PHILIPPINE JOURNAL OF NURSING

OFFICIAL PUBLICATION OF PHILIPPINE NURSES ASSOCIATION, INC.

Bridging the Gap Towards Access and Equity of Health Care

PJN Volume 81 No. 1 • ISSN No. 2012-3906
JANUARY-JUNE 2011

Philippine Nurses Association, Inc.[1]

VISION

To be a 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. To zealously provide a strategic directions and programs that will enhance the competencies of nurses in order to be globally competitive.
2. To passionately sustain the quality of professional life and colleagueship with and among nurses.
3. To continuously strengthen internal capacity and capabilities for quality care and services by nurses.
4. To enthusiastically explore possibilities of collaboration towards the unification of nurses.

PROGRAM THRUSTS

1. Generate programs and activities that will prepare nurses for global competency.
2. Promote the socio-economic and political welfare of nurses.
3. Establish national and international networks/linkages to advance the vision and life purpose of the PNA.
4. Intensify our membership campaign.
5. Participate actively in multi-sectoral plans, projects and programs in support of education and research, nursing practice and quality health care delivery.
6. Promote the professional image of nurses and nursing.

[1] *Approved during the First Board of Governors Meeting, November 29-30, 2009 at the PNA Board Room*

Contents

Editorial

Relentless Pursuit Towards Access and Equity to Health Care

The pursuit of access and equity to health care is a central objective of many health care systems. Our country, the Philippines, although endowed with rich natural resources, has also been besieged by a backward economy described to be semi-feudal and semi-colonial. As such, it remains in perpetual underdevelopment and crisis. Remnants of imperialist domination persist; exploitation still existing in the countryside where the landlord-tenant relationship prevails; the cities teem with unemployment. Incomes are depressed, wages are low, and the majority of the Filipino people live in abject poverty.

The poverty of the Filipino people can be attributed to many factors, such as the foreign domination over economic, political and social structures; the policy of consigning areas to be resource bases for trans-national corporations; the neglect of the state for social services; and the unresponsive and corrupt bureaucracy. The poverty of the people finds its manifestation in their health status. One of the indicators of the state of development of a society is health, and in the Philippines, the health situation is very poor. The health problems of the people include: malnutrition, high infant and maternal mortality rate, poor environmental sanitation, lack of potable water supplies, high incidence of communicable disease, misdistribution of health personnel and facilities, and prohibitive costs of medical care. These are continuing signs (in fact, perpetual signs) of huge gaps in access and equity of health care. These are gleaned in the articles that follow. The article of Celso Pagatpatan, ***"Structuralist-behavioral Explanation of Inequity and Tuberculosis,"*** reflects differences in social features by political, social, economic, geographic, gender, ethnic and age differences. Health or health status is determined not only by health care, but also by other non-health determinants such as social status, education and economic level, gender, environment, etc.

The principles of access, equity, social justice and solidarity come to mind when more than three decades ago, the health-for-all goal and the primary health care (PHC) approach were adopted by all WHO Member Countries. The HFA and PHC was an empowering approach to bridge gaps as it highly placed equity in health care in the public policy agenda. The PHC approach also provided the key route in making available universal coverage of health care affordable to all, particularly those excluded by many health systems. Although primary health care facilitated the wider distribution of health care by geographical area or by level of care, its responsiveness was not adequate. This was mainly due to limited political commitment resulting in limited resources to fully operationalize it. This led to the ushering of a new universalism, i.e. provision of high-quality essential health care for all, rather than all possible care for the whole population.

Access to health care was defined as the possibility of obtaining health care when it is needed. It could mean physical, economic, and cultural access. **Equity** is more of an ethical concept that is synonymous to social justice and fairness, both concepts that can be relative and given different meanings by people at different times and circumstances. According to the WHO, the focus of equity in health is mainly on the health of the vulnerable population in absolute rather than relative terms. It also is described by inclusion, which requires that no one in the community should be left out. Therefore, equity in health care means narrowing gaps**.** Equity measurement identifies the relative and absolute gaps in the state of health. The World Health Organization has operationally defined obtaining "equity in health" as "Minimizing avoidable disparities in health and its determinants including but not limited to health care between groups of people who have different levels of underlying social attributes. The WHO's definition of *"equity in health"* actually encompasses two different aspects. Equity in health (health status) involves the attainment by all citizens of the highest possible level of physical,

turn to page 3

President's Message

Greetings from the President!

ICN's theme for the 2011 International Nurses' Day is "Closing the gap: increasing access and equity." This theme acknowledges that health is not just a "commodity produced by health services" (ICN 2011). There are many social determinants that play an important influence on the acquisition of health. We nurses must recognize that providing health services to our people will not necessarily lead to good health because "access" does not equate to availability. Many of our people know that there are services provided in our health centers yet how many of our *kababayans* actually avail of them? Some of these barriers to access such as socio-cultural and structural contexts, lack of knowledge to name a few, are what we nurses should very well address as health workers. As the largest group of health professionals in the country, we can do a lot to remove barriers and improve access. We can readily provide information through health education and improve the system of providing health services in whatever setting we may find ourselves.

The key elements to access, according to ICN (2011) does not only include availability, but also among others, utilization, relevance, effectiveness and equity. Merely providing health services without ensuring that these services are what our people need and proving them to be effective (evidence-based) will not lead to good health for the populace. Instances where we have a ratio of one nurse to a population of 20,000 (reality in the field) is a good example of "inequity." This situation means that our people, especially in the far-flung areas of the country, have no equal opportunity to access and utilize the services of our nurses. This situation is also unfair for our nurses who must bear the burden of providing access to health services under difficult situations.

Knowing that the Philippine Nurses Association is recognized by the government as its partner in health development, your nursing leaders work tirelessly for the improvement in the work conditions of our nurses both in the private and public health institutions. We have continuously advocated for positive work environments for our colleagues because our nurses need someone to care for them and look after their welfare. They are already very busy providing the needed health services and working to remove the barriers to access and equity for our people.

We realize that some of the impediments in moving our profession forward are legislative. Together with the Board of Nursing and other nursing organizations, we are earnestly reviewing our current nursing law in the hopes of addressing the gaps and the barriers for our profession to be truly able to help in the health development of our people and in nation building.

Let's acknowledge that one of the barriers to access and equity to health of our people is the lack of competencies in our nursing colleagues. With this in mind, the Board of Nursing together with the nursing leaders, nursing organizations, nurse practitioners and those in the academe, are reviewing the core competencies that are expected of registered nurses. We need to ensure that our nurses are competent and globally comparable so that wherever our nurses are, home or abroad, they will be able to function and provide adequate, relevant and effective nursing care and health services to their clients.

An unfortunate barrier to adequate and relevant nursing service in our hospitals is the pervasive and continuing practice of "volunteerism". Despite pronouncements by the Department of Health, the Philippine Hospital Association, Association of Nursing Service Administrators of the Philippines and the many legislative committee hearings on the matter, this practice continues. I say that this is a barrier because our hospital clients are denied the adequate nursing services they deserve because "volunteer nurses" comprise the majority of the nursing staff. "Volunteer nurses," in reality, are not allowed by the hospital to give the full range of nursing services such as the administration of medications and treatments that leaves the client with reduced access to adequate and appropriate nursing care. This is one area that all nursing leaders, not only the Philippine Nurses Association, need to address with fervor and true commitment in order to prohibit the practice and to hire adequate staff nurses following DOH standards. Only with unified and strong commitment among all nurses,

particularly our nursing leaders, may we ensure that this barrier to health services in the hospitals will be eradicated.

Despite all the odds that our profession is facing today, I am hopeful that we can address the barriers to health and ensure equitable access to health services for our clients. Like our Kababayans who have bounced back after "Ondoy", these barriers to access can be surmounted if we work together to ensure that the lack of capacity and availability of health personnel, differences in language and culture, the lack of knowledge and information given to our people regarding available services are addressed.

When I see our young nursing leaders especially in the chapters, take an active role in deciding the future of our Association and of our profession, I am heartened. I know that the future generation of nurses will make sure that the light of idealism, caring and service will continue to burn brightly. Each of us must continue to light our own candle of hope rather than curse the darkness of despair.

Mabuhay ang ating propesyon! Mabuhay ang mga nars!

Teresita R. Irigo-Barcelo, PhD, RN
National President

from page 1

psychological and social well-being; and equity in health care means that health care resources are allocated according to need. Health care is provided in response to legitimate expectations of the people and health services are received according to need, regardless of the prevailing social attributes and payment for health services is made according to the ability to pay. Therefore, equity in health care implies a commitment to ensuring a high quality of realized access or utilization of health services, according to needs and for all. The entire concept of access and equity, including its implication to nursing, is captured in this year's theme of the International Nurses' Day Celebration headed by the International Council of Nurses: ***Closing the Gap: Increasing Access and Equity.***

As nurses, we can contribute in bridging the gap towards access and equity to health care by viewing health holistically or as a social phenomenon; diagnosing problems and needs collectively; focusing interventions on those that are identified by the people and advocate methods of health work that are comprehensive, relevant, participatory, democratic, liberating, supportive of critical thinking, and empowering; and identifying outcomes that are clear and shared among nurses and the people.

"***Redefining Nursing from a Filipino Perspective"*** **is a concrete example of how to generate more responsive and more relevant nursing services. In our midst are nurse leaders, Dr. Remedios Fernandez (*"The Outstanding Professional for 2010"*) and** Ms. Zenaida Concepcion (*"An Angel Nurse"*), who have proven their effective leadership and good governance. They are the Florence Nightingales of our time, because they too, like Florence Nightingale persevered as if *"Nothing Stood in Their Way."* We also relive, in our minds and hearts, one great leader, Minda Luz Quesada, who, during her times fought fiercely and advocated for access and equity through relentless advocacy in all fronts, the parliaments of the streets included. Her paper, "Advocacy Work in Perspective," though written in the 80's, continues to challenge nurses to use advocacy in our quest for social transformation, a condition characterized by access and equity.

Such challenges reverberate in the modern Gabriela Silang nurse leaders of our times fierce, determined, principled. Lyda J. Canson, a staunch advocate of human rights reflects her advocacy on *"Sexual and Reproductive Health and Rights."* Dr. Josefina Tuazon shares her thoughts on *"Why there is nursing unemployment?"* citing our role in the situation. Indeed, in the great American union member, Albert Einstein's famous words: *"The world will not be destroyed by those who do evil but by those who watch them without doing anything".*

Indeed, the health care system is embedded in a larger social system. Inequities in health care closely reflect larger social, economic and political inequalities. The way mass poverty keeps interposing and complicating proposals for health care reform is a nagging reminder that there is no getting around the need for a systematic approach to change. Only then will the gap be narrowed and will people enjoy access and equity in health care.

Erlinda Castro-Palaganas, RN, PhD

RESEARCH ARTICLE

ARNOLD F. RIVERA, RN

Graduate of the University of Santo Tomas College of Nursing (2002). He is currently a faculty member of Chinese General Hospital College of Nursing at Sta. Cruz, Manila, Philippines. He received his Master of Arts and Nursing degree (Major in Nursing Administration) at the University of Santo Tomas College of Nursing in 2008 and is currently pursuing his Doctor of Philosophy in Education (Major in Special Education) at the University of the Philippines-Diliman.

Redefining Nursing from a Filipino Perspective

ABSTRACT

This study aimed to explore, describe and document the experiences of nurses in order to come up with a unique definition of nursing as experienced in the hospital setting. Using the phenomenological approach, specifically, the descriptive phenomenology of Husserl, this study describes the lived experiences of twelve (12) full time staff nurses who saturated data in this research rigor. Purposeful sampling was utilized to select participants in four (4) tertiary general hospitals (government and private) in Manila, Philippines. An in-depth interview was used to generate data about the participant's personal and professional experiences' in nursing. The interviews were transcribed verbatim, and were analyzed and described using a descriptive phenomenological methodology. The three main themes that emerged were: (1) Nursing being defined as performing tasks that alternate between caring and using medical-technical approaches, (2) Nursing being defined as a health care profession, and (3) Nursing being defined within the boundaries of high cultural appraisal and challenged socio-institutional status. The findings have implications for nursing educators, administrators and leaders to create means to further enhance the caring attributes of Filipino nurses; to perform evaluation per institution to identify the specific needs of the nursing workforce and bring changes wherever deemed applicable that could improve nursing practice.

Key words: *phenomenology, nursing experience, definition of nursing*

Redefining Nursing from a Filipino Perspective

A definition of nursing derived from staff nurses' experiences can reflect indigenous practice values, which in turn act as a rich source of ideas and inventiveness in developing a relevant knowledge base to inform practice. However, a local study that deals with the perception of nursing by hospital staff nurses is still lacking. In this period when nursing enrollment in the Philippines is at its highest number and many have the goal of going abroad in mind, nursing needs to be clear for every Filipino nurse. It is difficult to clarify the characteristics of the nursing profession and the problems that exist within this field. Gaining, therefore, an understanding of the nurses' perception regarding their profession can improve knowledge on this subject. Professional identity is an important factor that determines how nurses perform their duties and perceive their profession. A nurse's sense of identity is determined not

only by personal experience but also by how the general public views the work of nurses. Hence, environmental factors influence how nurses view themselves (Cook, Gilmer & Bess, 2003). Further clarification of the factors that influence what nurses think and how they work can improve understanding about the nursing profession (Nasrabadi & Emami, 2006).

BACKGROUND

Nursing practice in the Philippines was believed to originate the same way that nursing began in other parts of the world. Customary health care practices for the sick were performed in caves during the earliest time. Caring practices continued from Spanish colonialism until World War II when Filipino women took care of sick and wounded soldiers (De Belen & Locano, 2006). The American occupation of the Philippines influenced the professionalization of nursing. Establishment of nursing schools began in 1906, a year after Americans started training Filipino nursing students. The curriculum, however, was never a mirror-image reproduction of the American nursing curriculum (Choy, 2003). At present, Filipino nurses must obtain a 4-year bachelor's degree from any nursing education institution duly recognized by the government, then pass the national licensure examination for nurses conducted by the Philippine Professional Regulations Commission (PRC). The Philippine Nurses Association (PNA) is the major national organization for Filipino nurses and has 92 local chapters and 7 international chapters. The Commission on Higher Education (CHEd) is a government institution that regulates both nursing curriculum and education institutions. It is responsible for school accreditation and reinforcement of rules and regulations and the setting of minimum standards for each institution.

PURPOSE AND OBJECTIVES OF THE STUDY

The purpose of this descriptive phenomenological study was to explore the staff nurses' lived experiences being nurses in a hospital setting. Specifically, it aimed to (1) explore and describe the lived experiences of staff nurses working in a hospital setting, (2) identify factors influencing their conceptualization and practice of the profession, and (3) identify needs of nurses working as bedside nurses.

SIGNIFICANCE OF THE STUDY

This current study will contribute to the literature by focusing on the lived experiences of nurses with the intention of providing an improved understanding of nursing as defined, experienced and practiced in the hospital setting. The outcomes of this research can assist and support new registered nurses, nursing academicians, and nursing administrators in improving aspects of nursing as deemed applicable in their own setting or institution. The findings of the study will provide for an improved understanding of nursing, and subsequently assist in instigating the necessary support for nursing staff and in turn ultimately improve the quality of care to clients.

METHODS

RESEARCH DESIGN

Descriptive phenomenological methodology was used to improve the understanding of staff nurses working in the hospital setting. The philosophical underpinnings of Husserl informed this research because of its descriptive orientation, whereby individuals are seen as the vehicle through which the "essence" of the phenomenon of interest can be accessed and subsequently described (Sanders, 2003). A phenomenological approach is well suited for this study since the focus is on lived experience from the perspective of the informants, and because little is known about this experience at a time when there is an increased demand for international employment.

SAMPLE AND SAMPLING TECHNIQUE

Twelve (12) hospital staff nurses were the informants that saturated the phenomenon under study. They were mostly staff nurses providing direct patient care in four tertiary general hospitals in Manila, Philippines, aside from two coming from private hospitals and two from government operated hospitals. Purposive sampling was done with the assistance of the directors of nursing of the institutions as well as the nursing supervisors of the selected informants. Data was gathered from December 2007 to January 2008 in their respective work areas. A majority of the informants were female (83%), married (58.3%), with a BSN degree as their highest educational preparation (83.3%), Catholic (66.7%) and with an average of eight to nine years of experience (mean: 8.75). Table 1 shows the profiles of the informants that participated in the study.

DATA COLLECTION

After approval, the researcher asked for a referral from the nursing supervisors to identify staff nurses who could openly describe nursing practice in the Philippines. The interview was done in the clinic area where the phenomenon of interest occurs. In this set up, the informant was able to extract experiences that were valuable in the study. A semi-structured, in-depth individual interview was the chosen data

Informant Code	Sex	Civil Status	Highest Educational Preparation	Religion	Years of Experience
101	F	M	BSN	Protestant	15
102	M	S	BSN	Christian	6
103	M	M	BSN	Catholic	9
201	F	S	BSN	Catholic	3
202	F	S	BSN	Catholic	4
203	F	M	BSN	Catholic	4
301	F	M	BSN	Christian	6
302	F	M	BSN	Christian	9
303	F	S	MAN	Catholic	10
401	F	S	BSN	Catholic	10
402	F	M	MAN	Catholic	9
403	F	M	BSN	Catholic	17

Table 1: Informants' Profile

collection method. An interview guide was designed to facilitate the interviews, and was reviewed by experts and pretested to achieve validity. The interview was approximately held for 30-60 minutes or longer as permitted and as necessary. The informant, however, was given the right to end the interview or withdraw from participation at any time without penalty. To conclude the interview process, the researcher provided the informant with contact information should there have been any questions.

