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Closing the Gap: from Evidence to Action

Philippine Nurses Association, Inc.[1]

VISION

The caring and fortifying light giver committed to providing opportunities for the professional growth and development of world class Filipino nurses, Filipinos and people of the world.

MISSION

1. Zealously provide strategic directions and programs that enhance the competencies of nurses to be globally competitive.
2. Passionately sustain the quality work life and collegial interactions with and among nurses.
3. Continuously strengthen the internal capacity and capabilities for quality care and services of the nurses.
4. Enthusiastically explore possibilities of collaboration towards unification of nurses.

PROGRAM THRUSTS

1. Generate programs and activities that would prepare nurses to be globally-competitive.
2. Promote the socio-economic-political welfare of nurses
3. Promote the Positive Practice Environment (PPE) for nurses.
4. Establish national and international networking/ linkages to advance the vison and life purpose of the PNA.
5. Intensify membership campaign.
6. Participate actively in the multi-sectoral plans, projects and programs in support of education and research, nursing practice, and health care delivery to improve the quality of life of the people we serve.
7. Promote the professional image of the nurses and nursing.

[1] *Approved during the 1st BOG Meeting, December 11-13, 2010 at the PNA Board Room.*

Contents

Closing the Gap: Moving from Evidence to Action

Good health does not exist in an economic and social vacuum. Health is a social phenomenon, interplay of the socioeconomic, cultural and political structures of society. The Philippine society is a picture of glaring inequality between the privileged rich and the toiling masses. This inequality can be rooted in the flaws of an age-old social structure characterized by elite control of the resources of a backward and non-industrialized economy, the instrumentalities of the state and the exploitation and oppression of the majority of the Filipinos. The country reels under the dominance of foreign capitalists and has fallen to claws of a competitive international economic order. Thus, the alarming disease profile of the Philippines illustrates the multiple factors of malnutrition, inadequate housing, unsanitary water and improper waste disposal in the propagation of the diseases such as tuberculosis, malaria, diarrheal diseases, prevalent among the poor. These are among the enormous gaps that need to be "closed" thru an evidence-based practice (EBP).

ICN's kit for the International Nurses' Day for 2012 reveals that for nurses to close the gap, they have to piece together a four piece puzzle: understanding the EBP, searching and identifying sources of evidence, making the case for change and moving from evidence to action.

Over the past few decades, there has been an increasing emphasis on ensuring that health care decisions are based on the best available evidence. The urgent call to constantly strive to use EBP to nursing services has never been so real. This evidence-based approach to health care attempts to bridge the gap between research and nursing practice in various work settings. Truth is, Florence Nightingale started it all as reflected in her writings: "What you want are facts, not opinions...The most important practical lesson that can be given to nurses is to teach them what to observe, how to observe, what symptoms indicate improvement, which are of none, which are the evidence of neglect, and what kind of neglect."

EBP is the use of the best research, theory or expert opinion, plus the patient's unique circumstances and personal values, combined with clinical judgment to achieve the best outcomes. EBP utilizes evidence from solid qualitative and quantitative research, patient preference, clinical expertise and judgment, and available clinical resources to determine best practice in improving patient outcomes (Zuzelo, 2007). Care provided must be constantly evaluated and improved on the basis of new and refined research knowledge. Nurses therefore need to identify "what evidence to use, how to interpret the evidence and how confident are we in the findings" (ICN 2012, p.24). In closing the gap and moving evidence to action, do nurses understand the whole gamut of EBP?

All evidence has its value and nurses must learn how to gather and apply evidence in one's practice. The ICN lists potential sources of evidence: Research by health professionals or academics; Research by companies e.g. pharmaceutical companies; Reviews of research and clinical guidelines; Expert opinion; Opinion of colleagues; Clinical experience; Experience of patients, carers or clients; and Clinical audit data. As a starter, nurses are encouraged to visit the following sources of EBP guidelines for health care: www.cochrane.org/reviews/; www.joannabriggs.edu .au/cqrmg/about.html; and www.guidelines.gov. Nurses should utilize the evidences from research to push for the needed reforms to close the gaps of inaccessibility and inequality in health care systems. In closing the gap and moving evidence to action, do nurses have access to all these sources for an EBP?

Making the case for change needs an environment conducive for an EBP. The realities on the ground are reflected in a systematic review of the literature (Dobbins M, Ciliska D, DiCenso A., 1998) on research utilization. The study found that the facilities are inadequate for implementation; the nurse does not feel she/he has enough authority to change practices/procedures; the nurse does not have time to read research; the nurse feels the results are not generalizable to own setting. The study further revealed that organizational factors explained 80-90% of the variance in research utilization, environmental factors accounted for 5-10% of the variance, and

individual characteristics contributed only 13%. While nurses should appreciate the value of research and its benefit of self-practice; be willing to change/try new ideas; document needs to change practice; and be capable of evaluating the quality of the research, the role of the organization to allow the nurse to build on these capacities is more important. With this scenario, how far can nurses go in closing the gap and moving evidence to action?

Moving from evidence to practice entails professional health associations to play a vital role in establishing leadership, standards and models in this area. How does our association rate along these areas? We need to realize that after all these long years of protracted struggles for reforms in the health care system for the health of clients and for the health of professionals who work within the system, much remains to be done. More collective efforts need to be felt… muted voices need to be heard... stronger leadership needs to be appreciated.

The way forward to an EBP means we need to have an enabling environment for us to practice our profession the way we should… the way it should. Therefore, as community of nurses, we need to influence and participate in policy making, by being aware and up-to-date on the issues and participating in solving and analyzing such. We need to provide care where the clients are with the skills necessary to provide health care to those who are most disadvantaged and deprived. We need to gain technological expertise, which is necessary for critical thinking, for research and formulation of new technologies. We need to provide effective leadership by participating in and defending actions to safeguard health and well-being.

This issue illustrates that nurses can make a difference, no matter how small it may be. The research on "Nurses Migration, Deployment, Enrolment and Board Passing Trends in the Philippines (1999-2008)" by S. Cirujales and S. Kuan and the research on "Nurse Training and Nursing Education in the Philippines during the Spanish and American Periods" by Dr. Cruz, et.al, provide important information about the context of the nursing profession in the country. We need to understand such context to enable us to develop innovative ways of doing things and to respond appropriately. The excellent documentation of the project, "Pause for Patients' Safety" of the Manila Doctors Hospital led by nurses, Dr. de Leon, et. al provides evidence in promoting patients' safety. The article on "Achieving Universal Health Care" by the Medical Action Group will remain just a concept and empty promises if we cannot even avert the privatization or corporatization of the 26 DOH retained government hospitals. Let us remember that the ultimate goal of the critical practice of nursing (and any health profession) is to facilitate change in the environmental condition that threaten safety and well-being, inhibit health behaviors, and limit access to resources necessary for the pursuit of health. The move to privatize these government hospitals will further widen the gap of ill health with the rich enjoying the privilege of good health and poor being deprived of the right to good health. We need more nurses like Dr. Corazon de la Peña, not necessarily as outstanding as she is, to take the "center stage" too, as a nurse leader. Like her, we need to live the "the 6 C's of Caring, namely, Compassion, Confidence, Commitment, Competence, Conscience and Comportment". Ms. Nolasco captures the challenges of Dr. de la Peña's journey as simple, inspiring, mentoring nurse leaders. May the journey of Jerald Pelayo as a beginning nurse be touched and encouraged to do the same.

In closing the gaps from evidence to action, the PNA continues to take on the challenges. Beyond celebrating the International Nurses Day, the PNA needs more collaborative projects such as the partnership with the Plan International in serving the survivors of Typhoon Sendong. PNA needs to be more aggressive in disseminating information and advocacy, in building partnerships, in building capacity, in writing policy briefings on myriad issues and concerns affecting the nursing profession. We all need these to bridge and close the gaps. In the action continuum, PNA is doing its utmost best to be responsive but there is always room for more comprehensive and integrated actions. This explains the need for a thorough understanding of the social determinants of health. The use of an evidence-based approach should be seen as a tool to continually push and move us to more lasting solutions to deeply rooted gaps in the health care.

ERLINDA CASTRO-PALAGANAS, RN, PhD

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President's MESSAGE

Dear Colleagues,

We have been discussing our role in evidence-based practice (EBP) for sometime now. We have come to recognize that in our quest for quality and access to health care, EBP necessitates us to put our efforts into mobilizing a supportive environment for quality nursing that uses research findings appropriately. We now see the value of EBP and its emphasis in using the results of research and evaluation to the extent possible to select intervention techniques and other procedures that have evidence of effectiveness. The Philippine Nurses Association (PNA) recognizes that professional nurses are accountable to society for providing high-quality, cost-effective services. Thus, we strive to provide the leadership, in partnership with our stakeholders, to keep searching for new and more effective ways to serve our people.

As the Accredited Professional Organization (APO), the PNA continues to assert and push for the general welfare of our nurses through observance of work conditions approximating a positive practice environment. It's high time that we move for more welcome changes. May we not tire fighting for what the nurses deserve as stated in RA 9173 and RA 7305. Let us not allow evil individuals to further cripple the health care delivery system by privatizing health institutions. This is tantamount to taking away from us the basic benefits that have been sparingly provided. Let us not allow ourselves to be exploited for some selfish gains. This is a haunting gap we need to close.

PNA records show that its leadership has been figuring prominently in the legislative arena with the passage of RA 9173. The current leadership is never indifferent to taking positive steps to make nursing practice more relevant to the times and responsive to the needs of all nurse practitioners. The association has been very active as a member of the Technical Working Group for the passage of the House Bill No. 5592 and 5270, authored by Congressmen Rufus Rodriguez, Sonny Angara and Carlos Padilla consolidated into one known as an "Act Instituting Reforms to Further Develop and Strengthen the Practice of Nursing in the Philippines", repealing RA 9173. Likewise, PNA had closely worked with the Professional Regulation Commission Board of Nursing in the just promulgated Nursing Core Competency Standards by the PRC and the Nursing Profession Roadmap 2030.

The clamor for dynamism, vigor and pro-active involvement should continue. Let us not just be contented poking or bashing each other on Facebook, Twitter or through other social media. The bickering and negative criticizing should end. I believe that nurses are still up to all of these modern-day challenges, despite feeling bruised or beaten up by so many things. We can still be the catalyst to create the changes we have been wanting. Through continuous faith in God, coupled with selfless and dedicated work, we can close the nagging gaps besieging the nursing profession. EBP requires us to have the the skills and attitudes, the commitment to keep learning, to keep searching for new and more effective ways to serve consumers. This is a step forward from evidence to action in our efforts in closing the gaps in today's health care.

Patuloy nawang pagpalain ng Diyos ang PNA! Mabuhay tayong lahat!

Sincerely,

NOEL C. CADETE, RN, MAN
National President

Nurses Migration, Deployment, Enrollment and Board Passing Trends in the Philippines (1999-2008)

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Abstract

Over the years, trends in international nurse migration and deployment as growth strategy have tremendously increased, resulting in the proliferation of nursing schools, and remarkable increase in student enrolment in the nursing program. This is a telling indicator that migration has woven its way into the educational and work aspiration of Filipinos. This study thus aims to investigate the migration and deployment trends of Filipino nurses, trends of growth in the number of nursing schools, increase of enrolment and board passing rates; and find out the key dynamics that sustain migration phenomenon. Using the historical method of inquiry, data and information were gathered retrospectively from five (5) participating agencies, namely: CFO, POEA, CHED, PRC, and DOLE. The empirical data were then transcribed and subjected to analytical procedures, using the exponential time series analysis. The study revealed that the dominant destination country for permanent migration, that is for Filipino emigrant nurses, is the USA; and deployment of nurses, that is for temporary migration, is the Saudi Arabia. Thus, the rise and fall of overall migration and deployment is largely dictated by the demand of USA with more permissive law for permanent migration; whereas, migration to other countries has a very insignificant effect on overall Filipino nurse migration. There is a general decreasing trend in overall migration and deployment. Although deployment trend to Saudi Arabia, Kuwait and other countries is significantly increasing, deployment to the United Kingdom and Ireland is decreasing; hence overall migration cannot be predicted. In general, it cannot be significantly claimed that overall migration and deployment is increasing. With this scenario, nursing education with increasing enrolment and number of nursing schools coupled with decreasing board passing rate must be reassessed in the light of migration and deployment as a growth strategy.

Keywords: Filipino nurses, migration/deployment trends, nursing enrollment, nursing schools, board passing rates

Introduction

International migration has become a significant feature of globalized labor market in health care; and of all health care workers in the country, nurse

migrants have been prominent at the fore. This situation has been accelerated by shortages of nurses in developed countries besides the various "push and pull" factors that anchor on the socio economic and political realm.

Of the socio-economic factor, migration of nurses has positive effects in the Philippines. For instance, once employed in the United States, nurses can earn as much as twenty times what they were doing back home (Orozo, Lowell, Bump & Fedeura, 2005). Part of this money they send home to support family and other dependents. Remittances flowing back into the country from migrant nurses help boost the Philippine economy and support the local population (POEA, 2005; Dole, 2004). On top of remittances, if and when migrant nurses return to the Philippines, they bring with them greater amounts of training and experience, contributing to the social capital (Findlay & Stewart, 2004).

The government has reacted to the potential socio-economic benefits from emigration by sponsoring initiatives to facilitate the process. In 1982, the government created the POEA, responsible for optimizing the benefits of the country's overseas employment program. The Philippine National Bank (PNB) has also reacted with the programs that encourage remittance flows, and special remittance centers have been created in various parts of the United States.

Apparently, the Philippines is the leading primary source country for nurses internationally by design and with the support of government (Sto. Tomas, 2005; Lorenzo, 2002; Llorente, 2003; Adversario, 2003). The 2001-2004 Medium Term Philippines Development Plan views overseas employment as a key source of economic growth. Filipino nurses are in great demand because they are primarily educated in college degree programs and communicate well in English (Tan, 2005; Lorenzo, et al., 2007; Hawthorne, 2001) and because governments have deemed the Philippines to be the ethical source of nurses. Motivation for the Philippines to produce nurses for export is remittance income sent home by nurses working in other countries (Lorenzo, 2007; Ball, 2004; Brush & Sochalski, 2007; Galvez-Tan, 2006). In 1993, Bruce Lindquest reported that Filipino nurses working abroad sent home more than $800 million in remittance income. No other country produces many more nurses than are needed in their own health care system as the Philippines at a level of education that meets the requirements of developed countries (Lorenzo, 2007; Tan, 2006; Adversario, 2003).

Due to external demand trends, a boom in Philippine nursing education has been observed with the great rise in enrolment, resulting in a significant increase in the number of nursing schools. As many as two hundred (200) applications for new nursing programs were submitted during school year 2004-2005 alone. Only twenty-four (24) were approved for regular permits. Existing schools have increased their absorption drastically from only one to two sections of forty or fifty students to as many as sixty sections for the freshmen (CHED, 2006).

The proliferation of nursing programs which puts into question the quality of training, the specter of an oversupply of nurses, and the potential mismatch between skills needed and available human resources are societal-wide concerns that must be addressed and be weighed vis-à-vis individual aspiration (Muncada, 2008).

Another contextual issue of importance is the national level regulation of the nursing profession in terms of international level requirements to be able to practice in the destination countries. The existence of any international agreements that facilitate cross-border movement of nurses through mutual recognition of qualifications or by automatic registration in destination countries will increase influence migration flows (Zlotnik, 2003; Findlay & Lowell, 2002). The standards, competencies and qualifications required to practice as a nurse vary in different countries. This variation may become a barrier to migration of individual nurses, if they do not meet the criteria to practice in the destination country (Davis & Nichols, 2002; Buchan, Kingman & Lorenzo, 2007). These criteria include language proficiency as well as a qualification in nursing (Hawthorne, 2002).

