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TRANSFORMING GLOBAL HEALTH CARE THROUGH LEADERSHIP IN NURSING

Sheila R. Bonito, RN, MAN

Leadership and advocacy are important roles that nurses need to take on to be able to address the challenges facing the profession and to effect change towards better quality of care and higher standards of nursing education.

In the 4th International Conference organized by Philippine Nurses' Association, Inc. and Philippine Nurses Association of America, Inc. held last January, nurses from the Philippines and the United States were able to discuss the pressing issues that concern the nursing profession today. These issues range from changing health care scenario, advanced practice nursing, information technology in health care to global nursing shortage.

In this issue of Philippine Journal of Nursing, we have included papers that bear witness to the need for nurses to be leaders and to be instruments of change. We have also included papers that are evidence of nurses taking on the lead, advocating for health and quality of life.

President Gloria Macapagal-Arroyo, in her keynote address delivered by Hon. Ignacio R. Bunye during the International Conference, affirmed that nurses' clamor for transformation through leadership is shared by other sectors in society, and that transforming the system is the prime requisite before any real progress can take place.

Dr. Lucille Joel, in her presentation during the same conference, stressed that it falls on nurses to provide leadership among their own and on behalf of the people they serve. She said that without leadership, there is no vision, resulting in a vacuum. In her own words, "*We need leaders who have vision and who makes each one of us more comfortable with power.*"

Nurses can show evidence of leadership through their advocacy work. Some of these evidence include the projects on integrating health and wellness in elementary curriculum, developing a training manual for health workers in promoting healthy lifestyle in the community, and enhancing competencies of nurses and midwives in taking the blood pressure measurements and screening for hypertension.

Leadership is also about looking back at our roots and acknowledging the legacies of persons such as Dean Julita V. Sotejo, who was the prime mover for the college of nursing in a university setting. We also recognize the inspirations of the present such as Mrs. Maria Rita Villanueva-Tamse, who is the Outstanding Nurse for the year 2004.

Some interesting papers on intercultural management and caring with compassion for patients with AIDS and rabies are also included as areas of nursing research and practice where nurses can lead as well. Leadership is also looking for potentials in the future, so we feature thesis paper of graduate students on caring for older persons and caring for women.

Leadership abides in the people themselves, in their unity and faith in each other, and in their hard work and fortitude.

KEYNOTE ADDRESS OF PRES. GLORIA MACAPAGAL-ARROYO

(delivered by)
Hon. Ignacio R. Bunye

Magandang umaga sa inyong lahat, binabati ko ang lahat ng dumalo dito sa 4th International Nursing Conference ng Philippine Nurses Association of America, Incorporated at Philippine Nurses Association, Incorporated.

Tunay na maipagmamalaki natin ang mga Filipino Nurses, sila ay kilala sa buong mundo hindi lamang sa pagiging mapagmalasakit sa kanilang mga pasyente kundi gayundin sa kanilang dedikasyon sa trabaho at propesyonalismo.

Sa Asian leaders' summit on the fight against SARS sa Bangkok, Thailand noong nakaraang taon, mismong si Prime Minister Goh Chok Tong ng Singapore ang nagpatunay sa kadakilaan ng ating nurses at iba pang mga manggagawa sa kanilang bansa. Kahit malakas ang banta ng SARS noon, tuloy-tuloy ang kanilang pag-aalaga ng mga pasyeste sa mga ospital. Ang papuring ibinigay ni Prime Minister Goh Chok Tong sa ating mga nurses ay isang malaking karangalan para sa ating bansa na lalong nagpatingkad sa pagkilala sa katangian ng mga Pilipinong nagtratrabaho sa ibayong dagat. Bukod sa karangalang ito, nais ko ring bigyang pugay ang inyong malaking kontribusyon tungo sa pagpapaunlad ng ekonomiya ng ating bansa. Kaya naman,

naniniwala rin ako na dapat lamang na gantihan ng pamahalaan ang inyong tulong.

Of course, the greatest gift that your government can offer in return for your sacrifices is winning the fight against poverty, since this was primarily the reason for your venturing overseas away from your loved ones. That fight is now being won through reforms that aim to give our people better economic and social opportunities to improve their lives. These opportunities include broader access to basic services and improved health care for all, especially the poor, because they are the most vulnerable to illness. And I take pride in the

accomplishments we have made in this regard that have surpassed those of previous administrations.

Allow me to share with you my thoughts regarding your theme for this year's conference: "Transforming Global Healthcare through leadership", particularly on our local policy directions regarding healthcare. Your sector's clamor for transformation through leadership is shared by other sectors of our society, and I firmly believe that transforming the system is the prime requisite before any real progress can take place.

Sa ilalim ng aking administrasyon, ginagawa natin ang lahat para repormahin ang sistema ng pamamahala upang ito ay mas mabilis na makatugon sa mga pangangailangan ng mga karaniwang mamamayan. Ang hangad natin ay mabilis, matapat at mapag-unawang serbisyo sa lahat ng tao sa lahat ng dako. Nais kong gamitin ang pagkakataong ito upang banggitin ang ilan sa ating mag bukod-tanging tagumpay, partikular na sa larangan ng kalusugan.

Noong nakaraang taon lamang umabot sa 9.9 bilyong piso ang ating inilaang badyet para sa health sector. Sa kasalukuyan, mahigit sa 44 milyong katao na ang kasali sa Philhealth Insurance Program. Ito ay katumbas ng mahigit sa 54% ng kabuuan ng ating populasyon. Ibig sabihin nito, mahigit sa kalahati sa ating sambayanan ang mabibigyan ng tulong sa kanilang gastusin para sa pagpapagamot. Inilunsad na rin natin ang rehistrasyon ng mga retirado at mga pensionado sa ilalim ng programang ito upang lalong dumami ang mabibigyan ng benepisyong pangkalusugan.

Sa ilalim ng "GMA 50" O Gamot na mabisa at abot-kaya program" ng pamahalaan, naibaba natin sa halos kalahati ang presyo ng maraming pangunahing gamot. Kasama dito ang apatnapu't dalawang (42) parallel imported drugs na anti-hypertensives, antibiotics, anti-asthma at anti-diabetes. Ang mga gamot na ito ay mabibili natin sa may dalawangdaang (200) mga ospital ng gobyerno at walongdaang (800) botika ng barangay sa ibat-ibang bahagi ng ating bansa.

Sa pamamagitan ng DOH at mga kaalyadong organisasyon nito, pinalawak din natin ang mga proyekto hinggil sa Family Planning at Reproductive Health, ang Garantisadong Pambata, Women's Health and Safe Motherhood, Environmental Health and Hygiene, at pag-puksa ng malubhang sakit tulad ng kanser, diabetes, at sakit sa puso.

Sa ating pinalakas na kampanya laban sa droga, ang bilang ng mga nahuling drug lords at pushers ay pinakamarami sa ating kasaysayan.

In the past six months, we have raided and dismantled 18 Shabu Laboratories, warehouses and other storage facilities. We have seized 13 billion pesos worth of shabu thus far. We have

also cleared more than 3,500 barangays of pushers and users; 143 local drug groups have been put out of action. The street price of drugs has climbed threefold and we will push it higher by curtailing the supply. Drug-related crimes are down. We now have a brighter prospect of achieving the full deliverance of our nation from the disastrous effects of illegal drugs and the malignancy of narco-politics being propagated by drug syndicates. The anti-drug campaign is also part of the security of our country and is needed to ensure investments to create jobs and give the average Filipino the opportunity to move ahead and to protect his family.

Bukod sa usaping pangkalusugan, marami na ring naging bunga ang ating ipinatutupad na mga reporma sa larangan ng ekonomiya at kaunlarang panlipunan. Sa unang pagkakataon, 90% ng mga barangay sa buong kapuluan ay ating nabigyan na ng koryente, nakapagpatayo tayo ng mahigit animnaraang (600) bagong eskwelahan sa mga komunidad na walang paaralan. Ang ating programang pabahay ay masasabing pinakamalawak na programang pabahay sa alinmang administrasyon. Hindi rin matatawaran ang pakinabang na naidudulot ng ating roll-on/roll-off nautical highway. Bukod sa maginhawang paglalakbay ng ating mga kababayan, nakakabawas na rin ito ng treinta porsyento ng gastos sa pagbibiyahe ng mga produkto mula Mindanao patungong Luzon. Ito ay nangangahulugan ng mas malaking kita ng mga magsasaka at mangingisda at mas mababang presyo naman sa mga mamimili. Ang lahat ng ito ay mga halimbawa ng magagawa natin kung determinado at tapat ang liderato sa pagbabago.

We are fighting for change and I am determined to bring this nation together through the strength of my leadership. But leadership also abides in the people themselves, in their unity and their faith in each other, in their hard work and fortitude and in their fight for change.

Nagkaroon na tayo ng magandang simula dahil sa mga pagbabago na ating inilunsad mula noong 2001, subalit marami pa ang kailangan nating gawin. Ito ang dahilan kung bakit hinihiling ko ang patuloy na pagsuporta ng ating mga kababayan upang itaguyod ang ating mga pagkilos tungo sa pagbabago at pagkakaisa, sa reporma at rekonsilyasyon. Sa pamamagitan ng inyong tulong at ng ating sama-samang pagkilos, kaya nating makamit ang tunay na kapayapaan at kaunlaran para sa ating bansa.

Sa inyong lahat, hangad ko ang tagumpay ng inyong komperensiyang ito, at makasisiguro kayo sa aking patuloy na suporta tungo sa lalong ikabubuti ng inyong sektor.

Mabuhay kayong lahat.

