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Closing the Gap:

Sharpening the Image of Nursing

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PHILIPPINE NURSES ASSOCIATION, INC.

VISION
By 2030, PNA is the primary professional association advancing the welfare and development of globally competent Filipino nurses.

MISSION
Championing the global competence, welfare, and positive and professional image of the Filipino nurse.

CORE VALUES
- Love of God and Country
- Caring
- Quality and Excellence
- Integrity
- "Collaboration"

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Editorial

The Image of Nursing: What Matters

This issue's theme: Bridging the gap: Sharpening the image of the nurse brings to mind several questions. What is/are the gap/gaps? What needs to be sharpened in the image of nursing? What is our image? What should be our image?

The recent developments and outrage in a political leader's image of a professional nurse is a clear indication that indeed the image of the professional nurse is wanting. Over the years, we have reacted, even condemned, media – in print, television and even movies, for misrepresenting our image and roles as nurses. While we have great images of nursing leaders such as the likes of the late Minda Luz Quesada, Mary Vita Jackson, Erlinda Ortin, Anastacia G. Tupaz, their impact has not gotten into the consciousness of the public. The image of an uncaring nurse, assistant/handmaiden, sex object, meek and timid, in a hospital setting, is the dominant picture, a stereotype. PNA Pres. Cadete claims that "Even after decades of keeping patients safe through critical thinking and technical competencies, nurses are still viewed as unintelligent and unable to make critical decisions without consulting a physician". These stereotypes have to go. Nurses must sharpen the profession's image!

Does the public know that nursing is extraordinarily demanding, not only physically but mentally and emotionally? Does the public know that nursing has specializations – field of expertise requiring critical thinking and focus? Does the public know that we have more independent responsibilities than just carrying out the doctor's order? That we spend more time with the patient than the doctor or any member of the health team, all rely on us for updates, observations and evaluations? Does the public know that it took us all four years of college education to be honed into the competent and compassionate nurse that we really are, with or without the work environment that we deserve? Well, maybe "yes" or maybe "no". What should matter then?

Dr. Borromeo, Chair of PNA's International Committee argues that "Nothing is further from the truth! Nurses demonstrate a commitment to excellence in clinical knowledge, skill and practice, and we combine this commitment to excellence with compassion for our patients". We are confronted with many life threatening situations every day and we make critical decisions and judgements and assessments. We contribute to the well-being of our patients. You have to be a smart professional to quickly make those leaps that promote excellent patient care. Nursing is critical to delivering health care in every corner of the world. Nurses are there when life begins and when it ends—offering expertise, comfort, and care. Nursing lies at the very heart of humankind's commitment to caring for one another. Nurses are essential to the health of all the world's people…brave, patient, energetic, creative, diligent, tireless, nutty, sweet, gentle, crucial, and relentless. Yet in the our country, nurses continue to receive unprofessional and demeaning treatment the very government that should protect its most important human resource, considered the backbone of the health system. As ICN Congress' delegates Ms. Tingda and Dr. Palaganas captured in a session's message, nurses all over the world "… are the backbone of the health care system. Yet we, the backbone, have been a neglected sector in terms of our wages, working conditions, benefits and security of tenure. Contractualization, low wages, infringements on our democratic rights (e.g. form and be part of a Union), forced migration, have impinged on our roles to be agents of change, to be

creative and innovative in our ways of providing health care. One session has aptly described the nurses' situation today as “modern day slavery” . Modern day slavery covers a variety of human rights violations such as forced labor with unemployment, underemployment, gender discrimination to name a few.” RPA's story, I am a Nars, tells these all. But is the public aware of all these? Again, maybe “yes” or maybe “no”. What should matter then?

This issue shows the many faces of the nurse in various fronts - clinical, educational and administrative areas. These can help advance the image of nursing. Three academicians have undergone the rigor of conducting research and publishing their work. Bandaay's Family Factors in Developmental Delays in Children Under Six Years Old; Lumanlan's Student Satisfaction in Today's Baccalaureate Nursing Program and Lazalita & Llanes' Echoing Challenges and Hopes Through the Cancer Journey. Nurses contribute to the profession's body of knowledge. This is a rigorous and scientific. This year's most outstanding professional nurse is Dr. Milabel E. Ho, a nurse, a researcher, a professor and the President of the Western Mindanao State University. Ms Nolasco describes this outstanding professional nurse as “Just wishing to be remembered as “a nurse who cares” this Zamboanguenan with a winsome smile and a commanding voice has gone a long way indeed. From being a staff nurse in 1978 to becoming a university president because she truly cared and walked her talk – such hallmark virtues eventually earned her the respect and accolades of her colleagues and the bigger world”.

Ms. Valbuena, coordinator of the Centre for Philippine Concerns (CPC), an organization of Filipinos and non-Filipinos in Quebec, shares the image of Filipino women, mostly nurses migrating to Canada as caregivers. As caregivers, they experience deskilling and their experience working in Canada under the LCP is not regarded as “Canadian experience” which is often demanded by employers of foreign-trained professionals. They escape an unhealthy economy in the Philippines but find themselves struggling with concerns such discrimination and overworked demands for remittances they need to send to their families and attending to other family priorities due to demands for remittances they need to send to their families and attending to other family priorities.

The International Nurses Week (May 6-12, 2013) is always a good time to examine and depict the image of the nurse. Dr. Anonuevo, walks us through the week long celebration – from the kick-off motorcade, to a press conference, symposium, talent show, photo-exhibit and the culminating wellness clinic and position paper's message: “Our nation cannot afford to view nurses as any less than they are: exceptional leaders who make a vital contribution to our nation's health. We must ensure that all Filipinos have a highly skilled nurse, when and where they need one”.

Yes, it is time we tell the public the real image of the nurse. We made efforts to sharpen our image to the public. But more than just letting the public know who we are, what we do, the realities of our working environments, our wages, or our rights and privileges is working and demanding for such rights and privileges. Rachel Hadassah Safeek, a nurse's daughter, “feels a moral obligation to properly gain insight into societal barriers in healthcare by working in solidarity with marginalized and vulnerable populations, indeed “Making the Elimination of Health Disparities a Personal Priority”. This is to be a people's nurse. It means showing a united front in responding to the social determinants of health. It means uniting the nursing profession. It means walking our talk. Let us continue our journey of the caring nurses that we really are… who is not only compassionate and competent but critical, militant, and nationalistic!

ERLINDA CASTRO-PALAGANAS, RN, PhD

President's Message

This issue's theme: **"Closing the Gap: Sharpening the Image of Nursing"**, is definitely timely. Due to various events since last year, nurses have never been so challenged. We have been confronted to educate the public of who we really are and what we truly do. We felt belittled, derogated and stereotyped. We suddenly became too pressured to correct the misconceptions about us and our profession.

Much has been said and reacted on some people's false remarks about the nurses. We need not say more. Yes, we are educated professionals being vital in the Philippine Health Care Delivery System and actually on the frontline, but we are just seen as handmaids of the doctors, eternally carrying out their orders. This nursing image problem is actually not exclusive to the Filipinos. Nurses from other countries suffer the same because of irreverent media portrayals. Some of us even appear "invisible" among health care professionals. Nurses' daily devotion, compassion and heroism are overshadowed by these trivializing of nurses.

As mentioned, we, ourselves, must play the lead in improving the image of our profession. With the social media in full use, let us share and post those outstanding and most positive contributions of our colleagues in the society. If bombarding them with facts is truly needed, so be it! Let us really put our modesty aside.

We need to emphasize our roles as caregiver, communicator, teacher, client advocate, counselor, change agent, leader, manager, case manager and a researcher. This is aside from our expanded roles as clinical specialists, nurse practitioner, nurse-midwife, nurse educator, nurse administrator and as a nurse entrepreneur. With all these roles, how can one imagine a world without nurses caring for around 7 billion people?

As we have asserted during the International Nurses Week Celebration last May 2013, now more than ever, nurses are positioned to assume leadership roles in health care, provide primary care services to meet increased demand, implement strategies to improve the quality of care, and play a key role in innovative, patient-centered care delivery models. The nursing profession plays an essential role in improving patient outcomes, increasing access, coordinating care, and reducing health care costs. Our nation can't afford to view nurses as any less than they are: exceptional leaders who make a vital contribution to our nation's health. We must ensure that all Filipinos have a highly skilled nurse, when and where they need one. It is only then, we can remove that nagging gap and truly sharpen our image.

Let us keep that our caring passion aflame! Mabuhay ang nars, mabuhay tayong lahat!

NOEL C. CADETE, RN, MAN
National President

Research Article

Family Factors in Developmental Delays in Children Under Six Years Old

Cheryll Bandaay, RN, MAN[1]

Abstract

Developmental delay in children under 6 years old is prevalent not only in both developed and developing countries. It is alarming that the number of delayed children is increasing. It is obliging to find out the family factors that possibly affect developmental delays in children six years old and younger. The objectives of the study were the following: (1) Describe the characteristics of families of children with developmental delays. (2) Determine the factors that significantly relate with developmental delays when comparing families of children, with delays and without delays.

The sample was composed of 52 delayed children and their families, and 52 normal children and their families who were purposively chosen. The data was collected from March to May 2011 with the approval of the Saint Louis University Research Ethics Committee. The Metro Manila Developmental Screening Test was used to test child development. The Parent Behavior Checklist was used to assess parenting behavior of mothers. A questionnaire was used to collect family and child factors.

The results of analysis revealed that higher frequencies of delays occurred in children one (23.08 %) and three (23.08 %) years of age; first born or only child (36.54%), and in households with three children or less (32.69%). Families of delayed children are of low socio-economic status, whose mother predominantly scored low in all categories of parenting. It was also found out that more frequencies of delays occurred in the fine motor adaptive sector (86.54%), followed by the language (69.23%), gross motor (38.46%) and personal-social (32.69%) sectors respectively.

Results of the chi square test revealed that expectation parenting behavior is significantly associated to developmental delay in the gross-motor sector (p 0.005) in children under six years of age. Developmental delays in the gross motor sector in the three to less than six-year-olds are significantly associated with father's occupation (p 0.009) and expectation parenting behavior (p 0.022).

Analysis of factors associated with developmental delays when comparing delayed and normal children revealed that family factors are not significantly associated with developmental delays. A sub-analysis of age groups however revealed that mother's occupation and developmental delays are significantly associated in the three to less than six-year-old age group (p 0.026).

It is concluded that children with developmental delays belong to families with disadvantaged socioeconomic status whose mothers scored low in all subscales of parenting behavior; and family characteristics, parenting behaviors of the mother and child characteristics are not significantly related to developmental delays in children under six years years old. Therefore, health workers should be more vigilant in identifying children with developmental delays regardless of family characteristics.

Keywords
Family, Child Development, Children, Developmental Delays, Parenting Behaviors

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Introduction

Children belong to the high risk sector of the population because of their immaturity. One of the problems they are at risk of acquiring is developmental delays. Children are said to be developmentally delayed if they fail to acquire a developmental task or if they fail to reach a developmental milestone at the expected time based on a standard norm (Staples, 2007). It includes delayed appearance as well as persistence of primitive reflexes as a child grows older (Heilbroner & Castaneda, 2006).

Factors that cause developmental delays can be categorized as established, biological, or environmental (Staples, 2007). Among the factors affecting developmental delays, the environmental factors are the ones that can be modified. Earlier researches would show that disadvantages on socioeconomic variables were consistent indicators in children with developmental delays (Emerson, Graham, McCulloch, Blacher, Hatton & Llewellyn, 2009). A study in Korea and Thailand however showed that socioeconomic status was not a risk for delayed development in children (Bang, 2008; Isaranurug, Nanthamongkolchai & Kaewsiri, 2005). A correlational study further showed that the monthly household income was positively associated with communication, gross motor, and problem solving skills (Handal, Lozoff, Breilh, & Harlow, 2007).

Background

The prevalence of developmental delays in a study conducted in Auckland showed that there are 33% of infants who have one or more delays (Slykerman, Thompson, Clark, Becroft, Robinson, Pryor et al., 2007). In a 5-year study on under 6 children, it was found out that 41.5% of 2111 children had abnormal results on the Denver Developmental Screening Test (Nair, Babu, Padma, Potti, Elizabeth & Jeyaseelan, 2007). It is also estimated that approximately 3% of children in the high-income countries have an intellectual or developmental disability (Leonard & Wen 2002, cited in Emerson, Graham, McCulloch, Blacher, Hatton & Llewellyn, 2008).

What is more alarming is the study in Taiwan which showed that the reported number of children with developmental delays increased by 7.7% from the year 2003-2007 (Lin, Yen, Wu & Kang, 2009). In a progressive country like the United States, there are about 16% of children with developmental disabilities (American Academy of Pediatrics, 2001).

The International Child Development Steering Group stated that “Poverty and associated health, nutrition, and social factors prevent at least 200 million children in developing countries from attaining their developmental potential” (Walker, Wachs, & Gardner, 2007). The International Child Development Steering Group enumerated the multiple risks that detrimentally affect the development of children in third world countries which include poverty, malnutrition, poor health, and unstimulating home environments.

In the local setting, statistical data similar to that is not available. Direct and hard evidence might not be available but the issue is very palpable through indirect data. Approximately 17.5% of the total population is comprised of children 0-6 years old (Council for the Welfare of Children, 2007). An estimated 13.5 million 0-6 year old children may be affected by problems involving growth and development. The residual effects can even compound the problems as children grow up to adulthood.

The immediate environment of the child is the family. Good care from the family will afford the child of an environment that is conducive for growth and development. Literature review was able to establish that environmental factors indeed affect child development. This study looked into the families of children with developmental delays and attempted to describe them and looked into their commonalities and differences. In the Philippines, there are few studies similar to this. The gap in knowledge that this paper endeavored to fill in is to describe the families of children with developmental delays in terms of family characteristics, parenting behavior and child characteristics. This paper attempted to explore whether the family factors relate to developmental delays. This paper also attempted to corroborate

whether the findings of earlier studies done in other countries relating socioeconomic status to developmental delays is the same for the Philippine setting.

Objectives

This study aimed at determining associations of family factors to developmental delays in children six years old and younger in Baguio City. The objectives of the study were the following: (1) Describe the characteristics of families of children with developmental delays. (2) Determine the factors that significantly relate to developmental delays when comparing families of children, with delays and without delays.

Methods

To be able to answer the research questions, a descriptive retrospective correlational design (Polit & Beck, 2004) was used. The sample size was computed using 10% level of significance and 80% power. The ratio of controls to cases: 1 is to 1. The software used for computation was Epi Info 6. As shown in figure 1, the sample was composed of 52 delayed children and their families, and 52 normal children and their families who were purposively (Rubin & Babbie, 2009) chosen from twelve *barangays* in Baguio City.

The delayed group included children, six years old and younger, who were identified to be delayed using the MMDST. Children who manifested developmental delays caused by established or biologic factors or who had any illness at the time of data gathering were not taken as cases in this study. The parents of the children who qualified for the study were also recruited as respondents. Identification of children with possible developmental delays was done purposively by seeking referral from local developmental pediatricians and from *barangay* nutrition scholars. The normal group was selected from the source population (Rothman, 2008). Once a delayed child was identified and recruited, a normal child was purposively sampled and recruited from the same community where the delayed child lives. The strata of factors that were considered to be able to match the delayed child include age and gender.

The Metro Manila Developmental Screening Test (Williams, 1985) was used to test child development. The MMDST has been validated concurrently against the Gesell test and showed a Pearson correlation of 0.97 (Layug, 1980). A predictive validation was also done showing considerable consistency between first and second MMDST testing, which was done two years later. The findings of the study showed r=.77, p<.oo1. The test was administered and scored as stipulated in the MMDST administration manual.

Three research assistants helped in administering the tests. An inter-rater reliability was done in order to assess the degree to which different raters/observers give consistent estimates of the same phenomenon (Trochim, 2006). In order to facilitate quality assurance of the data gathered, a written protocol was given to the research assistants.

The Parent Behavior Checklist (Fox, 1994) was used to assess parenting behavior of mothers. The reliability and validity of the PBC was computed using Alpha coefficients for the three subscales: Expectations 0.93; Discipline 0.85; and Nurturing 0.73. This was administered and scored as stipulated in the PBC administration manual (Fox, 1994). A questionnaire was used to collect family and child factors. Figure 1 shows the flow of Data Gathering.

The data was collected from March to May 2011 with the approval of the Saint Louis University Research Ethics Committee. A signed written informed consent from the parent who is of legal age was obtained prior to administration of the test. Since the participants included children six years and younger, assent to participate in the test was not obtained. The right to privacy of the mother and child dyad and confidentiality of information gathered were observed.

Results

Descriptive statistics, frequencies and percentages were computed for categorical and nominal variables. To determine the association between family factors and developmental delay, the chi square test statistic was used. This test is appropriate for testing statistical association of relations of nominal data like the

Figure 1: Flow of data gathering

Referral from pediatricians 72 children

Not found in their addresses 2 children

Tested for MMDST 66 children

Excluded due to over and under weight 4 children

Normal finding in the MMDST 6 children

Abnormal finding in the MMDST 60 children

Normal after retesting 4 children

Delayed after retesting 56 children

Without Match 4 Children

Members of the Delayed Group: 52 Children

Children tested for MMDST 60 children

Abnormal finding in the MMDST 8 children

Members of the Normal Group: 52 children

Delayed after retesting 3 children

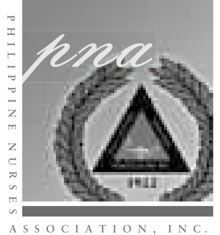
Normal after retesting 5 children

variables under investigation in this study. This test will also yield the p value which will determine the significance of the association.

Characteristics of Families of Children with Developmental Delays

The sample of delayed children is composed of equal number of male and female children (n=27) in this study. Most of the delayed children are 1-year-olds (23.08 %) and 3-year-olds (23.08%), the first child or the only child (36.54%) and belong to families with three children in the home (32.69%).