Trends in international nurse migration must, therefore, be seen in the light of some significant issues and concerns. From the global perspective, the controversy centers on the risk that predicted shortages and recruitment of nurses in developed countries threaten to deplete the supply of qualified nurses in less developed countries and undermine global health initiatives. A two-fold approach in this regard becomes cogent, involving greater diligence

by developing countries in creating a largely sustainable domestic nurse workforce; and greater investment by developed countries that will give priority to building adequate educational infrastructure for their own need while providing assistance for establishing education capacity in less developed countries that supply them with nurses. Intuitively, towards this end the forecast date of migration and deployment will be of far-reaching-value; hence, this study is conducted.

RESEARCH METHOD

Design

The design of the study is exponential time series. So, the method of gathering data is historical, i.e. in collecting the data and information, it is done in a retrospective way, using the relevant official records on migration and deployment for the last ten years (1999-2008) from the five participating agencies: CFO, POEA, CHED, PRC, and DOLE. From their records, data and information are culled consolidated and streamlined in terms of the constructs treated by this design, namely: trends on nurse migration, the number of schools offering nursing programs, increase of enrolment and board passing rates.

Participants

A minimum of three (3) employees from each of the five (5) participating agencies, namely: CFO, POEA, CHED, PRC and DOLE consulting a total of fifteen (15) served as data providers; they are, therefore, the participants of the study. They acted as a support group of this research endeavor by helping the researcher in obtaining the time series data from their respective agencies' official records for the time series analysis. This support group is purposively selected and in the selection, importance is given on their sufficient knowledge of the necessary data and information on file regarding migration and deployment of Filipino nurses in 1999-2008. Their direct and close involvement regarding the data/information as well as their willingness in supporting the research project thus become imperative.

Research Techniques

The documentary analysis vis-à-vis time series analysis served as the research techniques discussed below.

Documentary analysis is accomplished by collecting data and information from records/documents, and analyzing them so as to come up with the time series data in preparation for the time series analysis on nurse migration trends, growth trends in enrolment, number of schools offering nursing programs and board passing rates of graduates of the last ten years (1999-2008).

Time series technique (exponential model) handles data on the same variable at regular interval by year for establishing baseline measures, describing changes over time, keeping track of trends, and forecasting future (short term) trends. The time series data are presented in tabular and graphical forms. Of the graphs, the horizontal or x-axis is divided into time intervals by year and the vertical or y-axis shows the values of the dependent variables as they fluctuate over time (Velicor & Fava, 2003). The researcher thus looks into the patterns of increases or decreases over the whole time span from the graphs as supported by their corresponding tables.

Data Analysis

The model available in SSPS, particularly the exponential smoothing method is used to predict the short term prediction with Alpha as the parameter that estimates the effect of the time series data. Curve fitting for time series analysis is performed by selecting “regression” from the analysis menu and then selecting “curve estimation” from the regression option, leading to the choice of the exponential model, Y = b0eb1t, where, Y is the forecast value, b0 and b1 are the constants, e the natural number and t the time. This is the model used in forecasting the time series data.

Findings

Filipino Nurse Migration and Deployment to Top Five Destination Countries

A. Migration Trends

Table 1 *(page7)* presents the data on the migration of Filipino nurses and the top five destination countries. These nurses were employed by virtue of an immigrant visa, hence are allowed to permanently reside and work in the destination country.

Table 1: *Top Five Destination Countries of Permanent Filipino Nurse Migrants (1999-2008)*

Year	Migration Destination Countries					Total Filipino Nurse Migrants
	United States	Canada	Australia	New Zealand	Germany	
1999	306	41	15		3	365
2000	1076	98	34	4	3	1215
2001	1381	141	39	2	3	1566
2002	2057	127	36	6	3	2229
2003	2084	118	20	5	1	2228
2004	3837	100	30	1	4	3972
2005	3656	121	28	5	1	3811
2006	5790	102	30	5	3	5930
2007	1107	99	27	11	0	1244
2008	771	178	19	11	2	981
	2006	**103**	**25**	**5**	**3**	**2223**
Mean	**(93.73%)**	**(4.78%)**	**(2.08%)**	**(.21%)**	**(.17%)**	**(100%)**

**Source of Data: POEA & CFO*

As shown in the Table, the top five destination countries include the United States of America, Canada, Australia, New Zealand and Germany. The United States of America is the dominant migration destination country, accounting for 93.73 percent of the average annual migration of 2,223 during the period, 1999 to 2008. The remaining 6.27 percent is distributed to the other four migration destination countries with Canada getting 4.78 percent, Australia, 2.08 percent, New Zealand, .21 percent, and Germany, .17 percent.

In contrast, while the average annual deployment of nurse to the USA was only 335 from Table 4 in the succeeding page, the average annual permanent migration is 2006 in Table 1. This reflects the Filipino nurses' preference to work in the USA with more permissive laws for foreign nurses to stay permanently, particularly for Filipinos as far as the data from both tables revealed.

As shown in Table 1, there was an increasing trend in the migration of Filipino nurses from 365 in 1999 to the peak of 5,930 in 2006. However, a sharp drop was observed in 2007 when total migration was only 1,244, corresponding to about a 79 percent decrease compared to that of the total migration in the previous year. Figure 1 *(page 8)* presents the migration trend lines for each of the above cited countries and the combined migration to these countries.

The above results suggest that any change in the migration policies in the USA will likely affect the Nursing Education Program in the Philippines, considering that the country is internationally a leading primary source for nurses by design and with the support of the government; and for decades, the Philippines has been a sending country of well-trained nurses abroad particularly to the USA as a strategy for growth.

The decision to migrate is a complex variety of push and pull factors. Push factors are influences that arise from within the source country and facilitate a potential migrants decision to leave, while pull factors reflect actions and missions of recipient countries that create the demand for or encourage potential migrants to leave home (Dovlo, 2004 & Matinineau, Decker, & Bundrad, 2004; Kingma, 2001, Lorenzo et al., 2007).

The above results suggest that any change in the migration policies in the USA will likely affect the

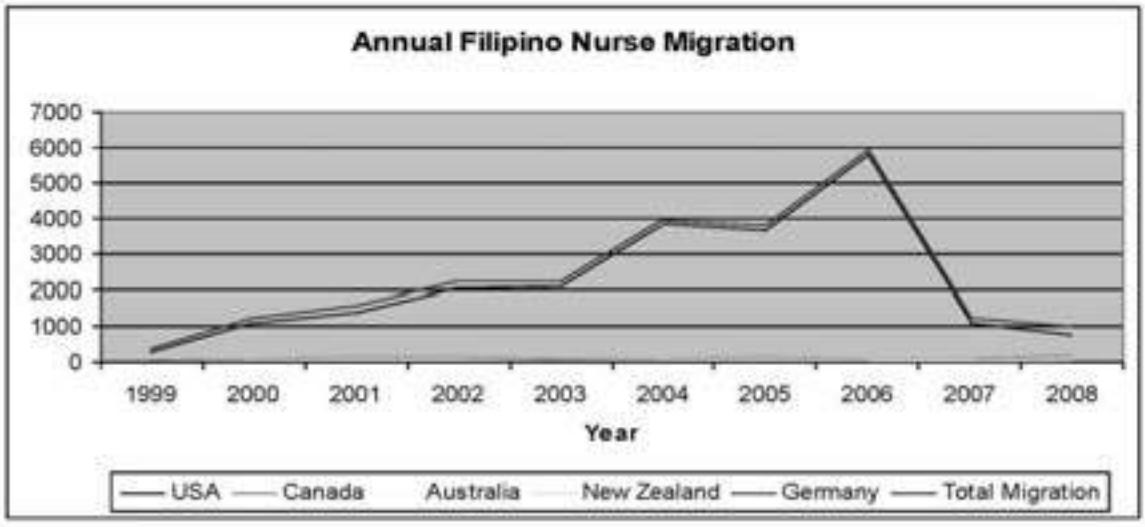

Figure 1: ***Migration of Nurses by Country and Total***

Nursing Education Programs in the Philippines that relies on foreign countries for employment of its nursing graduates.

Table 2 presents the results of the regression analysis on the above presented data on the migration of Filipino nurses.

As shown in Table 2, the migration to the top five countries, including the overall migration cannot be significantly predicted from the data. This is indicated by the R2 values ranging from .040 to .450 with corresponding p-levels, the least of which is .069. Hence, not significant at the .05 level. The regression equation is set up with two main variables: time in years (1999-2008) as the independent variable; and number of migrants to each of the identified destination countries as the dependent variables. Using the Statistical Package for Social Sciences (SPSS), the best fit curve was determined for the non-linear exponential model.

Table 3 *(Page 9)* presents the projected migration of Filipino nurses to the top five destination countries in the period 2009 to 2013. The predictions are based on the assumption of exponential growth of migration trend over time. Moreover, the same trend is expected to occur for as long as the same condition surrounding nursing migration prevails in the future.

Table 3 clearly shows, although not significant, the decreasing trend in migration to the USA and Australia, while that of Canada and New Zealand are both increasing.

In support of these observations, it may not noted that from Table 1, Canada and New Zealand only account for 4.78 percent and .21 percent respectively (less than 5 percent). Thus, even with the increasing migration to these two countries, overall migration can still decrease with the decreasing trend in migration to the USA which accounts for 93.73 percent of overall migration. Looking back, the projections thus play out; the fit of the USA line stands clear.

Table 2: ***Time Series Table for the Significance of Prediction of Migration Over Time By Country of Migration and for Total***

Deployment Country	R^2	Df	F-value	p-level	b_0	b_1
United States of America	.040	6	.25	.635	1581.02	.0516
Canada	.161	6	1.15	.325	101.91	.0303
Australia	.450	6	4.90	.069	41.50	-.0657
New Zealand	.178	6	1.30	.298	2.09	.1156
Germany	.062	6	.40	.551	2.97	-.0499
Overall Migration	.058	6	.37	.565	1687.3	.0564

Table 3: *Projected Filipino Nurses' Migration in the Next Five Years.*

Year	Destination Countries					Overall Migration
	United States of America	Canada	Australia	New Zealand	Germany	
2009	1485	177	22	10	1	1847
2010	1428	187	21	11	1	1808
2011	1373	198	20	13	1	1769
2012	1321	209	19	14	1	1732
2013	1271	221	18	16	1	1695

** Source of data: POEA & CFO. From these sources DEPLOMENT IS NOT = TO DEMAND.*

B. Deployment Trends

The data on the deployment of Filipino nurses by year and country of destination as well as the overall deployment are presented in Table 4.

Table 4: *Deployment of Filipino Nurses (1999-2008)*

Year	Deployment Destination Countries						Total Deployment
	Saudi Arabia	United States	United Kingdom and Ireland	United Arab Emirates	Kuwait	Other Countries	
1999	4031	53	934	378	53	505	5954
2000	4386	91	2755	305	133	654	8324
2001	5275	304	6949	249	192	844	13813
2002	6068	322	4035	424	108	953	11910
2003	5996	197	1754	267	51	953	9218
2004	5926	373	991	250	408	921	8869
2005	4886	229	843	703	193	914	7768
2006	5753	202	394	796	354	1029	8528
2007	6633	933	165	616	393	1013	9753
2008	8848	649	63	435	458	2165	12613
Mean	5,780(60%)	335(3.5%)	1,888(20%)	442(4.6%)	234(2.4%)	995(10%)	9675(100%)

** Source of data: POEA & CFO. From these sources DEPLOMENT IS NOT = TO DEMAND.*

Table 4 shows that the mean annual deployment of nurses from 1999 to 2008 is 9,675. The greater majority of these nurses, 5,780 (60%), were deployed to Saudi Arabia. The United Kingdom and Ireland turned out to have the second largest demand (1,888) comprising 20 percent of the total deployment. The other deployment destinations include the United States of America, united Arab Emirates, and Kuwait with respective mean annual deployments of 335 (3.5%), 442 (4.6%) and 234 (2.4%). A number of nurses were deployed to Other Countries with combined annual deployment comprising 10 percent of total deployment. Figure 3 presents the corresponding line graphs for the above data.

As shown in Figure 2 *(page 10)*, total deployment of nurses appears to be generally increasing. Except for that of the United Kingdom and Ireland**,** increasing trend is particularly observed in the deployment to Saudi Arabia , United States of America, United Arab

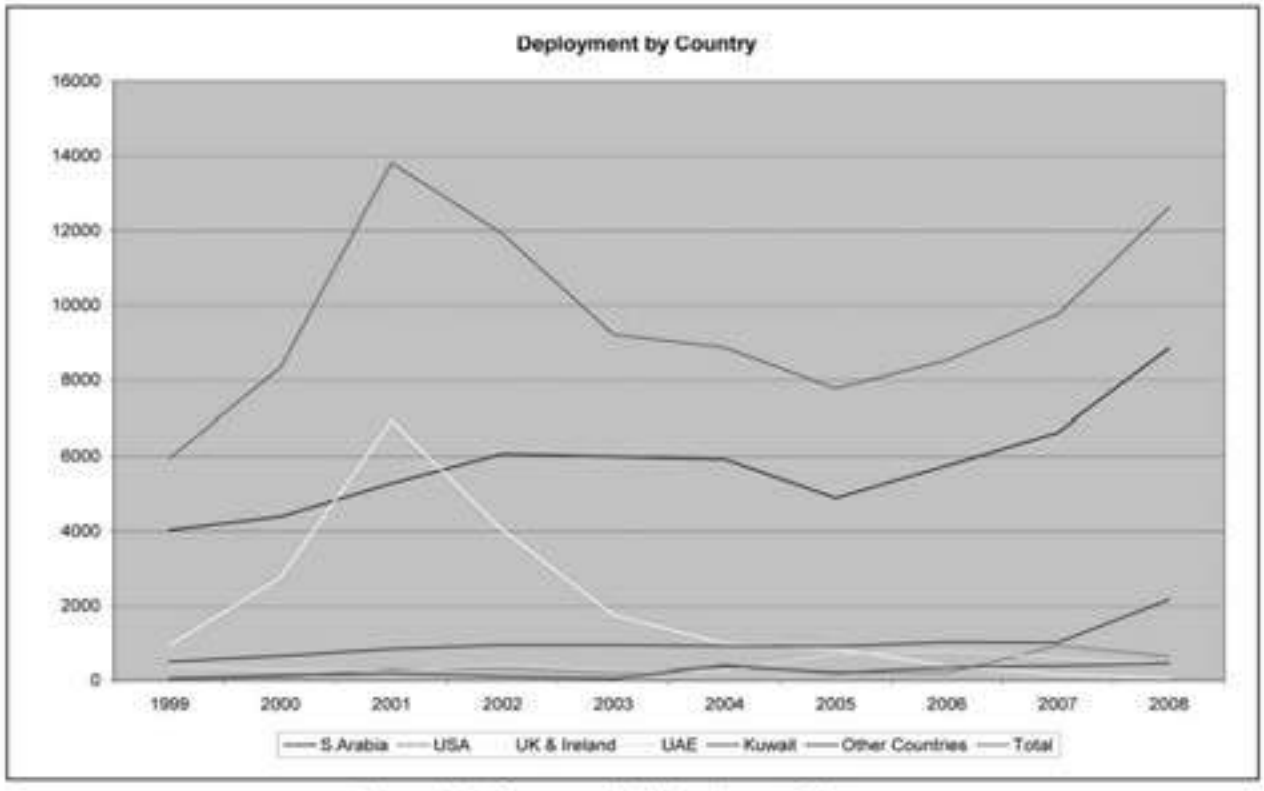

Figure 2: ***Deployment of Filipino Nurses by Country***

Emirates and Kuwait; including the combined deployment to Other Countries.

