

Republic of the Philippines

Located in south-eastern Asia, the Philippine archipelago (projected population 90.50 million in 2008)¹ lies between the Philippine Sea and the South China Sea and encompasses 300,000 square kilometres of land and water.

Although the 7,107 islands are favourably placed in relation to south-eastern Asia's main water bodies, they are located in the typhoon belt and affected by cyclonic storms each year.

The Republic of the Philippines is divided into 81 provinces with 136 cities. Manila (population 1.58 million)² is the capital and the surrounding National Capital Region of Metropolitan Manila (population at least 11 million)³ is the country's political, economic and social centre.

The United Nations Human Development Index ranks Philippines 90 out of 177 countries worldwide (value 0.771). This places the Philippines in the group of countries with medium human development.⁴



According to the 4-part typology developed by the International Observatory on End of Life Care, the Philippines is categorised as a country in Group 3: that is, with localised palliative care provision.⁵

Palliative care service provision

Current services

In the Philippines, 34 organisations provide 108 hospice and palliative care services (Table 1). Alongside these providers, a wide range of groups give compassionate care to the dying.

Table 1 Palliative care provision in the Philippines

<i>The Philippines: Hospice-palliative care organisations</i>	<i>Freestanding unit</i>	<i>Hospital unit</i>	<i>Hospital Inpatient support</i>	<i>Consultancy</i>	<i>Home care</i>	<i>Day care</i>	<i>Clinic</i>	<i>Counselling</i>	<i>Psychosocial support</i>	<i>Total</i>
AKBAY Inc, Cagayan de Oro					1					1
Buena Vista Verde Caring Centre, Cebu			1		1	1				3
Alay Kapwa Kilusang Pankalusugan (AKAP)					1					1
Aruga, Jose Reyes Memorial Medical Centre, Manila									1	1
Ayala Alabang Hospice Care Foundation					1		1			2
Bigkis ng Tayabas Inc, Quezon									1	1
Central Luzon Pain Management and Hospice Care Centre				1	1		1	1	1	5
Children's Hospice of the Philippines Foundation, Manila		1								1
Cradle of Hope: James L Gordon Memorial Hospital									1	1
De La Salle Hospice Care Programme					1				1	2
Disciples of Hope, Naga								1	1	2
Far Eastern University: Nicanor Reyes Medical Foundation			1	1	1		1	1	1	6
Francis Regis Clet House and Pain Clinic, Mother Seton Hospital			1		1		1			3
Iloilo Mission Hospital: Pain and Palliative Care Clinic					1		1		1	3
Madre de Amor Hospice Foundation, Laguna					1	1			1	3
Kythe Inc			9							9
PALCARE Volunteer Group, Manila			1		1			1	1	4
PALCARE/ JIREH	1						1	1	1	4
Palliative Care Centre, Cebu Cancer Institute, Perpetual Succour Hospital		1	1		1	1	1		1	6
Philippine Cancer Society							1			1
Philippine Children's Medical Centre: Hospice Care Programme		1	1		1				1	4
Quezon-Lucena Cancer Society Hospice HCP					1					1
Remedios AIDS Foundation			1	1	1	1	1	1	1	7
Ramon Aboitz Cancer Foundation, Cebu					1	1			1	3
Rizal Medical Centre, Pasig		1								1
San Lazaro Hospital for Infectious Diseases: Starfish Programme			1					1	1	3
SM Foundation Inc Quezon City General Hospital		1								1
St Ignatius Hospice Foundation, Cagayan de Oro					1					1
Smiles Support Ng May K, Davao									1	1

The Medical City Cancer Centre, Pasig: Palliative Care Service			1	1	1		1	1	1	6
University of Santo Tomas Hospital Hospice, Manila					1		1	1	1	4
University of the Philippines-Philippine General Hospital: Supportive, Palliative and Hospice Care Programme		1	1	1	1		1	1		6
University of the Philippines-Philippine General Hospital: Munting Paraiso		1	1				1		1	4
Vineyard Medical Foundation, Cagayan de Oro					1		1			2
Western Visayas Medical Centre, Iloilo: Hospice Care Programme		1			1		1	1	1	5
34 organisations										
Total Services	1	8	20	5	22	5	15	11	21	108

The movement towards palliative and hospice services in the Philippines began in the 1980s and took a significant step forward when pain relief became incorporated into the government's Cancer Control Programme in 1990. The following year, the Philippine Cancer Society founded the first home care programme and offered support to other interested groups. Seventeen years later, 34 hospice-palliative care organisations provide end of life care to needy members of the Philippine population.

Two features figure prominently. First, is the range of settings under which palliative care is given. In the Philippines, less than 40% of hospitals belong to the government and many of the private hospitals achieve a level of investment which the government cannot match. As a result, patients with money are attracted to private care; those who are poor gravitate towards government facilities. Some public hospitals provide whatever they can free of charge; others have 'pay' wards alongside 'charity' wards. As both public and private hospitals offer palliative and hospice care, a range of services – inpatient, outpatient and home care – may be accessed by patients on a 'pay' or 'charity' status. Alternatively, the community-based hospice organisations usually make free-of-charge provision for patients who are admitted to their programmes.

Second, is the perception of 'hospice' and 'palliative care'. Although these expressions are sometimes thought to be coterminous, palliative care in the Philippines has a sharp focus on pain control - reflecting its historical links with the Pain Society of the Philippines - whereas 'hospice care' has a strong association with dying and support for the bereaved. So hospice care may be offered as a discrete element of a hospital-based palliative care service (as found at The Medical City) or as a dedicated programme offered by a community-based NGO. Yet the message is clear. Madre de Amor Hospice Foundation is 'dedicated to the care and comfort of the dying'⁶ and the Manila-based Palcare Volunteer Group receives patients 'where death is foreseeable in 28 to 48 hours'.⁷

Caring for patients who are close to death, particularly over long periods or where two or more people are dying simultaneously, places special demands on the people involved. Nurse Nancy Legaspi is a member of the Starfish Project at San Lazaro Hospital for Infectious Diseases and comments:

'Sometimes there are two or three dying patients; but I remember the starfish [story]⁸ and have checked for one patient at a time. I know that my time is

limited and I would rather focus on the one patient because they need quality time if you are really going to help them and their families.’⁹

Captain Maribel Develos is the Child Life consultant in the department of paediatrics at the Armed Forces of the Philippines Medical Centre, and speaks of the personal cost of working with children:

‘It’s one of the challenges: being close to the children. I’ve been here more than six years and I’ve known these children from the time that they were diagnosed up to the time that, usually, they die from their illness. And during those years of treating them, dealing with them, spending happy moments with them - especially during parties, during light moments, activities - it’s difficult to watch them die. As a doctor of course, we all want our patients to get well; but we have our limitations, we can only do so much. And if we see a child dying, memories flash from the time we saw them healthy - having fun during our parties; and now that we see them differently: very, very ill and up to the last breath of their lives, it’s difficult for us.’¹⁰

Producing and retaining a workforce trained in end of life care is one of the many challenges facing Filipino hospice providers. At the Madre de Amore Hospice Foundation, volunteer trainer Eva Data gives an insight into the difficulties, ‘Sometimes we train lots of volunteers, about 80 or so, and only one remains. Why? Because they think it is very tough’. Unsurprisingly, executive director Dr Rhodora ‘Dory’ Ocampo is careful not to over burden her volunteers ‘in case they don’t want to do it any more’.

The challenges to hospice and palliative care development may be summarised under the following headings:

Palliative care and society

- The Philippines is a resource constrained country
- Lack of public awareness
- Provision is problematic in remote areas and patchy throughout the archipelago

The health care community

- Lack of training among medical and nursing staff
- Low credibility/ interest in palliative care
- Low number of doctors with S2 licences (essential to prescribe morphine)
- Unwillingness of doctors to refer patients

Government

- Lack of political will to support palliative care
- No government stream for hospice funding

Service provision

- Maintaining a pool of trained and available volunteers
- Securing administrative support

- Funding
- Procuring drugs, equipment and materials
- Training
- Becoming over attached to patients, particularly children

Notwithstanding these challenges, and in the face of enormous need, hospice-palliative care activists strive to improve the quality of life of their patients and ensure that, when the time comes, these vulnerable members of Philippine society die with an element of dignity. Dr Nina Leonor of the Western Visayas Medical Centre (WVMC) explains the organisation's approach:

'In our locality we usually cater for patients who are poor, because most of our patients are indigents. They cannot afford their medicines because usually by the time a patient is referred to us, all their finances and all their physical, moral and spiritual reserves are already drained. So we are faced with a terminally ill patient whose finances have been drained with laboratory tests before they were referred to us, and the consultant can no longer do anything for the patient.

'So what we do is to find the means whereby the patient has a better life in a short period of time. We manage their pain; we mobilise the family support system; we do counselling, not only with the patient but also with other members of the family. Aside from that, if the patient is admitted in our wards, we find the means to support their daily needs; and if the patient is sent home and they live within five kilometres, then we do home visits for them. After that, our last service offered to this group of patients is bereavement care for the family.'¹¹

Some providers, such as the University of the Philippines - Philippine General Hospital (UP-PGH), have a large number of patients. This is because hospice, palliative and supportive care forms part of the curriculum of the department of family and community medicine. Other organisations, with fewer personnel, come into contact with smaller numbers (Table 2).

Table 2 Hospice care activity: five providers

Provider	Activity	Number	Date
Philippine Children's Medical Centre	Referrals	118	2006
UP-PGH Supportive, Palliative and Hospice Home Care Programme	Out Patients Department (OPD)	308	2005
	Inpatient Hospice service	262	2005
	Home visits	2,052	2005
Palcare	Home visits	20	2005
Central Luzon Pain Management and Hospice Care Centre	New patients admitted (Average)	100-150	Per year
Ramon Aboitz Foundation Inc	Counselling	Around 4 per week	
	Psychosocial activities:	Around 50 per week	

Volunteers, both with and without a health care background, are key members of hospice organisations. In 2002, Palcare became the first palliative care volunteer programme affiliated with an academic medical centre to gain recognition from the

Philippine Department of Health (DoH) and the Philippine Cancer Society (PCS).¹² Its members – like those of other hospice providers - are drawn from a variety of sources and have wide-ranging backgrounds. Some are health professionals. Others are community volunteers, retired academics, teachers or university students. Many of them also have links with Christian organisations such as Sinag (which supports hospitalised indigents) or the Daughters of Mary of the Immaculate Conception.

A feature of Filipino culture is its strong religious tradition. Ninety three per cent of the population claim to be Christian - mostly Roman Catholic - and this perspective is integrated into the country's public life, social networks and personal spiritualities. Meetings begin with prayer. Festivals demonstrate the tenets of faith. Ceremonies, rituals, novenas and devotions point to a distinct relationship between the secular and divine. Importantly, the essence of life is filled with a moral purpose. In this scenario, human mortality is viewed in a broader context, informed by belief and surrounded by mystery. Dr Alex Alip, chair of the department of family medicine at PGH explains:

‘All of the patients and all of the families have, in one way or another, had some involvement in things dealing with religion. So Filipinos rely on religion and the spiritual aspect to give them support, to help them - not just as a last resort, but as something that is really incorporated into the care that we give.’¹³

Within Filipino hospice programmes, this blending of belief and care may be seen as a motivating factor that draws volunteers towards the dying: in effect, framing the nature of the interaction and providing succour for both patient and caregiver. Volunteers speak readily and clearly about their commitment, as:

- A means of providing holistic care: ‘I would like to be a doctor who also helps patients in their spiritual life’ (Joy Saquibal)
- A source of illumination: ‘it helps me understand the meaning of death’ (Randylon Claudio)
- A self-sacrifice for others: ‘to become an image of my God - loving, caring, as if a brother to my sick brothers and sisters’ (Rogelio Reyes)
- A thanksgiving after surviving cancer: ‘this is my way of giving thanks to God for the extension of my life’ (Bernardita Mikesell)
- A mission: I’m a nurse and a member of the Daughters Mary Immaculate and I feel that I have a mission to help cancer patients (Betty Mag-iba)
- An activity that provides meaning: ‘I’m giving sense to my life because I help the patients, and I learn from them even in small matters’ (Tellie Cayabyab).

Volunteer Tess Gonzales recounts how her life experiences have led her to the hospice movement and a sense of fulfilment in caring for others.

‘I’m a retired elementary school teacher. And early on after I left the Philippines in 1974, I was lucky enough to get a job in the University of Missouri, a paediatric department where a portion of the place was devoted to children, mostly dying of cancer. And so I acquired that feeling, that certainly there is so much more to life than just being healthy. And then when I came

back to the Philippines, I went straight into the room of my 32-year-old sister who was dying of breast cancer. It was quite traumatic because it was the first experience after being away from the country for four years: to go into the corridors of the hospital, to hold in my arms a dying sister whom I had not seen for four years.

‘It seems there was a lot of us who developed cancer - seven of us, first cousins - so much so that the University of Minnesota sent a cousin-in-law of mine whose wife was also dying of cancer, to research on the health habits we had as a family. Later on, the cancer went on to the next generation: a niece 29, and another 38, who succumbed to the same disease; and so when I also went through this baptism of fire it was kind of payback time for me. Payback time because I consider myself very lucky to have survived, with all those people along my bloodline already going back to the Creator.

‘But besides being payback time I feel that there’s so much to life that we have to really give of ourselves, totally. To give and find meaning to our lives by serving others, because that’s the continuance of the mission that God has given us. So I feel very blessed that we hearken to the call of the hospice. For not only do we touch the patients as a kind of duty, but we are even more blessed - because what better teacher do we have than the dying, who show us the meaning of the sanctity of life and the dignity of death. So we are blessed that we continue our mission together, to give our time and life to this hospice foundation in order also to experience what the dead go through, and their family: the family who are frightened by all this coming along their way, and for us to be able to lighten the cross for them, and help them travel - and cross - the road back to their maker.’¹⁴

In their 2006 paper ‘Integrating volunteers in palliative care: the Philippine experience’ Emmanuel Gorospe and Agnes Bausa report on the recruitment and activity of volunteers and the results of their involvement in the Palcare programme. Volunteers are screened and interviewed for suitability and, once accepted, trained in basic nursing care, the use of alternative pain relieving modalities (such as massage, music and play) and the psychosocial dimension of care. Some volunteers specialise in paediatric care and are trained in the Child Life Programme. Each week, a patient update takes place where volunteers are invited to join nurses, social workers and medical staff for comprehensive discussions: an innovation that breaks away from the traditional, hierarchical meeting from which volunteers are excluded. This is because volunteers have been found to make significant contributions to patient care, especially in the following areas:

- Assessing the patient’s outlook and disposition. Filipino patients shy away from expressing personal concerns with medical staff, but the longer interaction with volunteers give insights into patient anxieties and existential concerns.
- Validating family dynamics and support systems. Filipino families have traditionally been the primary caregivers for family members and volunteers

are in a prime position to assess the level of care being received by the patient and any signs of carer fatigue.

- Assessing overall quality of life. Filipinos are reticent about expressing pain or discomfort and volunteers are in a prime position to notice small changes depicting any improvement or deterioration in the patient's condition.

The authors conclude that despite differences in professional backgrounds, the common aspiration among volunteers and medical staff enables them to form strong collaborations. They also form effective liaisons between palliative care programmes and local communities, and provide valuable psychosocial care of the chronically ill and dying.¹⁵

Reimbursement and funding for services

Funding for medical services in the Philippines comes from a mixture of public and private sources that include insurance schemes and out-of pocket payments. In 2005, the government's share of total health expenditure declined to 29% whereas out-of pocket payments increased to 48%, a rise of 5% since 2001 (Table 3).¹⁶

Table 3 Sources and amount of fund for health care in the Philippines, 2005

Sources	Amount (in million Pesos)	% Share
Government	51,922	29
National	28,651	
Local	24,772	
Social Insurance	19,899	11
Philhealth (Medicare)	19,253	
Employees' compensation	646	
Private sources	106,848	59
• Out-pocket	87,508	
• Private insurance	4,344	
• Health Maintenance Organisations	7,082	
• Employer-based plans	5,755	
• Private schools	2,158	
Others	2,102	1
All sources	180,772	100

Source: National Statistics Coordination Board

In this situation, the financial burden on families is very high. In its country profile on the Philippines, WHO state:

Paying for health care is an issue because of its poverty impacts. Under the current health care financing arrangements, low income families are pushed into poverty due to payments for health care. Almost 80% of total health expenditure is spent on personal health care services. In contrast, only 10% is used for public health care services. The same percentage is also used for the

administrative spending needed to run the entire health system. These are signs that the Philippines is not spending enough or effectively for health.

Health care financing resources are largely spent on hospital-based curative services and not enough on preventive and promotive health services, and subsidies for health services are poorly targeted.¹⁷

A key element of the government's support for the poor is the charitable disbursement of funds raised through the Philippine Charity Sweepstakes. The organisation's stated mandate is:

To provide funds in order to sustain free medical and health services to the poorest of the poor, and to augment the current resources of various institutions and organizations providing health services to the general public.¹⁸

This mandate is carried out through a variety of initiatives which include:

- Individual Medical Assistance Programme (IMAP)
- Endowment Fund Programme
- Upgrading of Medical Facilities
- Medicine Donation
- Medical Equipment Donation
- Outreach Programmes
- Special Programmes

Indicative support across these programmes includes:

- Instances where the Philippines Charity Sweepstakes Office (PCSO) assumes responsibility for the cost of hospitalisation for a patient – including the medicines, medical, surgical or blood supplies, and diagnostic procedures (IMAP).¹⁹
- The establishment of free medical and dental missions in depressed areas within and outside of Metro Manila. Under this program, the PCSO also gives to out patients free consultations and medicines (Community Outreach Programmes).²⁰
- Assisting the enrolment of 539,670 indigent families in PhilHealth's *Medicare para sa Masa program*.²¹ This is a joint undertaking involving PCSO, the Philippine Health Insurance Corporation (PhilHealth), and local government units (LGU). For the initial implementation of the programme, PCSO has allocated PHP 67 million (US \$1.514million, GB £0.767 million)²² under the PCSO-Philhealth Greater Medicare Access Program - Special Programs Umbrella.²³

Despite the support of government, sourcing funds for treatments and drugs is a concern for both health care providers and the patient. Dr Annabelle de Guzman, of the Western Visayas Medical Centre, comments:

‘The patients that we are admitting are all charity patients: they don’t have to pay anything. But we don’t have a health care system like in England, where the National Health Service provides everything. What the government can provide here is only free bed and free food – and sometimes laboratory tests. But the medicines: the patients have to fund their medicines. So sometimes we also have to look for medicines for them. And if they need any procedures – like when they can’t eat anymore – then sometimes we also have to find money for the materials that are to be used for the surgery.’²⁴

A factor here is that government funding is capped at pre-determined levels according to diagnosis and need. Even for patients with insurance, there is often a shortfall in benefits. Dr Andrew Ang explains:

‘Insurance here in the Philippines has a widespread problem: it does not settle everything sometimes but only 25% of the bill. If you have a 100,000 pesos bill, only 25,000 comes from the insurance and 75,000 is settled by the patient. So even if you have a good insurance policy, it still doesn’t cover all the bill. And hospice patients, who come late, don’t get anything.’²⁵

This is compounded by the fact that medical posts in government hospitals are generally unsalaried. Agnes Bausa, a family medicine physician and founder of the Palcare Volunteer Group comments:

‘We have a system in this university hospital whereby you are affiliated here but your item is known as WOC – that is “work without compensation”. We are assigned with different tasks, like helping the department in the training of medical students and residents, assisting in different departmental committees and hospital services without receiving a salary. The incentives of being a WOC are that you can admit your private patients in this hospital’s pay ward and add the university hospital as your affiliation in your resume or calling card.’²⁶

The effect of this ‘without compensation’ service means that consultants mainly rely on fees from their private practice to provide for themselves and their families. Where physicians volunteer to support hospice care, this is usually after these first two priorities have been fulfilled. Dory Ocampo:

‘I need to keep my ear, nose and throat practice because it puts food on my table and it feeds my children. So I call my ENT practice ‘my profession’ and my palliative care practice ‘my vocation’, because I don’t receive money from it; but there are probably not a lot of people with the same mindset.’²⁷

Against this back-drop, imaginative schemes have been compiled that access funding and donations in kind from multiple sources: governmental and philanthropic as well as business enterprise and the local community. For example, CHILD House was established by means of a joint collaboration between PCSO, the Metro Manila Development Authority, the Technology and Livelihood Research Center and the

Ricky Reyes Foundation Inc. The latter organisation is an NGO established by the beauty guru and philanthropist Ricky Reyes²⁸ which under-writes the daily operations of CHILD House, whereas PCSO grants an endowment for the CHILD House human resource fund and to part-subsidise the maintenance and operating costs.

Table 4 gives an indicative list of primary and community donors that support the work of CHILD House. In addition requests are made to named donors who provide funds for medications or assistance with transport up to an agreed limit that ranges from PHP 1,000 (US \$23, GB £11.44)²⁹ to PHP 56,000 (US \$1,265, GB £640) per patient per request. CHILD House is also supported by various groups and individuals – including schools to prayer groups – that help the NGOs day-to-day operations.

Table 4 Indicative donor support for CHILD House, 2005

Donor:	Donation/ Pesos
Philippine Charity Sweepstakes Office	822,182
Ricky Reyes Foundation Inc	530,484
Food for the Hungry Foundation	297,887
Reyes Haircutters Inc	177,200
Hands	158,738
Salvation Army	82,000
Little Bookroom Inc	65,069
Ms Jeennee Garcia	56,100
Dr Rachel Rosario	54,411
GMA Kapuso Foundation	42,000
Ms Susan Sy	38,800
Women and Travel Inc	28,000
National Food Authority	3,000
Hermigildo Dichoso Jr	1 nebulizer
Les Reyes	1 computer + printer
Make a Wish Foundation	1 TV set
St Cecelia Prayer Group	2 sacks rice; 2 bags assorted goods
Mrs Regio	10 sets of dining tables; 20 double deck beds with foam
Kosy Enterprises	25 sacks of rice
Mr Conrad Tolentino	1 box of assorted toys
Lenny's catering	1 plastic bag of toys
Diliman Preparatory School	2 boxes biscuits; 1 plastic bag mixed fruits; 1 plastic bag toys

Source: CHILD House Annual Report, 2005

There is a view among hospice-palliative care practitioners that government funding has become more restricted since the last change of administration. In part, this is thought to be because the previous Minister of Health was sympathetic to palliative care due to his personal experience of his wife's cancer. Whether or not this is the case, there is no doubting the effects of reduced funding on service provision, outlined here by Dr Celina Vilches, leader of the pain and palliative care clinic at Iloilo Mission Hospital in Western Visayas:

‘The problem with us was that we were not thinking of generating our own income and we became so dependent on the funding of the PCSO that when the funding was removed we had nothing. The first thing that went was the pain medications; so you can just have a free consultation. The next day we could not give chemo drugs. We can do the chemotherapy with the help of our

doctor but patients have to buy their own chemotherapy drugs; so it's kind of sad. Then after that, the ambulance driver has to go because we don't have any funds for the driver any more. And later on we even have to give the ambulance to the hospital because we could not anymore continue the maintenance of this ambulance. So now what we are left with, instead of the multidisciplinary team, is only one nurse which the hospital was kind enough to provide. So if we can charge the patient, we charge. If the patient does not have money, then they become our charity patients. And we still do home visits with them, but this time we use our own car and everything. We still have this office here, and we still do our own type of hospice care, but it's not as ideal or as multidisciplinary as it was before ,because of lack of funding.'³⁰

Dr Elmer Pedregosa, the director of Iloilo Mission Hospital, is sympathetic to the needs of the pain and palliative care clinic. While appreciating the contribution of donors, he highlights the difficulties caused by the sudden withdrawal of funds. As a result, there has been a move towards greater self- determination in financial matters:

'In the past, as this hospital grew, it was fully funded by missionaries. I think the donors were so many that donations came in from different churches in the United States, or even other areas. But of course there's a plus and there's a minus on that; and I think it came to a head when the Filipino management took over, that at one time or another this should be a self-sufficient hospital.