In terms of family characteristic, the findings show that most of the delayed children have families of low income (84.62%) and more than half of these delayed children belong to nuclear families (57.69%). About half of the parents have completed high school education as the highest educational attainment (mothers 50 %; fathers 51.92%). Majority of the fathers are skilled workers (86.54%) and more than half of the mothers are unemployed (55.77%). In terms of the parenting behavior, mothers of delayed children predominantly score low in all subscales of parenting: discipline (85.58%), nurturing (70.19%), and expectation (51.92%). When the delays are categorized per sector of development as shown in table 1, most of the delays occur in the fine motor adaptive sector (86.54%) and in the language sector (69.23%). There are 38.46% of the children who have delays in the gross motor sector, and 32.69% of the children have delays in the personal-social sector.



Family Factors that are Associated to Developmental Delays

Comparing the data of delayed children to the data of normal children gave way to finding out which of the factors significantly relate to developmental delays.

As shown in Table 2, the sample is composed of 52 children with developmental delays paired with 52 normal children. By chance, it turned out that half were girls and half were boys. In the delayed group, about a third of them were first born, 36.54% in the normal group, 40.38% were first born. Most of the children belong to low income families (delayed 84.62%, normal 94.23%), with the normal group having more low income families. More than half of the fathers of children in the delayed group (57.69%) did not finish college while more than half of the fathers of children in the normal group (53.85%) finished college. More than half of the mothers in both groups did not finish college (delayed 51.92%, normal 53.85%). Most of the fathers in both groups are skilled workers (delayed 86.54%, normal 84.62%). Most of the mothers were unemployed (delayed 55.77%, normal 71.15%). There were more children in the delayed group who belong to nuclear families (delayed 63.46%, normal 50.00%).

Table 1. Frequency Distribution of Delayed Children According to Family Characteristics per Sector of Development (n=52)

Family Characteristics		Personal-Social n=17 (32.69%)		Fine Motor Adaptive n=45 (86.54%)		Language n=36 (69.23%)		Gross Motor n=20 (38.46%)	
		F	%	F	%	F	%	f	%
Sibling Order	First born	9	17.31	16	30.77	13	25.00	6	11.54
	2nd and above	8	15.38	29	55.77	23	44.23	14	26.92
Family Income	Low	13	25.00	39	75.00	30	57.69	19	36.54
	High	4	7.69	6	11.54	6	11.54	1	1.92
Father's Education	College	10	19.23	19	36.54	14	26.92	8	15.38
	Non-college	7	13.46	26	50.00	22	42.31	12	23.08
Mother's Education	College	9	17.31	22	42.31	17	32.69	8	15.38
	Non-college	8	15.38	23	44.23	19	36.54	12	23.08
Father's Occupation	Skilled	15	28.85	38	73.08	30	57.69	15	28.85
	Professional	1	1.92	3	5.77	2	3.85	1	1.92
	Unemployed	1	1.92	4	7.69	4	7.69	4	7.69
Mother's Occupation	Skilled	6	11.54	21	40.38	18	34.62	6	11.54
	Professional	0	0	1	1.92	1	1.92	0	0
	Unemployed	11	21.15	23	44.23	17	32.69	14	26.92
Type of Family Structure	Nuclear	10	19.23	27	51.92	24	46.15	10	19.23
	Extended	7	13.46	18	34.62	12	23.08	10	19.23
Parenting Behavior									
Nurturing	High	4	7.69	15	28.85	13	25.00	7	13.46
	Low	13	25.00	30	57.69	23	44.23	13	25.00
Expectation	High	5	9.62	22	42.31	19	36.54	4	7.69
	Low	12	23.08	23	44.23	17	32.69	16	30.77
Discipline	High	2	3.85	7	13.46	5	9.62	4	7.69
	Low	15	28.85	38	73.08	31	59.62	16	30.77

Findings show that mothers in both groups scored low in nurturing (delayed 69.23%, normal 71.15%) and discipline (delayed 84.62%, normal 86.54%) parenting behaviors. It further shows that there are more mothers of normal children who scored low in nurturing and discipline. For the expectation parenting behavior, more than half of the mothers in the delayed group (55.77%) scored low while more than half of the mothers (51.92%) of normal children scored high.

Table 2 shows that family characteristics have no significant relationship to developmental delays. The result could have been brought about by the unintentional sampling bias wherein a homogenous group was unintentionally recruited which fails to reflect diversity in the population. The resulting sample is composed of an over representation of low income families and an under representation of high income families.

A sub-analysis of age groups was done based on the study done in Thailand which showed that there were more delays in the 3 to < 6 age group and that in contrast to the zero to < 2 age group, child upbringing was a significant factor influencing developmental delays in the three to six age group (Isaranurug, et al., 2005).

The sample of the delayed group was divided into the 0 to <3, and 3 to <6 age groups. For the 0 to < 3 age group, family characteristic shows no significant relationship to delays. In the sub-analysis of the 3 - <6 age group, as shown in table 3, significant relationship

Table 2. Number and Percentage of Delayed and Normal Children per Family Characteristics and Chi Square Analysis of Family Characteristics to Developmental Delays in Children 0 to < 6 years (n=104)

Characteristics		Delayed		Normal		p value
		n=52	%	n=52	%	
Sibling Order	First born	19	36.54	21	40.38	0.687
	Not first born	33	63.46	31	59.62	
Family Income	Low	44	84.62	49	94.23	0.111
	High	8	15.38	3	5.77	
Father's Education	College	22	42.31	28	53.85	0.239
	Non-college	30	57.69	24	43.15	
Mother's Education	College	25	48.08	24	43.15	0.844
	Non-college	27	51.92	28	53.85	
Father's Occupation	Skilled	45	86.54	44	84.62	n/a
	Professional	3	5.77	4	7.69	
	Unemployed	4	7.69	4	7.69	
Mother's Occupation	Skilled	22	42.31	13	0.25	n/a
	Professional	1	1.92	2	3.85	
	Unemployed	29	55.77	37	71.15	
Type of Family Structure	Nuclear	33	63.46	26	50.00	0.166
	Extended	19	36.54	26	50.00	
Parenting Behaviors						
Nurturing	High	16	30.77	15	28.85	0.830
	Low	36	69.23	37	71.15	
Expectation	High	23	44.23	27	51.92	0.432
	Low	29	55.77	25	48.08	
Discipline	High	8	15.38	7	13.46	0.780
	Low	44	84.62	45	86.54	

is reflected in mother's occupation (p 0.026) and developmental delays. The result suggested that children are more likely to be normal when their mothers are not working. It is possible that the time afforded for a child by mothers who do not work promote timely development. Children receive appropriate developmental stimulation if their mothers are not employed. Another possible explanation is that the presence of the mother in the home is an environment conducive for timely development.

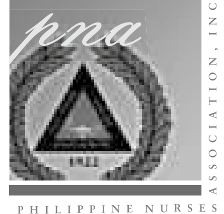
Family Factors that are Associated to Delays in Each Sector of Development

Earlier in this section, table 1 presented frequencies of delays per sector of development based on the data belonging to the delayed group, supplementary analysis of this data is presented in the succeeding tables.

The family characteristic that has a significant relationship with gross motor delays on children under six years old is expectation parenting behavior (p 0.005) as shown in table 4. The data suggests that gross motor delay is likely to occur in children younger than 6 years old if the mother's expectation parenting behavior is low. Low expectation refers to a behavior wherein the parent does not look forward to the achievement of developmental tasks. Possible explanation to this is the tendency of mothers to be overprotective towards their young children. In preventing harm or injury from happening to their child, mothers, inadvertently fail to give opportunity for gross motor development.

Table 3. Number and Percentage of Family Characteristics of Delayed and Normal Children and Chi Square Analysis of Family Characteristics to Developmental Delays in Children 3 to < 6 years old (n=56)

Characteristics		Delayed		Normal		p value
		n=28	%	n=28	%	
Sibling Order	First born	10	35.71	11	39.29	0.783
	Not first born	18	64.29	17	60.71	
Family Income	Low	25	89.29	26	92.86	n/a
	High	3	10.71	2	7.14	
Father's Education	College	9	32.14	13	46.43	0.274
	Non-college	19	67.86	15	53.57	
Mother's Education	College	12	42.86	13	46.43	0.788
	Non-college	16	57.14	15	53.57	
Father's Occupation	Working	25	89.29	26	92.86	n/a
	Unemployed	3	10.71	2	7.14	
Mother's Occupation	Working	14	50.00	6	21.43	0.026*
	Unemployed	14	50.00	22	78.57	
Type of Family Structure	Nuclear	20	71.43	17	60.71	0.397
	Extended	8	28.57	11	39.29	
Parenting Behaviors						
Nurturing	High	12	42.86	10	35.71	0.584
	Low	16	57.14	18	64.29	
Expectation	High	15	53.57	19	67.86	0.274
	Low	13	46.43	9	32.14	
Discipline	High	1	3.57	0	0.00	n/a
	Low	**27**	**96.43**	**28**	**100.00**	
*** Significant**						



The sample was divided into the age groups as done earlier. For the 0 to < 3 age group, family characteristics had no significant relationship to delays. In the 3 to < 6 year-old age group, which is shown in table 5, family characteristics that have a significant relationship to developmental delays are father's occupation and gross motor delays (p 0.009); and expectation parenting behavior and gross motor delays (p 0.022). The data suggests that gross motor delay is more likely to occur in delayed children aged three to under six years if the father is a skilled worker. However, it would not be accurate to conclude this because majority of the fathers are skilled workers (86.54%), thus, an over representation of this category and an under representation of the other categories, rendering the cells incomparable.

Consistent with the finding for the 0-<6 age group, association of gross motor delay and expectation parenting behavior (p 0.022) is also illustrated in the three to less than six age group. This association was not however revealed in the findings for the 0-<3 age

Table 4. Chi Square Analysis of Family Characteristics of Delayed Children to the Delays in each Sector of Development in Children 0-6 years Old (n=52)

Family Characteristics	Personal-Social	Fine Motor Adaptive	Language	Gross Motor
Sibling Order	0.087	0.709	0.924	0.439
Family Income	0.257	0.299	0.701	0.101
Father's Education	0.093	0.975	0.454	0.790
Mother's Education	0.625	0.766	0.853	0.357
Father's Occupation	n/a	n/a	n/a	n/a
Mother's Occupation	n/a	n/a	n/a	n/a
Type of Family Structure	0.628	0.189	0.472	0.111
Parenting Behavior				
Expectation	0.134	0.086	0.063	0.005*
Nurturing	0.430	0.310	0.211	0.601
Discipline	n/a	0.931	0.654	0.466
* Significant				

Table 5. Chi Square Analysis of Family Characteristics of Delayed Children to the Delays in each Sector of Development in Children 3 to < 6 years old (n= 28)

Variables	Personal-Social	Fine Motor Adaptive	Language	Gross Motor
Sibling Order	0.172	0.520	0.693	0.856
Family Income	0.078	0.006	n/a	n/a
Father's Education	0.483	0. 741	n/a	0.926
Mother's Education	1.000	0. 436	n/a	0.483
Father's Occupation	0.756	0.444	0.603	0.009*
Mother's Occupation	0.580	0.315	0.157	0.758
Type of Family Structure	1.000	n/a	n/a	0.201
Parenting Behavior				
Expectation	0.126	0. 216	n/a	0.022*
Nurturing	1.000	0.436	0.782	0.350
Discipline	n/a	n/a	n/a	n/a
* Significant				

group. A possible explanation for this is that gross motor delays are more evident in older age groups. It could also be possible that the effect of parenting behavior is not immediate and manifests its effect only when a child is exposed to it for a period of time.

Discussion

Family factors that significantly relate to developmental delays were detected in older children, aged 3 to <6 year old. A possible reason for this is that the effects of the family milieu take consequence after a few years of being exposed to such environment. Environmental risks for developmental delays, especially those that involve the family, entail basic needs, nutrition and shelter to provide psychological and emotional security (Staples, 2007). In order to have normal development, adequate environmental stimulation was needed. Adequate environmental stimulation was denied if a child lives in difficult situations like single parent, low socio-economic status and some cultural conditions (Mukherjee & Nair, 2008). These conditions interfere with normal interaction with the environment, which was at this time, the child's family, more importantly, the parents.

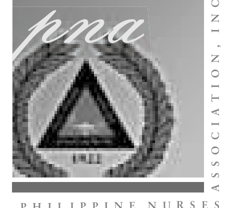
Lev Vygotsky's sociocultural model of child development highlighted that the child's parent was considered one of the more competent associates who make noteworthy influence on the child's development (Shaffer, 2008). Within the ecological framework of Urie Bronfenbrenner's ecologic theory, the child's family was also highlighted as one of the influential factors in child development under the microsystem.

Most of the delayed children manifested delays in the fine motor adaptive sector. Similarly, a study in Brazil including 35 children zero to six years old showed that delays were more frequent in the "fine motor adaptive" category (3; 42%), (de Moraes, M., Weber, A., de Castro e Oliveira Santos, M., & de Amorim Almeida, F., 2010). Corroboration between literature and the findings of this study implies that a child with fine motor adaptive delays will likely be delayed in the MMDST because it has an influence on the development of other sectors. The development of the neurologic system requires sufficient nutrition from conception of the child through the early childhood years, as well as sensory stimulation, activity and social interaction (Medina, 2008). Thus, a child with fine motor adaptive delays can also have gross motor delays and cognitive delays.

The findings also imply that fine motor adaptive delays occur more frequently in families who fail to provide enough to meet the nutritional requirement of a child from conception to birth and onwards.

Looking into the associations of family factors to the delays per sector of development, fine motor adaptive delays hardly showed association to developmental delays. It is possible that fine motor adaptive delays, as a reflection of neurologic development have better association biologic factors than environmental factors. Fine motor adaptive delays for the most part are affected by the maturation of the neurologic system (Heilbroner & Castaneda, 2006), which are usually caused by undefined prenatal conditions.

The family factors that showed significant associations are father's occupation and mother's expectation parenting behavior, both to gross motor delays. The finding of this study implies that in contrast to fine motor adaptive delays, gross motor delays are the ones that are affected by family factors. On occupation of parents, a study done in UK would show that households with disadvantages on parental occupation were consistent indicators in children with developmental delays (Emerson et al., 2009). Failure in the gross motor test was usually associated with an obese child or a child who was malnourished or who has no energy to carry out activities that involve large muscle groups (Martin & Fabes, 2008). Overcrowding in the home where the child has limited space to move was also found to be associated to delayed gross motor development (Joshi, 2005). In this study, there are more frequencies of skilled workers in the delayed group. These fathers are mostly on daily wages. It is possible that they have meager means in providing for the needs of their families. The data also suggests that gross motor delay is likely to occur in children younger than 6 years old if the mother's expectation parenting



behavior is low, as there are more frequencies of low expectation in the delayed group. A low expectation refers to a behavior wherein the parent does not look forward to the achievement of developmental tasks.

Although parenting behaviors were not significant variables for developmental delay in this study, it needs to be enhanced because the findings show that mothers scored low in all subscales of parenting.

The family is the immediate environment of a child. It is important that families know the importance of the mental, emotional, and physiologic support they can afford for the child. The challenge to health workers who would like to promote development to children of families with underprivileged socioeconomic conditions is to be able to plan for interventions that would address the nutrition, mental stimulation and emotional support of a child at a low or no extra cost for the family.

One of the limitations of the study was that the Parenting Behavior Checklist, which is a foreign tool, was not tested for its validity, taking into account that there could be cultural biases that could have affected the assessment of parenting behavior of the Filipino respondents. Another limitation is that the respondents who agreed to participate in the study are those from lower economic background.

Conclusion

Based on the findings, the following conclusions were made:

1. Children with developmental delays belong to families with disadvantaged socioeconomic status whose mothers scored low in all subscales of parenting behavior.
2. Gross-motor delays in children under six years old is affected by Expectation Parenting Behavior.
3. Mother's occupation is a factor that affects developmental delays in children aged three to six years old.

As a recommendation, Health workers should be more vigilant in identifying children with developmental delays regardless of family characteristics. It is also recommended to educate parents on parenting behaviors, specifically setting expectations in their young children to facilitate timely gross-motor development. Further, early detection of developmental delays will prevent further developmental delays in children.

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Research Article

Student Satisfaction in Today's Baccalaureate Nursing Program

Paolo T. Lumanlan, RN, MAN[1]

Abstract

Student satisfaction is one of the many important factors that any academic institution must consider for it is very helpful in refining academic processes, improving the quality of education, and evaluating the institutional efficiency. Therefore, this study aimed to (1) measure Filipino students' levels of satisfaction in today's BSN program, and (2) see the satisfaction differences between those enrolled in private and government higher educational institutions (HEIs). A cross-sectional comparative design was used. A total of 505 nursing students from different private and government HEIs in Central Luzon were conveniently recruited during the 2nd semester of A.Y. 2012-2013. Both descriptive and inferential statistics were run using the Statistical Package for Social Sciences (SPSS) version 20. Mean ratings showed that the students enrolled in both private and government HEIs are generally satisfied with their current baccalaureate program (x=4.02 and x=3.55 respectively). In addition, Mann-Whitney test revealed that there is a significant difference between the satisfaction levels of students enrolled in private and government nursing schools in the Region ($p<.05$). Overall, students are satisfied with the in-class teaching, clinical teaching, the program itself, and the support and resources of their department. However, those enrolled in government HEIs have lower satisfaction ratings as compared to those enrolled in private nursing schools. Academic administrators must further develop the instructional competencies of the faculty, as well as improve nursing facilities and laboratories by making them well-equipped, adequately-staffed, and readily available to meet

Keywords
baccalaureate, satisfaction, nursing education, Philippines

Introduction

Almost all HEIs continuously participate in a number of quality assessment activities that evaluate their academic performances through graduation, examination, and employment ratings (Chen, Farmer, & Wayman, 2012). In that manner, Weirs-Jenssen, Stensaker, and Grogaard (2002) believe that students may also share valuable insights in quality assessment for the enhancement of the program. In fact, student satisfaction is one of the factors in international competition and a criterion in obtaining accreditation in higher education institutions (HEIs) (Arambewela & Hall, 2009 and NLNAC, 2008, as cited in Kantek & Kazanci, 2012); thus, school administrators must work intensely to satisfy the diverse academic needs of their students.