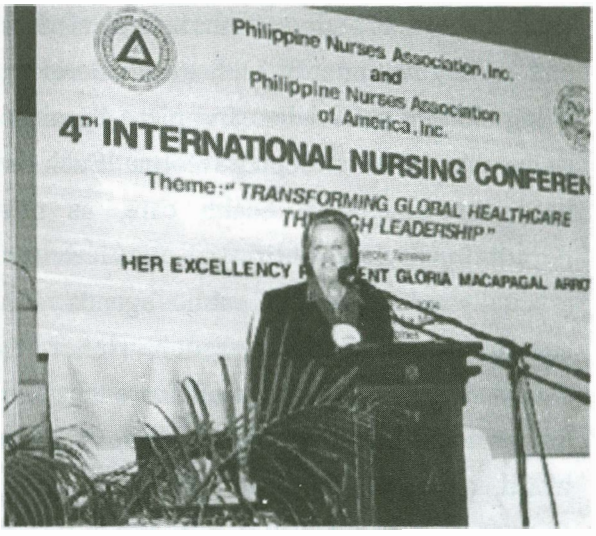
President Gloria Macapagal-Arroyo signed into law the Philippine Nursing Act 2002 (now known as the Republic Act 9173) during the Nursing Convention held at the Manila Hotel last October 2002.

TRANSFORMING GLOBAL HEALTH CARE THROUGH LEADERSHIP

Lucille Joel, EdD, RN, APN, C, FAAN

Burgeoning technology and communications, coupled with dramatic economic, political, social and environmental shifts worldwide, relative free movement of people across national boundaries, and advances in transportation have created unprecedented opportunities for international exchange and dialogue on many important issues. While the United States has always been involved in international affairs, currently there is a more dynamic dialogue about the nature and goals of this involvement. Most importantly, the sentiment of these discussions has changed from one-way messages to reciprocal instruction and debate. It is becoming more and more obvious worldwide that there is a need to devise systems based on mutuality and respect. One people is not better nor worse than the other, just different. Of importance to the nursing profession is the fact that health care has become a significant part of this dialogue.

The nursing profession, in the Philippines, the United States and internationally, is in a strategic position to not only participate in, but to move, this dialogue forward. Nurses are the largest health care group working internationally and have heightened awareness and interest in global concerns. Testimony can be found in the large number of international programs established in Colleges of Nursing and



in the readiness for faculty and student exchange. Nurses, throughout the world, have long been advocates for safe, affordable, and quality health care; their agendas are more alike than different. In many societies nurses are the conscience of health care; having nothing to loose but much to gain. And so, it is essential that nursing move quickly to assume its rightful place at the forefront of internationalism.

In the United States over the past decades there has been an intensifying debate about the merits of our health care system, and criticisms of its inability to meet the needs of the poor, minority populations, and the disenfranchised. There is also concern over inequities in health care, accompanied by a rising consciousness and willingness to confront socio-political injustice by designing programs to counteract

such inequities. And there has been progress, though incremental. Some see this as confusion, others recognize it as the American way. American public policy change has usually taken the form of a subtle dance between federal and state governments, with eventual reform being slow to materialize and piece by piece, rather than broad sweeping reform. Such has been the case with health care, as new populations and additional services are gradually added to the public agenda. Yet, solutions can become much richer by considering strategies for health care that have proven to be effective in other regions of the world.

The involvement of nurses in this international debate has been fueled by the primary care movement that started in other parts of the world before the United States. This movement requires community participation, with a shift away from hospitals and high technology. It assumes coalition formation, and a starting point nearest to the people we serve. Nurses' continuous, egalitarian relationship with patients makes them the natural choice to lead this movement. Vivid examples can be found in developing countries where the nurse leads the primary care team and is highly dependent on people to learn about their own care.

The primary care movement grew out of the need to share scarce resources as equitably as possible to promote and protect health. This movement has brought to public attention the inequities in health care and health status between the rich and the poor, in both developed and developing countries. In the United States, until 1965, with the advent of Medicare, the public program for the elderly, health care was almost exclusively directed at secondary and tertiary care, care of the acutely ill and those with long-term disabilities and chronic disease problems. It is only as more public dollars were invested in health care that primary prevention became a priority. The architects of the Medicare program believed that better health would save dollars rather than costing more. Ultimately, this may not be so since Americans are living longer and falling prey to chronic diseases that they learn to live with.

In 1979, the US Department of Health and Human Services launched the *Healthy People* initiatives, currently in their third generation, to improve the well being of its people and correct disparities in health. This brought the United States into the mainstream of primary health care. In the 1980s, the growth of managed care further established primary care services as routine. Periodic physicals, mammograms, sigmoid and colonoscopies, and screening for other cancers, blood pressure and diabetes have become the management of choice. And in some communities many of these screening techniques are free to the public.

Primary health care brings to US nurses the opportunity to share problem solving with their

international colleagues. And it brings to nurses worldwide the challenge to be leaders in design of systems and policy formulation. For primary health care is built on a spirit of collaboration between the nurses we represent and the people we serve. And to nurses this instinct for collaboration and advocacy has historically been at the very core of our professional identity. These qualities became lost and indistinguishable as we became medicalized, and over reliant on technology.

Primary health care is built on a spirit of collaboration, not cooperation, and demands unique sensitivities. The meaning of health and health care are relative, and specific to the culture in which they are experienced. The national philosophy of life, perception of health and illness, and the role of government in providing health care can vary dramatically. Each of these factors conspires to define the nature of services that are acceptable and available to a people. This is of particular importance to the nurse, who must advocate for what the public is ready, willing, able and ready to accept.

The philosophy of life in the United States builds on the historic roots of self-sufficiency and self-reliance. "Survival of the fittest" and "fierce individualism" aptly described the early American experience. But these ideas could be challenged today, given our robust and diverse immigration. Whereas the immigrants of the early 1900s strained to be personally responsible for their needs and become assimilated into the American Way; more recent arrivals cling to their own culture and aim for little more than an accommodation with the traditionally American philosophy of life. This represents dramatic shift from the melting pot philosophy of immigration in an earlier era, to today's cultural mosaic.

Indeed, life is more peaceful, if not simpler, where there is consistency of language and values. And these values cut across all dimensions of life, beliefs about the family, are families or individuals the health care decision makers and what about marriage and child rearing; work, do you live to work or work to live; education, is it intended exclusively for the gifted and economically affluent; politics and government, when do we look to government for protection and for what, do we aim for the best opportunities for the most, or everything for everybody; the nature of health and health care, is health prime physical condition or is it being pain free and able to conduct your business of daily living. Without singling out any one country, one only has to look at those countries whose peoples are more alike than different; and compare them with more multiethnic societies.

In the United States, people have always been considered to be responsible for their own health or primary health care. Except for the immunization of children, which has a community value, primary health care services had rarely, until relatively recently, been funded

through either government or private health plans. Additionally, the United States system of health care is a blend of public/private dollars and programs. Health care services are predominantly provided by private sector, even if funded to large extent by government. Government currently pays almost 50% of the health care bill in the United States. And the priority of the consumer has often been freedom of choice, choice of provider, choice of setting, choice of services, except where freedom costs more dollars, then this privilege is often willingly compromised.

It is proven that 80% of the health care needs of a person could be taken care of by themselves, if they were given the education and that they have the willingness to do so. In Cuba, the nurse and the physician and their families lived right next to the clinic or in some cases in the same building as the clinic. There is infinite collaboration, there's no confusion over anyone's role, the doctor is there to heal and the nurse is there to develop the capacity of the people to take care of themselves, primary care. They are on duty 24 hours a day for 5 days a week. But 24 hours means that someone from the same locality could come to get a nurse or physician out of bed at two in the morning if there is a problem.

Minorities who were disenfranchised in much of the health care we give are now included, so many of the health problems they have were identified in the last generation. Primary care brought to nurses the opportunity to share problem solving with international colleges as we begin to move on this agenda. The primary health care movement brings to nurses worldwide the challenge to be leaders in designing systems and policy formation. In the US, since we've had a vigorous primary care agenda, there have been significant undertakings. The role of the Diabetes educator has become well established, respected and invaluable in many health care settings. There have also been a primary care clinics established towards people with certain chronic diseases and conditions. And there have been clinics set up with clinical specialists with primary care skills who just ministered to patients. In these clinics, nurses are conversant in primary care and have specialty preparation. There are similar clinics for people with diabetes, cancer, and so on. During the same period we had many nursing centers established-primary health care settings that are nurse managed, nurse staffed and nurse run. The physician present is contracted and there is a physician to refer ill patients to, but the assumption is that nurses can totally manage the health care services and to provide the services for the vast majority of Americans.

The values that each culture has, cut across all dimensions of life, beliefs about family or decisions on the ill person made by the ill person or by the family. One cannot be an expert on every culture so maybe the best you can do is to listen and take your directions from the patients

themselves and one big area of controversy is who makes the health care decisions. There are some, cultures, wherein the sick person does not participate in those decisions. One needs to be sensitive enough to know the difference and to defer to the patient in their cultural context. Is education exclusive for the intellectually gifted and the economically endowed, or does anyone who is smart enough have the right to the education? Do we live to work or do we work to live? You have to determine this with your patients Do we look to government to protect us? The nature of health and health care is also a cue for cultural differences. Many people bring to their adulthood their eating patterns as children. It is very interesting to look at cultural patterns socio-economic condition.

It is easier to define solidarity among nurses because of their social mission and details of their work. Regardless of the national practice regulation, or education background, there have been many fruitful partnerships that had been established between nurses. Nurses have been instruments of change, but their nursing has rarely been a recognized force. Those who have claimed leadership and risen to public recognition have been commonly seen as social reformers than as nurses. For instance, Margaret Sanger and her work in reproductive health worldwide, Adelaide Nutting and her work in women's suffrage, Lillian Wald and her work in community health services internationally, and even Florence Nightingale, who for us is synonymous with nursing, is studied as an icon in military health and hospital reform. Though nurses are the largest group of health care providers, they persist as hidden treasures. Nurses are stereotyped as being cooperative, subservient and non-threatening. Yet we are extremely well positioned to be leaders in health care by our numbers, by the trust in the public places in us, and the fact that nurses are well-embedded in the health care system.