DATA ANALYSIS

The Colaizzi (1978) methodological approach was chosen to investigate the phenomena of interest because it identifies phenomenon as it is experienced. It facilitates an access to implicit and explicit meanings embedded in the informant's descriptions through constant validation of responses as the meaning and essence of phenomenon emerge. The seven-step data analysis was followed in this methodological approach, namely: (a) all transcriptions were read thoroughly by the researchers; (b) significant statements that directly pertained to the investigated phenomenon were extracted; (c) the meaning of each significant statement was spelled out (formulating meanings) with creative insight; (d) all the formulated meanings were organized into clusters of themes; (e) results were then integrated into an exhaustive description of the investigated topic; (f) the description of the investigated phenomenon was formulated into a statement of identification of the fundamental structure; (g) informants were asked about the findings thus far in a single interview session.

ETHICAL CONSIDERATIONS

Formal ethics approval for this research was obtained from University of Santo Tomas Graduate School Ethics Committee of a University. All participants received written and verbal information about study purposes, procedures, benefits and potential risks and were informed that they could withdraw from the study at any time and signed a consent form before the interview started. Privacy and confidentiality were also considered, thus, the researcher has secured those informants' names and any other potentially identifiable information not to be included in any document.

ESTABLISHING TRUSTWORTHINESS AND RIGOR

The central goal in maintaining rigor in qualitative inquiry is to correctly represent the participants' experiences as reported (Streubert & Carpenter, 2007). This was achieved through prolonged engagement with the data, verification with respondent feedback, use of extracts from respondents' verbatim accounts, and peer debriefing. Providing evidence of an audit trail and ensuring technical accuracy in recording and transcribing were strategies used to increase the reliability of the procedures and data generated. Consistent with Husserlian phenomenological method, the researcher undertook the process of 'bracketing', a common technique used to ensure that rigor is not compromised due to researcher bias. This was accomplished by first identifying any pre-conceived assumptions and beliefs held about the phenomenon, and through journal writing prior to and during the data collection and analysis stages. Additionally, a peer researcher (the research adviser) who had no previous contact with the population or the phenomenon of interest served as a mentor.

FINDINGS

The three main themes that emerged from the analyses were: (1) Nursing as defined as performing tasks

that alternate between caring and using a medical- technical approach, (2) Nursing as defined as a health care profession, and (3) Nursing as defined within the boundaries of high cultural appraisal and challenged socio-institutional status. The first theme refers to the tasks nurses perform and how this routine approach differed from the caring approach. Three clusters supported the first theme, namely: the caring approach, medical approach and technical approach. The next theme, however, pertains to the meanings and goals of nursing that are reference-based and reflective of being a body of knowledge in health care. Book-based meaning of nursing and goals of nursing were the two initial clusters under this theme. Lastly, the third theme refers to the external circumstances the may influence their perception about their profession. Three clusters, namely: social circumstance, cultural circumstance and institutional circumstance, supported the last theme.

Theme 1: Nursing defined as performing tasks that alternate between caring and using a medical-technical approach

A dominant feature that emerged from the nurses' definition of nursing was caring. Hospital staff nurses responded that nursing is synonymous to caring and identified gestures on how they provide care for clients. *"*nursing *hangang ngayon* (until now) is still synonymous to caring…if you're a nurse, you cannot just cure without the care…" according to informant 201.

Informants also shared compassion and affectionate care in providing nursing care to patients. They have iterated that they do their best efforts to deliver care to their patients and help them recuperate from their illnesses.

> *"301: talagang hangga't maari ginagawa namin yung dapat gawin sa pasyente* like for example *na iturn ang pasyente* every two hours *pero* at least within the shift *naiturn namin ang* patient*, pinipilit naming gawin ang aming* responsibility for the patient *kahit gaano pa man kadami yan…kaming mga* nurses *dito nga gusto naming gumaling yung pasyente… hanggat maari ibinibigay namin kung meron kami kasi nakakaawa ang pasyente kasi masaya kami kapag gumagaling sila at nakakauwi…"* (As long as we can, we really do what needs to be done for the patient. For example, in turning the patient every two hours, we make sure to turn them at least once within the shift. We try to fulfill our responsibility to the patient no matter how numerous they are. We, the nurses here, want our patients to recuperate. As much as we could we give them what we have, we feel pity for the patients and we are happy when they heal and can go home.)

However, aside from the caring aspect of their professional duties, the informants narrated the routine works or tasks perform in the clinical areas as well. These are the medical and technical activities they perform that alternate with provision of patient care. Examples of the usual tasks they perform were carrying out doctors' orders, administration of medications, assessment, monitoring, collaborating with health care team and the patients.

Theme 2: Nursing defined as a health care profession

Informants also described nursing patterned to the meaning derived from textbooks. Hospital staff nurses showed strong conviction on nursing as a profession as well.

> *"*201: nurse should have the KSA, knowledge, the skills and attitude, binding *pa din yun* (it is still binding)… nursing *pa din* is a profession"

> "401: *nakikilala na tayo bilang isang professional na sa isang* health care team, *hindi na tayo* under *ng* doctor, *kundi pantay pantay na"* (we are now recognized to be professionals being part of the healthcare team, we are no longer under the doctor, instead we are now even.)

Hospital staff nurses reiterated that they perform their job for the common goal of uplifting the health status of clients. "Nursing is maintaining wellness of the patients" whereas "we (nurses) give health teachings… for promotion of health," shared by informants 101 and 303 respectively.

Theme 3: Nursing defined within the boundaries of high cultural appraisal and challenged socio- institutional status.

Nursing, in the Philippines, is considered a noble profession. Unlike the experiences of registered nurses in neighboring Asian countries (Sawada, 1997; Burnard & Naiyapatana, 2004; Nasrabadi & Emami, 2006;), nursing in the country is being looked highly upon and respected. These nurses also claimed that they share an equal level of responsibility with the doctors in terms of healthcare. Informant 101 mentioned *"pag* nurse *ka, nakakaangat ka alam mo yun, mas nirerespeto ka, iba ang tingin sayo dahil sa nalalaman mo kesa sa nalalaman nila (of the patients)… So ang nurse e mahalaga at mas kapakipakinabang"* (if you are a nurse, you know that you are above the rest, people respect you more because of your knowledge compared to theirs… So a nurse is important and more valuable.)

Some of the experiences of the informants, however, fell within the old-fashioned cultural problems or notions

towards nurses as the handmaids of doctors. Informant 302 shared *"makakaencounter ka ng mga* doctors *na medyo* rude *ng konti kasi parang tingin nila* nurse *ka lang* and they are doctors *tingin nila alalay"* (you can encounter doctors who are rude, they look at nurses as their handmaids).

The nursing profession in the Philippines is facing a number of challenges. Common examples are the proliferation of nursing schools, the deteriorating quality of nursing graduates, and the effect of the brain drain phenomenon. One participant noted the commercialization of nursing schools while another commented that nursing is like sold like hotcakes to gain profit for the school offering the course.

Another dominant characteristic that emerged from the informants' experiences was that the nurses faced poor working conditions. A general shortage of staff nurses due to rapid turnover has also accounted for the extra workload of the respondents. According informant 302, *"kulang kami sa* staff so *hindi mo marender yung talagang* quality patient care*. Kasi as* much as you always wanted to do all those responsibilities, the problem is you can not *kasi talagang ang dami talaga"*(we are understaffed so we cannot render quality patient care. As much as you always want to fulfill all those responsibilities, the problem is you cannot because we are outnumbered). The respondents also identified the inadequacies of the hospitals such as the lack of supplies that contribute to the poor delivery of care to patients. This led to a feeling of frustration for the nurses. Low salary or wages were also a pattern in their responses as a cause of dissatisfaction in their work. *"Overwork, underpaid ika nga …,"* reported by informant 102. Although the informants are working under poor working conditions, for them, nursing is not merely a job because they enjoy and love the task of caring for people in need of their service.

The recommendations of the informants revolved around the perceived need to improve the attitudes, behaviors, skills and knowledge base of nurses. Informant 301 suggested that students should "be observant, *wag magtatago sa CI* and *huwag tamad…"* (be observant, do not hide from the CI and do not be lazy). Other informants, however, encouraged the inclusion of more health teachings to patients and to know the cases of the patients further. To nursing academicians, they encouraged added exposure to clinical areas and increased hands-on experience.

A majority of the informants called on nursing administrators to provide more trainings/seminars to keep their knowledge and skills abreast with current updates in the medical field. Most of them requested to have continuous training programs to boost their capability in providing quality care to their patients.

Moreover, improvement of nursing administrators and trainers was also suggested together with the resolution of the problem in nursing shortage and work-related problems. The informants' appeal was to formulate means to hasten the hiring process in order to fill the gaps in the rapid turnover of nurses leaving for abroad. Also, number of informants as well suggested trainers both in the hospital and in the academe to be stricter and to adhere to professional standards. They also shared ways to improve relationships among their co-workers in the clinical areas. Most of them also seeked for improvement in professional compensation in their work.

DISCUSSION

The findings of this study support the results of Edens' (1987) study which suggest that the ideal professional is a person who becomes socialized and adjusts to the specialized knowledge, skills, attitudes, values, norms, and interests needed to perform their professional roles acceptably. The following interacting domains of potential professional self-growth can be defined as results of the socialization process: self-image, role concept, attitudes, values, and personality.

Utilizing Aristotle's theory of causality in thematic analysis, nursing, for hospital staff nurses who participated in this study, is defined as a profession in which the essence of nursing work revolves caring and nursing activities that are performed towards the goals of promotion of health and prevention of illnesses. In addition, nursing is defined as a culturally highly appraised career where, that because of globalization, is currently under a challenged social and institutional status.

For hospital staff nurses, nursing is a profession that exemplifies caring. Leininger and MacFarland (2002, as edited) identified religious values (mainly Roman Catholic) as one of the dominant cultural values among Filipino-Americans and is reflected in giving comfort to others, tender acts when one is ill and being pleasant as much as possible. Furthermore, this is true not only among professional nurses but also among individuals entering the nursing profession. In the study of Ryan and McKenn (1994, as cited in Cook, Gilmor, & Bess, 2003), it was found out that medical students were more cure oriented and nursing students were more care oriented. In addition, this is also consistent to the study made by Beck (2000) that the top 3 themes that emerged as reasons for choosing nursing

as a career were: (1) desire and love of helping others, (2) a fulfilling profession, and (3) prior work or volunteer experiences. In terms of professional identity, a nurse's sense of identity is determined not only by personal experience but also by how the general public views the work of nurses. It is an important factor that determines how nurses perform their duties and perceive their profession (Cook, Gilmer & Bess, 2003). In nursing literature conducted by Crawford, Brown and Majomi (2008), there are many concerns on nursing's lack of recognition and possibly the erosion of professional identity in nursing in its move away from "hands-on" care, having a culture that values or, at least, tolerates being oppressed, perceived as "dirty work" for "softies." Neighboring Asian countries experienced similar situation. In Japan, there is a nursing labor shortage because of the low social position of work, poor working conditions, traditional discrimination among women, disregard for religious mentality and a short history of hospital nursing (Sawada, 1997).

In light of this, hospital staff nurses have a strong sense of professional identity reflected in the respondents' quotes saying *"pag nurse ka, mas nakakaangat ka"* (if you are a nurse, you are above than the rest), *"nirerespeto ka"* (you are respected), *"mas kapaki-pakinabang"* (more valuable) and "they (doctors) envy us". According to Cook, Gilmer and Bess, (2003), environmental factors influence how nurses view themselves. In this era when there is an increasing number of professionals shifting into the nursing career, the professional identity of Filipino nurses is strengthened. Moreover, in contrast to the literature purporting that nursing is a semi-profession, a majority of the hospital staff nurses were convinced that nursing is a profession. Nursing as a profession has been discussed by Kozier, Erb, Berman and Snyder (2004) and complies with the requirements of being one. Nursing has been valued and highly appraised in the Philippines in comparison to other Asian countries. Leininger and MacFarland (2006) identified religious values (mainly Roman Catholic) as one of the dominant cultural values among Filipino-Americans and is reflected in giving comfort to others, tender acts when one is ill and being pleasant as much as possible. This is also consistent with the study of Castillo (2002), that cultural and Christian traditions influenced Filipinos to become proficient health care providers. Moreover, according to Castillo (2002), Filipinos are socialized to care for others; of particular importance is care for immediate family that extends to care for others. Caring towards the family is consistent, on the other hand, the study of Bulatao (1966 as cited in Panopio & Raymundo, 2004) identified four Filipino values namely: (1) emotional closeness and security in the family, (2) approval from authority, (3) economic and social betterment, and (4) patience, endurance and suffering. Panopio and Raymundo (2004) have also identified the American colonial influences among Filipinos, one of them being equal opportunities in education its ability to mobilize social status.

The findings show that hospital staff nurses often operate in undesirable work environments. They are overworked and underpaid and an overwhelming number of patient assignments caused dissatisfaction in the delivery of care to patients. Steers (1988 as cited in Nasrabadi & Emami, 2006) suggests that job satisfaction is best understood as the discrepancy between how much a person wants or expects from the job, and how much the person actually receives. When individuals perceive that the outcome of their occupation is met or exceeded, they are satisfied. Hence, Lu (2008), Nasrabadi and Emami (2006), Takase, Maude and Manias (2006) support that the work environment must be more conducive for nurses, an environment where nurses can use their skills more and that can lead to improvement in the quality of nursing care. Ghazzawi (2008) identified three factors that are most important for accepting and staying in a job and these were compensation, flexibility to balance life and work, and meaningfulness of the job. In addition, the administration's support for their work, benefits, flexibility, independence, and job security were considered very important to overall job satisfaction.

Meanwhile, in the Philippines, the proliferation of nursing schools unsatisfactorily created the problem of having too many students to educate and train which, according to Harrison (2004), may eventually lead to inadequate or "unsustainable" nursing practicum the providing quality patient care.

IMPLICATIONS

Caring has been the major theme in the answers of the respondents, reflecting Filipino culture and tradition. This therefore, together with the high social regard for the profession, should be maintained or even enhanced by nursing leaders as well as by mentors in the academe and in the clinical areas. Instilling Filipino values further and molding nurses in line with this tradition will help exemplify the caring attributes of Filipino nurses in their workplaces.

On the other hand, respondents in the present study complained of the heavy workload in their workplaces because of the rapid turnover of nurses for international migration; therefore, if the hiring process and orientation and

training program were hastened, it would help to ease the problem. Hospital staff nurses cannot be stopped from seeking for greener pastures but nursing administrators can help in training and filling the gaps to prevent understaffing and excess workload for nurses in the Philippine hospitals.

Another source of dissatisfaction among hospital staff nurses aside from increased workload is the monetary compensation for their professional work. Hence, nurse administrators can be their advocates in seeking dialogues with the hospital administrators or employers in order to increase their wages or work benefits.

The findings of this study support the need to empower nurses thru trainings, seminars, and postgraduate education as well. Hence, the Philippine Nurses Association, Association of Nursing Service Administrators of the Philippines, as well as hospital administrators are encouraged to organize symposia, seminars, or related learning activities that will provide nurses a wider outlook on nursing and to enhance their skills.

The perceived decrease in the competency of new graduate nurses should also be addressed, particularly by the nursing academe. Nurse educators, therefore, are in a vital position to influence the self-image of their students and of the profession as a whole.

The results of the study can be a starting point for further research in a certain aspect of nursing in the Philippines, to verify and confirm to the settings other than the hospital, or perform research using other methodologies such as quantitative or integrated researches.

CONCLUSION

This study examined the experiences of twelve staff nurses working in a hospital setting in Manila, Philippines. The concept of the 'lived experience' as a research framework assisted in the development of a deeper understanding of staff nurses and their experiences. The lived experiences of the respondents in this study that explores nursing as practiced in their workplaces confirmed that caring is still the ultimate unifying factor. The findings revealed that the culture and traditions of Filipinos rooted back to Spanish colonial influence are still reflected and valued in today's society. Care towards the older persons and valuing the family translate to caring for their patients. This was also reflected in the reasons why some nurses leave for international employment, they care for the welfare of their family, hence they choose to leave and mobilize their family's social status. The ability of nurses to provide an improved social status to their families increases the respect towards the profession in the country even further. These are consistent with the study of Bulatao (1966 as cited in Panopio & Raymundo, 2004) that identified four Filipino values. The Filipino cultural background improved the perceived social status of nursing in comparison to neighboring countries.

The findings of this study have provided an insight into nursing as practiced and experienced in the hospital setting. The knowledge generated through the descriptive phenomenological approach enriches the understanding of nursing with the potential to benefit nurses, nursing educators, nursing administrators and nursing leaders.

What is already known:

1. Numerous nursing theorists have worked to redefine nursing and to provide a unique knowledge base for nursing practice.
2. Chinese, Iranian, Japanese and Korean nurse scholars have discussed some distinctive features of nursing theory development from Asian perspective.
3. Nursing in the Philippines is seen as a profession from the West and nursing definitions are reflective that of Western literature.

What this paper adds:

1. Filipino registered nurses articulate nursing as it is practiced in terms of the meaning of the term nursing in relation to “essence,” activities, goals, and as a profession.
2. Nursing in the Philippines is highly valued compared to neighboring countries.
3. Cultural factors underpinning the Filipino nurses' conceptualization of nursing were discussed.
4. Due to commercialization, the nursing profession in the Philippines is faced with various challenges, socially and institutionally.

References

Beck, C. T. (2000). The experience of choosing nursing as a career. *Journal of Nursing Education, 39*, 320322.

Castillo, M. (2002). Caring in the Diaspora: Filipino Immigrants, Health Care, Healing, and Religion. *Religious Healing in Boston: Reports from the Field.* Pages 67-71. Retrieved from http://www.hds.harvard.edu/cswr/resources/print/rhb/reports/13.Castillo.pdf

Choy, C. (2003). *Empire of care: Nursing and migration in Filipino American history*. USA: Duke University Press.

Cook, T., Gilmer, M.J., & Bess, C. (2003). Beginning students' definition of nursing: An inductive framework of professional identity. *Journal of Nursing Education*. 42, (7), 311-317.

Crawford, P., Brown, B., & Majomi, P. (2007). Professional identity in community mental health nursing: *A thematic analysis. International Journal of Nursing Studies.* 45, (2008), 1055-1063.