'I think the hospital was in a crisis, almost like a transition from a donorship into a self-liquidating hospital. It was really a tough climb, because you were so used to being funded. And then, all of a sudden, it dwindles and the hospital was in a situation wherein they have shut up services. But I think the hospital has already adapted to the idea that we will run the hospital on our own.'³¹

For nongovernmental hospice organisations such as Madre de Amor and Ayala Alabang, self-sufficiency is crucial since services rely heavily, if not exclusively, on voluntary contributions. In its quarterly newsletter *Sharing Hospice* Madre de Amor acknowledges the individuals and organisations that have made donations during the previous period. For example, the donor list in issue 26 (December to March 2007) mentions 36 individual and nine organisations. For Ayala Alabang, strong support is provided by the Church of the Poor Foundation of the Parish of St James the Great. Dr Cenon Cruz:

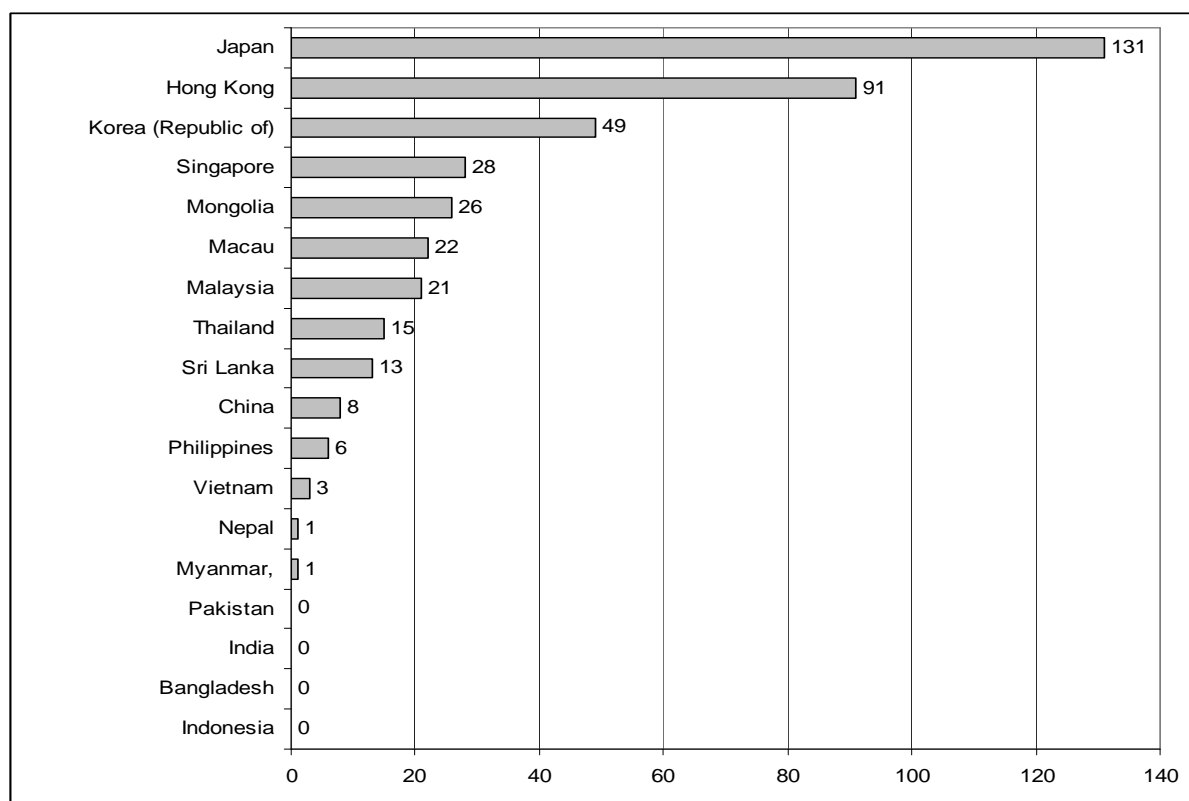
'We have no funds except donations from the church. If ever there are other donations, they are very little. Mostly they come from the church. Okay, we [parishioners] have good jobs, and the church was put up by residents' donations. It's a big church in the category of the cathedral: air-conditioned. We have six, seven masses on holidays; and this is where we get our support.'³²

Opioid availability and consumption

The International Narcotics Control Board (INCB)³³ has published the following figures for the consumption of narcotic drugs in the Philippines during 2005: codeine 0 kg (down from 30 kg in 2004); morphine 20 kg; oxycodone 12 kg; pethidine 11 kg.

For the years 2003-2005, the average defined daily dose consumption of morphine for statistical purposes (S-DDD)³⁴ in the Philippines was 6. This compares with other countries in the region as follows: Japan 131; Korea (South) 49; Sri Lanka 13; and Nepal 1. No morphine consumption was reported to the INCB for four countries (Table 5).

Table 5 Average daily consumption of defined daily doses of morphine per million inhabitants, 2003-2005: countries of Central, South and East Asia



Source: INCB, 2007

Morphine became more readily available for medical purposes in the Philippines towards the end of the 1980s when several developments smoothed the way for easier access to the drug. The Philippine Cancer Control Programme (1990) identified pain relief as a key element; the Dangerous Drug Board revised its over-restrictive regulations on the prescribing, purchasing and dispensing of morphine; and the Bureau of Food and Drugs approved the registration of morphine sulfate tablets. In 1991, the Philippine Guidelines for Cancer Pain Relief was published alongside a physician awareness programme in tertiary hospitals and an education course for community-based health workers. Links were also established with what is now known as the Pain and Policy Studies Group of the University of Wisconsin-

Maddison. This led to a survey of the knowledge and practice of cancer pain management among Filipino physicians, and a project to examine the relationship between the severity of cancer pain and its treatment (Table 6).³⁵

Despite this activity, formidable challenges remained. In a 1995 article in *Cancer Pain Release* Dr Adriano Laudico, Associate Professor of Surgery at the University of the Philippines and a leading advocate for cancer pain relief observes:

Drug distribution remains a barrier to morphine availability, however, because pharmaceutical companies do not have an efficient national distribution network: we have occasions when a hospital runs out of morphine and our system cannot respond quickly. We clearly need a better infrastructure to monitor needs and solve problems in the field. All of our smaller hospitals are under the control of local authorities, so mayors and governors can play an important role in expanding the programme to the grass-root level.³⁶

Table 6 Initiatives to combat cancer pain in the Philippines, 1988-1995

Date	Event
1988	Dr F Takeda (Saitama, Japan) visits DoH as WHO consultant on cancer pain relief
1989	Noreen Teoh (WHO-Geneva) assists in educating potential national leaders
1990	Philippine Cancer Control Program: pain relief becomes part of the new government policy
1991	Guidelines on Cancer Pain Relief published: DoH-Philippines Cancer Control Program
1991	The Philippine Cancer Society – Patient Outreach Service begins pilot project on cancer palliative home care.
1992	Dr K Foley (WHO Collaborating Center, New York City) encourages oncologists, surgeons and pain specialists in Manila to make cancer pain relief a priority
1992	Philippine College of Surgeons convenes a workshop: cancer pain relief and palliative care
1993	Manila Mayor Alfredo Lim sets up a cancer pain and palliative care ward at Ospital Ng Maynila
1993	The Philippine College of Surgeons and the Philippine Academy of Family Physicians begin cancer seminars nationwide to bring the WHO method to community-based health professionals.
1994	Cancer Treatment Guidelines, 2 nd edition: DoH/ Philippine College of Surgeons
1994	Caring at Home published by Philippine Cancer Control Program and the Philippine Cancer Society – Patient Outreach Service
1995	City of Manila sets up three-day seminars to train all municipal health professionals in the principles of cancer pain and palliative care.

Source: A Laudico, *Cancer Pain Release*, 1995; 8:3³⁷

Alongside these developments, anaesthesiologist Dr Cenon Cruz, the erstwhile president of the Pain Society of the Philippines, did much to sensitise the medical profession and national regulators to the benefits of morphine. Having studied pain and its management in the US during the mid-1980s – an interlude that included a fellowship at the Seattle Multidisciplinary Pain Centre under John Bonica – Cruz committed himself to the furtherance of pain education throughout the country. He was also committed to the acceptance of the Pain Society of the Philippines as a chapter of the International Association for the Study of Pain, together with the

establishment and spread of pain management centres: an initiative that led him into the wider regions of palliative and hospice care.³⁸

By 2007, progress had been made on several fronts. In a statement highlighting the influence of the national umbrella organisation Hospice Philippines, its president, the attorney Asuncion Kalalo, stated that the issue of morphine availability had been partly resolved in cases where terminally ill patients were in need of pain relief.³⁹ Hospice Philippines had been granted permission to prescribe morphine and in some instances this was unproblematic. Dr Marie Elise ‘Baby’ Allado describes what happens at the Ayala Alabang Hospice Care Foundation:

‘If there’s pain we give the patients medicine for pain. The National Hospice Council – which is the umbrella organisation now reaching all the hospices all over the country – has been given the right by the Department of Health to dispose of morphine. So we give them morphine if they need morphine for the pain. Of course we follow the step ladder. First, we start from the beginning, with non-steroidal, anti-inflammatory drugs and then we go for opioid-like medicines and then morphine. So physical symptoms we take care of so that the patient is comfortable.’⁴⁰

While such practice is exemplary, a literature review reveals the bigger picture. In 1998, a survey conducted by the Philippine Cancer Society indicates that 65% to 75% of the 37,623 cancer patients who die annually experience unrelieved pain.⁴¹ Later studies indicate that opioid consumption is minimal. In their 2001 paper on the use of opioids in chronic pain management, Francis Javier et al⁴² note that in 1999 the amount of morphine imported by pharmaceutical companies was 15 kg whereas the INCB allocation was 87 kg. And data from the Dangerous Drugs Board show that 43% of the national opioid importation was purchased by six major hospitals. To prescribe opioids in the Philippines, a doctor requires what is known as an S2 licence. Yet according to Javier, only 4% of the 86,818 physicians possess this licence, the result being that opioids are denied to 96% of the country’s physicians.

At the First Congress of the Association of Southeast Asian Pain Societies held in Manila during December 2006, Drs Francis Javier and Minerva Calimag reported their survey of 211 physicians about the use of opioids in the Philippines. While they found an ‘adequate’ awareness of the WHO analgesic ladder, they identified a resistance to the prescribing of strong opioids such as morphine. In effect, ‘Step 2’ of the ladder was being treated as a comfort zone: an area where physicians tended to ‘overstay’. This is partly due to the government’s regulatory policies, a factor that has also affected physicians’ attitudes towards narcotics licence application. Javier and Calimag conclude that the use of opioids in cancer pain management remains very low, 20 years after the introduction of the WHO 3-step ladder.

These findings chime with the experiences of hospice-palliative care activists who have contributed to this study. At the Central Luzon Pain Management and Palliative Care Centre, Dr Ilirna Edejer highlights the effects of ensuring narcotic drugs are strictly regulated yet available for medical purposes:

Opioid drugs are readily available locally but the Philippine Drug Enforcement Agency is giving us a hard time in securing medicines for our patients. It's because of the rampant illegal usage and we cannot blame them because they're just doing their jobs.⁴³

Alex Alip comments on the inhibition among Philippine doctors to prescribe morphine:

'We have not totally removed that thinking [about addiction] from a lot of our physicians, those who have not been in tune with the developments in palliative care. But that is gradually changing and a lot of physician communities are slowly accepting the usefulness of the drug, though of course we cannot deny that there are still some people who would frown on the use of it. In fact, they still think that morphine is more negative than positive.'⁴⁴

Canon Cruz draws attention to the inconvenience of getting an S2 licence but suggests this may be used as an excuse by doctors who are less than confident about prescribing opioids:

'The difficulty is that very few doctors will take the time to get an S2 licence. It's not expensive, but the point is that unlike before, when I could just ask my secretary or my drug representative to get me an S2, doctors now strictly have to apply and go there in person to get it. So these doctors are giving that excuse [for not obtaining it].

'But I think that's not the real reason. The real reason is they're not comfortable, because only doctors who pass through anaesthesia, who pass through pain medicine are comfortable. When I say comfortable, they can prescribe many hundreds of thousands of dosages for narcotics, and they are comfortable about it. But when you can only prescribe below 10 milligrams, a doctor might give the initial [supply] but when it doesn't go as they expect, they've now got a difficulty how to go about it. So they might as well not start. That's how I see it.'⁴⁵

Alex Alip confirms that, even among doctors who are prepared to prescribe morphine, advice is often sought from experts.

'Some people, even if they have a special prescription, still rely on the experts to help them prescribe. These are the doctors whom everybody else asks about morphine prescriptions. How should we prescribe? How many tablets do we give to this patient? What would be the period of time that we can give this morphine? So the reality is: still not too many physicians would be prescribing it themselves. We still rely on experts.'⁴⁶

The combined effect of this dearth of licensed doctors and the reliance on a small number of pain management experts has meant that even though morphine has been procured by government, stocks have remained unused. As a consequence, the Ministry of Health morphine budget was withdrawn. Dory Ocampo:

‘I think the reason why they cut off the morphine budget was because it was under-utilised. So the problem was distribution. They didn’t know where to give the morphine. You obviously have to give it to centres where people are using it. You have to give it to hospice OPDs instead of just dumping it into the hospitals and then finding some of these hospitals don’t even want to use it.’⁴⁷

This not only means that morphine supplies have to be purchased by the patient, but that access to it is patchy. Agnes Bausa:

‘Patients have to buy morphine unless we have some donated medicines available through Palcare. The government does not provide morphine. There are some instances where they sell morphine in the pharmacies but it’s not always regularly sold. This is because, as I heard from one of the chief pharmacists, morphine is not an income-generating drug so they do not really get money out of it – and their priority is life-saving and antibiotic drugs. But morphine is not a priority drug, so sometimes it’s not available in the pharmacies and people will go out into the *Mercury Drug*⁴⁸ stores, which is most commonly where morphine is sold.’⁴⁹

The government has publicised its efforts to lower the price of commonly used medicines, although the poor seem to have felt little benefit. This is partly due to inadequate supplies of low-cost medicines in government hospitals, but also because of the pricing power of multinational drug companies and the preference for branded drugs by both physicians and patients.⁵⁰

These and other issues relating to drug use in the Philippines have been examined by a group led by Dr Henry Lu, president of the PSP supported by the Pain and Policy Studies Group⁵¹ and the Open Society Institute. A workshop titled *Assuring Availability and Accessibility of Opioid Analgesics for Pain and Palliative Care* took place over three days in April 2008 in Boracay Island. Designed to identify common problems relating to opioids in the countries of Indonesia, Thailand and the Philippines, the workshop was similar in design to others held since 2000 in Latin America, sub-Saharan Africa and Eastern Europe.⁵² The format brings together country teams including clinicians, policy-makers and regulators to identify achievable targets for each country along with an implementation strategy and action plan.

The workshop agenda includes the following items:

- Pain control in cancer and AIDS: a focus on the use of opioids – Henry Lu (PSP)
- Pain control in children – Mary Callaway (OSI)
- UN drug conventions and access to controlled opioid analgesics – Willem Scholten (WHO-Geneva, Department of Medicines, Policy and Standards)
- Opioid Use in ASEAN Countries – Francis Javier (PSP)

- Access to analgesia: barriers to opioid availability – Karen Ryan (WHO Collaborating Center for Pain and Policy Studies at the University of Wisconsin-Madison).
- Principle of balance: the role of national governments, methods and resources to improve access to opioid analgesics – David Joranson (WHO Collaborating Center for Pain and Policy Studies at the University of Wisconsin-Madison)
- Defining terms: addiction versus physical dependence – David Joranson
- Overview of the WHO guidelines for the evaluation of national opioid control policy

Speaking at the meeting, the Philippine Health Secretary, Francisco Duque, acknowledged that the country's morphine use was minimal and itemised the multisectoral barriers posed by physicians, patients and suppliers. In response, he announced that PHP 10 million (US \$225,900, GB £114,415) had been made available for the purchase of opioids to relieve cancer pain among the poor.⁵³

National and professional associations

Hospice Philippines

Formerly known as the National Hospice and Palliative Care Council of the Philippines (NHPCCP), this national association was launched in 2004 under the auspices of the Philippine Cancer Society with 16 founding organisations and 81 individual members. President Asuncion Kalalo observes:

The formation of a national council is a significant step in the advancement of hospice and palliative care as the alternative in administering care for the terminally ill patients and their families. Through the national council, we intend to establish hospice units in various places in the Philippines and engage in advocacy for the inclusion of hospice and palliative care as part of the medical care programme entitled to the health benefits under our law.⁵⁴

The organisation's key elements are described as follows:

- *NHPCCP*: Hospice and palliative care is care for the terminally ill which aims to provide comprehensive relief of symptoms using the skills of a mix of health disciplines, together with education and assistance for both patient and family so that they are able to maintain care in the place which best suits the patient's needs, and remain confident and mutually supportive throughout.
- *Vision*: As prime movers of hospice and palliative care in the Philippines, we are committed to ensure the best quality of life for terminally ill patients and their families.
- *Mission*: To promote networking and cooperative linkages with local and international agencies through advocacy, education and training, standardisation of care and services, research and registry.⁵⁵

By October 2007, the re-named Hospice Philippines reported a membership of 24 organisations. An article in the Medical Observer that month highlights the association's growing influence.

The network facilitates cross referrals of patients to institutions catering to distinct segments such as children with cancer, persons with HIV/AIDS and rabies, and offering special services such as halfway house care and quality of life support activities (e.g. music and art sessions, spiritual formation, beauty regimens, microfinance). Its existence has partly resolved the availability issue of morphine, a drug restricted by the national Dangerous Drugs Board, among terminally ill patients in need of pain relief. The Department of Health has authorized it to distribute the painkiller through its members, especially for indigents. The government has also declared the first week of October [each year] as National Hospice and Palliative Care Week.⁵⁶

To bring a sharper focus to its work, Hospice Philippines has created a number of subgroups, each led by a chair and co-chair. These include training and education, membership, resource generation/ finance, research and advocacy.⁵⁷ A general assembly and election of officers is scheduled for June 2008.

Pain Society of the Philippines

The Pain Society of the Philippines dates from the mid-1980s when a group of anaesthesiologists, among whom Cenon Cruz featured prominently, became interested in the study of pain. In 1987 a delegation from the Philippines went to Germany to attend the 5th World Congress on Pain, held in Hamburg. That same year, the Society was granted provisional membership of the International Association for the Study of Pain (IASP). Regular membership followed in 1990.⁵⁸

The IASP was founded in 1973 to bring together scientists, clinicians, health care providers and policy makers to stimulate and support the study of pain and to translate that knowledge into improved pain relief worldwide. In 2007, IASP reported a membership of more than 6,300 individuals from 108 countries in 69 chapters.⁵⁹ The president of the Philippines Chapter (PRP) is Dr Henry Lu.

The purposes for which the Pain Society of the Philippines (PSP) is organised are stated to be educational, scientific and charitable, and include the following:

- 1 To promote education and training in the field of pain
- 2 To help organize Cancer Pain Referring Centres
- 3 To promote and facilitate the dissemination of new information in the field of pain
- 4 To help improve the management of patients with acute and chronic pain by bringing together scientists, physicians and health professionals of various

disciplines and backgrounds who have an interest in pain research and management

- 5 To encourage the adoption of a uniform classification, nomenclature and definition regarding pain and pain syndromes
- 6 To inform the general public of the results and implications of current researches in the area
- 7 To engage in such other activities as may be incidental to or in furtherance of the aforementioned purposes⁶⁰

Typical of the PSP's community activities were those which marked the Global Day Against Pain, held on 17 October 2005. Christina I Hermoso reports:

With the theme *No Filipino Child Should Be In Pain*, the Pain Society of the Philippines ... will hold various activities, including 'A walk for a cause' (from the Museo Pambata to the Rajah Sulayman Plaza, both in Manila), entertainment shows, and a free clinic for consultations dealing with pain in children and adults alike with anaesthesiologists, neurologists, rheumatologists, psychiatrists, pediatricians, and other medical experts present.

"The event will be participated in by young cancer patients with their families, PSP members, and other medical societies involved in pain management. We hope to increase public awareness on the different aspects of pain with the objective of improving pain relief in children as we believe that pain relief is a human right," said Dr. Henry U Lu, president of the PSP. Lu said it is important "to educate parents, children, and even medical practitioners on the effective methods to lessen pain associated with treatment to minimize potential physical and psychological effects and increase the chances for a successful treatment."⁶¹

Asia Pacific Hospice Palliative Care Network (APHN).

The APHN evolved over a series of meetings (which owed much to the support of its patron, Shigeaki Hinohara) from 1995 until March 2001, when the organisation was registered in Singapore. Although the Secretariat is based in Singapore, the Association is a regional organisation with fourteen founding sectors (geographical regions in which members are located). These include: Australia, Hong Kong, India, Indonesia, Japan, Korea (South), Malaysia, Myanmar, New Zealand, Philippines, Singapore, Taiwan, Thailand, and Vietnam.⁶²

The aim of APHN is to empower and support individuals and organisations committed to alleviating suffering from life-threatening illness in the Asia Pacific region. More than 1000 individuals and organisations from 29 countries have registered as members since 2001.⁶³ The Association's objectives are:

- To facilitate the development of hospice and palliative care programs (both service providers and umbrella bodies) and other relevant initiatives
- To promote professional and public education in palliative care
- To enhance communication and dissemination of information
- To foster research and collaborative activities
- To encourage co-operation with local, regional and international professional and public organisations

Nine key areas of activity have been identified:

1. Linking individuals and organisations
2. Publishing a directory
3. Establishing a website
4. Clinical fellowship scheme
5. Visiting faculty scheme
6. Travel bursaries
7. Donations of medicines
8. Donations of textbooks
9. Asia Pacific conferences⁶⁴

Among APHN's twenty council members are Dory Ocampo (currently the assistant honorary treasurer) from Madre De Amor Hospice Foundation and Asuncion Kalalo, president of the Hospice Philippines also of the Ayala Alabang Hospice Care Foundation. Previous Filipino council members include Dr Alberto Roxas, Dr Catherine 'Cathy' Krings, Dr Luzviminda Kwong and Dr Antonio Villalon.

Education and training

In the Philippines, hospice-palliative care education and training opportunities arise in a variety of contexts that range from international conferences to medical school curricula, in-house hospital initiatives and NGO seminars.

International conferences and courses

1st Congress of the Association of Southeast Pain Societies

In 2006, the First Congress of the Association of Southeast Asian Pain Societies (ASEAPS) was held in Manila (29 November – 2 December), hosted by the Pain Society of the Philippines. It was in 2004 that the countries of Indonesia, Malaysia, Singapore, Thailand and the Philippines signed a memorandum of understanding to found the Association. Led by President Cynthia Goh, its primary aim is to pool the education expertise and resources of member countries 'to constantly equip and

update each other on significant trends, issues, treatment and interventions on the alleviation of pain'.⁶⁵

Faculty members from ASEAPS countries were joined by other well-known speakers in the field of pain and palliative care. Plenary sessions include:

- Central sensitisation – Prof Anthony Dickinson.
- Fibromyalgia syndrome – Prof Irwin John Russell.
- Neuropathic pain: What we can learn from translational research – Prof Ralph Baron
- Pain associated with spinal cord injury pain: Mechanisms and treatment – Prof Michael Cousins.
- Pain relief: A universal human right – Prof Michael Cousins.
- Advancing palliative care globally: transforming the culture of death – Prof Kathleen Foley.
- The meaning of pain: From cure to comfort – Prof Cynthia Goh.
- Advances in cancer pain management – Prof Kathleen Foley.
- The contributions of psychology and psychiatry to the management of pain – Prof Michael Bond.
- Management of Cancer pain in the terminal stage – Prof Ian Maddocks.

