concentrate properly, you won't be able to provide proper service.”

PHN2: “It's really unavoidable that there are patients who will get angry and that is not enough to insult you. You can't go along with that and get angry too. I just told myself inside to be calm and be patient because nothing will happen if you both explode in anger.”

PHN3: “Sometimes, you can't avoid feeling sorry for your patient which is something you shouldn't show because it might discourage him. So, we should have a border on being emotional, let's focus on giving the best care that can help them. Set aside your personal feelings at work.”

PHN4: “Maybe those patients with attitude, you really need to be patient for that. If the patient is angry, you shouldn’t be angry as well. Maybe just do breathing exercises and then be calm. Sometimes, I ask for help from my co-workers that they try to talk to the patient when my powers can't take it anymore and I might have a temper tantrum next”

PHN5: “Sometimes I really can't handle the paperwork I have to do because it stressing me out even more. So, sometimes I ask my co- workers to help me finish so that we don't get so stressed and disfigured, right? They also told me that if I ever need help, I should not be shy to ask. And it’s the same case for me. We’re helping each other here.”

PHN6: “Here in our workplace, if you have concerns, you have co-workers who will support you. If you need someone to talk to about a problem, they are willing to listen. You are already stressed about the papers to be submitted; they are to the rescue to offer help. We get along well here at work.”

PHN7: “My coping mechanism whenever I'm stressed at work were my pets at home. That's what makes me happy.”

These experiences reveal that emotional demands are intertwined with workload and patient interaction. Nurses must regulate their emotions while maintaining therapeutic relationships, even when patients are distressed or confrontational. Peer support emerged as an important resource because nurses could seek assistance from colleagues when emotional or workload demands became difficult to manage.

This finding is supported by Kawi et al. (2024), who examined health information sources and health-seeking behaviors among 1,202 Filipinos living in medically underserved communities. The researchers found that family and friends were the most common source of health information, while healthcare professionals accounted for only a smaller proportion of reported information sources. The study further found that many participants relied on herbal medicines, prayer, and other nonprofessional sources when ill. These findings suggest that health information received outside the formal healthcare system may influence patients' decisions and behaviors. The findings are also consistent with a study on Filipino patients' healthcare experiences, which identified culture and language as important influences on healthcare access and trust. Patients reported greater trust in healthcare professionals who communicated in understandable and relatable ways and demonstrated positive interpersonal behaviors. This supports the present finding that repeated explanation and language adaptation are not merely communication techniques but important mechanisms for establishing trust and encouraging patient participation.

IV. Consequences of Interacting Health-System Challenges

This theme describes the consequences that emerged when workload, resource limitations, communication difficulties, and patient-related barriers converged. The effects were experienced not only by the nurses but also by patients through delayed services, interrupted treatment, unmet needs, and reduced opportunities for comprehensive care.

A. Delayed and Incomplete Patient Care

Participants described circumstances in which patients could not receive immediate or complete care because of high patient volume, limited resources, medication shortages, and competing responsibilities.

PHN1: “Let's just say that there are many patients, since there are only a few of us here, that's why the response time is longer. We can't accommodate them immediately.”

PHN2: “Delayed access to medication can indeed lead to drug resistance and worsen the condition of the patient. It's crucial to address these supply issues promptly to ensure timely treatment for everyone in the TB DOTS program.”

PHN3: “Sometimes, we run out of medication here. Because it's not available, we need to wait, causing delays in the service provided to the patient.”

PHN4: “It can be challenging when patients have beliefs in alternative practices like traditional healers. This can affect the effectiveness of the health teachings we provide.”

PHN5: “When the medication is not available, there's a process to follow to obtain it. So even if the patient urgently needs it, we have to wait for its arrival. This delays the service because waiting is necessary.”

PHN6: “Due to repeatedly explaining instructions to the patient, instead of attending to multiple patients, I spend a lot of time with one patient. This delays my accommodation of other patients.”

PHN7: “You know, when you're stressed, sometimes you might come across as impatient with your patients. That could lead to them losing trust in you. It might make your health teachings less effective.”

The findings demonstrate how the different challenges reinforce one another. For example, high patient volume increases workload; workload limits the time available for health teaching and documentation; communication difficulties require additional time; and medication shortages can interrupt treatment even when nurses have completed their responsibilities. Thus, unsuccessful or delayed care cannot be attributed to a single factor. It is better understood as the outcome of interacting individual, organizational, and system-level determinants.

B. Emotional and Professional Consequences

The inability to meet patient needs also affected the nurses emotionally. Participants described frustration, disappointment, guilt, and exhaustion when they could not provide the care they believed patients required.

PHN1: “I get frustrated when I can't provide the needs of my patients. I feel like I didn't fulfill my role as a public health nurse.”