It falls on nurses to provide leadership among their own and on behalf of the people they serve. And leadership is about power. Power has to be understood as the product of social relationships. Power is given or it does not exist. Sometimes it is given freely, sometimes coercively; often it is withheld as a demonstration of defiance. Power may be awarded by a system, it may be a personal attribute, or it may be shared by those who possess it with those who wish to empower others.

The underlying principle of power and its connection to leadership are abstract, but the proofs are in the personal experience, of each of us. A manager may find it difficult or impossible to move an agenda despite being in a position of authority. Or a manager may be far more successful in controlling the behavior of others than reality wants. Each scenario depicts leadership only by its absence or in a negative form. The outcomes are largely dependent on the choices of the followers. And there are leaders who motivate you to walk that extra

painful mile, who wear their power elegantly and comfortably, but purposely, and convince you that there is an end beyond the means. But without leadership, there is no vision, resulting in a vacuum. Nurses seem enthralled with leadership but afraid of power. From another perspective, nurses cling to a view of themselves as oppressed, controlled by external forces, and therefore absent any responsibility for their shortcomings.

Occasions for leadership wait around every corner, many of us will have to accept in order to leave nursing better than we found it. We need leaders who have vision and who makes each one of us more comfortable with power, and we need followers who trust in this vision, we need citizens who feel the responsibility for the actions of this generation and are highly invested in change, but we also need the silent majority who profess no preference, tolerate no inconvenience, but who can be moved and influenced to take on the work of change. For those who are neither leaders nor followers nor citizens find themselves marking time and place and going nowhere.

***Dr. Lucille Joel** is past President of the American Nurses Association and past Vice President of the International Council of Nurses.*

Dr Lucille Joel receiving a plaque of appreciation from PNA President Ruth Padilla with Dr Carmelita Divinagracia and Ms. Asuncion Lipat witnessing.

INTEGRATING HEALTH AND WELLNESS IN ELEMENTARY CURRICULUM

Teresita Irigo-Barcelo, RN, PhD
Araceli Ocampo-Balabagno, RN, PhD
Sheila R. Bonito, RN, MAN
Bernadette Pablo, MA

Introduction

The Department of Education recognizes the importance of starting healthy habits early in life. Most habits in adulthood can be traced back to habits learned in childhood, such as diet and nutrition and physical activity. The project aimed to integrate health and wellness in the elementary curriculum through sample lessons. Nurses' evidence of leadership can be seen through advocacy work not only in health field but also in public education.

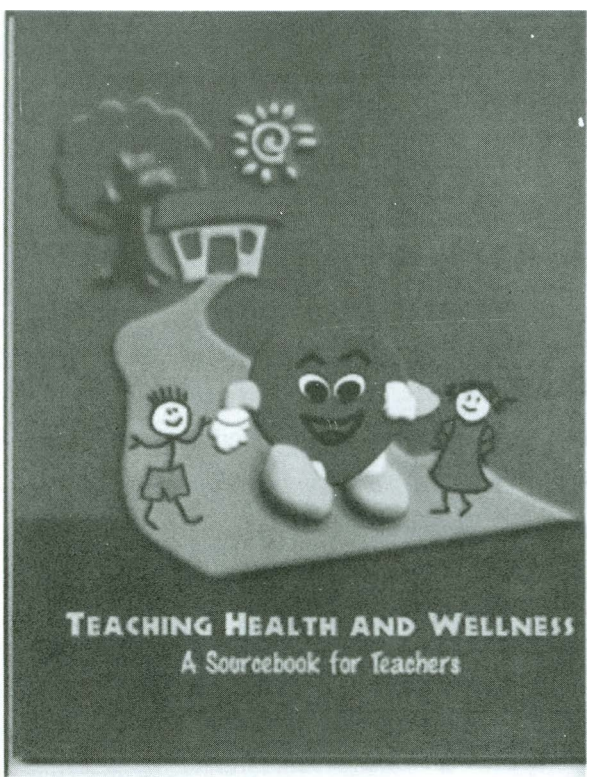
Objectives of the Project

The project was an in-service training for elementary teachers teaching health using the distance-education mode. It developed and pilot-tested Sourcebooks and Teacher's Guide that contain concepts of health and wellness to be integrated in the science lessons for Grades 1-6.

Project Output

Six Sourcebooks (one per grade level) were written as handy reference for selected health concepts that teachers can use when preparing lesson plans. To facilitate the integration of the concepts of health and wellness in the elementary curriculum, the Department of Education Elementary Learning Competencies was strictly followed. The concepts that needed to be integrated were carefully laid out taking into consideration the learning competencies so that there was only minimum disruption of the established protocol. The health facts and concepts were added to the appropriate parts of the curriculum.

The Teacher's Guide was written by practicing master elementary school teachers. It included guidelines on how to do independent



learning using distance education, how to use the source books, sample lesson plans with class activities and pupil assessment. The unique features of the Sourcebook include:

A. Four common themes contained in every grade level, such as:
   - wellness and health promotion
   - personal health
   - emotional and psychosocial health
   - safety and environmental health

B. A concept map, which was color coded to facilitate referencing, visually illustrates the concepts covered in each grade following the Department of Education's Elementary Learning Competencies

C. A series of Self-check Questions for self-assessment of the teachers

D. A set of Activities to illustrate how to integrate the concepts in teaching science and health

E. A Glossary of Terms with translation in Filipino.

Evaluating the Effectiveness of the Source books and Teacher's Guide

A *pre-test* and *post-test* method was used to determine the pupil's change in knowledge before and after the teacher used the source book appropriate for a particular grade level. *Focus group discussion* among teachers who used the source book and teacher's guide was conducted to determine the perceptions and attitudes of the teachers towards the source books and the Teacher's guide. Specifically, they were asked to comment on the readability, clarity of the objectives, completeness of materials, appropriateness of the content to the grade level, usefulness of the source books as a whole and its individual parts, and use of distance education as a mode of in-service training.

The school principals made classroom visits during the class period for Science and Health and evaluated the teacher's performance using the standard Department of Education form.

Conclusions and Recommendations

The teachers who participated in the pilot study found the source books and teacher's guide very useful and informative. They found it easy to integrate the concepts of health and wellness because the concepts were integrated within the expected learning competencies prescribed by the Department of Education. A few comments to improve the source books were about graphics and illustrations. The distance mode was found to be an efficient and effective way of training the teachers without taking them away from their teaching job for a long period of time. The project recommends the adoption of the source books and Teacher's Guide in all public elementary schools.

***Dr. Teresita Barcelo, Dr. Araceli Balabagno, Prof. Sheila R. Bonito**, are faculty members of the University of the Philippines Open University (UPOU) while and **Dr. Bernadette Pablo is from UP Diliman** .* *This project was funded by the Department of Education and Department of Health.*

DEVELOPMENT OF A TRAINING MANUAL FOR HEALTH WORKERS IN PROMOTING HEALTHY LIFESTYLE

Josefina A. Tuazon, RN, DrPH
Luz Barbara P. Dones, RN, MPH
Sheila R. Bonito, RN, MAN

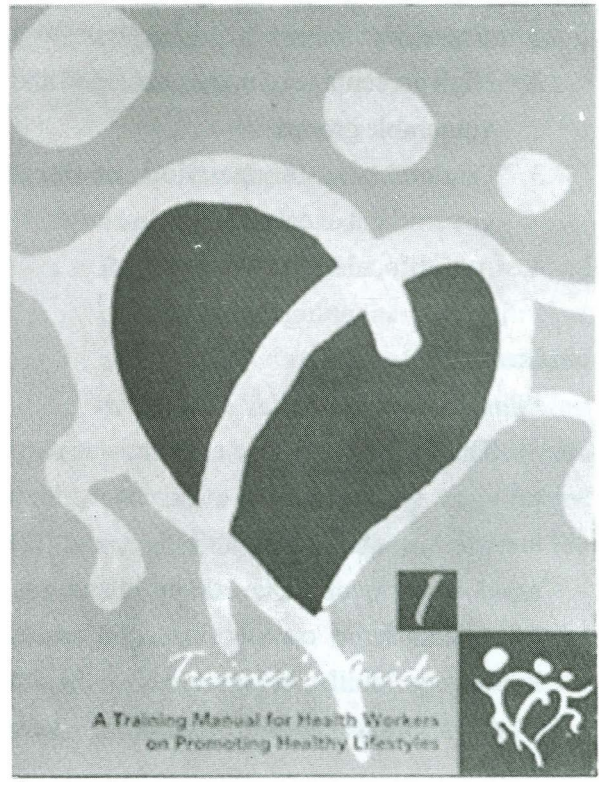
Introduction

The Philippines is currently in the midst of an epidemiological shift from infectious diseases to increasing prevalence of noncommunicable diseases (NCDs). This changing pattern has been attributed to increasing life expectancy, changing lifestyles and unhealthy habits. Review of the major NCDs show that there are common risk factors. These are smoking, sedentary lifestyle and poor nutrition. One approach therefore is to prevent and modify these underlying causes and risk factors using a population or community-based approach. To achieve this, there is a need to train and reorient health workers at the primary care setting for the integration of primary prevention of NCDs in their regular activities.

This project had two major components: (1) a training needs assessment of various levels of health workers on the prevention and control of noncommunicable diseases from two project sites, and (2) the development of a training manual for an integrated community-based program for prevention and control of noncommunicable diseases.