It is worthwhile noting that of the two major deployment destinations, the demand of the United Kingdom and Ireland has been decreasing since 2001, while deployment to Saudi Arabia has been increasing after 2005. Apparently, Saudi Arabia is the major deployment destination while Other Countries Combined may soon be a destination prospect for Filipino nurses as shown by the sharp increasing deployment trend towards the end of the study period, 2008.

The above data were trend analyzed using time series regression analysis with an exponential model. Table 5 presents the F-values, their corresponding probability levels and the constants, b_0 and b_1, for the exponential model $\mathbf{Y = b_0 e^{b_1 t}}$.

Table 5: ***Time Series Table for the Significance of Prediction of Deployment Over Time by Country of Deployment and for Total***

Deployment Country	R^2	df	F-value	p-level	b_0	b_1
Saudi Arabia	.651	8	14.90	.005	4083.50	.0251
United States of America	.623	8	13.24	.007	74.4128	.0251
United Kingdom and Ireland	.653	8	15.05	.005	7660.15	-.3854
United Arab Emirates	.328	8	3.90	.084	259.396	.0815
Kuwait	.574	8	10.79	.011	58.4683	.2053
Other Countries	.706	8	19.23	.002	527.450	.1030
Total	.092	8	.81	.395	8196.53	.0251

Table 6: *Deployment Forecast of Nurses for the Next Five Years*

Year	Destination Countries						Total Deployment
	Saudi Arabia	United States	United Kingdom and Ireland	United Arab Emirates	Kuwait	Other Countries Combined	
2009	7,818	843	110	635	559	1637	10,799
2010	8294	1051	75	670	687	1815	11,073
2011	8798	1311	51	748	843	2012	11,354
2012	9334	1634	34	812	1035	2231	11,642
2013	9902	2038	24	881	1271	2472	11,938

Table 5 *(page 10)* reveals that deployment to Saudi Arabia, United States of America, United Kingdom and Ireland, Kuwait and the Other Countries Combined can be significantly exponentially predicted from the data, while deployment to the United Arab Emirates and Total deployment cannot.

More particularly, there is a significant increasing trend of deployment to the countries: Saudi Arabia, United States of America, United Arab Emirates, Kuwait and to the Other Countries Combined, as indicated by the R^2-values and corresponding p-levels ranging from .011 to .002 with positive constants, b_0 and b_1. On the other hand, deployment to the United Kingdom and Ireland is significantly decreasing with R^2-value of .653, corresponding p-level of .005 and constant b_0 = .7660 and a negative value of b_1 (-.3854). Whereas, deployment to the United Arab Emirates, although suggesting an increasing trend , cannot be significantly predicted over time as revealed by the R^2-value of .328 with p-level of .084.

In terms of total deployment, the R^2-value of .092 has a p-level of .395, indicating that overall deployment cannot be significantly predicted from the data. This result may be attributed to the fact that the two topmost destinations, Saudi Arabia and the United Kingdom have opposing trends, the first increasing while the other decreasing. Hence, in general, it cannot be significantly claimed that overall deployment is increasing. This result is alarming considering its possible effect on the employment of the increasing number of graduates.

Table 6 presents the deployment forecast for the next five years for each of the destination countries. Based on the predicted values, Saudi Arabia, USA and the Other Countries Combined are the countries that are expected to have greater demand for Filipino Nurses. Moreover, of the expected total deployment, Saudi Arabia will remain to be the topmost deployment destination.

As indicated, independent of external factors (e.g. closing or ban on nurse recruitment, government or political health care and other employment policies and obstacles), that may arise, there would be continuing increase in the migration of nurse professionals (O'Dowd, 2004; Armstrong, 2005; Buchan & Kingma, 2005). Simoens, Villenueve, & Hurst (2005), indicated that there is a growing demand for nurses in high income countries due to the health needs of rapidly ageing and highly medicalized populations. Internationally recruited nurses provide what has been described as a "quick fix" to the lack of health personnel in developed countries (Kimball, 2004).

Employment prospects in the international arena continue to pick up due to the improvement in global technologies and countries' economies. Qatar, Guam, Palau and Japan had signified their need for Filipino health workers, among others (Pasadilla, 2004).

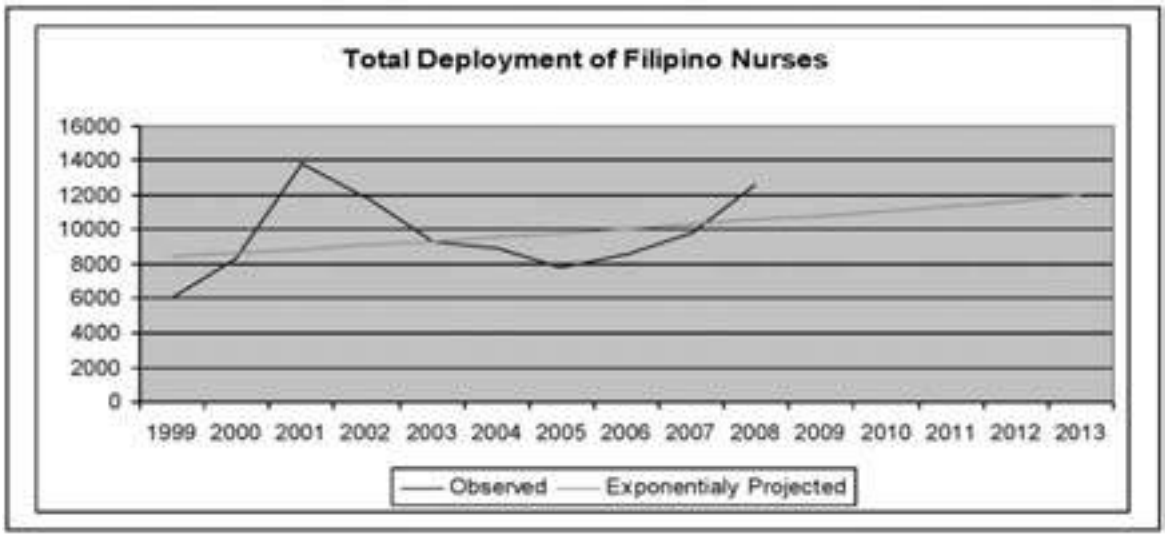

Figure 3: *Observed and Projected Total Deployment of Filipino Nurses*

C. Enrolment Trends

As shown in Table 7, the enrolment during the first three years (1999-2000 to 2000-2001) of the study was still less than 30,000 (27,463- 27,833). However in the School Year 2001-2002, enrolment started to increase with the peak enrolment of 453,896 during School Year 2006-2007.

Table 7: *Trend of Nursing Enrolment (1998-2008)*

SCHOOL YEAR	ENROLMENT
1998-1999	27,463
1999-2000	25,951
2000-2001	27,833
2001-2002	49,895
2002-2003	94,106
2003-2004	178,626
2004-2005	295,742
2005-2006	397,195
2006-2007	453,896
2007-2008	421,194

Moreover, the results of the time series regression analysis with an exponential model further revealed a highly significant positive relationship over time of enrolment in nursing schools with an F-value of 116.93, p< .0001, and constants of b_0 =.387and b_1= 13569.558 Hence, the resulting exponential forecast model of

$$Y = .387\, e^{1,3569.558t}$$

where **Y** is the forecast value, **t** is the n^{th} year, and **e** is the natural number.

Using the above model, enrolment in the next three years, on the average, is expected to grow exponentially. Table 8 presents the enrolment forecast in the next five years. This model will continue to hold along with the following assumptions:

Table 8: *Enrollment Forecast (2008-2009 to 2012-2013)*

SCHOOL YEAR	ENROLMENT FORECAST
2008-2009	959,227
2009-2010	1,412,683
2010-2011	2,080,502
2011-2012	3,064,018
2012-2013	4, 512,473

(1) That the demand for Filipino Nurses continues to increase;
(2) That the country recognizes positive economic value in the deployment of Filipino nurses;
(3) That the equality of Filipino nurses meets international standards.

The Table 8 clearly shows that if the trend continues, enrollment in nursing will be more than four million (4,512,473) in the next five years. This is

more likely to happen when no other developments will hamper the trend, particularly in the employment market for nurses like' the following:

(1) Peace and order situation in countries where our nurses are deployed;
(2) Financial performance of these destination countries ; and
(3) Change in the policies relevant to salaries/hiring of foreign nurses among destination countries.

The above result is the consequence of the perceived increasing demand for nurses in the international market and the economic conditions in the country. However, based on the result of the study, only one country, Saudi Arabia, significantly accounts for overall deployment of our nursing graduates. This makes the market very vulnerable, for any untoward development in Saudi Arabia could affect an adverse effect of an overall deployment. This finding strongly suggests the need to maintain good diplomatic relations with Saudi Arabia and develop more linkages with other employment markets for the appropriate placement of the prospective graduates. Otherwise, from the trend of enrolment in nursing, the country will soon have oversupply of nurses a condition the country must avoid. The performance of nursing schools should be closely monitored by CHED. Nursing schools with low board examination performance should be warned if not closed, if they continue to have low performance. More importantly, proper control measures must be established to safeguard the opening/recognition of nursing programs.

D. Trend in the Number of Schools Offering Nursing

With the increasing trend in nursing enrollment, schools especially those with dwindling enrolment, have ventured to add nursing course to their program offerings. This scenario has triggered the proliferation of Nursing Schools. Table 9 exhibits the data with the increasing trend up to SY 2006-2007.

Table 9: ***Number of Nursing Schools in the Philippines (1998-1999 to 2007-2008)***

SCHOOL YEAR	Number of Schools
1998-1999	190
1999-2000	186
2000-2001	183
2001-2002	202
2002-2003	232
2003-2004	300
2004-2005	344
2005-2006	437
2006-2007	465
2007-2008	463

Table 10: ***Exponential Time Series Forecast for the School Years (2008-2009 to (2012-2013)***

School Year	Number of Nursing Schools Forecast
2008-2009	557
2009-2010	631
2010-2011	714
2011-2012	810
2012-2013	918

The trend in the number of schools in the Philippines offering nursing is increasing, as revealed by the result of the exponential time series analysis with F-value 97.83 and probability level less than .0001, which is highly significant. More particularly, the exponential time series model for the trend is given by

$$Y = 140.646\, e^{.1251\, t}$$

The fit between the observed number of schools is evident in the exponential trend line in Figure 2 *(page 14)*. This means that if the demand for nurses in other countries continues, the demand in the enrolment will continue which will encourage more schools to open a nursing program.

Table 10 presents the projected values on the number of schools for the next five years. The forecast values clearly show the increasing trend in the number of schools.

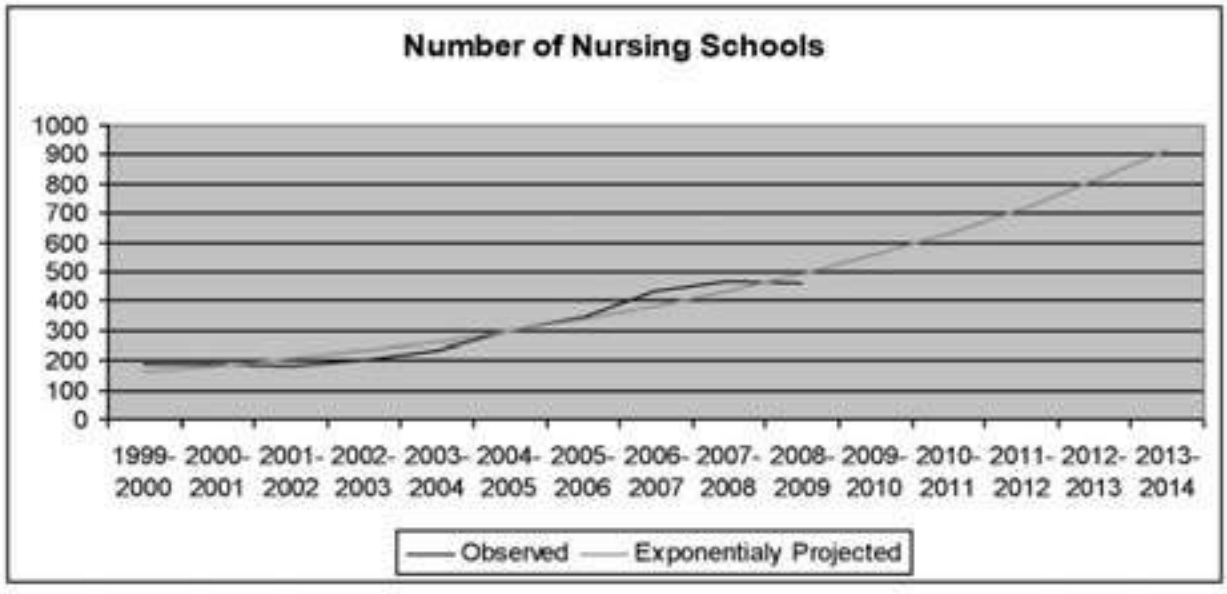

Figure 4: ***Trend line of the number of nursing schools***

The Table evidently gives a clear picture that the number of nursing schools in the Philippines will be about a thousand in the next five years. This will happen if both domestic and foreign demands for nurses will continue to rise and generate a rapidly growing nursing education demand.

By law of supply and demand, the condition will attract investment in the offering of nursing as a new program, or the opening of new schools of nursing.

The above result is due to the increasing enrollment of nursing students resulting from the perceived in the employment market for nurses. However, only Saudi Arabia remains to be the topmost destination country for our nurses. This weakens the demand, unless other countries like Qatar, Guam, Palau and Japan will pursue their demands for Filipino nurses.

Table 11: ***National Board Passing Rates in Nursing (1999 -2008)***

Year	Passers	Rate
1999	8,313	50.4
2000	4,601	49.6
2001	4,430	53.6
2002	4,228	44.8
2003	7,528	48.8
2004	12,587	52.24
2005	25,951	52.24
2006	37,030	46.03
2007	60,199	45.78
2008	67,220	43.90

E. Trend in Nursing Board Passing Rate

The data on the number of nursing board passers and the nursing board passing rate for the past ten years (1999 to 20080 is presented in Table 11.

As shown in Table 11, the number of nursing board passers has significantly increased from the least of 4,228 observed in 2002 with the highest 67,220 in 2008. However, a downward trend in the passing rate was observed.

The time series analyses using an exponential model show that the number of board passers is significantly increasing with F-value of 116.93 with $p<.001$. On the other hand the passing rate has an F-value of 3.85 with $p<.085$, hence not significant. This means that while the number of board passers can significantly be predicted from the data, the passing rate can not.

Table 12 presents the forecast in the next five years of both the number of board passers and the passing rate from 2009 to 2013.

As shown in the table, the total number of board passers, if not affected by other factors, is expected to rise to 299,945 represents about 40 percent (42.93) of the total number of test takers.

Table 12: *National Board Passing Rates in Nursing (2009-2013)*

Year	Passers	Rate
2009	82,221	45.15
2010	113,631	44.58
2011	152,041	44.02
2012	217,033	43.47
2013	299,945	42.93

The results indicate that while enrollment and consequently graduates of nursing schools are significantly increasing, the downward trend is passing rate is not statistically significant. However, there is a need to have proper control measures to stop the downward trend, as this may be a sign that the equality of nursing education is deteriorating.

