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"Nurses' Continuing Commitment to People's Health"

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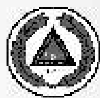

Philippine Nurses Association, Inc.[1]

VISION

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

MISSION

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

PROGRAM THRUSTS

1. Generate programs and activities that would prepare nurses to be globally-competitive.
2. Promote the socio-economic-political welfare of nurses.
3. Establish national and international networking/ linkages to advance the vision and life purpose of the PNA.
4. Intensify membership campaign.
5. Participate actively in the 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 the nurses and nursing.

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[1] *Approved during the 1st Board of Governors Meeting, January 8-11, 2009 at the PNA Board Room*

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> "Individual commitment to a group effort -- that is what makes a team work, a company work, a society work, a civilization work."
> *Vince Lombardi*

EDITORIAL

Nurses' Continuing Commitment to People's Health

Everyday, we come to grips with the realities of our profession. Around the world, health care delivery systems are in crisis. Today, millions of people lack access to even the most basic care. Wealthy nations around the world feel the crippling strain on budgets brought about by the soaring cost of advance medicine. The age of informatics and high-technology indeed save and prolong lives, but it has also led to impersonal health care systems. The shortage of nurses, meanwhile, has left rural health units, hospitals at all levels including state-of-the-art hospitals, seriously and dangerously understaffed.

These realities continue to remind us that Nursing is critical to delivering health care in every corner of the world. Nurses are there when life begins and when it ends-offering expertise, comfort, and care. Nursing lies at the very heart of humankind's commitment to caring for one another. Nurses are essential to the health of the entire world's people, yet the global shortage of nurses continues to worsen. Brave, patient, energetic, creative, diligent, tireless, nutty, sweet, gentle, crucial, relentless-these are apt and suitable words for the astounding nurses of these times. Nursing requires expertise, ingenuity, and a deep sense of compassion. Yes, there is no room for uncaring, one-track minded, incompetent, inflexible nurses for this bruised and blessed planet.

Indeed, the nursing profession is much like a kaleidoscope-complex, multifaceted, vibrant, interesting, colorful, and amorphous as it constantly takes on different forms and shapes. The theme of this issue, **"Nurses' Continuing Commitment to People's Health",** views the nursing profession as it is likened to the diversity and creativity seen through a kaleidoscope. As one twists and turns it, different forms, opportunities, and experiences are produced based on the path that is chosen. This issue brings us back not only to the challenges of Alma Ata, but to the very core value of our profession: commitment to serve the people. The articles on *Revisiting Alma Ata and Health For All, Return to Alma-Ata and Comprehensive Primary Health Care Remains an Essential Tool to Achieve Health for All* send messages that continue to reverberate all over the world as a continuing challenge to live the essence of PHC as an approach and strategy to serve the people. Such challenge has long been exemplified by the evidence of the Council for Health Development's experiences captured in the article, *Working for People's Health, Struggling for Social Change* and Dr. Araceli Maglaya's paper, *Nurses as Leaders in Primary Health Care*.

We all have our experiences on how it is to make a difference, how it is to be part of improving the profession, and how it is to make an impact on the health of people whose lives we touch. Such experiences are mirrored in the papers, *Mothering as Embodied in Philippine Empirical Literature and Issues in Nursing Education Management in the Philippines*.

There is a remarkable camaraderie in nursing that has no borders. It is formed out of the desire to make a difference. *Nurses' Voice: Echoes from the Field*, illustrates the global interconnectedness of nurses from Canada, Illinois, and the Philippines. These voices echo the commitment not only to nurses but to people's health.

In our professional journey, we continue to turn and twist our kaleidoscope to find our niche in the nursing profession and make a difference**…to care…to advocate…to innovate…to be a nurse.** The Feature Articles on the *AGT Awardee: Dr. Carmelita Divinagracia* and on *Mae Rachelle: The People's Nurse* reveal two faces of nurses committed to people's health. The birth of two nursing specialty groups: *The Philippine Nursing Research Society and the Nagkakaisang **N**arses sa **A**dhikaing **R**eporma sa Kalusugan ng **S**ambayanan (**NARS**, Inc.)* are initiatives toward a similar goal.

Along our journey, there are people and groups/organizations that allow us to look through the kaleidoscopic perspectives of the world of nursing. They show nursing in action: values and wisdom, of trust and community, of methods and practices, and of enrichment and growth. Let us hold on to our nurse leaders' promise, our *Board of Governors' pledge towards an "Unwavering Commitment to Serve"* as outgoing PNA President, Leah Primitiva Samaco-Paquiz, takes a bow. Their leadership is shown in the various activities of the association: *Celebrating the 86th Foundation Anniversary, 51st Nurses Week Celebration & National Annual Convention*; *PNA Chapters and Nursing Specialty Groups in action*. With our nursing leaders and colleagues, we walk through guided nursing path as we tackle issues and concerns of nurses in Asia and a health issue such as the Melamine Poisoning. The *Book Feature* section offers us a good selection of books on PHC and Public Health, enough to nourish our minds, hearts and souls to keep aflame the zeal to serve the people.

This issue reverberate the call and constant reminder coming from all fronts: we have chosen a profession that calls for our Commitment to Serve the People. **This is to be a Nurse…this is Nursing…a World of Continuing Commitment to People's Health.**

ERLINDA CASTRO-PALAGANAS, *PhD, RN*
Editor-in-Chief

PRESIDENT'S MESSAGE

My term as National President of the Philippine Nurses Association (PNA) ends December 30, 2008. I thank all of you for trusting me as your National President for the last two consecutive years (2007 and 2008). These were indeed fruitful years spent contributing for the enhancement of the national and international image of the nursing profession. Legitimate issues and concerns of Filipino nurses have been the central focus of the PNA during my term.

"As one strong voice, we must stand firm in leading our fellow nurses in undertaking their tasks to serve the people in the communities".

The social responsibility of PNA to its thousands of nurse-members never stopped despite enormous challenges emerging every now and then. This is a reflection of PNA's genuine commitment to the Filipino nurses, theme of this issue, "***Nurses' Continuing Commitment to People's Health***". As one strong voice, we must stand firm in leading our fellow nurses in undertaking their tasks to serve the people in the communities, clinical or hospital-setting, educational institutions, health researches, health education, advocacy and health campaigns, and in whatever settings we may find the nurse.

As you can glean from the President's report, the PNA continues to affirm its commitment to serve the nurses and the people in various forms. Advocacy activities being in the forefront notably: the intensification of campaign for increase in the salary of nurses (RA 9173 implementation); the full implementation of Magna Carta of Public Health Workers (RA 7305); the campaign against the exploitative provisions of the Japan-Philippines Economic Partnerships Agreement (JPEPA); and the support for nurse-victims of the Sentosa Recruitment Agency. There were various campaigns such as the campaign against unfair practices in some hospitals of On-the-Job Training cum Volunteerism; Ethical Recruitment of Filipino Nurses; and the renaming of the C-6 circumferential road into Philippine Nurse Parkway. Capability-building of our nurses was done through the conduct of three Training of Trainers (TOT) on the Prevention and Management of Multi-Drug Resistance Tuberculosis (MDR-TB), Community-Based Disaster Management (CBDM) and Environmental Solid Waste Management (ESWM). Towards more efficient and effective service to our organization, we crafted renewed services for PNA members such as On-Line Remittance of Membership Fees and Chapter Share thru Union Bank, On-line Application for PNA Membership, and the "Magiting na Nars" Award.

We are the carpenters of our profession. Each day we hammer a nail, place a board, or erect a wall. We build our profession one day at a time. Our attitudes and the choices we make today build our profession for tomorrow. Together, we will build wisely. We will continue to seek the Divine Providence's guidance as the Master-builder of our profession! We are confident that He will show us how to build a strong foundation for the profession of our life.

Let us constantly be reminded that "the Nursing Profession" we chose calls for our Commitment to Serve the People.

DR. LEAH PRIMITIVA G. SAMACO-PAQUIZ
National President, PNA

REVISITING ALMA ATA AND HEALTH FOR ALL

DECLARATION OF ALMA-ATA[1]

International Conference on Primary Health Care, Alma-Ata, USSR,
6-12 September 1978

Under WHO Director General Dr. Halfdan Mahler of Denmark (1973-88) the goal of "Health for All" was proposed and was formally put forth in the 1978 WHO-UNICEF Alma-Ata Declaration. The attendees of the conference realized that improving health called for a comprehensive approach whereby primary health care was seen as "the key to achieving an acceptable level of health throughout the world in the foreseeable future as a part of social development and in the spirit of social justice." WHO, Declaration of Alma Ata, as reported in "Report on the international conference on primary health care".

The Alma-Ata Declaration affirmed health as a fundamental human and right and called for a transformation of conventional health care systems and for broad intersectoral collaboration and community organizing.

The International Conference on Primary Health Care, meeting in Alma-Ata this twelfth day of September in the year Nineteen hundred and seventy-eight, expressing the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world, hereby makes the following Declaration:

I

The Conference strongly reaffirms that health, which is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.

II

The existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries.

III

Economic and social development, based on a New International Economic Order, is of basic importance to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and developed countries. The promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace.

IV

The people have the right and duty o participate individually and collectively in the planning and implementation of their health care.

V

Governments have a responsibility for the health of their people, which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, international organizations and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this target as part of development in the spirit of social justice.

VI

Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central unction and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with

[1] *Alma-Ata (Russian: Алма-Ата) is now known as Almaty (Kazakh: Алматы;*

the national health system bringing health care as close as possible to where people live and work and constitutes the first element of a continuing health care process.
the national health system bringing health care as close as possible to where people live and work and constitutes the first element of a continuing health care process.

VII

Primary health care:

1. reflects and evolves from the economic conditions and socio-cultural and political characteristics of the country and its communities and is based on the application of the relevant results of social, biomedical and health services and public health experience:
2. addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly;
3. includes at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common disease and injuries; and provision of essential drugs;
4. involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the coordinated efforts of all those sectors;
5. requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate;
6. should be sustained by integrated, functional and mutually-supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need.
7. relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community.

VIII

All governments should formulate national policies, strategies and plans of actions to launch and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors. To this end, it will be necessary to exercise political will, to mobilize the country's resources and to use available external resources rationally.

IX

All countries should co-operate in a spirit of partnership and services to ensure primary health care for all people since the attainment of health by people in any one country directly concerns and benefits every other country. In this context the joint WHO/UNICEF report on primary health care constitutes a solid basis for the further development and operation of primary health care throughout the world.

X

An acceptable level of health for all the people of the world by the year 2000 can be attained through a fuller and better use of the world's resources, a considerable part of which is now spent on armaments and military conflicts. A genuine policy of independence, peace, détente and disarmament could and should release additional resources that could well be devoted to peaceful aims and in particular to the acceleration of social and economic development of which primary health care, as an essential part, should be allotted its proper share.

* * * * * *

The International Conference on Primary Health Care calls for urgent and effective national and international action to develop and implement primary health care throughout the world and particularly in developing countries in a spirit of technical co-operation and in keeping with a New International Economic Order. It urges governments, WHO and UNICEF, and other international organizations, as well as multilateral and bilateral agencies, non-governmental organizations, funding agencies, all health workers and the whole world community to support national and international commitment to primary health care and to channel increased technical and financial support to it, particularly in developing countries. The Conference calls on all the aforementioned to collaborate in introducing, developing and maintaining primary health care in accordance with the spirit and content of this Declaration.

RETURN TO ALMA ATA

15 September 2008

Dr. Margaret Chan
Director-General of the World Health Organization

30 years ago, the Declaration of Alma-Ata articulated primary health care as a set of guiding values for health development, a set of principles for the organization of health services, and a range of approaches for addressing priority health needs and the fundamental determinants of health.

The ambition, which launched the health for all movement, was bold. It assumed that enlightened policy could raise the level of health in deprived populations and thus drive overall development. The declaration broadened the medical model to include social and economic factors, and acknowledged that activities in many sectors, including civil society organizations, shaped the prospects for improved health. Fairness in access to care and efficiency in service delivery were overarching goals.

With an emphasis on local ownership, primary health care honoured the resilience and ingenuity of the human spirit and made space for solutions created by communities, owned by them, and sustained by them. Above all, primary health care offered a way to organize the full range of health care, from households to hospitals, with prevention equally important as cure, and with resources invested rationally in the different levels of care.

> "It assumed that enlightened policy could raise the level of health in deprived populations and thus drive overall development."

The approach was almost immediately misunderstood. It was a radical attack on the medical establishment. It was utopian. It was confused with an exclusive focus on first-level care. For some proponents of development, it appeared cheap: poor care for poor people, a second-rate solution for developing countries.

Nor could the visionary thinkers in 1978 have foreseen world events: an oil crisis, a global recession, and the introduction, by development banks, of structural adjustment programmes that shifted national budgets away from the social services, including health. As resources for health diminished, selective approaches using packages of interventions gained favour over the intended aim of fundamentally reshaping health care. The emergence of HIV/AIDS, the associated resurgence of tuberculosis, and an increase in malaria cases moved the focus of international public health away from broad-based programmes and towards the urgent management of high-mortality emergencies.

In 1994, a WHO review of world changes in health development since Alma-Ata bleakly concluded that the goal of health for all by 2000 would not be met.

What can be gleaned from the experiences of a movement that failed to reach its goal? Apparently, quite a lot. Today, primary health care is no longer so deeply misunderstood. In fact, several trends and events have clarified its relevance in ways that could not have been imagined 30 years ago. Primary health care increasingly looks like a smart way to get health development back on track.

The Millennium Declaration and its Goals breathed new life into the values of equity and social justice, this time with a view towards ensuring that the benefits of globalization are more evenly distributed between countries. The AIDS epidemic showed the relevance of equity and universal access in a substantial way. With the advent of antiretroviral therapy, an ability to access medicines and services became equivalent to an ability to survive for many millions of people.

Stalled progress towards the health-related Millennium Development Goals forced a hard look at the results of decades of failure to invest in fundamental health infrastructures, services, and staff. As we have seen, powerful interventions and the money to purchase them will not buy better health outcomes in the absence of efficient systems for delivery.

The rise of chronic diseases has uncovered further problems: the burden of long-term care on health systems and budgets, the costs that drive households below the poverty line, and the need for prevention in a situation in which most risk factors lie outside the direct control of the health sector. In other words: fairness, efficiency, and multisectoral action.

In August 2008, the Commission on Social Determinants of Health issued its final report. Its arguments make a compelling call for close attention to health in all government policies, in all sectors. Gaps in health outcomes are not a matter of fatethey are indicators of policy failure. Not surprisingly, the report champions primary health care as a model for a health system that acts on the underlying social, economic, and political causes of ill health.

In October 2008, WHO will issue its World Health Report on primary health care. Timed to commemorate the Alma-Ata anniversary, the report offers practical and technical guidance for reforms that can equip health systems to respond to health challenges of unprecedented complexity. Although the report does not aim to launch another social movement, it does ask political leaders to pay close attention to rising social expectations for health carecare that is fair as well as efficient, and incorporates many of the values so brilliantly articulated 30 years ago.

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COMPREHENSIVE PRIMARY HEALTH CARE REMAINS AN ESSENTIAL TOOL TO ACHIEVE "HEALTH FOR ALL"[1]

Interim Position of the People's Health Movement (PHM) October 2008.

The Comprehensive Primary Health Care (CPHC) approach articulated in the Alma Ata Declaration in 1978, remains as relevant today as it was 30 years ago. It recognized the need for a new international economic order if inequities in health were to be successfully addressed.

A PHC policy in 2008 needs renewed commitments that should affirm and consolidate Alma Alta and also take into account new realities.

PHM insists that PHC should be take account of but also influence the political, economic and social processes in each specific context CPHC should also be based on the fundamental concept that all citizens have rights to the conditions that create health. It must:

- include not only the primary level of care, but also a working referral system to secondary and tertiary levels of care;
- be adequately financed through public sources;
- ensure systems of health care provide equitable access and care according to need;
- through action across sectors public health interventions and health promotion address the social, political, economic and environmental determinants of health and just be limited to health care;
- empower communities, especially the most disadvantaged and marginalized, so that they can act as protagonists in improving their health and their livelihoods;
- use technology in a manner that is sensitive to local needs and contexts;
- combine traditional and modern medicine to maximize the benefits to patients; and
- embed policies and interventions in the human rights framework with a special focus on the rights of vulnerable groups
- PHM has identified new challenges that have emerged in the last 30 years and which should be incorporated in a renewed commitment to PHC.

PHM notes that:

- Neoliberal globalization brings new threats to health such as; the increase in trade in unhealthy commodities, international trade agreements that: promote the penetration of transnational corporations into the health sector, enforce patent rights that are used against the interests of poor people, and apply unfair rules in the international trade of agricultural products that devastate the livelihood and health of poor farmers.
- Selective, vertical health programs remain dominant, and not only fragment wider health systems, but also draw away scarce resources from public health systems, treating patients as passive recipients of care and ignoring the ever-present socioeconomic and political determinants of health.
- Increasing privatization and commercialization of health systems has undermined the role of the public sector and has often eroded standards of care among health workers whose activities may be influenced more by the profit motive than the health needs of the communities they serve.
- Poor countries have continued to lose their health workers under the current unregulated health workers' labor market. Regulation must ensure an adequate human resource base for the health systems of all countriesincluding compensating poor countries for their losses as a consequence of migration (i.e., costs of training and opportunity costs of losing skilled staff).
- Intellectual property rules continue to make life-saving medications unavailable and unaffordable to the people who need them the most. PHC requires universal access to essential (mostly generic) medicines.

[1] I attended the 15th Canadian Conference on International Health as a PHM Delegate. The Health Action Information Network (HAIN), whose Board of Directors I head, is the Secretariat of the PHM in the Philippines. I am sharing this position of the PHM as a challenge to the nursing profession. PHM reiterates the core principles of Alma Alta. PRIMARY HEALTH CARE IN 2008 AND BEYOND, must, in addition, address these new challenges at local, national, regional and global levels. PHM asserts its commitment to putting the health of marginalized groups as the focus of its call for 'Health for All Now' a call made by the PHM in 2000 in its People's Health Charter (www.phmovemnet.org) Dr. E.C.Palaganas

WORKING FOR PEOPLE'S HEALTH, STRUGGLING FOR SOCIAL CHANGE

35 years of Community-based Health Programs in the Philippines

Cynthia M. Vargas, *RN*
Director, Field Assistance Unit, Council for Health Development (CHD)
*Convenor, Nagkakaisang **N**arses sa **A**dhikaing **R**eporma sa Kalusugan at **S**ambayanan (**NARS**, Inc.)*

What moved them to sow the first seed?