Objectives

1. General Objective: To develop a training manual for primary health care workers on integrated community-based prevention and control of non-communicable diseases.
2. Specific Objectives:
   - 2.1 To describe health needs, problems and lifestyles of the community related to the development of non-communicable diseases;
   - 2.2. To describe the knowledge, skills and attitudes of various levels of health workers at the primary care setting



Scientific Papers

setting regarding prevention and control of non-communicable diseases; and

2.3. To develop a training curriculum and manual that would develop basic skills and competencies of health workers in the prevention and control of non-communicable diseases using an integrated community-based approach.

Pilot Areas

There were two sites selected by the DOH for this project: the Municipality of Pateros in Metro Manila to represent an urban community and the Province of Guimaras in Western Visayas representing a rural area. The project sites were selected based on the following criteria:

1. High prevalence of non-communicable disease risk factors
2. High percentage of underprivileged and vulnerable groups
3. Demonstrated cooperation of local government executive
4. Active local health workers

Methods

Phase I Training Needs Assessment

The training needs assessment was two-pronged: (1) assessment of health workers knowledge, skills and attitudes; and (2) rapid assessment of health problems and lifestyles of the community. To assess knowledge, skills and attitudes of health workers, focus group discussions were conducted among municipal health officers and selected hospital physicians involved in the outpatient department of the provincial hospital, public health and school nurses, and rural health midwives. Skill in blood pressure measurement was assessed for these participants just prior to conducting the FGD using an observation checklist. A knowledge test, lifestyle survey and training needs questionnaire was also distributed to most of the target health workers including the FGD participants.

To ensure that the training manual was appropriate to the needs of the community, a rapid assessment of the community health problems, resources and lifestyle practices was also conducted. Lifestyle practices covered were nutrition-related practices, physical activities, and use of cigarettes/tobacco and alcohol.

These data were collected using several qualitative research methods as follows: (1) review of secondary data/ records where available; (2) focus group discussions of selected respondent groups; and (3) key informant interviews of various stakeholders such as local government officials and school officials

- *Lifestyle Survey* - a series of questions to determine the lifestyle and behavior of respondents in connection with risk factors for non-communicable diseases. Questions ranged from personal information, to alcohol drinking and smoking habits, to nutrition and

physical activity patterns.

- *Training Needs Questionnaire* - a list of minimum expected competencies of health workers in relation to the different non-communicable disease programs of the DOH. Respondents were asked to rate how skilled they were for each competency.
- *Knowledge Test* - set of questions covering risk factors, guidelines for screening and diagnosis of the 5 major NCDs, and other guidelines on nutrition, physical activity and exercise, and smoking. The items were based on the different guidelines from DOH, FNRI, American Association of Sports Medicine, etc. The questionnaire consisted of 65 true-or-false items and 31 multiple-choice questions.
- *BP Skills Test Checklist* an observation checklist for the performance of BP measurement adapted from the DOH-UPCN project on "Translating Hypertension Guidelines for Nurses and Midwives". This was administered to all physicians, nurses and midwives participating in the FGDs.
- *Focus Group Discussion (FGD) Guide* Guides were developed depending on the target participants. Health worker groups included (1) professional health worker group consisting of physicians, nurses and midwives, and the volunteer barangay health workers and barangay nutrition scholars. Other groups included mothers, fathers, older persons, young adults, and adolescents mainly taken from schools, schoolteachers, school nurses, and barangay officials.
- *Key Informant Interview Guide* - political and health department leaders were interviewed to give details on the direction and sustainability of existing and future health programs on the sites.
- *Review of Records Checklist* - a list of information to be gathered from review of records that need not be included in the other tools. It comprises of information such as demographic variables, predisposing, enabling factors and vital statistics. Records reviewed included health center reports and records of health statistics, services, facilities and equipment, and municipal or provincial health/development plans and reports.

Phase II Development of Training Manual

- Review of current literature and collection of guidelines on nutrition, physical activity and exercise, smoking and alcohol use. Of particular interest was to locate and compile guidelines and consensus statements by experts and organizations appropriate for the Philippine situation.
- Review of the basic competencies needed for public health workers in the primary prevention of non-

communicable diseases.

- Consultative meetings with experts and the Department of Health were conducted to ensure that content of the manual were accurate and according to expected standards and resources of the health system.
- A series of meetings and writeshops for the writers involved in the development of the training manual. In particular, this included the project team, other faculty members of the UP Manila College of Nursing, representatives from the Department of Health, and a health education and promotion consultant from the UP College of Public Health.

Phase III Field Testing of Draft Manual

The draft manual was field tested by implementing a training of trainers (TOT). A total of 30 respondents (16 from Pateros and 14 from Guimaras) attended consisting of four doctors, 11 nurses, 11 midwives, one medical technologist and three from DOH Central and Provincial Head Office.

The local trainers under close supervision of the project team, subsequently conducted two separate trainings for health workers in the abovementioned provinces.

Phase IV Evaluation of the Draft

There was very good response from the respondents during the training program. They particularly appreciated the learning activities utilized, following the dictum of 'learning can be fun'. They had high regard for the resource persons' and facilitators' level of expertise. Conducting practicum in the actual community setting was effective and highly appreciated by the participant. The skill development activities, practicum, and interactive nature of the training program were essential strategies in this program.

Follow-up of respondents two months after training showed that the objectives of the training program were partially achieved, particularly in the development of specific skills like blood pressure measurement, measurement of BMI, waist circumference and waist-hip ratio, measurement of peak flow meter for asthma and teaching self-breast examination.

Phase V Enrichment of the Manual

Using the valuable lessons from the actual implementation of the training programs in Pateros and Guimaras, the feedback from the respondents themselves, and the evaluation visits conducted by the project team, the draft manual was revised and enriched to the *Promoting Healthy Lifestyles An Integrated Community-based Approach to Prevention and Control of Non-Communicable Diseases: Training Manual for Health Workers.*

The Final Training Manual

The training manual serves as a guide for primary health care providers such as doctors, nurses and midwives in promoting

healthy lifestyles for individuals, groups and community. The approach to prevention and modification of major risk factors, such as unhealthy nutrition, sedentary lifestyle, and smoking will prevent, not only one, but most of the major NCDs. Emphasis is on population-based approaches that will impact on a larger portion of the population than the individual or clinical approaches.

Selection of the content was based on a list of competencies expected of health workers, primarily nurses, midwives and doctors, to fulfill their roles in promoting healthy lifestyle change. Existing Department of Health Guidelines, clinical guidelines and consensus statements by expert groups regarding prevention and control of specific NCDs and risk factors provided the backbone for the content. Local guidelines were used whenever available such as in hypertension, cancer, obesity and asthma. If not available, international or regional guidelines endorsed by local experts were utilized such as in COPD and diabetes.

The training manual now consists of four booklets and seven sessions. The first booklet is the Trainer's Guide. The rest of the booklets contain the content and reference materials needed for the discussion and processing of activities per session. Effort was also taken to make the format and language simple and more relevant to intended users of the manual.

Impact of the Project

The final training manual is currently being reprinted by WHO for dissemination nationwide. The training of national core of trainers was conducted in October of 2003 and the training of health workers is currently being implemented at the regional and provincial levels by the DOH using this manual. Advocacy efforts through this project also resulted in the following encouraging developments:

- A 'Healthy Pateros' week was conducted on December 2 - 7, 2002 wherein the 'Integrated Community-based Non-Communicable Disease Control and Prevention Program' was officially launched.
- Guimaras Province launched the 'Integrated Community-Based Non-Communicable Disease Control and Prevention Program' on February, 2003.
- A case study of this project is currently being written as a regional publication of the World Health Organization Western Pacific Regional Office for dissemination in the region.

Dr. Josefina Tuazon *and* ***Prof. Luz Dones*** *are faculty members at the College of Nursing, University of the Philippines Manila, while* ***Prof. Sheila Bonito*** *is from UP Open University.* *This project was undertaken by UPCN , funded by the World Health Organization, Western Pacific Region.*

TRANSLATING HYPERTENSION GUIDELINES FOR NURSES AND MIDWIVES

Araceli Ocampo-Balabagno, RN, PhD
Cecilia M. Laurente, RN, PhD

Background

The Department of Health in its program development thrust in the care of clients with chronic illnesses recognized the need for guidelines to improve and enhance the level of competencies (knowledge and skills) of nurses and midwives in hypertension care. This supports their significant role as frontliners in the detection and control of hypertension in the community.

Objectives

To translate the Clinical Practice Guidelines on the Detection and Management of Hypertension into teaching materials for the use of nurses and midwives

1. To identify the role of nurses and midwives on hypertension detection and management;
2. To identify the learning needs of nurses and midwives related to the assessment, treatment and monitoring of hypertension;
3. To identify relevant contents from the hypertension guidelines that can address the learning needs of nurses and midwives;
4. To identify competencies on hypertension assessment and monitoring, and;
5. To develop teaching materials based on identified competencies appropriate for nurses and midwives, especially those working in the community.

Methodology

Project Sites: Baguio, Iloilo, Davao

The site was based on data where findings of blood pressure increase were highest based on a study by DOH-FNRI in 1998.

Phases

First - the assessment of local conditions (survey) to learn the current knowledge and skills level of the health providers (nurses and midwives) in relation to the perceived requirements of how best the guidelines can be applied

Second - the development of the management guidelines, known as the modules, and the process of quality circle, e.g. peer review, roundtable discussion and consultation with experts

Third - the field-testing of the modules, the conduct of focus group discussions (FGD) and consultative workshops to determine the utilization and applicability of the modules

Participants

An average of sixteen (16) participants (8 nurses and 8 midwives) were selected from each site for a total of 48. Representatives as to their area of practice were considered. Hence,

nurses and midwives were selected from practitioners in the community, the hospital, and teaching institutions.