Discussion

Filipino nurses prefer to work in the USA. This is manifested by the annual average migration of 2006 migrants to USA. In contrast with the average annual deployment of 335 from the period 1999 to 2008 to the same country. Of the top five migration destination countries, the USA accounts for 93.73 percent of the average annual migration. The remaining 6.27 percent is distributed to Canada (4.78 %), Australia (2.0 %), New Zealand (.21 %) and Germany (.17 %). These figures may indicate that the four destination countries of deployment have different migration policies, or that nurses in the Philippines are selective of the countries (Kingma, 2004) where they would like to migrate to. There is a general decreasing trend of overall migration, and that of the countries: USA, Australia and Germany while increasing trend was observed in Canada and New Zealand.

Deployment has increasing trend particularly in Saudi Arabia, USA, United Arab Emirates, Kuwait and Other Countries Combined. Apparently, Saudi Arabia is the major deployment destination while the United Kingdom and Ireland has decreasing deployment trend. Hence, the overall deployment cannot be significantly predicted. Nursing schools whose responsibility is to manage the supply factor should have selective admission for proper control measure in enrolment. Continuing evaluation of need, revision of curriculum is definitely triggered if we talk of not only supply/demand, but relevant supply/demand. With changing environmental trends, change is constant in education and training. Thus, revision of curriculum goes hand in hand with the need or demand assessment to overcome irrelevance of our educational products/services in the training of our nurses for export, strengthening of competences of nurses must be done to cope with relevant demands not to exceed it.

The insignificant overall deployment and migration of nurses vis-à-vis the significantly increasing enrolment and the number of nursing schools poses a risk on both the nursing graduates and the school with nursing programs. This means that there is a high tendency that the increase in the number of graduates will surpass the demand in the supply of nurses for deployment and migration, causing an oversupply of nurses in the country. With an oversupply of nurses, unemployment and underemployment problems will crop up. When this happens, a decrease in nursing enrolment is likely to follow which could create more problems.

Various government agencies such as the POEA, CHED and the PRC claim that there really exists an oversupply of nurses in the country which contributes to the unemployment rate. Oversupply of nurses in the Philippines is reflected in recent statistics which shows that as of 2008, there are 460 accredited nursing schools. The total B.S. Nursing graduates reached 67,728 in the same year. The unemployment rate of nurses could be between 50,000 to 80,000 per year (POEA, 2006).

The maintenance of nursing education and subsequent practice standards is a continuous challenge of establishing and maintaining standards (Blythe & Baumann, 2008). With the many nurses in the country not many hospitals can give the necessary experience as required by other countries. There should be strict regulation of nursing schools applying for accreditation as one of the many ways to ensure quality nursing education. Licenses of nursing schools which cannot provide quality education should be revoked.

Moreover, the decreasing trend in the passing rate in the nursing board examination need to be reassessed in the light of its possible effects on nursing deployment, migration and the economy. The government should institute strict monitoring of existing institutions. The former PNA President, Dr. Barcelo, has led the organization to push for the delivery of quality nursing education and training coupled with stringent recruitment and retention of student that will ensure them of quality education in their chosen field. This is with the end in view of putting the country's nursing education on par with the rest of the world.

On the whole, the results of the study suggest the need to put in place effective measures that will address long-standing problems/concerns; measures that are meant to provide genuine long-term solutions and not temporary band-aid remedies.

It is to be emphasized that the empirical data analyzed can give a clue as to what obligations and responsibilities that the discipline of nursing has to address. Necessarily, this must guide the education, training institutions, and career mobility of our nurses vis-à-vis the whole health care enterprise and well-being of the country.

Conclusion

This study analyzed the trends in the migration and deployment of Filipino nurses, growth of enrollment in nursing, increase number of nursing schools and nursing board passing rate in the next five years based on the data in the ten year period (1999-2008) with the use of time series curve fitting regression exponential model. Significant and insignificant trends were revealed. USA is the dominant migration destination of Filipinos which would imply that any change of migration policy in the USA will affect the career mobility of our nurses. Consequently, the nursing education program of the Philippines will also be affected.

In terms of overall migration and deployment, an insignificant increasing trend was observed vis-à-vis significant increasing trend in enrolment and number of schools. This opposing trends call for some stringent control measures so that trends do not reach unmanageable proportions. Nursing schools and/or training institutions whose responsibility is to manage the supply factor, should have a continuing education program that would regularly strengthen, enhance and update the competencies of nurses. As explained in the preceding, if we talk of supply/demand factors these factors must be "relevant". As we know change is constant with changing environmental trends. Thus, in education, the "revision of curriculum" has to be done regularly to overcome irrelevance of products/services; that is to produce nurses with sure relevant training/ education for development.

The downward trend in the passing rate is not statistically significant. This can be easily reversed if proper control measures are put in place. For instance CHED can regulate the quality of training and education for our graduates to meet international standards taking into account ideal class size, competencies of teachers and effective school curriculum.

If control measures must be instituted it becomes necessary to create a dynamic international data base that would support both the extent of supply and demand factor as well as the degree and impact of global nurse migration. It must be noted that nurses represent a small portion of highly skilled workers who migrate, but the loss of health human resources for developing countries can mean that the capacity of the health system is compromised.

Above all, it is significant that nurses remain vigilant of the health needs of expanding technology. In the next decade, the health care delivery system shall require the acquisition of multi-skills and more specialized trainings. And there will be more job opening for highly qualified nurses nurses who are competent enough and multi-skilled.

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Nurse Training and Nursing Education in the Philippines during the Spanish and American Periods

Abstract

This paper provides an overview of the development of nursing education in the Philippines from the arrival of the Spaniards in the 16th century until the period following World War II. A review of available literature shows the minimal progress made in nurse training during Spanish occupation, and the progress made following the introduction and significant influences of a more structured American model of nursing education in the country. Literature also highlights the role of religious orders and the private sector in the development of nursing education in the Philippines. Much remains to be learned in regards to the development of nursing education in the Philippines which may be useful in fully appreciating the significant role of the nursing profession in the Philippines and its history.

Key words: Nursing Education, History

Introduction

The history of nursing education in the Philippines is closely aligned with the history of medicine in the country. With the arrival of Ferdinand Magellan in 1521, developments in Philippine education were relatively slow owing to the belief of Spanish colonists, notably the friars, that the education of the natives would be detrimental to their rule over the islands (Agoncillo and Guerrero, 1977). It was decreed that the education of the natives be restricted (Elliott, 1916). It was, therefore, not surprising that very little progress was made in regards to educating the early Filipinos. The growth of educational institutions in the Philippines during the Spanish occupation was not a priority which allowed the proliferation and continued use of traditional health care practices that were guided by a mixture of religion, magic, and the supernatural (Dela Cruz, 1983). It was not until 1577/1578 that an implied

apprenticeship training program for male "nurses" who were called *enfermeros* was put in place through the initiative of the Catholic Franciscan order in the islands (Dela Cruz, 1983; Giron-Tupaz, 1952; Limson, Danguilan, Gutierrez, de Jesus, Crisostomo & Roxas, 1999). Subsequent progress in the area of nursing education was not achieved until after the arrival of the new colonizers in 1898. This paper will discuss the development of nurse training in the Philippines during the Spanish occupation of the islands, and the progresses made in nursing education since the time of American occupation beginning 1898 up to 1950. It will conclude with an analysis and critique of nursing education in the Philippines, and the availability of literature to provide a better understanding of the issues surrounding its subsequent development in the country.

Early Nurse Training During the Spanish Period and Fray Juan Clemente

In general, the development of all levels of education in the Philippine Islands during the Spanish regime was very limited, and mostly controlled by the Catholic Church which greatly influenced the affairs of the state and, in many instances, had a hand in the appointment and retention of Governor Generals sent by the Spanish crown. The goal of the colonial government was primarily to spread Catholicism; the Spanish friars viewed education as a barrier to their salvation, as well as "positively dangerous to the established order of things" (Elliott, 1917, p. 220). During their over 350 years of occupation of the country, very few educational institutions were established by the Spaniards and these postsecondary institutions were designed to educate the rich and famous of the time, that is, the children of Spaniards and the mestizos (children borne of mixed marriages between a Spanish male and a Filipino native) (Elliott, 1917). Furthermore, Bantug, as cited in Choy (2003) emphasized the unequal educational system under the Spaniards which only provided educational opportunities to men, while having little support even for primary education of women. Filipino women were expected to look after the household and therefore had no need to further themselves through education. The education of *indios*, a derogatory term used by the colonizers to refer to island natives, focused on Catholic doctrines, "and the duties of humility and obedience to superiors" (Elliott, 1917, p. 222). The Spaniards, to ensure their hold on the natives, severely restricted their education. This resulted in what Le Roy (1914) described as pitifully inadequate schooling of the Filipinos under the Spanish regime. Subsequently, early Filipinos continued to rely mostly on traditional healers, divination, superstitions, magic charms and crude folkways to address health issues. The practice of *herbolarios* (herbalists) and witches was very popular among the natives (De Morga, 1907).

In 1578, however, by some stroke of luck, a lay Spanish brother belonging to the Franciscan Order, Fray Juan Clemente, who was described as being religious, humble, charitable, and with a genuine desire to help the sick, initiated his nursing and catechetical works amongst the natives and other foreigners in Manila (Giron-Tupaz, 1952). This was regarded as the beginning of nursing practice and training in the Philippines. At a time when leprosy was feared, Fray Clemente "took them under his care, bathed their sores, fed them and nursed them back to health" (Giron-Tupaz, p. 14). He was skillful in the use of herbal medicines which made up for the limited availability of drugs (Giron-Tupaz).

According to Giron-Tupaz, news about Fray Clemente's nursing work became known throughout the islands, and they started to call him the *enfermero.* This term was originally used to refer to religious personnel who provided nursing care to the sick, and was subsequently applied to native attendants. There was no mention of Fray Clemente providing nursing training to early Filipinos. However, Giron-Tupaz did mention of *practicantes*, Filipino male attendants who were "previously instructed in the art of caring the sick" and who ably assisted *enfermeros* in managing hospitals, taking care of patients, begging alms for the maintenance of hospitals, and performing other nursing tasks (Giron-Tupaz, p. 16). Incidentally, the Franciscan Order was reported as being primarily responsible for the establishment of various hospitals in the Philippines during the Spanish regime (Giron-Tupaz). The same religious order may be responsible for the training of *practicantes* before formal nursing education was introduced. As of this writing, no information can be obtained to clarify the specifics of this training. No further information was reported from available

literature in regards to any progress made in the area of nurse training during the Spanish regime in the Philippines.[1]

Nursing Education During the American Occupation and Post-World War II

Following the defeat of the Spaniards in the Battle of Manila Bay in 1898, the new colonial masters sought "to establish a popular form of government in the Philippines" that would subsequently prepare the Filipinos for self-government (Elliott, 1917, p. 224). Part of their plan was to introduce a public education system using English as the medium of instruction and which was closely patterned after the United States of America's model. Alongside these efforts to promote primary education, the Americans also began to introduce industrial and professional training opportunities that were essential in the economic development of the colony (Elliott, 1917).

In 1906, the Iloilo Mission Hospital (IMH) was founded by the Baptist Foreign Mission Society of America (BFMSA) as the first nursing school in the Philippine Islands through the efforts of Dr. and Mrs. Andrew Hall, Presbyterian seminaries who were stationed in Iloilo City, the Philippines (Central Philippine University [CPU], 2007; Giron-Tupaz, 1952). Leadership and training were initially made by American nurses led by Martha Mills who became the school's first superintendent (Giron-Tupaz, p. 28). The school was said to have initially persuaded four female students who were provided instruction in reading, writing, arithmetic and nursing; three of them graduated from the three-year program in April 1906 (Giron-Tupaz, p. 28). The new nurses were initially maltreated and insulted by their family and patients who viewed them as muchachas (maids or servants); with time, they soon learned the great value of these three nurses for the kind of work that they provided in caring for the sick (Giron-Tupaz, p. 29). The year 1907 saw the establishment of four new nursing schools in Manila. These were the St. Paul's Hospital School of Nursing (SPHSN), the Philippine Training School for Nurses (PTSN) (initially housed under the Philippine Normal School, and subsequently renamed the Philippine General Hospital School of Nursing), the St. Luke's Hospital School of Nursing (SLHSN), and the Bethany Clinic School of Nursing (subsequently renamed Mary Johnston Hospital and School of Nursing) (Dela Cruz, 1983; Giron-Tupaz, 1952; Mary Johnston College of Nursing Alumni Association, 2010; Philippine General Hospital, 2009). These institutions were founded by the Sisters of St. Paul de Chartress, the Philippine Commission, the Episcopal Church of the Philippines and the Methodist Mission, respectively (Giron-Tupaz). These institutions offered programs whose length varied from three to four years (Giron-Tupaz). It is interesting to note that the admission requirements for these training programs varied greatly, and many of the applicants did not complete secondary education (Giron-Tupaz). The PTSN, for example, implemented an entrance exam, and the completion of seventh grade as requirements for admission (Giron-Tupaz, 1952). The Goldmark (1923) report on nursing and nursing education in the United States, and the Weir (1932) report on nursing education in Canada described a very similar situation to that which was observed in the Philippines. Considering that schools of nursing of the Philippines and Canada were patterned after the American system, this finding is not very surprising. It also shows that students in these countries could enter nursing with limited education; in other words the situation was similar in the colony and at home in the United States.

A few years following the founding of these institutions, three of them, namely, SPHSN, PTSN and SLHSN collaborated to implement a central school of nursing idea that allowed them to standardize theoretical instruction and to pool their resources to offer a common first year curriculum that consisted of "anatomy and physiology, massage, practical nursing, material medica, bacteriology and English" (Giron-Tupaz, p. 62). These institutions maintained their respective admission requirements and curricular offerings for subsequent years of their respective programs. Thus, SPHSN offered a three-year program while the PTSN and SLHSN had four-year programs. The PTSN, later renamed the Philippine General Hospital School of Nursing (PGHSN) led these institutions in raising the standards of nursing education and the academic requirements for admission to nursing programs (Giron-Tupaz; Philippine General Hospital, 2009). In 1930, completion of secondary school became a requirement for admission to the PGHSN, and by

[1] *An unverified entry in Wikipedia (2012) reports that the first nursing educational program was offered by the University of Santo Tomas through the Escuela de Practicantes. This school was supposed to have been founded in 1870, and subsequently closed in 1904.*

1933, admission preference was extended to those applicants who successfully completed six units of credit at the University of the Philippines College of Liberal Arts (Giron-Tupaz).

Between 1911 and 1948, 12 more hospital-based schools of nursing were founded (Giron-Tupaz, 1952) across the islands, bringing the total number of hospital-based nursing programs to 17 by 1948. Ten of these hospital-based nursing programs were founded or supported by religious orders and organizations. They were unevenly located in a few parts of the country, with nine programs based in Manila, two in Iloilo, and one program each in Baguio, Capiz, Cebu, Dumaguete, Iloilo, Occidental Negros and Zamboanga. An interesting initial feature of these hospital-based nursing programs was the absence of standardized requirements for admission into their nursing programs and curriculum. Information on curriculum content was also limited. The number of years allotted for instruction varied from three to four years. It was not until 1924 when the Education Section of the Filipino Nurses Association (FNA) published "The Standard Curriculum for the Schools of Nursing Intended for Nursing Instructors in the Philippines" which not only helped raise the standards of all nursing schools at that time, but also assisted in the "formulation of internal rules and regulations governing board examinations for nursing" (Giron-Tupaz, p. 136). This parallels events in the United States as outlined in the Goldmark (1923) report where a similar initiative was proposed. In Canada, a close neighbor of the United States, this initiative was not adopted until 1936 following the release of the Weir (1932) report. It can, therefore, be said that standardization of nursing education occurred earlier in the Philippines than in Canada owing to the country's ties with the United States.