Two items outside of these presentations have a particular bearing on palliative care development in the Philippines.

First, Ian Maddocks ('End of life care: Asian vs Western model') draws attention to end of life care programmes that have been developed in the West: programmes that focus on cancer, were founded in the tradition of Christian altruism and delivered in a variety of settings - the hospice, home and hospital. These programmes tend to emphasise symptom management, family involvement, and the co-ordination of professionals and institutions extending through the settings of care. Although such programmes have been strongly embraced by those Asian societies most influenced by Western example (usually through colonisation), Maddocks observes:

The many differences in history, culture, religion language and affluence throughout Asian societies mean that inevitably there will be differences in the underlying aims, institutions and practices of palliative care, as well as the resources that communities are able to devote to this aspect of health care.⁶⁶

Francis Javier ('Pain and education: Philippines') notes the scant attention given to pain and its management in Philippine medical education. Consequently:

Medical students graduate from medical schools with tens of hundreds of memorised protocols for managing infections, heart and lung diseases, endocrine problems, surgical, medical and paediatric emergencies and even exotic genetic conditions *only to face a blank wall* if presented with a cancer patient suffering from moderate to severe pain.⁶⁷

Javier further suggests that pharmacology in medical schools focuses on the ‘evils’ of opioids, causing respiratory depression and addiction. Such attitudes towards opioid analgesics become ingrained in the student’s mind and are eventually carried forward into practice. But in the light of advocacy by the Philippine Pain Society - and patient access to greater information via the internet - ‘medical practitioners are starting to give pain a second look, lest the patient goes to another practitioner who knows his pain management.’⁶⁸

7th Asia Pacific Hospice Conference

In September 2007, the Asia Pacific Hospice and Palliative Care Network held its seventh conference in Manila, hosted by Hospice Philippines. Titled *Nurturing Partnerships in Hospice Care* invited speakers were drawn from APHN sectors and the US. Pre-conference workshops focused on physical suffering and ethical issues (Tables 7 and 8).

Table 7 Pre- conference workshop (APHN, 2007): Physical suffering

Topic	Leader
The basics of pain management	Prof MR Rajagopal (I)
Are opioids safe?	Dr Noreen Chan (S)
Morphine for breathlessness	Dr Sue Marsden (A)
The management of spinal cord compression	Dr Temsak Phungrassami (Th)
The management of malignant bowel obstruction	Dr Ednin Hamzah (Ma)
The Assessment of spiritual needs	Dr Doug Bridge (A)
Should treatment cease at the end of life?	Dr Rosalie Shaw (S)

A=Australia, HK=Hong Kong, I=India, Is=Indonesia, J=Japan, Ma=Malaysia, My=Myanmar, NZ=New Zealand, P=Philippines, S=Singapore, Tw=Taiwan, Th=Thailand, V=Vietnam

Table 8 Pre- conference workshop (APHN, 2007): Ethical issues in clinical decision making for advanced cancer

Topic	Leader
Clinical and ethical issues in dealing with cancer management	Dr Ghauri Aggarwal (A)
Truth telling	Dr Ednin Hamzah (Ma)
Justifying clinical investigations in advanced cancer	Dr Noreen Chan (S)
Exploring therapeutic options in dying	Dr Ghauri Aggarwal (A)
Is compassionate care an ethical responsibility?	Dr Rosalie Shaw (S)
Human rights in palliative care	Dr David Brumley (A)
Euthanasia: Dignified death or simplified killing?	Dr Ghauri Aggarwal (A)

A=Australia, HK=Hong Kong, I=India, Is=Indonesia, J=Japan, Ma=Malaysia, My=Myanmar, NZ=New Zealand, P=Philippines, S=Singapore, Tw=Taiwan, Th=Thailand, V=Vietnam

Plenary lectures and symposium presentations are shown in Table 9.

In addition to these plenary and seminar presentations, the spread of oral and poster presentations were as follows:

- Oral presentations – Australia 2, China 2, Hong Kong 1, Japan 1, Korea (South) 4, Malaysia 1, Mongolia 1, Myanmar 0, Philippines 4, Singapore 3, Taiwan 30, Thailand 1, Vietnam 1

Table 9 Plenary lectures and seminar presentations (APHN, 2007)

Plenary/ symposium title	Topic	Leader
Day 1 – 27 September 2007		
Nurturing partnerships in hospice palliative care (P1)		Prof Cynthia Goh (S)
Partnerships in pain (S1)	Is morphine an essential drug?	Prof MR Rajagopal (I)
	Evaluating interventional cancer pain management	Dr Aleax Yeow So Nam (S)
	The child in pain	Dr Dido Gustilo-Villasor (P)
Partnerships in service delivery (S2)	Bridging hospital and community	Dr Ednin Hamzah (Ma)
	Partnerships in hospice development in Korea	Prof Youn-Seon Choi (K)
	Increasing palliative care coverage in Taiwan	Prof Ying Wei Wang (Tw)
Spirituality (S3)	Existential suffering	Dr Eric Cassell (US)
	Healing without curing	Dr Doug Bridge (A)
	Spiritual preparation for dying	Sr Geraldine Tan (S)
Partnerships in research (P2)	Generating evidence for palliative care	Prof David Currow (A)
	Australia: Research evidence and policy update	Prof Margaret O Connor (A)
	Benchmarking palliative care	Dr Stephen O Connor (US)
Palliative care nursing (S4)	The nurse as carer	Sr Geraldine Tan (S)
	Palliative care: a specialist qualification	Prof D Valderama (P)
	The Hope perspectives	Carmencita Abaquin (P)
Caring for carers (S5)	The power of hope	Liese Groot-Alberts (NZ)
	Spiritual transformation: grief to celebration of life	Prof Cecilia Chan (HK)
	Quality of life for caregivers	Gerrie Padilla (US)
Complementary therapies (S^)	Evidence for complementary alternative medicine	Leonila Dans (P)
	Interface between eastern and western medicine	Dr Phillip Tan Gatue (P)
Day 2 – 28 September 2007		
Diagnosing suffering (P3)		Dr Eric Cassell (US)
Ethical issues in palliative care (S7)	Patient autonomy in the Asian population	Prof Cecilia Chan (HK)
	Terminal sedation for refractory symptoms	Dr Eric Cassell (US)
	Suffering and the law	Prof Norchaya Talib (Ma)
Palliative care and children (S8)	Developing a best practice model for paediatric pc	Carol Quayle (A)
	Children facing losses	Prof MR Rajagopal (I)
	Uplifting the spirit: The Child Life Programme	Fatima Garcia (P)
Partnerships in non-cancer palliative care (P4)	Partnerships in AIDS care	Sanghamitra Iyengar (I)
	Infectious disease and palliative care	Dr Sue Marsden (A)
	Focus on the elderly	Dr Shelley dela Vega (P)
Bereavement (S9)	Long term effects of grieving on the life story	Liese Groot-Alberts (NZ)
	Grief assessment: who is at risk	Dr Agnes Bausa (P)
	Family grief experiences after the death of a child	Carol Quayle (A)
Symptom management (S10)	Place of holistic care in symptom management	Dr Sue Marsden (A)
	Managing symptoms in a resource poor setting	Dr Noreen Chan (S)
	Empowering the family in symptom management	Dr Andrew Ang (P)
Building up organisations (S11)	Encouraging corporate sponsorships	David Prail (UK)
	Engaging governments	Dr Stephen Connor (US)
	Winning over doctors	Dr Cynthia Goh (S)
Day 3 – 29 September 2007		
Partnerships in palliative care education (P5)	Teaching palliative care	Prof Satoru Tsuneto (J)
	Palliative care education: training the trainers	Dr Cynthia Goh (S)
	Can we teach compassion	Dr Rosalie Shaw (S)

New developments in the Asia Pacific region (P6)	Philippines: Impact of the national hospice council	Atty Asuncion B Kalalo
	Korea: Palliative care service models	Prof Young-Seon Hong (K)
	Thailand: Creating awareness in Thailand	Dr Temsak Phunggrassami
	Palliative care as a public health issue	Mary Callaway (US)
	New APHN partners	Dr Rosalie Shaw (S)

P=Plenary lecture, S=Symposium

A=Australia, HK=Hong Kong, I=India, Is=Indonesia, J=Japan, Ma=Malaysia, My=Myanmar, NZ=New Zealand, P=Philippines, S=Singapore, Tw=Taiwan, Th=Thailand, V=Vietnam

- Poster presentations – Australia 1, China 0, Hong Kong 2, Japan 8, Korea (South) 7, Malaysia 0, Mongolia 3, Myanmar 1, Philippines 8, Singapore 6, Taiwan 35, Thailand 0, Vietnam 0

Presentations from the Philippines, both oral and poster are shown in Table 10.

Table 10 Presentations from the Philippines (APHN, 2007)

Title (Oral/ Poster)	Author(s)
Dynamic education meets dynamic culture through the Starfish Palliative Care Education programme at San Lazaro Hospital for Infectious Diseases, Manila (O)	Larri Hayhurst, Lolito P Cruz
Learned helplessness of family members in hospital death and dying (O)	Mary Grace Lacanaria, Engelbert Manuel, Roderick Ortega, Eugene Perez
Knowledge toward cancer pain and the use of opioid analgesics among Family Medicine residents and medical students in the State University: implications for changing the medical school curriculum (O)	Maria Fidelis Manalo
The overseas Filipino worker: coming home to die (O)	Pretzel Villanueva, Rhodora Ocampo
The 13-year experience of the Home care programme of Ayala Alabang Hospice Care Foundation, Inc (P)	Ma Elisa Allado
The Hospice and Family Care Foundation of the Philippines, Inc (P)	Annabelle de Guzman
Health-seeking behaviour among breast cancer patients in the Madre de Amor Hospice Programme (P)	Dolores Ardez, Rhodora Ocampo
The bereavement programme of the Madre de Amor Hospice Foundation (P)	Virginia Cabrera, Rhodora Ocampo
Adequate analgesia resolves euthanasia (P)	Luzviminda S Kwong
Establishing a hospital-based consultative palliative care service: experiences from a four-week clinical attachment in two Singaporean institutions (P)	Jesus Eugenio G de Jesus
Ch.I.L.D Model: A tool in the psychosocial care for children with chronic illness (P)	Ma Fatima O Garcia
Integrating volunteers in palliative care: the Philippine experience (P)	Emmanuel C Gorospe, Agnes Bausa

APHN Diploma in Palliative Care/ Graduate Certificate in Health (Palliative Care) Flinders University

In June 2006, APHN launched a course leading to a graduate certificate/ diploma in palliative care in association with Flinders University, Adelaide. The stated aim of the course is to give medical and nursing professionals the opportunity to deepen the knowledge base on which their practice is founded. This one-year distance learning program includes two 2-week classroom intensives in Singapore and a 4-week clinical attachment at an accredited palliative care programme in Singapore or elsewhere in the Asia Pacific region. A three-month attachment is necessary for the diploma.⁶⁹

Forty seven doctors and nurses applied for 16 available places and three of the successful applicants were from the Philippines: the Manila-based Johan Monson; and Dennis Dignadice and Gene de Jesus from Iloilo: all of them family medicine specialists.

In 2007 twenty students were enrolled from eight countries. Six students came from India, five from Singapore, two from Malaysia and one each from Nepal, China, Myanmar and Thailand. The three Philippine representatives are: Jocelyn Barbaza, who helped establish a hospice home care programme for the University of Perpetual Help Rizal Medical Centre (although she has since been based in Singapore); the anaesthetist Joyce Santos (working in private practice in Manila), and Andrew Ang of UP-PGH.⁷⁰ Ang comments:

Thanks to a traveling scholarship grant from IAHPC, I was able to complete the first classroom intensives held in Singapore. It was difficult, but very productive. Difficult because one has to stay in a foreign land and study for two straight weeks; productive because the curriculum deepens one's knowledge of palliative care in every way.

I was refreshed about the rich history of palliative care and was updated on the new trends and guidelines in symptom management and communication. The course gave me the opportunity to compare the services we provide our patients in the Philippines to that of Australia and Singapore, and through this I was able to discover our strengths and weaknesses. I was also able to learn from my colleagues in neighbouring countries in the Asia Pacific. The opportunity to meet and study with leading figures in palliative care also made the event valuable.

Overall, the experience provided me a better understanding of what palliative care is. The new knowledge and the experience that I gained has provided me a greater sense of confidence – confidence not only in the provision of palliative care, but also to try and convince my colleagues at home that palliative care makes a difference.⁷¹

Medical school curricula

The hospice approach was introduced to the Philippines in 1989 when it was incorporated into family medicine at the University of the Philippines-Philippine General Hospital, the country's biggest charity hospital. The department of family medicine was founded in 1975 and built on the family practice residency training programme which began the previous year. Hospice care was well placed, since family medicine was regarded as an opportunity to decrease fragmentation and enhance the continuity of patient care. Information from the family medicine department states:

The discipline espouses holism, It looks at the illness situation not only as a biomedical phenomenon but also as a psychosocial-cultural construct. Disease is not caused simply by a germ or by a clogged artery, it is also determined by

poverty or by dysfunctional relationships. It is often said that when a patient gets sick, the entire family is affected.⁷²

The regular residency programme covers a period of three years. The first year mainly focuses on primary care in the outpatient department and the ambulatory emergency room. During year 2, residents learn about inpatient care and critical care. Year 3 residents concentrate on the community setting, the local health centre, district and tertiary hospitals. Experience of supportive, family and hospice care occurs in month nine of year two and hospice care in months five and six of year three (Table 11).

In 2000, the family medicine department offered a fellowship in hospice and palliative care, the first in the Philippines. This one-year programme is designed to train doctors in the assessment and management of physical symptoms – such as pain – as well as the psycho-socio-spiritual aspects of hospice and palliative care. Training is undertaken in a variety of settings that include the home, clinic, day care centre, hospice inpatient ward, and community-based centre. Places are offered to those who have completed the family medicine residency programme; ten fellows graduated by the end of 2007.

Table 11 Department of Family and Community Medicine, UP-PGH: Overview of clinical rotations

	Month 1	2	3	4	5	6	7	8	9	10	11	12
Yr 1	Family Medicine				Pedia	OPD	E O	D R	SX	Gynae	ENT	MH
Yr 2	SX OR	Internal Medicine		Tox	EM	Paedia Ward + ER		FW	SPH	FMC	FMC	E
Yr 3	Rural		Urban		Hospice		RITM	OB		FMC	FMC	E

E=Elective, O=Ophthalmology, D=Dermatology, Sx=Surgery, Or=Orthopaedics, FW=Family wellness, MH=Mental health, SPH=Supportive, Palliative and Hospice, Care, R=Radiology, EM=Emergency Medicine

Alex Alip, chair of the family medicine department, outlines the benefits of the supportive, palliative and hospice care programme:

‘The sub-speciality in hospice, palliative and supportive care offers ample training opportunities for people who want to be involved in the care of terminally ill patients, those needing long term chronic care, long term nursing care and people who have degenerative conditions. In addition to symptom management, they would also offer services in counselling, bereavement care and family conferences – and take care of the patient when the patient is in the last stages of his life.

‘This care might take place in the hospital or the patient’s home. We have a hospital-based hospice unit but our trainees and our consultants can also go on home visitations. So we work closely with the family plus other organisations that might be involved in care – like affiliated NGO and governmental organisations, and those organisations involved in the care of cancer patients. So we are happy to say that it is a multidisciplinary type of work.’⁷³

Although UP-PGH was the first medical school to teach hospice care programmes, courses are also offered at other universities. At the Far Eastern University-Nicanor Reyes Medical Foundation (FEU-NRMF), medical students have been taught ethics around death and dying since 1997. Since 2007, the curriculum has been modified to include the following topics:

- General principles of palliative care
- Pain control
- Symptom management
- Terminal care
- The multidisciplinary team approach

Year 1 medical students have a 5-hour input. Interns, residents, paramedics and Year 4 medical students have eight 1-hour sessions during their two month family medicine rotation; they also make home visits.⁷⁴

Hospital-based training

The Starfish Project: San Lazaro Hospital for Infectious Diseases, Manila

This hospital-based programme began in 2001 after the Australian nurse educator, Larri Hayhurst, was invited to develop a long term palliative care education programme by San Lazaro's Dr Benito Arca. As Hayhurst put a training team together, she became aware that some of the programme's principles were at odds with the hospital culture and its death taboo. And she was shocked to discover that two people died of Rabies in San Lazaro every day.

By 2002 the programme was under way and partnerships had been formed with San Lazaro staff and with the hospice pioneer Cathy Krings, founder of the PGH hospice unit. International experts Sue Marsden and Liese Groot-Alberts were recruited. Dr Eduardo Bruera 'offered to analyse the data from the new rabies treatment regime at San Lazaro and use it to form a palliative care protocol for worldwide use'.⁷⁵

An internal report, detailing the project's rationale and operation plan (2004-2006), locates palliative care within San Lazaro's *Hospital as a Centre of Wellness* programme. This initiative aimed to provide holistic care to terminally ill patients and also train caregivers, both health professionals and significant others. So palliative care blended well with its purpose:

To further address the needs of these patients with life-threatening or terminal illness, a palliative care education programme has been designed to enhance the management not only of these patients but also of their extended families who are adversely affected by the prolonged illness or eventual death, and the professional carers who are also seeking resolution to their own personal pains which affect their performance.⁷⁶

In the first two years, quarterly workshops were conducted by a combination of foreign consultants and local staff. An enhancement programme, aimed at strengthening the skills of the core team, was put in place. Here, items centred on key issues in the areas of HIV/AIDS and rabies. In total, the partnership entailed 19 visits over a six year period. Indicative examples of the programme's elements in 2002 and 2005 are given in Tables 12 and 13.

Table 12 San Lazaro Hospital palliative care initiative: Education for Empowerment, 2002

Date	Activity	Participants	Number
Sat 5 Jan	Trainees connect with consultants		
Mon 7 Jan	Fundamentals of palliative care (Days 1 and 2)	SLH + PGH nurses	30
Tue 8 Jan		Medicos del Mundos staff	
Wed 9 Jan	Complexity of communication	Drawn from previous participants	20
Thu 10 Jan	Trainee teacher training		
Fri 11 Jan	Administration and overflow		
Mon 14 Jan	Fundamentals of palliative care (Days 3 and 4)	SLH + PGH nurses	30
Tue 15 Jan		Medicos del Mundos staff	
Wed 16 Jan	Teaching experience: evaluation for trainees		
Thu 17 Jan	Rabies, the nursing perspective		
Fri 18 Jan	Administration and follow up		
Concurrent course			
Jan 7 -10	Rabies study		
Jan 14 -16	Rabies project		

Table 13 San Lazaro Hospital palliative care initiative: Examples of course titles and key elements 2005

Date	Title	Key elements
July 2005	Philosophy and principles of palliative care	Introduction to palliative care
		Filipino culture of death and dying
		Introduction to symptom management
		Communication skills
		Breaking bad news
		End of life decision making
		What is nursing?
		Loss and grief
November 2005	Self care for the professional carers	Getting to know myself
		Getting to know my family
		Getting to know others
		Getting to know the environment
		Natural emotions and feelings
		Distorted emotions and unfinished business
		Stages of loss
		Analysis of psychological issues in the home and workplace

NGO-led training

Training is a prominent feature of hospice organisations in the Philippines. When the Philippine Cancer Society began its home care programme for indigent cancer patients (1991), it was accompanied by a training programme designed to support its personnel in a new venture. Workshops were organised and the Society produced training manuals in English, Filipino, Ilocano and Cebuano. Hospice Philippines continues this tradition. In April 2008 a scientific symposium was organised with the Philippine Society of Medical Oncology titled ‘When do we say enough is enough?’ The panel included the oncologist Antonio Villalon, Fr Eric Marcelo O Genilo SJ (a moral theologian) and Fermin Adriano, the founder of Madre de Amor.⁷⁷

As interest in hospice care gathered momentum during the mid-1990s, the PCS worked with Josefina ‘Jo’ Magno, a Filipina doctor at that time involved with hospice care in the US. She visited the Philippines for four months in 1994 and, in addition to speaking to a large number of medical and community groups, accepted the invitation of the newly-bereaved Dada and Fermin Adriano to advocate for hospice care in Laguna. Dory Ocampo – who was present at Jo Magno’s talk and later became the programme director of Madre de Amor – recalls how Magno stressed the importance of training:

‘Very early on Dr Magno told us, “Rhodora, you have to train your volunteers, you can’t just send them out without them knowing what they’re going to do.” So initially she sent her daughter to do some of the training with us.’⁷⁸

Jo Magno’s point was well received and training has become integral to the Madre de Amor operation. A comprehensive volunteer training manual includes the following sections:

Principles and practice of palliative care

- Definitions
- The need for palliative care
- The goals of palliative care
- Palliative care and suffering: inter-professional care
- Multidisciplinary and inter-professional teams
- Principles of palliative care
- Barriers to palliative care

Symptom control

- Breathlessness
- Cough
- Oral problems
- Pressure sores
- Nausea and vomiting
- Poor appetite
- Constipation

- Sleeplessness

Pain

- Types of pain
- Causes of pain
- Pain measurement
- The analgesic ladder
- Opioids

Ethics

- Effective communication
- Withholding or withdrawing treatment
- Artificial nutrition
- Artificial hydration
- Euthanasia and physician assisted suicide

How to start your hospice visit

- Before the visit
- Actual visitation
- Attending to spiritual needs
- Patient and family requests
- Other needs

Preparation of the dying patient and the family

- Introduction
- Dying well
- Love
- Reconciliation
- Forgiveness
- Assurance about loved ones
- Letting go
- Faith and prayers
- Physical aspect of dying

Grief and bereavement

- The volunteer and the family
- Aspects of grief
- Ten ways to express sympathy
- Bereavement services

In March 2007, Madre de Amor Hospice Foundation conducted its 28th Hospice volunteer training programme. Training is also provided for other groups and organisations.

Palcare Volunteer Group

The Palcare Volunteer Group was formed in 2002. It is closely associated with the Supportive, Hospice and Home Care programme of UP-PGH and builds on the expertise of its personnel: social workers, nurses, residents and fellows. Between 2004 and 2006, Palcare conducted four training courses for potential hospice groups and three courses for volunteers. Requests for training have also been received from parishes and local government groups and the organisation is looking to expand its work in this field. A typical 3-day Palcare training course on the basics of hospice care is shown in Table 14

Table 14 Palcare training course: From cure to care – the basics of hospice and palliative care

Day 1 Basic principles in hospice palliative care
Opening prayer
National anthem
Welcome
Introduction to hospice and palliative care
Terminally ill adults and their needs
Terminally children and their needs
The terminal phase
Common symptoms
Pain
Nausea/ vomiting
Constipation
Palliative emergencies: an overview
Day 2 Basic communication
Grief and bereavement
The grieving family and their needs
Communication workshop
Communication with empathy and honesty
Active listening skills
Demonstration
Group demonstrations with facilitators
Day 3 Nursing skills
Getting the vital signs
Patient transfers: bed/ wheelchairs/ stretchers
Grooming: bathing in bed
Shampooing
Perineal care
Colostomy care
Bed sore care
Bedridden patients: changing bedding
Feeding (NGT, peg tube, high back rest)
Return demonstration

Examples of the Palcare range of courses are shown in Table 15.

Table 15 Palcare courses and workshops April 2003 – May 2006

Date	Title	Participants	Number
18-20 May 2006	From cure to care: the basics of hospice and palliative care	Nuns, seminarians, Barangay health workers, volunteers	40
15-18 June 2005	From cure to care: the basics of hospice and palliative care	Manila City Hall employees, DSWD employees, PAL Foundation employees	80

19-21 May 2005	Introductory seminar: Hospice palliative care for caregivers and volunteers	Nurses, volunteers, caregivers	20
June 2004	Hospice and palliative care training course for hospice volunteers (3 days)	Nurses, volunteers	60
13-15 Sep 2003	Child appropriate play training	Doctors, nurses, volunteers	20
13 June 2003	Self discovery workshop	Doctors, nurses, volunteers, caregivers	20
6 April 2003	Massage therapy and aroma therapy training	Doctors, nurses, volunteers, caregivers	35

Palliative care ‘coverage’

In the Philippine archipelago, hospice palliative care services are generally found in the more populated areas of Luzon, Visayas and Mindanao. The coverage of individual organisations is determined by several factors: whether the patient is ‘fee-paying’ or ‘charity’; access to transport, funding (for fuel) and personnel as well as distance from the organisation. Coverage examples are given in Table 16. While the majority of patients have a cancer diagnosis certain programmes admit patients with other conditions.