PHN2: “I felt like I failed to achieve my goal when my TB patient became resistant because the medicine was not available.

PHN3: “We nurses, we do home visits. They don't acknowledge what we say because sometimes they have something else to believe so it kinda hurt our feelings.”

PHN4: “It hurts when you explain everything, put in all the effort, and then they don't listen because they believe the local faith healer (albularyo) more.”

PHN5: “I'm disappointed with myself when they ask for help but you couldn't help them because the medicine is not available.”

PHN6: “It's just disappointing that there are unappreciative patients. You were helping them already but they are still hostile in answering you. It's doubtful if the help I gave really helped them.”

PHN7: “I was exhausted from the amount of paper works I needed to finish, so when I got home, I felt sluggish and tired.”

These narratives reveal that the consequences of system limitations are also emotional. Nurses may internalize unsuccessful outcomes even when the causes are beyond their individual control. The findings therefore highlight the importance of distinguishing professional accountability from system responsibility. Nurses remain committed to patient care, but their ability to achieve desired outcomes depends partly on staffing, supplies, facility capacity, patient participation, and organizational support.

C. Work-Life Spillover

The demands of public health nursing extended into the nurses' personal time, particularly through unfinished documentation and extended service hours.

PHN1: “I think it was about bringing my work at home. Bringing my paper-works at home for me to accomplish it and pass it tomorrow has been part of my life.”

PHN2: “It is normal for us to work overtime even if there’s no added salary for it since there are a lot of patients who needs our services. You can’t go home because you are the nurse.”

PHN3: “Once I finished my paper works, I offer my help to my co-workers that I will be the one who will accomplish it since it needs to be pass. So, I brought it at my home, I’ll finished it so that even in that small gesture I can help them and they won’t get stress.”

PHN4: “If you work in a rural setting, always remember being culturally sensitive, since patients here have a lot of different beliefs. So, you have to explain more so that they’ll believe you. It’s not about saying the instructions, it wasn’t like that at all.”

PHN5: “It wasn’t required by my work but I was doing it. My unfinished paper-works were like my assignments so I brought it at home. It needs to be accomplished, since I wasn’t able to finish it in RHU due to a lot of patients.”

PHN6: “It was extending my work time in order to accommodate our patients. It doesn’t mean that it is 12pm, it’s lunchtime. It doesn’t mean that it is 5pm, it’s time to go home. We need to render our services to our patients even if it is beyond our time.”

PHN7: “Just like what I do in my paper-works. Even if I don’t like to do it, I don’t have a choice. I need to accomplish it at home since I didn’t finish it in RHU. It basically means that I brought my work at home, that’s where I work overtime even if there’s no payment for doing it.”

Banzon et al. (2024) found that a rural Philippine primary care network experienced limitations in the availability of prescribed medicines, with private-sector partners helping to supplement medicine access. Their findings suggest that collaboration among healthcare providers can help address gaps in medicine availability and improve continuity of care. This is relevant to the present findings because the participants' ability to provide treatment was sometimes determined by whether the required medicine was physically available at the RHU. The communication-related findings are also significant. PHN6’s experience shows that when a patient requires repeated explanations, the nurse must spend additional time with that individual, potentially delaying other patients. Thus, communication is not separate from workload; it becomes part of the workload itself. Similarly, PHN7 indicates that stress may affect the nurse-patient interaction, potentially weakening trust and the effectiveness of health education. The consequence is therefore recursive: heavy workload can increase stress, stress can affect communication, communication difficulties can consume more time, and additional time demands can further increase workload.

V. Adaptation, Collaboration, and Professional Resilience

Despite the challenges, participants demonstrated various strategies to sustain service delivery. They used available resources creatively, managed competing priorities, collaborated with colleagues, attended seminars, and developed patience and resilience. These responses demonstrate that nurses were not passive recipients of difficult working conditions; they actively adapted to them while maintaining their commitment to patients and communities.

A. Resourcefulness and Strategic Problem-Solving

Participants described resourcefulness as a way of finding alternatives when conventional resources or approaches were insufficient.

PHN1: “You need to be strategic. Whatever resources are available, use those to solve any challenges that comes in your way.”

PHN2: “If you know your goal, you can really think of any way to achieve it. That no matter what challenges you've encountered, you will find a way. Because you were focusing on your goal.”

PHN3: “I always find a way because I want to help. As long as I can, it's not like when a problem comes, or there are many challenges, you just give up.”

PHN4: “It’s about being strategic. Especially to those who keeps on believing their beliefs. Find a way on how you’ll explain it properly.”

PHN5: “You have to be strategic in order for you find ways on how you'll overcome those challenges. Since helping your patient is your responsibility as the nurse.”