In the corporate world, keeping the customers satisfied will eventually lead to loyalty (Haghtalab, Ahrari, & Amirusefi, 2011; Mittal & Lassar, 1998) that may serve as a strategy to attract other customers through word-of-mouth and by recommendations (Mavondo, Zaman, & Abubakar, 2000). In the academe,

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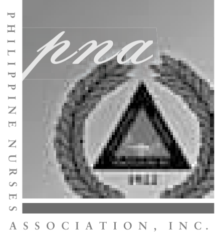

on the one hand, students are considered to be the most important clients and primary recipients of quality service (Douglas, Douglas, & Barnes, 2006). In order to keep the students completely satisfied, all teaching and non-teaching personnel in any educational institution must abide to the principles of quality customer service – which will then eventually lead to school fidelity, higher retention rates, and endorsement to other stakeholders.

Kantek and Kazanci (2012) believed that the value of student satisfaction is very essential in refining academic processes, improving the quality of education, and evaluating the institutional efficiency by enabling HEIs to modify their strategies to get a feel of their students' academic needs and to develop a structure that will constantly evaluate how successfully they meet or go beyond students' academic needs. Therefore, this must be highly recognized by school administrators due to the increased competitiveness of various educational institutions (Elliot & Shin, 2002).

Several scholars identified various antecedents of satisfaction in higher education. Researchers reported that students' expectations, perceived quality, image, and value of higher education significantly impact satisfaction levels (Alves & Raposo, 2007) and that students' experiences are directly related to their satisfaction and intention to stay in the academe (Kara & DeShields, 2003). In addition, studies have shown that satisfaction has significant impact on student motivation (Elliott & Shin, 2002), learning (Guolla, 1999), loyalty and perceived reputation of the school (Brown & Mazzarol, 2009; Helgesen & Nesset, 2007), and academic performance (Oja, 2011). However, on the other hand, dissatisfaction of students may result to diminished academic motivation and study behavior (Cor, Ellen, & Egbert, 2007) that might cause them to leave the institution (Freeman, Hall, & Bresciani, 2007).

It is in this reason that student satisfaction should be constantly assessed to address the emerging academic needs of the students and prepare them to become competent professionals in the future. It is suggested that by focusing on these aspects, HEIs can align their organizational structure, processes, and procedures to become more customer-oriented.

Background

In the Philippines, the Bachelor of Science in Nursing (BSN) program aims to prepare future nurses to demonstrate global professional competencies in the practice of the profession (Commission on Higher Education [CHED], 2009). However, the Philippine nursing education is currently faced with numerous concerns which include non-compliance by HEIs to government regulations and policies, gradual phasing out of nursing programs, dwindling and disturbing decline in the Philippine Nurse Licensure Examination (PNLE) national passing percentage (CHED, 2011),program costs, and decreasing enrollment. With all these, it is really vital to assess the satisfaction level of nursing students with their educational experience as this may help in the improvement of the academic program.

Study Purpose and Hypothesis

The primary goal of this study was to determine students' levels of satisfaction in their BSN program during the 2nd semester of A.Y. 2012-2013. This was done by measuring the quality of in-class teaching, clinical teaching, program, and the support services of the institution using the tool developed by Dennison and El-Masri (2012). In addition, this study sought to know the difference between the satisfaction level of those students enrolled in private and in public nursing schools.

It was hypothesized that there is no significant difference between the satisfaction levels of those enrolled in private and in public HEIs.

Method

Research Design

This study utilized a cross-sectional comparative research design to measure the differences between two groups on a single variable. Specifically, the design helped in determining the differences of nursing students' level of satisfaction on their current baccalaureate program as to the type of HEI they are currently enrolled in.

Instrument and Data Collection

The Undergraduate Nursing Student Academic Satisfaction Scale (UNSASS) (Dennison & El-Masri, 2012) was utilized in this study and permission to use the instrument was obtained from the corresponding author, Dr. El-Masri.

UNSASS is a 48-item inventory, answerable by a five-point Likert scale from 1 (strongly disagree) to 5 (strongly agree), that measures the satisfaction of nursing students as to in-class teaching, clinical teaching, program, and support and resources. Internal reliability test of the original study revealed an overall Cronbach's alpha coefficient of 0.88; while validity testing revealed a content validity index of 0.83.

In this study, internal reliability test showed an overall Cronbach's alpha coefficient of 0.98 which demonstrated a very high level of internal consistency with Filipino sample. The explanation of the study purpose, distribution and retrieval of questionnaires were done by intermediaries (faculty members).

Sampling and Participants

Through convenience sampling, a non-probability sampling technique, 505 junior and senior nursing students from different private and public HEIs in Bulacan, Pampanga, Tarlac, and Zambales were recruited to participate in this study.

Ethical Considerations

The technical and ethical approval was obtained from the University Research Council. The Council is composed of a variety of research experts who primarily evaluates research works and promotes scholastic research integrity. Prior to data collection, formal letters were given to the college deans of the identified HEIs to allow the researcher float the questionnaires in their respective departments.

The explanation of the nature of the study, as well as the distribution and retrieval of the survey instruments, were done by intermediaries (faculty members). Furthermore, students were assured of their right to refuse to participate or to withdraw at any stage during the study. Therefore, accomplishing the questionnaires imply consent from the study participants. The survey data were treated with utmost confidentiality and no identifying information was reported in any part of this study.

Data Analysis

All statistical tests were run using the Statistical Package for Social Sciences (SPSS) version 20. Frequency and percentage distributions, means, and standard deviations were used for description purposes. To test the difference between the levels of satisfaction of students enrolled in either private or public HEIs, Mann-Whitney test was utilized.

Results

A total of 505 junior (56.75%) and senior (43.25%) nursing students enrolled in the second semester of school year 2012-2013 voluntarily participated in this study. These students were recruited from the different private (73.61%) and government (26.39%) higher educational institutions in Bulacan (18.89%), Pampanga (54.27%), Tarlac (16.90%), and Zambales (9.94%).

It can be seen in Table 1 *(page 6)* that the students, both in private and government HEIs, are generally satisfied with their academic program (x=4.02 and x=3.55 respectively); however, students enrolled in state colleges and universities (SUCs) gave lower ratings as compared to those enrolled in the private nursing institutions. Moreover, these students from SUCs are uncertain of their satisfaction in the areas of in-class teaching (x=3.38) and the support and resources (x=3.29) available in their department.

To further determine if there is a significant difference on students' satisfaction level between the types of HEI, a Mann-Whitney test was utilized, with alpha level set at 0.05. Therefore, Table 2 *(page 7)* showed that there is a statistically significant difference between the satisfaction levels of students enrolled in private and in government HEIs as to in-class teaching (U=12542.5, p=.001), clinical teaching (U=12898.5, p=.001), program (U=13550.0, p=.001), support and resources (U=13519.0, p=.001), and their overall satisfaction (U=12954.5, p=.001) scores.

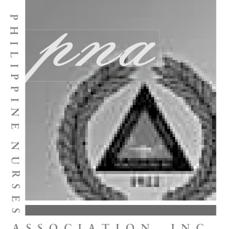

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Table 1

Mean Ratings of Students' Satisfaction according Type of HEI

Undergraduate Nursing Student Academic Satisfaction Scale (UNSASS) Items	Private	Public
In-Class Teaching	*3.92*	*3.38*
I can freely express my academic and other concerns to faculty members.	3.81	3.26
Faculty members are easily approachable.	4.11	3.59
Faculty members make every effort to assist students when asked.	4.17	3.52
Faculty members make an effort to understand difficulties I might be having with my course work.	4.05	3.42
Faculty members are usually available after class and during office hours.	3.88	3.52
I can freely express my academic and other concerns to the administration.	3.50	2.92
Faculty members are fair and unbiased in their treatment of individual students.	3.67	3.19
Faculty members provide adequate feedback about students' progress in a course.	3.99	3.38
I receive detailed feedback from faculty members on my work and written assignments.	3.79	3.44
Channels for expressing students' complaints are readily available.	3.65	3.15
Faculty members are good role models and motivate me to do my best.	4.02	3.57
The administration shows concern for students as individuals.	3.91	3.26
Faculty members demonstrate a high level of knowledge in their subject area.	4.21	3.74
Faculty members take the time to listen/discuss issues that may impact my academic performance.	4.07	3.49
Faculty members create a good overall impression.	4.02	3.42
I am generally given enough time to understand the things I have to learn.	3.90	3.49
Clinical Teaching	*4.03*	*3.48*
Clinical instructors are approachable and make students feel comfortable about asking questions.	4.02	3.48
Clinical instructors provide feedback at appropriate times and do not embarrass me in front of others.	3.84	3.31
Clinical instructors are open to discussions and difference in opinions.	4.05	3.60
Clinical instructors give me sufficient guidance before I perform technical skills.	4.16	3.66
Clinical instructors view my mistakes as part of my learning.	4.12	3.58
Clinical instructors give me clear ideas of what is expected from me during a clinical rotation.	4.16	3.52
Clinical instructors facilitate my ability to critically assess my client's needs.	4.11	3.60
Clinical instructors assign me to patients that are appropriate for my level of competence.	4.09	3.64
Clinical instructors give me verbal and written feedback concerning my clinical experience.	4.02	3.49
Clinical instructors demonstrate a high level of knowledge and clinical expertise.	4.19	3.67
Clinical instructors are available when needed.	3.95	3.42
Clinical instructors provide enough opportunities for independent practice in the lab and clinical sites.	4.11	3.64
Clinical instructors encourage me to link theory to practice.	3.88	3.39
Instructions are consistent among different clinical and lab instructors.	3.76	3.32
Faculty members behave professionally.	4.12	3.50
The Program	*4.15*	*3.66*
This program provides a variety of good and relevant courses.	4.15	3.66
The program enhances my analytical skills.	4.20	3.74
Most courses in this program are beneficial and contribute to my overall professional development.	4.23	3.75
The quality of instruction I receive in my classes is good and helpful.	4.18	3.72
I usually have a clear idea of what is expected of me in this program.	4.09	3.64
The program is designed to facilitate teamwork among students.	4.13	3.59
The program enhances my problem-solving or critical thinking skills.	4.23	3.73
There is a commitment to academic excellence in this program.	4.24	3.73
As a result of my courses, I feel confident about dealing with clinical nursing problems.	4.14	3.81
Going to class helps me better understand the material.	4.25	3.91
I am able to experience intellectual growth in the program.	4.20	3.92
Overall, the program requirements are reasonable and achievable.	4.12	3.77
Support & Resources	*3.94*	*3.29*
The secretaries are caring and helpful.	3.96	3.72
The secretaries behave professionally.	4.03	3.67
Support at the clinical and computer labs is readily available.	3.90	3.01
Computer and clinical labs are well-equipped, adequately staffed, and are readily accessible to meet.	3.90	3.05
The facilities (classrooms, clinical and computer labs) facilitate my learning.	4.08	3.36
Overall Satisfaction Rating	*4.02*	*3.55*

Table 2

Mann-Whitney test of students' satisfaction as to type of HEI

	In-Class Teaching	Clinical Teaching	Program	Support & Resources	Overall Satisfaction
Private (mean rank)	285.19	284.23	282.48	282.56	284.08
Government (mean rank)	161.30	163.98	168.88	168.65	164.40
U value	12542.5	12898.5	13550.0	13519.0	12954.5
p-value	.001	.001	.001	.001	.001

Discussion

The purpose of this study was to determine students' levels of satisfaction in their BSN program during the 2nd semester of A.Y. 2012-2013. In addition, it sought to know the difference between the satisfaction level of those students enrolled in private and public HEIs.

Results revealed that students are generally satisfied with the in-class teaching, clinical teaching, the program itself, and the support and resources of their department. However, results of the comparative analysis indicated that there is a significant difference between the satisfaction levels of students enrolled in private and government nursing schools. Those who were enrolled in SUCs have lower satisfaction ratings as compared to those enrolled in private nursing schools. Most of the uncertainties were addressed to faculty members and the support and resources in the department. Specifically, students are quite uncertain on how nursing faculty members deliver classroom and clinical instructions, give appropriate feedback to student performances, address students' academic and non-academic concerns, enhance students' intellectual development, and how they treat students fairly. Moreover, results suggest that students were also uncertain about the technical support that they need such as the availability of clinical and computer laboratories.

The results of this study are in consonance with studies conducted in other countries which found that student satisfaction is greatly affected by faculty-student communication (Umbach & Porter, 2002) and students' perception of teacher-student relationships (Wendorf & Alexander as cited in Kantek & Kazanci, 2012) wherein faculty contact is directly related to student satisfaction. Sohail and Shaikh (2004) reported that contact personnel greatly influenced students' rating of satisfaction – which was also supported by several studies (Surprenant & Solomon; Crosby et al.; Bitner et al., as cited in Sohail & Shaikh) – and that physical evidences (tangible services) come next.

They suggested that school personnel must be friendly and courteous and must be knowledgeable as to the policies and protocols. Faculty members must also communicate with the students as often as possible, by providing adequate feedback to students' progress. To further support these findings, Wellard, Woolf, and Gleeson (2007) believe that facilities and laboratories are vital in facilitating teaching and learning experience in any nursing institution – where exceptional educational experiences happen (Bradley & Postlethwaite, 2003). Clearly, students' perception of the school facilities is one of the main considerations of their intent to stay in the institution (Price, Matzdorf, Smith, & Agahi, 2003).

Therefore, due to the significant difference of students' levels of satisfaction, government HEIs that offer baccalaureate degree in nursing must further develop the competencies of their faculty members. Administrators must properly assess, plan, implement, and evaluate faculty development programs geared towards the improvement of tripartite roles of nurse-educators in instruction, research, and extension. However in this study, administrators may further refine the instructional capabilities of their faculty through trainings and seminars that will upgrade their teaching strategies and methodologies; develop effective interpersonal communication skills; enhance

constructive feedback mechanisms; and improve faculty's measurement and evaluation of students' cognitive, psychomotor, and affective learning domains.

Since nursing is a practice-based discipline, administrators must incorporate quality clinical training in their curriculum to prepare students in their actual workplace. This may be made possible by improving the facilities and laboratories of nursing schools that are well-equipped, adequately-staffed, and readily available to meet the needs of their students. According to Gomez and Gomez (as cited in Wellard et al., 2007) "student learning should be within a range of conditions that are experienced rather than simply focused on stable and unchanging conditions" (p. 2). This means that students must be exposed to practice settings to enhance clinical accuracy and develop confidence in dealing with actual patients.

Limitations and Directions for Future Research

First, to establish generalizability of the findings in the Philippine setting, a larger sample may be drawn through national surveys. Since measurement of satisfaction may involve response and self-selection bias, assuring confidentiality among the study participants is not enough. Therefore it is recommended that further validation studies may be conducted to fully capture students' level of satisfaction with their academic program.

In addition, the results of this study showed that students enrolled in government nursing schools have lower satisfaction ratings as compared to those enrolled in private HEIs. Future studies may be conducted to specifically determine the factors affecting students' lower levels of satisfaction in such type of government institution.

Lastly, other researchers may also venture on assessing the academic and non-academic needs of the students. By addressing these needs, the administration may be able to help, guide, and mold the students to become more successful in their chosen careers.

Conclusions

This study provided useful information in evaluating student satisfaction both in private and government HEIs. It was concluded that, generally, students are satisfied with their baccalaureate program. However, significant differences were noted as to in-class teaching, clinical teaching, program, and support and resources. Students enrolled in government nursing schools have lower ratings as compared to those in private colleges and universities. The study highlighted the need for school administrators to further develop the personal, professional, and instructional capabilities of their respective faculty members, as well as improve the institutions' facilities and laboratories to provide quality clinical training to their students.

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> "When I think about all the patients and their loved ones that I have worked with over the years, I know most of them don't remember me nor I them. But I do know that I gave a little piece of myself to each of them and they to me and those threads make up the beautiful tapestry in my mind that is my career in nursing."
>
> *~Donna Wilk Cardillo, A Daybook for Beginning Nurses*

Research Article

Echoing Challenges and Hopes through the Cancer Journey[1]

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Keywords
breast cancer, communication experiences, echoing, phenomenology

Abstract

Cancer as a disease exists as a global health concern. Among all types, cancer of the breasts was noted as one of the most common in the Philippines. Narrow focus has been attributed in understanding the communication experiences of patients and their spouses from the time of diagnosis to post treatment. Employing the descriptive phenomenological inquiry, the purpose of this study was to explore breast cancer patients and their spouses' lived experiences of their communication as a couple from their own frame of reference during the time of diagnosis and post treatment. Examining individual accounts of five (5) couples from an in depth qualitative interviews and following Colaizzi's method of data analysis, three main themes surfaced as similar among the participants: (a) Breaking the News (b) Hearing the Sound of Silence (c) Keeping the Faith. The three emerging themes reflect the couple's communication challenges during breast cancer illness and generated a continuum of varying emotions.The communication of couples during cancer was associated with great effort to find ways to build hope, stay together and found meaning and purpose to continue supporting each other. The couples in the study embraced cancer and brought them closer together.

Introduction

A diagnosis of cancer is undoubtedly distressing and most of the time overwhelming for both patient and the family (Chalmers, et al., 2003). A diagnosis of cancer is a challenge to the person having the illness and their family members (Mcleod, Tapp, Moules & Campbell, 2010). Consequently, concerns related to the physical and psychological impact of the disease has been greatly acknowledged (Boehmke & Dickerson, 2006). Thus, a holistic approach in the care of cancer illness has been the core and utmost consideration of the health care team globally.

Healthcare providers are the primary sources of information, and as such communicating with cancer patients is a challenge. Nurses as significant members of the health care delivery system must gain an understanding of the communication process in cancer illness from the viewpoint of the patient and family members to be able to provide the nurses a significant framework so as to effectively address the patient and the family therapeutically.

Reflections on the concept of communicating with a cancer patient emerged as the researcher had experienced difficulty on what to say to a family member, friend, and colleague diagnosed with cancer. Her experience as a psychiatric nurse does not spare her on the thoughts about "How will I approach him/her?" and "What do I tell him/her?" Thus, it is worth noting if these questions are also identified as a major concern of the family member of a cancer patient.