De Belen, R. & Loarca, J. (2006). *A Handbook in nursing law and ethics*. Quezon City, Philippines: Gilcor Printing Press.

Edens, G. (1987). Professional socialization in nursing. *Paper presented at the Annual Research in Nursing Education Conference.* January 4-16. Electronic version.

Ghazzawi, G. (2008). Job and career satisfaction rank high in survey. *The ASHA Leader*. (June 17).

Harisson, S. (2004) Overcrowded placements hinder student learning. *Nursing Standard*. 18, (22), 7. (February 18)

Kozier, B., Erb, G., Berman, A., & Snyder, S. (2004). *Fundamentals of nursing: Concepts, process, and practice. (7th ed.).* Upper Saddle River, New Jersey: Pearson Education, Inc.

Leininger, M. & McFarland, M. (2002). *Trancultural nursing: Concepts, theories, research and practice. 3rd edition*. New York, USA: McGrawHill Medical Publishing.

Lu, J. (2008). Organizational role stress indices affecting burnout among nurses. *Journal of International Women's Studies*. 9 (3). 63-78.

Nasrabadi, A.N. & Emami, A. (2006). Perceptions of nursing practice in Iran. *Nursing Outlook,* 54, (6), 320-327.

Panopio, I. & Raymundo, A. (2004). *Sociology: Focus on the Philippines*. Quezon City, Philippines: Ken Inc.

Sanders, C. (2003). Application of Colaizzi's method: interpretation of an auditable decision trail by a novice researcher', *Contemporary Nurse*, vol. 14, (3), 292 - 302.

Sawada, A. (1997). The nurse shortage problem in Japan. *Nursing Ethics*. 4, (3), 245-252.

Streubert, H, & Carpenter, D. (2007). Qualitative research in nursing: Advancing the humanistic imperative, 4th Ed., Philadelphia, USA: Lippincott Williams & Wilkins.

Takase, M., Maude, P., & Manias, E. (2006). The impact of role discrepancy on nurses' intention to quit their jobs. *The Authors. Journal Compilation*. 1071-1080.

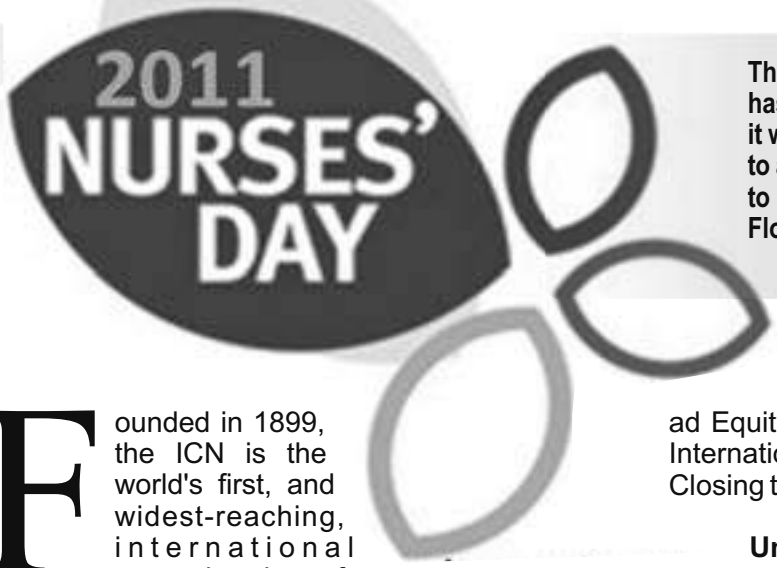
"Embrace optimism as a carefully disciplined act of political resistance."

Ron Labonte, 2008

SPECIAL FEATURE

CELEBRATING INTERNATIONAL NURSES DAY[1]

CLOSING THE GAP: INCREASING ACCESS AND EQUITY



The International Council of Nurses (ICN) has celebrated this day since 1965. However, it was only in 1974 that a decision was made to appropriately celebrate the day on May 12 to coincide with the birth anniversary of Florence Nightingale, widely considered as the founder of modern nursing.

Founded in 1899, the ICN is the world's first, and widest-reaching, international organization for health professionals. The ICN works to ensure quality nursing care for all, sound health policies globally, the advancement of nursing knowledge and the presence worldwide of a respected nursing profession and a competent and satisfied nursing workface. In the Philippines, the Philippine Nurses Association (PNA), founded in 1922, aims to promote professional growth towards the attainment of the highest standards of nursing. The ICN accepted the PNA (then known as the Filipino Nurses Association or FNA) as one of its member organizations in 1929.

This year's theme of the International Nurses Day **"Closing the Gap: Increasing Access and Equity".** The continuing concern of access and equity of health care, both challenges nurses to understand the enormity of the problem of access and equity in health care, and to recognize that with knowledge, courage, vision and commitment, nurses are well placed to take a lead role. The sections on Understanding Access and Equity, The Burden of Inequality and Nurses Enhancing Access and Equity are excerpts from the publication of the International Council of Nurses (2011) entitled, Closing the Gap: Increasing Access and Equity.[2]

Understanding Access and Equity[3]

Access refers to the ability to obtain an item or service at the required time. Exactly that constitutes good access is difficult to define, and will vary according to context. However, as noted by Chapman et al. "good access exists when patients can get the right service at the right time in the right place" (Chapman et al., 2004. 374)

Key elements of access include availability, utilization (use of available services by the utilization (use of available services by the population), relevance (service provided reflecting the service needs and preferences of the population groups), effectiveness (whether the desired treatment or service outcomes is achieved), and equity, which refers to differences in the access across different groups, as discussed later in this chapter (Chapman et al., 2004). Barriers to access can include:

- Lack of capacity and availability (including rationing). Examples include long waiting lists for particular types of treatment, shortages of

[1] International Nurses Day (IND) is celebrated around the world every May 12 to recognize the valuable contributions nurses make to society.

[2] The Philippine Nurses Association was granted permission to reproduce in print these parts of the publication, International Council of Nurses (2011). Closing the Gap: Increasing Access and Equity. Geneva, Switzerland. Please note that due to space limitation, all references are not reprinted. All cited references in the article can be requested from the Editorial Board of the Philippine Journal of Nursing. The article with references is also available in the PNA website.

[3] This section is an excerpt from Chapter 1, pp. 5-10.

infrastructure or staff so that a service can't be provided, or lack of services at the place or time they are needed.

- Cost. Full or partial payment for many types of health services remains the norm in many countries, which can be a significant barrier to the poor.
- Language and culture. Making provision for members of the community to access health services in their community language is an important par to making health care accessible and effective. Similarly,. Failure to cater for different cultural norms can adversely impact on the willingness of people to seek help as well as the effectiveness of treatment.
- Lack of knowledge and information. Access includes access to information about one's own health, about preventative strategies and approaches, and about the kinds of services that are available. For example, failing to provide public health messages in all community languages restricts access to information and can thereby directly impact both on an individual's health, and on their capacity to proactively work to improve health and identify and access the services they might need.
- Mobility and migration. Mobile populations may find it difficult to identify and access services, particularly if administrative barriers (e.g. requiring a long-term address for registering at a medical practice) exist. Ensuring good practitioner engagement and continuity of care is also an issue.
- Employment. In some countries, access to health services is strongly linked to employment status, such as in the USA where many people are reliant on employer-sponsored health plans. Lack of employment can therefore limit access. Conversely, reliance on marginal, casual or cash-in-hand employment limits the ability for people to access health services without incurring significant costs through lost income.
- Staff sensitivity and preparedness. Professional standards and ethics require nurses and other health professionals to provide services competently and professionally, and to treat patients with respect and sensitivity. Effective training and management should support nurses in maintaining these standards.
- Discrimination. Despite the commitment of health services and professionals to deliver effective health care, instances if discrimination on the basis of gender, race, sexual preferences or socio-economic status continue to exist. It is important to note that discrimination is not always active-the failure to address inequalities ineffectively or provide treatment for or to stigmatize certain conditions can also represent a form of discrimination.

Restriction in access can also impact directly on quality of care. For, example, many people living in remote and rural locations in both the developed and developing world have less access to the range of health services and to the skills of qualified health practitioners such as nurses than do their city-based counterparts. This can directly impact on the quality of care received. For example, access to appropriate birthing care in rural areas has been identified as a key factor to be addressed in achieving improvements in maternal mortality (UN, 2010).

Improving access to care also involves “taking into account the social factors influencing access” (Ministry of Health and Social Policy of Spain 2010, p.16). However, improving access may conflict with other policy imperatives such as cost containment (Chapman et al., 2004). The importance of addressing the social determinants of health is discussed in more detail later in this document.

The relationship between access and equity

“Unequal access to resources, capabilities and rights lead(s) to health inequalities.” (Ministry of Health and Social Policy of Spain, 2010), and access to health systems is an important part of improving health outcomes. In health care, there are a number of concepts and assumptions commonly implied by the word “equity”. It may imply a basic level of services that all persons are able to access and benefit from. In most developed countries this may include the ability to see a health professional when they are ill, the ability to access basic medicines, the ability to obtain emergency care, and the ability to receive care and support through childbirth.

The analysis of outcomes and “the extent to which empirical distributions correspond with specific interpretations of equity” is an important field of study in health care. In his article “Evaluating Equity in Social Policy: A framework for comparative analysis”, Osterle (2002) consolidates various authors' discussion of these notions into three simple dimensions, as quoted below. His article provides a useful discussion applying this framework to the provision of long term care.

- WHAT is to be shared (e.g. resources, burdens);
- Among WHOM (the recipients); and
- HCW (the principles)”

(Osterle, 2002, p.59)

Achieving equity in regard "what" might involve defining a minimum set of services or level of resources that ii is reasonable and acceptable for persons to have access to. This may also involve defining the particular quality standards or expectations that will apply. These less tangible factors can be important measures of equity, particularly when dealing with service users who may come from diverse cultural backgrounds (Osterle, 2002, pp. 51-52).

The "whom" in Osterle's model refers to the fact that, even in developed countries, some people may be excluded from these services through social circumstances, geographical location or another factors (Osterle, 2002, pp. 52-53). To what extent they should be treated unequally in order to reach an equitable distribution is part of the allocation principle" (Osterle, 2002, p. 53). However "need" can be a relative term in itself. And can be measured in different ways, such as mortality, morbidity mortality of life.

As noted by Osterle, "Social policies aimed at equalizing access are aimed at equalizing potential, not actual use of services" (Osterle, 2002, p. 52). As a result, service provides may target particular population groups or problems in order to achieve improved outcomes. This "positive discrimination" (Ministry of Health and Social Policy of Spain, 2010) or favoring of specific groups, who have been historically discriminated against in programmes or policies, is seen as means by which health care systems can seek to achieve better equity in outcomes.

Various forms of rationing may also be used in an effort to balance the sometimes competing priorities of need and equity.

Ethics and human rights

The Pan American Health Organization (PAHO) has also recognized that the concept of justice is important, and that "all inequities are the product of unjust inequalities". It states that while "*just* and *unjust* are subject to various interpretations. In the context of health, one of the more accepted definitions of *just* refers to equal opportunities for individuals and social groups, in terms of granting access to and using the health services, in accordance with the needs of the various groups of a population, regardless of their ability to pay." (PAHO, 1999). This enshrines the notion of universal health care and access as part of a just health system.

Health care cost and rationing

Even in those countries where Governments have a policy commitment to universal health care provision, providing health services represents have a significant and often growing budgetary demand. Many developing countries also require significant increases in national health budgets in order to meet basic population health needs, and battle against other sectors to carve out "fiscal space" for health (ICN & WHO, 2009).

One mechanism used within health sector to manage this tension is rationing. While it can be argued that withholding any treatment from an individual is unethical, it can also be argued that introducing transparent rationing system can at least provide the pre-condition for community discussion and debate about priorities when resources are limited.

Implicit rationing is more common. Cost-cutting strategies have resulted in raised thresholds for hospital admissions and shortened lengths of stay. This can directly impact on quality of care and patient outcomes. This illustrates that decision-making about the level of care provided and to who are being made at various levels on a daily basis. It is therefore important that issues of equity are analyzed and considered at each of these levels.

As Dey and Fraser highlight in their discussion of aged-based rationing in the health system, the desire to limit the cost of health care and to develop ways to allocate the available resources raises important ethical dilemmas.

THE BURDEN OF INEQUALITY[4]

Delivering on the Millennium Development Goals

The need to improve access and equity lies at the heart of the Millennium Development Goals (MDGs), which were agreed by 192 member states in 2001.

In his foreword to the 2010 progress report (UN, 2010), UN General Secretary Ban Ki-Moon describes the MDGs as representing "human needs and basic rights that every individual around the world should be able to enjoy - freedom from extreme poverty and hunger; quality education,

[4] *This section is an excerpt from Chapter 2, pp.11-24.*

productive and decent employment, good health and shelter; the right of women to give birth without risking their lives; and a world where environmental sustainability is a priority, and women and men live in equality".

The Goals are:

1. Eradicate extreme poverty and hunger
2. Achieve universal primary education
3. Promote gender equality and empower women
4. Reduce child mortality
5. Improve maternal health
6. Combat HIV/AIDS, malaria and other diseases
7. Ensure environmental sustainability
8. Develop a Global Partnership for development

The MDGs reflect the need for multi-sectoral approaches in order to improve the health, welfare and well-being of the world's population. The international commitment to the MDGs recognizes the interconnection between health and other indicators of disadvantage: "avoidable health inequities arise because of the conditions in which people grow, live, work and age, and the systems put in place to deal with illness. The conditions in which people live and die are, in turn, shaped by political, social and economic forces" (CSDH, 2008, p. i). The relationship between inequities in education, income, gender and health is discussed further in this chapter.

Health-related MDGs

Health related goals include reducing child mortality rates by two-thirds, maternal mortality ratios by three-quarters, and halting and reversing the spread of HIV, tuberculosis and malaria by 2015 (Stuckleretal., 2010).
A review of the health-related Millennium Development Goals conducted in 2008 (WHO, 2008a) found that while progress was being made, significant inequities remained. Most of the targets are unlikely to be met by 2015, and low-income countries are falling further behind their targets.

Key constraints identified in achieving these goals include:

- Shortages of well-trained health workers;
- Insufficient responses by governments to the health needs of their populations, for a variety of reasons, in "fragile states"; and
- The need for greater cooperation between sectors: private, public, voluntary, and community and faith-based.

The need for increased donor funding and greater government spending on health was also noted. However, statistical analysis of the data conducted by Stuckler et al. analysed variations in rates of change in MDG progress versus expected rates for each country.

Gender

Every year more than 350,000 women die from preventable complications related to pregnancy and childbirth (Ban, 2010). As the United Nations notes in its most recent report on the MDGs, "gender equality and the empowerment of women are at the health of the MDGs and are preconditions for overcoming poverty, hunger and disease." (UN, 2010, p. 4)

The United Nations' *Global Strategy for Women's' and Children's Health* was launched in 2010 in an effort to address preventable death and illnesses and improve access to services for women, focusing on "equity of access and outcomes, making sure we reach those who are especially disadvantaged and marginalized". Achieving the MDGs is a key part of this, and would equate to saving the lives of four million children and about 190,000 women in 2015 alone (Ban, 2010).

Also, the WHO has recognized the importance of engaging men and boys in promoting gender equality and improving the health of both men and women, recently releasing *Policy approaches to engaging men and boys in achieving gender equality and health equity.* The policy briefly outlines and promotes policy approaches which can "accelerate shifts towards gender equality in the home, decrease levels of violence and sexual exploitation, support emerging safer sex practices, and reduce men's excessive consumption of alcohol." (WHO, 2010a)

Ethnicity and culture

There is widespread evidence from across the world that ethnicity and culture can have a significant influence on both the accessibility of health services and the quality of care that is provided by those services. The ability to provide effective services to people from different cultures is often referred to as "cultural competence". As outlined by Brach and Fraser (2000), lack of cultural competence in service delivery can lead to a range of consequences including:

- Missed opportunities for screening due to lack of knowledge about prevalence of different conditions amongst different groups;
- Lack of knowledge about traditional remedies and possible harmful interactions; and
- Diagnostic errors resulting from poor communication.

Ineffective communication - whether because of language difficulties or differing interpretations or understanding - can lead to poor patient experience and reduce the ability for the person to participate effectively in decision making regarding care and treatment, to the extent that meaningful consent cannot be given. It is also important to note that cultural background can influence help-seeking behavior, and therefore have an important influence on whether a person accesses health care at an appropriate time. Effective service delivery needs to seek ways to negotiate and overcome such cultural barriers to access.

Socio-economic status

The poor experience significant barriers to health care including limited purchasing power, lower rates of health insurance, lower health literacy and often live in slums or remote or rural areas which are often underserved by health systems and experience shortages of health professionals (Bhattacharyya et al., 2010). Unhealthy attitudes and behaviors are also associated with social exclusion, with higher rates of obesity and smoking, and higher risk of developing a drug addiction (Ministry of Health and Social Policy of Spain, 2010, p. 43). For this reason, the Commission on the Social Determinants of Health called for reinforcement of "the primary role of the state in the delivery of basic services essential to health". (CSDH, 2008, p. 15). Even where health care is provided free, the poor are less likely to access it due to time lost from work and incidental costs such as transport (Birdsall &Hecht, 1995).

Location and rurality

Geography is a significant factor in access to services, and often co-exists with other social risk factors that are known to contribute to poor health such as low socio-economic status and poor sanitation and living conditions. In developing regions, children in rural areas are more likely to be underweight that urban children, and in Latin America, the Caribbean and parts of Asia, this disparity has increased in recent years (UN, 2010, p.5).

A recent project has also highlighted significant disparities within different urban areas, with a third of the urban population worldwide living in slums or shanty towns. The analysis shows that there are differences within, as well as between, cities. The report sees addressing these issues within cities as an important part of achieving the MDGs (WHO et al., 2010).