Table 16 Examples of coverage provided by hospice and palliative care organisations

Organisation	Coverage
Alay Kapwa Kilusang Pankalusugan (AKAP)	Three areas of Metro Manila
Ayala Alabang	Residents of Muntinlupa City (Metro Manila)
Central Luzon Pain Management and Hospice Care Centre	Olangapo City and the provinces of Zambales, Bataan, and part of Pangasinan, Pampanga and Tarlac
FEU-NRMF Hospice palliative care service	Charity: Barangay Holy Spirit and Payatas. Pay: Quezon City and Manila
Madre de Amor	5 towns and numerous barrios around Laguna lake (Luzon)
The Medical City Hospice Home Care	Negotiated agreements with individual patients
Palcare	Metro Manila area (more than 5 Km from PGH)
Ramon Aboitz Foundation	Province of Cebu + all who attend RAFI centre
Remedios Aids Foundation	Metro Manila and Cebu City + all who travel for care
San Lazaro Hospital for Infectious Diseases	San Lazaro (countrywide) patients with AIDS, TB, rabies and patients in the critical care unit
UP-PGH Home Care Programme	5 Km radius from PGH (Manila)
Western Visayas Medical Centre Hospice Programme	WVMC inpatients; home care patients within the 6 districts of Iloilo City

Palliative care workforce capacity

The absence of a Philippine hospice and palliative care database makes it difficult to give a reliable indication of the country’s total workforce capacity. In September 2000, Asuncion Kalalo reported that Hospice Philippines had ‘24 hospice care units and 520 individual hospice care service providers in Luzon, Visayas and Mindanao’.⁷⁹ Yet this figure only covers member organisations of the national association, and even so, details regarding the type and number of personnel in each category are unavailable.

Despite the lack of comprehensive figures local information gives an illuminating insight into the balance of hospice palliative care teams and the roles of its members. For example:

- Ayala Alabang Hospice Care Foundation: 1 doctor; 1 nurse; 6 volunteers; 1 spiritual director; several priests⁸⁰
- CHILD House: 1 project director (doctor); 1 full time (FT) medical officer; 3 volunteer staff; 2 administrative assistants⁸¹
- Far Eastern University - NRMF: 2 consultants; 6 residents; 1 nurse⁸²
- Madre de Amore: 1 programme director (doctor); 2 FT nurses; 1 administrative assistant; 50 volunteers⁸³
- The Medical City: 1 palliative care consultant; 1 surgeon; 1 ENT consultant; 2 oncologists; 1 gynaecological oncologist; 2 radiation oncologists; 1 interventional radiologist; several pain specialists; several residents; 1 OPD clinic nurse; 1 home care nurse; several pain service nurses; 2 administrative assistants⁸⁴
- Palcare: 1 programme director; 1 FT nurse; 1 FT social worker; 1 FT driver; 90 volunteers⁸⁵
- Philippine Children's Medical Centre: 1 coordinator; 1 doctor; 2 nurses; 1 social worker; 20 volunteers
- Remedios AIDS Foundation: 1 doctor; 1 nurse; 2 medical technicians; 6 other staff including social workers
- San Lazaro Hospital for Infectious Diseases: around 10 health professionals are actively involved in palliative care at any particular time

History and development of palliative care

During the 1980s, important innovations were undertaken by Filipino doctors interested in the management of pain that in 1989 led to pain management being included in the Philippine Cancer Control Programme and morphine becoming available in accredited government hospitals. That same year, hospice and palliative care were included in the family health care programme of the department of family and community medicine at the University of the Philippines - Philippine General Hospital. Then, in 1991, the Philippine Cancer Society broke new ground when it established the country's first home care programme for indigent, terminally ill cancer patients led by a multidisciplinary team made up of a doctor, nurse and social worker.

Also in 1991, a collaborative effort that included the Philippine Department of Health, AIDSCOM, the Academy for Educational Development and some private individuals founded the Remedios AIDS Foundation as a response to the growing AIDS epidemic. The NGO first began with a hotline through which clients could access distance-led counselling and education, together with a drop-in centre that provided face-to-face counselling and printed materials. Eventually, these services were enhanced by information dissemination, training provision, clinic and laboratory services, and palliative-hospice care.⁸⁶

The founding of the Kythe group in 1992 by Carmen 'Ecar' Castro and Fatima 'Girlie' Garcia was initially intended to provide psychosocial support for children with cancer at the East Avenue Medical Center. Yet as interest grew, it became registered as a non-stock, non-profit organisation in 1994 and in 1998 incorporated the Child Life Programme which has since become accessible in nine Philippine hospitals. Girlie Garcia, Kythe's executive director, explains the organisation's approach to working with seriously ill children:

'The policy of Kythe is that we don't want to capitalise on the sorrow, the pitiful sight of the child. That's why our programme is called 'Child Life'. We say that there is life even if you are sick; it shouldn't stop. So that's what we capitalise on. As much as possible, we feature happy faces, smiling faces in our posters - like going down the slide - even if the children have an IV machine attached to them. They are playing, and that's what we want to focus on: that while they're here, while they're alive, we should give them a semblance of normal childhood.'⁸⁷

The fledgling hospice movement was given a boost in 1994 when Josefina Magno returned to her native Philippines to campaign for hospice care, bringing with her a wealth of experience from her hospice work in the US. She had trained as a doctor at Manila's Catholic University of Santo Tomas, served on the National Science and Development Board and became the erstwhile assistant to the Philippine Minister of Health. Crucially, she had personal experience of cancer, first through caring for her husband, who died in 1954, and then when she was diagnosed with breast cancer. This personal engagement drew her to hospice care as an alternative to futile treatment and the view that death was a medical failure.⁸⁸ Speaking in 1995, she recalls her efforts to support hospice care in the Philippines during the previous year:

'I gave doctors four months, everywhere: the rotary clubs, churches, parish groups, city organisations, medical schools, hospitals, universities. In four months, I had a commitment from two medical schools. They will develop hospice programmes in their schools and introduce hospice in their curriculum. I had the biggest private medical centre in Manila starting a hospice programme. I had a university town starting a hospice programme. And then I talked to the Minister of Health: very important. The Minister of Health said, once I have demonstrated hospice in Manila, he will see to it that hospice care is available to every region, province, municipality, barrio of the Philippines. He declared 1995 'Hospice Care Year' in the Philippines. He also raised a National Convention last January, where he brought all the doctors from all the regions to Manila. I developed the programme. And after

the Convention all these doctors went back and started to develop programmes.⁸⁹

This flush of enthusiasm, underpinned by government support, resulted in the founding of numerous services during the mid and late 1990s. Madre de Amor, driven by the death of Sarah, Fermin and Lourdes ('Dada') Adriano's teenage daughter, opened in 1994. Endorsed by Jo Magno, the NGO soon attracted widespread support under the leadership of its young doctor, Dory Ocampo. Ayala Alabang opened that same year alongside Makati Medical Centre and the hospice service at the Philippine Children's Centre. Other services opened at the Central Luzon Pain Management and Hospice Care Centre and the University of Santo Tomas (1997). In 1998, a hospice programme opened at the Western Visayas Medical Centre (in Iloilo), the Eduardo J Aboitz Cancer Centre (in Cebu); and in Manila, Munting Paraiso – which focuses on children – was founded at PGH. By 2000, the Canossian Sisters of Charity had opened a hospice programme in Mindanao and the Buena Vista Caring Centre had opened at the Perpetual Socorro Hospital in Cebu City. In the early years of the twenty-first century, developments include the postgraduate residency and training programme at UP-PGH, the Starfish Programme at San Lazaro Hospital for Infectious Diseases, the Palcare Volunteer Group programme in Manila, the SM Foundation at Quezon City General Hospital, the opening of CHILD House in Quezon City, and the launch of a national hospice association.

Despite these gains, palliative care activists tell of a loss of momentum due to weak government support after a change of administration resulted in re-ordered priorities and a reduced commitment to end of life care. Funding that had previously found its way to hospice care was re-directed or became harder to access which had an effect on training and services. By 2007 the hospice fellowship and residency programme at PGH had been suspended. Hospice provision at Iloilo's pain and palliative care clinic was a shadow of previous times, and a number of the founding organisations included in the launch of the national hospice association (2004) had either closed or reduced their services. Dr Ilirio Edejer, of the Central Luzon Pain Management and Hospice Care Centre, comments:

Unfortunately our source of funds was terminated by the present government in 2002. So now we advise those who belong to the third class of our society to seek help from the Philippine Charity Sweepstakes Office. But the processing is so slow that sometimes the patient will succumb to death before the approval is given.⁹⁰

Although the challenges are formidable, there are signs that palliative care continues to progress at both local and tertiary levels. During 2007, Palcare formed an innovative association with the Christian NGO 'Jesus Is Reigning in Every Heart' (JIREH) to provide medical, psychosocial and training services at a 'halfway house' in Bulacan. In addition, new services opened at FEU-Nicanor Reyes Medical Foundation and at The Medical City. Maria Fidelis 'Liza' Manalo:

I head both units. The one of FEU-NRMF Medical Center is attached to its medical school so aside from the usual palliative care services we have the academic/educational component. Lectures and workshops pertaining to

palliative care are given to medical students, interns, residents and the rest of the medical staff of the hospital.

The Medical City is more developed. We pride ourselves in having a truly multidisciplinary team approach to cancer care. The advantage in this institution is that most of the consultants are relatively young, with further training abroad. The outpatient, the inpatient units and the home care services are very much in place and are utilized by the patients. We are very lucky to have a colorectal surgeon heading the Cancer Center who understands what palliative care is all about and is very supportive of us.⁹¹

Remarkably, the Department of Health Region XI has announced a half billion peso hospice programme to construct a freestanding facility for cancer patients being treated at Davao Regional Hospital (2007). Structural costs are estimated at PHP 200 million (US \$4.518 million, GB £2.288 million) with a further PHP 300 million (US \$6.777 million, GB £3.432 million) needed to equip it. Regional director Dr Paulyn Jean Ubial comments, 'We would be constructing this in stages as the budget is yet to be approved by a funding agency' (Table 17).⁹²

Table 17 Time line of hospice palliative care development in the Philippines

Date	Event
1984	Manila hosts World Congress of Anaesthesiologists under chairmanship of Cenon Cruz
1986	Cenon Cruz visits US to study pain management
1987	Philippines granted provisional membership of IASP
1989	Supportive, Palliative and Hospice Care initiative: University of the Philippines-PGH
	Pain control integrated into Philippine Cancer Control Programme
	UP College of Medicine adopts IASP core curriculum in pain
	Morphine available to DoH accredited hospitals
1990	Pain Society of the Philippines granted regular membership of IASP
1991	Philippine Cancer Society opens first home care programme
	Remedios AIDS Foundation becomes operational
1992	Kythe Inc founded by 'Icar' Castro and 'Girlie' Garcia: East Avenue Medical Centre
	First national convention on pain medicine
1994	Philippine Cancer Society initiates training in association with Josefina Magno
	Madre De Amor Hospice Foundation established
	Ayala Alabang Hospice Care Foundation established
	Kythe registered as a non-stock, non-profit organisation
	Hospice programme opens at Makati Medical Centre
	Philippine Children's Centre begins hospice programme
1995	First palliative care symposium held by PCS and DoH: Jo Magno guest speaker
	Manual published in English and Filipino by PCS
1997	Central Luzon Pain Management and Hospice Care Centre opens, Olongapo
	Hospice programme established at the University of Santo Tomas
1998	Kythe psychosocial activities become known as the 'Child Life Programme'
	Hospice and Family Care Foundation of the Philippines established, Iloilo
	Munting Paraiso opens: University of the Philippines-PGH
	Hospice Care Programme established: Western Visayas Medical Centre
	Palliative care service begins in the Eduardo J Aboitz Cancer Centre, RAFI, Cebu
1999	Canossian Sisters of Charity include hospice care in community programmes: Mindanao
	Buena Vista Verde Caring Centre opens: Perpetual Socorro Hospital, Cebu City
2000	University of the Philippines-PGH begins post-graduate residency and fellowship programme
2001	Quezon-Lucena Cancer Society HHP opens
	Starfish programme opens: San Lazaro Hospital, Manila
2002	Palcare Volunteer Group formed

2003	SM Foundation established at Quezon City General Hospital
	CHILD House Inaugurated, Quezon City
2004	Kythe accredited as an NGO by the Philippine Council for NGO Certification
	CHILD House opens
	NHPCCP launched, later re-named Hospice Philippines
2007	Hospice halfway house opened in Bulacan by PALCARE in partnership with JIREH
	Palliative care service opens at Far Eastern University-NRMF
	Palliative care service opens at The Medical City, Pasig
	Kythe has a presence in 9 hospitals
	MoH proposes a freestanding hospice facility in Davao at a cost of half a billion pesos
2008	Hospice Philippines forms 5 subgroups
	Policy study: opioids in the Philippines conducted by Henry Lu
	Opioid policy development workshop held in Boracay Island
	Minister of Health announces PHP10 million to provide opioids for cancer patients who are poor

Hospice/ beacon case studies

Supportive, Palliative and Hospice Care Programme (SPHC): Department of Family and Community Medicine, University of the Philippines-Philippine General Hospital, Manila

Hospice and palliative care were included in the Family Health Care programme of the department of family and community medicine at UP-PGH in 1989. It was a landmark achievement that brought together a combination of training initiatives (for medical students and family medicine residents), service provision (for chronically and terminally ill patients, both cancer and non-cancer) and research projects.

Significantly, the pioneering SPHC consultant and programme coordinator, Cathy Krings, brought together public health and NGO services through her role at PGH and as leader of the Philippine Cancer Society's Home Care programme. She also had an influential role at the MoH which helped to gain support for the hospice movement and drive it forward. Reflecting on the challenges facing the SPHC programme, she lists the following:

- Convincing hospital administration to allocate beds, approve the programme and endorse the programme to the hospital
- Convincing other departments to work with the programme
- Making day-to-day reminders to training MDs, consultants (MDs) and nurses to recognize the need for a hospice referral and a hospice service for their patients
- Creating awareness of hospice in PGH
- Fundraising for hospice - including salaries for hospice staff, medicines and supplies for patients, transportation for home visits, administration, training and education: almost all aspects of a hospice service. The hospital only provides the rooms and whatever meagre existing supplies it can allocate for the patients
- Developing good paying placements (jobs) for graduates of the training programme⁹³

The SPHC programme has expanded its services to include a 3-bedded inpatient hospice unit at the Cancer Institute-Andres Soriano Foundation, a consulting service,

an outpatient clinic, counselling and home care services. Table 18 shows how patient numbers have increased between 1997 and 2005.

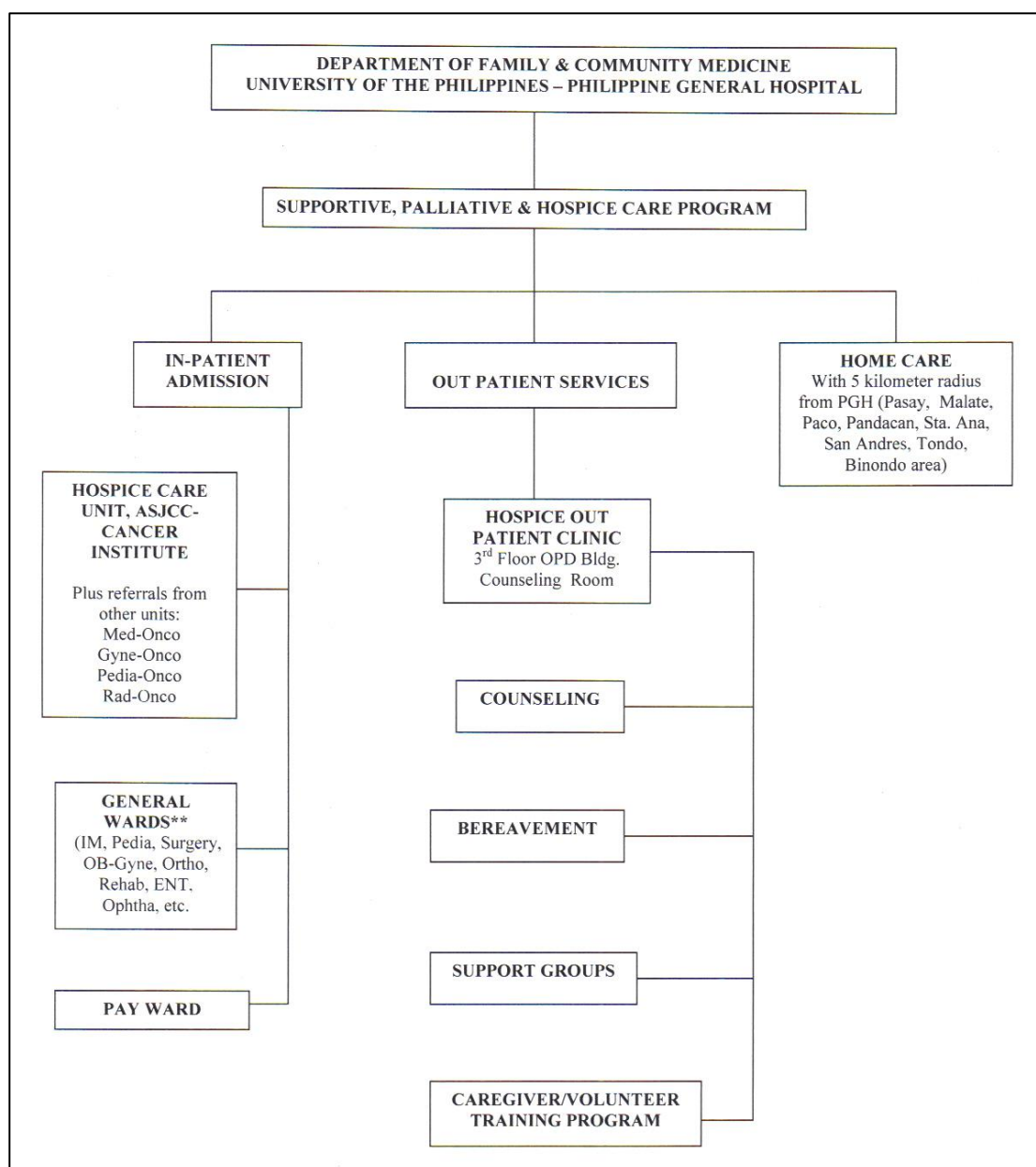
Referrals to the SPHC programme are received from the charity wards of PGH and institutions such as the Philippine Cancer Society, the Makati Medical Center, and Ospital ng Maynila. Patients are also received from concerned individuals living in Quezon City, Valenzuela, Las Pinas, Caloocan, Mandaluyong, Bulacan, Cavite, Pasig, Pampanga, and Batangas. At present, home care can only be provided within a 5 km radius of PGH due to constraints on funding and personnel.

Table 18 Patient activity in three sections of the Supportive, Palliative and Hospice Care Programme, UP-PGH, 1997-2005

Activity	1997	1998	1999	2000	2001	2002	2003	2004	2005
Outpatient hospice service	140	266	474	501	693	418	275	295	308
Inpatient hospice service	71	109	89	104	128	163	192	291	262
Home visits	799	768	946	955	1,223	1,335	1,370	1,890	2,025

. The organisational structure of SPHC is shown in Figure 1.

Figure 1 Organisational structure of the supportive, palliative and home care service at UP-PGH



Source: Palcare Volunteer Group

Palcare Volunteer Group, Manila

The Palcare Volunteer Group was founded in 2002 to enhance the SPHC programme at PGH's department of family and community medicine. It supports the hospital-based work and accepts home care referrals for patients who live outside of the 5 km radius covered by the SPHC programme. Inspiration for the NGO came from four doctors: Howard Hernandez, a former palliative care volunteer in Canada, hospice pioneer Cathy Krings and two graduates of PGH's hospice fellowship programme, Grace Kaw and Agnes Bausa (currently the chief executive officer and programme director).⁹⁴

Palcare's stated aim is to 'facilitate and enhance a patient's quality of life for the duration of his/her remaining days'. This is done in a variety of ways, including:

- Hospital ward visiting
- Home visits
- Bedside care
- Companionship
- Emotional support
- Pastoral counselling
- Active listening
- Play therapy
- Massage therapy
- Medicine sharing
- Fundraising
- Donor seeking
- Financial pledges
- Bereavement care⁹⁵

These activities are undertaken by volunteers, who have come forward in great numbers to give their support. Agnes Bausa:

After posting announcements and volunteer programme promotions, motivated people from all walks of life started joining the group. From undergraduate, graduate and medical students (from the University of the Philippines and the University of Santo Tomas) to medical specialists, teachers, businessmen, lawyers, artists and housewives: everyone announced their willingness to help. It was no coincidence that most who volunteered were young and determined students and professionals in their formative years. Because of their first hand experiences, they became aware that a lot of people needed their help. With this, the volunteers yearned to reach out and offer whatever help they can.⁹⁶

Between 2005 and the first half of 2006 the number of Palfcare home visits increased dramatically as more patients were referred to Palfcare for home visits (Table 19). By 2007 over 130 volunteers had been recruited and trained. Patients were not only referred from PGH but also from Ospital ng Maynila and the Philippine Children's Medical Centre. Importantly, the work of Palfcare was reaching both a Filipino and international audience through articles in the (Manila) Sunday Times,⁹⁷ The Medical Observer⁹⁸ and palliative care journals.^{99,100}

Table 19 Palfcare home visits in Metro Manila, 2004-June 2006

Area of Metro Manila	2004	2005	To June 2006
Manila	6	5	15
Quezon City	4	4	6
Makati	0	1	1
Marikina	3	2	0
Pasig	1	0	0
Caloocan	2	0	2
Malabon	3	0	2
Valenzuela	2	1	2

Bulacan	1	0	0
Pasay	0	1	0
Las Pinas	2	2	1
Paranaque	5	0	4
Muntinlupa	0	1	2
Cavite	2	1	4
Laguna	2	1	2
Tarlac	0	1	0
Tagaytay	0	0	1
Total	33	20	42

Source: Palcare

In March 2008 a new collaboration was formalised between Palcare and the Christian NGO 'Jesus is Reigning In Every Heart' (JIREH). As a result, a freestanding facility has become a hospice 'halfway house' to cater for patients and their families in the Metro Manila area of Bulacan. The premises have been provided by JIREH, who will accept patients and volunteers regardless of religion, nationality and economic status. Palcare will provide the medical and psychosocial support to assist JIREH 'in educating and developing the skills of its pastors, lay ministers, members and volunteers in the palliative care approach in dealing with terminally ill patients'.¹⁰¹

Kythe Inc¹⁰²

When Icar Castro and Girlie Garcia, two graduate psychology students from the Ateneo de Manila University, formed the Kythe group in 1992 to give psychosocial support to paediatric patients at the East Avenue Medical Centre, there was no indication that it would also become a vehicle for advocacy and fundraising, pioneer the Child Life Programme and, by 2006, serve over 6,000 children per year. Yet the organisation chimed with a growing desire among Filipinos to make better provision for hospitalised children with chronic and life-threatening illnesses and see an improvement in their survival rate, currently around 30%.