Initiatives to professionalize nursing through the introduction of baccalaureate education within a university environment was initiated by visionary nurse leader Julita Sotejo as early as February 1, 1946; this led to the creation of the University of the Philippines College of Nursing in 1946 with Sotejo as its first dean (Giron-Tupaz, 1952). Between 1946 and 1949, six other colleges or universities began to offer programs leading to the degree of Bachelor of Science in Nursing degree (Giron-Tupaz, 1952). These institutions included the University of Santo Tomas (1946)[2], the Manila Central University (1947), Philippine Union College (1947), Central Philippine College – Iloilo (1947), St. Paul's School of Nursing – Iloilo (1949), and Silliman University (1947) (Giron-Tupaz). This move was initiated as nursing leaders of the time recognized the need to move from an apprenticeship model where students were viewed as employees, to that of education-focused nursing programs (Giron-Tupaz). Until 1950, no other policies, guidelines or legislations were introduced respecting the regulation or standardization of nursing education in the Philippines.

Discussion and Conclusion

Significant improvements were achieved by the nursing profession in the Philippines since the introduction of the first hospital-based nursing program in 1906, up to 1950. It is notable that majority of these nursing programs were offered by private institutions, and in many instances, supported by religious orders and organizations. This indicates the existence of a partnership between government and private institutions in the education of the Filipinos, a trend that continues to this day. Furthermore, education offered by private institutions, in most instances, was used as a means to convert Filipinos from paganism to Christianity. However, there continues to be a huge gap in regards to the knowledge available on the historical development of nursing education in the Philippines. This may potentially mask the actual experiences of individuals who figured prominently in the development of nursing education in the Philippines that could have provided a different lens in understanding their life stories that are relevant to nursing. To date, there has only been one book published on the history of nursing in the Philippines which was published by pioneer nursing leader Anastacia Giron-Tupaz in 1952. This textbook has never been revised, and no further editions were produced since its initial publication. It should be noted that the authors do not claim to have reviewed or accessed all relevant literature, nor do we discount the possibility that other authors may have published relevant work due to limitations posed by geography and technology. Nevertheless, this paucity in nursing education literature exists and can be due to a variety of reasons.

[2] In her book, Giron-Tupaz (1952) reported that "the first group of 63 students under the regular four year course leading to B.S.N. were graduated [from the University of Santo Tomas] on April 2, 1950" (p. 110). This suggests that the UST offered a university-based BSN as early as 1946.

Education was primarily controlled by religious orders during the Spanish regime. These religious orders' ecclesiastical provinces extended beyond the Philippines and it was suggested by Blair and Robertson (1908) that archival collections pertaining to the Philippines may have potentially found their way in other places in Asia such as China and Japan. Blair and Robertson further suggested that many documents relevant to the history of the Philippines (and presumably nursing) were already in the hands of private individuals and religious orders. Since becoming private properties, access to these materials became difficult. Whether these documents have been preserved or not is unknown. The same authors noted further how the war of 1896-97 between the Spaniards and Americans in the Philippines led to the destruction or looting of countless documents and books by Spaniards, Filipinos and Americans. This may be particularly true if one considers that the initial knowledge on nurse training during the Spanish regime points to the role played by the Catholic Franciscan Order.

While Giron-Tupaz (1952) managed to document the establishment of nursing programs from 1906 to 1949, limited information on individual nursing programs, alongside policies, guidelines and legislations are available. It can be assumed that many of the archival materials and documents that would have shed light on these were destroyed during the Japanese occupation of the Philippines between 1942 and 1945. Agoncillo and Guerrero (1977) noted how the Japanese Imperial Army took over government buildings, hospitals and schools, and transformed these structures into their headquarters. Documents and materials that were not deemed important to their rule were eventually discarded and destroyed. As the Americans sought to re-capture the Philippines from the Japanese towards the end of World War II, many of these buildings and hospitals were either burned to the ground, or destroyed as a result of aerial bombing between the Japanese and American forces. Whatever was left of the nursing schools were ultimately destroyed as the Japanese escaped. Another possible reason may be the lack of documentation or the absence of the same that would have provided a better understanding of the development of nursing education in the Philippines.

This paper is not intended to be a treatise on the development of nurse training and nursing education in the Philippines. If at all, our hope is to stimulate interests and discussions in the topic that can serve as the basis for further investigations on the history of nursing in the country in general. Much is to be learned from the history of nursing education in the Philippines. As a component of the history of nursing in the Philippines, nursing leaders and educators in the country should take leadership in advocating for funding to explore and develop an archive for the profession that can be used by nursing researchers and students to better understand the profession. In a country where interest in history, in general, is rather limited, collaboration between nursing researchers, historians and historiographers should be promoted as a strategy to develop and generate new knowledge in this field of nursing.

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to page 39

Eleanor M. Nolasco, RN

An Outstanding Nurse Take Centerstage... Finally

The awarding of "professionals who excelled in their respective fields of professional endeavor in the past years or entire career," has always been an anticipated part of the annual celebration of the PRC Anniversary and Professional Regulations Week in June.

"The quality of a person's life is in direct proportion to their commitment to excellence regardless of their chosen endeavor."
- Vince Lombardi

For this year, the recipient of the "Outstanding Professional in Nursing" Award was CORAZON B. DE LA PENA, M.A. Nursing., Ph.D Development Education, chosen for having "amply demonstrated professional competence of the highest degree and conducted herself with integrity in the exercise of her profession." This was with reference to her performance as presidential appointee to the Professional Regulations Commission, first as member of the Board of Nursing in 1995 and eventually as its Chair in 1999 to 2002.

The Awards ceremony held at the Fiesta Pavillion, Manila Hotel night became an emotional walk down memory lane for Ms. Cora when she served as gatekeeper to the portals of the nursing profession in the state's highest regulatory body. She was overwhelmed to see familiar faces of colleagues, mostly good friends too, who gathered to share the happy, if not glorious moment. They must have been somewhat relieved that finally, their friend and colleague, was formally recognized and honored for being the 'good soldier and faithful steward" that she were, not only during her 7-year stint at the PRC but all throughout her professional practice till the present. Such was Ms. Cora's dedication to the profession that she did not have any more time for other things. Nursing turned out to be the partner she never had in her personal life. She jokingly quipped that nursing is actually her "one true love." If there was another role she was devoted to, it was as daughter to her mother whom she kept company for 25 more years after she was widowed. Not that the latter was seriously sick; only Ms. Cora's natural protective instinct coming through. And even as her mother had peacefully passed away 2 decades hence, Ms. Cora never sought anybody else's warm company except those of her close family and friends.

The Quintessential Nurse with many "firsts" Mam Cora was born and raised in Davao City, the 5th among 6 children of a couple who relocated to Mindanao for its promise of bounty. Also in Davao where she has lived most of her life, Ma'am Cora completed her education and finished a degree as Graduate Nurse from San Pedro Hospital School of Nursing (now San Pedro College) in 1960. She belonged to the 2nd batch of 31 well-trained nurse graduates produced by the pioneer nursing school. At the time, the school did not have yet a

baccalaureate program, so Ms. Cora enroled in Far Eastern University (FEU) where she earned her BS in Nursing in 2 years under the tutelage of eminent nurse educator Dean Felicidad Elegado.

Soon thereafter, she was invited to teach in her alma mater becoming the first BSN graduate alumna in the school's nursing faculty. This auspicious start spun a lifelong commitment to teach, nurture and guide young women through the noble path of a caring profession, i.e., nursing. With a good head on her shoulder, a personable disposition and and caring attitude, not to mention being "single and available", opportunities to pursue higher education easily came her way. In 1970 she earned her Masters of Arts in Nursing at the Philippine Women's University under a scholarship granted by the Dominican Sisters of SPC. This accomplishment, plus the 8 years of prior clinical teaching gave her the cutting edge to become the 1st principal of the School of Nursing. Then two years later the School got accredited as a College and who else would qualify for the position of College Dean but Ms. Cora. Another "first" was affixed in her CV as the 1st alumna to be appointed Dean of the upgraded College of Nursing that now offered the baccalaureate course.

During her watch as school principal and later as College Dean, the performance of its graduates in nursing licensure examinations had always been exemplary, consistently churning hundred percent board passing. Her administrative skills and passion for excellence as exemplified by the quality of the nurse graduates again did not fail to impress so she was given a broader mandate to steer the entire school as it became a full-pledged College again a "first." Nine years hence, in 1991, with a Ph.D. in Development Education tucked in her professional sleeve, she organized the SPH Graduate School with Masters of Arts in Nursing as initial offering. You guessed right, it was again a "first" for Ms. Cora - the first Dean of the Graduate School.

Dean Emeritus and other citations

But as with all good things, Ms. Cora finally reached the end of the service road in the institution that she faithfully served for 31 years, helping build its solid reputation as a premier learning institution in the South even as she acknowledged its role in shaping her character and persona. Ms. Cora must have done a real good job that she was given the honorary title of Dean Emeritus "in perpetual recognition of her inestimable service and commitment to the institution and nursing education in the country" Other institutions and organizations who recognized and appreciated her positive influence and invaluable contribution also bestowed on her citations and service awards. Among them were PWU, UST, National League of Nurses and of course PNA specially the local chapter who looked up to her as a model and icon of nursing.

A Good nurse

A wise crack said, good nurses may retire, but they never tire. How true in the case of Ms. Cora. Already a septuagenarian and way past the compulsory age for retirement, she continues to make a difference. She continues being a "first". Like being the 1st Academic Program Coordinator at San Pedro College, a position she has held from 2006 to present. To this day she continues to be "an active life member of the PNA and the ADPCN working on standards and competencies of the profession and nursing legislation."

A proud nurse

Despite a hard-to-match and enviable track record, Ms.Cora has remained simple and humble in her ways. One thing though that she is mighty proud of are the nurse graduates of SPC whom she has mentored and who are now living testaments of the nursing ideals she has taught them. One of them in fact was in the shortlist of nominees for this year's "Outstanding Professional Nurse" award that Ms. Cora deservedly bagged.

The Real Nurse vs. The Registered Nurse

With frankness she confessed how mediocrity in students can upset her and how her passion for excellence has lent her an image of a "terror teacher." Yet she has remained consistent and uncompromising in her demand for the highest quality of nursing. Indeed, she exudes the aura of a nurse trained in the old school where the mantra was "service." She asked rhetorically, " Where are the R.N.'s or the Real Nurses? The ones who practice T.L.C. or tender loving care?" She lamented that instead, we have R.N's or Registered Nurses who demonstrate negative T.L.C. or total lack of care for the patient."

to page 37

PAUSE FOR PATIENTS' SAFETY

Rosie S. de Leon, *PhD, RN*
Arvin L. Joson*, RN, MAN*
Francis Justin P. Baltazar*, RN*
Ryan Kendrick P. Reyes*, RN*

This project won different awards from the Philippine Society for Quality in Health Care (PSQUA), Continual Improvement Program (CIP) of Manila Doctors Hospital and Award of Excellence in the 2011 Philippine QUILL Competition

Brief Description of the Project

In the Manila Doctors Hospital (MDH), practices that promote patient safety are of utmost importance to the institution. These are seen by all as an effective means of reducing the probability of adverse events arising from unimpeded execution of surgical procedures. For the MDH Operating Room Complex (MDH-ORC), a systematic approach is preferred in ensuring that no mistake takes place while performing surgical procedures on patients. Guided by this principle, the MDH-ORC "PAUSE FOR PATIENTS' SAFETY" Program was conceived. This program provides a system to encourage doctors and nurses in the Operating Room to utilize the *Patient Safety Checklist (PSC*). The PSC is a tool used in surgical procedures composed of sets of verifications performed throughout the entire operative process. The Pause for Patients' Safety Program is an important component for MDH to achieve its vision of being the "Leading center of excellence and wellness in the Philippines providing holistic quality and SAFE patient care" to its stakeholders.

Need / Opportunity

In 2009, the World Health Organization mandated the use of the Surgical Safety Checklist, an instrument that addresses important patient information that has been in the forefront of ensuring patient safety during surgical procedures. MDH adopted this proposition, eventually formulating its own patient monitoring tool - the Patient Safety Checklist (PSC) which was launched on May 2009.

Seven months later, after several observations and evaluations have been conducted on doctors and nurses of the MDH-ORC, a low compliance rate for the use of the PSC had been obtained from its implementation. Based on the data collected from the Patient Safety Checklist Logbook, only **44%** of surgical cases were found to have been guided by the PSC from June to November 2009.

Manila Doctors Hospital

This result concerned the MDH-ORC team, since the incomplete checklists increase the possibility of surgical risks, directly threatening MDH's health programs and its corporate image. Several operative and surgical problems caused by incomplete Patient Safety Checklists are as follows:

- Incorrect patient identification
- Wrong procedure or operative site
- No consent for the procedure or anesthesia
- Allergies not noted
- Unforeseen aspiration risk
- Unavailable blood products if needed
- Incomplete or unsterile instruments and supplies
- Unavailable or faulty equipment
- A procedure not properly recorded
- Lost or mislabeled specimen
- Improper count of sponges and instruments

As an entry to the Manila Doctors Hospital Continual Improvement Program (MDH-CIP) 2010, the Pause for Patients' Safety Program presented an opportunity to enhance professionalism through communication, coordination and collaboration of the ORC staff and doctors that was seen to lead to enhanced patient safety practices and guaranteed standards of the hospital.

Intended Audiences

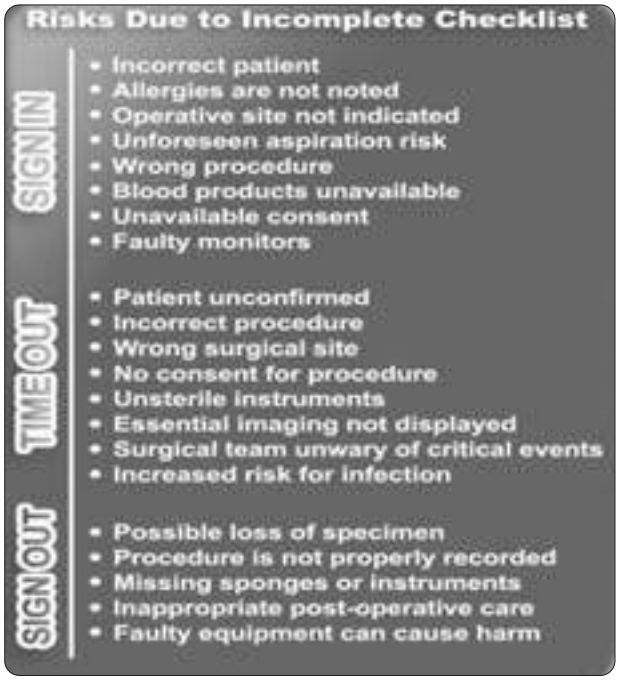
As a collaborative project for the MDH ORC team, the "Pause for Patients' Safety" Program was intended for internal audiences working at the MDH Operating Room Complex, outlined as follows:

- Surgeons and anesthesiologists with 10-30 years in service
- ORC nurses, aged 22 to 28, with 1-6 years in service and are able to function as circulating and scrub nurses in all types of surgical procedures

A survey conducted among surgical teams presented evidence that over familiarity is a rampant attitude within the MDH-ORC. Observations also revealed that an existing relationship between the doctors and the nurses prohibit the latter to comply with the PSC, as nurses do not contest instructions given by attending doctors due to their high regard for the said professionals. With this set up, communication between the surgical team and the responsibility /accountability for patient safety is compromised.

Goals / Objectives

The "Pause for Patients' Safety" Program aimed to accomplish the following objective:



1. To ensure quality of service and patient safety in the MDH-ORC by increasing the compliance rate in performing the PSC from 44% to 90% through proper and effective communication, cooperation, and coordination among of the ORC staff and doctors for the year 2010 onwards.