Tools

Two assessment tests were administered:

a. knowledge test on general concepts in hypertension care (written), and
b. blood pressure (BP) measurement skill test

Findings

One of the primary findings of this project is the identification of the learning needs of nurses and midwives in the community with regards to hypertension screening and care. Although there are many existing activities related to hypertension care that are being implemented, nurses and midwives reported that there are learning needs that can be enhanced to improve care. These are the following:

Wellness, health promotion and holistic approach

- Self-care responsibility, e.g. how to empower clients for self-care
- Basics of nutrition
- Exercise for health
- Environmental concerns

Prevention of hypertension

- Understanding of risk factors, e.g. smoking, obesity, diabetes, increase serum cholesterol, effects of alcohol intake

Physical assessment and hypertension screening

- Need to provide correct information on BP measurement procedure
- More information and guide on physical assessment and monitoring

Interventions and management

- Knowledge on medications
- Biobehavioral interventions
- Knowledge on the use of herbal products, e.g. garlic, lemon grass
- Compliance to care

Continuing care

- Care of chronic illness/stroke care
- Rehabilitation

Care of special clients with high BP

- Older person
- Pregnant

Recommendations

The module on Clinical Practice Guidelines on Hypertension Detection and Control for Nurses and Midwives posits important implications in its dissemination and utilization. Since correct blood pressure measurement and reporting are vital to hypertension detection and control, skills training and maintaining standards in BP measurements take priority. The general training and education in hypertension care should consider how knowledge and skills could be integrated in the provision of health services in varied settings.

***Dr. Araceli O, Balabagno** and **Dr. Cecilia M. Laurente** are faculty members of the College of Nursing, University of the Philippines.* *This project was done through their leadership and able contribution of other faculty members of UPCN. This was funded by the Department of Health.*

REMEMBERING DEAN JULITA V. SOTEJO

Nursing in the Philippines owes much to Julita V. Sotejo who worked for the collegiate nursing, placing nursing education at par with other professions. Her thesis, "A University School of Nursing in the University of the Philippines," for her Master of Science, major in Nursing Education degree at the University of Chicago, served as the blueprint for the Bachelor of Science in Nursing program.

Julita V. Sotejo who at the time (1946) was Chairman of Nursing Education Section of the Filipino Nurses' Association, presented to the members of the Association during their biennial convention the proposal to establish a college of nursing in the University of the Philippines. This was favorably met, and led to the passage of Resolution No.1 petitioning the creation or establishment of the college. The Board of Regents of the University, on recommendation of President Bienvenido M. Gonzales favorably endorsed the Filipino Nurses' Association resolution to President Manuel A. Roxas as well as to both houses of Congress. This came into fruition two years later. On April 9, 1948, the College of Nursing in the University of the Philippines was founded, with Julita V. Sotejo as first Dean.

Dean Sotejo was also elected as President of the Filipino Nurses' Association for a two-year term (1948-1950) and was re-elected twice (1950-1954). As a member of the Philippine delegation to the International Council of Nurses' Congresses, she brought honor to the association and her country as an acknowledged brillliant speaker.

Dean Sotejo was most instrumental in the passage of Republic Act 877 (Philippine Nursing Law) in 1953. She was also the first Filipino and the first Asian elected to the ICN Board of Directors. She founded the Academy of Nursing of the Philippines (ANPHI).

When she retired in 1971, Dean Sotejo was named Professor Emeritus of Nursing at the University of the Philippines. The University has also awarded her the degree of Doctor of Laws, *honoris causa*, on April 11, 1991.

(On March 5, 2004, the beloved Dean and Founder passed away peacefully after a lingering illness.)

OUTSTANDING NURSE: MARIA RITA VILLANUEVA-TAMSE

Maria Rita Villanueva-Tamse, Deputy Director for Nursing at the Philippine General Hospital, was the recipient of the Outstanding Nurse award given by the Professional Regulation Commission. The awarding ceremonies was held at the Philippine International Convention Center on June 22, 2004.

Mrs. Tamse was recognized Outstanding Nurse for her unparalleled competence and meritorious achievements as a professional nurse, holding various vital positions at the Philippine General Hospital; for her selfless dedication as nursing leader, counselor, administrator and resource person in the nursing profession; for her incomparable dedication to upgrade nursing education as professor/lecturer in several prestigious schools and universities and through her active involvement in the enhancement and development of nursing curriculum as member of the Commission on Higher Education (CHED) Technical Committee on Nursing Education; and for her remarkable leadership and unquestioned integrity as officer/member of various nursing and civic organizations.

INTERCULTURAL MANAGEMENT: BREAKING THROUGH THE CULTURE SHOCK

Carol O. Long, RN, PhD
Elizabeth Desano Rose, RN, MBA

Introduction

This study was done to help all newly relocated Filipino and other foreign educated nurses, nursing recruiters, and employers worldwide to have a broader, deeper and more comprehensive understanding of how to successfully have transition from foreign educated nurses into the American culture, nursing practice and workplace. From this understanding, more structures and culturally diverse educational programs can be developed. Hence, partnerships between professional organizations, hospitals, foundations, and nurse recruiters can be organized to achieve a common goal.

Purpose

The purpose of this study was to explore how Filipino nurses successfully transition into the American Culture, Nursing Practice and Workplace.

Methodology

The sample consisted of twenty-four (n=24) Filipino nurses working in Arizona and who had migrated from the Philippines. All of the nurses worked in hospitals with the majority of them working in Medial-Surgical or Critical Care Units. Over half of the nurses (54%) had less than 20 years experience as an RN. Among those with less than 20 years experience, two-thirds of the nurses (66%) were 31 years of age or younger and practiced in the United States for less than five years.

An open-ended questionnaire was distributed to the Filipino nurses attending the first Annual Philippine Nurses' Association of Arizona (PNAAZ). The questionnaire consisted of ten open-ended questions to elicit the participant's motivation to immigrate to the United States, to determine the difficulties that they encountered and other "lessons learned" while on their journey. The researchers evaluated the questionnaire with key membership of PNAAZ for readability and congruence with the phenomena under study. A consent letter was given to the PNAAZ at the conference requesting their voluntary participation in this study. Any identifying data was removed from the questionnaire. Data analysis consisted of identifying the themes describing the challenges of transitioning into a new environment and into the American nursing workforce.

Results

The themes that emerged from the open-ended survey questions were:

1. Culture shock was the most difficult part for immigrating nurse.
2. Complex medical technology, new procedures and progressive nursing practice were issues faced in the American hospital.
3. Professional values and goals were most important to many participants.
4. Economic security, educational opportunities and professional advancement were the prime motivators for immigration to the United States.

This study was made possible through the collaborative effort of the Satisfaction Management Institute and the Philippine Nurses' Association of Arizona.

Metrobank Foundation partners with Philippine Nurses Association

The Metr oba Foundation, Inc. (MBFI) rece tly igned a Memoranda h Agreem nt with the Philipp -Nurses Ass ciation (P NA) for the d velopment of a website to b d ve ped as one of the le ding sources of information on current nur g trends worldw ide. The grant will support the overall development f the website including design and maintenance by Phil Mt Technolog . The site will also provide various links to medical and academic institutions. PNA, a member of the International Council of Nurses, boasts of seven chapters around the world with more than 40,000 members.

Signing the agreement are (seated, from left) PNA vice president for Programs and Development Leah Samaco-Paquiz, president Ruth Padilla, Metrobank Foundation president Placido Mapa, Jr. and EVP Elvira Ong Chan. (Standing, from left) PNA program implementation division head Emy Tagle, general services head Mila Abella, Metrobank Foundation EVP and executive director Aniceto Sobrepeña, and asst. executive director Nicanor Torres, Jr.

AIDS-WISE WITH COMPASSION: A LIABILITY-FREE ZONE

Salud B. Zaldivar, RN, MA

Introduction

The prison environment is universally known as a community at high risk for the spread of communicable diseases, including HIV/AIDS. This captive population is regarded as the most disenfranchised sector of society whose social and medical needs are often overlooked and given the least priority. This is particularly true in developing countries.

Objectives

The objectives of this study is to transform prison staff and inmates to become peer educators and counselors through capability building on Basic AIDS and Counseling.

Methodology

This 12-month project is being piloted in the two major correctional centers for men and women in Metro Manila. As a strategy, a partnership was forged between the Research Institute for Tropical Medicine, the Department of Justice and the Positive Action Foundation Philippines, Inc. This partnership was characterized by mutual recognition and respect for cultural diversity and sharing of resources. And, this was evident during the Consultative Meeting held on November 21, 2001 and even continued throughout the project implementation and evaluation.

Results

The program's success can be attributed to the awareness and actions taken by prison communities as shown by the competence of men and women inmates in conducting AIDS prevention campaigns among their peers and constituents. They can now seek medical help regarding their reproductive health 'breaking the silence' on sexuality, gender sensitivity, conjugal visits, 'opportunistic sexual relations', and possibly the use of illegal drugs.

Counseling has significantly reduced burnout, particularly among Reception and Diagnosis staff as they were able to identify and unburden their stresses during the Grief and Loss, and Care for the Care Providers' sessions.

The unique feature of this project was the recognition that a change toward healthier life choices is incremental and non-lineal due to the relative burden of compounded loss of freedom, relationships, hope, and discrimination among

the captive population.

Inherent in the prison environment are certain risks such as gang clashes, hostages and jailbreaks. And though the inmates are not under any form of restraints or handcuffs, the researcher took these as great challenges, instead of impediments. In the end, the researcher must have communicated the good news that a 'liability-free zone environment' has now been entered into to make inmates AIDS-Wise with compassion.

Conclusion and Recommendations

The researcher did not only deliver the message in a culturally sensitive and attractive package, but also in a practical and long-lasting form that could be shared among peers. The values clarification approach to life choices has made the inmates realize that they can also help other inmates while still in prison.

The project is included in the UN AIDS 'Menu of Partnership Options in the Philippines' during the National Launching on October 17, 2002. It is a strategy for soliciting funds from donor agencies to support such priority programs.