Disability

Although people with disabilities tend to have a high level of contact with health systems and services, there is evidence that many disabled people have difficulty accessing care that is appropriate to their needs. Brown et al. (2010) note that two significant reports released in the UK have identified problems: Health Care for All identified problems including systematic institutional discrimination and failure to comply with and implement the Disability Discrimination Act. A parliamentary investigation in 2008 detailed breaches of human rights in respect to the right to life, freedom from degrading and humiliating treatment, and the right to privacy and family life (Brown et al., 2010, p. 354).

Diet and nutrition

Diet and nutrition have a significant impact on health, and have a close relationship with socio-economic status in both developing and developed countries. In cities, increasing consumption of foods high in fats and energy has led to what has been referred to as a "global obesity epidemic" (CSDH, 2008, p. 62). Meanwhile, in less developed areas, particularly rural areas, inadequate nutrition continues to be a major challenge, particularly among children and pregnant women in many parts of the world, where lack of nutrition in the early years hinders development and can establish lifelong health deficits. Reducing the global prevalence of underweight children is a key target in aims to reduce child mortality. Both these phenomenon are strongly associated with poverty.

Dowler points out that "the evidence is that structural and social issues, such as the amount of time and money people can devote to pursuit of good food and active living, the cost and accessibility of each of them, the physical area where households are located, and the general

social circumstances of the lives of those classified as lower classes ... constrain and govern choice to a considerable extent." (Dowler, 2001, p. 702).

High levels of diabetes, primarily associated with rising obesity, are also evident in indigenous communities in many parts of the world. In these cases, ongoing issues related to social dislocation and dispossession combine with other factors such as rurality and isolation, poor access to appropriate health

NURSES ENHANCING ACCESS AND EQUITY[5]

Professionalism and ethics

The international Council of Nurses has the principles of human rights and equity as an integral part of nursing ethics. This is affirmed within the preamble *to The ICN Code of Ethics for Nurses* (2006) which states that:

Many elements of the Code directly address issues of equity and access, including:

- The nurse promotes an environment in which human rights, values, customs and spiritual beliefs of the individual family and community are respected (ICN, 2006, p. 2).

- The nurse shares with society the responsibility for initiating and supporting action to meet the health and social need of the public, in particular those of vulnerable populations (ICN, 2006, p. 2).

- The nurse, acting though the professional organization, participates in creating and maintaining safe, equitable social and economic working conditions in nursing.

Training and skills development

Effective training and skills development, including a commitment to ongoing learning developments, is also needed if nurses are deliver the accessible care which promoted equity and it's free of discrimination.

Brown et al. identify shortcomings in nursing care for the disabled including negative views and lack of skill and knowledge about the needs of this client group. They also note, however, that many nurses have not received sufficient training to enable them to deliver quality care, citing a study of practice nurses which found that only 8% of respondents received training on issues related to learning disabilities.

It is also important that managers, including nurse managers, and employers ensure that they equip their employees with information and training appropriate to the needs and preferences of the local community.

Cultural competency

Ensuring that the workforce is culturally competent is an important part of increasing both the utilization of health services for all members of the community, but also helps improve quality of service by improving the patient experience and communication between health service providers and service users.
Key techniques for improving cultural competences have been identified by Brach and Fraser (2000) as follows:

- Use of interpreter service
- Recruitment and retention of staff who are members of majority groups
- Training to increase cultural awareness, knowledge and skills
- Coordinating with traditional healers
- Use of commonly health workers
- Culturally competent health promotion
- Including family and/or community members
- Immersion into another culture
- Administrative and organizational accommodations, including location of services, changes to the physical environments and hours of operation.

Developing role and flexibility

The development of new roles for nurses has also been investigated as an important strategy to improve access to many services.

Increasing the role and deployment of clinical nurse specialize and a practitioner has been demonstrated to improve quality care and reduce organizational costs. Chapman et al. conducted a review of strategies employed to improve access to primary care in the UK, and found that nurse-led primary care has been used to “combat poor service

[5] *This section is an excerpt from Chapter 6, pp. 39-44.*

access in areas having difficulties recruiting and retaining GPs'" and that nurse-led triage and telephone consultations could save time and improve access without affecting quality of care (though they go on to note that telephone access can infringe access to people with poor. English language skills, hearing or speech impediments or no access to phones) (Chapman et al., 2004).

Introducing appropriate new cadres in some areas has also been an effective way to reduce costs without adversely affecting patients satisfaction (ICN, 2010), and has been successfully employed in areas of severe workforce shortage.

Research

Evidence has shown that disparities arise in the area or research of health service delivery. A recent article analyzing nurse researchers in the area of HIV found that clinical research did not always adequately represent the population in question. For example, in the USA it was found that although black women represented 67% of new AIDS cases in 2005, they were underrepresented in all clinical trials. The author noted that this is not only poor practice in terms of clinical research, but also "precludes learning about the political, social and individual factors that influence the spread of the disease" (Cohn, 2007).

Cohn argues that nurses, with their experience of direct patient care and communication and the high degree of trust that they share with the general public in many countries, are "uniquely positioned" to ensure that patients are well informed and that research protocols are developed in a way that ensures proper participation and representation from all groups."Specifically, nurses recognize the importance of collaboration with marginalized population in management and treatment of disease" (Cohn, 2007, p. 274).

A tool to assist nurses undertaking research in addressing equity issues in their work has been developed by The Campbell and Cochrane Equity Methods Group. The Equity Checklist for Systematic Review Authors outlines a series of research questions aiming to guide researchers incorporating an equity perspective in all the aspects of a review, including search strategies and methods, the description and methodology of the studies considered, as well as analysis of the results (Ueffing et al., 2009). The authors encourage use and distribution of the checklist, which is available at http://equity.cohrane.org /our_publications.

Lobbying, advocacy and policy development

Nurses play an important role in policy development through developing a voice in analysis advocacy and research, particularly within the domains of health service delivery and restructuring. However, as authors such as Reutter and Duncan argue, the need to address the social determinants of health means that there is also a need for strong advocacy in the realm of broader public policy which "extend beyond traditional health agencies and government health departments to bring together sectors such as finance, agriculture, education, transportation, energy and housing" (Reutter & Duncan, 2002, p. 295).

National nursing associations provide a means by which nurses' interests can be articulated and provide a first point of contact with key stakeholders in government and civil society, and are key to the development of an effective contribution to policy debates on both how the health system is oriented, structured and managed, but also on broader policy issues which address the social determinants of health.

A Joint publication on macroeconomics by ICN and the WHO suggests areas for the nursing community to pursue in seeking to support workforce development and better health, including engaging in national and local debates on the importance of skilled health workers in achieving outcomes (ICN & WHO, 2009, p. 34).

Lobbying and advocacy thus are a key part of nursing's role in addressing issues such as equity and access, and involve the development of a different skill set and acknowledge base. Nurse education is beginning to reflect this need, with the introduction of graduate courses which seek to build the skills needed for nurses to engage effectively in public policy development (Reutter & Duncan, 2002).

Reference [6]

[6] *Cited references in the article can be requested from the Editorial Board of the Philippine Journal of Nursing. Due to space limitation, all references are not reprinted. The article with references is available in the PNA website.*

FEATURE ARTICLE

CELSO JR PAGATPATAN, RN, MSN [1]; **VARUNGOVIND MOORTHY,** MD [2]

Structuralist-behavioral Explanation of Inequity and Tuberculosis

(Acknowledgement This paper was improved as a result of comments and guidelines from Aung Ching Thowai, MD, Bangladeshi physician and Master of Health and International Development student ; Samantha Meyer, PhD, faculty - Discipline of Public Health, Flinders University, Adelaide, Australia.)

INTRODUCTION

Nearly one third of the global population is infected with tuberculosis and at risk of developing the disease (Blanc et al. 2003). About 98% of TB deaths annually are in developing countries and the poor and marginalized communities suffer disproportionately from this disease (WHO, 2004). All of the 22 TB high-burden countries are in fact belonging to developing countries, including the Philippines, which accounts for 81% of all estimated cases worldwide.

Tackling tuberculosis effectively requires adequate understanding of the socio-economic inequity that impact on this disease. To control tuberculosis, the WHO had been advocating the directly observed treatment short-course (DOTS) since the early 1990s that was later restructured into STOP TB strategy. However, Lonnroth (2010) asserts that, although WHO aims to ensure equitable delivery of quality and appropriate technology for TB control, options combining curative approaches and preventive efforts to address social determinants of TB have not been fully considered.

Structural factors such as access to health services, living and working conditions contribute to inequity impacting on tuberculosis prevalence. Likewise, behavioral factors like smoking, nutritional intake and physical activity also play a role in inequity and this disease. Stronks et al. (1996) argues that understanding the overlap between the structural and behavioral factors is necessary to explain this inequity.

This paper aims to discuss inequity and tuberculosis, its historical context, taking into account the pre-bacterial period to the social determinants of health perspective. It seeks to understand inequity and TB through the structuralist-behavioral model and aims to assert the importance of tackling TB-related risk factors and its social determinants.

TUBERCULOSIS AND INEQUITY

As highlighted in many literatures, great differences in the health profiles of different nations and different groups within countries are undeniable. These differences that are unnecessary and avoidable but also considered

[1] *Member, National Council of NARS ng Bayan, a professional association of Community Health Nurses and People's Health Advocates; Regional council officer of the Philippine Nurses Association Cagayan Valley and a recipient to a doctoral research fellowship at the Flinder's University, Adelaide, Australia under the The Australian Leadership Award Scholarships (ALA Scholarships) 2011. He is among the eighteen Filipinos qualified for this award among the 205 qualifiers in the Asia Pacific.*

[2] *Indian physician and Master of Public Health student, Discipline of Public Health, Flinders University, Adelaide*

unfair and unjust refer to inequity (Whitehead, 1991 p. 219). Socio-economic inequities are prevalent which impact tuberculosis mortality and morbidity.

It has been a well-established and widespread knowledge that tuberculosis is closely linked to poverty. Deprivation associated with poverty relevant to TB includes overcrowding, poor ventilation, and malnutrition. These increase the rate of transmission and progression from infection to disease (WHO, 2004). A study by Son (2009) in the Philippines on TB incidence among adults showed that the poorest 20% of households are at almost 60% higher risk of being infected by TB than adults in the wealthiest 20% of households. This indicates that socioeconomic position is a major measurement of inequity and TB. However, it was argued that inequity and TB can also be measured through access to care (Whitefield, 1991 p.221-222), race or ethnicity (King, 2003 pp. 49), and gender (Thorson, 2003 p 55).

Access to Care

Fair distribution of health care should mean equal access to available care, to equal needs that implies equal entitlement to available services to everyone requiring ease of access in each geographical area and removal of other barriers to access (Whitefield, 1991 p. 221). Many of the poor and other vulnerable groups encounter an overlapping set of barriers to access to tuberculosis care more than the non-poor. Among these barriers are economics, the health system, socio-cultural and geographical contexts (WHO, 2005). Concrete examples of these barriers include excessive user fees for diagnostics and treatment, lost income and productivity, non-responsiveness and inefficient TB services, prevalence of social stigma and exclusion and, inaccessibility of TB centers.

Race or ethnicity

There is a profound differential distribution according to race. In a study in the United States by Mcbride in 1994, TB cases increased by 27% among Blacks, 75% among Hispanics and 47% among Asians but decreased by 10% and 23% among non-Hispanic and American-Indians respectively. King (2003), postulates two interconnected possibilities on ethnic and racial disparities of TB incidence, (1) disparities according to race is in fact a result of another variable, income level or access to health care; (2) racial and ethnic differences still have significant social consequences.

Gender

It has been noted by Thorson (2003) that there is a gender difference in terms of health seeking behavior as shown in a longitudinal study in Bangalore, India. Active screening for TB showed that females had up to 130% higher risk than men of progressing from TB infection to disease. This could be associated with the study conducted in Vietnam wherein more women delay care as a result of heavy association of stigma with TB among women (Hoa, et al, p. 10). Other gender related issues relevant to TB and inequity includes a higher incidence of TB among men which is related to their wider social network and greater number of contacts that would lead to a greater exposure to the bacteria; and the greater isolation of women TB patients among their relatives and neighbors.

Overall, the persistence of extensive inequities and high prevalence of tuberculosis is related to the insufficiency of the current public health strategies to meet the scale of challenge, and that this prevalence remains inextricably linked to wider factors such as poverty and social exclusion (Gandy 2003, pp. 11-12).

THE EPISODES OF TUBERCULOSIS HISTORY

The understanding and control of tuberculosis is one of the most significant chapters in the history of humankind from the pre-bacterial period to the social determinants understanding of the disease.

Pre-bacterial to lifestyle dominance period

In the 19th century, there have been several assumptions of TB's cause. William Beach in 1840 emphasized that TB is hereditary, marked by the features 'prominent shoulders' and 'narrow chest'. However, this prevailing idea was challenged by Jean-Antoine Villemine's 'contagion theory' by demonstrating the transmissibility of the infection in his experiment with animals (Gandy, 2003 pp. 16-37).

Moreover, a dramatic change happened in 1882, the 'contagion theory' was further expanded by a discovery by Robert Koch of the etiology of TB M. tuberculosis that is congruent to the then prevailing germ theory explanation of diseases.

Furthermore, in the pre- and early 70s, behavior and lifestyle explanation of health problems became a major focus in public health with little regard to social and economic circumstances. Public health programs are designed to persuade people to change their health-related behavior guided by several theories like the health belief model, social cognitive theory, among others (Baum, 2008 pp. 33-34). Tuberculosis has been strongly associated with smoking and poor nutrition as major risk factors for this disease.

Developing the social dimension of tuberculosis

The 'Health for All' concept of the Alma Ata Declaration in late 70s to mid-80s further influenced the idea that TB is to be highly regarded as a "social disease" in which the socio-economic condition of people is the main consideration. However, the Commission on Social Determinants of Health (2010) considered that neoliberal economic models dominant during this period impeded the translation of these ideals into effective policies in many settings. Little of these social models of health advocated by WHO and others were translated into practice, thereafter. Subsequently, there has been a dominance of 'selective' primary health care that considered medical intervention as more crucial than an approach that deals with the root causes of illness or the comprehensive primary health care.

Meanwhile in 1980, the Black Report produced convincing evidence that material deprivation was a major determinant of ill health and death. It also concluded that people's behavior is constrained by structural and environmental factors. This report was influential not only in Europe but also to other public health practices in many parts of the world (Irvin, 2006 p. 75). Building on the principles of the Alma Ata Declaration, Health Promotion charters were also produced subsequently that aimed to achieve greater balance between curative and preventive health services, and to ensure appreciation of the social and economic causes of ill health.

The DOTS, STOP TB strategy and the social determinants of health

Previous public health events and the increasing trends of TB led to the creation of the DOT strategy to control the disease and was later restructured into the STOP TB strategy. Many countries who implemented these strategies on a wide scale witnessed remarkable result (Blanc, 2003 p. 108). However, in a study by Lonnroth (2009) to identify historic and recent trends in TB burden, he argues that incidence is not falling as rapidly as expected. He further points out that it has been difficult to separate the effect of DOT strategy with that of social and economic development as the case notification rate remained approximately constant.

Until recently, the Commission on the Social Determinants of Health (CSDH) in 2005 has asserted the revitalization of the debate and actions to improve health and focus on the "causes of the causes" of diseases including tuberculosis by developing action frameworks in several fields to address the social determinants of health. Similarly in earlier year, Narayan (1999) had proposed the importance of TB paradigm shift to social understanding of the disease.

STRUCTURALIST-BEHAVIORAL EXPLANATION OF INEQUITY IN TUBERCULOSIS

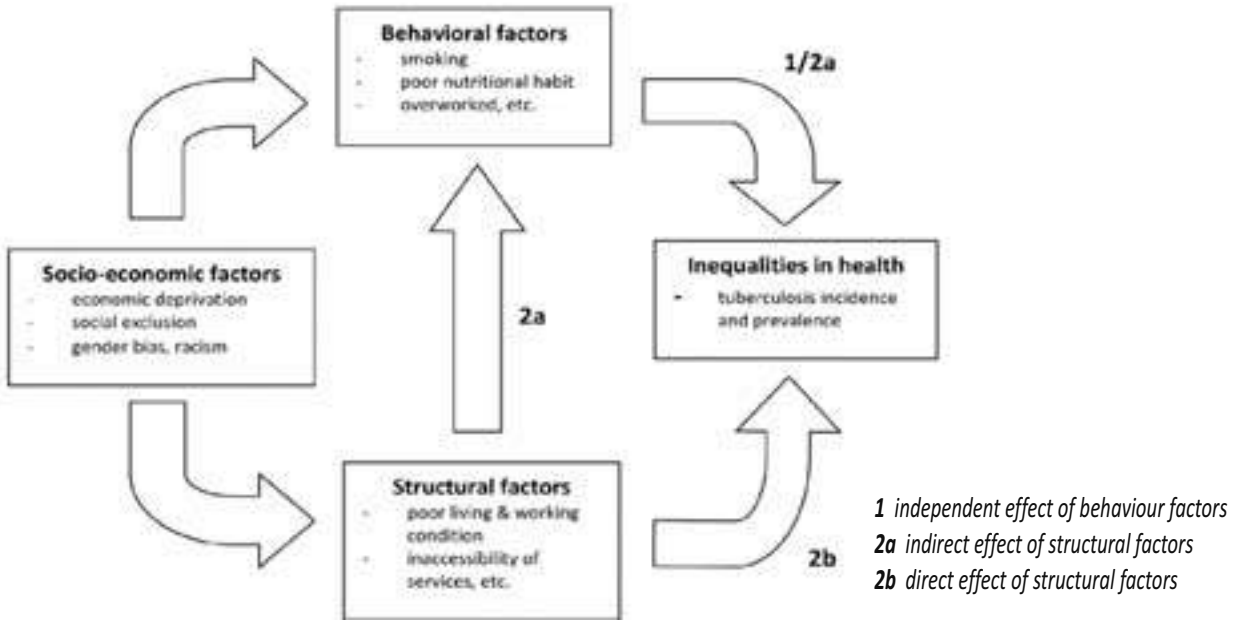
The classic and influential British document on health inequality, Black Report, presents several explanations of inequities/inequalities in health. As it recognizes the existence of social class variations in disease and early death, it sought to understand and explain the reasons of these variations. Among these explanations to health inequity includes the structural or materialist and behavioral explanations.