In the early 70s, the prevailing health situation was one of malnutrition, increase in preventable and infectious diseases, epidemics these were symptoms of the country's ill health. More so, these reflected the deteriorating economic conditions of our country. The majority of the people lived below subsistence level, suffered illnesses brought about by poverty and had no access to health care. Health professionals were either staying in the cities or going abroad.

Poverty and ill-health were thus seen to be inter-related. This according to the Council for Health Development (1998) was the scenario when the Community-based Health Program was born. This was the scenario when the Community-based Health Program was born and not much has changed in the country's situation since then.

The Council for Health Development (1985) traces the roots to the early efforts of the Rural Missionaries of the Philippines (RMP). In 1973, at the height of Martial law, the RMP Health Team composed of Sister Mary “Mayang” Grenough, MM, Sister Eva Baron, MMS, Sister Rosa Villanueva, ICM and later Sister Xavier Marie Bual, SPC was formed with the specific goal of starting community health programs in the rural poor communities through the training of community health workers or CHWs.

Pilot areas were started in 1975 in the 3 major islands Ilagan Diocese, Isabela for Luzon, Palo Diocese, Tacloban, Leyte for Visayas and Iligan Diocese, Lanao del Norte for Mindanao; with an initial 27 barrios in 15 towns (CCHD, 1998).

The Community Health Workers or CHWs increasingly gained the respect and confidence of the community members. They were consulted for health and medical problems, sometimes even for personal problems. And since they lived and most often grew up in the community, they were the next-door neighbor, the friend or the children's godparents. They related well and easily with the community and understood other possible factors affecting the community member's health and general well-being.

Health skills wise, stress was given to “first line of prevention”. Emphasis was placed on acquiring knowledge and skills on the concept of health and diseases, nutrition, home-nursing remedies and first aid. These trainings helped the CHWs in providing basic health services in their communities.

Experience was seen as the best teacher. Annual assessments were held so that co-workers shared common experiences. An informal atmosphere during these activities was developed to create trust and enable free expression of thoughts and feelings. Thus, problems, tasks to be done and expectations to be met were identified and dealt with in the spirit of camaraderie.

The assessment activities were also occasions when volunteers from different parts of the country learned different languages and cultures. At the same time, despite the different regional conditions, many similarities were discovered.

The training curriculum was further standardized. Health skills trainings were categorized into two levels: basic (level I) and advanced (level II). CHWs were trained so well that they could accurately diagnose diseases and recommend necessary medical remedies. Laboratory skills were also developed. Those with microscopic skills training could detect acid-fast bacilli in sputum as well as do basic urinalysis and stool exam, identifying various cells and parasites (Council for Health Development, 1998).

CBHPs also facilitated various health services in the communities namely health education, water purification, construction of simple sewage and waste disposal systems, immunization, maternal and child care, preventive dentistry, and disaster preparedness.

More complex services such as food supplementation, under-five clinic, minor surgery, mental and physical rehabilitation, refugee health care and simple laboratory procedures were also attained in selected programs.

Herbal medicine production was initiated and many communities built “Botika sa Barangay” (community pharmacy) which they themselves supported and operated. Some ventured into income-generating projects like soap-making.

The practice of traditional medicine was popularized. Education materials particularly about herbal medicine, acupressure and acupuncture were published. Appropriate technology was effectively put to use like the practice of CHWs making their own acupuncture needles and devising “needle sterilizers”.

Through the years, CHWs faced many difficulties, foremost of which were the economic hardships daily experienced by the community. Conditions in the remote rural areas showed the painful relationship of poverty and disease. The people got sick because they did not have enough to eat. When they got sick, there were no accessible health services. Even if there were services, the people could not afford medical fees, or even transportation costs.

It became evident that health problems could not be solved no matter how frequently the trainings were held or how many volunteer workers were developed. Root causes of poverty had to be studied and ways of solving these had to be considered. Clearer objectives began to emerge.

While the program was taking shape in the pilot areas, promotion and advocacy were being done in Metro Manila and other urban centers. From the three pilot programs, the concept spread, and 35 years after the first seed of CBHP was sown, there are now 60 member-programs training community health workers who in turn, presently serve the marginalized sectors in the whole country.

Approach to community health work

CBHPs found themselves confronted with the bigger problems that affected the people. It became clear that what the health programs needed and was trying to do was to start a new approach to community health work, an approach whose backbone would be the participation of the community. Community organizing was seen as an indispensable approach in building these health programs. There was recognition that health programs should not be limited to health care like applying first aid or providing medication.

Health care from the point of view of CBHPs was making the people aware of who they are and what kind of life they should have. It was the process of helping the people understand their situation, analyze what causes their miseries and bring about changes in their lives, in their communities, -- and even in society. Eventually, CBHP according to Lizares (1990) was defined as a process for health care delivery that seeks to develop the community. It seeks to answer the people's health needs by addressing their total well-being physically, mentally and spiritually. Lofty aims that demanded the following: 1) developing the social awareness of the people, 2) community-building through organizing, 3) increasing participation of the people in decision-making and 4) developing self-reliance.

For the programs to succeed health problems had to be solved first and foremost through people's participation and organization. The people articulated their problems and needs, analyzed them and worked towards their resolution. More CBHPs rendered significant support in organizing communities, a role which was not contradictory but in fact realizes the essence of what these health programs should be-one that maximizes the participation of the community.

Using the tool of social investigation and analysis, the programs were able to come up with a more systematic and deeper understanding of the economic, political and cultural conditions that affected the country and intertwined with the prevailing health situation. Lesaca (2000) argues that the recognition of the structural causes of ill health pushed the program concept to a new level. It was further affirmed that health was but one of the problems that beset the community and the society as a whole. The inter-connections of the health system with the economic, political and cultural systems were recognized.

Growth and Strengthening

Through the years CBHP bloomed not only in numbers but also in complexity.

Higher levels of knowledge, skills and attitudes concerning health and program management were provided to the CHWs. CHW organizations were established at the local and regional levels. Increasing coordination among CBHPs was made possible through the setting-up of regional and inter-regional formations like the Community-Based Health Services Association (CBHSA) in Mindanao; Community Health, Education and Training in the Cordillera Region (CHESTCORE) and the Visayas Primary Health Care and Services (VPHCS) in the Visayas. Island-wide and region-wide assemblies were held for trainings, consultations and conferences (Council for Health Development, 1998).

Unity and coordination work with other sectors at the national and local levels were strengthened. National and regional coordinating institutions of the CBHPs actively supported people's issues and launched special campaigns about these issues. A national organization of CBHPs was formed to achieve stronger organizational unity. The Council for Health and Development (CHD) was born in 1989. Staff members from the Rural Missionaries Health Team, Urban Missionaries Health Team and the Council for Primary Health Care combined their energy, wisdom, dedication and resources to assume bigger responsibilities namely:

- to assist and upgrade the management and operational capability of members through training and consultancy;
- to project and propagate an alternative health care system through research, documentation, publication, advocacy and assistance in setting up new health project in communities;
- to serve as a venue for sharing, cooperation and mutual protection, general summing-up and break-through experiences; and
- to act as resource center for human resources, health technology, services, finance and health data.

Lessons learned

On the other side of positive growth, there were also problems and weaknesses encountered.

The program's capacity and level of consolidation could not adequately meet the many facets of program work and the rapidly increasing requirements caused by the program expansion.

Performing more administrative work took the CHWs away from living and integrating with the community. They began to be office-based, going to outlying areas only to conduct trainings or render direct health care services. They were also lured to ideas and activities that were not congruent with the needs of the community. New systems were installed, such as organizational restructuring which narrowed their job description.

CBHPs also became "personality oriented" and too much importance was given to "expert" resource persons. This took away the sharing of work experiences, problems encountered and how these were solved by the CHWs themselves.

There were CBHPs that launched special projects that focused purely on health services and became characteristically dole-out in approach instead of adhering to the basic principle of community-based that is recognizing health as an integral part of the community life.

A "donor-driven" or "donor-dependent" attitude was developed because of the ready availability of foreign assistance. This eroded the CBHP principles of self-reliance or relying primarily on the community's own strength and resources.

CBHPs and CHWs were not spared from intensifying repression and militarization. There were cases of illegal arrest and detention, harassment and extrajudicial killings. These tragic experiences led to disruption and closure of some health program operations.

After going through a thorough self reflection, evaluation and summing-up, the programs again strengthened their resolve to continue being part of the people's movement for social change. It was further recognized that community-based approach to health care alone could not solve the causes of health problems. Concrete steps were undertaken to re-direct CBHPs back to community organizing.

A deeper study of local situations was done; program staff consciously and conscientiously went to the communities and worked with them. Along with this, they continuously updated their awareness about the issues that gravely affect the people. Knowing fully well the interrelatedness of poverty and ill-health, they studied the root causes of the people's misery. CHWs gained knowledge of the nation's concrete economic and political conditions namely foreign domination, anti-people government policies, corruption, landlessness and lack of jobs and opportunities that would improve people's lives and well being. Relationships with the people's organizations were re-established and strengthened.

CBHPs reaffirmed their commitment to the people's struggle, upheld the CBHP Vision, Mission and Goals and ratified the CBHP Implementing Guidelines or CIG. At the core of the CIG is the imperative to promote community organizing and advocate for people's issues (Council for Health Development, 2001).

The implementation of the CIG demanded also the transformation of the CBHP staffs and CHWs for intensive re-training, workshops and updating on community and health sector organizing, leadership skills, peasants' and other basic sectors' issues, and review classes on practical health skills.

These yielded positive results: people's organizations in CBHP areas have been reactivated, CHWs that were reported to have "dropped out" were in fact active and the people in the communities were very receptive.

Challenges

The 35 years of CBHP showed how it has evolved from an initial mobile-paramedic training health team to actually laying the seeds for a health care system at the community level; one which is nurtured, developed and defined by the community members because it is their own health program. CBHPs have survived and more so have thrived because they were rooted in a very strong and solid foundation THE PEOPLE OF THE COMMUNITY who struggle unceasingly to defend their lives and rights, and to develop their own appropriate health programs (Council for Health Development, 1998).

There have been errors along the way, but by recognizing and correcting these mistakes the CBHPs were able to improve and emerge much wiser and stronger. There are still rough roads ahead but 35 years of rich experiences promise that the CBHPs will continue to grow as long as the people embrace these as their own for the purpose of significantly changing their lives, their community and the whole society.

After 35 years, we say once more: *to all people too many to count, peasants, indigenous, women, youth, workers, church-people, hospital workers, health students and professionals, Filipinos and international friends and staff who have been part of creating the CBHP history, helping it to survive and thrive and who continue to serve, strengthen and shape the present and future of the CBHP vision and reality: a Philippine society where poverty, powerlessness and all forms of oppression shall have been terminated, in which health care will be nationalist, relevant, accessible, and responsive to the needs of the people* (Council for Health Development, 1998).

35 years of CBHP is a celebration of working for people's health and struggle for social change!

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"*Unless commitment is made, there are only promises and hopes; but no plans.*"
Peter F. Drucker

DELIVERING QUALITY SERVICE, SERVING COMMUNITIES: NURSES LEADING PRIMARYHEALTH CARE

Araceli S. Maglaya, *PhD, RN*

In 1978, the Declaration of Alma-Ata specified Primary Health Care as the key to attaining the target Health for All. It was viewed as part of development in the spirit of social justice.

As defined, Primary Health Care or PHC is essential heath care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self determination. Health for All means a level of health that permits all people to live a socially and economically productive life. Thirty years after 1978, it is imperative to examine the current scenario and the realities in the health care delivery system and the client system.

Health Care Delivery System Realities

The World Health Organization (2005) acknowledged that there is limited capacity of the country's health care system to deliver better outcomes due to the following reasons: (1) poor health care financing; (2) inappropriate health services delivery system wherein there is excessive reliance on use of high-end hospital services rather than primary care, including an effective mechanism for providing public health programs; (3) excessively high price of medicines leading to costly out-of-pocket payments and inadequate and irrational drug use; (4) weak enforcement of regulatory mechanism; (5) insufficient effort expended on prevention and control of emerging and re-emerging diseases; and (6) unavailability of timely and accurate data/information that makes it difficult to make appropriate decisions on policies and programs to improve health care.

The same Organization declared that there is inadequate resource for the health sector as shown by the following: per capita health expenditure decreased from P 1,484 (US$ 26.69) in 2001 to P 1,435 (US$ 25.80) in 2002; most common source of funds for health is out-of-pocket payments (43%); and that in 2002, 77% of health expenditure was used on personal health care; 11% for public health.

There also exists a geographical and socio-economic inequity. Poverty remains an overwhelming rural problem. Over half the rural population is poor, accounting for nearly two thirds of the country's total (World Bank, 1999). Most population live in rural and isolated communities where there is less and lower quality health services. Thus, the poor do not receive health services.

Most population live in rural and isolated communities where there is less and lower quality health services.

Client Realities: Social, Cultural and Political Differences

Ashford and others (2006) stated that inequalities occur when certain groups of people have less to say and fewer opportunities to shape the world around them. Socio-cultural and political factors create biases, and rules in institutions are seen to favor more the powerful and privileged groups. Persistent differences in power and status between groups become internalized into behaviors, aspirations and preferences also perpetuate inequalities. The striking differences in health status among socio-economic groups also reflect inequalities in terms of access to information, facilities that provide decent standards of living, and means to pay for good care.

A scene in a barrio in Batangas patients had to walk in order to get to a health care facility

According to the World Development Report issued by the World Bank in 2005, there are specific barriers to quality health care. One is the lack of information and knowledge on hygiene, nutrition, good health practices and where to go for specific health services. Lack of information and knowledge keep them from seeking care even when they need it and accessing public health care. Another barrier is the lack of voice or empowerment which delays decision-making to address health needs and problems, especially serious complications such as high-risk pregnancy or birth delivery. Services are inaccessible and of poor quality. Urban dwellers usually live closer to health services, while rural residents face greater costs in transportation and travel time to access services.

Often times, health personnel have to walk for hours just to deliver health services to those living in isolated areas. Pictures taken in Batangas.

Problems related to health care delivery affect the economically disadvantaged groups who are most likely to struggle with dysfunctional health services. Some health care providers are perceived as unresponsive. They are sometimes criticized for openly discriminating against individuals from certain economic classes or ethnic groups. In poor areas, there are more likely to have low- paid health providers who may miss work often or have little motivation or incentive to provide care. The "social distance" between service providers and their clients can be large, leaving clients feeling looked down upon or neglected.

Clients also suffer from the high cost of some services. Treatment of major illnesses and injuries can be prohibitively expensive for poor families. Actual cost of treatment may become too steep when informal payments (out-of-pocket) are needed to ensure receipt of certain drugs and services. Added to this are the problems in transportation cost and the time to be away from work to travel to a health care facility.

Community Health Nursing Practice: A Model

Given these realities 30 years after the Alma-Ata Declaration, the Philippine Nurses Association takes a breathtaking theme, Nurses Leading Primary Health Care. In order to understand what needs to be done and how nurses can take the lead in PHC, it is necessary to go through a terrain, a model of Community Health Nursing Practice. This helps us to understand why we are not quite near the goal Health for All, and where we can move on.

The Art of nursing practice is caring towards human becoming while its Science is the practice-based evidence and evidenced-based methods and tools.

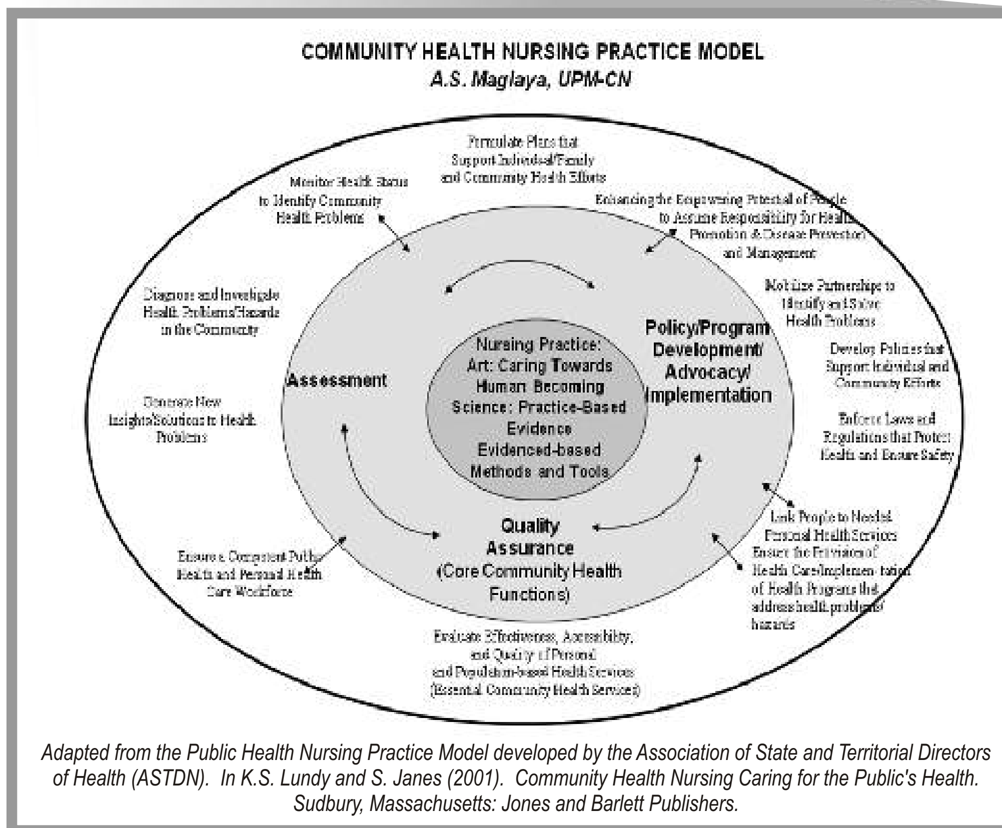
Human Becoming. The Theory holds that the person in the true presence of a Nurse (who at all Realms of his or her Universe, believes in and honors the Person as knowing the way) illuminates meaning, synchronizes rhythms and moves beyond.

The PROCESS involves the following: (1) **Explicating** which is making clear what is appearing now through languaging. Structuring in a multidimensional fashion is co-creating reality through the languaging of valuing and imaging, and shedding light through uncovering what was, is and will be, as it is appearing now; (2) **Dwelling** which is giving self over the flow of the struggle in connecting-separating-synchronizing rhythms; and, (3) **Moving** beyond which is propelling with visioned possibilities in transforming mobilizing transcendence or moving beyond the meaning moment to what is not yet.

Nurses Leading Primary Health Care Directions and Options

Nurses can become models of how to deliver quality health care service to enhance the empowering potential of clients in the communities. Empowered people enable themselves to address barriers to health and wellness, to prompt and appropriate management of diseases, and to disability reduction. In so doing, they achieve psychosocial and economic productivity and enhanced human responses to handle stresses and change.