MDH-ORC designed the "Pause for Patients' Safety" Program to ensure that the safety of all patients is of utmost priority for everyone in the hospital - an attempt to help live out MDH's Vision - to be the leading center of wellness and excellence in the Philippines providing holistic quality and safe patient care.

Solution Overview

To realize its objective, the program implementers outlined several steps that would help them get the full cooperation and active participation of the audience while performing surgical procedures. These steps are as follows:

1. **Review of the PSC Logbook**

The PSC Logbook is a tool that the MDH-ORC uses to monitor the compliance rate in performing the checklist. The logbook contained several fields that required certain information about the surgical procedure performed, which had helped

in identifying which among the surgical and support staff encourage the active use of the PSC. As part of the unit's performance evaluation, last December 2009, the PSC Logbook was evaluated to verify the compliance of the staff and doctors since its implementation last May 2009. After careful analysis, only a 44% compliance rate was produced from June to November 2009.

During the ORC Unit meeting last December 21, 2009, the compliance rate was discussed with the OR staff. A plan was made to notify doctors regarding the matter and for possible use in MDH-CIP 2010 as a problem to be addressed.

2. **Review of ORC Policies and Procedures**
As an addition to the review of the PSC Logbook, Mr. Francis Justin Baltazar and Mr. Ryan Kendrick Reyes both staff nurses at ORC, Ms. Analyn Salivio, ORC Head Nurse, Dr. Nelson Cabaluna, Committee on Operating Room Complex (CORC) Chair together with Mr. Arvin Joson, QA Coordinator and Dr. Rosie de Leon, Nursing Director reviewed on ORC Policies and Procedures and discussed standards of practice in the ORC. The implementation of the PSC and the compliance rate were also discussed and the group agreed that a guideline on how to perform the PSC must be established.

3. **Discussions and Problem Analysis**
On January 18, 2010, the start of the program and strict compliance in performing the PSC was announced during the Unit meeting of the ORC. The program implementation was discussed by Mr. Francis Justin Baltazar, RN. Invited for the program implementation are Dr. Nelson Cabaluna, CORC Chair and Dr. Ramon Pesigan, Department of Anesthesiology Chair. As planned during the review of policies and guidelines, a discussion between Dr. Cabaluna, the ORC staff and the Nursing Service Office was done. Concerns on why the June to November 2009 compliance rate was only 44%; what are the potential risks that could occur; and what solutions could be done to increase the compliance rate were discussed. Through brainstorming, root causes were classified and an Ishikawa diagram was used for cause mapping. A 100 sample surgical procedure surveys were taken and using a Pareto diagram, it was found out

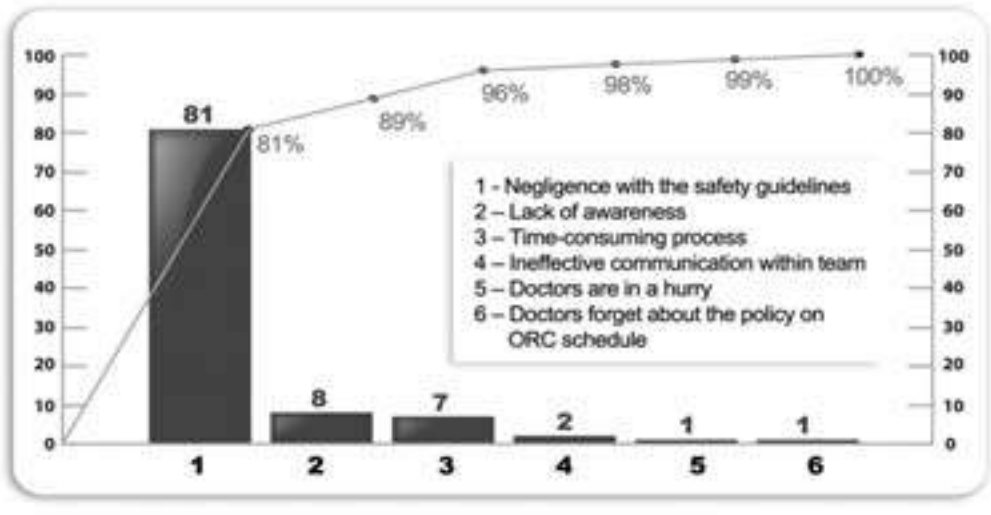
that 81% of the correspondents consider that negligence is the main cause for the 44% compliance rate.

During the CORC meeting dated March 2, 2010, an update regarding the study was done by Ms. Ermie Margaret Fernandez, RN, 2010 ORC Supervisor. This also served as a communication with the doctors regarding the strict compliance in performing the PSC.

During regular ORC Unit and CORC meetings, the monthly report of the compliance in performing the PSC and the trend is addressed.

4. **Investigating the work environment in the ORC**
As an addition to the January 18, 2010 meeting, ORC nurses voiced out that the attitude of the doctors is the main cause of low compliance rate in performing the PSC. In response, doctors and nurses discussed strategies to improve the working atmosphere in the ORC.

5. **Production of information materials**
To help disseminate information and remind everyone to utilize the PSC during surgical



procedures, posters of the checklist that were provided by Dr. Bernadette Hogar, Head of the Quality Management Office (QMO), were placed in every operating room theatre; leaflets were given to the doctors by the ORC counter clerks. Messages emphasizing the importance of using the PSC were written on all communication tools used. The MDH-ORC made sure that the information contained in the leaflets and posters could be easily remembered and appreciated by everyone who read through them.

6. **Giving out of corrective measures and monthly commendation for staff and doctors**

In collaboration with NSD, CORC and QMO, a Corrective and Preventive Action Request (CPAR) was given to staff and doctors who do not implement the PSC. As a positive counteract with the CPAR, monthly commendations were posted inside the ORC to recognize staff and doctors who implement with the said checklist. Evaluation of the performance is done by the Department Heads of NSD, CORC, and QMO.

7. **Setting up of a standard monitoring system**

Review of the implemented solutions was done by the program implementers together with Dr. Rosie S. de Leon, Nursing Director, Dr. Nelson Cabaluna, CORC Chair, Dr. Bernadette Hogar, Head of QMO and Mr. Arvin Joson NSD QA Coordinator last January 2011. Continuous monitoring of the PSC Logbook, constant reminders, giving out of CPAR or commendations and addition to the training program of the PSC were set to be the standard of practice in ensuring compliance in performing the PSC.

Implementation and Challenges

The relationship between doctors and staff was the most sensitive issue encountered by the entire MDH-ORC team. Before the implementation of the Pause for Patients' Safety Program, one challenge faced by ORC nurses was the doctors' 'superiority complex'. Nurses feared being reprimanded by doctors when they assert themselves, as such, they do not give suggestions, nor call doctors' attention while doing surgical procedures. Another challenge encountered by the MDH-ORC team is the over familiarity among members of the surgical team. Members of the surgical teams previously worked with each other and confident what will happen in performing surgical procedures.

To address the challenges stated above, the MDH-ORC put patient safety as the top priority in every procedure done at ORC. Doctors and nurses were likewise encouraged to foster healthy, professional relationships amongst themselves. With the intervention of the CORC, nurses and doctors were able to express their thoughts and sentiments, thus helping everyone improve their professional and personal relationships. The Corrective and Preventive Action Request (CPAR) and commendations were better means of conveying the message that the compliance of surgical team members to the PSC is constantly monitored by department heads and officers. Due recognition was given to all those who have used the checklist, thus boosting the morale of all members of the MDH-ORC.
A strain on the budget was experienced by the team, a budget of PhP 5,000.00 was given for the implementation of the project. This amount was expected to cover the cost for the production of communication tools, such as posters, leaflets, printouts, and snacks during meetings for the entire duration of the program. However, due to the conscientious planning of the MDH-ORC team, the money spent for the entire duration of the campaign was trimmed down to PhP 3,875. This meant that the program implementers had saved PhP 1,125 in over-all costs.

Measurement / Evaluation of Outcomes

The Pause for Patients' Safety aimed to accomplish the following objective:

- To ensure quality of service and patient safety in the MDH-ORC by increasing the compliance rate in performing the PSC from 44% to 90% through proper and effective communication, cooperation, and coordination among of the ORC staff and doctors for the year 2010 onwards.

In line with this, the following outcomes were produced:

1. There were a total of 44% in the compliance rate of the Patient Safety Checklist from the data gathered from June-November 2009. After the implementation of the strengthened campaign for the Pause for Patients' Safety Program, data gathered from January to December 2010 show 91% compliance to utilizing the PSC. With continuous monitoring, the positive trend continued. For year 2011 compliance rate to the PSC is 97.25%.

2. Over familiarity was broken down through participation of the whole surgical team by submitting to a new professional relationship and attitude. Mutual dependence among the surgical team is now more evidently seen.

3. Positive feedback evidenced by the ORC Survey for Continual Improvement Form from the surgeons and anesthesiologists notes that the professionalism of nurses in performing the PSC. Strict adherence to the standards and guidelines reflect the nurses' ability to initiate and perform their responsibilities well.

4. The “Pause for Patients' Safety” Program garnered a Silver Award during the 2011 MDH Continual Improvement Program's (MDH-CIP) Search for the Most Outstanding CIP last September 13, 2011. The program served as an external communication that broadened the range of audiences.

5. As we live our vision to be a leading center of excellence and wellness in the Philippines providing holistic quality and safe patient care, with just a minimal cost, patient safety is ensured.

"Time is a companion that goes with us on a journey. It reminds us to cherish each moment, because it will never come again. What we leave behind is not as important as how we have lived." from the film "Star Trek: Generations

Achieving UNIVERSAL HEALTH COVERAGE

Rx for the Ailing Health Sector: PhilHealth reforms

*by the **Medical Action Group***
http://magph.org/index.php?option=com_content&view=article&id=92:achieving-universal-health-coverage

IN MARCH 2011, Dr Shin Young-soo, the World Health Organization's regional director for the Western Pacific expressed concern over "the continued absence of sufficient healthcare coverage in the country." The WHO official noted that some 250,000 families "fall into financial hardships" because of the excessive cost of health care.

This observation comes in the midst of the Aquino administration's avowed push for Universal Health Coverage, especially for indigent Filipino families, as one of its health agenda. Such a universal health care system would bridge the healthcare disparities between the rich and the majority poor.

The 1987 Constitution provides that all Filipinos should have access to health services. This policy finds full expression in Article II, Section 15: "The State shall protect and promote the ight to health of the people and instill health consciousness among them." Article XIII, Section 11 provides that "The State should adopt an integrated and comprehensive approach to health development which shall endeavor to make essential goods, health and other social services available to all the people at affordable costs. There shall be priority for the needs of the underprivileged, sick, elderly, disabled, women and children. The State shall endeavor to provide free medical care to paupers."

And yet, from one administration to another, the same issues and deficiencies continue to plague the country's health sector. Key healthcare issues crippling the nation like the healthcare inequities, failed public healthcare financing, the continuous exodus of health professionals and weak health regulations pose critical challenges for the Aquino administration in attaining Universal Health Coverage.

Badly broken

Calling our country's health care system "badly broken" and in need of repair, President Benigno S. Aquino III outlined his plans for a reform package based on universal health coverage for all Filipinos. This plan would put the national government at center stage for funding healthcare services by amending Republic Act No. 7875 (otherwise known as the National Health Insurance Act of 1995) or enacting a new law by developing more extensive and equitable tax-based systems, or social health insurance-based systems or mixes of those. To ensure universal health coverage it will be necessary to increase the extent of prepayment and reduce the reliance on out-of-pocket payments and user fees.

This reform agenda for universal coverage is anchored on the provision of comprehensive but accessible and affordable healthcare services to all Filipinos. It focuses on expansion of coverage of the national health insurance system to include all

Filipinos within the next three years and provision of effective and affordable health care services that shall be accessible to all Filipinos in private and public hospitals.

While every Filipino is entitled to healthcare as provided by the Constitution, here in the Philippines, healthcare happens to be a privilege. The majority of the Filipinos rely on the private sector for their healthcare needs, thus making these services more of a commodity rather than entitlements. The majority cannot afford such services, resulting in grim statistics: for example, an estimated 60 percent of Filipinos die without seeing a health professional. Putting a stop to these healthcare inequities would require immense political commitment from the present administration.

Universal Healthcare

Universal coverage of healthcare means that everyone in the population has access to appropriate promotive, preventive, curative and rehabilitative healthcare when they need it and at an affordable cost. 1 Universal coverage thus implies equity of access and financial risk protection. It is also based on the notion of equity in financing, i.e., that people contribute on the basis of their ability to pay rather than according to whether they fall ill. This implies that a major source of health funding needs to come from prepaid and pooled contributions rather than from fees or charges levied once a person falls ill and accesses health services. 2 According to the World Health Organization (WHO), universal coverage requires choices to be made in each of the three components of a health financing system:

- Revenue collection: financial contributions to the health system have to be collected equitably and efficiently;
- pooling: contributions are pooled so that the costs of healthcare are shared by all and not borne by individuals at the time they fall ill (this requires a certain level of solidarity in society); and
- purchasing: the contributions are used to buy or provide appropriate and effective health interventions.

WHO further said that countries that have achieved universal coverage have developed prepayment systems that are commonly described as tax-based or social health insurance-based (SHI). In a tax-based system, general tax revenue is the main source of financing, and the available funds are used by the government to provide or purchase health services. In an SHI system, contributions come from workers, the self-employed, enterprises and government. In both, the contributions made by all contributors are pooled and services are provided only to those who need them. The financial risks associated with ill health in the population as a whole are shared by all contributors, and the pooled funds therefore perform an insurance function.

In tax-based systems, however, the insurance is implicit (in general, people do not know how much of their taxes fund health services), whereas in SHI it is explicit (in general, people know what they are paying for health). In both systems, the funds are usually used to purchase or provide services from a mix of public and private providers.

Health for all Filipinos

The country's deteriorating healthcare situation is urgent not just for the poor themselves but for all Filipinos whose general welfare depends on the good health of all. Radical changes in various arenas of the healthcare sector are imperative in order to reverse these rends.

To make health services available, accessible and affordable, the reform agenda seeks to resuscitate the largely sluggish health sector and promote efficiency, economy of scale and effectiveness in service delivery. One of these measures is the institutionalization of reforms in the Philippine Health Insurance Corporation (PhilHealth).

In 1995, the National Health Insurance Law, which established PhilHealth, called for health insurance for all Filipinos by 2010. However it is disturbing to know that since PhilHealth was created fifteen years ago, out-of-pocket payments have shot up from 40 to 54 percent of health financing in 2007. Ironically, even the country's national insurance program ends up devoting much of its resources reimbursing healthcare facilities and providers in the more developed and urbanized areas, while its coverage remains very low among rural and poorest areas. PhilHealth coverage according to the 2008 NDHS is lowest in the Autonomous Region in Muslim Mindanao (ARMM).

Based on the 2006 Family Income and Expenditures Survey (FIES), about 70 percent of the

population could not afford to pay for health care services due to their low income and the high cost of medical care. These are the same Filipinos that suffer from worse health outcomes because they are not able to access healthcare when they need it and where they need it. They are more likely to die without the benefit of seeing the inside of a hospital or receiving care from a medical professional. This is not surprising, given that the Philippines has a "highly resourced private sector", where seven out of ten health practitioners are working in the private sector and servicing only 20-30 percent of the population (the same population that can afford healthcare services).

The disparity in access to and use of health care services, resources and outcomes resulted in a wide gap in the health status between the rich and poor Filipino families. This situation threatens to get even worse because of the failed public healthcare financing. Based on the national budget allocation, a Filipino taxpayer spends only about P1.10 a day for health care compared to P21.75 spent by the government on debt servicing. With the increasing cost of healthcare services, even among those with a regular income, surviving a major ailment or illness is nothing short of a miracle.