The Child Life Programme is based on the premise that 'the hospital is not only a place to heal but also a place to learn, play and grow'. Consequently, the programme is designed to:

- Help the child cope with the stress and anxiety of the hospital experience
- Promote the child's normal growth and development in the health care setting
- Maintain the child and family's normal living patterns
- Provide opportunities for play, learning, self expression, family involvement, peer interaction, and gain a sense of mastery¹⁰³

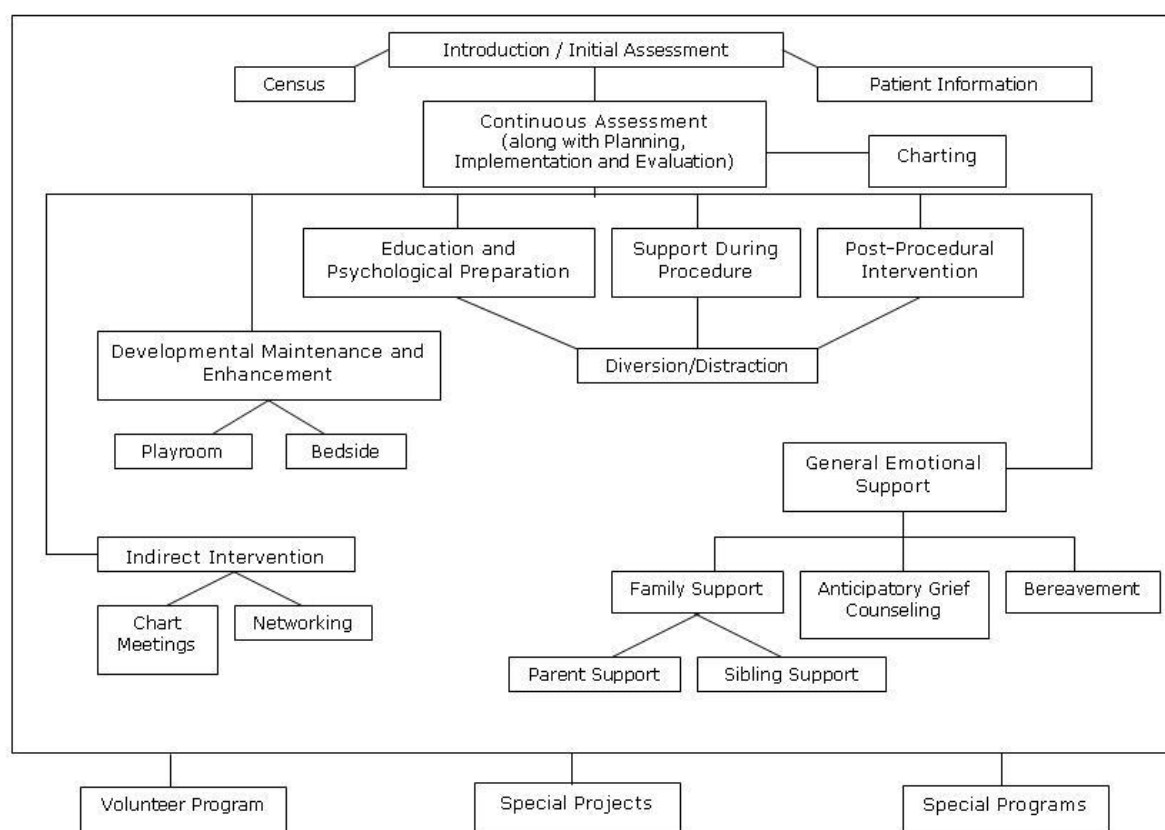
Standards for Child Life personnel are as follows:

- Child Life Programme Director - Master's degree and Child Life Specialist certificate from the Child Life Council
- Child Life Specialist – Master's degree and a candidate for certification by the Child Life Council
- Child Life Coordinator – a background in child development who has been trained by the Child Life Specialist

- Child Life Assistant – Bachelor’s degree with further study at Master’s level in an appropriately-related field¹⁰⁴

A structural flow chart showing the programme’s key elements and activities (known as the Child Life Logarithm) is shown in Figure 2.

Figure 2 The Child Life Programme logarithm



Source: *Child Life Programme Manual*

In 2006, 6,208 paediatric patients participated in the Child Life Programme in nine government hospitals nationwide (Table 20).

Table 20 Child Life Programme participants, 2006

Hospital	Patients (N)
AFP Medical Center	1,040
National Kidney and Transplant Institute	393
National Children's Hospital	1,121
Quirino Memorial Medical Center	606
University of Sto. Tomas Hospital (Charity)	595
Philippine Orthopedic Center	1,725
Davao Medical Center	334
Tarlac Provincial Hospital	29
Vicente Sotto Memorial Medical Center (Cebu)	365
Total patients	6,208

Source: *Kythe Year End Report 2006*

Opportunities for intellectual growth are regarded as a key element of childhood and Kythe's Integrated Reading Programme is designed to help meet this need. Here, children are engaged in reading and various other activities associated with a 'Book of the Week' written by a local author. Over 2,500 children participated in the scheme during 2006 (Table 21)

Table 21 Integrated Reading Programme participants, 2006

Hospital	Patients (N)
AFP Medical Center	336
National Kidney and Transplant Institute	960
National Childrens Hospital	336
University of Sto. Tomas Hospital (Charity)	240
Philippine Orthopedic Center	384
Davao Medical Cener	210
Vicente Sotto Memorial Medical Center (Cebu)	100
Total patients	2,566

Source: Kythe Year End Report 2006

In addition to psychosocial and developmental support, Kythe raises funds for the treatment of patients with both a cancer and a non-cancer diagnosis. In 2006 this amounted to over PHP 640,000 (US \$14,400, GB £7,290) (Table 22). The mother of a child with cancer tells of her difficulty sourcing drugs and the value of Kythe's support:

'As a parent it's really hard for us that our son, or our children, has a sickness like this. Sometimes it's very hard for us to face this kind of trial. But we have to stand on our own feet so that we can face these problems and accept these trials. We still have hope that we can carry on. As parents we have to thank God that we have been given strength and we have to thank also the staff of this hospital that they have this consideration for us - especially for our medicines for chemotherapy. Sometimes we don't have money for our hands. We cannot afford to buy all our medicines. So we have to give thanks that there are people who have this kindness for us, and accept from them the medicines they provide us with. As parents it's very hard to face our problems about getting chemo drugs for our children. For my son, there are still six chemotherapy treatments left and we have no money. So it's very hard for me, for us, as parents.'¹⁰⁵

Table 22 Kythe's spending on drugs and procedures, 2006

Hospital	Pesos
Cancer Fund - Chemotherapy medicines	
AFP Medical Center	124,918.36
National Kidney and Transplant Institute	550.00
National Children's Hospital	76,915.24
Quirino Memorial Medical Center	18,994.24
University of Santo Tomas Hospital (Charity)	106,945.00
Philippine Orthopedic Center	74,755.00
Davao Medical Center	5,132.76
Tarlac Provincial Hospital	106,720.30

Cancer Fund	514,930.90
Non-Cancer Fund – procedures and medicines	
National Children's Hospital	107,695.00
University of Sto. Tomas Hospital (Charity)	6,757.50
Philippine Orthopedic Center	1,670.00
Davao Medical Center	9,481.75
Non-Cancer Fund	125,604.26
Grand total	640,535.10

Source: Kythe Year End Report 2006

Volunteers are described as ‘the life-blood of the Child Life Programme’ and in 2006, over 880 people from 16 sources donated their time and expertise to support the children and their families (Table 23).

Table 23 Kythe volunteers, 2006

Source	Volunteers (N)
AFP Medical Center	234
Hands On Manila Volunteers	50
Kythe-Ateneo Volunteers	132
Citibank Volunteers	30
De La Salle University Rels 4 Volunteers	46
Xavier School Parents Auxiliary	30
Arrupe Jesuit Volunteers	5
UP NSTP Volunteers	9
Bata Batuta Woodrose –Paref School	45
Ateneo Christian Life Community	30
University of Sto. Tomas Hospital Volunteer	148
AFP Medical Center Volunteers	67
Davao Medical Center Volunteers	10
National Kidney and Transplant Institute Volunteers	12
National Childrens Hospital Volunteers	7
Quirino Memorial Medical Center Volunteers	27
Total volunteers	882

Having received treatment and drugs some children improve and return home, fortunate members of a minority group. Others do not survive. For Girlie Garcia, this is why hospice care is an important element of the Child Life Programme and included at an early stage:

‘Hospice is the heart of the Child Life Programme. What happens is that on admission – or on disclosure of the illness - the child is already going through the Child Life Programme, so it’s included from the beginning. It’s an expanded kind of hospice because we provide psychosocial help and total holistic care from the beginning all the way to the end of life; and afterwards we give bereavement assistance and all of that. Sometimes we call in bereaved parents and ask how they are doing and where they are now. Then we give them pointers or skills on how to move on - just so they know we haven’t forgotten them even if their children have died.’¹⁰⁶

There have been some learning experiences, however, as Aida Calagui points out:

‘In the early days of our Child Life Programme we would make this mistake of saying that it’s God’s will and all that. And we’d get reactions from the parents. They’d say, “That’s why I am angry at your God”. So we’ve learned, and when we train our coordinators we’ve told them that when that happens, sometimes you just don’t have to say anything. Just hold the parent. Just keep quiet and assure the parents that you are going to be there; just that. No spiritual comment. No saying, “At least your child is an angel now,” because we got the reaction, “But we can’t hug angels!” So we’ve learned. And it was a very painful realisation.’¹⁰⁷

As part of Kythe’s continuing care for the family, assistance is also given around the complex issue of returning the body to the family’s home province or whether to consider local cremation:

‘When the patient dies we are also there to support the family in terms of looking for a coffin or to consider what is to be done with the body. Sometimes, if the body is to be brought home, it’s more expensive to bring it all the way back to the province in a coffin. So sometimes we facilitate cremation. We suggest that, because sometimes the funeral parlours take advantage and offer very expensive services.’¹⁰⁸

In 2006, Kythe granted PHP 31,550 (US \$710, GB £360) in funeral and transportation assistance (Table 24).

Table 24 Kythe’s funeral and transportation assistance, 2006

Hospital	Transportation	Funeral Assistance
AFP Medical Center	300.00	1,000.00
National Children’s Hospital	-	8,000.00
University of Sto Tomas Hospital (Charity)	-	4,000.00
Philippine Orthopedic Center	-	12,000.00
Davao Medical Center	2,050.00	4,500.00
Total	2,350.00	29,500.00

Madre de Amor Hospice Foundation¹⁰⁹

When Madre de Amor Hospice Foundation opened the Philippine’s first community-based hospice programme at Los Banos in 1994, it owed much to the drive and resourcefulness of Fermin and Dada Adriano, whose daughter, Sarah, had died of

cancer the previous year.¹¹⁰ Heartbroken at the death of their eldest child, just 14 years old, the Adrianos determined to see better care for people with life-threatening illnesses. They were intellectually gifted, well connected, and held PhDs from English Universities. Both were professors at the University of the Philippines-Los Banos. Fermin, Sarah's father, was executive director of the Centre for Policy and Development Studies. He also wrote a column for *The Manila Times* and acted as its editorial consultant.

Motivated by their loss, the Adrianos met Josefina Magno in November 1993. It was an occasion that changed their lives. Fermin Adriano:

We learned that she was giving a talk on the concept of hospice, Moved by some hidden force, my wife and I attended one of her seminars. We were so touched by her presentation that right then and there we decided that we would be part of any organisation that would establish a hospice care unit. Little did we know that we would eventually be co-founders of a hospice in our own community of Los Banos.¹¹¹

Dada and Fermin were encouraged by members of their parish, both clergy and lay, and also by their wide circle of friends. Support also came from a group of Manila-based women, often referred to the 'golden girls'. One of these 'girls' was Carol Guerrero who later became chairperson of the NGO. She had been captivated by a 1991 magazine article 'Women who make a difference' that focused on Florence Wald and the founding of Connecticut Hospice (US). She kept the article, intending to consider something similar when the time was right. Then, during one of their weekly meetings, Guerrero broached the subject:

I explained that instead of meeting, lunching, we could put that same precious time to good use. We have done many things for ourselves, now it's time for others. Time to make our lives count for something before the light finally goes out.¹¹²

Shortly afterwards, members attended a seminar by Jo Magno and later heard about the fledgling group at Los Banos. Convinced about the need for a hospice service, the Los Banos-Manila link became a reality. Then, once the Securities and Exchange Commission papers were completed in August 1994, the Madre de Amor Hospice Foundation came into being - with Jo Magno as its chairperson - just one year after Sarah's death.

Dory Ocampo has been Madre de Amor's volunteer doctor since the hospice first began. Trained as an ear, nose and throat specialist, hospice care is far removed from her professional specialty, yet is of paramount importance in her life. She comments:

I don't think I'll ever be as awe-inspiring as Dr Magno. But with the help of my co-workers, two wonderful nurses and volunteers, we hope that somehow we could make a difference in our patients' remaining days here on earth.

The experience of being there for the patient and his family in their time of need is priceless. It has taught me many things – about myself and what I'm

capable of doing, about life and how it should be lived, about God and how his invisible hands guides us through life. I dedicate my work in hospice to my mother who died of breast cancer in 1992. Without her, I would have probably never have been a doctor.¹¹³

The history of Madre de Amor falls into three parts during which the breadth of its activities were rather different. During the early years, efforts were put into creating a niche for hospice in the community. Time was spent awareness-raising, recruiting volunteers and developing the service. In the middle years, as patient numbers grew, the Foundation adopted a policy of ‘franchising the hospice’. This meant training others to develop and deliver local hospice¹¹⁴ services – in Calamba City, Santa Cruz and San Pablo – with support from Madre de Amor. The latter years have seen the NGO turn its attention to the national association and the drive to incorporate hospice-palliative care into the public health system.

Since the NGO began there have been unexpected but important strokes of good luck. On one occasion, Madre de Amor held a celebration the Secretary of State for Health was invited to attend. Surprisingly, her unavailability played a major part in the hospice’s future ability to manage pain. Dory Ocampo:

‘The Secretary of Health didn’t come but she sent her assistant secretary, Dr Antonio Lopez. I sort of have heart-tugging programmes where you get everybody to talk and cry, and say how the hospice has helped them, so maybe he was touched. When we were about to end, he says to me, ‘Rhodora what do you need from the Department of Health?’ And I said, “Don’t dare ask me that question because I’ll really take you up on it.” And I told him “Dr Lopez, we need morphine.” And he said, “Okay this is my telephone number, this is my fax, call me up on Monday.” So first thing Monday, here I am on the phone, already talking to him and asking him what we had to do. So I got all the licenses that are necessary - and he gave me the morphine.

‘I didn’t need the Secretary of Health because this man was in charge of the morphine. And he made things so easy. So from ’96 onwards I have not had a problem with morphine because I can get it directly from the Department of Health. That means it’s not coming from the drug stores and it’s free. I felt a little selfish in the early days, but how could I know this would happen? That the Secretary of Health would send the assistant secretary who was in charge of the morphine? Then, when we started the national organisation I said, okay I better tell them my secret. So instead of me getting morphine directly from the Department of Health, we are getting it under the name of Hospice Philippines.’¹¹⁵

From small beginnings, Madre de Amor has made great strides forward. By 2006, the NGO had:

- Introduced hospice care to 11 of 30 municipalities in Laguna
- Established four hospice centres
- Trained 450 volunteers
- Sourced donations

- Secured morphine from the Department of Health
- Cared for 620 patients and their families
- Published a quarterly newsletter *Sharing Hospice*
- Published *Hospice Stories* - a chronicle and handbook of ten years caring for the terminally ill.¹¹⁶

Western Visayas Medical Centre

The establishment of hospice care at Iloilo's Western Visayas Medical Centre (WVMC) was driven by Dr Annabelle de Guzman, a family medicine physician who experienced hospice care during her post-graduate studies in the UK. Both the facilities and ambience of the premises impressed her greatly, as did the state of the patients. She observes:

The hospice patients were treated very well. They had art classes, music classes, a very nice chapel with services and a spa. Their garden was also very peaceful and had a calming effect on the senses. The doctors were more humane, family oriented and the patients were not treated like cases to be studied but as individuals. I myself would like to die in such a setting. And I hope to emulate that setting here in hospice care in the Philippines.¹¹⁷

The first step towards a similar service in Iloilo was to incorporate hospice care into the *Hospital as a Centre of Wellness* programme, run by the department of family and community medicine at WVMC. This was achieved in 1998, in consultation with other specialties that included: surgery; ear, nose and throat; obstetrics-gynaecology; paediatrics; ophthalmology; anaesthesiology; radiology; psychiatry; and internal medicine. This was viewed as a major step forward, based on a clear rationale that was outlined in the hospice care proposal:

If one only seeks a cure for the disease against all odds, the reality of impending death is never faced. Facing the imminent possibility of the end of life creates important opportunities, It allows people to resolve any interpersonal conflicts, it allows time to review their lives, perhaps find meaning, and it allows preparations for death.¹¹⁸

At WVMC, hospice care focuses on patients in the terminal stage of their illness. Most, though not all, have a cancer diagnosis. The programme's stated mission is: 'To support, propagate and expand the concepts of the hospice care programme for the care of terminally ill cancer patients in the region.' The target group includes those 'for whom death is certain and not too far distant'.¹¹⁹

Hospice services include:

- Pain and symptom control
- Oncology services
- Education and training
- Nursing care
- Psychological care

- Home care
- Spiritual care
- Social/ financial support
- Bereavement care

The hospice team is made up of the following personnel:

- Hospice care coordinator
- Primary attending physician
- Consulting physician: department of family medicine
- Nurses
- Social worker
- Dietician
- Physical therapist
- Clergy/ lay ministers
- Secretary
- Volunteers

The service is based within the WVMC Cobalt Building, where weekly talks are provided for patients waiting for radiotherapy. Titles include: ‘What is cancer?’ ‘Who can have cancer?’ ‘What is radiation treatment?’ ‘What is hospice care?’ ‘Psychological and spiritual aspects of healing.’

In 2002, the home care programme was enhanced by a 2-bedded inpatient unit housed in the women’s surgical ward. This later transferred to a 3-bedded room, fully equipped for hospice care in St Vincent’s Ward. From the programme’s inception (1998) until May 2006, around 300 patients and their families have been cared for (Table 25).

Table 25 WVMC hospice patients, 1998-2006

1998	1999	2000	2001	2002	2003	2004	2005	2006 (May)	Total
23	11	16	19	46	57	36	69	22	299

Alongside the inpatient and domiciliary features of the hospice programme, Annabelle de Guzman remained strongly drawn to the model of a freestanding hospice of the type she had encountered in England and this remained an important objective, central to her overall plans. In 2001, the Hospice and Family Care Foundation of the Philippines (HFCFP) was established, with Annabelle de Guzman as president, to support the hospice programme but particularly to raise funds for the planned ‘Hospice and Family Care Centre’. The early signs were encouraging. A memorandum of agreement between the Foundation and WVMC resulted in the donation of land – 800 square metres behind the Medical Centre - for the erection of a three storey hospice, the first in the Philippines. Its function was clear:

This facility will house the hospice patients of the hospital who will be undergoing chemotherapy, radiation and other palliative services. It will also house a chapel, a family room, a counselling area, business offices, and areas designated for staff conferences.¹²⁰

Fundraising has included raffles and rummage sales, concerts, auctions and special events. The 2005 World Hospice and Palliative Care Day was marked by a motorcade with participating vehicles adorned with streamers and balloons. Bands played. Hospital personnel and government officials mingled with students and representatives from the business world. Speeches from community leaders and local clergy urged support for the hospice project. The Governor's representative donated PHP 100,000 (US \$2,250, GB £1,140) and pledges flowed from the public, cancer support groups and bereaved relatives – all captured by the media and reported next day.¹²¹

In addition to such efforts, the intervention of the Philippines Charity Sweepstake Office caused hopes to soar. At the instigation of two Catholic priests, Fr Tagomila and Fr Villasis, the hospice project was endorsed by Archbishop Lagdameo in a letter to the Philippines' President Gloria Macapagal Arroyo. Three months later, in January 2005, a sum of PHP 5 million (US \$114,000, GB £58,315) was made available: PHP 1.5 for the construction of Phase I; PHP 3.5 million for Phase II.¹²²

With money to hand, construction began and by 2007 a two-storey shell had been completed. Yet rising costs have taken their toll and, from an original estimate of PHP 20 million (US \$451,800, GB £228,826) for the project, the figure has reached PHP 28 million (US \$632,515, GB £320,360). Annabelle de Guzman comments on the formidable challenge that remains:

Our [3-bedded] hospice ward is always filled up but there are very few hospital beds for our patients. We have started work on a 3-storey building exclusively for hospice patients (a first in Philippine history), but due to lack of funds we could not finish even the first storey. It's so pathetic to note that a lot of patients need beds - and we have a building that may accommodate a lot of patients - but due to lack of funding and sponsors, we could not make use of this Hospice Centre. Please help us pray for benevolent individuals who would help us finish what we have started so that ideal hospice care could be enjoyed by my poor country men.¹²³

Remedios AIDS Foundation¹²⁴

The first HIV infection was reported in the Philippines in 1984 and during the second half of the 1980s, a national AIDS/ STD prevention and control programme was introduced along with an AIDS registry. As the country's first AIDS Medium Term Plan was developed at the beginning of the 1990s, the Remedios AIDS Information Centre opened (1991), which became the Remedios AIDS Foundation (RAF) in 1992. The Foundation was established through a collaborative effort of the Philippines Health Department, AIDSCOM (the AIDS communication support programme), the Academy for Educational Development and a number of private individuals as a

response to the AIDS epidemic. It pioneered the country's first AIDS hotline – a telephone service which provided counselling and education - and a drop-in centre, where people could meet counsellors face to face or access materials about HIV and AIDS. Reporting in 2002, Nenita Ortega – RAF's then programme director for care services – comments:

Data gathered through the hotline provided direction as to how to further the Foundation's programmes and services. The data were subject to further validation by consulting with the community and our project partners. Today we provide information dissemination, training, and direct services that include clinic, laboratory and palliative/hospice care.¹²⁵

Working with clients who live with HIV/ AIDS presents many challenges. For example, not all HIV positive individuals disclose their status to family members, which presents an obstacle when trying to involve families as caregivers. Stress and burnout are ever-present dangers among volunteers, demonstrated by the high turnover of personnel in this group. And the possibility of discrimination is a constant concern, an issue that RAF addressed when establishing the hospice programme:

To meet this challenge, we involved everyone in the community when setting up the hospice programme. We prepared the community first, making use of massive education and awareness and slowly involving residents into the setting. Community people, along with HIV-positive people, were involved in every step and process of the undertaking until they had a sense of ownership of the initiative.¹²⁶

Ortega describes RAF's 'alternative approach' to palliative care for people living with AIDS. This approach builds on Filipino culture in which the family is the basic unit of society and responsible for its individual members. The Foundation aims to treat the problem in a holistic way by looking at the person, not the illness or infection. 'We look at the totality of the person's life, as well as the lives of family members.' In this wide-ranging approach, consideration is given to the psychosocial, spiritual, physical, economic and health needs of each client. In particular:

- Psychosocial needs are met through counselling, health education, stress management, peer group and client-with-family meetings
- Spiritual needs are met through meditation, relaxation and the strengthening of faith, whatever the religion of the client.
- Economic needs are met through training for business (candle making, handicrafts, fish farms) and start-up loans
- Physical and health needs are met through nutrition education, counselling at the onset of opportunistic infections, encouragement for medical advice and help to achieve drug adherence and compliance.