Although studies from the patient's perspective have consistently documented the significance of an effective patient and healthcare provider communication

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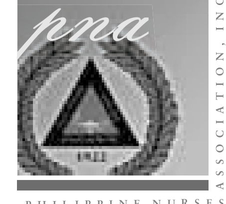


(McCarthy, 2010; Moyer, Sohl, Knapp-Oliver & Schneider, 2009; Step, et al. 2009; Best, Hiatt & Norman, 2008; Epstein & Street, 2007) and the role that communication can play on how patients experience the disease (Coyne, Wollin & Creedy; Street, Makoul, Arora & Epstein, 2009; Thorne, Hislop, Armstrong & Oglow, 2007), little is known about exploring cancer and communication within the family during the cancer journey and how couple communication impacts the cancer experience.

The World Health Organization (WHO) ranked cancer as a leading cause of mortality and morbidity worldwide. In 2010, an estimated 12.4 million new cancer cases and 7.6 million deaths from cancer have occurred worldwide as reported by International Agency for Research in Cancer (IARC). Although the 21st century has seen remarkable advances in early cancer detection, treatment and prevention, the incidence, prevalence and mortality rates for all types of cancers has noted a significant increase in cancer incidence all over the world (WHO, 2010). The global cancer burden doubled in the last thirty years and is estimated to double again between 2000 and 2020 and nearly triple by 2030 (WHO, 2010).

In the Philippines, the Department of Health (DOH) ranked cancer as third in the list of leading causes of death in the country, apart from infectious and cardiovascular diseases (2010). The leading cancer sites/types are lung, breast, cervix, liver, colon and rectum, prostate, stomach, oral cavity, ovary and leukemia (Philippine Cancer Society, 2009).

In Asia, the incidence rate of breast cancer among females is highest in Taiwan, Singapore and Philippines (Globocan, 2008). Cancers of the breast is now the most common cancer among women in the country, accounting for 16 percent of the 50,000 or 28 percent of the total cases of the dreaded disease and the number one cause of cancer morbidity and mortality among Filipino women accounting for almost 30% of all female malignancies (DOH, 2010).

Breast cancer is an illness of the couple, not a disease of the patient (Fletcher, Lewis & Haberman, 2010). There is a growing body of research that recognizes the impact of cancer on 'carers' and their needs (Luker, Wilson, Pateman & Beaver, 2003). As male partners may be subsumed under the term 'carer', existing studies provide little knowledge of the unique challenges male partners face such as long-term changes to relationships, roles and everyday life (Harrow, Wells, Barbour & Cable, 2008).

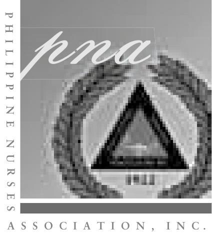
Spouses of cancer patients primarily responds to the demands related to their partner's illness. It is a fact that during the initial phase of the illness, spouses are frequently unwilling to add to the patient's burden by expressing their own needs (Ezer, et al., 2006). It is acknowledged that male partners can experience similar levels of distress as patients (Harrow, Wells, Barbour & Cable, 2008) and to be able to be effective in supporting women, they must be able to manage adaptively their own anxiety (Fitch & Allard, 2007).

Several studies have documented elevated levels of spousal distress (anxiety, depressed mood) and problems in marital communication (Baider, et al., 2003; Foy & Rose, 2001; Carlson, Bultz, Speca & St. Piere, 2000). Despite the magnitude of spouses' distress and its potential impact on their wives adjustment, there are few descriptive studies of the concerns spouses explicitly attribute to their wives' breast cancer (Fletcher, Lewis & Haberman, 2010).

Further, there have been some methodological limitations in previous studies of communication in the context of cancer; first, only a few studies have concurrently examined the perspectives of both patient and their family members regarding communication; second, there are limitations when research relies on only one partner, often the cancer patient to report on the communication between partners. The perception of one partner may be quite different from that of the other partner. Little analysis has been done regarding the relational dynamics that exist between breast cancer patients and their spouses. What is still needed is a descriptive study of couples' communication experience during breast cancer.

Methods

Employing the descriptive phenomenological inquiry, the purpose of this study was to explore communication experience in cancer and significantly contribute to current literature on cancer care. This method of investigation was a recognized research approach applicable in describing and transforming into language the phenomena of human experiences. The qualitative research design was chosen as an appropriate method to capture the experiences of persons with cancer and their spouses of their communication as a couple from their own frame of reference during the time of diagnosis and post treatment.This approach will involve direct exploration, analysis, and description of communication



experience of cancer patients and their spouses as free as possible from unexamined presuppositions aiming at maximum intuitive presentation and a capacity to stimulate our perception of their lived experiences while giving emphasis on the richness, breadth, and depth of these phenomenon (Streubert & Carpenter, 2011).

The study made use of purposive, non-probability sampling technique. The outcome of a qualitative study should be greater understanding of the phenomena (Streubert & Carpenter, 2011). Therefore, as the researcher seeks to inquire cancer communication among couples, the research participants were selected for the purpose of describing the communication experience of couples during a diagnosis of breast cancer. Study participants were chosen based from the inclusion criteria set by the researcher. First, the couples must be married and still living together after the diagnosis of cancer was made. Second, one of them was diagnosed with breast cancer within the last three years and had successfully completed the treatment phase. Lastly, the spouse must have cared for the patient during cancer illness.

The inquiry was conducted in the couple's homes as preferred by all study participants. The couple's homes played a significant role to their journey as they live with breast cancer and its treatment.A semi-structured questionnaire was used to access and capture the communication experiences of the couples during cancer illness. The participants in the study were asked the Grand Tour Question: Share your communication experiences as a couple during your breast cancer journey.

The researcher used an interview guide with a list of open-ended questions that outlined the main topics that the researcher would like to cover, but is flexible regarding the phrasing of questions and the order in which they were asked and allowed the participant to lead the interaction in unanticipated directions (King & Horrocks, 2010). This allowed an open dialogue extending beyond the parameters set by the researcher (Broom, 2005). The recorded information was personally transcribed by the researcher individually to minimize transcription errors and followed the steps of a descriptive phenomenology method of inquiry (Wojnar, & Swanson, 2007).

Mode of Analysis

Collaizi's (1978) Seven Steps of Phenomenological analysis was utilized to further analyze the data. First, the collected data as described by the participants about the couples' experience of cancer during cancer trajectory was reviewed. The transcription of the interview and the written descriptions were each read several times in order to get a sense of their total content; Second, the individual verbatim accounts were returned to participants for validation of their responses. The transcribed phrases or sentences directly pertaining to their description of the couples' communication experience were extracted from the original transcripts and were written on separate index cards; The third and fourth step was to spell out the meaning of each significant statement then organize the aggregate formalized meanings into clusters of themes; For the fifth step, formulated meanings and the clusters of themes were integrated into a narrative exhaustive description of the participants' lived experience of their communication as a couple during cancer illness; The sixth step was to describe, from the exhaustive description of the phenomenon, as unequivocal a statement of its fundamental structure of couple communication in cancer. The exhaustive description and the fundamental structure were then validated with the expert in phenomenological analysis. A final validating step was to return to the participants with the results of the analysis. The participants were asked if the fundamental structure of the phenomenon contained the essence of their original experiences. The five couples agreed that the fundamental structure of couple communication in cancer included the aspects they themselves had experienced.

Ethical Consideration

As this study involved cancer patients and their spouses as participants, ethical issues relevant to the study of human beings were considered. The researcher in response to the obligation to practice beneficence, treat the participants in an ethical manner by respecting their decisions, doing no harm, and maximizing their well-being. Moving on, the researcher respects the participants by protecting their autonomy through informed consent. The researcher ensured that prior to interview, each participant was knowledgeable of the benefits and risks of the study and voluntarily submitted self to participate. Further, the researcher maintained the confidentiality of information gathered during the interview and were not divulged to other people and for purposes other than this research. Also, the researcher documented the findings in a complete and objective manner, with full information on methodologies applied to allow assessments by colleagues and to increase public confidence in its reliability (Taylor, 1994).

Establishing Rigor

Consistent use of the method and the observation of bracketing were done by the researcher by putting aside pre-conceived beliefs about cancer and communication. This helped to ensure pure description of the data. Another way to confirm credibility of findings was doing member check (Creswell, 2003). Member check or respondent validation was done by the researcher during the interview process and at the conclusion of the study to increase credibility and validity. During the interview, the researcher restated or summarized information and asked the participant to determine accuracy. After the study has been completed, the researcher went back to the participants for them to critically analyze the findings and comment on them. The participants either affirm that the summaries reflect their views, feelings, and experiences, or that they do not reflect these experiences. If the participants affirm the accuracy and completeness, then the study is said to have credibility. This served to decrease the incidence of incorrect data and the incorrect interpretation of data. To ensure that the data collected were reliable and its findings were consistent and could be repeated over time, an inquiry audit or external audits (Creswell, 2003) that involved four experts in qualitative research and not involved in the research process to examine both the process and product of the research study was done. The purpose was to evaluate the accuracy and evaluate whether or not the findings, interpretations and conclusions are supported by the data.The findings was documented using audit trail as this process records the activities done over time and would allow the readers to clearly follow the line of thinking that the researcher used during data analysis. The researcher provided a thick description 'to enable someone interested in making a transfer to reach a conclusion about whether a transfer can be contemplated as a possibility' (Guba & Lincoln, 1985). Thick description is important as it places excessive emphasis on reliability. The results of the study will be used as a significant framework in understanding the communication of couples suffering from a serious health condition.

Findings

Examining verbatim accounts of five (5) couples from an in depth qualitative interviews and following Colaizzi's method of data analysis, the researcher extracted participants' significant statements and organized the formalized meanings into clusters of themes. Three main themes surfaced as similar among the participants: *Breaking the News, Hearing the Sound of Silence, and Keeping the Faith.*

Breaking the News

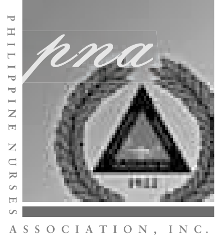
As the couples received the heart-breaking information that one has cancer, this emerging theme described the couples' communication challenges after a cancer diagnosis was made. BREAKING THE NEWS corresponds to the couples' experiences of resounding negative emotions brought by the sad information, which made their beginning journey with cancer difficult. Four communication challenges were identified by the couples during this phase which include grief responses such as disbelief (difficulty accepting the cancer diagnosis) as described by the cluster finding "*Dawning of an unexpected aberration*", bargaining (longing to live a longer life) as captured by cluster finding "*Bargaining for more time*", reducing fears and anxiety (engaging with positive people and thoughts) as described by cluster finding "*Taking a glimpse of what lies ahead*" and lastly the need to convey love and hopefulness throughout their journey in cancer (providing reassurance and feel a sense of security) as highlighted by the cluster finding *"Whispering Hope and Love."*

The couple's ability to integrate threatening information and concordance between the disclosure of information and their ability to deal with it was the first communication challenge along the cancer experience. Dominated by doubts that the diagnosis of cancer was unreal, disbelief as an initial reaction was noted as common to couples. A sudden threat to the couples' sense of normalcy caused a reaction of denial as their way of dealing with health adversity. As described by Psyche:

> *"The first time that I felt that there was a lump on my left breast I thought that it was just brought about by my monthly period. I never thought that it could be cancerous. Then it turned out, after the biopsy, that it was indeed cancerous. The first thing I thought of, it was blank, because all of a sudden I never expected that, although I'm aware that there are many cancer patients, I never expected that I can also be one of them."*

This was validated by Cupid's statements when he said:

> *"At first, she told me that she felt pain (left breast). But I told her that she might be suffering from premenstrual syndrome. Then weeks passed by, she went to the doctor*



for a check-up. Then she was scheduled for an operation which is the incision biopsy to see if it's malignant because the lump was increasing in size. So we took the first operation lightly but when we finally knew what the result was, things started to become more serious."

As Psyche fought over the unacceptable thought that she had cancer, another face of conveying denial was seen from responses made by Galatea which was cognitive avoidance. Acknowledging the reality was outweighed by ignoring the symptoms and not giving much attention to physical manifestations. This form of appraisal to a stressful situation was first seen as her way to cope with the disease. Galatea explained:

"... Every time we take a bath, we ladies will know if there is any change in our body. There you will feel if there are lumps. Since then, I noticed my lump grew faster. In one month time, there was a big difference... I visited a doctor. The doctor said we need to remove the lump, it's just mild. So I wanted them to put me to sleep. I went to three surgeons and they told me it will not happen because it's a minor surgery. I ignored it. I don't want infection and operation. I just used herbal medicines."

Although Galatea's partner Pygmalion felt compelled to maintain a positive attitude despite being worried with it, the wife's symptoms were taken lightly, minimizing the severity of the situation, and acknowledging treatment options such as surgery as common and helpful means. Pygmalion confidently stated: *"...Uhmm, of course I was worried, but the truth was, from my own view, since it was just a lump, I told her that it would be easy to remove it because it was just a lump. I knew that in the hospital, cases such as this, surgery is common."*

Bargaining for more time was the second communication challenge as represented by the cancer patient's statements after receiving their diagnosis. This highlighted their inner wish to continue their struggle with their overwhelming condition.

When I heard that, the first thing that came into my mind was that, of course my entire left breast will be removed, but then I thought that I want to prevent it. It doesn't matter anymore if I lose one part of my body. What's important to me during that time was my family. I need to live longer for my kids, for my husband, because we're not ready for this situation.-PSYCHE

The first thing I thought of..., of course my children are still studying, and I am worried about them. If you have a child, you want them to finish their studies and see them graduate. So I prayed, prayed.-GALATEA

I said to myself that this happened at the right time, I was already at my forty-eighth year so I really wanted to retire from my job. But I still waited until I was fifty years old then I resigned from my work and had my breast mass removed. I even told myself that last 2011 was really the right time to have my operation. My husband was already there, I already had my card, and my children are already grown-ups. –BAUCIS

It started 10 years ago, even before I got married, I knew there's something wrong because I usually do the breast exam and from that I was able to feel a small lump but I started bargaining with God. I told Him, "Papa God, I still don't have a child, wait". I told Him that I know that if I do the medications I would have to finish the process, I can't stop mid halfway, that's not possible, so I told Him, "Papa God, give me a child first".-ALCYONE

Reducing anxiety and fears was the third communication challenge as experienced in this theme. As the participants began to acknowledge the presence of cancer on their lives, their way to overcome the apprehension was to condition themselves with positive stories of people who had survived the illness, seeking information about the disease and its treatment.

I read magazines so I will know what will happen, and the testimonies of those who were cured. It was different when you know if you have [knowledge] about it. I interview patients with breast cancer so I can be strong to face my situation..-GALATEA

Ever since I knew, I'm still single when I feel the lump, so when I got strength to find out the truth, I do the research. If I felt weak, I stopped and waited again for the next year until I gathered all the facts and I prepared myself. -ALCYONE

As the fear of the unknown and uncertainty to treatment outcomes arise and dominated cancer patient's thoughts, the spouses respond by giving positive thoughts, words of encouragement and providing reassurance.

I told her that I'll be there with her, to help her. And I told her not to worry because it can be cured. Before we got home, we were kind of okay because we were able to talk about how we were going to face it.-CUPID

I didn't want to aggravate her fear, I'm just relaxed. I didn't say much. I just told her to have it checked but she didn't want to. At the same time, I also prayed, I was praying that she be okay. There were cases that I feel so concerned over her. There was this one time I told her that she shouldn't worry. She has a doctor and but she was also taking herbal medications.-PHILEMON

'That's nothing, Mommy. You can.' I always give her moral support by telling her that she can. I tell her to be strong and never to surrender against her condition because we can get nothing out of it. If she surrenders, she will not get well. But if she fights, we have a chance. If she fights, with God's help, we can overcome it.-CEYX

Overall, *"Breaking the news"* as an emerging theme elucidated how the cancer patients deal with their grief, negative thoughts, fears and uncertainty and how their spouses showed positive responses and be a source of emotional strength.

Hearing the Sound of Silence

Following a diagnosis of cancer, the women proceed through a similar clinical trajectory which includes surgery and chemotherapy. HEARING THE SOUND OF SILENCE as the second emerging theme that surfaced captured the couple's communication challenge of alleviating pain secondary to medical management. The cancer patients underwent series of medical interventions which made their emotional responses more diverse. The experience of pain due to treatment effects of chemotherapy was inevitable and it was in this phase that the woman recognized the need of having her spouse beside her. The spouse's presence and support made the participant withstand all the physical and emotional pain.

Three (3) communication challenges were identified in this phase which were described by the following clusters of themes *Being There* (offering self by constantly being present), *Holding On* (not saying anything but using touch and anticipating wife needs), and *Assuming Role* (adopting wife's roles and responsibilities). These cluster findings described the couple's nonverbal actions of staying together that enable them to withstand the physical and emotional difficulties during the treatment phase. As Psyche explained:

"During my very first chemo session, he was with me even though I knew that he's weak when it comes to things like that. After the IV was placed, I could really feel the pain, but he was there, rubbing my hand all throughout the procedure, although I know how tensed he was during that time (laughs). He from time to time would ask me if it hurts, and I would tell him that I'm fine. His mere presence during those moments made all the pain bearable. […] He's always with me. He's the one who took care of me, and he's always there to attend to my needs. Even during the surgery, he's always with me. He may not always say it, but I felt that he really cared for me through his actions."

The spouses' actions like the use of touch and anticipation of wife's needs were also helpful for both the participant and her spouse in dealing with the situation. These actions were also seen as a way of expressing their thoughts and feelings. The uses of non-verbal gestures in communicating were more apparent as the husbands reach out to their wife with cancer. All spouses expressed the need to provide their partners with both emotional and practical support, sometimes necessitating major changes to their usual routines and lifestyle. For example, 'Cupid' had taken a leave for six months in order to support his wife and became involved with her personal care. This observation was reinforced by Cupid's statements when he said:

"I'm the kind of person who acts more than speaking. I showed her how I support her. I even became more attentive to her. We were together for six (6) months. I took a leave from my work. I took home some of my work so I could be with her from morning to night. …I do household chores like cooking and doing groceries but I have no problems with that. I gave her everything she wanted to eat. During her therapy, when I see her getting bored, I'd be the one asking her to go out for awhile."