Nurses must have the motivation to use practice-based evidence and evidence-based methods and tools. They must possess the discipline in carrying out the standards of care to guide nursing practice. They must develop the competence in the use of participatory approach to understand clients' human responses to health and illness realities; and analyze with



Adapted from the Public Health Nursing Practice Model developed by the Association of State and Territorial Directors of Health (ASTDN). In K.S. Lundy and S. Janes (2001). Community Health Nursing Caring for the Public's Health. Sudbury, Massachusetts: Jones and Barlett Publishers.

clients realistic and effective options to improve attitudes or situations/resources.

In a participatory approach, we engage the community in an egalitarian relationship to look, think, and act, given the people's lived experiences on health, illness, health service access and understand why status quo is a mainstay.

Looking is gathering information, defining and describing the situation and the issue to be investigated within the context in which it is set. Community partners describe what they have been doing related to the issue or situation as they offer different perspectives, reflecting who they are, their culture and their life experiences. From the nurse-partner's perspective, looking means building a picture of the issue with its multiple perspectives, such as epidemiological, human response or socio-political-policy realities or models, to help community partners make sense of the complex reality that perpetuates the problem.

Thinking involves interpreting, explaining and analyzing the situation in terms of areas of success (What made it work?) or of deficiencies (What is missing? How did we come to be like this? Do we need to challenge certain taken-for-granted assumptions/realities that are evident in our thinking/practice/life? What can we do to address the situation and move on?

Acting attempts to resolve issues or eliminate the problem. The partners formulate solutions to issues, carry them out and jointly determine the worth, effectiveness, appropriateness and outcomes of the implemented activities/solutions. Acting includes reconstructing ("How might we do things differently?") and evaluating ("How will we know things have changed?"). By enhancing the competence of clients to understand, analyze and carry out options to address hopelessness, helplessness, hardiness, they can sustain motivation to change the current reality, in order to put health and health care in their hands.

Nurses as leaders can make plans for and prepare personnel in sufficient numbers to meet the nursing service needs of individuals, families and communities. They can link clients to needed services such as setting up effective two-way referral system from the community/home to an acute health care facility and back, and ensuring adequate hospital discharge instructions for accurate and effective home care. They can actively participate in health human resources analysis projection and development such as in professional growth in nursing career path. Further, nurses can Take the lead in developing policies, options and systems to address inequities, accessibility problems, unresponsive/ incompetent nurse service providers.

Nurses must create social systems in which models of nursing care/practice, excellent education and significant scientific inquiry are demonstrated and can flourish. Staff

nurses/practitioners can demonstrate competence in addressing health and health care delivery issues/problems/gaps using participatory approaches. They must have sustained interest for professional growth via formal or degree programs or short-term practice-based training. Nurse administrators can demonstrate a passion for/commitment to do periodic and effective audits to ensure quality and efficient services. Nurse educators can advance own competence through nursing practice and practice-based research.

Nurses must engage in research to enhance disciplined action in client care situation and generate new insights and solutions to health care delivery problems. Advance knowledge in nursing science through researches is the basis for improving clients' human responses to handle inequities, poverty and behavior change. There is a continuing need to develop Innovative and creative nurses to become future leaders who will articulate values that unify efforts to deliver quality service in partnership with communities, and ensure effective linkages and teamwork with partner institutions, change agents and policy-makers.

Conclusion

The 2008 PNA Convention theme "Delivering Quality Service, Serving Communities with Nurses Leading Primary Health Care," is about giving of self, heart, values and ideals. It requires risk-taking, overcoming resistance, challenging the norm, using the creation paradigm to change status quo.

Nurse leaders need to reinvent themselves by thinking and behaving in new ways. Deep change is transformative, involving creative experimentation, collaboration and a view to the future. Leadership requires all of us to... dare to care!

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MOTHERING AS EMBODIED IN THE PHILIPPINE EMPIRICAL LITERATURE

Cora A. Anonuevo, *PhD, RN*

Introduction

This article presents a selection of scholarly and empirical works on mothering. It focuses on how the experiences of mothering and being a mother are affected by the dynamics of gender relations, social class, employment, notions and meanings of mothering, in the Philippine context. It shows how women negotiate their traditional mothering roles given the competing societal demands and expectations. The literature review covers the following component issues: (1) Gender and Family Relations; (2) Mothering Practices and Experiences; (3) Notions and Meanings of Mothering; and (4) Human Agency and Social Structure.

Method

The search for local empirical materials included relevant printed or published materials such as researches, and unpublished materials such as theses and dissertations in the disciplines of nursing, psychology, sociology, anthropology and women studies. There were about twenty (27) materials reviewed and critically analyzed to determine which literature makes a significant contribution to the understanding of the topic (24 original investigations, two monographs, one review). The scope of the review follows the above-mentioned four domains or component issues. The findings and conclusions of the pertinent literature were noted, as well as how they vary from or similar to others.

Findings and Discussion

This section presents the findings and analysis of local empirical works on mothering highlighting the four major themes, each theme with several subthemes: Gender and Family Relations, Mothering Practices and Experiences, Traditional Notions of Mothering and Other Family Roles, and Human Agency and Social Structures. Child-rearing is a concept traditionally used in the Philippines as equivalent to mothering practice. The family is seen as the crucial site where these biological and socio-cultural functions are best carried out.

Gender and Family Relations

The nature of the social world depends on the shared definitions of roles and identities constructed through interactions between individuals according to their perceptions and expectations of each other.

Wife-Husband Relationship

While the Filipino family is moving towards a more egalitarian husband-wife relationship, male domination remains. Raymundo (1993) provided an interesting example in the area of sexual and reproductive health. In the family, husbands determine family size, initiate sex and make decisions on sexual matters. Husbands' control is extended in the productive domain where their wives work. Guerrero's study (1965), involving 52 husband-wife professionals working in the University of the Philippines (UP) Los Baños, revealed that these couples seemed confused about the role of the wife. The not-so-traditional husbands, although they felt the wife belongs in the home, expressed pride in their wives' work accomplishments. For traditional husbands, they would prefer that their wives stop working if they had a choice. This is echoed by Flores' (1969) study. Husbands get upset when their clothes are not darned properly, when the house is not in order, the children not dressed neatly and the meals not prepared correctly. They feel they are neglected. They get upset and disappointed if their wives come home late.

Thus, be it at home or at work, husbands exert control over their wives. They control the latter's reproduction particularly sexuality and restrict their mobility in the productive realm as well. Wives are made to feel guilty over alleged abandonment of their traditional household responsibilities over their paid work. As a result, there is an unequal gender relation between them.

Mother-Child Relationship

Domingo (1961) and Malay (1961) studied the relationship between child-rearing practices of the mothers and the behavior of the children. Both showed that child-rearing practice is only one of the factors affecting children's behavior. The others were children's level of development as well as cultural context (Domingo 1961). Malay (1961) showed that particularly in adolescence, mothers are less significant influences compared to the children's younger years. Adolescents are influenced by other factors like interaction with varied age groups in their school and community.

On the other hand, children of working mothers are affected by the latter's prolonged absence, according to de Jesus-Amor

(1966). These effects are different between boys and girls. The boy's romantic relationship may be affected while the girl will lack a female role model. The small child may regard the mother leaving him as an indication that she does not love him. It is generally accepted that the length of time a mother spends with her children is not as important in their upbringing as the quality of that love she shares with them.

As cited in Guthrie and Jacobs (1969), majority of the mothers were rearing their children the way they were reared by their own mothers. According to Lagmay (1983), mothers' emotional relationship is still highly nurturing and affectionate.

In Capuno's (2001) “On Our Own Terms: Journeys with our Mothers,” six middle-class women in their forties acknowledged the major influence of their mothers on their lives, whether positive or negative. Those with more positive relationship with their mothers have asserted their authority in terms of more egalitarian decision making and sharing of domestic chores with their husbands.

Mothers have strong influence on their children's lives and this is carried on throughout adulthood. While child rearing practices may have a big influence in children's behavior, there are also other factors affecting it such as their level of development, and the prolonged absence of mothers.

Effects of Women's Employment

Local studies showed that there are many problems for working mothers. These are neglect of the children, inability to fully cope with household duties, and the physical strain brought about by employment, maternity and childbearing (de Jesus-Amor 1966). Working wives have mixed feelings when they do not meet the expectations of husbands in fulfilling their household obligations. Some are apologetic, defiant, feel sorry or guilty (Guerrero 1965), while some get jittery or self-conscious (Flores 1969).

Sycip's (1982) study involving 73 working mothers showed that some women have to deal with the pressures coming from their own families and neighbors who blame them for not measuring up to their household obligations. The men, on the other hand, are rarely, if at all, blamed since they are perceived to have sacrificed a lot to adequately fulfill their role as the breadwinner of the family.

Verceles and Beltran (2004) observed that the higher one's income class, the better the chances of harmonizing work and family. Working mothers from the upper class are in a position to hire domestic helpers, purchase labor-saving household appliances, and use their own cars to and from work. They are also insulated from other familial factors which have a huge bearing on the work-family conflict: household structure, household lifecycle and unequal gender division of labor inside the home.

Hence, working wives/mothers face double burdens at home and at work. They are pressured by husbands, children and even families and neighbors when they do not adequately fulfill their traditional home responsibilities. Society in general perpetuates this notion. As a result, they experience feelings of guilt and a host of other negative emotions.

Although employment increased the wife's decision making in the household, power relations between the couple remain unequal. Wives have more pressure from husbands and society in general to fulfill their traditional responsibilities in the home.

Mothering Practices and Experiences

Child rearing in Different Class and Social Circumstances

Porio, Lynch and Hollnsteiner (1978) and Olano (1990) took into account class factor in child rearing. Interestingly, these two studies had different views. According to Porio, Lynch and Hollnsteiner (1978), child rearing values are similar across classes. Social class is determined by factors such as income, residence and education. The survey showed that it is Filipino cultural values that significantly affect child rearing. In contrast, Olano (1990) said that there are similarities and differences in child rearing particularly between lower and middle class mothers. Her study, involving 115 mothers from two barangays in Metro Manila, hypothesized that there was a relationship between the socioeconomic factors (income, educational attainment, age, number of children) and the child rearing practices of urban middle-income (C class) and marginal income (E class) mothers.

There were also differences in social circumstances in relation to location. Licuanan (1979), Ventura (1985), and Mendez and Jocano (1979) described child-rearing practices in urban and rural areas. The first two studies also specified the income group.

Licuanan's (1979) study on child rearing was focused in an urban low-income community in Quezon City. She interviewed 200 families with mothers as main respondents. Child rearing is not limited to providing physical care (feeding, toilet training and caring for illness) but also includes other aspects such as emotional care (establishing norms and rapport with children).

Ventura (1985) tackled agents and goals of socialization as well as style and techniques of child rearing across urban-rural settings and socioeconomic strata. Distinguishing between the socialization goals of low- and middle-income groups, the poorer parents teach their children to accept hardships in life, be thrifty, preserve harmonious relationships and improve their economic condition. The middle-income parents, on the other hand, stress self-reliance and achievement as primary goals. As to agents of socialization, the mother is the primary caregiver especially during infancy.

Mendez and Jocano (1979), in their case studies, differentiated child rearing between rural and urban settings. The study revealed that unlike in the rural area where special care and attention is given to the child between the ages of one and five,

dependency among urban children continued up to the tenth year.

Domingo (1961) and Lagmay (1983) both studied the community of Krus na Ligas in Quezon City. At the time of Domingo's study in the 1960s, she considered Krus na Ligas a semi-rural community while in Lagmay's study in the 1970s, the said community was an urbanizing one. Through participant observation and interviews, Domingo (1961) studied the close relationship between child-rearing practices of the mother and the behavior of the children. It was found that there was a close relationship but other factors such as level of development and cultural context are also present. The change of the community from semi-rural to urban was the context of Lagmay's (1983) study. Through key informant interview, participant observation, case studies and collection of autobiographies, the study found that mothers of Krus na Ligas over the years have held on to their traditional child care practices of weaning and breastfeeding and lengthy infant feeding learned from previous generations.

Most of the local studies showed that there are similarities and differences in child rearing among social classes. Aside from class, other factors considered were geographical settings (urban-rural), tradition or culture, and changes over time. Thus, child rearing practices are not the same for all.

Division of Labor in Child rearing

The mother is still ranked as the primary caretaker of her children (Mendez & Jocano 1979; Licuanan 1979; Lagmay 1983; UP-CHE 1985; Guerrero 1965). On the other hand, the father's main role is that of family provider. His role as a child caretaker is considered only secondary (UNICEF-Ateneo 1999).

Guerrero's (1965) study revealed that more and more husbands share in the tasks. Disciplining and tutoring the children and bringing them to school are just some of the tasks shared by husband and wife. Licuanan (1979) noted that fathers are expected to demonstrate concern for their children by overt displays of affection such as talking, playing and carrying. UP CHE (1985) said husbands' involvement in child care is in the socialization aspect such as playing with the children, taking them out, and helping them to develop interest in schooling.

Discipline is one aspect of child rearing where fathers figure prominently; either on their own or in tandem with their wives (Porio, Lynch & Hollnsteiner 1978; Licuanan 1979; Lagmay 1983; UP CHE 1985). When the mother fails to discipline a child, the father takes over and resorts to spanking if the child continues to disregard his warning (Jocano 1983). Fathers are also expected to be willing to assume the mother's child care role when she is away and when the usual secondary caretakers (maternal grandparents, older siblings, aunts and cousins) are not available (Licuanan 1979).

There is also division of labor on the types of training received by a child. The father trains his sons on the various ways of earning a living; the mother trains her daughters on the different household tasks, like cooking, dishwashing, laundering clothes, cleaning the house, and taking care of the younger siblings (Jocano 1983).

Local studies have shown that the mother is still the primary caretaker of her children. Husbands are beginning to share in such task, especially in the discipline aspect. However, husbands are often the last resort when the secondary caretakers are not available. That child care is still the primary responsibility of mothers reflects the unequal division of labor in child rearing.

Gender-differentiated Child Rearing

Until 5 or 6 years of age, Filipino girls and boys are treated very much alike (Guthrie & Jacobs 1969). Gender segregation begins when children reach school age (Mendez & Jocano 1979). This differentiation is reflected in the games children play. Boys start venturing out into the open fields, climbing fences, aiming shots, flying kites, and playing war. Girls stay close to the house, playing house and store games (Guthrie & Jacobs 1969). Sobritchea (1990) reported that girls are still advised against playing boy's games like 'larong bola' (ball games) and 'pagga-gala' (wandering about).

There is a clear difference in the amount of freedom granted to boys and the degree of restrictions given to girls (UNICEF-Ateneo Study 1999). Girls are kept closer to the home for an obvious stereotypical reason: she is needed to manage the household (Mendez & Jocano 1979). In terms of discipline, Sobritchea (1990) found differences in the normative form of punishment for boys (beatings with a wooden stick) and girls (pinching, slapping and scolding).

Household tasks assigned to sons and daughters also vary greatly (Licuanan 1979). The diverse tasks assigned to daughters are stereotypically feminine such as assisting in meal preparation (UNICEF-Ateneo 1999; Mendez & Jocano 1979; Lagmay 1983; Sobritchea 1990) and washing and ironing clothes (Lagmay 1983; Sobritchea 1990). The tasks assigned to boys are predominantly those requiring physical strength and endurance, having farther distance from the home and hardly any socio-emotional skills (UNICEF-Ateneo 1999).

The studies have shown that Filipino girls and boys receive equal treatment until school age. Until then, they are socialized to conform to their gender-based, socially-ascribed roles. These are reflected in the games they play, the household chores they perform and the kind of restrictions and discipline they receive from their parents. However, these are not fixed as gender-based assignments may be diluted to respond to given situations. Child rearing is also gender-differentiated in that it follows the traditional roles ascribed to males and females.

Traditional Notions of Mothering and Other Family Roles

All local studies point to the primary role of mothers on child rearing and household management. Child rearing consists of the various aspects of interactions that transpire between a mother and a child that range from physical aspects of feeding, weaning

and toilet training, to techniques of discipline, and education (Domingo 1961; Nydegger 1966; Mendez & Jocano 1975; Pineda 1992). It also involves the basic training process by which an individual internalizes the values, attitudes, skills and roles that shape one's personality, and becomes integrated into a social group (Guthrie & Jacobs 1966; Olano 1990).

According to Jocano (1983), mothers are primary decision makers in home management but the father is still recognized as the source of ultimate authority. Child training is a joint responsibility, with the father training his sons on earning a living and the mother training her daughters on different household tasks. In terms of behavior, Lynch & Makil (1968) opined that the ideal spouse or parent is seen as an understanding, warm, and loving person who is industrious and active in the part he or she plays in the family's economic survival and advancement. For a man, this means being a good provider; for a woman, it means managing the household well.

Regarding the relationship with God, Lynch & Makil (1968) further posited that the good wife and mother is a religious woman, close to God, without major vices of any kind. The same is not expected of husbands and fathers, but it is desirable that they be morally good and faithful to wives. Like mothers, it follows that daughters should also exhibit piety and faith in God.

De Jesus-Amor (1966) maintained that it is generally accepted, even by the women themselves, that their roles as wife and mother have priority over that of the work they may be engaged in outside the home. By working, they have added new functions and dimensions of social participation to their key role as homemakers. Society has gradually accepted the idea that women have not only the capacity and potential, but also the right, to seek and enter gainful employment.

There have been established notions on mothering activities and behaviors. Child rearing and household management are the domains of mothers. They are the primary decision makers in home management. In most cases, it is a shared decision between mother and father although the latter is still recognized as the source of ultimate authority.

There is an increasing acceptance of women's entry into the labor force. However, despite women's participation in the labor market, some still tend to believe that their real identity lay in doing their work as mothers.

Human Agency and Social Structure

There are social structures (institutions, traditions, moral codes, and established ways of doing things) but these can be changed when people start to ignore them, replace them, or reproduce them differently (human agency's autonomy). For agency to be valid there must be a choice.

Struggles of Women: Power and Recreating Mothering

Studies in the 1960s showed increasing acceptance of women participation in the public realm. According to Guerrero (1965), a modern Filipino woman, though not entirely subordinating her traditional wife-mother role to that of her career, has nonetheless expressed growing concerns for her personal happiness. Furthermore Guerrero argued that for both husbands and wives, economic need was the most compelling reason given for working. After the economic reason, is the desire to make use of one's education and training. Those who work because they enjoy it are less likely to stop working than those who work for additional income.