Structuralist explanation

The structuralist or materialist explanation emphasizes the role of economic and associated socio-structural factors in the distribution of health and well-being. It is described by Novak in 2010 as unequal distribution of material resources as a result of class differences that includes income, housing and working conditions. He further expounded that it is the individuals' social class position that determines their health.

Among the different strands of reasoning in this structural explanation is the direct role of economic deprivation. The Marxian critique explains the direct influence of poverty to the variation of health and mortality (Townsend et al. 1988 pp 106-107). Karl Marx (cited in Sullivan, 2002 p. 59-60) explicated that poverty is a result of the exploitative relationship of two conflicting social classes. This

Figure 1: Structuralist-behavioral explanation of inequity and tuberculosis



unjust relationship of a dominant class over a lower class will eventually result to the impoverished condition of the latter, resulting to inequitable circumstances in life.

To further describe economic deprivation or poverty, Banatar (2003) elaborated poverty as a condition that is deficient and is deprived materially, socially and emotionally and which includes lack of economic resources; lack of education; lack of access to basic life resources such as food, water and sanitation; and lack of control over one's life. It brings not only material disadvantage but also social exclusion. People living in these conditions are at more risk for tuberculosis and a higher possibility of progression to disease.

Behavioral explanation

The Black Report provides two versions of behavioral explanation labeled as 'hard' and 'soft' version (Macintyre, 1997 pp. 727-729). The 'hard' version explains that an observable class gradient in health and length of life completely accounts for the health-damaging behavior of individuals. The 'soft' version, on the other hand, considers that certain health damaging behaviors have a social gradient that contributes to the variation in health and early death. According to Macintyre (1997), the working group of Black Report prefers the 'soft' version by further pushing the explanatory task to ask why such behaviors are persistent and common among poorer groups.

This 'soft' version is further supported by Novak (2010) and argued against the 'hard' version that systematic behavior in certain social groups is a consequence of lack of education, and other social deprivations. Stronks et al (1996) identified several behavioral factors, such as smoking, alcohol consumption, physical activity, body mass index.

Overlap of Structuralist-Behavioral explanation

Stronks et al. (1996) proposes an overlapping structuralist-behavioural explanation of socioeconomic inequities, saying that there is an indirect contribution of structural conditions through behaviour. This connection should be considered to avoid overestimation of the behavioural explanation especially the 'hard' version. Crawford (1977) further posits his concern to analyze the interdependence between the contribution of behavioral and structural factors in order to avoid the so-called 'ideology of victim blaming'. This model was used and applied in this paper to understand inequity and tuberculosis prevalence and incidence.

The above model, explains how structuralist and behavioral factors overlap. There can be

independent effects of behavioral factors. However most of the behavioral factors are related to the structural factors or just a by-product of the later to the former.

In Tuberculosis, the commonly mentioned TB risk factors are smoking, excessive work and poor nutrition that plays a direct and indirect influence to inequity. However, structural factors that include, deprivation of material resources as a result of poverty and social exclusion, gender bias, racial discrimination, among others, are major contributing factors to inequity.

To illustrate, smoking for instance is a common example of how behavioral factor can simply be accounted to the health damaging attitude of an individual that has direct influence (1/2a) to health. However, the interconnection of structuralist-behavioral explanation was explained by Graham (1993) saying that a high smoking rate among women in lower socio-economic groups are associated with a high level of material deprivation among these groups, as an indirect effect of structural factors to health through behavioral factors (2a). Furthermore, a more recent study by Novak (2010) explains smoking as a reflection of multiple socioeconomic and psychosocial chains of risk experiences by the men and women with low socio-economic position during upbringing. An example of the direct effects of structural factors (2b) to health includes living in communities where smoking is highly prevalent.

This model supports the idea that environment restricts freedom of choice or behavior is chosen to compensate for unfavorable circumstances. It has policy implications wherein the choice of policy promoting health behavior should be supplemented with measures that aim to reduce material inequities.

CONCLUSION

An effective control and treatment of TB requires understanding of the underlying root causes of variations of morbidity and mortality. Focusing on reasons how inequities are produced and its impact on TB must be fulfilled. The structuralist-behavioral explanation provides a framework on how effective interventions to TB in the public health setting can be addressed. The overlap between the structural and behavioral factors must be well considered to avoid the ideology of 'victim blaming' and create a more objective and caring perspective in its control and treatment.

It demands not only clinical or pharmacological care. Early diagnosis and ensuring compliance to treatment are essential components but a structural approach to care that is a comprehensive social and cultural approach can create a broader and more lasting impact. Recommendations like the ban on tobacco advertising, creating safer living and working conditions and addressing malnutrition can be instituted. Moreover, the call of the Commission on the Social Determinants of Health to national and local governments to address poor access to health services, social exclusion, employment conditions and gender and racial inequity is an urgent task.

However, it must also be clarified that health education and health promotion interventions that primarily aim to improve attitudes and behavior, are essential components of TB control and treatment. Furthermore, incorporation of preventive approaches that gives importance to proximate TB risk factors and the social determinants behind them is essential.

Proposed additional interventions to the TB control strategy by Lonnroth et al. (2009) should be supported and include programmatic public health actions, health system strengthening and upstream intervention beyond the health sector.

Finally, the long struggle against tuberculosis has taught us much lesson. There have been improvements on how humankind addresses this centuries old problem. Though there are challenges along the way like increasing multi-drug resistance and the compounding effect of HIV to TB incidence, it is hopeful that we can gradually reach the end of the road in closing the gap. Inequity is not inevitable and tuberculosis can be eliminated as we draw lessons from its history and understand inequity in its context.

Reference

Baum, F 2008, *The new public health, 3rd edn*, Oxford University Press, Melbourne.

Blanc, L & Uplekar, M 2003, 'The present global burden of disease', in M Gandy & A Zumla (eds), *The return of the white plague*, Verso Publishing, London, pp. 95-111.

to page 24

from page 23

Commission on Social Determinants of Health, 2010, *A conceptual framework for action on social determinants of health, discussion paper 2 (policy and practice)*, WHO, Geneva.

Gandy, M 2003, 'Life without germs: contested episodes in the history of tuberculosis', in M Gandy & A Zumla (eds), *The return of the white plague*, Verso Publishing, London, pp. 15-38.

Hoa, NP, Chuc, NTK & Thorson, A 2008, 'Knowledge, attitudes, and practices about tuberculosis and choice of communication channels in a rural community in Vietnam', *Health Policy*, vol. 90, no. 1, pp. 8-12.

Irvin, L, Elliot, L, Wallace, H, Crombie, I 2006, 'A review of major influences on current public health policy in developed countries in the second haft of the 20th century', *Perspective in Public Health*, vol. 126, no. 2, pp. 73-78.

King, N 2001, 'Immigration, race and geographies of difference in the tuberculosis pandemics', in M Gandy & A Zumla (eds), The return of the white plague, Verso Publishing, London, pp. 39-54.

Lonnroth, K, Jaramillo, E, Williams, B, Dye, C, Raviglione, M 2009, 'Drivers of tuberculosis epidemics: the role of risk factors and social determinants', Social Science and Medicine, vol. 68, pp. 2240-2246.

Lonnroth, K, Jaramillo, E, Williams, B, Dye, C, Raviglione, M 2010, 'Tuberculosis: the role of risk factors and social determinants', in E Blas & A Kurup (eds), *Equity, social determinants and public health programs,* WHO Press, Geneva.

Macintyre, S 1997, 'The Black Report and beyond what are the issues?', *Social Science Medicine*, vol. 44, no. 6, pp. 723-745.

Narayan, T & Narayan, R 1999, 'Educational approaches in tuberculosis control: building on the social paradigm', in D Porter, M Grange (eds), *Tuberculosis an interdisciplinary perspective,* Imperial College Press, London, pp. 489-509.

Novak, M 2010, *Social inequity in health explanation from a life course and gender perspective*, Umea University, Sweden.

Son, H 2009, 'Equity in health and health care in the Philippines', *ADB Economics working paper series*, no. 171, Philippines.

Stronks, K, Dike van de Meen H, Looman C, Mackenback J 1996, 'Behavioral and structural factors in the explanation of socio-economic inequalities in health: an empirical analysis', *Sociology of Health and Illness*, vol. 18 no. 5 pp.654-674.

Sullivan, S 2002, *Marx for a Post-Communist Era*, Routlegde, London

Thorson, A & Diwan V, 'Gender and tuberculosis: a conceptual framework for identifying gender inequalities', in M Gandy & A Zumla (eds), *The return of the white plague*, Verso Publishing, London, pp. 55-69.

Townsend, P & Davidson, N (eds) 1982, *The Black Report*, Richard Clay Ltd, England

Whitehead, M 1991, 'The concepts and principles of equity and health', *Health Promotion International*, vol. 6, no. 3, pp. 217-228.

WHO/WPRO 2004, *Reaching the poor: challenges for tb programmes in the Western Pacific Region,* WHO Press, Geneva.

WHO 2005, *Addressing poverty in tb control: options for national tb control programmes*, WHO Press, Geneva.

Equity, ecologically-sustainable development and peace are at the heart of our vision of a better world -

- a world in which a healthy life for all is a reality;
- a world that respects, appreciates and celebrates all life and diversity;
- a world that enables the flowering of people's talents and abilities to enrich each other;
- a world in which people's voices guide the decisions that shape our lives.

There are more than enough resources to achieve this vision.

People's Charter for Health (People's Health Movement, 2000

FEATURE ARTICLE

FLORENCE NIGHTINGALE: *Nothing Stood in Her Way*

CECILIA M. LAURENTE, RN, PhD

Nursing generously grants Florence Nightingale many appropriate titles: Mother of Nursing, Mother of Nursing Education, Architect of Nursing and Lady with the Healing Lamp. She had a colourful life although controversial. Passionate in character but militant in stance, she almost single-handedly put nursing on the map of the world of the professions, like medicine, architecture, law, engineering, which were and still are occupied by mostly men.

Influencing events

Born in an elite, upper-class English family, Nightingale was influenced by at least three major events in her life. First, she was extremely dissatisfied and frustrated by the dull, routine life of women in high society. Joining wild parties, drinking, working as prostitutes because of their low self-esteem, lacking in education and facing unemployment, having life at the lowest socio-economic strata. Second, her education and training is equal to that of men in the male-dominated Victorian English society. She had an active and keen interest in activities beyond household and social life. Third, she disliked the inadequacy and inefficiency of the care given by hospital staff to patients. She was likewise frustrated by the inadequacy and inefficiency of her training in a nursing school managed by hospital. She had long hours of dull routine classes, no time to interact with patients and their families as well as with medical staff and other professional and non-professional colleagues, no socialization and even academic discussions among them.

Using Political Power

Nightingale was a consummate political woman. When the Crimean war broke out (l854-l856), she organized a contingent of nurses, mostly untrained, and travelled to Scutari, Turkey, to supervise a military hospital. In spite of the distrust and obstacles placed in her way by some military physicians and staff in authority, she was able to revolutionize the military system and health care for British soldiers, proving that nurses can make a difference. She was well-loved by soldiers that whenever she entered their room with the famous lamp, they almost kissed her shadow, a sign of appreciation and gratitude, as well as high esteem to a woman and a nurse at that.

She used her social and intellectual skills and political power to bring about evolutionary and revolutionary change in health care and nursing in the nineteenth century. She protested against the corridor system of hospitals for pavilions; she issued the anonymous blue book on military

sanitation in which showed the frightful morbidity and mortality rates of the Crimean war. She gained the support of powerful friends in government. Her incredible power came from her determination to pursue changes and the support of friends in government. She was indeed a strong-willed woman with social and financial power; having excellent education and coming from a wealthy family. She developed connections to powerful men, since there were few powerful women at that time in England other than Queen Victoria. She sought the support of her friends and in turn supported them when they needed her help.

In essence, she used her public support, her political and social connections to people in powerful positions in government.. She used her intelligence and social skills to reach an unparalleled position of leadership. Thus, she was able to gain personal power and move health care and nursing to the present era.

Shaping Nursing

After the war, Nightingale used her wealth and money, raised by the public to honour her achievements, to establish the Nightingale Training school for Nurses in London. This was the first independent and formal nursing curriculum in the western world. She instituted public health nursing and curricular reforms. She continued to oversee her school - even from her bed while she was ill. Some of her reforms were: admitting qualified students (of sound mind and body), instituting curriculum that focused on the whole person, not merely on the physical aspect, which she called a "holistic" approach; conducting training covering not just hospitals but also the community setting and anywhere nurses were needed.

Nightingale's concept of training is that it must consist of two branches: the training of the **mind** and of **character.** The training of the mind could be done through didactics and tested by examination, but the training of the character could be done by personal contact and supervision in the practice setting--hospitals and community. Character training was an essential part of Nightingale's curriculum. She viewed the primary reason for the clinical practicum to be character formation, not technical competence. The RLE (related learning experience, as called now) is an important part of character formation.

Nightingale conceptualized nursing by developing what is called Nightingale Environmental Model. Nightingale viewed disease as a reparative process and described the nurse's role as manipulating the environment to facilitate this process. Her ideas regarding environment included ventilation, warmth, light, diet/food, cleanliness, variety and noise as presented below.

Patient -Individuals, responsible, creative, in control of their lives and health and desiring good health

Health - A state of well-being, using one's powers to the fullest

Illness - The reaction of nature against the conditions in which we have placed ourselves. Disease is a reparative mechanism, an effort of nature to remedy a process of decay.

Environment - External to the person, but affecting the health of both sick and well persons. The environment, one of the chief sources of infection, must include fresh air, fresh water, efficient drainage, cleanliness and light.

Nursing - A service to people intended to relieve pain and suffering. The goal of nursing is to promote the reparative process by manipulating the environment.

To enhance her nursing curriculum, she integrated research and statistics which were extremely needed to determine morbidity and mortality rates in public health, as well as to know the level of performance of nurses and staff and academic performance of students.

Continuing the Legacy of Nightingale

In honouring her memory, the University of Philippines College of Nursing Alumni Association (UPCNAA), sponsored a forum entitled, "Rekindling the Spirit of Florence Nightingale" last June 16, 2011 with Dr. Annabelle Borromeo (Chief Nursing Officer at St. Luke's Medical Center) as speaker. After citing the life and achievements of Nightingale, she gave comments and proposals, as follows, connecting the scenario at her time with the present:

- Nightingale believed that the form of training she designed required close supervision and personal interest in each of the students; and that it was not compatible with producing nurses by the hundreds and thousands as is occurring today. She was urged to increase admission of students, to reduce standards, for many odd and unjustified reasons. But she vehemently refused to back down to the whims of higher authority. Then followed a period when nurses became scarce so that Nightingale's methods were presented, and many again opposed as expected, but her results were never questioned, realizing probably that she was, after all, correct.
- Not all hospitals are ideal for RLE (related learning experience). Some hospitals serve only to illustrate what nursing is not. Observations are that, nurses are cruel to patients, yelling at them, treating them with disrespect. Nurse-patient ratios are poor, conditions of patients' rooms or wards are likewise poor. But we teach to students to give "ideal" care in an unsafe, uncomfortable environment

to page 28

FEATURE ARTICLE

ELEANOR M. NOLASCO, RN
Chair, Advocacy Committee, PNA

Remedios L. Fernandez, Ph.D R.N. M.N. was conferred the 2011 Outstanding professional in the field of nursing by the Professional Regulation Commission during rites held on June 22, 2011 at the Fiesta Pavilion of the Manila Hotel.

Dean Remy, The Outstanding Professional

For the current Dean of the Graduate School, Arellano University, this added feather to an already bedecked cap as a nurse is another testament to a brilliant practice spanning more than 4 decades. And while she may well rest on the laurels and citations she has collected through the years, the PRC award is special as it included her in the roster of outstanding professionals in other fields of professional practice.

"Professional" was in fact how she was described by an equally accomplished colleague and good friend who affirmed and attested to her "competence, professionalism and adherence to the highest principles of nursing practice." With her scholastic accomplishments, broad experience, extensive training, and active involvement in the accredited professional association (PNA) and specialty group (ADPCN) she is undoubtedly already in the pro league of expert resources in nursing especially in the academe which is her forte.

An Exemplary Student. Ever since she was in their hometown in Capiz, Dean Remy has consistently performed well as a student. Her excellent academic record, in fact, was what served as her passport to the State U where she gained entry as scholar to her choice course, which was nursing. While it relieved her parents who had bare means to support their daughter's university education, it had been an uphill climb for the young scholar who fended for herself and earned her keep by taking on tutorial jobs in between school hours. This encumbrance caused a semester's delay in Remy's graduation yet when she finally graduated and took the nursing licensure examinations, she remakably landed in 6th place. She also fared well in the midwifery boards, where she placed third in the overall.

Quest for knowledge. The scholar was relentless in her quest for knowledge and excellence, pursuing higher education despite obstacles along the way. For her Master's education, she had to hurdle financial and physical constraints, more so the latter as she shuttled by train weekly between school in UP and work in Iraga as a full-time faculty of nursing. This became untenable when she got pregnant with her first child, forcing her to quit her job (her first) from the school she pioneered with two other classmates who eventually migrated abroad. Almost singularly, she mentored the school to a hundred percent passing rate in the nursing board exams during the eight years she taught there.

In 1976, she finished her Master's degree and thereafter was appointed Dean of Medical Center in the Lucena Educational Institution. Three years later she undertook the Deanship of Martinez Memorial Colleges where she served from 1979 to 1995.

As a Dean, she carried her trademark work ethic that left no room for leisure nor rest, until she got a wake up call from the big C that forced her to slow down and realign her priorities. Already a widow that time, with 4 young children to support she lightened up on her workload and took up higher studies for a "pleasant diversion". The "diversion"paved the

way for Dean Remy to finish her doctorate, albeit a bit delayed, still successfully reaching the top of the academic ladder to earn the distinctive title "Doctor of Philosophy in Nursing."