PHN6: “I am able to use here my skill of being resourceful. Resourcefulness like in times of struggles, I can find alternatives or ways to achieve my goals in providing certain services.”

PHN7: “Even if you are not very smart, broaden your mind. Ask yourself, what is the best way for me to overcome these challenges in order for me to provide the services that my patient needs. They say, if you don't want, there are many reasons, if you want, there are many ways. If you want to achieve your goal, be strategic to accomplish it.”

Resourcefulness allowed the nurses to continue functioning despite limitations. However, these strategies should not be interpreted as substitutes for adequate institutional resources. Rather, they demonstrate how frontline nurses compensate for gaps in the system. Their ability to adapt is valuable, but sustained reliance on individual resourcefulness may conceal organizational deficiencies that require administrative intervention.

B. Time Management and Prioritization

Time management was another strategy used to balance patient care, documentation, and program responsibilities.

PHN1: “You should be good on how you will distribute your time here. It doesn't mean that it's your free time, you would rest. You should try to accomplish your paper works during those times. That's why time management is the key here.”

PHN2: “Time management is very important here. Since your work here wasn't all about providing services to the patient, you also have paper-works, seminars etc.”

PHN3: “You should be good at managing your time here or else due to lack of time you won't finished things on time. We have paper-works to accomplish here so we need to find time on when are we going to do it in order to accomplish it on time.”

PHN4: “Here, we don't just provide the services to our patient. We report it. That's why we find any free time to do it in order for us to finish it and pass it on time. You should be good at managing your time here since we have a lot of activities here.”

PHN5: “You should practice time-management. If you're not excellent at it, you'll end up having load of unfinished works since you might not be able to accomplish them on time. Aside from accommodates our patients in order to provide their needs, we also have other things to do like those paper-works.”

PHN6: “You need to be understanding to your patients. Have a very long patience to them. Because in the future, there will be a patient that is stubborn, bad attitude or even you need to explain to them in many times or remind them.”

PHN7: “You need to learn how to manage your time. There are so many works, but your priority is to give the quality service based on your patient needs. One thing, find a free time where you can do your paper works in order for you finish it on time.”

The participants viewed time management as essential because their responsibilities were multidimensional. However, their accounts also demonstrate that individual time management has limits when patient volume, staffing, and administrative requirements exceed available working time. Effective time management should therefore be complemented by realistic workload allocation, adequate staffing, efficient documentation systems, and appropriate prioritization of essential services.

C. Collaboration, Seminars, and Workplace Support

Collaboration and continuing professional development provided nurses with additional knowledge and practical support.

PHN1: “Support from my co-workers. We do the work through collaboration and brainstorming. You will learn something new which you can apply it to your work. You learn something from them and they are also learning something from you.”

PHN2: “Yes, there were seminars conducted. It broadens our knowledge and I can share it to my patient through health teaching.”

PHN3: “They are also sending us in seminars. We learn from it. It helps us to be updated in the current trend of how we can implement in our RHU. They explain it properly and we gain knowledge on how are we going to implement it in our RHU.”

PHN4: “A support for our professional developments includes doing gatherings so that we can brainstorm. At the same time, we also have seminars that keep us updated in the current trends. We also help each other as a team.”

PHN5: “We work as a team. If we have gatherings, I learn something from them which helps me to have an additional knowledge that I can use while working as a public health nurse. For example, my co-worker told me that if I’m struggling to accommodate my patient that has a different belief, you need to explain to them in a way that they can easily understand and make it very credible that it can help them achieve health and wellness.”

PHN6: “There are many seminars that the government provide in order to to help us. It helps us gain knowledge and share it to our patients through health education or health teaching.”

PHN7: “We have a seminar provided by the government. It helps us in teaching health educations to our patients.”

These accounts show that workplace support functioned as both an emotional and professional resource. Collaboration enabled nurses to share responsibilities, exchange knowledge, and assist one another when workloads became difficult. Seminars strengthened their capacity to respond to changing health needs and communicate health information to patients. These findings suggest that organizational support and continuing professional development can strengthen nurses’ capacity to adapt to challenging community health environments.

D. Patience, Forbearance, and Professional Resilience

The participants’ experiences ultimately shaped lessons concerning patience, humility, continuous learning, and commitment to service.

PHN1: “As early as possible, practice your patience. Extend your patience because here, whoever your patient is before, they might become your patient again since you're in the RHU.”

PHN2: “Study diligently. Your knowledge will serve as your weapon to provide quality services to your patients.”

PHN3: “Extend your patience, my colleagues. There are numerous patients with difficult attitudes who may engage in confrontations with you. It's essential not to escalate the situation.”