Women are stronger and resilient than they are generally given credit for, and modern women have taken the duties of gainful employment and the rigors of motherhood in stride (de Jesus-Amor 1966). Flores (1969) suggested that the government and the community recognize this new emerging pattern. More day nurseries, child centers, and family clinics may be established to extend help to young couples so that they may become more effective parents. Part-time jobs may be made available to young mothers so that they will not abandon their primary role of motherhood in favor of a full-time job.

A local study by Sycip (1982) revealed how middle-income working mothers devised coping strategies towards their personal and family burdens. The strategies most frequently mentioned in the area of economic problems included tight budgeting, prioritizing expense and avoiding unnecessary purchases, and supplementing the monthly income by accepting sideline jobs. Whenever there are health problems in the family, most of the working mothers would either personally care for sick family members by giving them proper medication or just by being with them, or else get the possible best treatment by bringing them to the doctor.

In the case of mothers and daughters, Capuno (2001) pointed out that mothers consciously or unconsciously were applying a feminist perspective to their experiences. This local study is significant because it departed from earlier local studies that used the traditional paradigm in analyzing mother's role in the socialization of their children. The study showed how the three concepts of patriarchy, feminism and mothering operate in an interlocking fashion to significantly shape the lives of women.

The above studies showed mothers' efforts to recreate mothering. That is, they resist the traditional mothering they learned from their own mothers and present a vision of a new mother who also has to take care of herself and not only her children.

Women and the society in general are beginning to accept their potential and rights for gainful employment not only for personal satisfaction or for the family but for the community and the nation.

Conclusion

In the Philippines, the 1960s saw the emergence of a number of descriptive studies on child rearing in rural and urban communities. Study results are replete with references to traditional notions of mothers as primary caretakers of children, and to gender relations.

In recent Philippines studies, women's struggles to be equal with men and to break away from traditional notions are explained through a feminist or women-centered standpoint. It views inequality and oppression as arising from patriarchy and oppressive social structures. Moreover, the focus is not only on one or few disciplines but became more interdisciplinary.

The evolution of mothering studies revealed how the works of women academics and feminists have also acquired deeper analysis and have been more attuned to the lived experiences of mothers. From the positivist tradition (particularly the structural functionalist perspective), women writers have become more actively engaged in participatory and eventually women-centered and feminist research. There is a healthy mix of quantitative and qualitative analysis to complement and mutually reinforce each other.

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ISSUES IN NURSING EDUCATION MANAGEMENT IN THE PHILIPPINES[1]

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Introduction

The Philippines, once more, caught the attention of the world when the issue of cheating and leakage in the Nurses Licensure Examination broke out in June of 2006. That single incident put into question the integrity of the hundred of thousand nurses that leave the Philippines to at least 32 major countries around the globe. For the country in particular, the incident is the lowest ebb of the proud history of the nursing profession that has, lately, been searching its soul for quality education amidst the alarming increase in the number of nursing schools and nursing student population. For concerned leaders and educators in the nursing profession, the incident was only the "tip of the iceberg" and called for the urgent need to look into the nursing education itself in the country.

According to Galvez Tan, Sanchez and Balanon (2004), the importance of the nursing profession in the country stems from the fact that the Philippines is the biggest health service provider of overseas nurses globally. The combined dollar remittances of nurses and other Overseas Filipino Workers (OFW) help keep the Philippine economy afloat. Lorenzo (2006) opines that the demand for nurses abroad and the lack of better earning opportunities in the country coupled with the persistent national government budget deficit, have turned nursing schools into profitable investment for the private sector. The result is the phenomenal growth of the number of nursing schools all over the country from 40 to 450 over the last five years.

However, as the provision of health care services passes from the government to the private hands, the predominance of private investments in nursing education has made government regulation and control over the quality of education moot and academic. It has been observed that the delivery of quality health care, once a hallmark of public service slides, more often, into private profit-making venture. In effect, Galvez Tan (2004) asserts that the government has facilitated the supply of health professionals abroad more than it provided for the health care delivery system in the country. This has spawned not only a serious health care crisis looming in the horizon; it also has made the nursing profession a commodity for exchange.

In this situation, striking the balance between quality education and access to nursing profession directly falls on the management of nursing schools primarily the school owners and deans. The challenge for academic institutions that prepares professional nurses is ensuring quality nursing education that is responsive to the emerging demands of health care system both in the sending as well as in the recipient country. This has become the task of managing nursing education (Hutcherson and Williamson, 1999).

The playing field in nursing education

A quality health care system provides good health to the public in forms that are delivered in the most convenient or "client-friendly", cost-efficient and most effective system possible. Hutcherson and Williamson (1999) claim that the setting of quality standards for a responsive health system are no longer the exclusive domain of governmental policy decision-making processes and structures but are dictated by client satisfaction. The provision of health care services, in other words, has become a business enterprise where the primary concern of customers is quality service while owners (government, corporations and individuals alike) put premium on economic profitability and survival.

The nursing education, therefore, needs to address those expectations in the light of changing environment, notable of which are the following:

- Today's population are so diverse in terms of the nature and the prevalence of illness and diseases requiring changes in nursing practices from purely clinical or physical to spiritual as well as psychosocial health of the population as reflective of the clients' diverse values and beliefs (Heller, Oros and Durney-Crowley, 2003).
- Rising costs in health care and the levels of incomes among the population have led to new settings and care management mechanisms that are more determined by the client preferences and income capacities (Hutcherson and Williamson, 1999).
- Technological advances also opened opportunities for continuous innovations in health service delivery systems. The information technology, for example, has introduced new forms of clinical diagnosis and treatments via electronic methods like the inexpensive hand-held biosensors. The

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traditional documentation system has been replaced by electronic methods (Hutcherson and Williamson, 1999; Russo, 2001).

- The globalization of goods and services also brought with it the spread of disease and the reemergence of infectious diseases (Fritsch, 2005).
- More significant, since the opening of countries to freer flow of trade, is the wealth of information and options available to the public such that educated consumers have become active decision-makers in health care and its management. This has also challenged traditional health education and promotions techniques some of which even put the traditional ethical and societal values on the spot (Stokowski, 2004; Kunaviktikul).

Lenburg (1999) and Redman, Lenburg and Walker (1999) argue that the changing environment, therefore, has imposed on nurses the demand for a wide range of knowledge and skills to manage the various needs of patients and populations. The need to inculcate critical thinking and lifelong learning becomes necessary traits among professional nurses. For nurses to gain a competitive edge in the care and management of critical components in the health care delivery requires not only completion in nursing program but a demonstrated competence or “evidence” in leadership in interdisciplinary and collaborative practice for continuous quality improvements.

Issues in education management

The review of literature on the competencies of a dean conducted by the UPM-CN (2005), reveals that in the Philippines where the nursing school has become a demand-driven enterprise, the changing environment puts constant pressures on education management to adopt, innovate or perish. For one, this requires continuous learning and redesigning of education program to meet contemporary nursing practice in the interest of public good and global competition. The ability for management to communicate to the various stakeholders about the changing environment and its demands on nursing education; and to mobilize resources and support through a decision-making-action process requires leadership and management skills that fall primarily on the shoulders of the dean of nursing school. Thus, deans are expected as leader and manager, as curriculum planner, teacher and mentor; and, as researcher.

As leader and manager, deans are expected to provide direction, guidance and control of the institution they lead. Key issues in this respect relate to planning, faculty competency development, resource generation, fund sourcing, and interdisciplinary collaborative linkages for continuous quality improvement. Moreover, deans are expected to provide professional, personal and ethico-moral leadership.

In response to the need for developing and maintaining the quality of nursing education in the Philippines the University of the Philippines Manila College of Nursing serving as a World Health Organization Collaborating Center for Leadership and Nursing Development entered into a collaborative partnership with the Association of Deans of Philippine Colleges of Nursing in order to develop, implement and evaluate a training program as sustainable initiative to maintain the quality of nursing education in the country while strengthening the individual capabilities of the deans for leadership role (WHOCC-UP-ADPCN, 2006). The first step was to conduct, focus group discussion in April 2005, to identify the competencies of deans as perceived by the deans, the faculty and students.

The following specific leadership and management issues were pointed out and discussed in the April 2005 focus group discussions among deans, faculty members and students of colleges of nursing coming from three major islands of Luzon, Visayas and Mindanao. Aside from identifying issues, some recommendations to address those issues were also put forward in the focus group discussion. (WHOCC-UP-ADPCN, 2006)

Planning. In the context of competitive provision of health care, planning becomes a tool for positioning the academic institutions in the provision of professional nurses or world class nurses: nurses that are capable of demonstrating health care services. Current nursing practice covers strong communication skills aside from clinical experience. Care and management of critical health care service components require nurse managers and executive who must have business acumen and knowledge of financial and personnel management, skills in organizational development, negotiation, linkage building and coordination.

The issue on planning is how to position the country as the best source of world class nurses by setting the standard or benchmarking nursing education and practice. On this issue, urgent actions are directed at addressing the current health care crisis mainly, the deteriorating quality of practice and lack of competent personnel.

Faculty development. Positioning the country in the global arena requires the formation of top caliber nursing school faculty. This is the area where the diaspora of health professionals continue to inflict the greatest damage the brain drain in country is real and literal! Unless policy control and better work incentives are effectively combined to address the labor export policy in the country, mustering the number and quality of professional faculty by nursing schools would be very expensive investment to maintain.

Acquiring, developing and maintaining masters and doctorate degrees traditionally have been the way to upward mobility of academic institution. Increasingly, however, the competency-based professionalism has become the “industries”- the health providers industries included- growing preference. Academic degrees documents have become ordinary papers even when printed in golden sheep's skin.

Industries as well as small businesses require "evidences" that are demonstrable skills. In this aspect, there is a common consensus among deans and faculty members on the need for deans of school to have experience in running a school or at least managing a unit thereof on top of clinical experience.

On this issue, in the rush to establish nursing schools in the country due to the global demand for nurses, many of the deans of newly-opened nursing schools are first time deans with little experience in nursing education; a number of them were recruits from having just retired from nursing service. While the older deans who came from the nursing service have managerial and clinical experience, they are the product of the old school curriculum and are often critical of, if not resistant to the implementation of Associate in Health Sciences Education (AHSE) curriculum.

Resource generation. The central concern of resource generation is the creation and maintenance of a high quality learning environment. Focus is given to the continuous development and improvement of the physical and financial assets of the school. The generation, mobilization and utilization of those assets are dictated by the amount and quality necessary for the acquisition, development and continuous improvement of the school faculty, administrative and other support staff and their working environment as well as the well-being of the students.

On this issue, not a few nursing schools in the county lack the necessary or even the basic facilities and learning materials that a nursing school must have. In it is this area, where basic interest and priorities of deans and owners of schools collide, often ignited by cost considerations. Often, the choice is a toss between quality or cost.

Collaborative linkages. Establishing collaborative linkages is key to quality development and global competitiveness. This is particularly important for a dean as a leader and manager in curriculum planning and accreditation, material development, upgrading of physical facilities and research. Collaborative linkages aim to bring nursing schools to higher level of recognition through establishing linkages, partnership with foreign institutions, and providing distance learning. In a highly congested course like nursing, competition, at times to the point of "pirating" faculty members, the need to strike and maintain harmonious co-existence among schools becomes possible through collaborative linkages.

Areas for collaborative linkages include, among others, the following:

- *In the areas of curriculum development*: Strengthening of nursing curriculum to cater to global market by integrating global health nursing practice and trends; by integrating "best practice" in the curriculum. Positioning the country as best source of world-class nurse through benchmarking with international nursing education and practice. Curricular certification of nursing programs following national and international standards focusing on well-defined competencies.

- *Human resources and professional development*: Creating opportunities for innovative sharing of human and material resources through formation of consortium of schools/resources and hosting visiting professors. Creating common advocacy to standardize pay scale among health professionals and strict implementation of RA 9173.

- *Instructional material development and research*. The need for support for the acquisition of state of the art equipments, facilities and materials are high on the list of most nursing schools in the country. The provision of technologically advanced facilities, particularly the upgrading of clinical resources that would measure up to the expanding admission of students while addressing international standards.

  For research concerns, the need for synergy in clinical and didactic among practitioners and integrating cultural diversity are important areas for collaborative linkages.

- Fund sourcing. Beyond material, physical and capacity building necessary to position the school to international competitiveness, collaborative linkages is most important in fund raising activities of the school. In this respect, innovative fund raising activities in collaboration with alumni and international donor agency are a must.

Initial Efforts

Prompted by the need to address the above stated issues, the UP Manila College of Nursing and the Association of Deans of Philippine Colleges of Nursing in partnership with the Asian Institute of Management (AIM) developed and implemented a three-day workshop on "Leadership and Management Development Program for Nursing Deans". (WHOCC-UP-ADPCN, 2006; 2007) The program intended to help the participating deans to:

- Analyze the impact of local, national and global environmental factors to their institution, the country and the profession;
- Develop greater self-awareness as leaders in nursing education;
- Develop a strategic plan for addressing institutional issues related to leadership and management; and,
- Develop a strategic plan to address priority leadership and management issues in nursing education.

The training program focused on leadership and management for deans. The first training was conducted in December 2005 and March 2006 that benefited 59 deans from the three major islands of the country. A follow up training was also conducted on September 23-25, 2007 at the Asian Institute of Management in Makati City and benefited 38 deans, associate deans and senior faculty members representing 36 nursing colleges from various parts of the country.

The clamor to conduct more training programs led to the idea of establishing a nursing academy for training of deans and faculty. This is in view of the fact that the initial effort, the two batches of training covered only 12.8 percent of the total number of deans nationwide. Scaling up the coverage to include regions with dearth of professional development opportunities would require

institutional support such as a training academy or localized provisions of training program, probably with assistance from CHED Center of Excellence as facilitator or organizer and with technical assistance from ADPCN and UPCN (WHOCC-UP-ADPCN, 2007)

Development Agenda

More important than the academy for training is the realization among the deans to come up with a comprehensive agenda for action to address the continuous development of a quality nursing education in the country. Among these are: (WHOCC-UP-ADPCN, 2007)

- Overall framework for a harmonized and sustained development of Philippine deans. At present, there is no ready framework that provides the overall direction and guides the continuous development of competencies of deans in the country. Developing competency standards could be the center of excellence of the proposed Training Academy for Deans in the country.
- Strategic plan development. As recommended through the training evaluations, there is the need for an overall direction and policies towards the development of the deans, spell out the governing principles, specify the goals and objectives to be met, chart the key strategies to be pursued, list the indicators to measure success and identify and estimate the resources need to implement the Framework.
- Partnership building with related agencies. Shaping the nursing education system in the country is a task for the nursing school deans in partnership with other stakeholders in the health system and nursing education. The interrelation of education, health system, employment, and policy development require harmonization of policies and existing regulations governing nursing practice and its continuous development.

As a WHO Collaborating Center, the UP Manila College of Nursing faces the challenge of upholding the culture of excellence in nursing education at two levels. One, is by improving its graduate program at the masters level by developing a competency-based masters curriculum focused on clinical nursing specialization and a nursing administration specialty having two tracks- hospital and nursing school management. The graduate programs are currently being offered in both residential and distance education mode. Other venues or approaches are being explored to reach prospective graduate students especially those in remote areas. At another level, non-degree training programs and short-courses are continuously being developed and implemented to address the leadership and management issues on a short-term and palliative basis.

Conclusion

In real-time context, the call among environmental advocates about “thinking globally and acting locally” can be applied to the management of nursing education. The strategic concern of management in nursing education is how to position the country's nurses in the global health care industry.

This position can only be attained by producing professional and world-class nurses. The quality of nurses that the academic institution will produce largely depends on how the academic leader is able to (1) create and sustain a high quality instructional environment; (2) motivate and develop a faculty with intellectual, personal and professional integrity; and (3) maintain the institution's high standard of nursing education utilizing a curriculum that prepares a student to assume beginning professional competencies

The changing environment in terms of patients and population preferences due to shifting demographics, costs of health care and levels of income among the populations, technological advancement, global trade among others, puts constant pressures on education management to adopt, innovate or perish. These are shifting tectonic plates that management of nursing education will have to steer academic institutions across national borders in the interest of public good and global competition.

The skillful steering is on the shoulders of the deans of nursing schools the captain of the ship in nursing education. The key is continuous quality improvement in nursing education through rigorous planning, faculty development, resource generation and collaborative linkages.

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2008 ANASTACIA GIRON TUPAS AWARD:

Sharing the legacy of nursing excellence[1]

She emerged "first among equals" in a shortlist of outstanding nurse achievers for the highly coveted title considered the most prestigious in the nursing profession.

CARMELITA DIVINAGRACIA nee DE LA CRUZ is the 2008 recipient of the "Anastacia Giron Tupaz" Award for "exemplary leadership, outstanding professional competence and significant contribution to the nursing profession."

The presentation of the award was one of the highlights during the 86th Foundation Anniversary, 51st Nurses Week Celebration and Annual Convention of the PNA held at the Tent City, Manila Hotel on October 21 to 23, 2008.

"Dean Carmel, Divine, Divinegrace"

For those who are somehow privy to her personal details or part of her inner circle of friends, these are names of endearment that they alternately use to address the subject whom they believe is totally deserving to don the "big hat" of nursing icon AGT.

Her 10-page single-space Curriculum Vitae citing her professional accomplishments gathered and earned through 48 years of nursing practice would have made even AGT proud to bestow her legacy of model nurse to Dean Carmel.

Dean Divine's rise in the professional ladder was not meteoric, but rather steady. She claims to have been just an "average" nursing student at the UERMMMC where she graduated. She was, however, full of zest and motivation to learn. Inspired by her mentors, she bloomed, and as they say, the rest is history. She earned both her master degree and doctorate in Nursing from the University of the Philippines that cited her as an "Outstanding Alumna in Nursing" in 2006.

The string of citations and awards she has earned in her professional practice is an attestation to her significant contribution especially in the academic field. It is here, in fact, that she has made her mark and built a niche of competence. The same standards of nursing competence she pushed hard for to ensure that the country's products are "globally competitive".

But in the course of pushing for reforms in nursing education, she and some other driven nursing leaders found themselves treading into dangerous course where the risks are too high. It was a battle she had to concede philosophizing that there is still a war to conquer.

Her record as a leader and member of eminent organizations and institutions is highly acknowledged. Among these is the Association of Deans of Philippine Colleges of Nursing or ADPCN where she has been president from 1995 to 2005; and currently. In her alma mater, the UERMMMC, she started as staff nurse later becoming member of the faculty of College of Nursing and finally, the College Dean - sitting from 1984 till present. She was appointed concurrent Dean of the Graduate School of Nursing from 2003 to 2006. In June 2004, she was awarded a Plaque of Recognition as Dean "for unquantifiable support, dedication, devotion and for being a great inspiration to all the students of UERMMMC."