Success, however, for this "doctor" was not merely having the title but what comes with it. Just as respect is not something one demands but earns. In her long years of practice, Dean Remy has demonstrated what it is to be a "professional" in name and substance, despite having been embroiled in a controversy that shook the profession to its core some years back.

Career Highlights. Highlights in Dean Remy's career included having been appointed Project Director of the Johns Hopkins Program for International Education for Reproductive Health (JHPIEGO)-Association of Philippine School of Midwifery (APSOM) project in 1995. The main program thrust was the training of midwives and nurses in Reproductive Health using a competency-based training approach with the end goal of providing quality services for clients on family planning and reproductive health. The project provided Dean Remy many opportunities for service not only in the country but in other Western Pacific Region countries as well.

Early 1999, Dean Remy was appointed member of the Board of Nursing, sharing in the board functions to regulate nursing practice that was then "booming" with the high demand for Filipino nurses abroad abeted by the government's labor export policy. In 2002 she was made member of the Technical Committee on Nursing Education (TCNE) until 2006 when the unregulated increase in nursing schools reached atrition level that led to the "leakage" scandal. Dean Remy was among those caught in the "eye of the storm" by virtue of her position, yet, she didn't buckle. She had been beaten black and blue but in the end she was absolved from any liability, proving to all and sundry that you can't put a good (wo)man down. Throughout this ordeal, her constant solace were prayers and faith in a Higher Being who had unfailingly redeemed her in all of life's trials, including her early face-off with the dreaded C while still nurturing a young family.

And with this "dark episode" in her career already behind her, Dean Remy has slowed down a bit yet she continues to be involved and engaged in endeavors and advocacies of choice. Being one of the pillars of the ADPCN, she mentors other nurses in her current capacity as Dean of the Arellano University Graduate School. She's also part of the circle of leaders paving a roadmap for a better future for nurses and the profession.

The Outstanding Midwife (1994), Anastacio Giron Tupaz Awardee (1996), Outstanding UP Alumna in Nursing Education (2000), Outstanding Alumna in Nurse Administration (2002), Professional Awardee by UP Manila (2002) Distinguished Mambusaonon (2004) and this year's Outstanding Professional Nurse - is still not done "nursing".

from page 26

conditions in hospitals and communities.

- There is a need to collect data on a national scale of the number of quality RLE slots are available per region. These objective data should be the basis for making decisions about whether or not to open nursing schools and to determine the quota on how many nursing schools should be allowed per region. It is further proposed that this be a joint project of PNA, ADPCN, and ANSAP.
- Getting behind the Nursing Roadmap is a step in the right direction. Harnessing the collective efforts of all nurses toward the achievement of common goals is important. This Nursing Roadmap needs to be a priority of nursing leadership. Many nursing organizations are involved in this endeavour.
- To become more political in approach like Nightingale, use correct, relevant data to help our decision-makers to see the light in our favour. We must invest in databases that measure our contributions to the care of our people and society. We need to measure patient outcomes. We need to collect data on "never events" or "near misses" that were prevented because of nursing vigilance and interventions.

Finally, Borromeo gave the following inspirational characterization of Nightingale:

"Florence was a one-woman dynamo. No efficiency, no corruption, no bureaucracy could ultimately stop her from bringing healing to countless suffering people, particularly those impacted by war. Her writings along with her action gave us clean, predictable and safe health care".

Nightingale passed her global vision to us to extend our own horizons of possibility: remembering who we are, considering what we can do, who we care for, and why?

Nightingale died a little more than l00 years ago at the age of 90, life-fulfilled. May her legacy continue in us, especially in Philippine nursing leadership.

References

- Borromeo, Annabelle, J.V. Sotejo Annual Lecture."*Rekindling the Spirit of Florence Nightingale"*, unpublished Talking Points, 20ll
- Chitty, Kay Kitrell(l993) *Professional Nursing- concepts and Challenges*. Philadelphia: WB Saunders.
- Dossey, Bm (2009) Healer. *Florence Nightingale: mystic, visionary, healer*. New York: FA. Davis Company.
- Nightingale F. (l860). *Notes on Nursing: what it is and what it is not*. New York: D. Appleton and Company.

FEATURE ARTICLE

The Nurse Warrior is an Angel

ELEANOR M. NOLASCO, RN
Chair, Advocacy Committee, PNA

She did what she was wont to: do things she feels must be done as a matter of course. And for this Filipino nurse, a good standing overseas worker in KSA for almost 25 years now, organizing Filipino nurses in Jeddah into one body was essential as it was important. In fact, it was long overdue. And so, Zenaida Concepcion, or "Zeny" as she is fondly called, founded the PNA Jeddah chapter in July 2009 capping the many years of almost single-handedly helping her fellow nurses adjust in that generally conservative Islamic country of Saudi. Establishing the Filipino nurses association with her as founding president, finally formalized the civic mission of Zeny in the country that gave her the opportunity to realize her dream of a better life for her family and for herself, as well. Blessings she felt she needed to share one way or the other with her fellow nurses and other Filipinos who took the path she did early on.

Dynamic leader. Through the years that she had been helping out as a senior Filipino nurse in the conservative society of Saudi Arabia, she had come to realize the importance of a formal organization to facilitate representation for distressed Filipino nurses in that foreign land. She also saw the need for a venue to develop camaraderie among Filipinos and ease homesickness and loneliness that usually hit newcomers who experience culture shock. Even old timers occasionaly want to loosen up a bit in the company of their countrymen. That historic moment in the lives of Filipino nurse-expats in the western region of Saudi Arabia happened in 2009 upon the initiative of Zenaida Concepcion. And the association has since grown to its present 300-plus membership and continues to grow -- much to the credit of the founding president Zenaida Concepcion's solid organizing efforts.

Soft-hearted warrior. Zeny has the propensity to raise arms against any form of injustice that she sees or is reported to her. The warrior in her likely emanates from a soft spot that she has for the underdog or the disadvantaged, a possible mirror of circumstances in her own life. As the eldest *"ate"* among 5 siblings, a terminally ill mother and a wayward father, Zeny had to take on the reins of the family even as she was just starting a nursing career. As if this wasn't enough, she herself was in a shaky marriage with two young boys, aged 4 and 12, to provide for. And while Zeny the nurse would have wished to personally take care of her ailing mother and be a loving mother to her two young boys, the problem of economics ruled. So in 1986, she bid her family good-bye and joined the exodus of nurses to Saudi that beckoned with the promise of handsome emoluments. Actually, the local conditions then for Zeny and other nurses did not offer much of a choice. Meager wages and a lack of professional incentives served as the "push" that drove nurses in their numbers to succumb to the irresistible "pull" of lucrative contracts offered by the Arabian government that needed

skilled nursing manpower to man its public hospitals. Our government, in fact, saw "gold" in the high demand for the country's skilled workforce, particularly nurses, and made labor export a central policy. For their significant contribution to the Philippine economy as a top source of dollar remittances, nurses were hailed as among the country's modern heroes.

> ***"Strive not to be a success, but rather to be of Value"***
>
> *Albert Einstein*

To Zeny, the distinction of being named a *"hero"* was not only well-earned but well-lived. She is a hero not only for her "*remittances"* to the country during more than two decades of being an OFW, but equally, if not more significantly, for her efforts to help fellow nurses and other Filipinos deal with the drawbacks posed by the social environment of the host country. Also in her list are victims of exploitation and other forms of injustice that were often work-related, like the violation of work contracts, physical abuse and displacement. These people find in Zeny an ally, a friend and a champion. Zeny, whose tough life had made her into a strong and courageous person, exercised the same qualities in dealing with problems brought to her attention. Her no-nonsense and direct personality often mistaken as being "*mataray"* but eventually, people see the warmth, sincerity and generous spirit within.

Competent OR nurse. Zeny not only possesses a big heart, but also a notable nursing proficiency that has earned her praise from her superiors and employers. Her competence as an OR nurse are attested to by the number of citations and plaques of appreciation given her by the hospitals and other institutions she has worked in.

For her civic work among distressed Filipinos, she is a recognized partner by the Philippine consulate. Some of the activities she has initiated or rendered in partnership with the Philippine consulate are practical training seminars for OFWs, assistance related to absentee voting, fundraising for Ondoy victims and socio-cultural activities for the Filipino community.

In her most recent visit to the country, she had consultations with policy-makers and other nursing leaders including members of the Board of Nursing to whom she presented the more pressing issues and concerns of nurses in Saudi, most of which pertained to their employment status.

The accomplished nurse. Zeny is extremely grateful for having achieved her present stature as a Filipino nurse in the global community. She also feels she has done equally well as a daughter and a mother to her two sons whom she left behind many years ago in her quest to give them a better life. Her sons are now themselves accomplished adults, a doctor and a nurse, who share her service mission. She has also found a new life partner who is supportive as he is inspiring. She is presently in the process of exiting from Saudi Arabia where she has worked for the last 25 years and which has rewarded her generously and afforded her a comfortable estate in Philippine soil. But as this chapter of her life now closes, a new one begins.

> ***"You've got to follow your passion. You've got to figure out what it is you love--who you really are. And have the courage to do that. I believe that the only courage anybody ever needs is the courage to follow your own dreams."***
>
> *Oprah Winfrey*

This quote from a personal idol, Oprah Winfrey, may well be Zeny's, who as she looks back in her colorful life can proclaim, "I've followed my passion (nursing) and confirmed what I loved (serving). I mustered the courage to follow my dream..." and I succeeded.

"It is really a good feeling to make effort and help our *kababayans* especially when they do not have the voice to speak up or muscle to stand for their rights. Life has made me strong and courageous. It is through respect, friendly, warm and genuine interpersonal relationships with people that we gain trust and eventually, teamwork ..." Zeny H. Concepcion

MINDA LUZ M. QUEZADA, RN, PhD[1]

ADVOCACY WORK IN PERSPECTIVE

Introduction

I would like to commend the College of Home Economics for initiating this lecture workshop series on advocacy work. I know that there some of you who have been doing advocacy work, in particular in the field of food and nutrition.

To be honest with you, I'm not a self-conscious practitioner of advocacy and this will be the first time for me to speak formally on the subject. For this talk I have had to read more about the subject. In the process, I discovered that I have been an advocate for certain groups and a variety of issues and concerns. I was not conscious of the term "advocacy," though most of the time I was living it. So I should thank you for including me, for I was able to do some reflections on my experiences and lessons derived from advocacy work. I trust this public sharing would not be construed as a boastful act, but a humble contribution in the understanding and appreciation of the process of advocacy.

To organize my thoughts, I have adopted the conceptual framework of advocacy in Social Rehabilitation popularized by UNICEF. I shall enrich these, however, with insights gained from my own experiences in advocacy which I recall now, started as far back as the late 1960s. I was a school public health nurse then at the Philippine Normal College (PNC) when I organized the State Colleges and Universities Nurses Association of the Philippines. This group of health service providers felt disadvantaged and under privileged in terms of conditions of life and work in comparison to their counter parts the members of the academe. Shortly after this, I initiated the organization of the PNC Employees Association after hearing a lot of their problems, issues and concerns while consulting at the Medical Clinic. In both of these groups, one could sense the feeling of helplessness, powerlessness and hopelessness. I felt that these individual groupings had to be channeled to organized actions. So much for a brief history of advocacy from a personal standpoint.

Before proceeding, let me define some terms.

Definition of Terms

The key word here is "advocate" and the Random House dictionary refers to it as a verb and a noun. As a verb, to advocate means “to plead in favor of; support or urge by argument; to recommend publicly." On the other hand, as a noun, it refers to “a person who defends; pleads for in behalf

[1] *Founding member and pioneering President of the Alliance of Health Workers; former Professor of the University of the Philippines, College of Public Health; Former BOG and President of the PNA. She was a member of the 1987 Constitutional Commission; A pillar of PNA as Past Vice-President for Programs and Development,1982-1983 with Mary Vita as President.*

of another, intercedes, vindicates or spouses a cause by argument. Its synonyms are lawyers, attorney, counselor, counsel, and barrister."

The same source defines advocacy as "the act of pleading for or giving verbal support to a cause."

UNICEF views advocacy as "the organization of information into argument used to persuade an audience towards some attitude or predisposition to action." An "advocate" according to UNICEF's issues and concerns would thus have the role to "persuade leaders, decision makers in both government and non-government organizations to undertake policy and operational program decisions towards improving the situation of infants, children, women and other vulnerable members of families and communities as a whole."

What does it take to be an advocate?

1. Commitment to values

Advocacy requires being driven by strong values which you are willing to stand and fight for, sometimes even die for. What is your standpoint? *Para ano? Para kanino ba ang iyong panindigan?* For example, do you strongly believe in people's human rights and in social justice? Does it disturb and move you to take some kind of action when you personally witness injustice, suffering and anomalies amidst the growing dehumanization in our society? Are you willing to take risks in the process of pursuing your social goals?

An advocate for popular issues and the causes of the disadvantaged must necessarily take risks. Since you are for change in the situation, you invariably run into conflict with those interests are treatment by advocated change. For one, you can get labeled as an activist, a leftist, even a communist. You have to be firmly committed to your causes that such experiences do not discourage you from continuing your advocacy role. This value commitment, in turn is something you develop in the process of socialization from your home, church, school, peers and other social networks.

Advocacy work, in addition to being a teacher and researcher, can be an actualizing experience. That is, if your sense of fulfillment means giving of yourself, time, talents or experience, and yes, even your limited resources, for the cause you are espousing, and the people whose issues and concerns you are pleading for. For me, advocacy loses its meaning when you get paid to do the job. It's something you do because you truly believe in what you are doing.

2.A good knowledge, understanding and appreciation of the situation/cause or people/group whose issues and concerns you are advocating.

It is not enough however, to be value-driven to be an advocate. You need to have a good grasp of your advocacy issue and concerns. You cannot be theoretical about these. You learn more concretely in praxis, in actual encounters, interactions and transactions with the people. This exposure is an educative and transforming process, more than with classroom teaching learning can over achieve on creating critical consciousness of our social realities. This way, somehow, you internalize people's issues and concerns and you are able to speak as if they were your own.

3.Ability to express your thoughts clearly, rationally and affectively.

This easily comes when you know from where you speak because you have a sundial and been immersed in praxis. But it requires organizing your thoughts, preparing arguments/counter arguments, and offering alternatives decision-options backed by supporting materials in anticipating of question, opportunism, and possible rejection. Bear in mind to avoid technical jargon when addressing audiences coming from a different field.

Decision-makers are not just convinced by empirical-rational presentations. You have to combine with affective appeals. Dramatize your cause with real-life situations to help break through indifferent and callousness. Also, utilize existing motivational forces among your target audiences. This means knowing what kind of motives would drive these people into action statue, prestige, self-esteem, popularity, and self-fulfillment.

4. Ability to persuade

Your pleadings as an advocate can be persuasive if you have established credibility and trustworthiness. Credibility is usually associated with expertise or knowledge of the subject matter and your legitimate position. Just as important in persuasive communications are the perceptions of your trustworthiness. Do people think you can be trusted to pursue the cause and not mold them to out in the process of struggles? They will look unto your track record of positioning on some issues. *May* consistency *ba ang paninindigan mo? O may* history *ka bang* opportunism *sa* self-serving hidden agencies?

5.Ability to organize, establish alliances or coalitions and mobilize people to support a common cause.

It makes a lot of difference, especially for politicians and some other decision-makers, to know that your cause has the backing of organized sectors. But in order to reach out these sectors, you must start a core group or an organization to help in the needed groundwork, e.g., data gathering, networking, mobilization and the like.

You must have the skill to unite people/groups on a common issue and standpoint to reduce possible conflicts in terms of strategies and tactics.

6. Patience and self control

These traits are needed because advocacy work may not immediately show results. The passage of legislation could take years. Our group, the Alliance of Health Workers, advocated a Magna Carta of Public Health Workers as early as 1987. It was enacted into law five years later to be precise; last March 26, 1992.

You must learn to be patient when understanding and appreciating the nature of the legislative process, why people behave the way they do, and why not all your plans materialize.

You have to exercise self-control when you have the strong urge to give up, when all things are not going as planned. Especially when you see that some of your close allies have given up due to fatigue and other personal reasons.

On the beneficiaries

- Quality of life concerns
- Social and cultural setting
- Demand for the services to be offered
- Willingness and ability to participate in actions
- Plurality of needs

Identify the problem/concerns

- Select most critical problems/issue/concern for action.
- Identify specific policy/program implementation shortcomings that are hampering progress.
- Identify target audience or decision makers to whom advocacy will be directed.

Formulate your plan of action

- Specify objectives or the desired decision/action required for policy change.
- Decide on arguments and materials required to support advocacy; and activities to produce them.
- Define roles and locus of responsibilities for identified tasks.
- Establish procedures for coordinating work.
- Identify alliances/conditions that can support advocacy; mobilize support required decisions.
- Prepare a timetable for action; schedule of meetings; participation in major national events; etc.
- Prepare budget to support advocacy activities.
- Decide on procedure for assessing performance and results.

Implement your plan of action

- Prepare the position paper on the issue using appropriate data and persuasive appeals.
- Identify your official spokesperson and communication system.

If the strategy agreed upon requires the efforts of several people, then a coordinating system is needed. Who will speak for the groups? Unauthorized persons can without meaning to, create real problems if they speak for the group. Look for skills that are needed. Do not be restricted to the office a person holds. For instance, a very good head of an association may not be the most effective spokesperson. Sometimes, due to the personal relationships of a member of the group to a top policy-maker, that person might be the best choice of a spokesperson.

Presentation of issue and position to appropriate bodies/groups

Here, the advocacy group arranges meetings with potential alliances for possible coalition formation, with the media and policy-makers/official. "*Ako, magpapakahirap, eh wala naman akong* material gains *na mapapala rito sa aking gawain. Gastos pa nga ako ng gastos sa sarili kong bulsa."* But one must control this strong urge to quit.

What are the key elements in advocacy planning?