In addition, advice on alternative therapies is available to help reduce the pain of clients who cannot obtain antiretroviral drugs or antibiotics for opportunistic

infections. Theoretical and practical training in home based care is available for family members, who are supported by community volunteers trained in bedside care. For those who are coming towards the end of life, there is a special time to speak about preparation, the dying process and its implications. Nenita Ortega:

Those who are in the terminal stage often have a clear state of mind. Talking about death and the dying process is well accepted in the Philippines, and clients are open to the idea of talking about death because it helps them process the situation and make decisions and plans that will reduce the burden on the family. The family members are part of the processing; their participation helps them accept what may eventually happen to their ill relative. In our program, these families are able to seek support from other people, particularly families who are in similar situations. The support may be more psychosocial than financial. Many of our clients who have gone through this session claim that it is easier for them to accept the fact of death and move on. Eventually, these family members become volunteer caregivers and form part of a support system for others who are going through what the volunteers have gone through.¹²⁷

Hospice success stories

Filipino palliative care activists recognise success in a variety of ways. These range from the commitment of volunteers to the effects of psychosocial interventions, the establishment of a fellowship training programme and the small but significant individual contributions to the care of the dying.

At Madre de Amor, Tess Gonzales points to the volunteers:

‘I would attribute the success of the hospice to the spirit and goodness of the volunteers. They are very dedicated you know: retired – mostly in their 50s, 60s and above, like the group of people in Manila who wanted to put meaning into their lives, into our lives. And what would be a better way of doing service to God than to be with the dying, because they really are the people who need the most care and the most love.’¹²⁸

Kythe’s Cynthia Manzanares attributes the changed behaviour of their hospitalised children to the psychosocial care encapsulated in the Child Life Programme.

‘The initial reaction of children to the hospital is they become very withdrawn, very reserved or difficult to talk to. And in hospitals that have poor support for the Child Life Programme the tendency of the children is to just stay in bed, sleep all day, and nothing developmental really happens. But in the hospitals where the program is flying right now, you’ll notice the children are more adaptive. The hospital setting isn’t as threatening and the children don’t stay in their beds anymore. They don’t mind talking to visitors and they can communicate with just about anyone. When you introduce them to the programme - and you try to make them see that the programme is here to help

them - they become more compliant to medical procedures. They can even explain what their illnesses are all about, or what they're going through.'¹²⁹

A major breakthrough at San Lazaro's Hospital for Infectious Diseases was the use of haloperidol for rabies patients. Cirena Cabanban:

'Not much has changed physically, only the medication has changed. Sue Marsden was here when the first dose of Haloperidol was given to a rabies patient and staff on the ward saw the effect; that's why everybody was encouraged to use Haloperidol. The head of the department was reluctant to use it but when that first dose was given and everybody saw its effect, then little by little the use of Haloperidol was accepted.'¹³⁰

For Celina Vilches, success is placed in the context of the reduced services at Iloilo Mission Hospital's pain and palliative care clinic, brought about by the withdrawal of Charity Sweepstake funding in 2000.

'The only good outcome of this pain and palliative care clinic is that the hospital was able to secure its own pain medications. So right now we have morphine ampoules for injections. Morphine tablets are very much available and even oxycontin, which is oxycodone, is available because of the clinic.

'And then another thing: because we are here, people have become aware of pain management. So now the nurses know how to give morphine and they are not afraid. If I have a pain patient I would rather they are admitted to the Mission Hospital because the nurses are already so familiar with pain medication; that is one good thing about the training.'¹³¹

At Philippine General Hospital, Cathy Krings focuses on the academic and service developments. For her, success is:

The establishment of a post-residency training programme in hospice and palliative care in a university-based training institution; and the establishment of a volunteer group to help run the operations of the PGH hospice programme which includes fund raisers, donors and volunteers.'¹³²

Rachael de Rosario reflects on the state of newcomers to CHILD house and notes the development of coping skills and maintenance of hope.

'What we do when the parents and the patients come into the CHILD House is that we take care of them, we take care of them in a holistic manner, we don't just hand them over to the hospitals, but we do help them cope and we try to empower them so that they will, in a way, be responsible for the treatments and they will also be given courage to undergo whatever it is that is in store for them. It's very uplifting and very liberating to see that patients who came here without knowing anything at all about their disease, or how to go about getting treatment, are already teaching others what to do. And we all contribute, from the upkeep of the facilities, to sharing stories, to being a shoulder to cry on, to giving comfort to others. Most of all, I think it's the

collective spirit of not giving up; and hoping - hoping that tomorrow will be a better day, a better day than today.’¹³³

Among the volunteers, the opportunity to offer support on a personal level brings its own reward. Rosita Villanueva:

‘I had one patient that I cannot forget because when I saw him, he was lying down without a mat or clothes - no shawl, nothing - and his father got a piece of rug to cover the lower part of his body. When I went home I told this story to my children, to my grandchildren. I felt so sorry, unhappy, and when I went to bed I prayed for this man. I even gave him the clothes of my dead husband - Barong Tagalog and long pants – and I brought glasses, cups and saucers and something to eat, like pancit canton or rice, anything that I can bring. And I felt a little bit happy when he cried out, “Thank you very much.”’¹³⁴

Ethics and ethnography

Ethical issues

In the Philippines, health care is influenced by a number of factors including the predominance of private medicine, the financial status of the patient and the family’s role in caring for its sick members. These have been addressed in a medical code of ethics formulated by the Philippine Medical Association (promulgated as Republic Act No. 4224) which outlines the duties of Filipino physicians: to their patients, to the community, to allied professionals, to their colleagues and to the profession.¹³⁵ In practical terms, the application of this code raises particular issues for those who care for patients at the end of life.

Within the realm of patient autonomy, informed consent is based on the patient’s appreciation of their physician’s diagnosis, together with an understanding of the available options. The duty to deliver such information – though not necessarily to the patient - is stated in Section 5 of the Philippine code of ethics. ‘Timely notice of the serious tendency of the disease should be given to the family or friends of the patient *and even to the patient himself* if such information will serve the best interest of the patient and his family’.¹³⁶ Within the prevailing culture families are rarely encouraged to question or discuss, so medical decisions are generally left to the judgement of the medical practitioner. Manuel Medina:

‘It’s a consent for the doctor to do what he thinks is right, after telling you why he thinks it’s right. Not a lot of options, not a lot of decision-making. And you need a lot of that with regard to advanced illness in hospice and palliative care work with patients.’¹³⁷

Regarding disclosure, Cenon Cruz believes that patients are becoming increasingly aware of what a medical diagnosis means and, as a general principle, should be told their diagnosis:

‘I always maintain my conviction that these people who are sick, especially the adults, will have to know. But of course you have to know the family. I have to take time explaining because it’s even harder for these people not to know they are this serious when you know their condition. You cannot hide it. Initially they will say, “That was before; but now...” I don’t find any difficulty in principle because people are more exposed now. You read it everyday in the paper. You see it on the television, this palliative care. They know. We also have seminars going on. We have fundraising events. People are exposed to the different stages of denial, acceptance and compromise. So it’s not so difficult to tell them now.’¹³⁸

Children, however, are different. They present a raft of complex considerations which relate to their level of maturity, relationship with their illness, confidence in adults and the umbrella of family support. Girlie Garcia:

‘There are several factors when we think about children. One is whether the child is developmentally able to understand what the sickness is all about, and that would normally be about age seven and above. Then we can tell them the name of the sickness, what the sickness is about, all that. What we observe then is that compliance is high because there is no masking the truth. There’s no, “Why is my hair falling off?” And you say, “It’s just heavy”. So the objective is to establish trust from the beginning.

‘Now we also take into consideration their coping style. If the child is an information-seeker then by all means we tell them everything. If the child is a suppressor and they just say, “Tell me if it hurts”, then we don’t divulge everything. The deniers, say, “I don’t have illness; there’s nothing wrong with me”. And that’s what we work on. We try to slowly introduce what the illness is about through the games, through our medical play, through our preparation for medical procedures. That’s what the Child Life Programme is all about. But eventually, every child has to know: those who’ve reached an age of reason.’¹³⁹

The ethical code also acknowledges the caregiving role of the Filipino family. The lack of professional end of life care means the dying become dependent on the support of their relatives and this may lead them to assume a passive role both within the family and in relation to their illness. Authoritative individuals take decisive roles and medical decisions are decided in an extended family context that includes parents, grandparents, siblings and in-laws.¹⁴⁰ Within this network the role of the ‘financial’ - the person who guarantees and provides funding for treatment – is crucial. Agnes Bausa:

‘Here in the Philippines, the one who usually signs the consent form is the ‘financial’ – that is, the financial guarantor, not necessarily the next-of-kin - because our culture dictates that whoever is the ‘financial’ will decide if the family will, or will not, go forward with the treatment. So it is not the next-of-kin way, where the wife decides for the husband, or if the wife is not available it would be the eldest son. And if the ‘financial’ is an aunt, then doctors have to wait for her decision to fund any chemo or medicines.’¹⁴¹

In the debate surrounding end of life care, the Catholic Church has an influential voice. While its position is clear and firmly grounded in belief and doctrine, clinical questions arise. Manuel Medina:

‘A lot of the population is Catholic and we need to know what the Catholic Church says. The Catholic Church has discussed its stance in the end of life and palliative care areas. But when you get down to the doctors, they are the ones who deal with the patient on an individual basis, trying to decide what is moral or not. There are still many questions and the practice is still trying to improve.’¹⁴²

Life/ oral histories

Dr Alex JB Alip – *chairman, department of family and community medicine, University of the Philippines-Philippine General Hospital, Manila*: interviewed by Michael Wright, 13 March 2007. Length of interview: 25 minutes.



Alex Alip is a family physician who trained at the University of the Philippines during the 1980s. He became chairman of the department of family and community medicine in January 2007 and explains the range of duties associated with the role. He tells how the department offers accredited training in the sub-specialty of supportive, palliative and hospice care, including a fellowship programme for those who have completed residency training in family medicine. He discusses the protocol, usage and availability of morphine and points to a continuing resistance to the drug in some parts of the medical community. Turning to the broader aspects of hospice and palliative care, Alex Alip speaks of the integrated approach practised within family medicine, of the place of counselling, and the need to take account of the spiritual and religious dimensions of Filipino culture.

Dr Mae Lynn Acebuque – *training officer, department of family and community medicine, Western Visayas Medical Centre*: interviewed by Michael Wright, 15 March 2007. Length of interview (WVMC group): 1 hour 5 minutes.



Mae Lynn Acebuque has worked in the WVMC department of family and community medicine for nine years and was in post when the hospice programme was first introduced. She speaks of her role as training officer and tells how hospice care has forged links with the departments of psychiatry and anaesthesiology as well as local nursing schools. Turning to patients, she compares the western and eastern approaches to diagnosis disclosure and, against the background of the strong Filipino family structure, explains the dual demands of speaking first with the family and then with the patient. She is heartened by acceptance of hospice within the health community and details the referrals from colleagues in other fields, who initially seek counselling for their patients rather than clinical management. In this context, she considers the time given to stress debriefing

is important. Mae Lynn tells how WVMC caters for indigent patients and what this means for those who have 100 pesos – equivalent to around US \$2 – to spend on the total cost of their medical intervention. In future, she hopes more of these patients can be covered by an expanded medical insurance scheme.

Dr M Elisa ‘Baby’ Allado – *family physician, Ayala Alabang Hospice Care*

Foundation: interviewed by Michael Wright, 14 March 2007. Length of interview: 57 minutes.



Baby Allado trained at PGH and qualified as a family physician in 2000 after a previous career in business. This fulfilled a life-long dream that had been put aside in her early life but which came to fruition when she changed direction after caring for her father after he was diagnosed with cancer. Baby became associated with Ayala Alabang when its president, Asuncion Kalalo, sought to fill a vacancy and heard she was involved in hospice care. She speaks of her role at Ayala Alabang: of patients aged from 3 to 96 years old, of her work in symptom control, psychosocial and spiritual care, family conferencing, and grief therapy. She highlights the condition of the poor who live in squatter camps outside the village fence, of the limited options available to them and how this impacts upon end of life care. As part of its provision, the hospice has founded a convent-based outreach clinic, shortly to be replaced by a permanent facility which will house day and respite care. Baby describes how, for her, becoming a doctor is ‘less of a career pathway and more of a calling’ and this is what sustains her as she supports people coming towards the end of their life.

Adrian ‘Rams’ Andrei – *student nurse and volunteer, Palcare Volunteer Group, Manila:* interviewed by Michael Wright, 16 March 2007. Length of interview (with Juana Jannette Jamisola): 17 minutes.



‘Rams’ Andrei tells of his interest in the arts and how, in his younger days, he worked as a fashion designer in the United Arab Emirates but says he could turn his hand to anything: stitching, artwork, singing and dancing. In Manila, he has worked on the charity wards at Philippine General Hospital and studied to become a nurse. He finds working in the health service more fulfilling than the more ‘frivolous’ world of fashion and hopes one day to become a doctor, possibly an oncologist. In the meantime, he is enjoying his involvement in palliative care and likes working for a charity.

Dr Andrew E Ang – *co-ordinator, supportive, palliative and hospice care unit, department of family and community medicine, University of the Philippines-Philippine General Hospital, Manila:* interviewed by Michael Wright, 12 March 2007. Length of interview (with Agnes Bausa and Manuel Medina): 74 minutes.



Andrew Ang graduated from the City College of Manila and then undertook residency training in family medicine at UP-PGH. This was followed by a one year fellowship in hospice, palliative and supportive care and in 2007, he began the APHN-Flinders University

diploma/graduate certificate course. He reflects upon the Philippine health care system and outlines the private and public health pathways open to people who seek treatment in urban and provincial settings. He comments on the impact of health insurance schemes that don't meet the full costs of treatment, and explains how hospice patients fare in a predominantly fee-paying, curative treatment environment in which palliative care is rarely viewed as a rigorous discipline among the medical profession. He recognises that country-wide, hospice care lacks support but considers the 'growing pains' are not dissimilar to those in other countries where development is slow. In future, he envisages a greater roll for NGO and religious organisations. Despite the challenges, he finds hospice care 'rewarding, because you get to know people in a different light'.

Ass Prof Agnes Bausa – *consultant and hospice training co-ordinator, supportive, palliative and hospice care section, department of family and community medicine, University of the Philippines-Philippine General Hospital, Manila; and executive director of Palcare Volunteer Group*: interviewed by Michael Wright, 12 March 2007. Length of interview (with Andrew Ang and Manuel Medina): 74 minutes.



Agnes Bausa tells how she was drawn to hospice as a result of her father's experience of cancer. After her training in family medicine she joined the hospice fellowship programme at PGH and subsequently visited Hospis Malaysia in Kuala Lumpur, led by Ednin Hamzah. It was a formative time and demonstrated what could be done with a strong team and local support. She outlines her role at PGH and explains how the hospice unit supports a PGH home care programme for patients living within five kilometres of the hospital.

Turning to the formation of Palcare, she speaks about its purpose, the care it gives to 'home-bound PGH patients', the drugs it uses and the training it provides. She speaks also of the challenges: dealing with late referrals; breaking bad news to patients who don't know their diagnosis; sustaining staff morale in a scenario where most patients die within a month; securing funding; sourcing a regular supply of morphine; and relying on the goodwill of volunteers in the absence of a salary. In the face of formidable barriers, she regards the existence of the NGO a major success, and looks forward to a time when hospice care is more generally available, provided by a trained workforce with sustainable funding.



Eva Biticon – *retired nursing aid and volunteer, Madre de Amor Hospice Foundation*: interviewed by Michael Wright, 13 March 2007. Length of interview: (Laguna group) 45 minutes.

Eva Biticon retired from her post as nursing aid at Laguna Provincial Hospital in 2000 and thereafter decided to join Madre de Amor Hospice Foundation alongside other members of her church group, the Daughters of Mary of the Immaculate Conception. She recalls how the NGO's training helped her relate to patients with advanced cancer and prepared her for home visits. Her patient visits have now become an important part of Eva's life. Sometimes she is pained by her patients' poverty and poor state of health, and even though she occasionally feels tired, she regards her hospice commitment as a priority.

Antonio D Bustrillos – *retired professor of chemistry and volunteer, Madre de Amor Hospice Foundation*: interviewed by Michael Wright, 13 March 2007. Length of interview: (Los Banos group) 1 hour 17 minutes.

Antonio Bustrillos joined Madre de Amor along with his wife, Nena, after they left academic life. Wishing to serve the community they felt drawn to the hospice movement as a way of supporting their compatriots at a critical time in their life. He tells how, after he sought the advice of his parish priest, he felt that his church position as a lay minister would complement his hospice role, since he could take the Christian sacrament of Holy Communion to the patient. He tells how he and Nena work as a team. And as they have transport available, they have been able to support patients not only in Los Banos but also in Calamba and Santa Cruz.

Nena Bustrillos - *retired professor of human ecology and volunteer, Madre de Amor Hospice Foundation*: interviewed by Michael Wright, 13 March 2007. Length of interview: (Los Banos group) 1 hour 17 minutes.

Nena Bustrillos speaks of her background in human ecology and how she spent ten years working for the United Nations: nine years based in Rome and one year in Kenya. After she and her husband Antonio retired, they had a full life which involved their family and local church. But when they joined a Christian charismatic movement, they became aware of the need to spend more time serving their community. Nena tells how they joined Madre de Amor and undertook the volunteer training programme prior to visiting patients at home. That was ten years ago. Nena explains how being alongside the patients, hospice care has touched their lives in a special way. She hopes that, despite the passing years, they continue to find the strength to continue their work.

Dr Cirena R Cabanban – *family medicine specialist and former chair, Starfish Palliative Care Education Programme, San Lázaro Hospital for Infectious Diseases*: interviewed by Michael Wright, 12 March 2007. Length of interview: (with Nancy Legaspi and Mario Logmao) 1 hour 10 minutes.



Cirena Cabanban speaks of her background at San Lázaro Hospital and how she was introduced to palliative care by the Australian Larri Hayhurst who, along with her New Zealand colleagues Sue Marsden and Liese Groot-Alberts, led the hospital's Starfish Palliative Care Education Programme that began in 2001. As the programme developed, Cirena became chair of the core palliative care team and describes how the approach has been incorporated into the care of patients with AIDS, rabies and tuberculosis alongside those in the critical care unit. She outlines the challenges of caring for these patients, detailing the special issues associated with rabies and the benefits of prescribing the antipsychotic drug Haloperidol. She goes on to mention the work with family members (particularly those in denial), the place of group sessions, the development of art work and the ongoing training of staff.

Aida B Calagui – *coordinator of the Child Life Programme, department of paediatrics, V Luna General Hospital, Armed Forces of the Philippines Medical Centre, Quezon City*: interviewed by Michael Wright, 14 March 2007. Length of interview (with Girlie Garcia and Maribel Develos): 46 minutes.



Aida Calagui has been coordinator of the Child Life Programme at AFPMC for seven years. She explains how the programme enhances the life of children who are chronically and terminally ill through psychosocial care, the celebration of anniversaries and events, the granting of wishes and the involvement of volunteers and community groups. Volunteers have an important role to play as patients from afar might stay at the hospital for several years, along with one or more relatives. Aida – affectionately called ‘Ate’ (‘big sister’) by the children – speaks of the constant need to find sponsors for chemotherapy drugs and other medications required by the children, and the emotional effect this has on family members living with uncertainty and trying to support their sick child.

Lita Canonizado - *volunteer, Madre de Amor Hospice Foundation*: interviewed by Michael Wright, 13 March 2007. Length of interview: (Los Banos group) 1 hour 17 minutes.



Although Lita Canonizado frequently volunteers to support organisations and events, she resisted joining the hospice movement because she was fearful of being around sick people. Yet since being invited to join the hospice team, Lita’s sister and husband have both received a cancer diagnosis; and through her dealings with her family and visits to the hospital, her attitude changed. Influenced by this experience - and heartened that both relatives survived – she became a volunteer around two years ago. She speaks of her patients and explains her sense of fulfilment when she is able to offer assistance. Recalling the time she helped a female patient to have a wedding that was unaffordable in the past – with priest, flowers, and a reception - she described it as ‘one of the lightest moments I had as a volunteer’.

Alis Capiral – *retired researcher, and volunteer, Madre de Amor Hospice Foundation*: interviewed by Michael Wright, 13 March 2007. Length of interview: (Los Banos group) 1 hour 17 minutes.



Alis Capiral speaks of her work at the International Rice Research Institute and how, when she retired, she looked around for an organisation that required volunteers. Eventually, she found her way to Madre de Amor and has been associated with the hospice for 12 years. Initially, Alis preferred to drive rather than visit patients and helped by transporting priests to those who had need of one: a role she valued as she saw herself as ‘a signpost to Jesus’. As time passed, she saw the transforming effect that hospice care had on other volunteers and found that she too could visit patients. It is an activity that Alis finds fulfilling and she welcomes the opportunity to learn from those she serves.

Dionna May 'Daydee' Castillo – *volunteer staff, CHILD House, Quezon City*: interviewed by Michael Wright, 16 March 2007. Length of interview (CHILD House Group): 10 minutes.



Daydee Castillo speaks of how she enrolled for a vocational course at the Ricky Reyes Learning Institute and heard that volunteers were needed at CHILD House, which Ricky Reyes was supporting. As her course was part-time, she decided to volunteer and by March 2007, had stayed for over three years. She says that her work with the children brings her a sense of contentment and that she can ask nothing more of God. Daydee does not gloss over the fact that life in the Philippines can be hard. Yet she feels that her experiences at CHILD House have helped her resist any tendency to complain and have given her a sense of perspective

Tellie H Cayabyab – *retired teacher and volunteer, Palcare Volunteer Group, Manila*: interviewed by Michael Wright, 12 March 2007. Length of interview (Palcare group): 1 hour 5 minutes.



Tellie Cayabyab began volunteering when she retired from her work as a teacher. Not wanting to let life slip by, she joined the Catholic Sinag organisation based at PGH and found that visiting and being involved with patients gave fresh meaning to her life. She had experience of working in the Cancer Institute and when she heard about hospice care from Sr Perlita, she joined the Palcare Volunteer Group. Tellie has developed a strong interest in hospice work and has discovered that she not only gives to the patients, but receives and learns from them too – a process she describes as 'giving sense to my life'.

Lillian Ching – *volunteer, Madre de Amor Hospice Foundation*: interviewed by Michael Wright, 13 March 2007. Length of interview: (Calamba group) 32 minutes.



Lillian Ching speaks of her desire to serve her patients as 'maybe the call from God' and because of this, she goes to great lengths to be supportive and meet their needs. Many people she visits have no money, no food or habitable shelter, and this pains her. Although she sometimes feels tired when she returns home, she feels a sense of satisfaction that she has been faithful to her call. Before visiting her patients, Lillian Ching prepares herself by praying for her patients, her family and herself. She gives thanks, too, for Madre de Amor's training programme that has helped her to cope with whatever she finds.

Randylon Claudio – *volunteer coordinator, Palcare Volunteer Group, Manila*: interviewed by Michael Wright, 12 March 2007. Length of interview (Palcare group): 1 hour 5 minutes.



Randylon Claudio considers hospice care to be a fight against dehumanisation, a way of valuing human beings and uplifting a person's quality of life. To sustain him in his work with patients, he explains how he calls into a Christian adoration chapel to 'find

solitude, tranquillity and peace' whenever he undertakes a visit. As a result, he feels empowered to serve and any stress is relieved. He tells how volunteering has not only taught him how to use his talents for the benefit of others, but how to value his own life too, and understand more clearly the philosophy of death.

Dr M Cecille Cruz – *paediatric oncologist, Philippine Children's Medical Centre, Manila*: interviewed by Michael Wright, 14 March 2007. Length of interview (with Maria Rafael and Beth Jayobo): 46 minutes.



available.

Cecille Cruz completed her fellowship in paediatric haematology and oncology in 2006 and is now a clinical research fellow who sees her future in specialised paediatric oncology. Her interest in palliative and hospice care arises from her work with dying children and her referrals to the PCMC hospice programme. She points to the low survival rate of Filipino cancer patients compared with those in developed countries – and against a background of obvious need, Cecille hopes to see palliative care training become more readily

Dr Cenon R Cruz – *president emeritus, Pain Society of the Philippines and chairman, Ayala Alabang Hospice Care Foundation, Inc*: interviewed by Michael Wright, 13 March 2007. Length of interview: 63 minutes.