In her acceptance speech of the AGT Award, Dean Divine looked back to her humble past and simple childhood in a province in the North when she first dreamt of becoming a nurse. Inspired by a community nurse who was a regular visitor in their place, she knew early on what she wanted to become. So after finishing high school on top of her class, the *"probinsyana"* dared venture into the city to fulfill her dream. She finished the nursing course on track. From then on, there was no stopping her from living her dream to become another "Florence Nightingale."

Looking at her resume and by the sheer number of her social involvements, you would think the lady must be married to her

Then and Now: Dr. Milabel Ho, AGT Awardee for 2007, proud to pass on the honor to this year's AGT Awardee: Dr. Carmelita Divinagracia.

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[1] *Anastacia Giron Tupas Award is the highest award given by the Philippine Nurses Association to perpetuate the legacy of the founder of the Filipino Nurses Association. Her invaluable contribution likewise is exemplified in the field of nursing in particular and in health services and community in general.*

Tribute to Rachelle Mae Palang (1986-2008), Press Freedom Fighter and Nurse for the People

"Only a very FEW persons can walk the path that Rachelle "Mae-Mae" Palang had taken and only a very few people could choose the decisions she had made. Her martyrdom will always be an inspiration for every one who truly wishes to change our corrupt society and heal the illness within our country. Not all of us can be a HERO. Thank you, Rachelle Mae, for teaching us how to love and for inspiring us how to serve the least fortunate ones."

- Fr.Chito

She was young and bright. But unlike most of her contemporaries, she chose to practice her profession under difficult and harsh conditions in a poor rural community where the rewards are anything but material.

Rachelle Palang, were she not outstanding and exceptional, would have been thought of as "weird" for taking the rough course shortly after passing the 2008 nursing board exams. Instead of training her sight at the green pastures that beckon, she volunteered for a medical mission in the Negros hinterlands. And there she lived her dream of "serving the people" as she believed nursing should be. And where she found life -- that was where she lost it, too. She was killed on September 18, 2008 by bullets from military elements during an alleged encounter with rebel forces. She was barely half-way through the 3-month community volunteer work that must have been the beginning of her chosen path when her young life was snuffed.

Mae-Mae: outstanding student, gifted writer, dead at 22. While tragic, her abrupt and untimely death may well be a celebration of life fully lived. For as the revered Abraham Lincoln said, "… And in the end, it's not the years in your life that counts. It's the life in your years."

Following are tributes for Mae-mae by those who shared her convictions: a priest and her best friend.

Maria Carla Alvarico, R.N., CEGP Cebu Chairperson writes: "We shed our tears for Rachelle Mae "Mae-Mae" Palang, who was ruthlessly killed… Her only fault, if it is a fault at all, was her love for those who are suffering because of an unjust system. Her only crime, if at all it is called a crime, was to give up her dreams of living a life of comfort in exchange of serving those who need her the most the poor and the deprived.

Rachelle could have chosen a different path. A path that could have led to a comfortable life for her and her family. But she chose the path less traveled. The path of suffering just so others would live comfortable lives. A path of selfless devotion and service to the people".

Rachelle gave a deeper meaning to health care and to her profession as a nurse.

ANASTACIA GIRON TUPAZ AWARD...

profession. Well, she is not - having been blessed as well in her personal life. Married to an eminent medical doctor Dr. Romeo Divinagracia, their union bore three children.

The "average" student has evolved into a leader in her chosen career with accomplishments probably even surpassing her own expectations. She has reached the pinnacle of recognition but instead of slowing down she continues to gratefully give to and do more for the profession that has greatly rewarded her not so much materially as in 'divine' ways.

AGT must be smiling from above looking at another one of her stewards. *(LMNolasco)*

Carmelita C. Divinagracia, Ph.D., R.N. is an exemplary nurse who has dedicated her life in the service of the nursing profession. Her sterling leadership has raised the bar of excellence in nursing education; ushered a greater sense of professionalism; heightened the integrity of the profession and paved the way for good governance of the profession.

Her commitment to see the fruition of the vision of nursing is evidenced by her indefatigable acts and undaunted advocacy in promoting quality and excellence in nursing education. She is a living nursing icon who created a trail that made a difference in nursing today and for the future generations of nurses.

Melamine Poisoning: "Tip of the Ice Cream"

Romeo F. Quijano, *MD*
Professor, Department of Pharmacology & Toxicology
UP College of Medicine Former Chairperson, Health Alliance for Democracy

Like many similar incidents in the past, the melamine poisoning scandal is just a symptom of a decadent global food system characterized mainly by corporate greed and government neglect. The government ridiculously tries to show it is doing something to address the problem by parading to the media hurriedly confiscated milk products yet at the same time, it downplays the dangers by echoing a familiar corporate whitewash that humans will have to ingest unrealistically huge volume of contaminated milk to be poisoned. Just as quickly, Nestle and other companies put out expensive advertisements proclaiming that their products are safe, even without undergoing appropriate tests. These short-sighted and self-serving knee-jerk reactions, do not protect the health of consumers but perpetuates the pathetic state of affairs as far as food safety is concerned.

Food safety has never been a serious concern of government and corporations, particularly with the advent of corporate globalization. WTO provisions related to food safety, for example, clearly subordinate protection of health and environment to corporate interests. Countries, especially the weaker countries, are forced to import food products contaminated with toxic chemicals or substances. Any attempt to ban or restrict such harmful substances, even those already banned in other countries, is met with fierce resistance by corporate giants and their host countries. Such is this case, for example, for pesticides, artificial sweeteners and additives, GMOs, and now melamine.

Exposure to melamine and related chemicals, in fact, is not new. Melamine is a triazine synthetic chemical used, usually with formaldehyde, in a wide range of products such as kitchen dishes and utensils, formica, laminate flooring, whiteboards, furniture, cleaning agents, fabrics, glues, colorants, flame retardants, fertilizers, and drugs.

Melamine is also a metabolite of cyromazine, a triazine pesticide commonly used in vegetable and chicken farms. In 1987, melamine was dempnstrated to be present in coffee, orange juice, fermented milk and lemon juice, originating from migration of melamine from the cup made of melamine-formaldehyde resin. From 1979-1987, there was a widespread melamine contamination of fish and meat meal in Italy and in 2004, there was nephrotoxity outbreak in pets in Asia. Again in 2007, thousands of cats and dogs, mostly in the US, became seriously ill or died of acute renal failure after eating pet food contaminated with melamine and related triazine compounds such as ammelide, ammeline trichloromelamine and cyanuric acid. Hogs, chicken and fish were also found to be contaminated with melamine and cyanuric acid. Cyanuric acid is a common disinfectant used in swimming pools together with chlorine. Cyanuric acid was used as an ingredient in herbicides and is also used in the production of melamine and sponge rubber. It is also an intermediate chemical in the bacterial degradation of melamine and in the production of chlorinated bleaches and whitening agents. Trichloromelamine is the chlorinated form of melamine and is mainly used as disinfectant and cleaning agent.

Melamine may cause adverse reproductive effects, may affect genetic material and may cause bladder cancer based on animal data. it may also cause skin, eye, respiration tract irritation and irritation of the digestive tract with nausea, vomiting and diar4rhea, and may damage the urinary system. Cyanuric acid and trichloromelamine have pretty much the same spectrum of toxicity as melamine. However, cyanuric acid and trichloromelamine have the greater toxicity potential, particularly in causing kidney damage, developmental toxicity and cancer.

By themselves, melamine and cyanuric acid are considered to be of low acute toxicity by regulatory agencies based on standard risk assessments for each chemical. It is from this limited risk assessments for each chemical. It is from this limited risk assessment that official tolerance levels (e.g. "15 cups of milk per day for several months") are derived. However, multiple source and multiple chemical exposures, including exposure to both melamine and cyanuric acid (which has been found to be much more toxic in combination), is the more likely exposure situation and this should be the basis for assessing irsks to human health. Other important triazine compounds must also be considered in the assessment of risks. For example, the triazine herbicides exemplified by atrazine are structurally and toxilogically similar to melamine and cyanuric acid. These herbicides are known to cause neuroendocrine and endocrine-related developmental, and reproductive carcinogenic effects.

Despite the limited scientific data and the low acute toxicity attributed to melamine and related to triazine compounds, much can be said about the potential harm that these chemicals pose to animals and human beings. The mechanism of renal toxicity of melamine and cyanuric acid is well established and that acute or chronic exposure would likely result in adverse renal toxicity that could lead to renal failure. Existing empirical and scientific data indicate that exposure levels sufficient to cause harm are likely to be reached under present circumstances. In fact, the European Food Safety Authority, despite using the conservative risk assessment methodology, came up with this statement, "in worst case scenarios with the highest level of contamination, children with high daily consumption of milk toffee, chocolate or biscuits containing high levels of milk powder would exceed the TDI (tolerable daily intake)." This assessment did not consider potential additional exposures likely to occur in developing

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ISSSUES AND CONCERNS OF NURSES IN ASIA

9th Asia Workforce Forum and 5th Alliance of Asian Nurses Associations' Meeting in Taipei, Taiwan

Dr. Leah Primitiva G. Paquiz, National President and Governor of NCR Zone 2, and Dr. Leticia B. Puguon, Governor of PNA Region 2 and Nurse IV of the Provincial Health Office of Nueva Vizcaya represented the Philippine Nurses Association (PNA) in the 9th Asia Workforce Forum (AWFF) and 5th Alliance of Asian Nurses Associations' Meeting last November 26-28, 2008 in Taipei, Taiwan.

The International Council of Nurses hosted the AWFF. The forum provided a venue to discuss the various issues and concerns confronting the nursing profession and nurses in the 11 participating countries. The topics included environmental scan on the developments in nurses' working conditions as well as developments outside nursing profession. Nursing data on wages and the ICN Survey on Workforce Profile were also tackled. Updates on various relevant programs and projects include: the Positive Practice Environments for Health Care Professionals by Dr. Mireille Kingma of ICN; the Needlestick Injuries Project by the Philippine Nurses Association; Asia Workforce Research by the Nurses Association of Thailand; Workplace Violence by the Japanese Nursing Association and Thailand. Also presented were pressing issues such as: Retirement Plan by Dr. Jennifer L. Wang Professor and Chairperson of the Department of Risk Management and Insurance of Taiwan; and the 2nd Home for Retired Foreign Nurses by the Malaysian Nurses Association; Task Shifting, Retention Strategies, and the role of National Nurses Association and the Role of Trade Unions.

The 5th Alliance of Asian Nurses Associations' meeting held on the third day tackled various strategies to strengthen the nursing profession such as: Strategies to Promote the Image of Nurses and the Nursing Profession; Investment Strategies to Strengthen the National Nurses Associations Financial Status; and Strategies on Lobbying with Government for Policy Initiative.

The Taiwan Nurses Association served as the gracious host to a Reception Dinner, a trip to the "Night Market", and a tour to the Taipei University Medical Center.

FIRST NATIONAL NURSING RESEARCH CONFERENCE: THE BIRTH OF THE PHILIPPINE NURSING RESEARCH SOCIETY

On the 13th and 14th of November, 2008, the First National Nursing Research Conference was held in General Santos City with the theme, "*Adventures of Nursing Research: Stories from the Field.*" The conference was intended for nurses and other health care providers, researchers, administrators, and educators engaged and/or interested in nursing research and evidence-based nursing practice. It provided participants with knowledge related to feasible and relevant strategies to integrate research findings and evidence into practice. It also aimed to enable nurses to enhance organizational strategies for sustaining environments supportive of research and evidence-based practice. Moreover, the participants were also given the chance to exchange research initiatives and agenda with colleagues in order to increase collaborative research opportunities. Financial assistance was provided to qualified applicants, notably paper presenters. There was a good turnout of participants from across the country - from Laoag City in the north to Zamboanga City in the south, making this conference a timely initiative to create the research infrastructure in the country.

According to the conference convenor, Dr. Erlinda Palaganas and co-convenor, Prof. FJ Babate, the 1st National Nursing Research Conference garnered a huge success. There was a total of 104 participants, including guests, resource persons, and nurse volunteers. The conference was supported by educators and nursing leaders led by Dr. Edgardo Claudio, Vice-president of Notre Dame of Dadiangas University; Dr. Carmencita Abaquin, Chairperson of the Board of Nursing; Gov. Ruth Thelma Tingda, National Chairperson of the Philippine Nurses Association, with Dr. Erlinda Palaganas, Prof. FJ Babate, Dr. Rusty Francisco, Dean Grace Valderrama, Prof. Cora Añonevo, Dr. Teresita Barcelo and various Deans and Chief Nurses.

The ceremonial ribbon-cutting activity was led by Dr. Edgardo Claudio, the Vice-President of Notre Dame of Dadiangas University; Dr. Carmencita Abaquin, the chairperson of the Board of Nursing; Gov. Ruth Thelma Tingda, the national chairperson of the Philippine Nurses Association, assisted by Dr. Erlinda Palaganas and Prof. FJ Babate, the conference convenors.

Various facets of Nursing Research and the Nursing Profession emphasized by various nursing leaders: Dr. Carmencita Abaquin (Chair, BON); Prof. Deogracia Valderrama, RN, MAN, MHA (Dean, College, School of Health Sciences, Mapua Institute of Technology ; Dr. Rusty Francisco, (President NCCLEX) and Dr. Cora Añonuevo, (Professor, UPM-CN).

The presentations on Paradigms and Perspectives in Nursing Inquiry and the Trends on Nursing Research set the tone of the conference. Hon. Carmencita Abaquin's parallel discussion of the importance of research vis-à-vis the Nursing Law further reinforced the place of research in the nursing profession. The case of the College of Nursing of the Easter Colleges Inc. presented by Ruth Thelma Tingda with colleagues, Vanessa Tuban and Red Cloud Capuyan, in the initiatives and attempts to integrate research in the culture of the college, was a passionate and very encouraging story, despite the ups and downs it traveled. Dean Grace Valderama challenged the delegates to operationalize an evidence-based practice in every field of Nursing. The role of Policy Research in Nursing convincingly presented by Prof. Babate, is one of the field of research that needs to be explored and undertaken by nurses. Prof. Añonevo's story on Ethics and Nursing Research, based on her praxis as nurse researcher, was befitting to end the conference.

The more exciting and motivating portion of the conference was the opportunity provided by the nurse-researchers to present their research papers both orally and thru posters. As written by Janelle Castro, a faculty and budding researcher from the UERMMMC College of Nursing, "the conference was a venue for both excitement and nervousness. The idea of delivering one's own research in front of a crowd of experts did give me a feeling of anxiety, but as the last part of the professional session pulled in, the feeling became enhancing rather humiliating. I found myself enjoying the comments and indeed gained a lot of insights on how to improve my work. The conference was a remarkable event that opened up opportunities to the participants and gave them an unforgettable experience that they can value on for the rest of their lives".

The conference also launched the beginning of the Philippine Nursing Research Society, a SEC registered professional organization of nurses. The PNRS aims to promote recognition of nursing research as vital to nursing as a scientific discipline. It also aims to link nurses with similar research interest on nursing and nursing-related thrusts in the academe and health care setting; provide forum for dissemination and critique of nursing research, thrusts, publications, continuing education, and training. Furthermore PNRS aims to foster ethical standards in nursing research. The first set of officers include: Dr. Erlinda Castro-Palaganas (President); Dr. Teresita I. Barcelo (Vice-President); Prof. Jerome Babate (Secretary); Dr. Cora Añonuevo (Treasurer) and Dr. Irma Bustamante (PRO).

MELAMINE POISON...

countries, such as cyanuric acid in swimming pools, melamine from the pesticide cyromazine and in contaminated vegetables, fish and meat, and melamine leachate in kitchen wares. Since milk and milk products from China were already banned in Europe at the time of the assessment, the worst case scenario for European children did not even consider potential sources from milk and ice cream!

The extent of harm that melamine and related compounds have caused is not clear at this time but the problem is not just melamine and simply confiscating products will not solve the problem. Government officials should not downplay the dangers of toxic chemicals contaminating food. Mechanisms for appropriate monitoring and timely intervention should be established. Food safety should be placed high in the political agenda and greed, corporate and otherwise, eliminated. Safe food should be put in the hands of the people!

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NARS

*Nagkakaisang **N**arses sa **A**dhikaing **R**eporma sa Kalusugan ng **S**ambayanan*

It took a while coming, but its birth was no less auspicious or less welcome. Its idea is as relevant as it was in the 70's when abject poverty and disease were the twin realities that faced the people. Health care then was more a privilege that only the rich can afford. While it has been universally enshrined and declared that Health is a right for all and health care is a state responsibility, these were more in the realm of the abstract.

The challenge then for the health sector was to work for the establishment of a "people-oriented, nationalist, relevant and responsive" health care system based on the people's felt needs and actual conditions. A good number of idealistic nurses heeded the challenge and joined the people's movement for change. One initiative was the setting up of community-based health programs that enabled the poor communities and sectors to gain knowledge and skills to manage their health and Jives. Going into community service or joining people's health organizations were akin to taking the road less traveled because it meant sacrifice and giving up opportunities for material gains. On one hand, it was a noble and an outstanding human feat epitomized by the mother of nursing herself, Florence Nightingale, who selflessly devoted all her life to service of the trodden.

Unlike public health nurses under government service who have their own organization, community nurses integrated into people's organizations or engaged in health advocacies, are hard to tract down and even harder to organize. The moment they merge with people's organizations or immerse in community health work or advocacy, they shed off their professional status and become one with the people. Nursing titles matter little and the people's interests take the center-stage. This may be the biggest factor why no professional association of NGO-community health nurses has been set up so far, until now.

Welcome the *Nagkakaisang **N**arses sa **A**dhikaing **R**eporma sa Kalusugan ng **S**ambayan or **NARS***. This SEC-registered, PRC-recognized professional association of community health nurses and people's health advocates was officially launched during the first National General Assembly held in November 30, 2008 at Bayview Hotel, Manila. It was founded by 35 nurses engaged in various forms of community work and health advocacy, representing some 15 institutions and organizations in the academe and the private and public health sectors.

"Empower the community health nurses and people's health advocates to uphold and protect the people's right to health and development".

Gathering these nurses from all over the country had been made possible with the assistance and support of health institutions that believed in the important role of the nurse in bringing about meaningful changes in society.

For indeed the NARS' vision is "a healthy society of empowered communities where there is social justice and equity and a people-centered health care system that is responsive, relevant and accessible." The NARS' mission thus, is to "empower the community health nurses and people's health advocates to uphold and protect the people's right to health and development."

One of the program thrusts is organizational expansion to pave the way for the consolidation of best practices in community health nursing. These can serve to motivate nurses, especially the young ones, to go into this field of nursing. This will also fortify the ranks of community health nurses as they participate in pushing the people's agenda for genuine change, in the health system in particular, and in society, in general.