A replication of this project in five other prison communities outside Metro Manila is being recommended.

Salud B. Zaldivar *is former Head of the Nursing Department at the Research Institute for Tropical Medicine and former member of the Board of Nursing of the Philippine Regulation Commission.*

Mrs. Erlinda Ahorro, *Executive Director*, and Dr. Leah Paquiz, *Vice President for Programs and Development*, represented PNA in the launching of the National Hospice and Palliative Care Council of the Philippines held on February 17, 2004 at the Makati Sports Center.

DEATH BY RABIES: THE LAST FRONTIER FOR ETHICAL CONCERN

Salud B. Zaldivar, RN, MA

Introduction

Death by rabies is a critical public health menace, whereas those who opt to remain in the hospital face death devoid of human dignity, and deprived of medical and social services. In a major research hospital for infectious diseases, more than 75% of clients seen in the Outpatient Department had complaints that are dog-bite related. In 2001, an average of two cases per month availed of Home Against Medical Advice (HAMA) within a seven-month period. According to World Health Organization, rabies is endemic in the Philippines and ranks as the 4th highest worldwide. It is reported that the domestic dog is responsible for more than 98% of all human cases. However, transmission among humans is theoretically possible.

Objectives

This study aims to find out what are the ethical, legal, socio-cultural and economic realities that impact on patient surrogates to request/demand for HAMA? It also aims to find out what are the reasons for physicians to grant it?

Methodology

During a symposium on 'Rabies and Dog Bite Management' held on May 22, 2002, a survey was done to determine perceptions regarding rabies. The symposium was attended by 90 representatives from 35 municipal health offices in Luzon. They consisted of doctors, nurses, veterinarians, community engineers, and teachers. A questionnaire was distributed with the aim of soliciting information that would determine some pre-conceived ideas that might need clarification during and beyond the open forum.

Results

Some of the responses that served as eye openers were as follows: Majority agreed that, "timely immunization is the only protection offered to an exposed person." However, "access to treatment depends on one's financial resources, and prioritization of age/gender in a family unit." Very few signified that 'they were willing to sacrifice their pet dog for laboratory confirmation of rabies to ensure the safety of a life." A significant number agreed that, "once

told that rabies is lethal and irreversible", "relatives should not be denied of their final request to take the patient to a faith healer."

Should palliative care be considered given the odds of extra expenses on drugs? On the other hand, a remarkable number disagreed, 'If you were the Barangay (community) leader, would you take the responsibility of having a constituent with rabies be brought home from the hospital?'

However, because of lack of existing hospital policy, patients with rabies are allowed HAMA. Physicians and health personnel are concerned that they may be charged with violation of human rights due to illegal detention against the patient's will.

Additional basic questions aired were:

1. Do we have ethical obligation to change policies, and reform laws for effective rabies prevention and management?

2. Can individual, including cultural diversities reconcile with universal standards of health care?

3. The incidence of rabies exposure in the Philippines is more critical and lethal than HIV/AIDS, yet this condition seems to be the last frontier for ethical concern.

Conclusions and Recommendations

In the developed countries, rabies has long been eradicated, as compared to the economically constrained ones. Bioethicists need to study the economy and the politics of health, humanities, human rights, and the issue of equity, and prioritizing the allocation of resources. Having to witness a patient die with rabies is a lesson in compassion. But, to watch dozens of them die, inevitably transform health professionals to become numb and callous about the respect for the dignity of man.

CAREGIVING ROLES, PERCEIVED EFFECTS AND COPING STRATEGIES OF OLDER WOMEN CAREGIVERS

Bernadette Marheni Luan, RN, MAN

Introduction

The social cost of the urbanization and migration of women becomes one of the interesting issues and concerns recently. Without regard to the benefits provided to the families, the absence of mothers in some families forces grandmothers to take over the roles of caring for the children who are left behind. However, the steady increase of female longevity over their male counterpart denotes the low quality of life during their later age brought about by poverty, widowhood, and deteriorating health. Moreover, in the absence of mothers, the caregiving roles fall more heavily on the older women. Thus, the older women in the community become a high-risk population. The need for understanding the older women caregivers' quality of life and health needs post as a challenge worth exploring.

Objectives

The main purpose of this study was to explore the caregiving roles, perceived effects, and the coping strategies of older women in caring for children left behind by overseas Filipino Women Workers (OFWWs).

Methodology

To answer the stated problems, one-on-one interview and in-depth life stories became the main source of data. Observations during home visits and focus group discussions concretized the phenomenological and research field approaches in exploring and describing the experiences of older women caregivers. Non-probability sampling methods, particularly network sampling were utilized to identify 20 participants who were between 55 to 84 years of age and who were taking care of their grandchildren aged 17 years old and below.

The caregiving roles, perceived effects, and coping strategies of older women caregivers were explored and documented during a period of seven weeks of fieldwork. Camera, cassette recorder and field notes were used for the data collection with the participants' permission.

Results

Four main topics emerged from the study:

- ***Caregiving***
- ***Perceived effects***
- ***Coping strategies***
- ***Resiliency***

The first topic was subdivided into two sub-topics: roles and history.

The caregiving roles consisted of three themes: namely, as guardian mothers, breadwinners and property watchers. The guardian mother roles were subdivided into several tasks: physical and household, budgeting, religious, decision-making and socio-educational tasks.

The caregiving history was subdivided into several themes: reasons for being caregivers, differences between taking care of one's own children and grandchildren, quality relationship between caregivers and care recipients, common problems encountered by caregivers, and support availability within the family and the community.

From the second topic on perceived effects emerged three themes in the degree of subjective response: neutral, positive, and negative.

From coping strategies emerged six themes: praying and faith in God, seeking support behavior and soliciting help from others, problem solving strategies, emotional coping strategies, practicing relaxation, and engaging in productive work.

From the last topic on resiliency emerged five themes: meaningfulness and sense of direction and mission, self-efficacy, philosophical attitude in light of sense of morality and faith in God, warm bonding with care-recipient and family members, and community protective factors in light of sense of community involvement experience and positive community norm and feedback.

Conclusions

This study showed that the older women's roles in caregiving focused mainly on being guardian mothers, who played a functionally central role in filling the void left by the OFWWs and in saving the life of young generations. Along with their experiences, they subjectively perceived their roles in a wide range of degrees relating to the problems encountered and support system availability that could maximally be utilized. They created win-win solutions to their situation in coping

with their problems. Their chances to win the situation and solve their problems arising from their caregiving roles came mainly from their personal capacity, courage, flexibility and adaptability to restore balance, with the support from the family and community

Recommendations

Implications drawn from the study emphasized multidimensional aspects including cultural sensitivity and other important aspects in assessing at-risk populations. Enrichment of qualitative curricula and some additional courses on gerontology and sociology to the recent graduate curricula can help the interested researchers to have a broader knowledge and information.

Recommendation for further research includes grounded approach to build and develop theories pertaining to perceived effects on caregiving roles, coping and resiliency, health-seeking behavior, health belief and practice, and self-promotion among older women caregivers.

Ethnographic study on caregiving can also be done to similar populations. Further correlational studies may also be conducted to look into some factors that contribute to the perceived effect, coping strategies, and resiliency. Community nurse practitioners should focus on primary preventive program in order to optimally assist and sustain older women's capacity, adaptability, and flexibility in taking care of themselves.

Likewise, community nurses have the opportunity to develop health promotion programs, utilize family health-center and community-based approaches, and actively initiate network, coordination, and collaboration within the community to provide support system through intersectoral and multidisciplinary approaches. Some programs such as catharsis hour program for caregivers and training package modules for caregivers and their families were also recommended.

Bernadethe Marheni Luan *was a graduate student at College of Nursing, University of the Philippines Manila. This qualitative research was her thesis for the degree of MA in Nursing, with Prof. Cora A. Anonuevo as the Adviser.*

RELATIONSHIP OF SELECTED PERSONAL VARIABLES AND ELEVATED BLOOD PRESSURE AMONG POSTPARTUM PATIENTS

Mary Rose Arcedo, RN, MAN

Introduction

In the Philippines, hypertensive disorder in pregnancy is considered to be one of the leading causes of maternal and fetal morbidity and mortality. There are some factors that are believed to predispose a woman to hypertensive disease in pregnancy such as age, nulliparity, familial history of hypertension, multiple gestations, paternal factors, and socio-economic status (Chelsey, et al, 1984).

Nurses can look for the predisposing factors in the assessment phase of nursing process to find out the possible alternative intervention. Monitoring of blood pressure closely, promoting good nutrition, providing emotional support, encouraging in regular hypertensive treatment and suggesting some relaxation techniques are choices of interventions that can be done in managing hypertension in pregnancy.

Objectives

This study aims to describe the incidence of hypertensive disorder in pregnancy specifically elevation of blood pressure among post partum patients in a tertiary level hospital, during the period January 1 to June 30, 2003. Specifically, it seeks to answer the following problems:

1. What is the incidence of post partum elevation of blood pressure among patients confined during the period of January 1 to June 30, 2003?
2. What is the profile of mothers who delivered from January 1 to June 30 2003, in terms of:
   a. Age
   b. Marital status
   c. Paternal Factor
   d. Socio-economic status
   e. Number of children
   f. Systolic Blood Pressure
   g. Diastolic Blood Pressure
3. What is the profile of mothers with post partum elevation of blood pressure when grouped according to:
   a. Age
   b. Marital status
   c. Paternal Factor
   d. Socio-economic status
   e. Number of Children
4. Is there a relationship between age, marital status, paternal factor, socio-economic status, number of children and incidence of elevation of blood pressure among postpartum mothers?

Methodology

This study utilized a descriptive design to determine the incidence of postpartum

elevations of blood pressure among pregnant women and establish the predisposing factors that lead to this condition. A correlation design was also used to identify the association between variables of age, marital status, paternal factor, socio-economic status and number of children.