Cenon Cruz reflects on his 40 years practising anaesthesiology and speaks of the occasion when, under his chairmanship, the World Congress of Anaesthesiologists was held in Manila (1984). Two years later, he visited the United States to undertake extended studies in pain management and while he was there, met John Bonica and Kathleen Foley. He tells of his involvement in the development of pain management at the Philippine General Hospital and St Luke's Medical Centre, of his screening programme for prostate cancer, and how he later became involved in the Ayala Alabang Hospice Care Foundation. He draws attention to the challenges facing hospice-palliative care in the Philippines: the lack of public awareness, funding issues, security restrictions that inhibit work with indigents and an enduring resistance to morphine - except perhaps for terminal care - within the medical profession. He gives details of the service provided by the Ayala Alabang HCF and explains its association with the Church of the Poor Foundation in the Parish of St James the Great – a relationship that results in pain relief and spiritual care. He looks forward to a greater understanding of the benefits of palliative care and the development of a professional service.

Rachel Cruzado – *volunteer staff, CHILD House, Quezon City*: interviewed by Michael Wright, 16 March 2007. Length of interview (CHILD House Group): 10 minutes.



Rachel Cruzado is the cousin of her CHILD House colleague Marianne De La Roca and tells how she arrived at the House at the end of 2003. She and her family live close to the compound which

houses the Philippine Charity Sweepstake Office on whose land the Metro Manila Development Authority renovated an old building which became the CHILD House facility. One of the developers used to eat at her aunt's restaurant and when she heard that volunteers were needed, Rachel decided to apply. She had been without work for some time and regarded the opportunity to join the CHILD House team as a call from God. She says that she loves working with the children and 'when this came into my life, it made me happy.'

Eva Data – *nutritionist, University of the Philippines and volunteer, Madre de Amor Hospice Foundation*: interviewed by Michael Wright, 13 March 2007. Length of interview: (Los Banos group) 1 hour 17 minutes.



Eva Data is a neighbour of Dory Ocampo and was invited to join a volunteer training programme in 1994, shortly after the NGO was founded. She explains how she was reticent about visiting the sick, so she decided to support the hospice by preparing food for its various functions. Yet as she heard other volunteers speak about their patients, she decided the time was right for her to begin visiting people. As she was welcomed into families, she discovered the depth of the volunteer's role: to care for people who 'have inner fears and inner hurts which they don't share with their family because they don't want to hurt them'. Eva speaks of her sister, a nurse in the US, and of the psychological support available to those dealing with stressful situations - unlike in the Philippines. Yet she considers the Filipino character to be likened to the bamboo, sometimes bent but never broken. For Eva, it is this, together with a strong sense of faith that moulds the Filipino's capacity for resilience.

Dr Annabelle P De Guzman – *president, Hospice and Family Care Foundation and chair, department of family and community medicine, Western Visayas Medical Centre*: interviewed by Michael Wright, 15 March 2007. Length of interview (WVMC group): 1 hour 5 minutes.



Annabelle De Guzman trained in family and community medicine and then studied for a Masters degree in medical education at the University of Surrey (UK), supported by funding from the British Council and the University of the Philippines. It was in England that she was introduced to hospice care and was instantly impressed by the difference it made to the lives of patients: during social times 'terminally ill people were literally amused, some were laughing ... and there was dignity in dying'. On her return to the Philippines, she determined to establish a hospice programme that included an inpatient facility and training centre. In 1998, she established a home care service as part of the WVMC's *Hospital as a Centre of Wellness* programme and began recruiting and training volunteers. Fundraising events went hand-in hand with a donation of PHP 5 million from the PCSO towards the construction of the building. Meanwhile a hospice ward opened in 2004. Annabelle de Guzman speaks of the challenges of beginning a new hospice service: raising community awareness; gaining the support of colleagues; training staff and volunteers; dealing with disclosure; raising funds and providing free services and medicines. Despite the rising costs of the building project she is

heartened by the widespread support for the hospice programme and looks forward to the added input of two doctors currently training in Singapore.

Marianne P De La Roca – *volunteer staff, CHILD House, Quezon City*: interviewed by Michael Wright, 16 March 2007. Length of interview (CHILD House Group): 10 minutes.



Marianne De La Roca is the cousin of her CHILD House colleague Rachel Cruzado and tells how she arrived at the House in a similar way: after hearing from the Ricky Reyes Learning Institute that the organisation needed volunteers on a long-term basis. She quickly found that she liked the work and enjoys being around children. By March 2007, she had worked at CHILD House for three years and three months and attends every day of the week excepted Sunday.

Although she is saddened by the plight of the children, she finds the work fulfilling and a source of satisfaction in her life.

Dr Maribel M Develos – *Child Life consultant, department of paediatrics, V Luna General Hospital, Armed Forces of the Philippines Medical Centre, Quezon City*: interviewed by Michael Wright, 14 March 2007. Length of interview (with Aida Calagui and Girlie Garcia): 46 minutes.



Captain Maribel Develos speaks of the health care provision at the 1,200-bed AFP Medical Centre, which is offered to military personnel and their families free of charge. This tertiary facility is the biggest military hospital in the Philippines and patients are referred from other military and station hospitals countrywide. Maribel Develos has been associated with the paediatric department for six years and has an overall responsibility for the Child Life Programme, of which hospice is a part. She speaks of the care for chronically and terminally ill children; of the closeness between staff and families due partly to the military bonds and as well as prolonged contact with the children; and of the benefits brought about by the psychosocial care provided by the Child Life Programme,



Dr Erwin Francisco B Estimo – *medical officer, CHILD House, Quezon City*: interviewed by Michael Wright, 16 March 2007. Length of interview: 10 minutes.

Erwin Estimo trained in internal medicine and previously worked with indigenous people in a mountainous provincial region that lacked basic facilities such as electricity. He tells how he became involved in CHILD House after hearing about it from his cousin, the CHILD House project director Rachael Rosario. He outlines the difficulties faced by poor Filipinos who live in far-away islands and have to journey to Manila for their disease to be treated. High travel and treatment costs, compounded by a lack of accommodation and - for diseases such as cancer - the need for cyclical interventions, mean that some of those who arrive in the capital all-too-frequently give up and die. Erwin Estimo tells how CHILD House addresses these issues; how many residents are uninformed

about their disease; and he how sleeps on the premises, ‘so I’m readily available any time they need me.’

Margie F Gabat – *medical technologist and volunteer, Palcare Volunteer Group, Manila*: interviewed by Michael Wright, 12 March 2007. Length of interview (Palcare group): 1 hour 5 minutes.



Margie Gabat recalls how her father was diagnosed with cancer in 2003 and underwent a course of chemotherapy that lasted almost a year. At that time, she worked as a medical technologist for the Philippine National Red Cross but decided to resign so she could give more support at home. Her father survived and when Margie heard about Palcare in June 2004 she decided to become a volunteer ‘to return the blessing that God has given us’. She enjoys working with indigents patients and ‘being on their side’.

M Fatima ‘Girlie’ Garcia – *co-founder and executive director, Kythe Foundation*: interviewed by Michael Wright, 14 March 2007. Total length of (2) interviews: 54 minutes.



‘Girlie’ Garcia speaks of her training in psychology and how, as a student working with cancer patients alongside her colleague Carmen ‘Icar’ Castro, they recognised the need for a more holistic approach to care. Together, they began to provide psychosocial support to paediatric cancer patients in East Avenue Medical Centre (1992) and in 1994 registered Kythe as a non-stock, non-profit organisation. She describes the programme as ‘an expanded kind of hospice’ that provides care throughout the illness of a hospitalised child and – for the family – beyond that in the event of the child’s death. Kythe’s aim, she says, is ‘to educate the patient about their illness, support them through medical procedures and help them cope with the whole hospital setting’; it is also to provide a semblance of normal childhood and achieve the best possible quality of life for each patient.

Dr Melissa V Gobencion-Roa – *resident in family medicine on rotation at the Hospice Unit, University of the Philippines- Philippine General Hospital, Manila*: interviewed by Michael Wright, 12 March 2007. Length of interview (with Anisa Riza C Jundis): 22 minutes.



Dr Melissa Gobencion-Roa is a third year resident in family medicine at the Eastern Visayas Medical Centre (EVMC), Tacloban City. As the first resident from her institution to be sent to the PGH hospice unit, she sees herself as a pioneer on a path that others will follow.

Although she knew about hospice care before arriving in Manila, there were no opportunities to gain practical experience at EVMC and information was sparse: ‘we don’t even have a text book yet’. In just a short time, she has been impressed by the nature of hospice care and the central place of communication

Teresita ‘Tess’ C Gonzales – *retired teacher and volunteer, Madre de Amor Hospice Foundation*: interviewed by Michael Wright, 13 March 2007. Length of interview: (individual and Los Banos group) 1 hour 27 minutes.



Teresita Gonzales tells how she left the Philippines to work in America (1974) where she accepted a post in Missouri working with children who had cancer. This experience sensitised her to hospice care and demonstrated ‘there’s more to life than just being healthy’. Four years later, she returned to the Philippines to find her sister dying of breast cancer: a disease that Tess, alongside other family members, also had to face. Tess survived, and speaks about how she became committed to hospice care; of her involvement with the

Adriano family during the later stages of their daughter’s life; how she became a founder member of Madre de Amor; of the role played by a group of influential women who became known as the ‘golden girls’; and the significance of the name ‘Mother of Love’. In addition to her work with patients, Tess Gonzales is also editor of Madre de Amor’s quarterly newsletter, *Sharing Hospice*.

Jove Iglesias – *volunteer, Madre de Amor Hospice Foundation*: interviewed by Michael Wright, 13 March 2007. Length of interview: (Laguna group) 45 minutes.



Jove recalls how she became a hospice volunteer ‘accidentally’. While looking for a job, she attended a Madre de Amor seminar and – although she still has no salary – decided to join the hospice team. It was a good decision and she appreciates the opportunity to support others by spending time with them. Jove thinks that her inability to provide physical things means that she concentrates on her relationship with the patient, trying to bring some cheerfulness into the patient’s life that, sometime during the visit, will lead to a smile.

Juana Jannette B Jamisola – *volunteer, Palcare Volunteer Group, Manila*: interviewed by Michael Wright, 16 March 2007. Length of interview (with Adrian ‘Rams’ Andrei): 17 minutes.



Jannette Jamisola used to work at an ice cream parlour and tells how life changed for her in December 2004 when she was diagnosed with cancer. It was a difficult time. She lost her job, her husband worked irregularly as a contractor, and they had a 5-year old daughter to bring up. First came an operation followed by six months of chemotherapy and by the time Jannette found Palcare, her whole life seemed out of balance. She was so impressed by Palcare’s support that she became a volunteer and, instead of returning to the ice cream parlour – or other lucrative employment – now works without salary as the NGO’s secretary with the full support of her husband.

Dr Jesus Mario Logmao - *anaesthesiologist and chair, palliative care core group, San Lazaro Hospital for Infectious Diseases*: interviewed by Michael Wright, 12 March 2007. Length of interview: (with Cirena Cabanban and Nancy Legaspi) 1 hour 10 minutes.



Mario Logmao has been involved with the palliative care team for around a year and has taken over as chair of the core team from his colleague Cirena Cabanban. He speaks of the value of palliative care and the innovations that have accompanied the approach: training in the breaking of bad news, a sharper focus on the needs of the dying, more involvement with the family and greater attention to psychosocial care. Among many challenges, he highlights the resistance to palliative care due to its absence from medical school curricula; a perceived lack of interest from the Minister of Health; and the number of palliative care-trained staff who leave the hospital to pursue careers elsewhere.

Beth Jayobo – *clerk, Special Projects Office, Philippine Children's Medical Centre, Manila*: interviewed by Michael Wright, 14 March 2007. Length of interview (with Maria Rafael and Cecille Cruz): 46 minutes.



Beth Jayobo has worked in the PCMC special projects office as clerk/coordinator for the hospice programme for the last 10 years. Her duties include: the preparation and dissemination of hospice-related information; the administration of referrals to the hospice care (multidisciplinary) committee; and the scheduling and co-ordination of visits from volunteers and other non-government groups that provide psychosocial, spiritual, emotional and even financial support to hospice patients. Beth Jayobo regularly comes into contact with the children and their families, and values the broad approach of the hospice programme

Dr Anisa Riza C Jundis – *hospice fellow, University of the Philippines-Philippine General Hospital, Manila*: interviewed by Michael Wright, 12 March 2007. Length of interview (with Melissa V Gobencion-Roa): 22 minutes.



Anisa Riza Jundis finished her residency in family medicine in Dumaguete City (Visayas islands) in 2006 and then moved to Manila to undertake fellowship training in hospice and palliative care at UP-PGH (2007). She acknowledges that salaries are poor in hospice care but explains that, during her residency, she was moved by the number of people with cancer for whom 'nothing could be done'. Anisa tells how she found the course at PGH so she could learn how to care for these patients and thereafter return to her own province and provide a home care service.

Dr Nina Lyne D Leonor – *senior resident, department of family and community medicine, Western Visayas Medical Centre*: interviewed by Michael Wright, 15 March 2007. Length of interview (WVMC group): 1 hour 5 minutes.



Nina Leonor is in the fourth year of her residency training and speaks of her special interest in family medicine: a specialty that covers whole-life experiences, paediatrics to geriatrics. She thinks that hospice care is well placed within this field and outlines the two-month PGH-based modules in counselling and hospice care delivered in Manila during the second year of her course. Nina describes the

plight of the indigents who are referred to the hospice service, cases where not only the family's financial but also their emotional and spiritual resources have been drained. She details how support is given through pain management, counselling, spiritual care, and mobilisation of the family support network. Nina Leonor also gives examples of ethical issues surrounding disclosure and informed consent, and how these affect the patient's options and decision-making.

Nancy M Legaspi – *nurse, infectious diseases critical care unit, San Lazaro Hospital for Infectious Diseases*: interviewed by Michael Wright, 12 March 2007. Length of interview: (with Cirena Cabanban and Mario Logmao) 1 hour 10 minutes.



Nancy Legaspi tells of her work in San Lazaro Hospital's critical care unit and how palliative care came to be incorporated into the unit's provision for the dying and in the hospital more widely. Against a background of many needy patients, she explains her commitment to the 'starfish' approach: that making a difference for even one person is worthwhile. Turning to rabies, she speaks of the plight of the indigent poor who begin treatment after a dog bite but lack the funds to complete the course – and of the broader impact of

rabies on patients and their families. Here, she is appreciative of the assistance given by Sue Marsden that led to a new protocol and more effective symptom control.

Cesar Madamba – *retired professor of biology and volunteer Madre de Amor Hospice Foundation*: interviewed by Michael Wright, 13 March 2007. Length of interview: (Los Banos group) 1 hour 17 minutes.



Cesar Madamba details how he and his wife looked for something different when they retired from academic life and were encouraged to become involved in hospice care by their son, a US-based oncologist. He recalls the time when his parents died and notes how differently patients are treated within the hospice programme. He speaks of dying within Filipino culture and what living with a chronic condition means for indigent patients. He speaks too of the

fear of a life-threatening diagnosis and how families wish to conceal such information in case voicing the words brings about the event. Cesar Madamba is appreciative of the support provided by Madre de Amor, the local parish and individual priests.

Victoria 'Betty' C Mag-iba – *chief nurse, Laguna Provincial Hospital and volunteer, Madre de Amor Hospice Foundation*: interviewed by Michael Wright, 13 March 2007. Length of interview: (Laguna group) 45 minutes.



'Betty' Mag-iba speaks of her role as the chief nurse at the 200-bed Laguna Provincial Hospital and the demands of managing a service that includes 120 nurses and 59 permanent and casual nursing aids. Despite the demands of her job, Betty belongs to the Christian group, the Daughters of Mary of the Immaculate Conception, and decided to volunteer her services to help patients referred to Madre de Amor; an activity she describes as her 'mission'. She speaks of her visits to patients, of the impact made by a life-threatening

diagnosis and the support that can be given by dedicated volunteers. In addition to her psychosocial support, Betty is also able to train carers in basic nursing skills and is appreciative of the supply of morphine available from the Los Banos group. She would like to see hospice care available in every part of the Philippines and spread to the whole world.

Dr Josefina Magno (1922-2003): interviewed by David Clark, 9 December 1995.
Length of interview: 59 minutes.



Josefina Magno was born in the Philippines in 1920, and was encouraged academically by her lawyer father. Thus she studied medicine. Having married another doctor, the couple moved to the USA in the 1940s to set up a private practice. After eleven years of marriage, and seven children, her husband died of a malignancy and Josefina Magno returned to the Philippines to work as secretary to the Assistant Secretary of Health. However, she decided to return to the USA after Marcos became President, and returned to medicine. It was an episode of breast cancer resulting in a mastectomy which introduced her to the great suffering of those in the terminal stage of cancer, and she visited St Christopher's in London, and the palliative care programmes at St Luke's Hospital in New York, and the Royal Victoria Hospital in Montreal to gain her hospice education. Subsequently Josefina Magno went on to help found hospice programmes in both Georgetown and Northern Virginia in the USA, and in Manila in the Philippines. The interview also discusses the development of the National Hospice Association (USA) (1980), the National Hospice Institute (USA) (1984), the International Hospice Institute, and the Association of Hospice Physicians (USA) (1988), as well as the 1984 Bill for hospice reimbursement (USA).

Dr Elna S Mangao – *resident physician, department of family and community medicine, Western Visayas Medical Centre*: interviewed by Michael Wright, 15 March 2007. Length of interview (WVMC group): 1 hour 5 minutes.



Elna Mangao is a second year resident physician. She speaks of her work with terminally ill cancer patients, in association with the senior resident Nina Leonor and training officer Mae Lynn Acebuqui. Elna Mangao explains the challenges of caring for dying patients when the main thrust of the residents' training programme is to save lives. In this scenario, she states that communication with the patient and family members is especially important, particularly if the patient is young and vulnerable. She tells of her involvement with a 12-year-old girl whose parents do not want her diagnosis disclosed, and how she is searching for the right approach for both the patient and family members.

Cynthia Manzanares – *Child Life projects officer, Kythe Foundation*: interviewed by Michael Wright, 14 March 2007. Length of interview: 16 minutes.

Cynthia Manzanares is a psychologist who was introduced to Kythe through her husband's connection with Rotary International. Her family has a strong connection with health care – her father is a doctor and her sisters are nurses – and she harboured

thoughts of working in a hospital setting. So, in 1999, she became a Kythe volunteer and has since been appointed to the full-time post of administrator. She explains her role and how it builds on her interest in the Child Life Programme. Although Cynthia Manzanares visits many hospitals, she has a special input into the National Children's Hospital where, in the absence of a coordinator, she has been counselling parents, educating children about their illness and engaging in anticipatory grief work. She tells of the difference made by the Child Life Programme: how children who have previously been withdrawn become more trusting and receptive, capable of speaking with health professionals about their illness; and how the whole family is supported, including siblings who may be feeling overlooked by a sharper focus on the sick child. Among the many successes with patients, Cynthia Manzanares also points to the empowerment of parents - which leads to better decision-making - and looks forward to a time when more hospitals incorporate the Child Life Programme into their provision.

Sr M Perlita T Marasigan SPC – *volunteer, Palcare Volunteer Group, Manila*: interviewed by Michael Wright, 12 March 2007. Length of interview (Palcare group): 1 hour 5 minutes.



Sr Perlita thinks hospice care is essentially about team work and compassion. Her background as a pharmacist has given her a broad understanding of health care and an insight into the experiences of patients. Her pastoral ministry is a service to the poor and through her work she feels she has come to understand the meaning of existence. Although Sr Perlita's pastoral care is rooted in her faith, she explains there is no discrimination between patients of different persuasions. All religions are respected: 'we don't advise, we don't convert, we don't reprimand and we don't judge.'

Girlie S Medegia – *medical student, University of the Philippines and volunteer, Palcare Volunteer Group, Manila*: interviewed by Michael Wright, 12 March 2007. Length of interview (Palcare group): 1 hour 5 minutes.



Girlie Medegia explains how April Padua, a fellow medical student invited, her to become a volunteer to help care for a patient. As she had previously been on a paediatric ward, Girlie agreed and, despite the demands of her studies, tells how she looks forward to her volunteer work – listening to the children, painting with them, reading stories and getting to know their families. Through this involvement, she has become increasingly aware that life is not the same for everyone; that hope is a crucial factor; and there is fulfilment in being of service.

Ass Prof Manuel Medina Jr – *consultant, supportive, palliative and hospice care unit, department of family and community medicine, University of the Philippines-Philippine General Hospital, Manila*: interviewed by Michael Wright, 12 March 2007. Length of interview (with Agnes Bausa and Andrew Ang): 74 minutes.



After graduating from the University of the Philippines, Manuel Medina moved to the US and trained in family medicine at the McLaren Regional Medical Center (Michigan State University). He describes his experiences in the US, his connection with hospice, and how he became sensitised to ethical issues around care at the end of life. When he returned to UP-PGH, he drew on his overseas experience to contribute to the work of the hospice unit and supported initiatives to network locally and countrywide. He speaks of the growing awareness of palliative care among oncologists, the boost given to end of life care by the Papal declaration, and the growing interest in palliative care from hospitals with a Catholic foundation. Without funding however, issues around the recruitment and payment and retention of staff remain formidable obstacles. Highlighting current issues, Manuel reflects on the ethical debate surrounding end of life care; the role of the Catholic Church; the meaning of confidentiality; and the nature of informed consent. In the future, he hopes for the introduction of a funding scheme that attracts physicians and meets the treatment costs of patients.

Bernardita Mikesell – *dentist and volunteer, Palcare Volunteer Group, Manila*: interviewed by Michael Wright, 12 March 2007. Length of interview (Palcare group): 1 hour 5 minutes.



Bernardita Mikesell reflects on her ten years as a cancer survivor and tells how she joined the Philippine Cancer Society in 2000 and then became a Sinag volunteer as a way of giving thanks for her life. She understands how it feels to live with cancer and visits patients both to offer support and as a living symbol of hope. Since joining Palcare, her volunteer activities take up three and a half days per week. Although she still practises as a dentist, Bernardita Mikesell now has little time for professional work. Volunteering brings her sense of satisfaction, though she would like to do more, especially for the poor who lack funds for their medicines.

Dr Rhodora ‘Dory’ DR Ocampo – *ear, nose and throat consultant and programme director, Madre de Amor Hospice Foundation, Los Banos*: interviewed by Michael Wright, 13 March 2007. Length of interview: 48 minutes.



Rhodora Ocampo tells how the Madre de Amor Hospice Foundation was established when the parents of 14-year old Sarah Adriano wanted to provide a hospice service after the death of their daughter from cancer. Dory Ocampo attended Josefina Mango’s hospice presentation (1993), given at the request of the Adrianos, and from that moment, became a volunteer. She describes her ENT practice as her profession and her hospice work as her vocation - and explains how the Foundation expanded from four volunteers in 1994 to the current multiple-base organisation with around 50 volunteers and staff. She outlines the training provided by Rosalie Shaw, how morphine was accessed for patients, and the way in which the NGO developed an equipment bank to support domiciliary care. Dory Ocampo outlines her role within Hospice Philippines and APHN, and now looks to

the government to help bring about a ‘paradigm shift’ in the training of Filipino health professionals.

April P Padua – *medical student, University of the Philippines and volunteer, Palcare Volunteer Group, Manila*: interviewed by Michael Wright, 12 March 2007. Length of interview (Palcare group): 1 hour 5 minutes.



April Padua heard about hospice care through her preceptor, Agnes Bausa and subsequently decided to become a volunteer, working particularly with children. She reflects on the demands of studying and volunteering in a context where, for every child, each day counts. Despite sometimes feeling tired, she thinks it important to keep in regular touch and feels inspired by the children’s strength. She prays regularly, both for the children and their families but also for herself, to be sustained in her work.

Dr Elmer Pedregosa – *hospital director, Iloilo Mission Hospital*: interviewed by Michael Wright, 15 March 2007. Length of interview: 10 minutes.