The officers-elect in the 1st General Assembly are: President, Eleanor M. Nolasco; Vice presidents: for Luzon, Maristela Presto-Abenojar; for Visayas, Sr.Florence Laroco; and Mindanao, Maribel Jane H. Mendiola; Secretary, Consuelo Gundayao; Treasurer, Jocelyn Santos-Andamo; Auditor, Ariel V. Pabelonia; and, PRO, Erlinda C. Palaganas.

A BOARD OF GOVERNOR'S UNWAVERING COMMITMENT TO SERVE…

Article IV, PNA Constitution and By-Laws states that the corporate power of the Association is vested on the Board of Governors (BOGs), the highest governing body of the Association. The BOG is composed of representatives from the different regions of the country, all of whom, the general membership voted during the annual convention.

Composed of nurses with proven leadership abilities, having served for three (3) consecutive years of active membership in the region which he/she represents; endorsed by the chapter where he/she belongs, the BOGs commits and offers willingness to serve the association, making oneself available and accessible. “

Serving for a 3-year term of office with one (1) re-election or another term of three (3) years, the BOGs govern the Association in the attainment of its goal and objectives. In the process of adopting and implementing the policies, plans strategies and projects of the Association for nursing and health development and other functions stipulated in the By-Laws, the unwavering commitment of these women and men to whom we have entrusted the Association, shines and inspires.

BOARD OF GOVERNORS 2008

TERESITA I. BARCELO, Ph.D., RN
Professor, Head, Research & Creative Writing Program
College of Nursing
University of the Philippines Manila
Governor, NCR Zone 1, (2007-2009)

“The longer and better I lead, the more I depend on the skills and expertise of others”.

LEAH PRIMITIVA G. SAMACO-PAQUIZ, ED.d, RN
National President, Philippine Nurses Association, Inc.
Governor, NCR Zone 2 (2006-2008)

“Commitment is serving and caring till it hurts”.

MA. ASUNCION M. GONZAGA, RN, MAN
Dean, College of Nursing - STI Makati
Governor, NCR Zone 3, (2007-2009)

“And we know that in all things God works for the good of those who love Him who have been called according to his purpose”. - Romans 8:28

LOUISE MARIE DIANO-FLORES, RN, DPA
Chief Nurse, Rizal Medical Center
Rizal Medical Center, Pasig Boulevard
Governor, NCR Zones 4 & 5, (2007-2009)

“Life continues whatever happens. All we need is to be positive and be brave with all the challenges we encounter. Faith in God is still the best armor”.

CORNELIA T. CHAVEZ, RN, MAN
Nurse III, EPI Coordinator,
NVBSP Coordinator
Parañaque City Health Office
Governor, NCR Zone 6, (2006-2008)

“Commitment and dedication should be the qualities of a Public Health Nurse”.

RUTH THELMA P. TINGDA, RN, MAN, MM
Faculty, College of Nursing
Saint Louis University, Baguio City
Chair of the Board of Governors, Philippine Nurses Association, Inc.
Governor, Region I, (2006-2008; 2009-2011)

“The things that stand between a person and what one wants in life are the will to try it and the faith to believe it is possible”. - Unknown

LETICIA B. PUGUON, RN, Ph.D.
Nurse IV, Provincial Health Office
Provincial Capitol, Nueva Vizcaya
Governor, Region II, (2008-2010)

“Health does not come from medicines. It comes from peace of mind, peace in one's heart and soul. It comes…love!”

The BOGs commits and offers willingness to serve the association, making oneself available and accessible

NORA GARCIA-CRUZ, RN, MAN
Chief Nurse,M.V. Gallego
Cabanatuan City General Hospital
National Treasurer, (2007-2009)
Governor, Region III

"Nurses are always at the forefront of Service".

SUSANA A. SALVACION, Ph.D., RN
Dean, Southern Luzon State University
Lucban, Quezon
Vice President for Programs and Development,
Philippine Nurses Association, Inc.
Governor, Region IV, (2007-2009)

"Nurses are created to commit themselves to serve humanity".

EMERLINDA E. ALCALA, RN, MAN
Dean, Bicol University College of Nursing
Legaspi City
Governor, Region V, (2007-2009)

"A wise man should consider that Health is the greatest of human blessings and learn how by his own thought to derive benefit from his illnesses". - Hippocrates

EUNICE I. BEDONIA
Provincial Health Team Leader
Provincial Health Team Office
Negros Occidental
Governor, Region VI, (2008-2010)

"We have to practice healthy lifestyle if we want to promote health and healthy living. Let us all walk our talk".

ROLAND L. FERMO
Presidential Executive Assistant
Asian College of Technology, Cebu City
Governor, Region VII, (2007-2009)

"Live life to the fullest".

BELEN L. TABALE
Retired Nurse
Governor, Region VII, (2007-2009)

Let's be sure that we always say what we mean and mean what we say, not only regarding health, but in every endeavor we are in.

FLORENCE ASAGRA ALCAZAR
Associate Professor IV, Director, Career
& Placement Office, Western Mindanao State University
Corporate Secretary, Philippine Nurses Association, Inc.
Governor, Region IX, (2007-2009)

"Destiny is not a matter of chance, it is a matter of choice, it is not something to be depended upon but something to be pursued".- Anonymous

CARMENCITA M. LUBGUBAN, RM, RN, MPH
Nurse V- Regional Program Manager
Department of Health, Center for Health
Development, Cagayan de Oro City
Governor, Region X, (2006-2008)

"It is wonderful to be a part of a community being a health service provider who continues to embrace the mission of providing health care to the uninsured".

ROBERTO V. PALEC, RN, RM, Ed.D., Ph.D.
Dean, College of Nursing
NDC-Tagum Foundation, Inc.
Vice President for Finance, Philippine Nurses Association, Inc.
Governor, Region XI, (2008-2010)

"Amor Con Amor Se Paga" ("Love Begets Love")

FELINA M. HERNANDEZ, RN
Chief Nurse,Cotabato Provincial Hospital
Amas, Kidapawan City
Governor, Region XII, (2007-2009)

"You give but little if you give your money, it is when you give of yourself that you have really given". - Kahlil Gibran

INCOMING BOARD OF GOVERNORS 2009

MARIDEL CALALANG-DE LA RAMA, RN, MAN
Chief Nurse, Calalang General Hospital
Governor, NCR Zone 2, (2009-2010)

"An individual has not started living until he can rise above the narrow confines of his individual concerns to the broader concerns of all humanity".- Martin Luther King Jr.

RENIE V. MALVAS, RN, MAN
Chief Nurse, MPI-Medical Center Muntinlupa
Governor, NCR Zone 6 (2009-2010)

"Do not wait for leaders; do it alone, person to person. One of the greatest diseases is to be nobody to anybody." - Mother Theresa

NEIL M. MARTIN
Assistant Dean, College of Nursing
Liceo de Cagayan University, Cagayan de Oro City
Governor, Region X, (2009-2010)

" You can, if you will "

Leah Primitiva Samaco-Paquiz

the president of the PNA, bow...

The lady's middle name must be "A" for advocate, in witness of how she had passionately and courageously pursued issues and concerns pertaining to nurses' welfare and the profession.

Leah Primitiva Samaco-Paquiz, the outgoing PNA president will be best remembered as such in the two years that she reined the association. As she relinquishes her post, she hopes her successor would continue on with the advocacies she has initiated or pursued with as much fervor as she has given. Central among these is the implementation of RA 9173 or the Nursing Law that has yet to see full light since its enactment in 2002; specifically, the provision that sets the entry level of government nurses to Salary Grade 15. There is also the JPEPA or the Japan-Philippine Economic Partnership Agreement, a controversial treaty with its "discriminatory provisions against our migrant health workers and its unfavorable impact on economic sovereignty and damage to the environment." Another is the 'professional image of the nurse and the dignity of the profession:' twin concerns that had also been top on her agenda.

"She rallied and lobbied for nurses' rights and welfare and people's health".

The intensity by which she has pursued her advocacies has brought her everywhere: from the august halls of Congress to health offices and institutions and even to the streets where, together with other health workers and popular sectors, she rallied and lobbied for nurses' rights and welfare and people's health.

She definitely does not intend to slow down with the ending of her term. It may even provide greater leeway for her to take bold positions and actions with less organizational constraints. She vows to continue being visible and actively involved in the arena of politics and social engagements for there are still "miles to go and promises to keep".

Leah looks forward to facing more challenges in the next year. If anything will be amiss it will be her husband's supportive presence who, after a lingering illness has passed away this year. In her intimations, she credits her husband for making her realize her grave responsibility to society and the profession she loves. The adage, "to whom much is given, much is expected," is something that Leah carries in her heart. She claims to draw strength and inspiration from the memory of her late husband who unselfishly and untiringly gave of his time and resources to help break down the injustices in society.

So, should you be in a forum or rally or any social event and you see a lady - prim, coiffed and a sight in her coordinated suit, passionately espousing for nurses' rights and welfare and people's health, it's not unlikely to be Leah naturally doing the rounds in pursuit of her convictions.

To Leah, the outgoing 30th PNA president, we say not "goodbye" but "see you around." Carry on!

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Luz Barbara P. Dones *is an Associate Professor of Nursing, UP Manila - College of Nursing (UPCN). She has been with the UPCN for almost 20 years, served as CECSP Head, belongs to the CHN specialty group and had been involved in training programs for nursing faculty in competency-based BSN Curriculum.*

Letters to the Editor [1]

Recruiting foreign nurses: unconscionable 'solution'

by ***Lori Hanson***

Department of Community Health and Epidemiology, Saskatoon

Re: Recruiters target Filipino nurses (SP, Feb. 21). While I sympathize with nurses and patients affected by our health worker shortage, the Saskatchewan Party government's solution to the problem is short-sighted and fraught with ethical problems of a global scale.

The international migration of health workers away from under-served areas in low income countries is one of the most serious global health problems. That the Philippines government encourages the out-migration of nurses should not assuage our global conscience, particularly when one considers that the Philippines government is one of the world's most corrupt.

We also shouldn't be placated by simplistic arguments about the free will of health workers. Of course their earnings will increase substantially in Saskatchewan, and the $14.6 billion in remittances these migrant workers send home every year is good news for their families. But at what cost to their society?

In Saskatoon, reports outline the deleterious health effects of inequality in our midst. Globally, in countries such as the Philippines, such inequalities are multiplied hundred-fold. Knowing this, how can health authorities laud this government's answer to the nursing shortage?

How will the policy help alleviate suffering for the 27 per cent of malnourished Filipino children under five years? How will it change the fact that 50 per cent of Filipinas give birth without the attention of skilled health personnel, and that for every 100,000 that do, 200 will die (compared to fewer than five per 100,000 births in Canada)?

There are ample arguments for the health workers' mobility rights, but these often don't mention that given a real choice, most would prefer to work close at home. That policies which exacerbate inequalities in healthcare are touted as the answer, rather than a short-sighted, piecemeal and partial solution, is lazy policy-making and lazy reporting. How about an analysis of the bigger issues?

Recruiting nurses from Philippines: win-win situation

by ***Bonie Blakley***

Vice-President of Human Resources, Saskatoon Health Region

I am a proud member of the Saskatoon Health Region team that visited the Philippines to recruit nurses and am troubled by the letter, Recruiting foreign nurses unconscionable 'solution' (SP, March 1). (see above)

I respectfully disagree.

When done ethically, the recruitment of nurses form the Philippines benefits and enriches both communities.

We receive highly qualified, dedicated nurses, and the candidates get well paying jobs to support their families and communities, thus benefiting their country's economy.

The Philippines educate more nurses than it needs, to export their expertise. These nurses are seeking a better life for themselves and their families.

There is no work for many of them at home and, when there is, the jobs don't pay well. Many work as volunteers to keep their skills and are bound to leave the Philippines; the only question is, what is their destination?

Having spoken with representatives from the Philippine Overseas Employment Administration, the Philippine government, the Canadian embassy, a president of a nursing college and a hospital administrator, it's obvious that the nurses value the opportunity to come to Canada. They want to come to Canada because they know their human rights are protected, and that they will not be abused, held to ransom or have their opportunities limited.

Our team has developed an ethical recruitment statement, which has actual numbers, and was endorsed by our regional colleagues. We will recruit no more than 10 nurses from a Philippines hospital and no more than three from a unit.

We will give well-prepared, talented nurses the opportunity to work with an employer whose values include respect, collaboration, compassion, excellence and stewardship.

The nurse also will have a union that represents their interests.

Our nurses have indicated that filling the region's nursing vacancies will enable them to provide enhanced patient care, have more manageable workloads and spend more time with their families. We are recruiting nurses to make it happen.

Today I am proud of my community, my province, my place of employment and my community than I have ever been.

And I can live with my conscience.

[1]These are two differing views on recruitment of foreign nurses for health facilities in Saskatoon, Canada. The Editorial Board invites nurses' voice on these two perspectives. Please send your "voice" to the email address of the PNA.

Joining Hands for Better Health: Life is a journey... a connection... a celebration.

by ***Benilda D. Hizon***
President, Illinois State Medical Society Alliance

The year ahead is filled with beautiful and exciting opportunities for all Medical Alliances across Illinois. In fact, we are in the midst of magnificent and transformative times in our Alliance. As we embark upon new journeys and all that lies ahead, it is my utmost hope and dream that with the power of our hands joined together, we can unearth ways to change the world to a healthier and more peaceful place to live. As we recognize and appreciate wonders of new beginnings, we must pay homage to our growth, the rich beauty of nature, and a time to make a new level of connection, friendship and understanding. Together we can explore possibilities to optimize our Alliances' capacity to discover new things and continue to create an adventure of spreading hope, goodwill and an understanding of love. As a new board year starts, let us be guided by the words of Helen Keller, “The best and most beautiful things in the world can not be seen or touched; they must be felt in your hands and cherished in your hands.”

My theme for the year, “Joining Our Hands For Better Health”, reflects my belief that the power of Medical Alliances lie in each other’s hands. Too often, we underestimate the power of touch, a smile, a kind word or a small act of caring, all of which have a great potential to turn life around. With each and every one of us united in missions and goals, we can offer the world an ounce of harmony and healing. As a professional nurse, a mother, and my role as your State President, I have always been fascinated by the concept of leadership and the characteristics that distinguish effective leaders. The definitions of leadership are many in number. At our annual meeting in April, I shared some personal leadership qualities that I feel make a good leader. My first belief is that leadership is like a journey, where there are a variety of directions from leaders on various ways to reach our destinations. Great leadership is not much about technique, methods or formulas, as it is about the “Total You”. We are the arterial network that gives meaning and life to our organization. You have the visions that magnify our impact. As we celebrate our 80th year, we have so much to be proud of, but we also have a number of challenges to face. In some ways, these are no different than the individual challenges we all face in our daily lives, in that they are new opportunities for our improvement and personal growth.

For example, membership retention and leadership role positions remain issues of concern to some of our counties. Accordingly, we need to make sure that our programs, activities and services are increasingly relevant to the needs of the changing faces of the Alliance. In addition, our medical Alliance, like the world it inhabits, is increasingly diverse. Our commitment to diversity helps us lead our Alliance on journeys of discovery, leadership and community. We need to reach out to potential members in numerous ways.

Juana Bordas, an expert in multicultural leadership said, “Multicultural leadership encourages an inclusive and adaptable style that cultivates the ability to bring out the best in our diverse organization and to fashion a sense of community relationship.” Have gatherings that promote family participation and cohesiveness; nominate and appoint diverse members who are qualified for leadership positions; be a mentor; network and solicit ideas from everyone; feature family skills and accomplishments; designate a diversity awareness celebration in your calendar of activities; plan an international dinner to savor different ethnic foods; ask other members to host your next meeting; feature authors from other parts of the world in your book club; and have that welcoming smile!...As Alliances, you know that legislative issues are changing quickly, and the change is accelerating. The leadership in our Alliances must-and does- keep up with the times. But we need to go beyond just keeping up. We must be at the forefront of change and lead our journey into the future itself. We need to be involved with one voice, call our lawmakers when asked, send a note or email them about our concerns and support our programs…In today's world, we need heroes of all ages and backgrounds to take advantage of the myriad of opportunities that exist to make a difference. When I reflect upon this concept of leadership, I am reminded of my own profound and rare cultural characteristics inherent in me about the importance of “Bayanihan System of Leadership or Heroic Leadership” The tradition is called bayanihan, from the Filipino word bayan, meaning town or community; and the word bayani, meaning hero. The term expresses the importance of being heroes to one another and the importance of sacrifice for the common good. The word bayanihan signifies a communal spirit of volunteerism that enables completion of seemingly impossible task through the power of unity and cooperation. It is a very powerful concept of mobilizing united and well-coordinated activities.

Our programs…In today's world, we need heroes of all ages and backgrounds to take advantage of the myriad of opportunities that exist to make a difference. When I reflect upon this concept of leadership, I am reminded of my own profound and rare cultural characteristics inherent in me about the importance of “Bayanihan System of Leadership or Heroic Leadership” The tradition is called bayanihan, from the Filipino word bayan, meaning town or community; and the word bayani, meaning hero. The term expresses the importance of being heroes to one another and the importance of sacrifice for the common good. The word bayanihan signifies a communal spirit of volunteerism that enables completion of seemingly impossible task through the power of unity and cooperation. It is a very powerful concept of mobilizing united and well-coordinated activities.

There is also another story that I encourage all Alliances to choose to play a part in. It is the story of millions of citizens who

[1] Benilda D. Hizon, Office Coordinator,Kidney Associates of Kankakee County, Kankakee, Illinois USA and current President of President Illinois State Medical Society Alliance. The author is a Filipino Nurse from Burgos Ilocos Sur and a graduate of the UERMMMC-CN, BSN 1979. She sends this message which she shared during her induction. Editorial Board believes we can learn from her message, at the same time be proud of a Filipino nurse leading an Alliance of health professionals. (Edited due to space limitation).

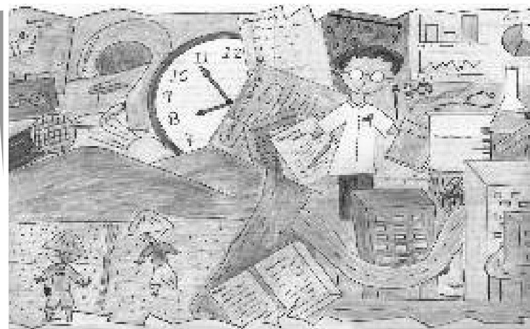
wake up each morning wondering where their next meal will come from. There are many people who survive from day to day, with no health care that sustain them. We all watched the Columbine and Virginia Tech tragedies unfold in front of our eyes. This is happening right here in suburban America and now rings close to home at Northern Illinois University. We have new initiatives designed to move our health promotion to the next level such as the kidney disease awareness and Stop America's Violence Everywhere (S.A.V.E.). Join the fight against this debilitating disease by holding educational campaigns to bring about more public awareness…Let us all be a part of the solution in teaching youth the skills they need to stop this cycle of violence…No one person can go "the miles alone" in meeting the needs of the organization. It takes each member reaching out to others to create the kind of learning and support network that has meaning. It is especially important that each member assume the task of positive outreach to others. I encourage each member to invite a friend or neighbor to come to your meeting. Let us all be a friend, a mentor or even a guide. Now is the time!