Zeus considers his wife needs by delegating tasks to their children and or doing the household chores for the family as he said:

"I didn't wake her up unless she has enough sleep. I do the household chores for her because I don't want her to do it. I also let my kids do the other household chores. Sometimes they hesitate to do it so I try to discipline them. [...] Sometimes, I absent myself from work to take care of her. […]Every morning, I cooked for them but sometimes when I have no time I asked my kids to cook. In the afternoon, when I come home from work, I started to cook while everybody including her try to clean the house. But when it comes to laundry, I don't let her do it instead I ask my kids to do it."

Ceyx gladly admitted that he was doing all the household chores for the wife. He willingly offered himself to do all of it as he confidently states:

"I did all of that (household chores). I don't want her to get tired. It's not good for her condition. Actually, what we really watched out for during that time was her immune system, it shouldn't get compromised. So I told her that I will be the one to do all the household chores. When the time comes that I think that she can do it, I will let her, because she also needs to exercise sometimes. ***[…]*** *It's not a problem with me. Especially now that I don't have work, we have to understand each other. I will take*

charge of the household, she will continue with her office works, and also take charge of our son since she's the one with income. By the time that I get a job, maybe that's the time that I will again be the breadwinner of our family."

In summary, the emerging theme *"Hearing the sound of Silence"* captured the couple's appreciation of each other's non-verbal efforts of communicating support and the spouse's provision of comfort thru their presence use of touch and adopting their wife's roles.

Keeping the Faith

This emerging pattern surfaced as the couple overcome the treatment challenges and highlighted the impact of cancer diagnosis to their communication and relationship. KEEPING THE FAITH as the last theme identified presented the couple's communication of conveying hope that they had successfully gone through the life-changing cancer illness together. An affirmation of closeness that the participants described as "greater than before", mutual openness, acceptance of their situation, and unfathomable love for each other were deeply felt by the breast cancer patients and their spouses during this phase. The couple's unending trust with each other, allowed them to overcome the continuum of negative emotions and pain brought by cancer diagnosis as described in the cluster finding "*Conveying Gratitude",* couples statements of appreciation and gratitude after successfully completing the treatment, "*Being Closer*" couples experiences of unity and harmony after cancer treatment and "*Advocating Hope*" by setting self as an example to other couples who had the same experience as theirs. Psyche was deeply grateful to Cupid as she stated:

> *"I want him to know that I was able to do everything. I survived, all because of my love for him. I still can't leave him. I love him so much, I still want to serve him, and I still have a lot to show him. I've been busy before I got sick. I wasn't able to spend much time with him. But when I got sick, I realized that all the material things, all the times I've spent working so hard, they're all nonsense. So I just want to tell him that at this point in my life, he's the one that I want beside me, from the moment I open my eyes every morning until the moment I close it at night. I really want to spend every single moment with him."*

Cupid felt that they more open in discussing topics about their kids, going back to work, and their daily concerns. They use humor and realized the importance of being open in expressing thoughts and emotions within the family as he conveyed:

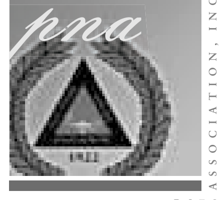
> *"We talk about so many things. First, the kids and then her work. After six (6) months of chemotherapy, we talked about her going back to work…Then we talked about more things like our everyday lives. These were not openly talked about before. Sometimes we joke around saying, "you had to be sick before we strengthen our relationship." I used to be quiet about my feelings and thoughts as I have mentioned earlier, but now I know that that was wrong. I learned that open communication is really important especially within family members. I want to set as an example to them. There were people who came to me and talked about their wives being diagnosed with cancer. I told them that we are very willing to share our experience. We became closer. We now understand each other. I can say that I have loved her more."*

Hera and Zeus were thankful that they were able to overcome cancer as a challenge. Hera was crying and emotional when she wanted to tell Zeus: "*I thought of you and my children. Since I got sick you took care of them. You were the one responsible to them. I am very thankful for that. […] I love you and my children very much. I don't want to leave you all yet.*

In the same way, Zeus felt happy how Hera was able to overcome cancer and its treatment as he uttered *"I'm happy that we overcome cancer as a challenge. We may have many debts because of her sickness but this didn't matter to me now. I value your life more, our family and our life together."*

Advocating Hope was evident in Baucis statements when she said:

> *"I have this friend who also suffered from cancer almost the same time as mine. At first, her mom called me and told me that her daughter has cancer and she doesn't want to undergo chemotherapy. So I told her that I'll visit them. And so I did one day and tried to convince her to have herself checked and treated. She asked me if I was okay, I answered yes of course. And I even told her that go ahead, have yourself treated, because after six months both of us will be okay. […] So it's like it became my purpose in life, to let people know that they don't have to be afraid. One time, a lady approached me and asked if what I was feeling that time. I asked her in return if she has a mass on her breast, and if it was regular or not in shape. I even offered myself to accompany her to the doctor but she resisted and told me she's scared. I wasn't able to convince her. So that's what I wanted to do, to convince those women who are already suffering from menopause to not be afraid of seeking consult. I really wanted to help those women. Because I know early detection is important. I want to be an advocate to let them know that they don't need to be afraid because*



they're not alone. Just always pray not to cure you but to guide you in your cancer journey."

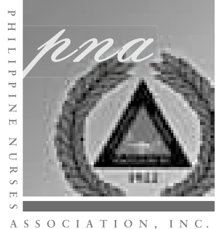
Alcyone also wanted to inform other breast cancer patients that *"it's not the end. It's a journey with Christ. Because that's where you will realize (crying) that He won't leave you. It's not as frightening as it used to be. Even the chemotherapy, it's not like what we read in the books or watch on TV, it's not that scary."* The overall communication challenge at this phase was centred on expressing gratitude to the spouse unrelenting support, displaying love more openly to each other, maintaining optimistic attitude for the future and by giving hope and inspiring others.

Discussion

This qualitative inquiry provided preliminary insights into the breast cancer patients and their spouses communication experiences as a couple as they lived with the disease and its treatment. The findings of this study captured a variety of communication challenges that the couples experience during each phase of their cancer journey. The family members' provision to support and care causes an enormous impact to cancer diagnosis (Plant, 1995; Edwards & Clarke, 2004; Harrow, Wells, Barbour & Cable, 2008). More often, the male partners are the most closely involved family member when a woman is diagnosed with breast cancer (Harrow, Wells, Barbour & Cable, 2008; Hoskins, 1995; Fletcher, Lewis, & Haberman, 2010). As an example, one study participant (Cupid) spends most of his time to be with the wife with breast cancer from the time of diagnosis until post treatment. He even gave up his work for a period of six months to take care of the sick partner especially during the treatment phase. Notably, these findings support the idea of cancer as a 'joint experience' (Illingworth, Forbat, Hubbard & Kearney, 2010) which began as patients and their spouses' journey together as they overcome their communication challenges after they received the breaking news of cancer diagnosis, face the pain in silence during cancer treatment and continue moving on with hope post treatment.

The significance of interpersonal relationships supports the research findings that close interpersonal relationships were clearly core mediating features in how the illness was experienced. This couples dynamics to cancer phenomenon can be further explained by Dyad-level theories (Manne, et al., 2011) which offered a framework to understand how couple processes affect behavior by accounting for the interpersonal (couple level) and intrapersonal (individual level) context of health behaviors as well as accounting for the unique level of interdependence in relationships). In this study, the cancer patients identified spouse encouragement as an important factor, or direct partner effect. This was highlighted after the woman received the diagnosis of breast cancer and the spouse responds by saying "We can" and "Let us seek treatment." Another facet of encouragement was the use of other cancer survivor past experiences to create a motivating message. These messages were related to the sharing of stories of trials that the woman with breast cancer had witnessed among other cancer patients, and the consistent support of their family and friends. Other examples of responses that indicated companionship as an important factor for couple communication include the ideas of ''being there,'' ''staying together,'' and ''being more open in sharing emotions with the spouse.''

While various studies attest to differences in how spouses adjust, we cannot ignore the effects of the gender-related response to illness, or the conclusion that men and women cope in totally different ways with illness in the family (Baider & Bengel, 2001). Epidemiological studies have characterized gender-related differences in social and instrumental roles, as well as in the quality of needs and support. The way in which couples adapt to their health problems and respond to the stress created by the illness may be influenced by the gender of patient and spouse (Baider, et al., 2003). In this study, the women initiate and communicate emotions; men try to avoid or withdraw from feelings and emotional demands. There is a trend towards expressiveness in women and instrumentality in men (Baider & Bengel, 2001). The significant gender and role differences associated with breast cancer may result in major differences in how couples share information and concerns during their cancer journey. Women were traditionally socialized to be open and more emotionally expressive; it is acceptable for breast cancer patients to openly talk about how the illness affects their lives. However, men, especially those holding more traditional conceptions of masculinity, often repress their emotions to show strength and invulnerability. The norms that "men don't cry" and "men need to be strong and tough" were the essential aspect of most masculine ideologies, which makes the communication between breast cancer patients and spouses difficult and at times impossible.



Similarly, breast cancer patients and their spouses achieved the same levels of adjustment to illness demands by organizing different behavior and coping mechanisms. The cancer patients and their spouses reveal and give emphasis to the impact of communication in their lives as they deal with negative emotions such as grief, fear of dying and uncertainty with treatment outcomes. Dealing with denial was one of the common communication challenges explored in cancer care (Owen & Jeffrey, 2008). Denial as a common initial reaction of the participants is normal to any condition that brings about grief and sadness such as cancer (Kübler-Ross, 1979). Due to this fact, cancer patients often prefer to keep conversations ordinary and normal rather than having emotionally intense conversations about the possible negative outcomes of their situation (O'Baugh, Wilkes, Luke & George, 2003) as focusing on negative aspects was considered unhelpful. Hence, women with breast cancer might distance themselves from the illness, preferring to talk about their life, hobbies, families and friends rather than their health condition. These coping strategies seemed to help them to find meaning and hope for the future (Kvale, 2007) and found to be associated with less emotional distress. In general, frequent and open communication about cancer seldom takes place within the family unit; avoidance of communication between patients and their families is a widespread phenomenon (Walsh, Manuel & Avis, 2005; Zhang & Siminoff, 2003).

Bargaining for more time is another communication challenge that the cancer patients experienced. Bargaining as the third stage of the grieving process (Kübler-Ross, 1979) where the grieving person attempts to postpone what is inevitable (e.g. death from a terminal illness like cancer) in order to find a way out of the situation. The cancer patients seemed to experience some sense of vulnerability as they deal with the unknown, including the possibility of death. At this point of their life, seeking meaning in their illness by turning to spiritual domains like attending to religious gatherings, praying and having time alone to communicate with the Almighty was taken as helpful means of maintaining hope throughout the cancer journey (Edser & May, 2007) which is seen as central to coping with this serious illness (Owen & Jeffrey, 2008).

Another communication challenge that the couples experience in journeying with cancer is maintaining a sense of optimism despite uncertainty. Optimism or an outlook of hopefulness and confidence is viewed as beneficial, more desirable than negative thoughts and pessimism. It has been argued that hope, or at least some realistic optimism with achievable goals, is an important component of cancer care, even when the patient is already terminally-ill (Twycross, 1997).

The treatment phase is one of the hardest times to go through in the patients' cancer journey. This is the time whereby the cancer patients undergo to a series of medical interventions. Thus, in essence, they are likely to experience physical side effects such as anemia, fatigue, hair loss, and infection (American Cancer Society, 2009). As these patients are faced with these problems, spouses' endless support and constant presence are greatly appreciated and needed. This goes to show that nonverbal communication can be of help to better express the feelings and thoughts of the participants. It is elucidated that nonverbal communication can be expressed through different forms such as facial expressions, touch, silence, listening and paralanguage (Argyle, 1988; Knapp & Hall, 2002). As the participants articulated that the mere presence of their spouses has made everything bearable. Further, the participants mentioned that simple reassurance of love and support served as big encouragement and empowerment to continue their cancer journey.

Communication in all phases of the cancer journey played an important role as it achieved optimistic outcomes for the woman with breast cancer and their male spouses. First, effective communication can positively affect couples' relationships. In the cancer population, holding back concerns is associated with lower marital satisfaction among couples, especially when patients experience relatively high levels of psychological distress or physical limitations (Hagedoorn, et al., 2000). Second, open communication between patients and families about cancer-related information is related to their positive adjustment, increased cohesion, and lower mood disturbance (Oh, Meyerowitz, Perez, & Thornton, 2007). Couples coping with breast cancer reported better adjustment when they are able to share information about the illness, its consequences, and their thoughts and feelings (Giese-Davis, et al., 2000; Pistrang & Barker, 1995) whereas cancer patients who hold back emotions and concerns report lower emotional well-being and more distress (Figueiredo, Fries & Ingram, 2004). It is also through their communication that they were able to move towards reintegration to normalcy as the couples tried to establish equilibrium between the woman's needs and the

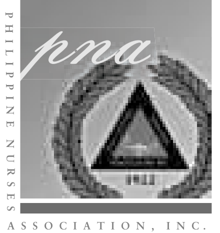
needs of the male spouse. As affirmed by one of the couples in the study they believed that they have successfully overcome the cancer challenge as a couple as Baucis verbalized *"I'm back to my normal self"* while her spouse Philemon conveyed *"Now that you have overcome this challenge, continue being strong and positive for us. I'm thankful to God that he did not let you feel so down and I am happy that we are back to our normal lives."* This study found that once the treatment was over, breast cancer patients and their spouses believed that they were ready to return to the "normal life."

To fully elucidate the phenomenon, an image of an ear was used as a symbol to describe the communication experiences of couples during their breast cancer journey. The ear as an anatomical structure is an important element in communication. It is through the ear that one would be able to listen to the messages and be able to respond effectively. As the couples journey together from the beginning of the breast cancer diagnosis, their communication experience was characterized by "echoing" which defined the couple's way of reverberating their thoughts and feelings to each other and how these thoughts and feelings bounces back to each other as messages and precipitated a response. In its literal sense, an echoe is a reflection of sound arriving at the listener some time after the direct sound. An echo is a means to send back the sound of, it is a consequence or a repercussion. In this study, echoing as it was narrated by the participants' accounts is a communication strategy for the women with breast cancer to echo her emotions during her cancer journey. As the couples embraced cancer as a joint experience, the male spouses received this echoes of emotions as a message of communicating their female spouses' innermost thoughts, feelings, emotions, fears, uncertainties and anxieties which prompted a response. As the couples began to receive the sad information of cancer diagnosis as represented by the pink ribbon highlighted in the emerging theme "Breaking the News", the female spouses may not directly convey thoughts of uncertainty to treatment outcomes and fear of dying to each other because of their denial, however, their male spouses still responded to these emotions positively by giving messages of optimism, love and hope. Two ears that form the shape of a heart captured the emerging theme "Hearing the Sound of Silence" which portrayed their communication experiences during treatment by being together, valuing presence and conveying love and support through actions like anticipating the needs of wife and assuming her role. As they move forward together after treatment, "Keeping the Faith" as represented by the image of a man and a woman inside the cancer ribbon conveyed that the couples embraced cancer and brought them closer together and made them more empowered to face the future with the assurance that they are still together despite the difficulties that they had encountered. The couples value their experiences and wanted to inspire others by being an advocate of hope.

Fig. 1. The Couple Communication Experiences in Breast Cancer

Conclusion

The findings of this study illumine the couple's communication experiences during breast cancer and gave insight as to the breadth and depth of these experiences. The cancer journey created communication challenges not only for breast cancer patients, but also for their spouses and generated a continuum of varying emotions. The research provided evidence that is relevant to the care for individuals and spouses coping with breast cancer at different points in the illness trajectory. New insights to the importance of the role of couple communication as coping strategies for women with breast cancer has been explored in this study. Communication between partners played an important role during breast cancer. "Echoing" is a means of the couples to convey thoughts and emotions associated with the diagnosis of breast cancer. It is a communication strategy that is capable of putting meaning and giving sense to how cancer was experienced and increased the couple's sense of control in coping with the uncertainty of cancer. Communication provided the cancer patients and their spouses faith and companionship as well as with opportunities to exchange information and share feelings and concerns. This sharing helped the couples to stop thinking persistently about upsetting events, developed insight into each other's perspectives about the situation, and to clarify the meanings of their experiences. The communication of couples during breast cancer is associated with great effort to find ways to build hope,



stay together and found meaning and purpose to continue supporting each other. The couples embraced cancer and brought them closer together.

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Feature Article

Professional Nursing: Scientific Practice or Simple Care?[1]

Rozzano C. Locsin, RN, PhD, FAAN

Marguerite J. Purnell, RN, PhD, AHN-BC

http://www.perpetualdalta.edu.ph/

Recently, the Philippine news media was abuzz about the image of nursing and how this unique practice is perceived. A prominent public figure inaccurately described the role of a nurse as "a room nurse," that is, one who does not need a baccalaureate degree because "they" are "mag-aalaga lang" or offer simple care. Obviously, this characterization can be offensive to scholars and practitioners alike at the core of professional nursing practice. When viewed from a different lens, however, an excellent opportunity is presented for the Filipino nurse to reflect on the lived meaning of professional nursing practice, and how the Filipino professional nurse is viewed by the public. Since nursing exists at the coming together of many disciplines in healthcare, this consideration is an important one.

How is nursing studied?

The highly technological environments in hospitals and other healthcare institutions apply social and economic pressures for contemporary nursing to be studied from a positivistic view of human beings (Silva and Rothbart, 1984), in which human beings are regarded as a collection of parts, and placing the study within a Newtonian "cause and effect" milieu. Exemplified in these views are the intensive study of the anatomy, and physiology of human beings, and the pathophysiological processes of diseases which are common to the multiplicity of disciplines in health care. Through these lenses, however, nursing science and expert nursing practice are often mistakenly pooled together with the knowledge bases of other disciplines,

[1] *Reprinted from The Philippine Star, May 9, 2013; www.philstar.com/science-and-technology/2013/05/09/939881/professional-nursing-scientific-practice-or-simple-care*

rendering the unique practice of nursing virtually indistinguishable. It is understandable then, if various notables, who are assumed to be knowledgeable about healthcare, fail to comprehend even a small portion of the complexity and scope of the human sciences underpinning expert nursing practice.