1. Education for political awareness and advocacy

Before engaging in advocacy works, people need to experience a conscientization process whereby they develop a critical awareness of the situation, reflect on their own feelings about this when they strongly feel the need to do something about the situation. How can they organize a

core group of individuals who share a common vision, mission, goals and strategies? And they, too, have the values and competencies listed above. There must be willingness on each part to share work collectively.

2. Establish an information system

It is crucial to have ready information on the following:

- Subject of advocacy a policy, legislation, a program/service for a particular problem and group.
- The "target person" (political leader, legislator, administration) from whom the advocate seeks an endorsement, a policy decision, or an intervention.
- The beneficiaries whose cause you are advocating.

Types of information that may be useful for advocacy purpose may include:

On the subject:

- Magnitude of the problem
- Policy decision needed to alleviate the problem
- Program interventions suggested and their advantages
- Capability of the government to implement the program
- Available resources internal or external

On the legislators/policy-makers/official/alliances others

- Their political priorities obtained from their campaign platforms, public pronouncements
- Their power to effect change position in the hierarchy of power and authority
- Background information (education, experience, reputation, religions/professional/ political affiliations, hobbies and the like)
- What influences their decision rational empirical evidences, pressure politics from constituents/party affiliations, church or media
- Best ways to reach the channels of communication e.g. mass media, telephone, fax, letters, telegram, home or office visits, through the secretaries or have required that you are thoroughly prepared for possible questions and counter arguments
- Keep members informed and involved so as to maintain interest and unity within your group. Open lines of communication and collaborative work. Use positive reinforcement whenever there is an occasion/reasons for stroking the person. Make each individual feel that their contribution means a lot to the attainment of collective goals.
- Hold regular action/reflection sessions to assess your strength and weaknesses attainment of objective and lessons learned.

What are some strategies to influence the decision-maker?

1. Study the needs of your audiences and establish/maintain smooth interpersonal relations with them.
2. The role models or stories/examples of success. People are more easily influenced by personal experience, especially of success.
3. Indicate mutual benefits for the beneficiaries and the decision-maker if your idea is accepted and the loss of opportunity if this is rejected.
4. Appeal to the decision-makers' need for status, responsibilities, acceptance and self-fulfillment. Some people are influenced because of their sense of pride, competition, fear of embarrassment, and drive for power. The advocate should be able to work on existing motivational forces.
5. Enlist the support of media, especially the opinion-makers like columnists, radio-television hosts/communicators. They can help project and legitimize your cause and influence decision-makers.

Conclusion

I would say that advocacy work offers an arena for translating our theories into practice thereby enriching our teaching. As an advocate, you can also feel actualized knowing that you are serving others.

References

International Council of Nurses, *"Guidelines for Public Policy Development Related to Health,".* Geneva, 1985.

The Random House. *College of Dictionary,* revised ed., New York: Random House, Inc., 1988.

UNICEF and Development of Health, "*Module in Social Mobilization Components,"* in *Training Course in Social Mobilization and Communicating for the Expanded Program on Immunization,* Manila, 1992.

LYDA J. CANSON, RN
Project Director
Development of Peoples Foundation, Inc.

Sexual and Reproductive Health and Rights:

Whose Rights? Whose Responsibilities?

Human rights are basic standards used to determine the quality of life that every human being is entitled to. Sexual and reproductive health are part of human rights. The World Health Organization defined reproductive health "as a state of complete physical, mental and social being and not merely the absence of infirmity, in all matters relating to the reproductive system and to its functions and processes." This implies that all women and men, regardless of their age, gender, civil status, socio-economic background, religious and political affiliations should be able to enjoy a mutually satisfying and safe sexual relationship, free from coercion or violence and without fear of infection or unwanted pregnancy or pregnancy-related death or disability. It also implies that everyone has the capability to reproduce and decide if, when and how often to do so. With this right, couples must exercise responsibility. Every individual has the right to access to information on sexuality and other reproductive health matters to be able to arrive at responsible decisions and behavior. Everyone has the right to remain free of disease, disability or death associated with their sexuality and reproduction. As human rights, sexual and reproductive health and rights (SRHR) are universal, that is, these are birthrights, not exclusive to any group, individual or society. SRHR is inalienable, meaning that it cannot be taken away from us and will stay with us for as long as we live. SRHR is also indivisible and interdependent, because all rights are equal in importance and none can be enjoyed without the other.

Every woman has the INDIVIDUAL RIGHT and SOCIAL RESPONSIBILITY to decide freely whether, how and when to have children and how many to have. It is the women who will suffer the adverse effects of such decisions. That is why men have a personal and social responsibility in their own sexual behavior and fertility, and for the effects of that behavior on their partner's and children's health and well-being. The government has a responsibility in the promotion, protection and fulfillment of SRHR through its policies, programs and services.

Although good health is a basic human right, we place more emphasis on women's health because, simply put, women, because of their disadvantaged position than men and because of biological and societal reasons, have more pressing health concerns than men. Battered by toiling each day for the household upkeep, women more often than not neglect their own health to give precedent attention to the demands of other family members as well as to a career.

A discussion on reproductive health and rights cannot be without a discussion of sexuality because these affect how we view and deal with sexuality in our daily lives.

In a patriarchal society where women are subjugated to men in all spheres of life, sexuality becomes a tool to control, oppress and exploit women, furthering their marginalization. Sexuality then becomes an arena for the exercise of unequal gender relations.

To talk about sexuality does not isolate it only in the biological sense. We should appreciate it within social, economic, cultural and political context. Women's' sexuality have largely been defined by the rest of the world, except by women themselves. From child birth to adulthood, their sexuality has been determined by men and institutions like the family, the school, church, media and multi-national corporations. Tradition and culture have also defined and reinforced their subordinate position. Women must fit within the mold of a sexual being, a sexual object and a perfect wife and mother.

Sexuality is the sum total of values, feelings and behavior patterns associated with the individual's consciousness of identity as a woman or man. It includes the cultural meanings attached to sexual behavior in its social sense as well as its biological aspects. In other words, it is how a man or woman feels regarding himself/herself in relation to the rest of humanity.

There are many parts of our bodies whose functions and potentials are unknown to us because of a culture that is not open to the question of sexuality. Even those that have the authority to speak objectively about our bodies (e.g. doctors, nurses) fail to give information, furthering our alienation to our bodies. Women as well as men have the right to understand their bodies and its processes.

Women who show interest in sex are considered "unusual." It should be emphasized that women, like men, also have sexual urges. Culture expects women to be healthy and prim at all times. In reality these traits are far from achievable because of the myriad tasks a woman faces at home in order to tend to the needs of her husband and children. This is even more so for women who do productive tasks. A gender power relation based on equality, democracy and mutual understanding could contribute much to the full attainment of sexual health. There is need to focus on the judicial questions relating to sexuality. Justice means giving each person his or her due and affirming persons according to their needs, potentials and capacities. This requires full consent for any sexual relationship, mutuality, equality of power and commitment.

Gender biases and prejudices also figure in the fulfillment of sexual and reproductive health, examples like, the "double standard" on morality. Men are allowed by society to have multiple partners in the belief that men are naturally polygamous. Women are expected to remain "virgins" until marriage as an intact hymen is the best gift she can offer her husband. Sexist language such as the, "sakit sa babae" in the tagalog language for sexually transmitted diseases, is demeaning to women as she carries the blame for the transfer of the disease. Of course, this is a myth as STDs are acquired through sexual encounters regardless of specific sex. Some policies are discriminating to women. To cite an example, prostitution is illegal in the Philippines, yet the Public Health Safety Regulation requires women working in bars, saunas, massage parlors and disco houses to secure a "pink card" as proof that she is free from sexually transmitted diseases. The "pink card" is renewed every week from the Social Hygiene Clinic. This is a presumption that women may be bought by men for sexual favors, legalizing prostitution. The "buyers," who are generally men, are not required to secure a "blue card" or any STD health clearances.

The sexual and reproductive health and rights of women are not separate from the overall socio-economic political and cultural situation. A woman remains under the shackles of poverty and continues to be a slave of patriarchal and elite domination. Reproductive health and rights will be far from attainable.

This is the reason why the struggle for reproductive health and rights is not only a personal struggle of individual woman to break chains that bind them to patriarchal domination and societal oppression and exploitation. Her struggle is also a political one. Women's voices must be heard in Congress. Men in Cossacks and men in Congress are still debating on what to do with women's bodies through the passage of the highly contentious Reproductive Health Bill. And to think these are men who have not experienced getting pregnant and giving birth; men, whose contribution to reproduction is but a few seconds of "ecstasy" while women experience nine months of difficulty. Men's bodies cannot be habitated by another human being for nine months. Only a woman's body can nurture another human being inside her womb. Only she can provide breast milk continually for two years.

The attainment of sexual and reproductive health is an individual right and social responsibility, but its fulfillment is the government's social responsibility. Reproductive Rights will not be served on a "silver platter." Women and men need to organize themselves so that their voices shall be heard. This is even more true for women. Only they can articulate their real life experiences of poverty, powerlessness, subordination, sexual abuse and exploitation.

Voicing out demands for the attainment of sexual and reproductive health and fulfillment of reproductive rights needs to be an organized effort and should be integral to the overall struggle of the majority, including nurses, to end poverty and the struggle to lay the foundation for total societal transformation.

NURSES AND ADVOCACY

UPHOLD FILIPINO NURSES' RIGHT TO DECENT AND HUMANE WORK CONDITIONS

TO VOLUNTEERISM FOR A FEE!

Statement of the Philippine Nurses' Association during the Press Conference held in PNA National Office, January 14, 2011

The Philippine Nurses Association (PNA) vehemently opposes the unfair labor practice of many hospitals known as "volunteerism for a fee" where nurses are asked to pay thousands of pesos in order to volunteer for months without salaries and benefits, and without employee-employer relationships. Hence, there is no legal protection for the volunteer nurses. Worst, some hospitals cover themselves from any legal problems by calling their scheme a "training program".

It is clearly an unfair labor practice on two grounds: (1) Registered Nurses who passed the Nurse Licensure Examinations (NLE) have passed through a 4-year Bachelor of Science in Nursing (BSN) curriculum that has provided them the necessary skills and knowledge to perform regular nursing functions in the hospital. Therefore, undergoing "volunteerism for a fee" as a form of training should NOT BE A PRE-REQUISITE FOR HIRING! "Volunteerism for a fee" is different from the accredited training programs approved by the Board of Nursing PRC that are conducted by PRC-accredited Training Providers. (2) Registered nurses doing volunteer work concretely augment the deficit of nursing staff in many hospitals wherein the standard 1:10 nurse-patient ratio is not met. The presence of volunteer-nurses make hospitals meet the regular staffing requirement without having to pay salaries to the nurses. In fact, they are made to pay in order to provide such nursing services, giving the hospital an additional revenue.

PNA demands for the government to ban the practice of "volunteerism-for-a-fee" and to prosecute the hospitals performing this unfair labor practice! Calling the nurses as "willing victims" because of the worsening unemployment problem in the nursing sector is outright victim-blaming! Let us protect these nurses who are taking care of the lives of many sick and dying people! The PNA believes that concrete SOLUTIONS must be done instead of blaming the nurse-victims.

1. The government must immediately fill-up vacant plantilla positions in many government hospitals to ensure quality nursing care.
2. The government must have the political will to create plantilla positions for nurses following the standard nurse-patient ratio especially in rural areas where millions of poor children, women, elderly and other marginalized sectors want to have access to basic and essential health care services. Being the largest sector of health care providers, the role of nurses in the realization of Universal Health Care must be recognized and valued!
3. Contractualization of nurses, Job-orders and "sharing in plantilla positions" must not be allowed by the government in any government or private hospital.
4. The Department of Health (DOH) and Department of Labor & Employment (DOLE) should regularly monitor hospitals and ensure that Training Programs for Nurses in the hospitals is conducted ONLY by BON-PRC accredited Training Provider/Hospitals with corresponding Certificates.

Putting an end to "volunteerism for a fee" will not only provide better nursing opportunities for the Filipino nurses but will be a measure to guarantee that Filipino people will be provided with quality nursing care!

PNA's WIN-WIN SOLUTION
To address "Volunteerism-for-a-Fee"

NURSES AND ADVOCACY

HEALTH SECTOR UNITED FOR WAGE FIGHT!

Unity Statement

We, health workers from different hospitals, health clinics and institutions are committed to serving the Filipino patients amidst a low health budget, understaffing, inadequate equipment and facilities, and inadequate salaries and benefits. Even as we pledge to serve our countrymen, we face the harsh realities of worsening economic conditions, the increasing cost of basic commodities, as we try to make do with our inadequate salaries and benefits.

A health worker in salary grade 1 in a public hospital earns only P7,575/month. Nurses who are supposed to be given at least P24,887 (salary grade 15) based on Nursing Act of 2002 receive only P17,099 (Salary Grade 11, 3rd tranche). Doctors in Salary Grade 16 (MO 1) get P24,423 (3rd tranche). These are both below the minimum cost of living of almost P30,000 set by the government. Job Orders and contractual nurses receive lower salaries and do not get benefits. In Quirino Province, two casual nurses work under the item of a utility worker, dividing for themselves the amount of P 160-170/day. Casual Doctors receive P14,000/month. Volunteers, who are actually registered nurses, work for free, and even pay the hospital for their "experience".

Like many Filipinos, we dream of having a decent house, putting our children in quality schools, satisfying our basic needs for healthy food, adequate clothing and recreation. But with incomes below poverty line, how else can we live decently?

We take care of the patients. But who will take care of us?

Years of fighting for wage and salary increases have won us victories, including additional allowances, and salary adjustments, the last of which was the salary increase, however small, by the Salary Standardization Law 3. But the increasing cost of basic commodities and rising inflation erode the value of our wages and salaries faster.

We launch our struggle for substantial wage and salary increase in these times when economic crisis is so bad we barely make both ends meet. The crisis drives away more than 3,000 Filipinos everyday to work abroad.

We rely on our united strength to call for an increase of at least P6,000 in the minimum pay of public health workers, salary grade 15 (P24,887) for nurses now, and P50,000 (salary grade 24) for doctors.

We get our inspiration from the workers before us who banded together in the 1980s, and as a result got salary increases. Likewise we take great pride as we continue the legacy of united and collective action that is instrumental in the passage of the Magna Carta of Public Health Workers.

We fight for salary increase so we can be in a better condition to serve our patients. We hope to encourage more fellow health workers to stay and serve our countrymen by fighting for substantial salary increases alongside our calls for additional plantilla positions, job security, adequate benefits, better working conditions and higher health budget. These will result to better and more quality services for our patients.

We add our strength and voices to the teachers, employees and other workers in both private and public sectors calling for substantial wage and salary increases. We seek the passage of House Bill 3746 sponsored by Anakpawis Party List Representative Rafael Mariano calling for a P6,000 salary increase, and House Bill 375 which seeks P125 increase for the private sector. We support House Resolution 1031 which seeks to investigate the non-implementation of Salary Grade 15 for nurses as stipulated in Nursing Act of 2002 (Republic Act 9173).

We call on our fellow health workers to unite. Let us fight for substantial wage and salary increase!

August 5, 2011

A MEMO TO P-NOY ON HIS SECOND YEAR FROM HIS 'BOSS' AND PARTNER IN NATION-BUILDING

In your recent SONA, you cited the nurse by exhorting the Filipino patient to thank the home-based nurse for choosing to serve in the country rather than work abroad where the pay is higher and the rewards are greater. While heartwarming, we say, nurses who are rendering critical service, especially public health nurses who serve the poor and the marginalized, deserve more than a simple thank you. You, in fact, as the highest leader of the land should manifest gratitude for the nurses who stayed put to man the house, so to speak, while the others sought greener pastures abroad. In fact, your kind but patronizing remark subtly deflects state responsibility in promoting the general well-being of the nurses in particular, and to maintain quality health service for the nation, in general, both reeling from declining state support and subsidy.

If we may be candid, along with the rest of the working class whose labor create the nation's wealth, we hardly feel like the "boss" that we supposedly are. Our salaries remain at starvation levels and benefits that are legally mandated are not implemented at all. Health, in fact, has received less and less government subsidy through the years, including last year on your first term as president.

You assert to be anything but … compared with the previous administration, yet we do not feel better off with our wages kept low while prices go up. Even the Nursing Law of 2002 that recognized the important role of the nurse, especially government nurses at the forefront of the health delivery system, by granting the latter a decent entry level salary at Salary Grade 15 equivalent to a little less than P25,000, remain monthballed for 9 years until now. For this gross and willful disregard of a sacred covenant that former PGMA signed with the nurses, must not P-noy exert more political will to right an injustice perpetrated for the longest time to his "partners in nation-building"?

For and in behalf of the Filipino nurses:

(Sgd.) **TERESITA I. BARCELO**, PhD, R.N.
National President
Philippine Nurses Association

NURSES' VOICE FROM THE FIELD

NURSING UNEMPLOYMENT -who is to blame?[1]

JOSEFINA A. TUAZON, RN, MN, DrPH
University of the Philippines Manila[2]

As I was collecting my thoughts and making the initial drafts for this maiden issue, I thought I would focus on the most urgent and worrisome concern of graduating nursing students and their families in the face of rising unemployment.

Even as this idea was evolving, there came the news of civil war in Libya that necessitated the repatriation of Filipinos. Last report was that some Filipino nurses, staying in hospitals, are still in Libya. Then on March 11, 2011, there was the 9.0 magnitude earthquake and the devastating tsunami that wiped out towns of northeastern Japan. Even now, the disaster is still evolving with the threat of radiation leak. A little over a month ago on February 22, a 6.3 magnitude earthquake also hit Christchurch in New Zealand, trapping 11 Filipino nurses inside a collapsed building among others. Initial reports said that the nurses were having review classes, preparing to sit for the New Zealand Board Exam. Authorities have declared no survivors in this building. Yet again, Bahrain has declared martial law. And on and on it goes!