What do you want to see happening in your county activities? Seize the opportunity to make a positive impact. Let's leave footprints for us to remember and share for the future. There are many roles and tasks that need attention. What task or role do you want to assume? … If we coordinate our collective passions we will do great things together in the months and years to come. It is certainly exciting times ahead. Our journey will be fun, fulfilling and adventurous. You hold opportunity in your hands. Cherish it! For life is a journey, a celebration…a connection.

Revisiting CO-PAR*

by ***Rogelio C. Carreon Jr.****, MM, RN*
Center for Health Development-CAR

I had a short stint as a lecturer in COMDEV in one of the Universities in Baguio. In one of my class sessions, Dr. Erlinda Castro-Palaganas graciously accepted my invitation for her to share her perspectives on CO-PAR. I am aware that she was among those who conceptualized and developed the concept during our student days in Saint Louis University College of Nursing during the mid '80s to early '90s. I remember we called it then, the Health Resource Development Program, where we immersed in the community for a minimum of one week and back again. Not that I was not confident on what I will impart to my students, but I thought having the "guru" in research and CO-PAR will do more than just transfer the knowledge. I thought that my students at the University of the Cordilleras deserve to see and listen to a role-model. And I was not wrong in my objective.



CO-PAR through the eyes of Clarisse Bañaga

All the whole one hour and more that my students sat and listened to Ma'am Caster bubble with her theories and experiences, my students listened so intently, unmindful of the time. I asked my students to send in their reflections the next meeting, and alas, I was amazed with what I received. I particularly would like to share Ms. Clarisse Bañaga's insights, and her illustration. I know that she painstakingly made her assignment. More than the high mark that I gave her was the thought that she and all my other students are creative and intelligent. We only have to provide them the opportunities and proper motivation. Ms. Bañaga writes:

Any type of research we were taught, is done systematically following a step by step process. I thought that all researches are the same. Just like the majority, I was wrong. I came to know that there are several ways of conducting research. One can either approach research quantitatively or qualitatively. …I thought one hour to grasp the concepts related to CO-PAR may not be enough but listening to someone with so much experience, I didn't even realize that the time was over. I learned so much and I would like to focus on some realizations. We are concurrently going through our research course and it made me realize that what we are being taught is the conventional, quantitative type of research. I realized that the goal of conventional research is to develop and test theories and to produce knowledge generalizable to wide populations. The researchers primarily use professionally-developed instrument for accurate and precise data gathering administered to subjects. The researcher collects the data objectively, because it context free, the researcher being uninvolved in the research process. When the whole research is finished, that's the only time they act to solve the problem based upon the information they gathered.

I realized that CO-PAR is a type of qualitative research, the goal of which is to solve the problems/issues of local concerns. Using the CO process is empowering as it involves the people to analyze their situation. The researcher actively participates in the research process, assisting in the community organization. Together they collect data and do actions which are researched, changed and researched again thoroughly by being a participant. It involves understanding the context to be able to empower, is value-based and is an iterative (action-reflection-action) process. I came to know that aside from questionnaires as tools to gather information, focus group discussions and key informant interviews can also be very valuable…I like best what was said about CO-PAR that it "encourages people to formulate accounts and explanations of their situation, and to develop plans that can resolve these problems. I also like the idea that the researchers contribute their expertise alongside the people to meet their goals for the betterment of the whole community…."

I felt really good reading similar insights from my students. And after appreciating close to 50 reflection papers, it dawned on me that we need to revisit further the concept of CO-PAR. We have to do justice to the concept of CO-PAR: a challenge I pose not only to Colleges of Nursing but to all development workers.

**CO-PAR or Community Organizing-Participatory Action Research is a social development approach that aims to transform the apathetic, individualistic and voiceless poor into dynamic, participatory and politically responsive community. Developed to make health services accessible and available for depressed and underserved communities in the Philippines, it is an approach and/or framework where the BSN curriculum is hinged.*

PNA CHAPTERS ON THE GO!

Catandunganon Professional Nurses in Action in the fields of Nursing Education, Nursing Practice, Nursing Research and Nursing Administration

Catanduanes PNA Chapter of Region V

The Catanduanes PNA Chapter of Region V, is led by Goyeta G. Pereyra, *MHED, RN*, President since 2004. Together with the chapter officers and members, all throughout the year, they attend several local, regional, national and international conventions, seminars, workshops and other nursing fora. As nursing leaders, they keep afloat the chapter's active involvement in the PNA activities and projects and demonstrate commitment and dedication in their respective places of work as professional nurses.

The officers and members believe that nursing as an honorable calling is translated into working faithfully and patiently with clients, learning and doing things to the best of one's ability, if not towards perfection. Activities of the chapter expose the nurses to critical-thinking, problem-solving, and decision-making skills as direct care providers, coordinators of care, managers, educators or client advocates. Attendance to nursing research conferences and research dissemination activities as well as participation in various forms of researches contribute to the development of their nursing knowledge and provision of care.

As a social force, the chapter leaders and members work together and try to cooperate with whatever needs to be done. "We listen with our heart and hear with our soul, as we continue to pledge our commitment to people's health".

20th Regional Convention of Philippine Region III

The 20th Regional Convention of the Philippine Nurses Association in Region III was held on the 28th of November, 2008 at the Highlands Camp and Conference Center, Iba, Zambales. The event was hosted by Zambales-Olongapo City Chapter with the theme, "Unity among Filipino Nurses: The Commitment to Service." The convention aimed to enhance leadership skills, build capability and sound attitude among nurses to cope with challenges of present times. The highlights of the convention include the inspirational message and insights from Honorable Anne Marie C. Gordon, Vice Governor of Zambales and from the keynote speaker, Honorable Atty. Amor D. Deloso, Governor of Zambales. PRC Commissioner Ruth Raña-Padilla motivated and inspired the participants with her talk on "Leadership yesterday, today and tomorrow". Dr. Augusto Salonga, Training Director of Tarlac State University, delighted the nurses with his topic on "Developing Positive Attitudes and Upgrading Skills". Director Jesusa B. Censon de Leon, of Civil Service Commission, befittingly ended the convention with her challenge: "Nurses as Community Builders."

Behind the success of the convention were Elizabeth M. Millora, (Over-all chairperson); Isabelito A. Nabong (Registration); Edwina S. Basco and Loreto D. Escobar (Reception and Socials); Fernando R. Aquino (Program and Invitation); Evelyn R. Rubia (Evaluation); Merceditas R. Tiongson (Documentation); Edelmira S. Bajacan (Awards); Marrizza V. Dollosa, and Alma A. Herredura (Raffles). The PNA Regional Council is composed of Evelyn R. Rubia (Bataan), Merceditas R. Tiongson (Bulacan), Edelmira S. Bajacan (Nueva Ecija), Isabelito A. Nabong (Pampanga), and Fernando R. Aquino (Tarlac). Their hard work and commitment to people's health through strengthening their members contributed to the success of the entire event.

86th Foundation Anniversary, 51st Nurses Week

"NURSES: Delivering, Serving,

1. Revisit the implementation of Primary Health Care in the context of addressing the prevailing health problems in the country;
2. Unify the members of PNA on its stand regarding various issues affecting the delivery of quality health services: advocacy to protect th
3. Promote Best PHC Practice that have been participated by Filipino nurses in various community settings public health, occupational he
4. Enhance the leadership of Filipino nurses in making significant contributions to attain "Health in the hands of the people" (PHC vision).

Celebration and National Annual Convention!

Leading Primary Health Care"

ne nurses' human rights and general welfare, migration of Filipino nurses and other policies affecting nursing practice.
ealth, primary health facilities, health promotion and health education, health advocacy and campaigns, community health organizing, etc; and

A Glimpse of Nursing Specialty Groups

Members of the Manabayukan community, home of Aetas, in Capas, Tarlac, join the CNGP Board in an outreach activity.

The Catholic Nurses' Guild Of The Philippines: Member, International Committee of Catholic Nurses

The Catholic Nurses Guild of the Philippines (CNGP) is a non-profit, non-political and self-governing association of Catholic Nurses in the Philippines founded in 1957. All Catholic registered nurses and senior student nurses of duly recognized nursing colleges in the Philippines can be members. Its **Life Purpose** is to proclaim gospel values as Catholic Nurses; envisions CNGP as **"a living witness to Christ's love"** by its **Mission** to: Promote spiritual, ethico-moral and professional growth as health care providers; Participate actively in the deliberation of issues affecting life; Strengthen relationships with local and international health agencies/organizations/schools; and Render socio-pastoral care to all our stakeholders.

The CNGP is currently led by dynamic leaders with integrity: Lucia V. Soltes, RN, MM (*President);* Shirley Peña, RN, MAN, *Vice President;* Marina Modina, RN, *Secretary;* Susan Castañeda, RN, *Asst. Secretary;* Lilia Eufemio, RN, MAN, *Treasurer,* Emerita Dacanay, RN, *PRO;* Emerita Panaligan, RN, *Auditor and* Doris Escalante, RN, Catalina Mata, RN, MAN, Lorena E. Abiera, RN, Sr. Ana Virginia Magpily, SSPS, MAN, Julia Basobas, RN, MSM, Ma. Luisa T. Uayan, MSN, DHSC, *Board Member* Ex-Officio Lita Batista, RN.

The CNGP has projects/programs geared toward pastoral care of patients (Catholics or Non-Catholics) and welfare of nurses. We offer seminars/lecture series, join medical missions and outreach programs to depressed communities. It adopted community in Capas, Tarlac called Manabayukan (where aetas live). On May 3, 2008, the Board distributed some of basic supplies with their partner community, (school supplies, slippers, soap, old clothes, etc.) reaching out to 33 out of 48 families or a total of 168 individuals. This activity was a collective endeavor of the Guild, with support (donation of cash and material goods) coming from the many chapters in the different hospitals/institutions.

The CNGP, in partnership with the community, has many plans that may contribute to the well being of the people. These plans include livelihood programs, spiritual enlightenment, health teachings among others. These, CNGP hopes to accomplish with the help of God.

The Renal Association of the Philippines

The Renal Association of the Philippines' (RAP) vision is "to present a professional atmosphere through teamwork, dedication, communication, leadership and pride of the member". Its mission statement is "to advance the professional development of the registered nurses practicing and interested in nephrology, transplantation and related therapies and to promote the highest standards of patient care". Led by Raquel Z. Tejada of the Philippine Health Center (PHC) as President, the RAP is a power-packed organization that continuously provide professional education to nurses all over the country. Sharing

RAP Officers 2008 take their Oath as they lead one of the most active and responsive specialty group in the country.

NEXT PAGE

The Essence of APDNPP

The Association of Private Duty Nurse Practitioners, Philippines (APDNPP) conceived 33 years ago in 1975. Since then, the Association has maintained a strong and reliable group of well-trained and qualified nurses in private nursing practice. Registry comes from different hospitals in Metro Manila and from the provinces. Thus, members abide with the standards and policies of their Chapter hospitals. Seminars and updates are conducted by the Association three times a year or as necessary. Respected and excellent resource persons are invited to share their expertise on relevant topics. Good response from the members and non-members is evident in the good attendance. The enthusiasm is high among them to absorb what is essential in the present trend in nursing practice.

To balance all these demanding responsibilities, the ADPNPP holds an annual sportsfest for mental and physical fitness and bonding. The Association also sends groups of nurses on medical missions, community and volunteer works.

Contrary to public perception that private duty nurses cater only to the elite and rich patients, the APDNPP members reach out to all patients in need of their nursing care. Thus, the well-trained, knowledgeable and professional private duty nurses gained the respect of doctors, co-workers, patients and their families as well. It assures the public of the best nursing care to anyone who needs it.

As a final note, APDNPP shares an important role in medical tourism as well as in striking a balance in the health care industry's supply and demand between workforce and service. *(Louella H. Duque and Margareth A. Lavadia)*

A GLIMPSE OF NURSING...

the leadership with Ms. Tejada are: Elizabeth M. Naco of the Asia Renal Center (Vice President), Brenda Z. Manalo, National Kidney & Transplant Institute (Secretary), Manalo Christian Noel A. Lamen, PHC (Treasurer), Flora E. Reyes, Asia Renal Care (Auditor), Maria Ginabelle B. Guina, AFP Medical Center (PRO); Board of Directors are: Felipa A. Abanador of the Daniel Mercado Medical Center, Fe M. Icban of Arellano University; Eusebio T. Alvarado III; Merciditas V. Jonson; and Ma. Nisan T. Manauis of the NTKI; Rowena M. Borro of the Therapy Mgmt Service; Aileen B. Dangani, PNP General Hospital; Ronald V. Marcel o of the Bayani Consulting Network Inc; Teresita Z. Dulay of the PGH and Ma. Isabel R. Matta, Kidney Solution Inc. The RAP's election concerns are taken cared of by Claudio T. Balles (NKTI), Noli F. Fiedacan (PHC) and Paulo F.Jacinto (PNP General Hospital). Valuable wisdom comes from its advisers: Jane MN. Sta. Ana, R.N., MAN, Angelita B. Borromeo, R.N., and Nerissa V. Mendoza-Gerial, RN, MHA, FPCHA Nerissa V. Mendoza-Gerial, RN, MHA, FPCHA, NKTI's Former Deputy Director for Nursing Service and Former Assistant Director for Nursing Service respectively.

COMMISSION ON THE SOCIAL DETERMINANTS...

social policies but they will be a fundamental result. Take the central policy importance given to economic growth: Economic growth is without question important, particularly for poor countries, as it gives the opportunity to provide resources to invest in improvement of the lives of their population. But growth by itself, without appropriate social policies to ensure reasonable fairness in the way its benefits are distributed, brings little benefit to health equity.

Traditionally, society has looked to the health sector to deal with its concerns about health and disease. Certainly, maldistribution of health care not delivering care to those who most need it is one of the social determinants of health. But the high burden of illness responsible for appalling premature loss of life arises in large part because of the conditions in which people are born, grow, live, work, and age. In their turn, poor and unequal living conditions are the consequence of poor social policies and programmes, unfair economic arrangements, and bad politics. Action on the social determinants of health must involve the whole of government, civil society and local communities, business, global fora, and international agencies. Policies and programmes must embrace all the key sectors of society not just the health sector.

That said, the minister of health and the supporting ministry are critical to global change. They can champion a social determinants of health approach at the highest level of society, they can demonstrate effectiveness through good practice, and they can support other ministries in creating policies that promote health equity. The World Health Organization (WHO), as the global body for health, must do the same on the world stage.

Closing the health gap in a generation

The Commission calls for closing the health gap in a generation. It is an aspiration not a prediction. Dramatic improvements in health, globally and within countries, have occurred in the last 30 years. We are optimistic: the knowledge exists to make a huge difference to people's life chances and hence to provide marked improvements in health equity. We are realistic: action must start now. The material for developing solutions to the gross inequities between and within countries is in the Report of this Commission.

For more information, visit www.who.int/social_determinants/en/.

PRESIDENT'S REPORT

July to December 2008

The achievements of the Philippine Nurses Association (PNA) for the period July to December 2008 which I spearheaded as the National President have paved the way for the improved image of Filipino nurses in many aspects. These even served as the unifying factor for many nurses to work harmoniously among themselves for the betterment of their services to the ***people*** whom they regard as ***partners in health***.

Uplifting and Protecting the Integrity of the Nursing Profession

The remaining months of this year were spent by the PNA in strengthening its internal capabilities, as well as in sustaining its advocacy to achieve its legitimate demands for better working conditions for its members and improved quality of health services for their clients.

The Board of Governors met last September 16-17 and October 18 - 19 to discuss and address the many challenges confronting nurses in the different regions. This includes the Continuing Campaign for the implementation of Republic Act 9173's provision for Salary Grade 15 for government nurses, the full implementation of benefits under the Magna Carta of Public Health Workers, the unemployment / underemployment among nurses pushing them to accept the exploitative “volunteerism/On-the-job training” schemes of some hospitals, and the demoralizing effects of poor health care delivery system secondary to understaffing problems among nurses and inadequate health budget.

PNA's successful 86th Foundation Anniversary and 51st Nurses Week Celebration during its National Convention held last October 21-23, 2008 in Tent City, Manila Hotel that focused on the theme ***“NURSES: Delivering, Serving and Leading Primary Health Care”***. Well-known experts in Primary Health Care led by its Keynote Speaker Dr Jaime Galvez Tan revisited the role of Filipino nurses in the realization of Primary Health Care in the country.

During this occasion, the PNA commemorative plate entitled **“NURSE”** approved and signed by the LTFRB and the PNA President has been introduced to the members of the organization, as well as to other nurses. The owner of the car using this commemorative plate is exempted from “color coding” restriction between October 2008 to December 2009. The nurses are proud in using this commemorative plate because of the special recognition that the owner of the car is a nurse.

The Assembly of Nursing Representatives (ANR) led by its Chairperson Noel Cadete deliberated and approved amendments in the Bylaws of the PNA last October 22, 2008 in Manila Hotel.

PNA received the recognition as the Outstanding National Health Provider Organization from the Council of Health Agencies of the Philippines (CHAP) last September 30, 2008. The award acknowledges the visibility nationwide as a concerned Accredited Professional Organization (APO) consistently protecting the rights and general welfare of the Filipino nurses.

During this period also, the PNA began its partnership with the Manila Times led by Dr. Dante Ang in crafting another noble award for deserving Filipino nurses who have done exemplary services in various fields of community work, teaching, clinical and/or hospital setting, research, health management and other fields. This award which will be called **The Magiting na NARS Award** will be launched in public on the 1st quarter of 2009.

Strengthening Organizational Capacity of PNA Toward More Responsive Services

In its desire to be accessible to as many nurses as possible, PNA has signed an agreement with the Union Bank to facilitate an On-Line Business where PNA local chapters and individual members can pay their membership fees online through the Union Bank. This mechanism will not only save time and moneys of local chapters, indeed, even remittance of chapter share from PNA national office to the chapters will be easier.

In addition, the board passers of June Nursing Licensure Examinations (NLE) were assisted by the PNA in their oathtaking ceremonies held last August 19-20, 2008 in the Mall of Asia.