The focus of nursing

In pursuit of a greater understanding, foundational questions to consider reside within the nature of the vulnerable human beings who are the focus and recipients of nursing care. What are their concerns? What matters to them? Should their concerns matter or should only knowledge of human parts and the pathological bases of disease direct nursing practice? Nurses are most popularly consigned to hospital settings which support a practice that is procedural and task-oriented, thus optimizing the efficient use of technology and minimizing human choices that might deviate from the unmistakable values of the instruments employed. The valuing of sensitive, expert nursing practice as positively influencing human health and well-being has suffered immeasurably from this separation of nursing values from patients' values and from their needs beyond the immediacy of the physical. What many may fail to realize is that the professional nurse is educationally prepared and highly skilled to expertly practice professional nursing, and to know human beings as persons who have hopes, dreams and aspirations (Boykin and Schoenhofer, 2001) and to live meaningfully as healthy persons. The person who is nursed and valued from any other narrower foundation of knowledge is deeply disadvantaged.

Science-based professional practice

The primary description of nursing in the public eye is developed from the visible activities that the nurse demonstrates in hospitals and other institutional settings. However, what may be invisible to most is that professional nursing is based on nursing science. This unique science is grounded in knowledge derived from rigorous research about nursing phenomena of interest; those human care responses to health, illness, and the maintenance of well-being. Thus the function of nursing is focused on promoting human health, preventing illness and facilitating early interventions. This is reflected in the professional nurse's license that authorizes the practice of nursing across a wide range of areas and venues: It is not merely limited to the practice of nursing in the hospital setting. Nursing practice in hospital settings is just one of many areas of nursing; however, it is important to note that this type of practice receives the most recognition and indeed, glamour, as the practice area where one can distinguish the true meaning of nursing and find the ideal demonstration of that which is called professional nursing.

Professional nursing in hospital settings

Without doubt, the exigencies of hospital nursing demand a practice that is characterized by technological expertise and sensitivity to the demands of a theoretically based human health care practice. While not commonly acknowledged outside of nursing, theories developed specifically for nursing practice serve to affirm and illuminate an environment that best serves the patient, the nurse, and the institution. One such theory, the theory of Technological Competency as Caring in Nursing (Locsin, 2005), serves nursing practice well by situating nurses within a technological milieu yet focuses on nursing as knowing persons who are participants in their care rather than simply being “objects” for nurses' care. The process of technological knowing as nursing (Locsin, 2009, 2010) as a rich professional practice is the ideal in such environments: the nurse is drawn to participate in the human practice of knowing persons yet is “at home” in the highly technological environment of contemporary health care.

Grounding values

Contemporary nursing practice is unfolding in myriad ways. Grounded within rigorous science and flexibly responding to the needs of society, professional nursing is thriving in an era of challenges, and moving toward a futuristic practice. However, it is the knowing and understanding of the one nursed that substantiates the existence of nursing as a discipline of knowledge and a practice profession. This same understanding refutes reportage that misrepresents

such a valued, honorable profession, and alternately holds fast to the idea that each human being is valued, and intrinsically worthy of receiving humane, expert care.

Professional nursing does just that.

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Feature Article

MILABEL ENRIQUEZ-HO, 2013 PRC Outstanding Professional, a 'Who's (W)Ho' in Philippine Nursing

Eleanor M. Nolasco, RN

Who's w(Ho)? Milabel Enriquez-Ho, that's who. Minus the pun, who indeed in the nursing circle has not heard of or at one point came across, or even brushed shoulders with Dr. Ho? A PNA lifetime member of good standing with more than 3 decades of solid nursing practice behind her, Dr. Ho is consistently in the thick of things as far as the nursing profession is concerned. Her deep involvement and participation in important activities and events pertinent to nursing through the PNA has significantly contributed to the latter's evolution as a professional organization that impact on the entire nursing practice. Her leadership and analytical skills honed in the Academe and other arenas of learning are always optimally utilized in important events like annual nurses' convention, international assemblies, acting in various roles as convener, facilitator, organizer, coordinator, or even simply as delegate with insightful inputs.

Her almost 20-page impeccable portfolio as a professional nurse creditably attests to her having "amply demonstrated professional competence of the highest degree and conducted herself with integrity in the exercise of her profession; and contributed to the advancement of the profession and effective discharge of its social responsibility".

It is also quite fortuitous that this recognition and award came a year after her ascent as the 5th President

of the Western Mindanao State University, a premier institute of higher learning in Region IX and one of the leading universities nationwide. It was a position that bestowed a huge honor but carried a monumental responsibility to which Dr. Ho proved equal and more. In her first year as university president she has initiated and sustained projects that boosted faculty development, modernized university facilities, enhanced learning-teaching programs and strengthened partnerships and linkages with other community stakeholders that further entrenched the respected image of the institution with its guiding post, "Un Famili, Un Universidad, Un Amor".

Another milestone in Dr. Ho's nursing career was having been chosen recipient of the "Anastacia Giron-Tupaz" Award in 2007. Such an award granted to exemplary nurses is considered the highest recognition that a Filipino nurse can aspire for, if not the most prestigious.

Just wishing to be remembered as "a nurse who cares" this Zamboanguenan with a winsome smile and a commanding voice has gone a long way indeed. From being a staff nurse in 1978 to becoming a university president because she truly cared and walked her talk – such hallmark virtues eventually earned her the respect and accolades of her colleagues and the bigger world. Thankful as she is for a "successful" career, what makes her even more grateful is seeing her two grown-up children carve their own niches in the professional world.

Dr. Milabel Enriquez-Ho is one outstanding nurse indeed most worthy of the 2013 PRC Outstanding Professional Award.

> "Caring is the essence of nursing."
>
> ~ *Jean Watson*

Feature Article

Filipino Women Caring for Your Health : But what do you Care?

Joyce Valbuena

Nurse watching over expectant mother by timefornurses, on Flickr. Photo used with Creative Commons license – Attribution.

In a country where nearly 33 percent of the population live under the poverty line, and where there is a rising unemployment rate, the drive to migrate for a better job and a better life remains a strong option for Filipinos.

Here is a classic story. Right after finishing her bachelor's degree in nursing, Linda flew to Canada to work as a caregiver at age 22. She did not bother taking her licensing exam or practicing the nursing profession in the Philippines in the hope that she would get brighter rays of the sun in the Americas to have a greener pasture. In the Philippines, a nurse has an average salary of $400 per month, whereas a caregiver in Canada earns about $2,000 a month or more. Like Linda, thousands of Filipino women and men choose to work abroad to support their families' needs.

The Philippines is one of the biggest sources of migrant labor serving the global economy. As much as 4,000 workers leave the Philippines each day, most of whom work in gendered occupations, such as nursing, domestic work, and entertainment. Many Filipinos migrate because they are able to earn higher wages

[1] This article is being reproduced with permission from the current Women and Health issue of Montreal Serai, an arts, culture and politics webzine at www.montrealserai.com

[2] Joyce Valbuena is the coordinator of the Centre for Philippine Concerns (CPC), which is an organization of Filipinos and non-Filipinos in Quebec who are concerned to end the situation of repression and exploitation in the Philippines. The CPC is celebrating its 30th founding anniversary this 2013.

abroad. They are largely driven by the financial needs of their families for whom sending remittances home is considered to be the main goal.

However, many of them enter receiving countries as non-citizens where they settle for jobs that are largely considered as unskilled or low-status work. Many migrant workers rarely get the opportunity to attain higher-status jobs. Furthermore, many are poorly paid and are compelled to endure exploitative working conditions.

Escaping an Unhealthy Economy

Many Filipinos, however, do endure the risks of being exploited while working in another country so that their families could escape poverty in their own country, or so that they can provide for the medical needs and expenses of their ailing family members.

In the Philippines, poverty incidence is essentially unchanged at 28 percent. According to the IBON Foundation, the unemployment rate has remained 11 percent in the last six years. The annual average number of unemployed Filipinos reached 2.8 million in 2012.

Clearly, the poverty situation will not improve without enough jobs for the people. With poverty, people`s health inevitably deteriorates.

The World Health Organization prescribes that at least five percent of the Gross Domestic Product (GDP) of a middle-income country must be spent on health. However, the Philippine government allocates only 2.2 percent of the national budget to health. Total health expenditure in the Philippines is only 3.7 percent of the GDP. With a population of 95 million, the estimated health budget for a person is only about $6 per year or a measly 20 cents per day. (Council for Health and Development, 2010)

Many Filipinos still become sick with preventable diseases. The Philippines is still ranked 9th out of the 22 countries burdened with Tuberculosis (World Health Organization). Among the women, 11 mothers are dying every day due to pregnancy and childbirth related complications. Maternal deaths comprise as much as 14 percent of all deaths of women of reproductive age (Philippines, Department of Health).

Among poor people, only two out of 10 have access to free health care and only three out of 10 are covered by social health insurance. Due to poverty, six out of 10 poor Filipinos die without being able to see a doctor. (IBON Foundation, 2010)

Among the health professionals, the responsibility and the difficulty of the job does not match their salary. For instance, a nurse who earns only $400 a month is charged with taking care of at least 50 patients. Because of the lack of government efforts to provide incentives, medical practitioners and health care providers often choose to work in a foreign country. About 70 percent of nurses and 68 percent of Filipino doctors are currently abroad. (Council for Health and Development)

To make the matter worst for the health situation of the people, the Philippine government has embarked on the privatization of health services, which has been on-going since the onset of this decade and has taken various forms and levels, such as hospital corporatization, privatization of hospital services such as laboratory work, conversion of public health facilities for other purposes, and outright sale of hospitals. The idea here is for the government to raise the revenues for their health services, such as charging higher fees, and generate the resources for the hospitals' modernization through entering into partnerships with private corporations.

At the same time, the government has cut its budget for health while allowing private corporations to enter the business of the health care industry. This has made health care services become more expensive and public health is being compromised. Obviously, the ones who will benefit are only those who can pay for such services. Thus, health care becomes more inaccessible to the people and the masses suffer further.

Feminization of migration: The Filipino women healthcare workers in Canada

Of the one billion people crossing national borders as migrant workers, 72 percent are women. It is estimated that 60 million women from poorer countries are recruited into care work for employment in wealthier nations every year. (UNPAC)

In North America and Europe, women from South America and Asia work in the homes of rich people so they can send money back to their families in their home countries. Many domestic workers leave their children and families behind choosing to care for others' children in order to feed their own. However, many domestic workers share common experiences of receiving low wages, long working hours, verbal abuse, being forced to act in roles of servitude, heavy work demands, loneliness, homesickness, the denial of having their own family life, racism, and vulnerability to sexual abuse and HIV. (UNPAC)

It is estimated that between 6 and 8 million Filipino women are living abroad, the majority of whom are working as domestic workers. In Canada, many of the women enter as temporary workers in the Live-in Caregiver Program.

In the 1960s, the first large group of Filipinos to arrive in Canada were mainly professionals who had earned university degrees. But in the early 1980s, the next big wave coincided with the movement to import domestic workers and live-in caregivers, primarily women with lower educational levels, as reported by Joe Friesen in the Globe and Mail (April 5, 2010). According Friesen's article, the Filipinos now dominate the caring industry in Canada. The Live-In Caregiver Program, which brings in nannies and care-workers for children and the elderly, is consistently more than 90 percent Filipino.

There is another angle here. From a racist stereotypical outlook, Filipino women are preferred to be hired as caregivers because they are viewed to be compliant, less resistant and hard workers. These pre-conceived notions regarding Filipino women also means that they are usually more subjected to exploitation.

Being overworked, Filipino caregivers are also prone to sickness. In many cases, they are not allowed by their employers to take some days off whenever they feel low in health. They are still obligated to do household tasks and other domestic chores even if they are down with flu or body aches. In most instances, they cannot not see a doctor right away to check their conditions. There are many stories of Filipino caregivers who have suffered from cancer while serving in the 24-month program or right after they finish their contracts. Because of physical and emotional fatigue, caregivers have a high risk of the deterioration of the immune system which leads to sickness.

Caregiving Services and the Aging Population

Canada has always had a chronic shortage of people willing to take paid domestic work because of its poor status, low wages and lack of employment benefits. This means that Canada is always looking for foreign workers willing to do domestic work. Hiring private care has become a particularly appealing alternative for professional Canadian women who can afford to pay for their household responsibilities. (Kapiga 2009)

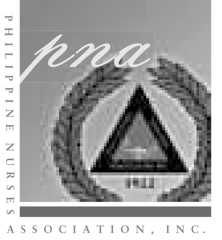
As explained by Kapiga's study (2009), this seemingly constant flow of Filipina live-in caregivers into Canada is due to the never-ending demand from middle and upper class Canadians for private healthcare as opposed to reliance on the public healthcare system.

Faced with an aging population and rising healthcare costs, Canada has to adapt to meet changing health care needs. Concerns have been raised that Canada's health care system will be unable to meet the growing health care needs of this aging population. (CIHI)

In contrast to the Philippine situation, here in Quebec, 80 percent of the population use the healthcare system each year. At 12 percent of Quebec's economy, health care is the most important sector. (Joe Friesen, Globe and Mail, April 5, 2010)

However, the baby-boomers who comprise the biggest chunk of Quebec's population, have started to reach their retirement age — a time when they will work less and begin to use more health-care services. The government has started to compress its compensation to providers of health services. It already spends less per person on doctors and hospitals, and in total public-health spending. (Colin Busby and William Robson, Montreal Gazette, February 14, 2013)

On the other hand, Quebec also faces a shortage of health care professionals. Nurses continue to be in high



demand throughout Canada, and the need is more pronounced in Quebec. According to the Citizenship and Immigration Canada (CIC), Quebec has become Canada's newest healthcare hotspot. The Canadian Nurses Association predicts that if healthcare needs continue to rise at current rates, the country will need 60,000 nurses to fill its labor shortage by 2022. One of the main reasons cited for this shortage is an aging population that is increasingly in need of health services.

In the research by Kabiga, she proposed a reform that would benefit both the Canadian health sector and the Filipino nurses who have entered the live-in caregiver program. The study recommended that Filipino caregivers should be allowed to continue practicing their nursing profession once they have their open permits upon completion of their 24-month requirement. This would be on the condition that they complete a one-year program or paid internship during which they become familiar with the Canadian health system and be equipped to take the Canadian nursing exam. Upon successfully passing the exam, they would be licensed to work in any Canadian hospital.

The study by Kabiga illustrated that this is highly plausible, as it has been done in the past during the 1960's and 1970's when Filipino nurses and teachers were allowed to migrate to Canada and continue working in their professions. Their skills and education were being recognized then.

This recommendation would improve the socio-economic situation of these women caregivers and they would be an asset to the Canadian workforce and economy.

In the case of Linda, after completing her 24-month live-in caregiver program, she applied to work as administrative assistant in a toy company, and then later on in a call center. She is now enrolled in a certificate course to become a dental assistant. She might not have chosen to take a chance to practice her nursing profession here in Quebec. Nevertheless, she is pursuing her goal to be in another health profession.

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News Article

Closing the Gap: Sharpening the Image of Nursing

International Nurses Week

Cora A. Anonuevo, RN, PhD

Press Conference

Symposium

Neem Tree Planting

ThThe Philippine Nurses Association (PNA) led the commemoration of the 48th anniversary of **International Nurses Week** held on May 6-12, 2013. May 6 is "International RN Recognition Day", while May 12 is the natal day of Florence Nightingale, the famous pioneer of modern nursing. This year's theme was "*Closing the Gap: Sharpening the Image of Nursing*."

The activities organized by PNA National and its chapters were aimed at changing popular, but highly inaccurate perceptions of nurses, the largest group of health professionals both in our country and in the world. "Even after decades of keeping patients safe through critical thinking and technical competencies, nurses are still viewed as unintelligent and unable to make critical decisions without consulting a physician," PNA President Noel C. Cadete said. "Nothing is further from the truth! Nurses demonstrate a commitment to excellence in clinical knowledge, skill and practice, and we combine this commitment to excellence with compassion for our patients," Dr Annabelle Borromeo, over-all chair of this year's event, pointed out. It is estimated that there are around 300,000 nurses in the Philippines, and 14 million worldwide.

As a kick-off activity, a motorcade attended by different specialty organizations and institutions, went around Taft Avenue and Quirino Avenue. This was followed by a service of ecumenical prayers and renewal of commitment of nurses by reciting the 'Nightingale Pledge'.

Another activity on the first day of the celebration was the opening of the photo exhibits that drew participation from Nurses Associations of Austria, Ireland, Saudi Arabia, and United Arab Emirates. The photos depicted the images on the real essence of nurses' work. A unique activity was "Draw-a- Nurse " held in cooperation with Mc Donald's and Arellano University Manila. This contest, participated in by children, aimed to increase their awareness on the role of nurses and used as a vehicle for showing appreciation for their favorite nurse. The drawings were also exhibited along with the photos at the new PNA Bldg 3.

A Press Conference on "What Nurses Do and What the Public Perceives Nurses Do," engaged media people on the burning issues affecting Filipino nurses and the nursing sector. The panel of speakers consisted of PNA Pres. Noel Cadete who gave a brief background and rationale of the International Nurses' Week Celebration; NLGN President Nilda Silvera spoke on government nurses' work in communities rendering comprehensive care to achieve the millennium development goals; CCNAPI President Maria Isabelita Rogado asserted that critical care nurses have areas of specialty and expertise and thus they require a lot of education and experience, and not mere training. Similarly, ADPCN President Elizabeth Roxas stated that nurses are well-educated professionals, many of whom have master's and doctoral degrees and some are engaged in research. PRC Board of Nursing Chair, Dr Carmencita Abaquin stated that the Board Examination for Nurses ensures that nurses who practice their profession render safe and competent care. Ang NARS (Party list) Lea Paquiz briefly presented the realities of nurses' work situation and people's health. The media panel consisted of representatives from Solar News TV, Manila Bulletin and Abante who came and stayed on to cover the whole morning's activities despite the competing May election fever.