As we race to reach the Millennium Development Goals by 2015, the health sector should be prioritized by the State today. However, the government's response remains anemic: total health expenditure only accounted for 3.8 percent of the country's GDP (2006), well below the 5 percent standard set by the WHO for developing countries like the Philippines.

Due to increasing cost of healthcare services and the lack of appropriate social protection, illness becomes a catastrophic experience, especially for the poor Filipino families. Out-of-pocket payments for health care services are increasing in the Philippines. Of the total health spending, according to the 2007 Philippine National Health Accounts (PNHA), only 9 percent was shouldered by social health insurance, both the national government and local government shared 13 percent, other sources at 11 percent, and 54 percent came from out-of-pocket payments made by the patients. This trend spells doom for individuals and families from the lowest income groups who have no pockets to begin with.

Based on the 2008 NDHS, only 42 percent of Filipinos are covered by some form of health insurance. Although it is the dominant insurance provider, PhilHealth coverage at the national level remains low at 38 percent of the population. Coverage through the Social Security System (SSS) is 11 percent, while the Government Service Insurance System (GSIS) covered about 2 percent of the population. Moreover, 2 percent of Filipinos are covered by private insurance or membership in health maintenance organizations (HMOs).

It will be impossible to achieve Universal Health Coverage without greater and more effective investment in health systems and services. Beyond these, central to attaining Universal Health Coverage are reforms to be instituted in PhilHealth.

The government must admit that PhilHealth has fallen short of its target, as health insurance barely protects 38 percent of all Filipinos (2008 NDHS). It is clear that the Social Health Insurance scheme as currently implemented by PhilHealth is not working towards the envisioned "sustainable, affordable and progressive social health insurance, which endeavors to influence the delivery of accessible quality health care for all Filipinos."

How can reforms in the PhilHealth be done? Certainly it will begin with making sure that over 11 million Filipino families who are the poorest of the poor will be supported and covered by an allocation of P15 billion to cover their PhilHealth premium.

Such reforms must go beyond the distribution of PhilHealth cards. The overarching philosophy is that access to health care services is based on needs and not on the capability to pay. Universal Health Care should mean that every Filipino will get not merely the card, but more importantly, the affordable and appropriate quality healthcare services that are their right. Thus in the medium-term, the development of an initial package of basic health services to be made available to every Filipino given the present resources available to the health system should be implemented.

1. See the background document "Social health insuranceSustainable health financing, universal coverage and social health insurance" to the Resolution of the Executive Board at its 115th Session (Resolution EB115.R13), www.who.int/health_financing
2. Technical Brief for Policy-Makers 2 on Designing Health Financing Systems to Reduce Catastrophic Health Expenditure

AN OPEN LETTER TO THE PRESIDENT TO STOP THE PRIVATIZATION OF PUBLIC HEALTH CARE SERVICES

Network Opposed to Privatization (NOP)[1]
of Public Hospitals & Health Services

H.E. President Benigno Simeon Aquino III
President, Republic of the Philippines
Malacañan Palace, Manila

Dear Pres. Aquino,

We, hospital workers, health professionals, community health workers, health science students, patients, indigent communities and concerned Filipinos raise deep concern regarding the country's deteriorating health situation and your government's response to this situation especially in fast tracking the privatization of government hospitals and health services.

We are deeply bothered that the intensifying privatization of public health care and services through various forms – public-private partnership, corporatization, user's service fee schemes, revenue enhancement program, outsourcing or outright sale will result to further inaccessibility of even the most basic health care services to the people especially the poor.

- Public-Private Partnership Program or PPP, government hospitals such as the Philippine Orthopedic Hospitals, San Lazaro Hospital, the Research Institute for Tropical Medicines, the Eversley Child Sanitarium in Metro Cebu and 21 more regional hospitals are now up for billions-worth bid to big private businesses to help in "modernizing and improving facilities and services" with the promised return of investment in "revenue sharing, lease fee per treatment for diagnostic equipment.

- Previous experiences with private-public partnerships in government hospitals have allowed the entry of private diagnostic and laboratory companies, private clinics and other private medical services companies to operate different hospital services charging exorbitant fees which squeezed out hard earned money from patients in public hospitals while depriving health services to those who cannot afford.

- 26 government hospitals are being fast-track for "corporatization". The DOH has also announced the plan to phase out the charity wards of public hospitals and replace them with PhilHealth wards.

- The land occupied by National Center for Mental Health (NCMH) along with the Women's Correctional in the Welfareville Compound in Mandaluyong City are being sold to give way to commercial business and condominiums.

[1] Network Opposed to Privatization or NO to Privatization is composed of concerned Filipinos, hospital workers, health professionals, health students, patients, indigent communities and other stakeholders. It has its beginnings in 1997 when the policy of privatization was introduced by the state. It continues with its advocacy to date in light of the Aquino administration's open and aggressive push for the privatization of health care. NOP can be reached through its secretariat in Rm. 206 Doña Anita Building, E. Rodriguez Sr. Avene, Quezon City, Telefax (02) 7254760.

- Government hospitals implement various forms of revenue enhancement programs -- the Philippine General Hospital (PGH) is now charging fees to indigent patients; the Philippine Orthopedic Center and other government hospitals have increased fees for laboratory and X-ray by 100% to 200%.

We are deeply dismayed that ***privatization*** of government hospitals and health services has resulted and will continue to result in:

- Government hospitals and public health care facilities being run like big business entities to enhance revenues and amass big profit by charging exorbitant fees for various health services rendered to patients;
- The poor and the marginalized segment of the population being deprived further of their right to health like access to essential health care;
- Continued diminution, deprivation of benefits, threat to the security of tenure and low wages of health workers which consequently have serious effects in the quality of service and care they rendered to their patients; and
- Further deterioration in the health status of the people.

We are alarmed that through the policy of privatization, health, which is a basic right and health services, which should be a state-provided social services HAS NOW BECOME AN EXPENSIVE COMMODITY that is beyond the reach of the people.

We are not confident and in fact, we are dismayed at how the government boasts of the Universal Health Care as its centerpiece 2010-2016 health policy when in truth this policy seeks to pass on the responsibility in financing people's health via the National Health Insurance Program (PhilHealth). This in essence means that it is the money of ordinary working people that are subsidizing public health care needs.

Thus, we call upon the Aquino government to:

- Immediately stop the privatization of government hospitals and health services. Take immediate and decisive measures to stop private biddings of the San Lazaro Hospital, Philippine Orthopedic Center and the Research Institute for Tropical Medicine. Stop the sale of National Center for Mental Hospital and the Welfareville property.
- Seriously realize the **state's responsibility** to provide for the Health of its people by ensuring a free, comprehensive and progressive health care system by allotting adequate budget for Health, 5% of GNP as recommended by World Health Organization.

"Only a life well lived for others is a life worthwhile"

Albert Einstein

Celebrating International Nurses Day 2012

Closing The Gap: From Evidence to Action

Message from The ICN:
12 May 2012

Dear Colleagues,

In our quest for quality and access to health care, we must constantly strive to use evidence-based approaches to nursing services. Today, health systems throughout the world are being challenged by inequities in quality and quantity of services and by reduced financial resources. Poorly informed decision making is one of the reasons services can fail to be delivered in an optimal way. It can also result in less efficient, ineffective and inequitable availability of health services. The use of evidence to inform our actions is a critical and achievable way to improve health system performance.

However, the increased availability of information can mean that rather than making finding evidence easier it can feel overwhelming. Now, more than ever, nurses need to learn not only how to gather evidence but also how to put that knowledge into everyday use. Not all evidence is robust or reliable. Nurses must learn to identify the best available evidence, taking into account the needs and preferences of health service users, while using their own expertise, skills and clinical judgement as to the feasibility of its use within the local context.

The IND Kit 2012 (http://www.icn.ch/images/stories/documents/publications/ind/indkit2012.pdf) empowers nurses to identify what evidence to use, how to interpret the evidence, and whether the anticipated outcomes are sufficiently important to change practice and use precious resources that may be needed elsewhere.

ICN believes that nurses are well placed to supply important information about context; about different systems, population group needs and the role of local politics and social factors. The use of an evidence-based approach enables us to challenge and be challenged on our approach to practice and to hold ourselves accountable. It allows us to constantly review our practice and to seek new and more effective and efficient ways of doing things, thereby increasing access and to care and well being.

Sincerely,

Rosemary Bryant
President

David C. Benton
Chief Executive Officer

PNA leads 2012 International Nurses Week Celebration

The Philippine Nurses Association, the accredited professional Nursing organization in the country, successfully spearheaded the celebration of the 2012 International Nurses Week last May 7-12. Chairperson of the Committee on Placement and International Affairs Mr. Fernando P. Urrutia led the week-long festivities which commemorates the birth of Nursing pioneer Florence Nightingale. Nurses from various fields and specializations heartily attended all of the activities.

The second half of the first day of festivities featured photos from PNA Austria, PNA Saudi Arabia, PNA United Arab Emirates and PNA Ireland in the First PNA International Chapters Photo Exhibition. The said photo exhibit was held in the newly acquired PNA Building 3. The photos showcased the international chapters' commitment and dedication to serving Filipino nurses worldwide thru their activities, programs and projects.

On the second day, May 8, officers, members and staff from PNA NCR Zones 2, 3, 4 and 5 revisited the Neem tree seedlings they've planted in Barangay T. De Leon, Valenzuela City during their 2011 Neem Tree Planting Activity. The group also conducted an impact survey on Dengue Case Prevalence before and after the tree planting in the said area.

Putting into action its sixth program thrust, participate actively in multi-sectoral plans, projects and programs in support of education and research,

National President Mr. Noel C. Cadete and Committee on International Affairs and Placement chair Mr. Fernando P. Urrutia opening the photo exhibit

NCR Zone 1 officers and members in their ceremonial tree planting at the PNA National Office

NCR Zone 2 officers and members with some local government officials from Valenzuela City

NCR Zone 2 officers and members during the Neem Tree project revisit

nursing practice, and health care delivery to improve the quality of life of the people we serve, PNA initiated a Nationwide Simultaneous Tree Planting Activity on May 10. Local PNA chapters all over the country joined this cause and planted trees in their respective areas. As part of the program, the local chapters conducted health teachings on Dengue prevention and management as well.

A motorcade capped off the week-long celebration on May 12. Over 140 nurses from different PNA NCR Zones 1 through 6 and nursing specialty and interest groups such as the Military Nurses Association of the Philippines (MNAP), Association of Private Duty Nurse Practitioners of the Philippines (APDNPP), National League of Philippine Government Nurses (NLPGN), Critical Care Nurses Association of the Philippines, Inc. (CCNAPI), Operating Room Nurses of the Philippines (ORNAP), Association of Diabetes Nurse Educators of the Philippines (ADNEP), and Nagkakaisang Narses sa Adhikaing Reporma sa Kalusugan ng Sambayanan (NARS ng Bayan) participated in this event. From the Quirino Grandstand the Motorcade for Nurses passed through San Juan de Dios Hospital then to Ospital ng Maynila Medical Center for the balloon-releasing activity, and lastly to the Philippine General Hospital for the a short program graced by their Deputy Nursing Director Ms. Imelda Mangaser. An ecumenical service and building blessing at the PNA National Office officially closed the whole International Nurses Week Celebration.

The whole celebration was supported by the PNA Board of Governors, chapter presidents, staff and nurses all over the country.

Balloon releasing ceremonies at Ospital ng Maynila Medical Center

(R) Mr. Cadete giving an inspirational message to the motorcade participants in the short program held at UP-PGH (L) Ms. Maria Luisa M. Medina during her discussion about the International Patient Safety Goal (IPSG)

from page 24

Living the 5 C's of Nursing

With her stature and age, nothing can faze nor daunt this lady no more. Instead, she continues to strive to live the essence of nursing embodied in what she termed "the 5 C's of Caring, namely, Compassion, Confidence, Commitment, Competence, Conscience." And a 6th component added by another wisened colleague: "Comportment" or bearing.

A final wish

While heartened she already has a lifetime's work as legacy, there is still one thing she hopes to be able to do, and that is to write. Write a book, write her memoirs, write something for posterity. But has she not imprinted yet her name in the hearts of the many young nurses and students she has mentored, the many patients she has lovingly cared for and the countless others whose lives she has touched not just by simply being a nurse but a nurse who simply did her job diligently and consistently in the best way she can. In the course, she was able to accomplish things while inspiring and encouraging others to do the same.

"Leaders accomplish great things and inspire others to grow in responsibility and skills. With perseverance, service, and reliability, leaders give their best in whatever job they're doing. Any of us can take on leadership roles and qualities just by doing our jobs in a dependable way and encouraging others to share in and help us in attaining a worthwhile vision. "

Working Together: PNA and Plan International

(from L-R) Gov. Neil M. Martin, PNA Gov. Region 10 and Chair, Board of Governors with Matt Crook Web and Social Media Editor (Plan Asia Regional Office) and Nopporn Wong-Anan Regional Media Specialist Plan Asia Regional Office, Bangkok, Thailand at Mandulog, Iligan City

MINDANAO, Philippines -- Global child-rights organisation Plan International has teamed up with the Philippine Nurses Association (PNA) to provide emotional support sessions to children affected by Typhoon Sendong, which has killed 1,470 and left 1,074 unaccounted for.

As thousands of children are reeling from stress caused by the deadly storm, which also left 430,500 homeless, the PNA has mobilised dozens of nurses at evacuation centres in Mindanao, where Plan Philippines is working with local authorities to support children and their parents.

"I was embarrassed initially to see so many foreigners and international organisations like Plan coming in to help affected people in Mindanao," PNA Chairman Neil Martin said. "It is the first collaboration of PNA with an international organisation on children and psychosocial initiatives," Martin said.

Typhoon Sendong, known as Washi internationally, caused heavy rains and flash floods on December 16 in Mindanao, affecting 624,600 people. The strong current in the swollen river carried timber from illegal logging sites downstream, damaging houses along the bank.

Cagayan de Oro and Iligan cities on the north coast of Mindanao were the most severely hit, with more than half of the currently displaced taking shelter in these two cities, where Plan and the PNA are working with affected children.

"Every time it rains I'm afraid that it's happening all over again, " said Jerome, an 11-year-old boy whose house on the riverbank was washed away by the 5-metre water in Cagayan de Oro. "It feels like a nightmare," said Jerome who survived the strong current by clinging on to a log for hours. Jerome is among thousands of stressed children Plan and PNA are looking to help under this collaboration.

Nurse responders, working and living in various cities in Mindanao, travel to evacuation camps in villages or cities to play and work with children, having them sing or draw pictures to express their feelings. The nurses will assess significant cues and may make

** Printed with permission; Source: http://reliefweb.int/node/476952.*

referral to the Mental Health and Psychosocial Support Services cluster for further treatment, Martin said.

Under this collaboration, Plan provides free transportation and meals for the nurse responders for the psychosocial support sessions. The PNA will also recruit and train laypeople on how to provide emotional support, also known as psychosocial support equipped with skill in Psychological First Aid (PFA) following Inter-Agency Standing Committee (IASC) guideline, to flood-affected children, in order to increase the number of children being assisted.

As of January 27, Plan has given psychosocial help to some 715 children. It is expecting to reach an additional 1,000 children and 160 adults as it embarks on future psychosocial sessions with the help of more nurse responders from all over Mindanao through the various chapter of PNA.

Plan's response in Mindanao has now focused on ensuring that all school-aged children are back to school. The organisation has already distributed back-to-school packs to about 5,000 school children in Iligan and Cagayan de Oro. Hygiene kits have also reached some 2,042 children and non-food items, including tents, have been given to some 3,970 families.