From July 1 to December 31, 2008, the PNA had an additional 65,956 members of which 19,009 are Life Members and 46,947 are Regular Members. Thus, the total number of PNA members for the whole year of 2008 is 104,366 of which 19,618 are Life Members and 104,366 are Regular Members.

During the PNA Christmas Party last December 3, 2008, the PNA awarded Dr. Dante Ang and Dr. Jaime Galvez Tan honorary membership to the organization (PNA) for their exemplary contributions and support for Filipino nurses.

In the field of Nursing Practice, the following capability-building activities were launched by PNA under the leadership of Ms. Delia Ramos. **(1)** The second Training of Trainers on the Care and Control of Tuberculosis and Multi-Drug Resistant (TB-MDR) Tuberculosis in Health Care Facilities held last September 8-12, 2008 in Bayview Park Hotel in collaboration with the International Council of Nurses (ICN); and **(2)** Trainers were trained on Community-Based Disaster Management (CBDM) last August 8 10, 2008 and organized Disaster Committees and Quick Reaction Teams among nurses in coordination with the Philippine National Red Cross(PNRC), Armed Forces of the Philippines (AFP) and the Citizen's Disaster Response Center (CDRC).

The Department of Nursing Research chaired by Dean Roberto Sombillo began developing the research tool for the

nationwide Study on Compensation of Filipino Nurses nationwide. With the help of Dr. Federico Macaranas and his Research Team, a seven-month research action plan was drafted to ensure that the findings of the study will be ready for dissemination by May 2009 in time with the celebration of the 2009 International Nurses Day and the International Labor Day.

Meanwhile, PNA regularly conducted series of Continuing Professional Education (CPE) seminars to sharpen the competencies of our Filipino nurses. A total of 27 CPEs attended by 7,471 nurses were conducted in the last six months of 2008. These include topics on Basic Infection Control Course, Nursing Skills Fair and Advanced Cardiac Life Support. Chairperson Ms.Belle Rogado. of the Needle stick and sharp injuries (NSI) Committee proposed a "self-liquidating project" concept of the NSI Prevention activities which will initially be orientation-seminars among nurses and nursing students and lead to policy advocacy and Training of Trainers.

The Department of Political Affairs actively chaired by Ms. Leny Nolasco led major mobilizations of nurses to advocate for the nurses' basic economic and political rights as health professionals taking care of the health of millions of Filipino people. Among these are the following:

(1) **Kick-Off Activities: Press Conference in PGH Conference Room 8th Floor, Noise Barrage/ green armband wearing infront of PGH and Launching of Signature Campaign last July 24, 2008.** These concerted actions of nurses have caught the interest of mass media, the general public and the concerned government agencies to look into the plight of Filipino nurses. PNA Chapters in different provinces also launched sustained actions such as local press conferences, symposia, armband wearing, and streamer hanging advocating "Salary Grade 15 for NURSES NOW!" Thousands of nurses all over the country, signed in the PNA's petition for salary increase and better work conditions.

(2) **State of the Nurses Address (simultaneous with President Gloria Macapagal-Arroyo's State of the Nation Address or SONA) last July 28, 2008:** Some 300 nurses from different hospitals and institutions joined the SONA multisectoral march to expose the plight of nurses and its impact to the overall deteriorating health care system. PNA criticized the government's "all out policy" to encourage migration of Filipino nurses to other countries without generating local jobs opportunities with just compensation.

(3) **Nurses' Delegation to the Department of Budget & Management (DBM) last September 11, 2008.** PNA delegates went to DBM to reiterate its position for the implementation of Salary Grade 15 for nurses as mandated in the Republic Act 9173 known as the 2002 Nursing Law. Learning from DBM that there is a Joint Resolution 24 filed in the Congress for the passing of Salary Grade III, the PNA reminded the government's obligation to immediately implement RA 9173 and Magna Carta of Public Health Workers that will give economic relief to health workers.

(4) **Motorcade to Congress (From Welcome Rotonda) on October 8, 2008.** More than 300 nurses and health workers joined the motorcade and showed their unity in advocating for their right to decent living wage by calling on the concerned government bodies to implement the Nursing Law 2002 that mandates SG 15 for Nurse 1 position. Copies of the PNA position paper were distributed in the offices of the Congressmen to get their support for this particular campaign.

(5) **Delegation March from Sandiganbayan to Congress last December 8, 2008.**
About 150 nurses and health workers marched from Sandiganbayan to Congress in their white uniforms to gain public support for their legitimate demand for decent living wage while they take care of the health needs of their country men. Cong. Carlos M. Padilla, Cong. Teofisto Guingona, III, Cong. Rafael V. Mariano of AnakPawis Partylist and Cong. Junie E. Cua of Committee on Appropriations expressed support to PNA's call for the implementation of RA 9173 and RA 7305. They promised to study the implications of the proposed SSL III (Joint Resolution 24) and ensure that the existing Magna Carta benefits of nurses are not be sacrificed.

(6) Continued assertion for a just and humane work conditions for nurses who will be recruited for Japan under the recent passage of JPEPA treaty.

Participation in International Conferences

At the International level, PNA participated in seven major conferences: **(1)** NGO Consultation-Workshop for the International Conference on Gender, Migration and Development last September 9, 2008; **(2)** 1st International Asia-Pacific Nursing Research Conference last September 4-5, 2008; **(3)** 59th Session of WHO Regional Committee for Western Pacific last September 22-26, 2008; **(4)** International Conference of the International Alliance of Migrant Workers and Refugees (IAMR) held in Bayview Hotel last October 27 30, 2008; **(5)** Symposium on "Ethical Recruitment of Filipino Nurses" organized by government officials and nurses' organizations in Saskatchewan, Canada last November 12-14, 2008; **(6)** 9th ICN Asia Work Force Forum (AWFF) held in Taipeh, Taiwan last November 26-27, 2008; and **(7)** 5th Alliance of Asian Nurses' Associations (AANA) also in Taipeh, Taiwan last November 28, 2008.

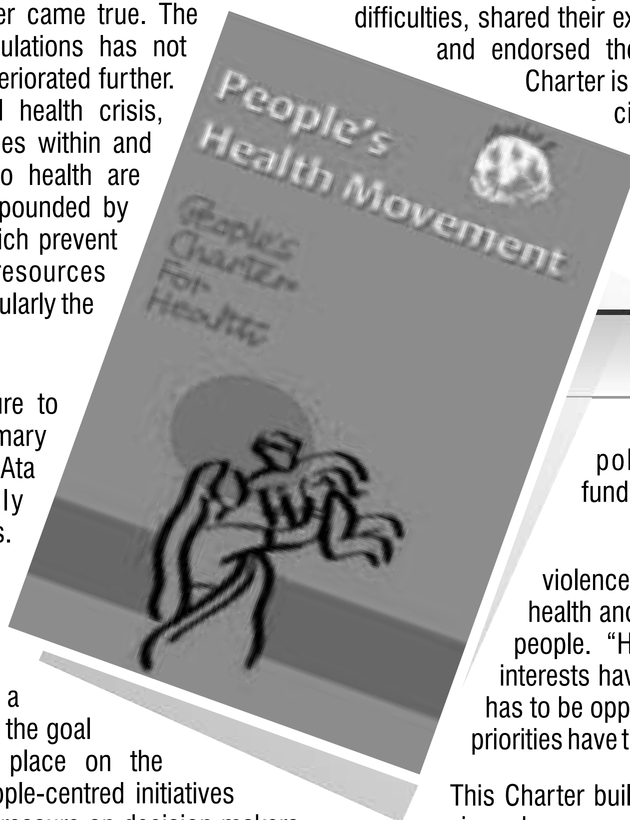
The voices of the Filipino nurses will continuously be represented by the PNA as it strongly asserts for an improved health care system where nurses remain to be the critical force in terms of commitment, competence and compassion in service!

BOOKS ON PHC AND PUBLIC HEALTH

THE PEOPLE'S CHARTER FOR HEALTH

In 1978, at the Alma-Ata Conference, ministers from 134 countries in association with WHO and UNICEF called for 'Health for All by the Year 2000' and selected Primary Health Care as the best tool to achieve it.

Unfortunately, that dream never came true. The health status of Third World populations has not improved. In many cases it has deteriorated further. Currently, we are facing a global health crisis, characterized by growing inequalities within and between countries. New threats to health are continually emerging. This is compounded by negative forces of globalization which prevent the equitable distribution of resources necessary for people's health, particularly the poor.



Within the health sector, failure to implement the principles of primary health care as set out in the Alma-Ata declaration, has significantly aggravated the global health crisis. Governments and the international community are fully responsible for this failure.

It is now essential to build a concerted international effort to put the goal of *Health for All* in its rightful place on the development agenda. Genuine, people-centred initiatives must be strengthened to increase pressure on decision makers, governments and the private sector to ensure that the vision of Alma-Ata becomes a reality.

Several international organizations and civil society movements, non-governmental organizations (NGOs) and women's groups decided to work together towards this objective. This group, together with others committed to the principles of primary health care and people's perspectives organized the People's Health Assembly, which took place on December 4-8, 2000 in Savar, Bangladesh at the Savar, on the campus of Gonoshasthaya Kendra (GK - People's Health Centre).

One thousand four hundred fifty-three (1,453) participants from 92 countries came to the Assembly which was the culmination of 18 months of preparatory action around the globe. The preparatory process elicited unprecedented enthusiasm and participation of a broad cross section of people who have been involved in thousands of village meetings, district level workshops and national gatherings.

At the Assembly, they reviewed their problems and difficulties, shared their experiences and plans, and formulated and endorsed the People's Charter for Health. The Charter is now the common tool of a worldwide citizens' movement committed to making the Alma-Ata dream a reality. We encourage and invite everyone who shares our concerns and aims to join us by endorsing the Charter.

The People's Health Charter's Preamble states that:

Health is a social, economic and political issue and above all a fundamental human right.

Inequality, poverty, exploitation, violence and injustice are at the root of ill-health and the deaths of poor and marginalized people. "Health for All" means that powerful interests have to be challenged, that globalization has to be opposed, and that political and economic priorities have to be drastically changed.

This Charter builds on perspectives of people whose voices have rarely been heard before, if at all. It encourages people to develop their own solutions and to hold accountable local authorities, national governments, international organizations and corporations.

The vision enshrines "Equity, ecologically-sustainable development and peace are at the heart of our vision of a better world a world in which a health life for all is a reality; a world that respects, appreciates and celebrates all life and diversity; a world that enables the flowering of peoples' talents and abilities to enrich each other; a world in which people's voices guide the decisions that shape our lives. There are ample resources to achieve this vision".

The principles of the Charter states that:

The attainment of the highest possible level of health and well-being is a fundamental human right, regardless of a person's

color, ethnic background, religion, gender, age, abilities, sexual orientation or class. The principles of universal, comprehensive Primary Health Care (PHC), envisioned in the 1978 Alma Ata Declaration, should be the basis for formulating policies related to health.

Now more than ever an equitable, participatory and intersectoral approach to health and health care is needed. Governments have a fundamental responsibility to ensure universal access to quality health care, education, and other social services according to people's needs, not according to their ability to pay.

The participation of people and people's organizations is essential to the formulation, implementation and evaluation of all health and social policies and programmes.

Health is primarily determined by the political, economic, social and physical environment and should, along with equity and sustainable development, be a top priority in local, national and international policy-making.

This Charter calls on people of the world to:

Build and strengthen people's organizations to create a basis for analysis and action.

Promote, support and engage in actions that encourage people's involvement in decision-making in public services at all levels.

Demand that people's organizations be represented in local, national and international forums that are relevant to health.

Support local initiatives towards participatory democracy through the establishment of people-centered solidarity networks across the world.

For more information, please visit **http://phmovement.org/cms/**

THE GLOBAL HEALTH WATCH

Global Health Watch is a collaboration of leading popular movements and nongovernmental organizations comprising civil society activists, community groups, health workers and academics. It was initiated by the People's Health Movement, Global Equity Gauge Alliance and Medact. It has compiled the second edition of its alternative world health report a hard-hitting, evidence-based analysis of the political economy of health and health care as a challenge to major global bodies that influence health. Its monitoring of institutions including the World Bank, the World Health Organization and UNICEF reveals that while some important initiatives are being taken, much more needs to be done to have any hope of meeting the UN's health related Millennium Development Goals.

GHW2's content includes

Introduction

A: ***Alternative Paradigm for Development***

B: ***Health Care Sector***

1. Health systems advocacy 2. Mental Health: Culture, Language and Power 3. Access to healthcare for migrants and asylum seekers 4. Prisoners 5. Medicines

C: ***Beyond health care***

1. Carbon Trading and Climate Change 2. Terror, war and health 3. Reflections on Globalization, Trade, Food and Health 4. Urbanisation 5. The Sanitation and Water Crisis 6. Oil Extraction and Health in the Niger Delta 7. Humanitarian Aid 8. Education - update

D: ***Watching***

1. Global Health Governance 2. Government Aid 3. TNC's

E: ***Pockets of Resistance***

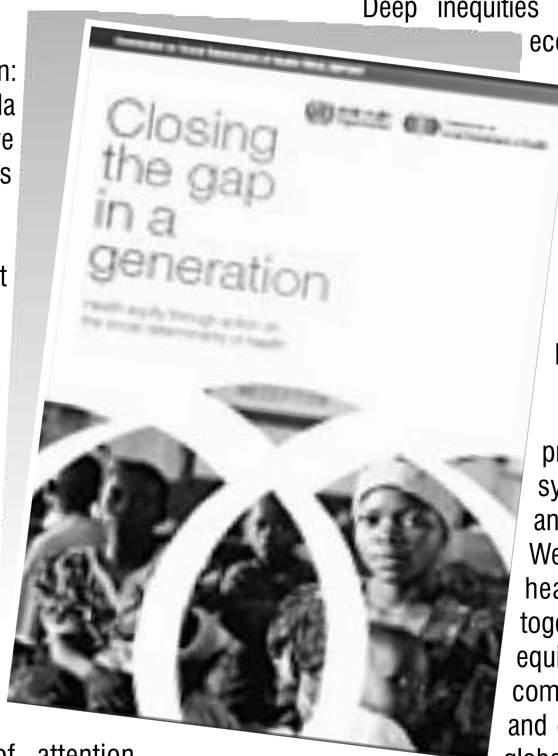
If you have not gotten hold of a copy of the book, you can download http://www.ghwatch.org/ .

COMMISSION ON THE SOCIAL DETERMINANTS OF HEALTH

The report of the WHO Commission on Social Determinants of Health clearly highlights the severity of the crisis in global health and health equity, the moral imperative of tackling this crisis, and the considerable scope and radicalism of the measures this requires. Specific recommendations are of a much more limited nature, probably because of the constraints of its mandate.

The report was launched 28th August 2008 by Dr. Margaret Chan, Director General, WHO in Geneva, saying that "*Health inequity really is a matter of life and death*" Margaret Chan. The commission calls for the need for more health equity because *"it is right and just",* human rights and social justice; quality and distribution of health seen as a judge of the success of a society and empowerment as a central objective.

In a nutshell, the CSDOH calls on: Putting SDOH on international health agenda and encourage action on them; Improve health globally; and Reduce health inequities within and between countries.



The Executive Summary of the Report (page 1) states:

The social determinants of health and health equity

The Commission, created to marshal the evidence on what can be done to promote health equity and to foster a global movement to achieve it, is a global collaboration of policymakers, researchers, and civil society led by Commissioners with a unique blend of political, academic, and advocacy experience. Importantly, the focus of attention embraces countries at all levels of income and development: the global South and North. Health equity is an issue within all our countries and is affected significantly by the global economic and political system.

The Commission takes a holistic view of social determinants of health. The poor health of the poor, the social gradient in health within countries, and the marked health inequities between countries are caused by the unequal distribution of power, income, goods, and services, globally and nationally, the consequent unfairness in the immediate, visible circumstances of peoples lives their access to health care, schools, and education, their conditions of work and leisure, their homes, communities, towns, or cities and their chances of leading a flourishing life. This unequal distribution of health-damaging experiences is not in any sense a 'natural' phenomenon but is the result of a toxic combination of poor social policies and programmes, unfair economic arrangements, and bad politics. Together, the structural determinants and conditions of daily life constitute the social determinants of health and are responsible for a major part of health inequities between and within countries.

The global community can put this right but it will take urgent and sustained action, globally, nationally, and locally. Deep inequities in the distribution of power and economic arrangements, globally, are of key relevance to health equity. This in no way implies ignoring other levels of action. There is a great deal that national and local governments can do; and the Commission has been impressed by the force of civil society and local movements that both provide immediate local help and push governments to change.

And of course climate change has profound implications for the global system how it affects the way of life and health of individuals and the planet. We need to bring the two agendas of health equity and climate change together. Our core concerns with health equity must be part of the global community balancing the needs of social and economic development of the whole global population, health equity, and the urgency of dealing with climate change.Health equity must be part of the global community balancing the needs of social and economic development of the whole global population, health equity, and the urgency of dealing with climate change.

A new approach to development

The Commission's work embodies a new approach to development. Health and health equity may not be the aim of all

TURN TO PAGE 39

The Philippine Journal of Nursing is the official journal of the Philippine Nurses' Association published biannually. It considers original articles written for Filipino nurses at all levels of the health care organization and in various settings. The Philippine Journal of Nursing will serve as:

1. Venue for the publication of scientific and research papers in the areas of Nursing practice and Nursing education,
2. Source of updates on policies and standards relevant to Nursing practice and Nursing education, and
3. Medium for collegial interactions among nurses to promote professional growth.

The Philippine Journal of Nursing invites original research and scientific papers, full text or abstract, written by professional nurses on areas of nursing practice and education.

Please submit two copies of manuscript, which should not be more than ten pages. Submission must be typed, double spaced on the 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 F.T. Benitez St. Manila, Philippines or send through email philippinenursesassociation@yahoo.com

The article should have a main title with subheadings to indicate the subdivisions in the text. Research articles should have the following parts: Introduction, Methodology, Results and Discussion. Abbreviations and acronyms should be spelled out. Photo of the author as well as photos that highlight article content maybe submitted. Black and white photos are preferred. Drawings and graphs should be clear.

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Theme for January-June 2009:
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Theme for July-Decmeber 2009:
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PNA HYMN

We pledge our lives to aid the sick
To help and serve all those in need
To build a better nation that is healthy and great

We’ll bring relief to every place
In towns and upland terraces
In plains and hills and mountains
We shall tend all those in pain

Beneath the sun and stormy weather
We shall travel on
To heed the call that we must be there
With our tender care

We pray the Lord to guide our way
To carry on our work each day
And grant us grace to serve the sick
And love to help the weak

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