The subjects included in the study were pregnant women admitted during the period of January 1 to June 30, 2003, with increased blood pressure, and who do not have any other complications such as renal disease/ renovascular hypertension, pheochromocytoma and hyperaldosteronism. Those who are diagnosed to have chronic hypertension, pre-eclampsia or eclampsia during pre-natal check-up were not included in the study.

Records of patients who were admitted to the hospital from January 1 to June 30, 2003 were reviewed. Laboratory report collection sheet, obstetrical and gynecological past/present medical history and assessment were carefully read by the researcher to identify if the patient has history of hypertensive disease in pregnancy. All those patients who met the inclusion/exclusion criteria and were recorded to have elevation of blood pressure after giving birth admitted at the hospital from the January to June 2003 were included in the study. If there was a recorded diagnosis of hypertension prior to pregnancy or during pregnancy, it was not included in the sample. A data recording tool was developed by the researcher to facilitate the retrieval of the data from records/charts of women who met the inclusion/exclusion criteria.

Results

1. Findings revealed that out of 14,325 admissions from January to June 2003, a total of 1,175 or 8.20% of patients were affected with postpartum elevation of blood pressure.
2. Profiles of mothers who delivered from January to June 2003 are as follows:
   a. Age
      Of the 14,325 total admissions, majority of the mothers are in the age range of 25-34 (n= 4,977 or 34.74%).
   b. Marital status
      Majority of the admitted mothers were married (n= 9,712 or 67.8%). The rest are single mothers (n = 4,613 or 32.3%).
   c. Paternal Factor
      Majority of the admitted mothers have not changed partner (n= 13,369 or 93.33%).
   d. Socio-economic status
      Highest percentage of admitted patients belongs to the middle class (n= 9,523 or 66.48%).
   e. Number of children
      Majority of the mothers have 1-4 children (n= 6,568 or 45.85%).
3. Profile of mothers with postpartum elevation of blood pressure:
   a. Age
      Among the 1,175 mothers with postpartum elevation of blood

pressure, majority are in the age range of 25-34 with total number of 512 patients. However, those in the age range of 35-47 yielded the highest incidence of 33.22% affected with postpartum elevation of blood pressure.

b. Marital status

Among the 1,175 mothers with postpartum elevation of blood pressure, most of them are married with the total number of 672.

c. Paternal Factor

Among the 1,175 mothers with postpartum elevation of blood pressure, majority have not changed partner in the current pregnancy.

d. Socio-economic status

Majority of the subjects with postpartum elevation of blood pressure were in the middle class.

e. Number of children

Majority of mothers with postpartum elevation of blood pressure have 1-4 children.

4. Relationships between the selected variables and the incidence of postpartum elevation of blood pressure

a. No significant relationship was found between the variables of marital status, paternal factor, socio-economic status and the incidence of postpartum elevation of blood pressure.

b. No correlation was found between the number of children and the elevation of systolic/diastolic blood pressure.

c. Significant relationship between age and the systolic blood pressure.

Conclusions and Recommendations

The result of this study can provide a basis of predicting factors that affect postpartum elevation of blood pressure. Further study should be conducted using the same variables particularly age and its correlations with socio-economic status among mothers who gave birth in a private hospital. Variables like weight, nutrition, and lifestyle may also be added. Mothers who were diagnosed to have postpartum elevation of blood pressure during their hospitalization should be followed up to find out if they actually develop hypertension later in life.

Mary Rose Arcedo *is a graduate of the College of Nursing, University of Sto Tomas. This was her thesis for her MA in Nursing with Dr. Teresita I. Barcelo as adviser.*

Philippine Nurses' Association, Inc. and Philippine Nurses' Association of America 4th International Nursing Conference

EDSA Shangri-la Hotel, Mandaluyong City
January 20-22, 2004

The 4th International Nursing Conference was declared a success when it exceeded the expected number of delegates, filling up the Isla Ballroom of the Edsa Shangri-La Hotel in Mandaluyong City last January 20-22, 2004.

The event provided opportunities for Filipino nurses around the world to meet and share their views and experiences. The conference's theme was "*Transforming Global Health Care through Leadership*" emphasizing the role of nurses as instruments of change and nurses taking an active role as leaders in effecting global healthcare.

Press Secretary Ignacio R. Bunye delivered the keynote address in behalf of President Gloria Macapagal-Arroyo. The President's keynote address captured in full the theme of the conference, recognizing that transformation through leadership is shared by other sectors citing various government efforts on healthcare. Her message was clear: that nurses should join hands with various sectors of society to effect change.

Dr. Lucille Joel, EdD, former president of the American Nurses Association and past Vice President of the International Council of Nurses was one of the speakers on the first day. She emphasized that it is important for nurses to realize that they are a massive force, a critical mass that can transform the immediate sphere that they are living at, if not the whole society. She also expressed that it falls to nurses to provide leadership among their own and on behalf of the people they serve.

Professor Amelia Maglacas vividly shared how the world looked like in terms of population distribution, quality of life, human development index and corruption index. One of the realities that she mentioned is that nurses' contribution to

Dr. Amelia Mangay-Maglacas, DrPH, RN, FRCN (UK), ScD (HON), receiving her plaque of appreciation from PNA President Ruth Padilla with Dr. Carmelita Divinagracia and Ms. Asuncion Lipat witnessing.

News Feature

health and society is largely inhibited by weak leadership as well as health systems favoring medical-oriented systems. She challenged the delegates to develop political savvy.

Reynaldo R. Rivera, MA, EdM, RN, Director of Nursing from The Brooklyn Hospital Center and Sara Mc Mannus, MBA, RN, Clinical Programs Manager of GE Medical Technologies, presented the latest developments in health care technology. They highlighted the important role of Information Technology in reducing medical errors and enhancing health care delivery. Both concluded that Information Technology can enhance nursing practice but not the panacea to all health care problems.

The second day of the conference was highlighted by the talk of renowned theorist, Madeleine Leininger, PhD, RN, CTN, LHD, FAAN. She shared some personal thoughts on healing and proceeded to discuss her well-known Culture Care Theory of Diversity and Universality. She emphasized some salient points in the theory:

- Care is the essence of nursing and a distinct, dominant, central and unifying focus.
- Culturally-based care/caring is essential for well-being, health, growth, survival, or to face handicaps or death.
- Culturally-based care is the most comprehensive, holistic, and yet, particularistic means to know, explain, interpret and predict beneficial congruent care practices.
- Culture care concepts, meanings, expressions, patterns, processes and structural forms vary transculturally with diversities (differences) but some universalities (commonalities).
- Most cultures have *emic* generic (lay, folk or indigenous) care and usually *etic* professional care, knowledge and practices that need to be understood.
- Culturally-based caring is essential to curing and healing, for there can be no curing without caring, but caring can occur without curing.
- Culture care values, beliefs and practices tend to be diverse, embedded, and need to be explicated to help people.
- Transcultural nurse-client conflicts, imposition practices, stresses and non-caring acts are indicators of the critical

Madeleine Leininger flanked by participants

need for to be explicated to help people.

- Nurses prepared in transcultural nursing can transform nursing and health care policies and practices to quality based cultural care

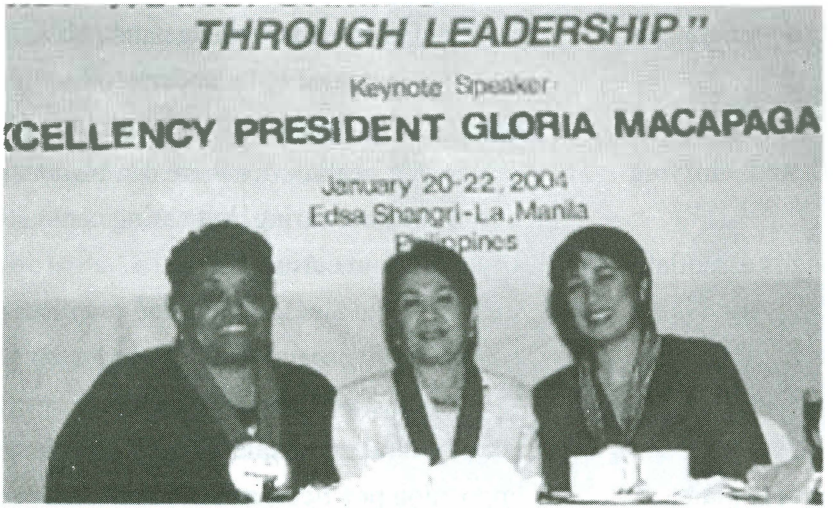
Dr. Leininger emphasized that nurses should provide care to patients in the context of their cultures and that it is the key to patient satisfaction. Caring is the essence of nursing and that spirituality is indispensable in the practice of nursing profession.

The very inspiring talk given by Dr. Leininger was followed by a panel discussion on "Addressing the Needs of Global Nursing Shortage" by distinguished nursing experts Honorable Eufemia Octaviano, EdD, RN, Chairman of the Board of Nursing, Professional Regulation Commission, gave an overview of the present scenario in the field of nursing education. As of November 2003, there were 353,733 registered nurses in the Philippines. She also presented a table on the distribution of nursing schools in the country based on PRC data.

Table 1. Distribution of Nursing Schools According to Region, 2002, PRC

REGION	Existing Schools	New Schools	Applicant Schools
NCR	48	3	18
CAR	4	1	-
Region 1	16	1	7
Region 2	7	-	4
Region 3	16	2	5
Region 4	21	1	12
Region 5	16	2	1
Region 6	13	-	3
Region 7	12	1	10
Region 8	5	2	2
Region 9	3	1	2
Region 10	7	-	1
Region 11	9	1	7
Region 12	16	-	-
CARAGA	3	-	-

Dr. Octaviano pointed out that there is an alarming increase in the number of applicants securing approval for opening of new schools of nursing. She proposed that in order to ensure quality education, there are eight areas that need to be addressed: (1) administration, (2) faculty, (3) curriculum, (4) instructional standards, (5) laboratory facilities, (6) related learning experience (RLE), (7) admission criteria, and (8) nursing service. She assured that the Board of Nursing is doing its best in fulfilling its mandate in ensuring the quality of professional nurse practitioners in the country.