"Plan always looks for partners to work with during an emergency response. Collaborating with a trusted organisation like the Philippine Nurses Association is a real boost to our work," said Balz Tribunalo, programme adviser for disaster risk management of Plan Philippines. • *Rachel Makayan*

Arlene Angeli B. Go, PNA Davao City Chapter playing and working with children, having them sing or draw pictures to express their feelings at Mandulog,Iligan City evacuation center.

PNA with Plan International during Psychosocial activities with the children at Mandulog, Iligan City evacuation center

Caring for the carers: Gov. Martin processing nurse responders and partners from Plan Philippines and Dep ED after the Psychological First Aid Mission at Mandulog, Iligan City.

from page 22

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Issues and Concerns of Nurses in Asia

12th ICN, Asia Workforce Forum (AWFF) and 8th Alliance of Asian Nurses Associations' (AANA) Meeting

PNA represntatives to the 12th ICN, Asia Workforce Forum (AWFF) and 8th Alliance of Asian Nurses Association Meeting last November 24-26, 2011 in Macau: Dr. Roland L. Fermo (Goveno, Region VII); Dr. Leticia B. Puguon (Governor of Region II); Dr. Teresita I. Barcelo (past National President and Governor of NCR Zone I) and Roger P. Tong-an (Governor, Region XI)

Roger P. Tong-an, *RN, MAN*

The International Council of Nurses (ICN) hosted this year's AWFF. The ICN was represented by Board members, Ms. Elizabeth Adams, Consultant Nursing and Health Policy and Dr. Masako Kanai-Pak . The forum provided a venue to discuss the various issues and concerns confronting nurses and the nursing profession in the 10 participating countries namely: Hongkong, Indonesia, Japan, Korea, Macau, Malaysia, Philippines, Singapore, Taiwan and Thailand.

Among the issues and concerns discussed were the following: Environmental scan on nurses' working conditions; Nursing profile/data such as nurses' wages and their contexts (ICN survey); Natural and man- made disasters; Challenges and barriers to prevention, mitigation, preparedness, relief; and Legislation regulation, education, practice , leadership and research. There were also substantial discussions on the impact of the economic downturn which included working environments, terms and conditions, staffing levels and migration (nurse and faculty migration); demographic changes; ageing population and workforce and declining birth rates.

Prof. Andrew Luk from Kiang Wu Nursing College of Macau conducted a training session (November 25) on the effects of professional nurses in the society . During the working session, topics discussed included legislation, regulation, customs and practice, overtime compensation / health and safety, shift work patterns/ length of shift / breaks between shifts, flexible hours/ work life balance; Positive practice environment opportunity to share creative and innovative success stories in relation to professional recognition, management practices support structures, education occupational health and safety were also discussed.

The host country, Macau, officially opened the 8th Alliance of Asian Nurse Association meeting on the third day. Among the highlights were the sharing of insights and strategies in identifying strength and overcoming weakness in promoting the nursing image and increasing and strengthening membership and networking. It was a great opportunity to participate in this year's Asia Workforce Forum and Alliance of Asian Nurses Association. It was indeed inspiring and challenging sharing and learning from participants from various countries the various initiatives in responding to the concerns of the nursing profession. The next AWFF and AANA will be held Thailand on November 21 to 23, 2012.

The Road to being a Registered Nurse: A Nurse's Journey

By Jerald Pelayo, RN
Top 1, NLE December 2011

Oathtaking Ceremony
March 29, 2012
Mountain View College, Main Campus
Malaybalay City, Bukidnon

(L-R):Director Estrella C. Malik, Jerald Pelayo, Dean Elsa P. Lucenara

Today, we cannot contain the pride and joy our hearts harbor. We can't help but marvel at God's wondrous ways of leading us through. Yes, while others right now are merely wishing to be present in this exact ceremony, we are so blessed to have been endowed with this hard-earned success. To God be the glory for faithfully keeping His promises to each one of us here.

To our very inspirational speaker, Director Estrella C. Malik, PRC Region 10, we all would want to offer you our sincerest gratitude for unceasingly firing our passion to serve our people as we elevate the standard of our profession. We all anchor the bedrock of our inspiration to accountably fulfill our obligation to the public on the pledge we promised to keep. To God we offer our willingness to serve others selflessly as we continue to fulfill our school philosophy, mission and vision!

I would like to start by greeting my colleagues, the newly registered nurses CONGRATULATIONS! The battle is finally won. We have done our best and now we are reaping the rewards of our 4/5 years of labor. This journey was never easy. We have suffered altered sleeping patterns due to the innumerable sleepless nights we spent digging through our books while preparing for the great battle. We had to deal with our anxieties topped with the mind-boggling questions of the board exam (especially when all of the choices seemed right and you just can't eliminate any of it). And how the days and nights seemed so long and endless while we waited in great hope for the results. It must've consumed the contents of our fervent prayers. And now finally, the battle is won. We can finally say we have fought a good fight for we have finally surmounted our biggest challenge yet - from stepping out of merely being a degree holder towards being proclaimed a PROFESSIONAL: A REGISTERED NURSE.

The board exam was difficult. By virtue of my direct experience, I could only assure myself that I answered 40-50 out of 100 questions correctly per nursing practice set. I even failed to mark the correct answers to simple questions which I believed expunged the anxiety of most of the takers. After the last set, I even thought of not passing the exam which means a GREAT DISAPPOINMENT for those who believed in what God can do through me. But I told myself, "Lord

because it was our battle, I did not fight the battle alone." I stopped trying more and started trusting Him more. My 5-year friendship with my books was barely sufficient to let me pass the board exams, but I tell you, our constant relationship was more than sufficient to amaze the world of his goodness and greatness. I topped the board exam not because of who and what I am; I did because of who God is. I topped the board exam not because I was too intelligent; I did because God has been too faithful to His promises. I learned that our sufficiency will turn out to be a deficiency unless we receive God's sufficiency.

The licenses we have earned at this stage in our lives wouldn't have been reached had it not been for the people who have pushed (and even pressured) us towards becoming registered nurses. These people may be our parents, our sponsors, our guardians, our clinical instructors, our dean, friends, family and loved ones and this next line I would like to address to them. On behalf of my colleagues, we thank you for becoming not only wonderful stress during one of the most trying times of our lives, but also for inspiring, praying for and believing in us. I, for one, have felt how it was like to be very much pressured, to be like butter scraped thinly over too much bread. Was that how you felt before, during and after the exam? I, too, have felt that weeks, months and even years before I took the board exam! I just could not forcibly stop people around from expecting too much from me. I seemed unaffected though but behind those trifling smiles are ruthless assassinations of my ego and unjustifiable pressure on my part. Yes, it was never easy to carry the burden of everyone's punishing expectation squatting on my shoulder. I believe my fellow nurses have felt that too. So to our stressors, we are thankful that on top of those people-induced stresses are the place that we held in your prayers. We owe to you who we are, where we are and what has become of us now.

To my fellow nurses, this isn't the end of our battle yet. I must say, this is just the beginning. Many other registered nurses ahead of us would welcome us to the world of ruthless competition and even unemployment. To them we respond with optimism and trust that God has a vast field of opportunity for those who are willing to enter into His ministry. Some of us may continue to pursue the nursing career. Remember that along with the license comes greater responsibility of taking care of other people's lives. Theoretical knowledge if left unrehearsed is useless unless put into practice. We should never get frightened with the opportunities disguised as challenges or hardships that come along our way. Some of us may move on to pursue greater heights or even enter a different field. Remember this, "God will let us do what we can do before He will do what we cannot do." Persevere in the work that you have begun, until you gain victory after victory. Educate ourselves for a purpose. Keep in view the highest standard that you may accomplish greater and still greater good, thus reflecting the glory of God.

Let your light so shine before men. You have within your reach more than finite possibilities. However large, however small your talents, remember that what you have is yours only in trust. Thus God is testing you, giving you the opportunity to prove yourself true. To Him you are indebted for all your capabilities. To Him belong your powers of body, mind and soul, and to Him these powers are to be used. Your time, your influence, your capabilities, and your skill- all must be accounted for to Him who gives all.

This has been our dream. This has been the utterance of our prayers. This has been our hopes. And now this miracle is our shared success. This is all our victory!

"And in the end, it's not the years in your life that counts. It's the life in your years."

Abraham Lincoln

Revisiting LOI 1000

LETTER OF INSTRUCTIONS NO. 1000

TO : **The Professional Regulation Commission,**
The Ministry of Human Settlements,
The Ministry of Foreign Affairs,
The Ministry of Public Works,
The Ministry of Education and Culture,
The Ministry of Highways,
The Ministry of Transportation and Communications,
The Ministry of Tourism, and all Government Agencies Concerned

WHEREAS, P.D. 223 created the Professional Regulation Commission charged with the supervision and regulation over the professional practice in the Philippines;

WHEREAS, in support of PD 223 and its implementing rules and regulations, the various professional organizations have voluntarily integrated themselves, one for each profession, and subsequently accredited by the Professional Regulation Commission.

WHEREAS, integrated professional organizations are necessary for the upliftment of the standards of the professions through their self-regulation and discipline for better service to the Filipino people;
WHEREAS, the PRC accredited integrated professional organizations contribute an important role in promoting and maintaining high professionals, ethical, and technical standards among its members through their continuing education activities, thereby elevating them to a higher level of competence, proficiency integrity and social commitment;

WHEREAS, the PRC accredited bona fide professional organizations which truly represent the professionals in our country, have proven their capabilities, competence and social consciousness by collaborating with government agencies in the pursuit of national goals, and through the several national regional and international conferences which they have sponsored, organized, or attended.

NOW, THEREFORE, I, FERDINAND E. MARCOS, President and Prime Minister of the Republic of the Philippines, by virtue of the power vested in me by the Constitution, do hereby order and direct the Professional Regulation Commission, the Ministry of Human Settlements, the Ministry of Foreign Affairs, the Ministry of Education and Culture, the Ministry of Public Highways, the Ministry of Public Works, the Ministry of Tourism, the Ministry of Transportation and Communications and all government agencies concerned to authorize and support only PRC accredited bona fide professional organizations, and their members to organize host, sponsor or represent the Filipino professionals in national, regional and international forums, conferences, conventions where the concerned professions are involved, AND I FURTHER ORDER AND DIRECT that all government agencies and any of its instrumentalities shall give priority to members of the accredited professional organizations in the hiring of its employees and in the engagement of professional services.

This Letter of Instruction shall take effect immediately.

Done in the City of Manila, this 20th day of March, in the year of Our Lord, nineteen hundred and eighty.

Source: ***Chan Robles Virtual Library*** *, http://www.chanrobles.com/letterofinstructions/letterofinstructionsno1000.html#.UHDm7JjMiSp*

Guidelines for Authors

The Philippine Journal of Nursing (PJN) is the official journal of the Philippine Nurses Association, Inc. It is a peer-reviewed journal, published biannually for subscribers and members of the association. It considers original articles written for Filipino nurses at all levels of the health care organization and in various settings. The PJN serves as:

- venue for the publication of scientific and research papers in the areas of Nursing practice and Nursing education,
- source of updates on policies and standards relevant to Nursing practice and Nursing education, and
- medium for collegial interactions among nurses to promote professional growth.

The PJN invites original research and scientific papers, full text or abstract, written by professional nurses on areas of nursing practice and education. If you are interested in submitting a manuscript for possible publication, please review submission requirements below.

Manuscript Preparation and Submission

Manuscripts are voluntary contributions submitted for exclusive review for publication in the PJN. Manuscripts containing original material are accepted for consideration if either the article or any part of its essential substance, tables, or figures has been or will be published or submitted elsewhere before appearing in PJN.

For additional information about manuscripts and queries about submitting manuscripts, please contact the editor: E-mail: philippinenursesassociation @yahoo.com.ph

The information below indicates the required presentation of manuscripts.

Format and style

The Publication Manual of the American Psychological Association (APA), Fifth Edition, provides the format for references, headings and all other matters. Check here for additional information about APA style: http://www.vanguard.edu/faculty/ddegelman/detail.aspx?doc_id=796

- Please submit two copies of manuscript, which should not be more than ten pages including abstract, text, references, tables, and figures. The author is responsible for compliance with APA format and for the accuracy of all information, including citations and verification of all references with citations in the text. Spelling may be in either American or British English. Submission must be typed, double spaced on letter-size (8.5" x 11") paper with at least 1" margin on both sides. Include a cover letter listing the author's contact number, address, title, institutional affiliation, position and other relevant credentials. All articles should be addressed to PNA Office at 1663 Benitez St., Manila, Philippines or send through e-mail philippinenursesassociation@yahoo.com.ph
- Manuscripts should be 12 font, double-spaced, with standard margins (about 1 inch). Fancy typefaces, italics, underlining, and bolding should not be used except as prescribed in the APA guidelines.

Content

The content of a typical manuscript includes:

Title page

Title

Should indicate the focus of the article in as few words as possible. It should not contain a colon or other complex structure. Titles should not exceed about 10 words.

Author information

Indicate for each author:

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(b) Title or position, institution, and location; to whom correspondence should be sent, with full address, phone and fax numbers, and E-mail address; provide E-mail address for all co-authors.

Acknowledgements

Briefly state name of funders, grant number and name ofmentors/ people with significant contribution

Abstract

A structured abstract with headings should be included as part of the manuscript. The abstract denotes: (a) purpose of the article, without detailed background; (b) design, including type of study, sample, setting, dates of data collection if applicable; (c) methods, such as interventions, measures, type of analysis; (d) findings; and (e) conclusions.

For manuscripts focused on review or theoretical analysis a structured abstract still is required, but the organizing construct may be stated instead of a design.

Key words

A few key words that are recommended for use in indexing should be listed at the end of the abstract.

Text

Successful articles have clear, succinct, and logical organization and flow of content. It contains the following:

- Introduction
- Background
- Methods
- Findings
- Discussion
- Conclusions

The text should indicate the characteristics of the setting in which the study was conducted. Whenever possible, the review of literature and the discussion, interpretation, and comparison of findings should include reference to relevant works published in other countries, contexts, and populations.

References

Follow the APA Form and Style; list of references should include only those references that are important and cited in the text. References should be the most current available on the topic.

Tables and figures/photos

Each table and figure should be presented on a separate page and uploaded separately. Placement of each table or figure should be noted in the text. The PJN does not use addenda, appendices, and colors. Photo of the author, as well as photos that highlight article content, are also welcome. Black and white photos are preferred. Drawings and graphics should be clear.

Time For Review, Decision, and Production

The average time from manuscript submission to the author's receipt of the editor's decision about publication is approximately 3 months. During that time, each manuscript undergoes a rigorous double-blind peer review. The editor's possible decision are (a) accept, with editing to follow immediately; (b) accept, pending satisfactory revisions by the author; (c) not accepted, but author is encouraged to make specified major revisions and return the manuscript to the editor for further consideration; (d) rejected. The editor normally encourages the author(s) to continue the work and to revise and resubmit the manuscript as part of the mentoring culture. The time required for revisions can vary. All manuscripts are edited and copyedited before they are sent to the printer. The corresponding author receives page proofs for approval before publication.

Publication is scheduled at the discretion of the Editor who reserves the right to postpone and cancel publications for reasons of space and other factors. All accepted manuscripts are subject to editing. Authors will receive a complimentary copy of the issue in which their respective articles appear.

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Call for papers

the PJN July - December 2012 Issue:

"Adventures of Nursing Research"

Erratum: The date of death of Dean Evangelina Maceda-Dumlao, as stated on page 30 of PJN July-December 2011 issue should read as December 19, 2011 and not December 19, 2012. We apologize for the oversight. - Editorial Board

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