A symposium, *Reminiscing Florence Nightingale Essence,* had Dr Annabelle Borromeo as speaker. She encouraged nurses to reflect, not necessarily on Nightingale's life, but on her "essence", her philosophy, her way of thinking and accomplishing things, making her the icon of the nursing profession. She urged the symposium participants to emulate her works and contribute to enhancing the positive image of nursing.

A role model of Nightingale's heroism is Carissa Juliana Jr. De Luzuriaga who was awarded by PNA as 'Bayaning Nars'. She was recognized for "her valiant and extraordinary deed which exemplifies her love of God and country, caring and integrity beyond the call of duty." This referred to the incident at the height of typhoon Gener in July 2012 when Ms Luzuriaga and some nursing students of St Paul University assisted an unknown woman on the street who was in labor to deliver a child.

The International Nurses Week event also displayed the creative and physical prowess of nurses. Held at the University of Makati Open Field, nurses performed Dancercise as a warm up to the tune of Jennifer Lopez' song "On the Floor". This was a prelude to Flash Mob, a Nursing Process dance. The latter showcased a collage video of the dance performed by nurses from different nursing organizations, nursing schools, and hospitals. The activity featured steps and actions that are symbolic of the higher order functions of the nurse such as assessment, planning, implementation, and evaluation. The activity concluded with a Human "NURSE" Formation, that symbolizes strength, unity and solidarity among Filipino nurses and their community.

A cultural show, Nurses Got Talent, was held to bring together nurses from different hospitals and schools in Metro Manila highlighting nurses' exceptional skills in the performing arts. The presentation was held at Makati Medical Center Auditorium. It was a way to provide a breather for our nurses who work hard every day caring for patients.

Efforts at reducing the devastating effects of dengue was a continuing concern. Neem Tree Visitation and Planting was done by NCR Zone 1 in Bgy Gen T de Leon and Zone 2 in Bgy Maysan, Valenzuela City. Study findings showed that Neem tree has the ability to repel mosquitoes. Tree planting was coupled with health education campaign conducted in respective communities to increase awareness on dengue and its prevention.

A culminating activity was held on May 12, 2013 with a Wellness Clinic providing free primary care services and screening such as EKG, blood sugar monitoring, eye examination, and blood pressure screening. Specialty organizations such as the ADNEP, CCNAPI, PSECN, RENAP and MCNAP managed the clinic . Another purpose of this nurse-led activity was to highlight nurse's role in promoting the health of our citizenry through health promotion and disease prevention services.

On stand-by emergency response during the one-week event was directed by PNA Disaster Preparedness Committee and assisted by medical teams from the Armed Forces of the Philippines, the Philippine National Police, and the MMDA Road Rescue Group. There were ready supplies and equipment for emergency support that included first aid kits and transport system equipped with stretcher and ambulance. Fortunately, there was no major incident during the event that necessitated medical emergency service.

Indeed, as concluded in the position paper of the PNA for the celebration, "Our nation cannot afford to view nurses as any less than they are: exceptional leaders who make a vital contribution to our nation's health. We must ensure that all Filipinos have a highly skilled nurse, when and where they need one."

PNA Disaster Preparedness Committee

Nurses Got Talent

Ecumenical Service

Motorcade

> "Nurses dispense comfort, compassion, and caring without even a prescription."
> ~Val Saintsbury

News Article

ICN's Wellness Tree Photo Contest: A Focus on Nursing and Health Promotion

Leonardo M. Nuestro, Jr., RN, MAN

Name: **Leonardo M. Nuestro, Jr.**
Country: **Philippines**
Photo Title: ***"Students Committed to Fight NCDs, too!"***
Photo Caption: "Philippine Nurses Association (PNA) conducts campaigns to colleges and universities to increase awareness about its Wellness Tree Program and secure genuine commitment to develop measures to fight NCDs. This one was taken from Arellano University, Manila, Philippines"

View all the Winning photographs at http://www.growyourwellness.com/wellness-tree-photo-contest-focus-nursing-and-health-promotion

Early part of the year, the International Council of Nurses (ICN) launched the "Wellness Tree Photo Contest: A Focus on Nursing and Health Promotion". Its main goal was to collect and share photographs which best represent culturally valid images of healthy behaviour and how nurses and nursing are actively promoting healthy lifestyles to turn back the tide of non-communicable diseases (NCDs) globally.

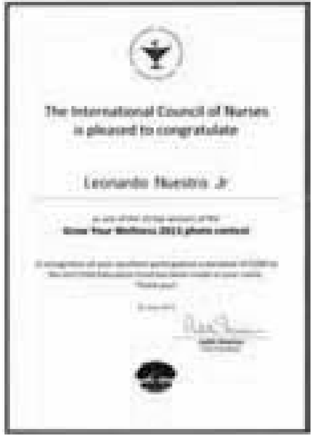
Participants were asked to submit photographs depicting, from a nurse's perspective, what constitutes healthy behaviours and examples of cultivating lifelong health in their respective countries/cultures. Participation was limited to nurses and nursing students from around the world who are at least 18 years of age.

Photographs were expected to be:

- Examples of nursing outreach campaigns for healthy living in your community/region
- Examples of nurses promoting healthy living through nursing interventions, tools and activities
- Examples of healthy nutrition in your country

Name: **Roger P. Tong-an**
Country: **Philippines**
Photo Title: ***"The Philippine Nurses Association In Action"***
Photo Caption: "Filipino Nurses Promoting Healthy Lifestyle in the community."

Gov. Roger Tong-an receiving his prize from Ms Paula from ICN/Pfizer New York in Melbourne Australia.



The International Council of Nurses
is pleased to congratulate

Leonardo Nuestro Jr

The International Council of Nurses
is pleased to congratulate

Roger P. Tong-an

- Examples of easily accessible physical activity in your country
- Examples of people taking the right steps toward healthy living

The Philippines scored a double when PNA's Executive Director Leonardo M. Nuestro, Jr. and PNA's Vice-President for Finance and Region XI Governor Roger P. Tong-an, won the Top 3 and Top 10 honors, respectively.

All Top 10 winners receive ad Florence Nightingale bear and donations were made to the Girl Child Education Fund (GCEF) in their names and their photos are featured on www.growyourwellness.com.

Mr. Nuestro being, a Top 3 finalist was given a 50% reduction on the fee for the 25th Quadrennial ICN Congress in Melbourne and has his winning photograph exhibited at the Wellness Booth at the Congress exhibition.

The distinguished judges who screened numerous entries from around the globe were Former ICN President Christine Hancock; Director Emeritus of the Pan American Health Organization (PAHO) Sir George Alleyne, and; ICN Nurse Consultant Yukiko Kusano.

These were the complete rankings:

1. **Leonardo Nuestro Jr. -** Top 3 finalist, Philippines
2. **Josiah Okesola -** Top 3 finalist, Nigeria
3. **Sheri Palmer -** Top 3 finalist, USA
4. **Shaikha Al Ali -** Top 10, United Arab Emirate
5. **Carmen Farrugia -** Top 10, Malta
6. **Rina Glucina -** Top 10, Australia
7. **Tahsien Okasha -** Top 10, Egypt
8. **Dejan Sotirov -** Top 10, Slovenia
9. **Roger P. Tong-an -** Top 10, Philippines
10. **Marla Weston -** Top 10, USA

News Article

So Proudly We Hail[1]

Heroic Nurse – the Last Surviving 'Angel of Bataan and Corregidor' – Passes Away[2]

"Angels of Bataan and Corregidor": Army nurses, wearing new uniforms, crowd into a truck following their February 1945 liberation from the Santo Tomas Internment Compound in Manila.

Mildred Dalton Manning, the last surviving member of a group of U.S. Army and Navy nurses taken prisoner in the Philippines at the start of World War II, passed away last week at the age of 98. For many, she had come to symbolize the dedication, strength, and heroism of nurses.

Born in 1914 on the eve of World War I, Manning volunteered for the U.S. Army Nurse Corps in 1939, as the world again teetered on the edge of global conflict. Originally stationed in Atlanta, she requested a posting on the Philippines, saying she wanted to "see the world." Decades later she would recall, "What I saw was a prison camp."

Manning arrived in Manila in October of 1941, six weeks before a series of Japanese attacks on U.S. outposts throughout the Pacific, including Pearl Harbor, the Philippines, Guam, Wake Island and elsewhere. The land battle for the Philippines raged for months, with U.S. forces gradually retreating to the tiny island of Corregidor at the southern tip of Bataan.

During the battle, Manning and her fellow Army and Navy nurses—the first unit of American women to be sent into service so close to the front lines of battle—treated the wounded day and night at a makeshift outdoor clinic in the jungles of Bataan. Over the course of four months, they cared for 6,000

1 http://statement-analysis.blogspot.ca/2013/05/so-proudly-we-hail.html
2 http://www.rwjf.org/en/blogs/human-capital-blog/2013/03/heroic_nurse_thel.html

patients, bandaging wounds with bombs falling around them. As the U.S. position deteriorated, they moved to Corregidor, where they would continue their work in a tunnel. There they earned their nickname, "the Angels of Bataan and Corregidor."

In May, five months after the battle began, remaining U.S. forces surrendered to the Japanese. The men on Corregidor were sent on the fabled Bataan Death March on their way to the harshest of treatment in prisoner of war camps.

Manning and her colleagues had a different ordeal ahead of them. Also taken prisoner, they were returned to Manila and held at a prison camp on the campus of Santo Tomas University, along with 4,000 civilians, mostly Americans. Over the course of the next three years, short on medicine, food, clean water, and supplies of all kinds, the nurses continued their work, treating fellow prisoners even as their own health deteriorated. While in captivity, Manning suffered from beri-beri, dengue fever, and malnutrition.

Still, she and her fellow nurses carried on. "We were scared and tired, but we kept working," Manning told the *Atlanta Journal-Constitution* in 2001. "We were under terrific strain, but we just did our job even when we were weak from not eating."

The ordeal continued until February 3, 1945, when a U.S. tank rolled through the gates of Santo Tomas. Remarkably, not one of the 77 Army or Navy nurses sent to the camp perished.

After her liberation, Manning was sent on a tour to promote war bonds, during which she met her future husband, an editor at the *Atlanta Constitution*. She subsequently returned to work as a nurse in Jacksonville, Florida, and is survived by a daughter, a son, five grandchildren, and a legacy of commitment and heroism.

Military nurses' contributions and sacrifices are often underreported and unappreciated, but Manning's tale is captured movingly in obituaries in The New York Times and Washington Post.

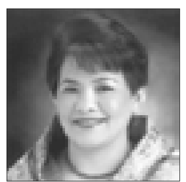
Mildred Dalton Manning

Photo taken from http://www.washingtonpost.com/rf/image_606w/2010-2019/WashingtonPost/2013/03/13/Obituaries/Images/Manning_Mildred1363203370.jpg

> "To do what nobody else will do, a way that nobody else can do, in spite of all we go through; that is to be a nurse."
>
> *~ Rawsi Williams*

News Article

The International Council of Nurses Congress: A journey of learning and reflections



Ruth Thelma P. Tingda, RN, MAN, MM

Erlinda Castro-Palaganas, PhD, RN

The International Council of Nurses (ICN) 25th Quadrennial Congress was held in Melbourne from 19th May 2013 to 22nd May 2013 with the theme: Equity and Access to Health Care". The main objectives were: 1) To advance and improve equity and access to health care; 2) To demonstrate the nursing contribution to the health of individuals, families and communities; and 3) To provide opportunities for an in-depth exchange of experience and expertise within and beyond the international nursing community. There was a pre-conference student assembly activity in the morning and the opening ceremony in the evening of May 18. A day after the conference, May 23, was the professional/facility visits.

The Congress brought "together evidence, experience and innovations highlighting the critical importance of equity and access to health care for communities and individuals, demonstrating how nurses are key to ensuring equal access and quality of health care for all". The Congress provided a "global platform for the dissemination of nursing knowledge and leadership across specialties, cultures and countries via the ICN scientific program, featuring keynote and main session invited speakers as well as a wide range of concurrent sessions including dynamic papers accepted through a highly competitive abstract selection process" (http://www.icn.ch/congress2013/en/index.html).

Tackling issues of equity and access for five days had indeed been a journey of learning and reflections with more or less 4,000 delegates from 138 member countries. These two big issues are universal health care challenges that Filipino nurses have been confronted with for decades. We are seen are the front lines to a health care system characterized as inequitable, unjust and inaccessible. We have continuously been challenged to facilitate the access to health care and be the conduit for individuals, families,

populations and communities. So many expectations from nurses, not only from the Philippines from all over the world. All countries are one saying that this world cannot exist without us, nurses. We are the backbone of the health care system. Yet we, the backbone, have been a neglected sector in terms of our wages, working conditions, benefits and security of tenure. Contractualization, low wages, infringements on our democratic rights (e.g. forms and is part of a Union), forced migration, have impinged on our roles to be agents of change, to be creative and innovative in our ways of providing health care. One session has aptly described the nurses' situation today as "modern day slavery". Modern day slavery covers a variety of human rights violations such as forced labor with unemployment, underemployment, and gender discrimination to name a few. We are enjoined to be aware and mobilized to build a universal health rights order, an order we ourselves are deprived with.

In the ICN conference it was recognized that governments all over the world cannot achieve healthy nation status without universal health care. And that UHC cannot be provided without maximizing the potentials of the backbone of the health care system. Mobilizing the nurse workforce towards this end was the challenge that haunted and reverberated in the plenary and session halls of the conference. In the keynote address of Dr. Michel Kazatchkine, from France and the UN Special Envoy for HIV/AIDS in Eastern Europe and Central Asia, acknowledged the nurses as the "key to improving access to quality and cost-effective care and to enhancing the health of populations". He also challenged health systems to meet growing demands and economic pressures for health care. This he says means responding to the needs of nurses such as "access to education, necessary resources and the appropriate support mechanisms".

Interesting and Noteworthy Sessions

We wish to share a few highlights in the plenary and concurrent sessions attended. There were so many plenary, main sessions (3 concurrent sessions), special organized scientific meetings and concurrent research dissemination sessions. It was impossible to attend all of the sessions thus we are sharing insights from the sessions we attended and found interesting.

Dr. Palaganas and Ms. Tingda with Dr. Mancuso, the best speaker of the conference.

The Plenary session on women, 'Holding up more than half the sky' by Leslie Mancuso, PhD, RN, FAAN, President and CEO of JHPIEGO, was powerful and engaging. If there was to be an award for the best speaker for the conference, it would go to Dr. Mancuso: powerful, passionate, pragmatic, politically challenging, and epitome of a nurse leader. She delivered her speech so well, you can feel it just coming straight from her heart. If we are all like her, we will be where we dream to be. Her message: "There is an increasing evidence base that highlights the importance of women in achieving safe, educated and successful societies. Despite this, women remain marginalized in many countries and communities, denied access to education and blocked from promotion in many careers. Nursing as a profession remains predominantly a female dominated profession and as a profession we face difficulties in securing a voice in many policy making arenas. With the changing burden of disease and the increasing need to redesign health systems so as to increase access to often the poorest and most marginalized groups in society this presentation will focus on how nurses can advocate for women in society" (ICN 2013, Program, p. 25).

Anne Marie Rafferty, Professor of Nursing Policy, King's College London, UK, presented her paper directed to the contributions of the nurse theorist, Virginia Henderson (VH) to the conference' s theme. It was a well thought and critical paper that increased awareness on VH's work vis-à-vis role of nurses today in achieving equity and access to health care. This is a "tradition" that started in 1997 in honor of VH.

The plenary session on "Obesity: Personal or Social Responsibility?" came in as a surprise. What was thought to be a simplistic, boring topic turned out to most interesting. Richard Visser, Minister of Health, Welfare and Sport of Aruba argued that obesity is an increasing threat to health. This concern is approached "by promoting personal responsibility for eating and exercise choices. However, there is an increasing realization that this approach has a number of limitations: many people do not follow through with healthy lifestyles and despite many years of effort in this area, obesity rates continue to rise. It can be argued that society is responsible for weight gain: so do we really have freedom of choice in what we eat? Is society actually encouraging us to be lazy? The session presented both sides of the argument and highlighted the role of nurses in reducing obesity rates" (ICN Program, 2013, p. 31). Such challenge included nurses who are among those found to be in such a situation.

There were sessions on nurse migration, articulating the realities of nurse movement both internal and external. Such movements are seen to impact access to health care. Issues of global policy directions on recruitment and retention of health professionals vis-à-vis intranational and international migration were posed as continuing challenges. The linkages and impacts of impacts of globalization, trade in services and agreements on nursing education were also the foci of discussions in main sessions. Since nursing education is influenced by the societal and cultural context which it evolves, nurses need to understand recent developments along this line. This extends to attempts to standardize the content, the length and other aspects of nursing education internationally. Nursing education without borders but whose and what context should education be?

Listening to the concurrent session themes, Nurses and the Workplace and The Nurse Workforce, made us realize that nursing and nurses can make a dent in people's lives. The passion and the steadfast position that each speaker displayed on issues affecting nursing and nurses re-charged the feeling of helplessness when one considers the insurmountable concerns confronting us, Filipino nurses. We are convinced all the more that we, nurses, can make a dent in the landscape of "equity and access to health care" ranging from our bedside patient-nurse interaction with the higher level of nurses influencing policies favorable not just for patients but also for nurses and for health. Ms. Sharon Morunga's presentation, "I'm Not A Racist…But..." touched on racism as among the social determinants of health and contributory to the ill-health of aboriginals of Australia. "Let us make accounting of our racial discriminatory actions. Let us act on the need to change." Speakers Patricia Iyer and Ashton on "Impact of Bullying on the Nursing Workforce" explored on the results of bullying on nurses (like absenteeism, complaints), on patients (e.g., safety), and organization (e.g., litigations). Leadership role on safe work initiatives and handling workplace incidents formed the conclusion of this paper. The global nursing workforce presentations from USA, UK, Australia, and New Zealand are saying one thing: there is an alarming shortage of nurses all over these countries. While each country's statistics may present a ray of hope for the employment our Filipino nurses, it is clear from each presentation that each of the aforementioned countries are working double time to exhaust possible internal solutions before internationally qualified nurses (IQNs) are even considered.