Dr. Barbara Nichols, Hon. Eufemia Octaviano, and Mrs. Rita Tamse

From the field of nursing service, Maria Rita Villanueva-Tamse, MAN, RN, Deputy Director for Nursing at Philippine General Hospital, presented the alarming rate of turn-over of staff nurses working in selected tertiary hospitals in Metro Manila.

Table 2. Turn-over Rates of Staff Nurses in Selected NCR Hospitals, 2001-2003

Hospitals	2001	2002	2003
Philippine General Hospital	24.79%	13.97%	12.46%
Philippine Heart Center	24.38%	15.52%	11.98%
University of Sto Tomas	20.57%	25.80%	24.63%
Ospital ng Maynila	-	13.60%	11.98%

Mrs. Tamse identified the following factors contributing to the nursing shortage:

- Growing demand from the international market for specialized care
- Aging workforce in western countries
- Technological advances
- Political and economic challenges in the Philippines

She also presented the various retention programs that nurse administrators are using to address the problem of nursing shortage, which include: building career paths by providing intensive training programs, utilizing progressive clinical nursing, mentoring, and pre-employment programs. She concluded by saying that nursing should look ahead and continue to develop its existing supply to ensure that delivery of health care will not be compromised.

Barbara Nichols, DHL, MS, RN, FAAN, Executive Director of the Commission on Graduates of Foreign Nursing Schools (CGFNS) commented that the key to resolving the issue is through better salaries and working conditions for nurses. She mentioned that among a total of 185,000 nurses who passed the CGFNS exam in 2003, 63% are Filipinos.

Another panel discussion was conducted with the following speakers: Cynthia Dayrit-Demetillo, MA, EdM, RN; Susan Gador, MA, RN, CPAN; Mila Velasquez, MN, RN, CS, NP; and Cecilia G. Peña, MAN, RN, APNC. The topic was Advanced Nursing Practice. The discussion focused on the challenges faced by clinical nurse specialists, the challenges and opportunities of nurse practitioners in the country. Advance nursing practice promises a better opportunity for growth of the profession through empowerment and autonomy.

Leticia C. Hermosa, PhD, JD, RN, presented competency-based learning organization, emphasizing the role of nursing institutions to serve as catalyst fostering leadership values among its members. She stressed that learning while working should be valued in the workplace.

Other presenters include:

- Josefina Tuazon, DrPH, RN, UP College of Nursing, shared the project Philippine Nursing Information System, a centralized nursing database focusing initially on nursing human resource production (supply) and utilization/deployment (demand). This was established, housed and managed by UP College of Nursing and National Institutes for Health Institute of Health Policy and Development Studies.
- May Mayor, MA, RN, Patient Safety Officer of the Department of Veterans Affairs of the State of New York shared valuable information update on patient safety. She stressed the need to develop a culture of safety and a positive approach to medical errors.
- Diana Gomez covered the issues and concerns of new breed of infectious diseases like avian flu, anthrax, and Severe Acute Respiratory Syndrome (SARS).
- Fr. Vic Sadaya of the Claretian Missionaries, shared his experiences in counseling and outlined some guidelines on how to prevent "compassion fatigue"
- Teresita Barcelo, PhD, RN, Vice Chancellor for Academic Affairs of UP Open University, discussed the challenges of building a culture of excellence in nursing.
- Pastor Ed Lapiz addressed the spiritual dimension of care, encouraging nurses to take care of the soul, and not only the body of the patient.

President's Message

Ruth R. Padilla

We live in a time of rapidly changing social and health care environment. We are only too aware of the social inequities brought by poverty. We are aware of the imbalance between the rich and the poor, especially when it comes to access to health care. We are also aware of current health trends, the increasing burden of non-communicable diseases, such as cardiovascular diseases and diabetes, on top of infectious diseases, such as tuberculosis. And we also recognize the current problems on out-migration of qualified nurses, nursing shortage and proliferation of nursing schools in our country and their implications to the delivery of health care.

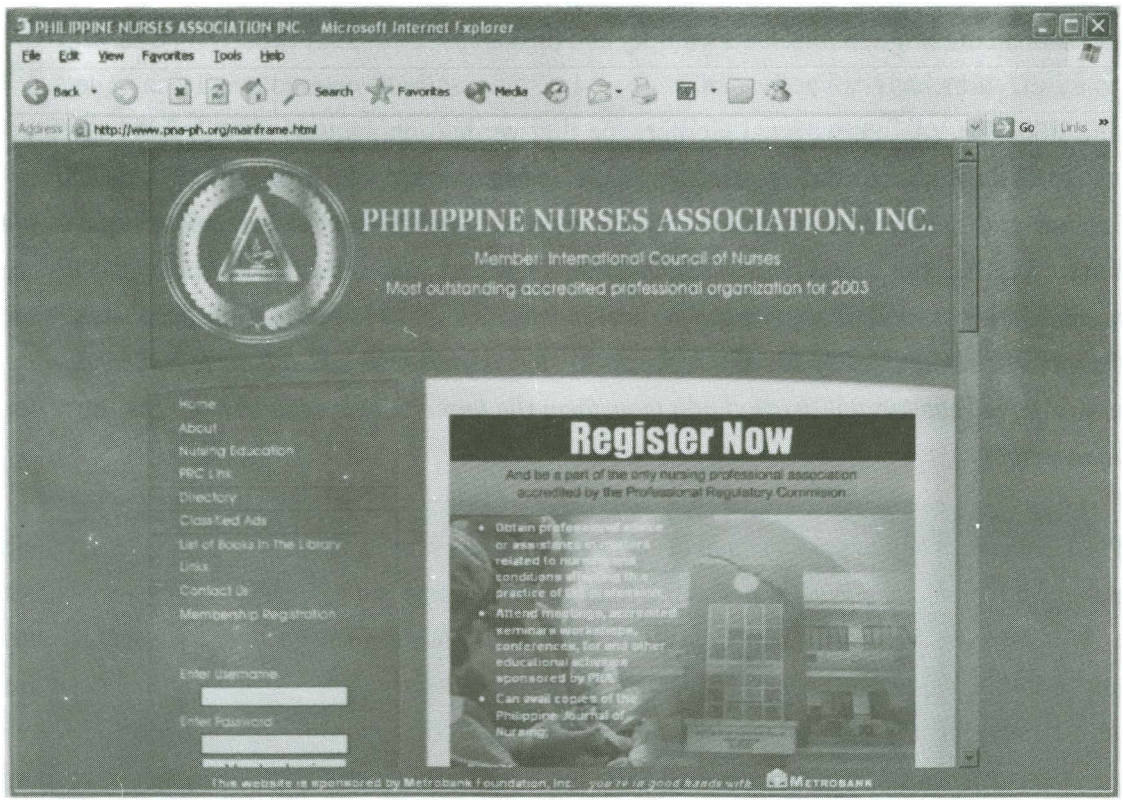
The PNA-PNAA International Conference that we had on January 20-22, 2004 gave us the chance to discuss these challenges. We have learned from that meeting of nurses from the Philippines and the United States that nurses have heightened awareness and interest in global concerns. And most importantly, we realized that nurses are in the position to make a difference, to be instruments in transforming the global health care through leadership. We need to take on the challenge to be leaders. As Dr. Lucille Joel puts it, "*It is important for us nurses to realize that we are a massive force, a critical mass that can transform the immediate sphere that we live in, if not the whole society.*"

PNA as the accredited professional organization has the responsibility of leading the profession in facing these challenges. We are striving hard to consolidate our efforts in addressing the issues. PNA is part of the Solidarity Movement between and among nurses from different institutions organized by Dr. Amelia Maglacas. PNA is also taking an active part on the ongoing activities of Technical Working Groups on Workforce Planning, Standards and Regulations, and Unity and Leadership, which was organized by the World Health Organization and UP College of Nursing as WHO Collaborating Center. PNA is also actively involved in Round Table Discussions with the Professional Regulation Commission Board of Nursing to address current issues and concerns in nursing development.

We are also actively pursuing the implementation of the increase in the salary of nurses as stipulated in RA 9173 and requesting the Department of Budget and Management to issue a Memorandum Circular to all local government units to implement the stipulated increase.

We cannot stop the stream of nurses leaving for opportunities abroad. But we have the responsibility to continue working towards building better career paths, salaries and working conditions for nurses working in the country. And we have the greater responsibility of providing quality care to our patients and maintaining the quality of nurses that we produce.

In keeping with the digital world, PNA has uploaded its website to provide wider access to Filipino nurses here and abroad. The site also provides links to various professional and academic institutions. Visit our website: http://www.pna-ph.org



Nurses need to be leaders of the profession and of the people they serve. Let us strive harder to put our efforts together and to live our purpose of promoting professional growth towards the attainment of highest standards in nursing.

RUTH R. PADILLA
PNA National President

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.

GOAL

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.

Article Selection

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 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 PNAoffice at 110 Benitez St. Manila, Philippines or send through email pna@thenet.ph

The article should have a main title with subheads to indicate the subdivisions in the text. Abbreviations and acronyms should be spelled out.

Photo of the author as well as photos that highlight article content are also welcome. Black and white photos are preferred. Drawings and graphs should be clear.

Publication is scheduled at the discretion of the Editor who reserves the right to postpone and cancel publications for reason of space and other factors. All accepted manuscripts are subject to editing.

Authors will receive a complimentary copy of the issue in which their respective articles appear.

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