I cannot help thinking our Filipino compatriots are in all these countries, and it is safe to assume that Filipino nurses form a big proportion of them. Many of these countries are popular countries of destination for our OFWs (overseas Filipino workers) and emigrants. Where do they go now?

Let's zoom back to the Philippine situation. As far back as 2006, nursing graduates were having difficulty finding jobs here and abroad. In September 2008, PRC Commissioner Ruth Padilla, a nurse and past PNA President, declared that there was unemployment of at least 400,000 nursing graduates. Understandably, this caused quite a stir!The Department of Labor and Employment (DOLE) immediately convened a meeting of relevant government agencies particularly the Philippine Overseas and Employment Agency (POEA) with nursing leaders and a consensus of the state of nursing employment or unemployment was arrived at, pegging the unemployment at about 150,000. This gave birth to the DOLE-initiative of the NARS program (Nurses Assigned to Rural Service) in 2009, and later, Project EntrepreNurse in 2010.

What is the point here?

As far back as 2002, when nursing recruitment for jobs abroad was at its peak, when new countries of destination were opening up like UK, Ireland, and even Singapore, when there was a "mushrooming" of nursing schools and nursing programs, when enrollments to nursing were reaching 4,000 just for one school alone, when doctors were taking nursing to go abroad, when everyone wanted to take up nursing, when everyone was making a business of nursing … many of us in the nursing circle were also sounding the alarm - to take a more strategic path and not respond to increased demand by just increasing the production of nurses.

Even then, we knew that at the rate we were producing nurses, we would end up with an oversupply. A more alarming thought was that quality of nursing education will go down. This will not only affect the high regard for Filipino nurses abroad, but will also affect the nursing services for the Filipino people in the country. Educating large numbers of students will necessarily need more faculty, school resources, and more importantly, more clinical areas and hospitals to field students.

[1] Reprinted with permission from Vital Signs Newspaper April 2011 issue.
[2] Josefina A. Tuazon is Professor and former dean of UP Manila College of Nursing.

As far back as then, we (albeit a small group of concerned nursing leaders) clamored for a moratorium in the opening of new nursing schools and programs. Much to our delight, a moratorium was declared by the Commission on Higher Education or CHED in 2004. However, the number of nursing schools still increased. At last count, we have 461 nursing programs/schools in the country.

Who is to blame?

They say this is not the time to point fingers and look for someone or something to blame. This is true if pointing fingers mean that we are looking to others and outside of ourselves for the blame. However, it augurs well for Nursing and the country for us to truly take stock of what happened, how it happened, and where systems and processes, particularly of regulatory agencies, have failed. This is an attempt at self-reflection for the purpose of becoming more enlightened, and therefore avoid the mistakes of the past, or at least, TRULY LEARN FROM THE PAST.

We are all to blame.

CHED has allowed the proliferation of nursing programs and they are to blame. PRC has failed to fully exercise their power to recommend the opening or closing of schools and they are also to blame. School owners and entrepreneurs have taken advantage of guileless students and families, accepting them even as they knew many of them did not have the aptitude for nursing, or that they did not have adequate faculty and clinical resources to educate the students as they should, or worse for some, virtually giving away diplomas for reasons we can only surmise as motivated by non-laudable reasons. Because nursing faculty are required to have a Master's Degree, we also had schools who churned out master's and PhD degrees, essentially circumventing the essence of the Nursing Law that only qualified and experienced nurses teach nursing students. What they gave were paper credentials, and schools have indiscriminately accepted these, closing their eyes for want of warm bodies to teach their large number of enrollees.

Families, including relatives abroad, pressured their children to take up nursing and go abroad to improve their families' economic situation, unfairly putting this burden on the shoulders of these children and they probably are to blame too. Our fellow Filipinos including those abroad took advantage of the great demand, became recruiters, and some exploited the nurses, promising employment where there was none.

Nurses are also to blame. Many nurses became deans and faculty for the first time. Retired nurses went back to the workforce mostly as deans or faculty. New graduates became faculty. Hospital nurses became faculty and the term "in-house preceptors" became a by-word and way for hospital nurses to augment their income.

At the outset, these developments were favorable to the nurses and nursing. This was the first time that nurses, especially faculty, were given commensurate salaries and additional income opportunities for hospital nurses. And as deans and faculty were pirated from one school to another, the package became more and more attractive.

So where is the problem?

This spawned some questionable practices where schools would hire deans and faculty without providing tenure and contracts, and faculty preferred it that way in case they decided to move on and accept a higher paying offer. Faculty would accept teaching assignments in two or three schools, sometimes following up students in clinical areas for 24 hours per day. There were fictitious deans, "flying" deans, "cellular" deans as new schools used the qualifications of some nurses to satisfy minimum requirements of CHED.

Hospitals also never had it so good with so many nursing schools wanting to field their students and paying affiliate fees set by the Department of Health (DOH). Unethical practices also developed with hospitals favoring schools that "donate" to their hospital, protecting their turf by requiring schools to use their hospital nursing staff as "in-house" preceptors, and worse in some cases, signing and certifying surgical and delivery forms for a fee!

Nurses allowed entrepreneurs, businessmen and school owners to dictate how we should do our job of educating nurses for fear of losing our jobs. We failed as deans and faculty to be the vanguards of nursing.

So are we surprised that today there is nursing unemployment? The country collectively mass produced nurses. Regulatory agencies essentially failed to regulate. DOH through their regulation of hospitals could do better. We, nurses, allowed it to happen. We failed to regulate ourselves and to police our own fellow nurses.

For the new graduates, congratulations! Unfortunately, you still have to hurdle the nursing licensure examination with about 35-40% chance of passing. Once you become an RN, you will add to the numbers of unemployed nurses. But all is not lost.

For schools, businessmen and politicians, it is time that nursing education is NOT treated like any other business. I

turn to page 42

NURSES' VOICE FROM THE FIELD

Letter to the Editor

Dear Ms. Palaganas,

Ann Landers would have raised her eyebrow seeing this letter starts with an apology. But apologize I must for the delay in expressing my pleasure upon receiving a copy of the Philippine Journal of Nursing Issue of Jan-Jun 2010. I remember you promised to put my name in the PJN mailing list. That was two years ago when you visited me at the Development of Peoples Foundation here in Davao City. I told you then that I have not receive any publication for more than a decade. The PJN Issue of Jan-Jun 2010 was the third publication I got hold of since your visit. Such journal came in August while I was on "house arrest" for falling health. I was at a low moment then. I wish to thank you for keeping your promise. It lifted up my spirit.

Kudos to you and the editorial staff for the well chosen articles and features in the PJN Issue Jan-Jun 2010. It has been a decade or so that discourses on social transformation, structural changes, social inequities and social injustice was heard from the nursing sector. The articles & features brought me back memories gone by, time of the 80's when nursing leaders such as Erlinda Ortin, Minda Luz Quesada and Mary Vita Jackson were actively and passionately advocating the need for social transformation and structural changes, to uphold and fulfill our human rights to health. It is heartwarming to hear that the PNA has awaken from its "hibernation" and reviving the discourses with much more depth. What a relief to know that PNA is actively engaging itself in critical and principled partnership with government. For aging nurses like me, lined up in the "parking area" waiting to go "on board," reading the PJN Issue Jan-Jun 2010 lights up the spirit to move on to eliminate all forms of exploitation, oppression and repression of nurses. I join the NARS ng Bayan & PNA in treading the path for social transformation.

Again KUDOS! God Speed!

Lyda J. Canson
Past Governor, Region XI
Development of Peoples Foundation
Davao City

from to page 41

totally appreciate that educational institutions need to earn to be self-sufficient and sustain its programs. However, schools have a higher mission to educate and prepare individuals for betterment of society. We prepare individuals not only to earn, but also prepare them to be good and productive citizens. We actually prepare them for life. This cannot be sidelined in favor of profit. And I believe that the two need not be opposing values if we handle it well.

This is the time to put our house in order. It is also the right time to make some sacrifices for the larger good, and to do whatever we can to protect the very good reputation that Philippine-brand nursing is known worldwide for.

This is the time for CHED to act on its mandate. Reports say that President Aquino appointed Dr. Patricia Licuanan as new CHED Chair last June 2010 with marching orders to close sub-standard schools. And Dr. Licuanan seems bent on acting upon these orders with our full support.

I was actually recently appointed by CHED as member of the Technical Committee on Nursing Education and I am taking this opportunity to serve again in another capacity. I am willing to do my part.

For families and students, the message is clear, this is not the time to take up nursing unless it is truly nursing you want and not just a way to go abroad.

It's All about PNA Membership!

The Philippine Nurses Association, as the only professional nursing association accredited by the Professional Regulation Commission, is committed to promoting the professional growth and development of Filipino nurses. For over 89 years, the PNA has been the only official organization of licensed professional nurses in the country and thus has served as the mouthpiece of Filipino nurses.

The caring and fortifying light giver, PNA aims to provide opportunities for the professional growth and development of world class Filipino nurses by (1) zealously providing strategic directions and programs that enhances the competencies of nurses; (2) passionately sustaining the quality work and collegial interactions with and among nurses; (3) continuously strengthening the internal capacity and capabilities for quality care and services of the nurses; and (4) enthusiastically exploring collaboration possibilities towards the unification of nurses.

Membership to the PNA is classified into four types: regular, life, honorary and associate. A regular membership status is given to a nurse who has paid the required fee for the current year. A lifetime membership status is conferred upon a nurse who has been a regular member for three consecutive years and who shall have paid the required fees. Honorary membership is awarded to a person who is not qualified as a regular or life member but who has rendered distinguished service to the Association in the attainment of its goals subject to the approval of the Board of Governors. Associate membership is granted to a nurse residing abroad upon compliance of requirements for membership.

As PNA members, nurses are entitled to the following benefits listed below:

1. Assistance and guidance on matters concerning socio-economic welfare and political rights of nurses.
2. Professional counseling and advice on "Rights of Migrant Workers" for nurses, planning to work overseas.
3. Referral for technico-legal advice on administrative and labor cases whenever necessary.
4. Access to Continuing Professional Education (CPE) opportunities with discounts through seminars, trainings, workshops, conferences, and other educational activities sponsored by the PNA.
5. Complimentary copies of the bi-annual issues of the Philippine Journal of Nursing (PJN) which can be accessed online.
6. Access to PNA library materials and information.
7. Linkage to the PNA website www.pna-ph.org
8. Discounted rates in availing the PNA dormitory.
9. Mutual Aid worth PhP 12,500 for lifetime members and PhP 3,000 for regular members plus Php 3,000 burial fee.
10. Recommendation for local and international grants/post-graduate studies for deserving PNA members.

These are the benefits and services that our organization offers to every member. There are benefits that also help them in extending their services to the Filipino people.

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:

(a) Name and degrees

(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 of mentors/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.

Peer Reviewers

Carmencita M. Abaquin, PhD, RN
Araceli O. Balabagno, PhD, RN
Teresita I. Barcelo, PhD, RN
Rosana Grace B. Belo, EdD, RN
Sheila R. Bonito, PhD, RN
Annabelle R. Borromeo, PhD, RN
Helen M. Bradley, PhD, RM, RN
Irma C. Bustamante, PhD, RN
Thelma F. Corcega, MAN, RN
Carmelita C. Divinagracia, PhD, RN
Letty G. Kuan, EdD, RN
Rusty L Francisco, EdD, RNC, CCRN, CNAA
Milabel E. Ho, EdD, RN
Leticia S. Lantican, PhD, RN
Mila Delia M. Llanes, MAN, RN
Fely Marilyn E. Lorenzo, DrPH, RN
Araceli S. Maglaya, PhD, RN
Josefina A. Tuazon, DrPH, RN
Deogracia M. Valderrama, PhD, RN
Phoebe D. Williams, PhD, RN

. . . . . .

Call for papers

the PJN July-December 2011 Issue:

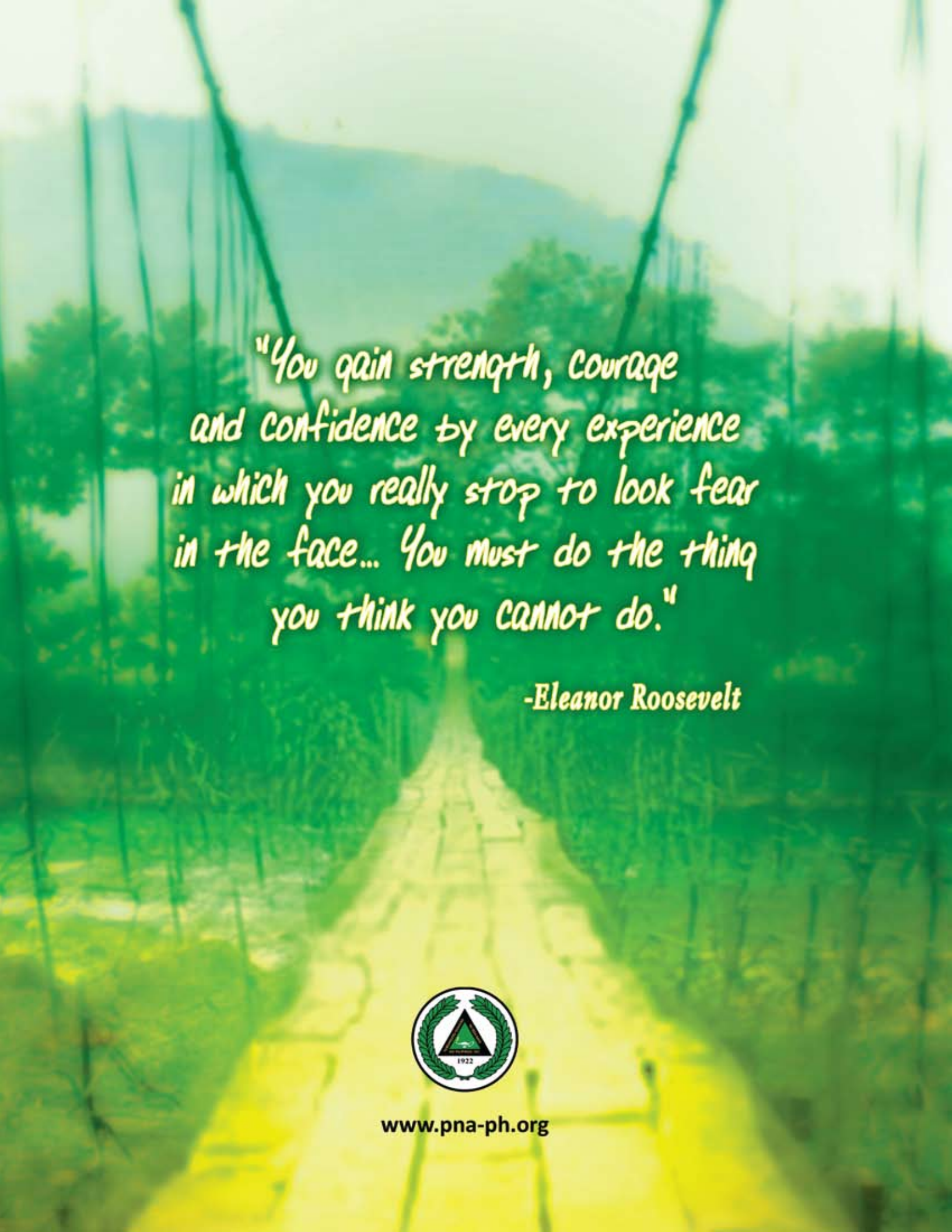
"Leadership, Service and Innovation for Effective Governance"

** We acknowledge the Council for Health Development for the use of some pictures in the cover of this issue.*

BOARD OF GOVERNORS 2011

- **GOV. TERESITA IRIGO-BARCELO**, PhD, RN
  President
  Governor, NCR Zone 1
- **GOV. MARIDEL C. DE LA RAMA**, RN, MAN
  Governor, NCR Zone 2
- **GOV. MA. ASUNCION M. GONZAGA**, RN, MAN, PhD
  Governor, NCR Zone 3
- **GOV. MABEL C. SAN JUAN**, RN, MBAH
  NCR Zones 4 & 5
- **GOV. RENIE V. MALVAS,** RN, MAN
  Governor, NCR Zone 6
- **GOV. RUTH THELMA P. TINGDA**, RN, MAN, MM
  PNA Governor, CAR
- **GOV. FLORDELIZA R. BOBILES**, RN, MAN
  Governor, Region I
- **GOV. LETICIA B. PUGUON**, RN, PhD
  Governor, Region II
- **GOV. NORA GARCIA-CRUZ,** RN, MAN
  Governor, Region III
- **GOV. ARIEL V. PABELONIA,** RN, MSN
  Treasurer
  Governor, Region IV
- **GOV. EMERLINDA E. ALCALA**, RN, MAN
  Corporate Secretary
  Governor, Region V
- **GOV. NOEL C. CADETE**, RN, MAN
  Governor, Region VI
- **GOV. ROLAND L. FERMO**, RN, MAN DPA
  Vice President for Programs & Development
  Governor, Region VII
- **GOV. ELNORA O. ARGOTA**, RN
  Region VIII
- **GOV. FLORENCE A. ALCAZAR**, RN, MEd, MAN
  Governor, Region IX
- **GOV. NEIL M. MARTIN**, MAN, MBE, RN
  Chairperson
  Governor, Region X
- **GOV. ROGER P. TONG-AN**, RN, MAN
  Governor, Region XI
- **GOV. FELINA M. HERNANDEZ**, RN
  Governor, Region XII
- **GOV. MINDAMORA U. MUTIN**, RN, PhD
  Governor, ARMM
- **GOV. ZENAIDA C. LAGNADA**, RN, CPHN
  Governor, CARAGA

PHILIPPINE NURSES ASSOCIATION
1663 F.T. Benitez Street, Malate, Manila 3004
Telephone Nos: 521-0937, 400-4430 / Telefax 525-1596
Email: *philippinenursesassociation@yahoo.com.ph*


"You gain strength, courage
and confidence by every experience
in which you really stop to look fear
in the face... You must do the thing
you think you cannot do."
-Eleanor Roosevelt
1922
www.pna-ph.org