The sessions on challenges brought about by current communicable diseases such as HIV/AIDS, and Tuberculosis, with emphasis on the various initiatives of the ICN. The member countries of the ICN must have benefitted much from the insights shared in making a difference through the ICN programmes along its three pillars: professional practice, regulation and socio-economic welfare. Other foci of debates and discussions were on the current concerns and challenges on Ethics, Disasters, Environmental Issues, and Ageing. Leadership, Changing scope of practice, eHealth, Mental health and well-being, human rights, patient safety.

The Congress however, failed to formulate resolutions that could have bounded the participants to commit themselves to actions towards equity and access to health care. A more critical analysis of the context of international nursing could have been better articulated and analyzed. This should pose as a challenge to the ICN leadership, with Dr. Judith Shamian, new ICN President and past President of the Canadian Nursing Association.

We have to acknowledge paper presenters from the Philippines: Dr. Erlinda Castro-Palaganas of UP Baguio and Ms. Ruth Thelma P. Tingda, then representing SLU-School of Nursing. Their paper entitled, "Laying down the foundation of a transformative health care delivery system: Contradictions and the struggles of community

health nurses" was well received and found interesting by the colleagues especially from Australia. One interesting comment raised was that nurses in most societies undergo such stage of the contradictions and struggles. Palaganas presented a collaborative work entitled, "Towards designing better indices of poverty and gender equity".

There were hundreds of poster presentations. It was a very engaging experience to visit the poster presenters, engaging them in discussions and gaining new researcher friends. There were two posters from the Philippine delegates: "Parents' decisions and beliefs on the circumcision of their children" by D. Dizon and D.M.D. Sonco of the Angeles University Foundation and "Functional indicators of a nurse's preparedness to withstand health emergencies and disasters by M.J. Villanueva, G. Cordero, G.S. Arquiza, and L.R. Gano of the Philippine College of Health Sciences.

Conference's added attraction

One of our favorite destinations in the conference venue was the exhibitors' booths. There were lots of give-a-ways: pens, key holders, fans, koalas, bookmarks, reading materials, USBs, cookies and many more. It was so much fun hoarding items we knew we can give away to our friends. The Korean Nurses Association were all dressed up in their national costumes promoting the next ICN Congress. If there is a group that is most active during the conference, it would be the Taiwan Nurses Association. They seemed to be more visible and had most of the poster and oral presentations. The Norwegian and Danish Nurses Association must have come in full force too because their colleague is an ICN life time awardee. They also gave a visual and photographic presentation about their efforts to enhance the image and public understanding of Nursing.

The Australian Primary Health Care Research Information Service (PHC-RIS) was most useful if we are to link it to the theme of the conference. The *eBulletin* which we signed up (and now currently enjoying the regular updates) presents recently published articles and reports, news items, media releases, upcoming conferences and courses, research grants, scholarships and fellowships, PHC RIS products and services and new and/or relevant websites in the primary health care field.

The best of them all: the volunteers. We all agreed that the hundreds of volunteers who personally attended to our needs, to our queries, even if it was not their job, were the unsung heroes of the conference. They were referred to as the "human face" of the conference. They were really great, endlessly helpful and obliging. They deserve a standing ovation. One of the volunteers, Rogelio Carreon, Jr., a Filipino nurse, went out of his way to be a volunteer for us. After his volunteer job, he showed us around the city, brought us to "pasalubong" centers and offered his home and much more. That's the tender loving care, the personal touch only a nurse can unselfishly share.

For most of us, this was our first to attend the ICN Congress (it was second for Dr. Palaganas) and though we had fun, met new acquaintances, did a lot of networking, and enjoyed learning, we think that it could have been more welcoming (with tea and coffee, dinner or lunch). It was the most expensive conference ever attended though. In four years' time, it will be Seoul, Korea. Let it be something to look forward to and financially prepare for.

The lighter side of the conference

On a personal note, my (Tingda) participation in the 25th ICN quadrennial Congress has been most memorable not just because of what transpired within the congress period but the days after. I was privileged to have experienced at least 2 rare things: toured several higher institutions in Melbourne where many of our Filipino nurses end up with their student visas; and enjoyed our Filipino nurses' warm hospitality while listening to their many happy and not-so-happy stories related to pursuing their dreams of a better life for themselves and their families. From the school tour and interactions with nurses, I am convinced that far beyond professional preparations of our Filipino graduates for overseas work is the critical need to hone their life skills of decision making, initiative, adaptability, and endurance. Yes, fellow-Filipino nurses, whether at home or overseas, we can do something to make other's life better. We can contribute to making "equity and access to health care" a reality.

From L to R: With Alumni of the Easter Colleges in Sydney; Rogelio Carreon, Conference Volunteer and host; visitto the Deakin University with Filipino nurse based in New Zealand, Ms. Josefina V. Pantig and Dr. Palaganas.

We also took time, though extremely limited, to get around the city. While some of us did get to explore and enjoy some states of Australia, most of us were content with a few areas of interest around Melbourne City. Indeed Melbourne is one of the most cosmopolitan and multicultural cities in the world. The diverse arts and culture, the songs and dances, entertainments, parks, museums are reflections of the 140 nationalities and 100 religious faiths and 180 different languages in Melbourne. Having each other in Melbourne's cold and mesmerizing city made the Conference is intellectually satisfying and enjoyable.

Some members of the Philippine delegation from left to right: Dean Carmelita D. Divinagracia, Ms. Jesefina Villarin-Pantig (based in New Zealand), Dr. Erlinda C. Palaganas, President Noel C. Cadete, Prof. Ruth Tingda, VPPD Mila Delia M. Llanes, Gov. Jemimah Bringas and Dr. Leticia Puguon.

The Flinders Street Station, the oldest train station in Australia is a beautiful sight to behold: empowering and refreshing with its yellow façade and green copper dome. Imagine almost 1500 trains and more than a 100 thousand commuters passing through each day, us included during our stay.

The Queen Victoria Market was one of the favourite destination not only for the "pasalubongs" but to appreciate the historic Institutional landmark of Melbourne.

Postscripts from Delegates:

Dr. Mila Delia Llanes, *VPPD, PNA, Gov. NCR Zone 6*

Attending the 25th ICN Congress is one strategic action that I decided to take as the current Vice President for Programs and Development of the Philippine Nurses Association (PNA), as it gave me ample opportunities to see nursing in a global perspective. The Congress was packed with topics/updates that are relevant to the programs and policy development not only to the ICN but also to the national nurses associations (NNAs).

Moderator, Julita Sansoni (ICN Board), Dr. Mila Delia Llanes (Philippines), Silvina Malvarez, (WHO PAHO), and Veronica Darko (Ghana).

I was a last-minute substitute for Dr. Teresita I. Barcelo, PhD, RN, former PNA President and currently the Dean of Centro Escolar College of Nursing, who because of unforeseen events, was unable to attend the Congress to present her paper, "Impact of Global Nursing Shortage: The Philippine Experience". The key points in the presentation were the status of external migration, its impact to the health care system in the country and how the Philippine government and non-government agencies are managing it. Literally, I felt like standing beside giants in global nursing leadership, as my fellow presenters were truly endowed with towering heights. With me on the panel were Silvina Malvarez, (WHO PAHO), and Veronica Darko (Ghana), with Julita Sansoni, ICN Board, acted as Moderator. I was not surprised when Ms. Malvarez reported that the Philippines is the number one country source of nurses, with around 110,00 nurses migrated during the period covered by her WHO report. I began my presentation by saying, "Perhaps, the positive thing that brings our consciousness about the report shared by Ms. Malvarez is the reality that we Filipino nurses have the opportunity to 'nurse' the world!" .

There were a number of questions that followed from Nicaragua, Japan, USA and South Korea during the open forum, which gave us Filipino delegates, the impression that they were interested with our nurses and nursing in the Philippines.

Truly, we had multiple doses of knowledge acquisition, networking and cultural exchange. I was invited to attend the colloquium for Leadership for Change Network as a preview to the Global Nursing Leadership (GNLI) Training, which I will be participating in Geneva this September, 2013. Moreover, Governor Roger Tong-an, Dr. Leticia Puguon and I participated in the Workshop on the Prevention of Non-Communicable Diseases, wherein we were required to submit after six months the progress of our initiatives in promoting wellness in our country. On a lighter note, the Congress made me proud to be a Filipino nurse especially during the opening ceremony when President Noel C. Cadete and I donned our Filipino costume and paraded with other country representatives in their colorful national costumes.

I am fully gratified and deeply motivated by the learning that I gained from the program offerings of the ICN Congress. ICN remains faithful to its reason for existence as it continues to represent the nurses worldwide and to be the voice of nursing internationally.

The alumni and the incoming participants to the 2013 Global Nursing Leadership Training together (Philippines), Silvina Malvarez(WHO PAHO),David Benton (CEO) 6th Rosemary Bryant, (President),7th and Stefanie Ferguson, (GNLI Director), 9th.

Over the years, ICN has been at the leading edge of policy and knowledge development (ICN, 2013). As takeaway lessons, I am inspired and motivated to heighten my resolve to journey with my fellow nurses in leading the Association as it ventures to its PNA Roadmap 2030. Indeed, there are many things we can do for nurses and nursing in our country, if we only do not consider who gets the credit. (Sotejo, 1997).

Dr. Leticia Puguon, *Delegate, Region 2*

Attending the ICN Quadrennial Congress was a very memorable and educational experience for me. For one, this was my first time to see the amazing Melbourne. It was also my first time to see and meet thousands of Nurses from 134 member countries of ICN all in the huge and marvelous Melbourne Convention Center. More than ever, it was a Reunion with all my colleagues and facilitators in the 2012 Global Nursing Leadership Institute I attended in Geneva, Switzerland on Sept. 8-14, 2012. It was also time to catch up with the ICN's various programmes such as the TB Project which has been running since 2005. The Philippines is among the 18 countries involved in the project. ICN reported that there are about 1,400 nurses in these countries who have been trained as trainers, cascading information to about 60,000 nurses and allied health workers. This project is in partnership with the Lilly Foundation working with United Way Worldwide. It is claimed that the challenges of TB as a chronic disease, in fact century disease in most countries such as the Philippines are multifaceted: poverty, inadequate health care delivery system, competing priorities and drug resistance to name a few.

It is always nice to be in the company of nurses, especially if the stories from the various corners of the world echoes mine.

There were many faces of the conference, mostly happy and fun.
We share you some photos of these phases.

Nurse's Voice from the Field

Making the Elimination of Health Disparities a Personal Priority

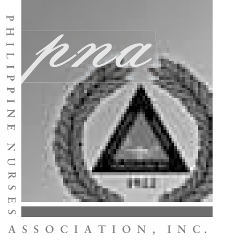
Rachel Hadassah Safeek[1]

[1] Ms. Rachel Hadassah Safeek is the daughter of a Filipino Nurse, Gina Padaco-Safeek, an alumna of Saint Louis University College of Nursing. Gina was a former student of Dr. Erlinda C. Palaganas, and proudly shared her daughter's critical and holistic perspective on global health.

I never intended to turn a family reunion upside down, but that is precisely what happened after I arrived home from my freshman year at Duke University. My family expected me to pursue a course of study heavily embedded within the biological sciences. However, I enrolled in FOCUS, a specialized interdisciplinary curriculum in Global Health and delved into health disparities education, research, and service.

Before FOCUS, it never occurred to me the manner and degree to which health care was more than just applications of the sciences. Mine was a myopic view of what healthcare was: administering care and treatment to the sick. I was unaware of the many social determinants of health, such as the struggle for basic socio-economic rights, e.g. access to food, water, adequate housing. FOCUS offered me insight into how denial of basic human rights leads to inequities in health care.

My new course of study aroused a passion in me to center my college education on studies in Global Health, proposing my own major, “Health Policy, Human Rights, and Health Disparities.” By studying health care as a human rights issue, I realize that diseases can also be prevented by combating structural barriers via health policy. Initially, I pursued research studies around HIV/AIDS transmission among African-



American women in Durham, NC, as there is a higher rate of transmission among this group. Later, I joined and am now director of Know Your Status, a student-run organization on campus that provides free rapid HIV testing to raise awareness about risky sexual behaviors. Finally, I pursued studies in a public health and human rights-themed study abroad program based in Salvador, Brazil involving health disparities and social injustices.

After a semester in Brazil, I returned to the United States empowered by individuals I met and uplifted through the studies. My passion for working with marginalized, HIV/AIDS populations led me to apply for an independent project grant through DukeEngage. Armed with the grant, I returned to Salvador to volunteer with female sex workers as a service project. I noted the unacceptable rates at which women reported illness due to HIV and other STI's in a country known for its universal health care. I studied the protection of sex worker rights in Brazil, and national programs aimed at reducing rates of HIV transmission among sex workers, as rates comprise a principal disparity in women's health.

In the future, I plan to return to Brazil and continue my work with marginalized populations and disparities in women's health. I also plan to pursue an MD/MPH, with the intention of working with minority communities and marginalized populations within the United States and abroad. As an aspiring physician, I feel a moral obligation to properly gain insight into societal barriers in healthcare by working in solidarity with marginalized and vulnerable populations.

With former Surgeon General Satcher, I would be interested in discussing the realization of health care as a human right in the United States, and whether this is foreseeable in the near future. I believe that in order to fully combat health disparities, one must acknowledge that health care is a human right. Realizing health care as a right is key to reducing disparities in health status and socio-economic conditions which impact health status as social injustices. I believe that with the expansion of health care coverage via the Affordable Care Act, our nation may have taken its first step to realizing the universal health care dream. My question is, when in the near future will the dream of universal health care be acknowledged through policy, and what steps can be taken to promote it?

About the Author: Rachel recently graduated with Honors Distinction from Duke University in her self-designed major: Health Policy, Human Rights, and Health Disparities. She focuses her research on issues in global health, specifically addressing topics related to HIV transmission and gender disempowerment. While at Duke, she was director of Know Your Status, a student-run and activist-based organization that provides free, rapid HIV testing to college students in the Durham, North Carolina area. She also launched the organization's campaign, “Fight Stigma”, encouraging young adults and students on academic campuses to get tested for HIV and combat stigma around the disease. Rachel was awarded a full grant through Duke University to spend six weeks in Salvador, Brazil researching HIV transmission among female sex worker populations. She used her research in Brazil to complete her undergraduate honors thesis in global health. Rachel's research with HIV prevention among college students was presented in 2013 at the 7th Annual International AIDS Society Conference on HIV Pathogenesis, Diagnosis, and Treatment in Kuala Lumpur. Rachel is a self-described health and human rights activist, committed to reducing health disparities, particularly among women and minority populations.

When you're a nurse you know that every day you will touch a life or a life will touch yours.

~Author Unknown

Nurse's Voice from the Field

I was an RN HEALS nurse-trainee and this is my story....[1]

I am a nurse presently working in a call center, a field vastly different from my professional training, but where I landed largely by force of circumstance and material necessity. Prior to this, I worked as a trainee under the government's RN HEALS program and was assigned in a tertiary specialty hospital where I had my "baptism of fire" as a nurse novice. It was suppose to be a "training and development" program that would enable us, young nurses, to hone our skills and gain experience for eventual employment. Even before this, I had already been availing of all opportunities to gain credentials to increase my chances of landing a nursing job. I even volunteered with a health NGO, joining disaster relief missions and community immersions during which times I felt proud and fulfilled as a nurse rendering service to indigent and marginalized communities.

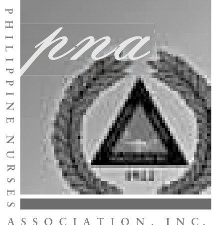
After almost a year, I finally got the "break" I've been waiting for: be a nurse in a hospital setting albeit a trainee. But barely had I warmed up when hard reality checked in knocking down all my notions about "positive practice environment" and the nursing profession being clothed with dignity and nobility . The situation I was in made me feel more like a second-class professional partially accomodated yet not duly recognized. I came to realize that the term trainee is an oxymoron of "registered nurse", a title I have rightfully earned and bestowed with certain legal privileges and benefits that were deprived me. I also recall Nursing Act of 2002 as the fundamental law that enshrines my right to a decent professional practice with provisions of "equal work for equal pay" and security of tenure. I performed nursing functions as a beginning nurse yet I was considered a "trainee" given a below minimum-wage allowance, with no security and adequate protection. Our status further marginalized us with just any member of the nursing service assuming authority over us, assigning us even non- nursing tasks simply because we were just "trainees". By merely asribing to us the title "trainee", the government with the acquiescence of the nursing authorities and even by our very own APO effectively nullified our status as registered or licensed nurses with certain inviolable rights. I believe this is a wrongful, unjust and illegal act on the part of the authorities that transgressed our fundamental labor and even human rights as important human resource of the country and development partners of the state.

I am therefore disheartened and demoralized as many of my fellow nurses under the RN HEALS program for this seeming sell-out by the supposed gatekeepers of the profession that made me feel less than what I believe is my true worth. I do not regret having taken up Nursing as a profession as much as I consider it a worthy vocation BUT my disillusionment has made me take a detour, but temporarily, until such time that I will be recognized and accorded the respect that I believe I deserve.

We often hear derisive comments about us young nurses not being at par anymore with nurses of yore. Maybe so. But is not the decline in the overall quality of nursing to a great extent also the accountability of our "leaders" who should have served as our "champions"? On the positive side we had leaders among them the late Minda Luz Quesada, Mary Vita Jackson and the recently departed Erlinda Ortin whose great labor and love for the profession contributed to the birthing of landmark laws such as the Nursing Act of 2002 and the Magna Carta of Public Health Workers that serve as benchmarks in our continuing struggle for just and fair treatment as nurses.

In the national elections held last May 2013, among the partylists that landed a seat in Congress was Ang NARS who asserted to represent the nursing sector. "Talks" like this come cheap. It is the "walking" part that we must be attentive to. As a nurse I will keep watch.
RPA

[1] ***RPA** are the initials of the author who shared her insights as a "pre-service trainee" belonging to the second batch of nurses in the governement's RN HEALS program started in 2011 under the Aquino administration supposedly aimed at addressing the unemployment problem of nurses while providing basic care to poor communities.*



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