PHN4: “Patience is crucial. You cannot engage in conflicts with your patients because it will only make them less likely to believe and trust in you, even if you're the nurse. They might even say they don't want you around because you're unfriendly.”

PHN5: “Be patient and be humble. It's good to build a close relationship with your coworkers and patients so they trust you more. You won't have a hard time giving them instructions like that.”

PHN6: “You should enjoy your work and be willing to share your knowledge with the community. It's also necessary to treat your patients with care so they feel comfortable with you.”

PHN7: “First and foremost, patience is key. We need to have a lot of patience in our duties, especially in RHUs, because we'll encounter many people who may not be well-educated. Just explain things thoroughly.”

This finding complements Aytona et al. (2022), who demonstrated that the workload of Philippine primary healthcare workers consists of numerous activities extending beyond direct patient care. Their findings suggest that staffing and workload assessment should account for the full range of activities performed by health workers. This is important in interpreting the present findings because the participants' need for time management was partly generated by the multiplicity of responsibilities assigned to them. The findings also support the principle that individual time management has structural limits. A nurse may prioritize tasks efficiently, but prioritization cannot completely resolve situations where patient volume, staffing limitations, documentation requirements, and program activities exceed the available working time. This was evident in earlier findings where participants brought unfinished paperwork home or extended their working hours.

CONCLUSION

The study concludes that the implementation of universal health services is shaped by the complex interaction between the professional responsibilities of public health nurses and the structural conditions within which care is delivered. The nurses' experiences revealed that high patient volume, extensive documentation, extended working hours, limited facility capacity, medication and supply shortages, communication difficulties, and culturally influenced health practices are interconnected rather than isolated challenges. These conditions may constrain nurses' ability to provide timely, comprehensive, and responsive care, while also contributing to emotional strain, work-life spillover, and difficulties in meeting patients' needs.

Despite these challenges, the participants demonstrated a strong commitment to their roles as public health nurses. They relied on resourcefulness, prioritization, time management, collaboration, continuing professional development, patience, and professional resilience to sustain healthcare services. Their experiences demonstrate that nurses are capable of adapting to difficult circumstances; however, individual resilience alone cannot compensate for persistent limitations in staffing, resources, infrastructure, and service capacity.

Ultimately, the effective and sustainable implementation of universal health services requires a systems-oriented approach that recognizes the shared responsibility of nurses, healthcare leaders, local government units, and other stakeholders. Strengthening workforce planning, ensuring reliable supplies and medicines, improving facility and service capacity, supporting culturally responsive communication, streamlining administrative requirements, and providing supportive working environments are essential to enable nurses to deliver quality care. The findings therefore emphasize that empowering public health nurses must go beyond encouraging personal resilience—it must also involve creating an organizational and health-system environment that enables them to fulfill their professional responsibilities effectively and sustainably.

RECOMMENDATIONS

In light of the findings and conclusions of the study, the following recommendations are proposed:

1. **Public Health Nurses** should continuously strengthen their competencies in community health nursing, effective communication, cultural responsiveness, health education, time management, and professional advocacy. They should also continue using appropriate adaptive strategies while maintaining their commitment to the health and welfare of individuals, families, and communities.
2. **Nursing leaders and health administrators** should regularly assess nurses' workload, staffing requirements, documentation demands, and distribution of responsibilities. Administrative processes

should be reviewed and streamlined when possible to minimize unnecessary workload and allow nurses to devote sufficient time to direct patient care and community-based services.

3. **Local Government Units (LGUs)** should establish regular consultation and feedback mechanisms with public health nurses and other frontline health workers to identify operational concerns, staffing gaps, and resource limitations. The concerns identified should be incorporated into local health planning, budgeting, and program implementation.
4. **Health authorities and responsible agencies** should strengthen the procurement, inventory, distribution, and monitoring systems for essential medicines, supplies, and equipment. Mechanisms should also be established to minimize shortages and ensure the timely availability of resources required for the delivery of universal health services.
5. **Communities and patients** should be encouraged to actively participate in health education, treatment planning, and other appropriate health interventions. Respectful communication and collaborative relationships between community members and public health nurses should be promoted to improve understanding, adherence, trust, and continuity of care.
6. **Nursing education institutions** should further prepare nursing students for community and rural health practice by integrating leadership, communication, cultural competence, health education, resource management, and systems-based approaches into nursing education and clinical experiences. Greater emphasis should also be given to developing nurses' ability to adapt to resource-limited and culturally diverse settings.
7. **Future researchers** may conduct similar studies involving public health nurses from other municipalities, provinces, or regions to determine whether comparable experiences occur across different settings. Further studies may also examine specific concerns identified in this research, such as workload, staffing, medication and supply availability, communication barriers, professional well-being, and their relationship to the quality and outcomes of universal health services.

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