Elmer Pedregosa outlines the history of Iloilo Mission Hospital. Previously known as the Union Mission Hospital, it is associated with the Convention of Baptist Churches and is the country’s first Protestant hospital (1901) and first training school for nurses (1906). He tells how the hospital has developed into a 230-bed teaching hospital affiliated to the Central Philippines University with five major departments and a community outreach programme. Turning to hospice care and the pain and palliative care clinic, he acknowledges the value of the multidisciplinary approach and the benefits brought about by the service, despite the withdrawal of PCSO funding in recent years. Elmer Pedregosa places the dwindling funds in the wider context of the hospital’s move towards self-sufficiency, and looks towards new sponsorship from groups such as the hospital’s alumni.

Maria ‘Mary’ Rafael – *officer in charge (acting) of the patient care division, Philippine Children’s Medical Centre, Manila*: interviewed by Michael Wright, 14 March 2007. Length of interview (with Beth Jayobo and Cecille Cruz): 46 minutes.



Mary Rafael began work as a nurse at PCMC in 1982. She joined the hospice team in 2000 and became officer-in-charge of the programme in 2006 – just one of her many responsibilities as the acting officer in charge of patient services. Despite her various roles both with and outside of PCMC, she speaks warmly of her ‘hands on’ involvement in hospice care and what it has come to mean to her. Over time, she gets to know the children and their family very well, and details memorable moments from the last few years.

Occasionally, there is the need for a mediator when parents cannot accept that their child is dying, someone to support the family as they prepare to care for their child in the later stages of life. Although this can be stressful, Mary sees this as an important feature of the hospice programme.

Rogelio R Reyes – *hospice nurse, University of the Philippines-Philippine General Hospital and volunteer, Palcare Volunteer Group, Manila*: interviewed by Michael Wright, 12 March 2007. Length of interview (Palcare group): 1 hour 5 minutes.



of a loving God.

Rogelio Reyes explains that his hospice nurse role is a special vocation for him. He speaks of the years he spent wondering why the human riches of wealth, property and accomplishment held little satisfaction for him, but then came to realise that ‘the most important things in life are love, peace and joy’. Rogelio Reyes believes these are gifts from God, so has decided to express his faith by caring for the sick and dying. His commitment to hospice care has become a vehicle for him to love his neighbour and reflect his perceived image

Nanie Romeo – *social worker, Palcare Volunteer Group, Manila*: interviewed by Michael Wright, 12 March 2007. Length of interview (Palcare group): 1 hour 5 minutes.



holistic care to patients.

Nanie Romeo has been Palcare’s social worker for three years – a role she describes as both ‘my mission in life’ and ‘a sacrifice’. Each day she meets patients in her office and makes an assessment of their needs: for medicines, counselling, chemotherapy and funding. She also meets patients on the ward and makes home visits to offer whatever assistance is available. She speaks of the nature of the Palcare team and the breadth of skills within it – medical, counselling, pastoral and nursing – and how much she values giving

Dr Rachael MB Rosario – *consultant anaesthesiologist, University of the Philippines - Philippine General Hospital and project director CHILD House, Quezon City*: interviewed by Michael Wright, 15 March 2007. Length of interview: 1 hour 15 minutes.



how she came to be involved with the Centre for Health Improvement and Life Development project (CHILD House). From small beginnings, the project was supported by the Philippines Charity Sweepstake Office and adopted by the philanthropist Ricky Reyes, which enabled the project to expand to its current facility. Rachael Rosario reflects on the aims and nature of the provision, the demands of raising funds, providing medical cover, giving psychosocial support to residents who are undergoing treatment and yet are dislocated from their homes, and the needs of those for whom no cure is found. She acknowledges the challenge of providing an holistic package of care in the Philippines, but is heartened by the possibility of

government and NGO organisations working together to cross boundaries and make provision for those who are poor and needy.

Luningning G Siarez – *head nurse, University of the Philippines-Philippine General Hospital, Manila and volunteer, Palcare Volunteer Group, Manila*: interviewed by Michael Wright, 12 March 2007. Length of interview (Palcare group): 1 hour 5 minutes.



Luningning Siarez tells how she became aware of hospice care when she joined the family medicine outpatient department and then began working with Agnes Bausa. When Palcare became established in 2002, there were further opportunities for domiciliary patients to receive medicines, equipment and psychosocial support and Luningning decided to volunteer, seeing this as a natural extension of her work. Part of her role is to teach basic nursing skills to caregivers to help the patient achieve a better quality of life at home. While

Luningning Siarez understands the emphasis on curative treatments she highlights the gap in provision for people who are not getting better. She also acknowledges the value of the PGH and Palcare training courses and the contribution that is made by volunteers.

Dr Joy Saquibal – *resident physician, department of family and community medicine, Western Visayas Medical Centre*: interviewed by Michael Wright, 15 March 2007. Length of interview (WVMC group): 1 hour 5 minutes.

Joy Saquibal is in the fifth month of her first year residency training at Western Visayas Medical Centre. She chose family medicine ‘to teach me not only to manage my patients but to counsel them as well’. Spiritual care is important to her and she



considers it part of the broader role of the family physician – especially in a Catholic country like the Philippines. She speaks of her involvement with patients and recalls a family conference she conducted which demonstrated the challenge of communicating with relatives who, despite a careful explanation of the diagnosis, remained in denial. She finds it helpful to end her rounds by praying for her patients and hopes that, in their joint experience of suffering,

families are brought closer together.

Daphne Tallada – *volunteer, Madre de Amor Hospice Foundation*: interviewed by Michael Wright, 13 March 2007. Length of interview: (Calamba group) 32 minutes.

Daphne Tallada explains how, six years previously, she attended a seminar on hospice



care with other members of her church’s pro-life group and subsequently became a volunteer. As one of her sisters had died of cancer she felt sensitised to the needs of both patients and their families, many of whom are desperately poor. She tells how some patients are left alone and others have few or no relatives to care for them so ‘we become like one family’. Although she enjoys the monthly group meetings with all Madre de Amor’s volunteers, Daphne Tallada looks forward to the day when Calamba City is not

only a satellite of the main group but is equipped with its own centre as well.

Dr Celina Vilches – *pain management and palliative care clinic, Iloilo Mission Hospital, Iloilo*: interviewed by Michael Wright, 15 March 2007. Length of interview: 34 minutes.



Celina Vilches trained at Iloilo Doctors College of Medicine and then went into practice at Palawan Baptist Hospital in the western Philippines. After two years she returned to Iloilo to train in internal medicine and it was during this time that first her mother and then her aunt became ill with cancer, whereupon Celina became increasingly interested in pain management. After training with Cenon Cruz, she established a pain and palliative care clinic at Iloilo mission hospital (1996), supported by PCSO. She reflects on how, at that time, a multidisciplinary team provided hospital-based and home care services that included symptom control, psychological counselling and spiritual care and how, when funding ceased, the provision diminished. She speaks of the lasting impact made by the clinic, the raised awareness of palliative care and the influence of hospice in professional practice. In the future, Celina Vilches hopes for an opportunity to re-establish a broadly-based hospice-palliative care programme.

Pretzel Villanueva – *hospice nurse, Madre de Amor Hospice Foundation*: interviewed by Michael Wright, 13 March 2007. Length of interview: (Calambra group) 32 minutes.



Pretzel Villanueva is a trained nurse who had previously worked in private practice but decided to move to the Madre de Amor Hospice Foundation when her mother-in-law became one of the hospice patients. In January 2006 she extended her skills by undertaking a palliative care course at Hospis Malaysia with Ednin Hamzah. She speaks of the nature of hospice care and how it differs from care in some Philippine hospitals, especially the engagement with spiritual and psychosocial issues. Unless she is needed more frequently,

Pretzel Villanueva visits patients once a week where she is primarily engaged with medical issues and training the family in basic nursing care.

Dr Noemae I Villanueva – *resident physician, department of family and community medicine, Western Visayas Medical Centre*: interviewed by Michael Wright, 15 March 2007. Length of interview (WVMC group): 1 hour 5 minutes.



Noemae is in the second year of her residency and chose family medicine because not many doctors work in the community despite the pressing need. She likes the multidisciplinary nature of hospice care and welcomes the opportunity to work with fellow professionals such as nurses, psychologists and priests. Sometimes, she feels apprehensive when she meets a new patient and is unsure what to expect. At such times, she finds a prayer is helpful, and the opportunity to speak with her fellow residents. Caring for the country's poorest people makes special demands, but she is heartened by the generosity she finds around her. She tells the story of a patient who

needed an endoscopy, which attracts a professional fee of 2,500 pesos. When she told the gastroenterologist about the patient's circumstances, the consultant waived the fee – and event she describes as 'the biggest thing that has happened with my patients'.

Rosita Villanueva – *retired teacher and volunteer, Madre de Amor Hospice Foundation*: interviewed by Michael Wright, 13 March 2007. Length of interview: (Laguna group) 45 minutes.



Rosita Villanueva lives in Santa Cruz and visits patients every Wednesday afternoon. She explains how she engages her patients in conversation, asking about their life before they were sick, their hobbies, family life, and the effects of their illness. She also speaks with family members and tries to help them understand what their relative is experiencing. Her work is mostly with the poor, and she recounts stories of the hardships suffered by indigents who, in their illness, not only lack medication but food and clothing. Rosita

Villanueva does what she can and recalls a time when she not only helped a family with food and utensils, but gifted some of her deceased husband's clothes.

Public health context

Population

The Philippine population of 90.50 million is made up of the following ethnic groups: Tagalog 28.1%, Cebuano 13.1%, Ilocano 9%, Bisaya/Binisaya 7.6%, Hiligaynon Ilonggo 7.5%, Bikol 6%, Waray 3.4%, other 25.3% (2000 census).

There are two official languages - Filipino (based on Tagalog) and English – and eight major dialects - Tagalog, Cebuano, Ilocano, Hiligaynon or Ilonggo, Bicol, Waray, Pampango, and Pangasinan¹⁴³

The Philippine population grew rapidly during the twentieth century and is expected to increase by 100% in the thirty years from 1980 to 2010 (Table 26).¹⁴⁴ This expansion, coupled with the size of the younger generation, has required the Philippines to double the amount of housing, schools and health facilities every twenty nine years just to remain at a constant level.¹⁴⁵

Although World Bank categorises the Philippines as a low-middle-income country, 41% of the population is estimated to be living on less than \$2 per day, 32% on less than \$1. Seventy per cent of the poor live in rural areas and poverty is concentrated in the north. Around half of rural families are poor as opposed to 20% of urban families. The average family income per annum in 2000 was PHP 144,039 (US \$3,245, GB £1,650). In the 20 provinces with the lowest average family income it was PHP 61,611 (US \$1,385, GB £705) in Masbate and PHP 85,240 in Taw-tawi (US \$1,920, GB £975). Countrywide, the average family income of rural residents is just 41% of that among urban residents.¹⁴⁶

Table 26 Population of the Philippines, census years 1903-2000

Year	Population (Millions)	Average annual rate of increase %
1903	7.314	2.87
1918	10.314	2.03
1939	16.000	2.11
1948	19.234	2.07
1960	27.087	2.89
1970	36.684	3.08
1975	42.070	2.78
1980	48.098	2.71
1990	60.703	2.35
1995	68.616	2.32
2000	76,504	2.36
2010 estimate	94.013	

Source: National Statistics Coordination Board

The Philippine National Commission on Indigenous Peoples (IPs) acknowledges the culture and identity of this segment of society: a group of communities with 110 ethnolinguistic groups found in various parts of the archipelago. Indigenous peoples are defined as a group of people or homogenous societies who have continuously lived as organised community on communally bounded territory. Since time immemorial, IPs have occupied such territories sharing a common bond of language, customs and traditions; and through resistance to political, social and cultural inroads of colonisation, have become differentiated from the majority of Filipinos. On account of centuries-long isolation, these people have fallen behind the mainstream population in terms of socio-economic development and have been identified as a vulnerable section of Filipino society. The Indigenous People's Rights Act (1997) addresses and encapsulates the rights of IPs, who:

have the right to an informed and intelligent participation in the formation and implementation of any project, government or private, that will impact on their ancestral domain, and that they have the right to participate in decision-making in all matters which may affect their lives and destinies.¹⁴⁷

Since the last quarter of the twentieth century, a culture of migration has occurred that has influenced the shape of Filipino society. Two trends have become apparent. The first is a shift from the more to the less densely populated areas as, against a background of a rising population, Filipinos went in search of land (especially to the Mindanao region). Next, a drift from the village to the urban areas saw the number of cities with 100,000 residents increase from 21 to 30 in the decade from 1970. By the early 1980s, an estimated one in four residents in Metro Manila was living in informal settlements.¹⁴⁸

This latter trend has become more pronounced in the twenty-first century, with the fast-growing economic activities in Metro Manila drawing more people to the National Capital Region, worsening the problem of human settlements and

pressurising services.¹⁴⁹ This has been replicated in other areas as the number of Philippine cities has now risen from 61 (1977) to 136 (2007).¹⁵⁰

Alongside this in-country migration, millions of Filipinos have left the country to seek a better life abroad. In the early 1990s, around half a million migrants were thought to be working outside of the archipelago.¹⁵¹ As of December, 2004, an estimated 8.1 million Filipinos, nearly 10% of the country's then population, were working or residing in more than 200 countries.¹⁵²

Religion holds a central place in the life of Filipinos and figures prominently in their corporate and personal sense of identity. According to the 2000 census, Filipinos are 93% Christian (Roman Catholic 81%), 5% Muslim and 2% unspecified.

Among the Christian community, the Catholic Church has engaged with local people by encouraging Filipinos to join the clergy and establishing a strong relationship between Christian doctrine and the pattern of family and community life. Strongly-held beliefs are expressed in a host of experiences, rituals and ceremonies that:

provide continuity in life, cohesion in the community, and moral purpose for existence. Religious associations are part of the system of kinship ties, patron-client bonds and other linkages outside of the nuclear family.¹⁵³

Epidemiology

In the Philippines, WHO (2007) indicates an adult mortality¹⁵⁴ rate per 1,000 population of 284 for males and 164 for females. Life expectancy for males is 64; for females 71. Healthy life expectancy is 57 for males; 62 for females.¹⁵⁵

Table 27 Leading causes of death, 2004

Rank	Cause	Deaths	% total
1	Diseases of the heart	70,861	17.6
2	Cerebrovascular diseases	43,077	10.7
3	Malignant neoplasms	40,524	10.1
4	Pneumonia	32,098	8.0
5	Tuberculosis	25,870	6.4
6	Chronic lower respiratory diseases	18,975	4.7
7	Diabetes mellitus	16,552	4.1
8	Certain conditions originating in the perinatal period	13,180	3.3
9	Assault	12,646	3.1
10	Nephritis, nephrotic syndrome and nephrosis	10,254	2.5
	Other	119,154	29.6

Source: Philippine National Statistics Office

During 2004, there were 403,191 registered deaths in the Philippines: 237,750 (59.0%) males; 165,441 (41.0%) females. The National Capital Region reported the highest incidence of death with 58,513 - 14.5% of the total. Calabarzon, with 55,813

(13.8%) deaths and Central Luzon, with 46,858 (11.6%) ranked second and third. The rest of the regions each contributed less than 10% to the total recorded deaths. Diseases of the heart were the most common cause of death, followed next by cerebrovascular diseases and malignant neoplasms (Table 27).¹⁵⁶

HIV/ AIDS

In December 2007, UNAIDS reported that the global HIV prevalence appears to have levelled off. However, the number of people living with HIV has risen to an estimated 32 million in 2007 from 29.0 million in 2001. Some 2.5 million people were newly infected with the virus in 2007 and 2.1 million died of AIDS-related illnesses.

In Asia, an estimated 4.9 million people were living with HIV in 2007, including the 440,000 people newly infected in the past year. Approximately 300,000 people died from AIDS-related illnesses during 2007. This same year in East Asia, there was nearly a 20% increase in new HIV infections than in 2001. HIV prevalence is highest in south-eastern Asia, with wide variation in epidemic trends between different countries. Myanmar, Thailand and Cambodia show declines in prevalence, but the epidemic is growing at a particularly high rate in Indonesia and Vietnam.¹⁵⁷

Figures held by UNAIDS estimate that in the Philippines up to 20,000 adults and children may be living with HIV (Table 28).

Table 28 Estimates of people living with HIV in the Philippines

Groups	Estimates	Range
Number of people living with HIV	12,000	7,300 – 20,000
Adults aged 15 to 49 HIV prevalence rate	<0.1	<0.2
Adults aged 15 and up living with HIV	12,000	7200 – 20 000
Women aged 15 and up living with HIV	3,400	1,800- 6,000
Deaths due to AIDS	<1,000	<1,000

Source: UNAIDS 2006 report on the global AIDS epidemic

The UNAIDS situation analysis for the Philippines (2006) highlights a range of initiatives and issues:

Efforts to strengthen the capacities of the National AIDS Council, both its members and its secretariat, have started to show positive results. The Council has developed a costed operational plan for 2007 – 2009, anchored on the country's *Fourth AIDS Medium Term Plan*. The operational plan serves as the national road map towards universal access to prevention, treatment, care and support, clearly defining country-specific targets, opportunities and bottlenecks along the way, and culturally appropriate strategies to address them. To have a more responsive policy environment, the AIDS Law of 1998 was reviewed in 2006 and proposed amendments were submitted to Congress.

Service coverage to people most likely to be exposed to HIV has broadened through the expansion of Global Fund sites. There is, however, a pressing need to enhance the scope of interventions to include, for example, needle

exchange in harm-reduction programmes for injecting drug users. Antiretroviral drugs are provided free of charge to both adults and children. Efforts to integrate HIV into programmes on tuberculosis and mother and child health are under way at the level of programme planning and implementation.

Deepening engagement of vital sectors, particularly the Catholic Church, was seen in 2006 in responding to HIV in the Philippines. This was primarily activated by the visit of the Caritas Internationalis Special Advisor on HIV and AIDS, and continued dialogue with leaders of the Catholic Church.

In a low HIV prevalence setting, it remains a colossal challenge to galvanise leadership action in advocating a stronger and sustainable response to AIDS when faced with other competing priorities. Strategies to prevent sexually transmitted infections in general, which are highly prevalent in the country, are being used to prevent HIV infection in particular.¹⁵⁸

In a country where developing palliative care services are focused on patients with cancer, the low prevalence of HIV raises the question of whether palliative care will become available for those with a non-cancer diagnosis, including people living with HIV/ AIDS (PLWHA). The challenges of extending palliative care to PLWHA are well documented: the need for complex treatments that can overstretch health services; balancing acute treatment with the control of chronic symptoms; problems associated with stigmatisation and discrimination; complex family issues, such as infection of both partners; role reversal in families, where young children look after their parents; and the burden on health care workers.¹⁵⁹

UNAIDS recognises that indigenous peoples are a vulnerable segment of society in which access to health care is limited but the risk of infection is high. In its report to the Permanent Forum on Indigenous Issues, UNAIDS comments:

The correlation between poverty and the risk of HIV infection is well recognized and occurs at many different levels. Those living in poverty are less likely to have access to education, health care and other social resources. Many factors linked to poverty and deprivation of identity make indigenous peoples more vulnerable to sexual exploitation, or to become victims of trafficking in women and children. It may be difficult for people living in poverty to afford condoms or to insist on their use. Moreover, the absence of hope, often associated with poverty, deprives individuals of the psychological and emotional resources to protect themselves and others against HIV infection.

Because so many indigenous peoples are economically disadvantaged, it is important to appreciate the nexus between poverty and increased vulnerability to HIV. An understanding of that connection needs to inform HIV policies and programmes for indigenous communities, since the issues involved transcend concerns about health alone and include fundamental questions about indigenous status and the relationship between indigenous peoples and the larger communities in which they live.¹⁶⁰

Health care system

The WHO overall health system performance score places Philippines 60/ 191 countries. This composite measure of overall health system attainment¹⁶¹ is based on a country's goals relating to health, responsiveness, and fairness in financing. The measure varies widely across countries and is highly correlated with general levels of human development as captured in the human development index.

The *Medium-Term Philippine Development Plan 2005-2010* emphasises that improving the accessibility and affordability of quality social services is essential to ensuring social justice and meeting the basic needs of every Filipino. WHO comments:

In this light, stakeholders in health and health-related sectors must intensify and harmonise their efforts to attain the country's vision of health for all Filipinos and continue its mission of ensuring the accessibility and quality of health care to improve the quality of life for all Filipinos, especially the poor.¹⁶²

The goals of the health sector are stated to be 1) better health for the whole population 2) development of a health system to meet the population's expectations and 3) equitable health care financing. The Department of Health has embarked on an implementation strategy designated *Formula One (F1) for Health*. The challenges can be summarised as:

- A growing budget deficit: insufficient investment in health services
- Iniquities in access to health care
- Excessive reliance on hospital rather than primary care
- Acceleration of urbanisation: poverty among urban settlers
- High infant mortality rates and under-reporting
- Retention of medical staff, particularly in rural settings
- Provision of health care to isolated groups
- Prevention and control of non-communicable diseases
- Improvement in health quality data
- Low financial risk protection: high out-of pocket payments¹⁶³

Since the 1980s, considerable gains have been made to the health care system. These include: the adoption of the primary health care approach (1979); the integration of public health and hospital services (1983); the reorganisation of the DoH (1987); devolution of health services to local government units (LGUs, 1992); and the streamlining of DoH functions (2000).

A patchwork of public and private facilities provides health care in the archipelago. Government facilities include provincial and district hospitals (managed by provincial governments), Barangay health stations and rural health units (managed by municipal governments). Private hospitals significantly outnumber public hospitals (Table 29).

Table 29 Health facilities in the Philippines

	1999	2000	2001	2002	2003	2004	2005
Hospitals (total)	1,794	1,712	1,708	1,739	1,719	1,725	1,838
• Government	648	623	640	662	662	657	702
• Private	1,146	1,089	1,068	1,077	1,075	1,068	1,136
Barangay health stations	14,416	15,204	15,107	15,283	14,490	15,099	15,436
Rural health units	2,212	2,218	1,773	1,974	2,259	2,258	2,266

Source: National Statistics Coordination Board

The challenges facing the Philippine public health service should not be underestimated. For example, there is a widespread lack of confidence in primary health care, where facilities are perceived as being low quality and are frequently bypassed. WHO:

Clients are dissatisfied due to long waiting times, perceived inferior medicines and supplies, poor diagnosis resulting in repeated visits, and personnel who are not always available, especially in rural areas, and are perceived to lack both medical and people skills. The result is that secondary and tertiary facilities are inundated with patients needing primary health care.¹⁶⁴

Another concern is the huge migration of doctors and nurses which not only creates a general shortage but makes the rural areas yet more vulnerable to deficiencies in health care personnel. The country's largest hospital, UP-PGH, loses between 300 and 500 of its 2000 nurses every year. Yet the drain occurs in both public and private institutions. An estimated 70% of all Filipino nursing graduates are working overseas. WHO:

[A] survey of nurse-medics further shows that more than 3,500 medical doctors have left as nurses since year 2000. A little more than 1,500 have just passed the national nurse licensure examinations in 2003 and 2004 (PRC 2004). At present, an estimated 4,000 doctors are enrolled in nursing schools. ... Midwives, the front liners in providing health services are also seeking jobs as caregivers in other countries. The scenario is that not only the public health structure will collapse, but the private health sector as well.¹⁶⁵

Despite the strain in both sectors, the mismatch between the total Philippine health personnel and the number working in government facilities is evident. For example, in 2004, less than 3% of doctors and only 1.3% of nurses were government personnel (Table 30).

Table 30 Health facilities in the Philippines

	Government personnel ¹						Total Personnel ²
	1999	2000	2001	2002	2003	2004	2004
Doctors	2,948	2,943	2,957	3,021	3,064	2,969	93,862
Dentists	2,027	1,943	1,958	1,871	1,946	1,929	45,903
Nurses	4,945	4,724	4,819	4,720	4,735	4,435	352,398

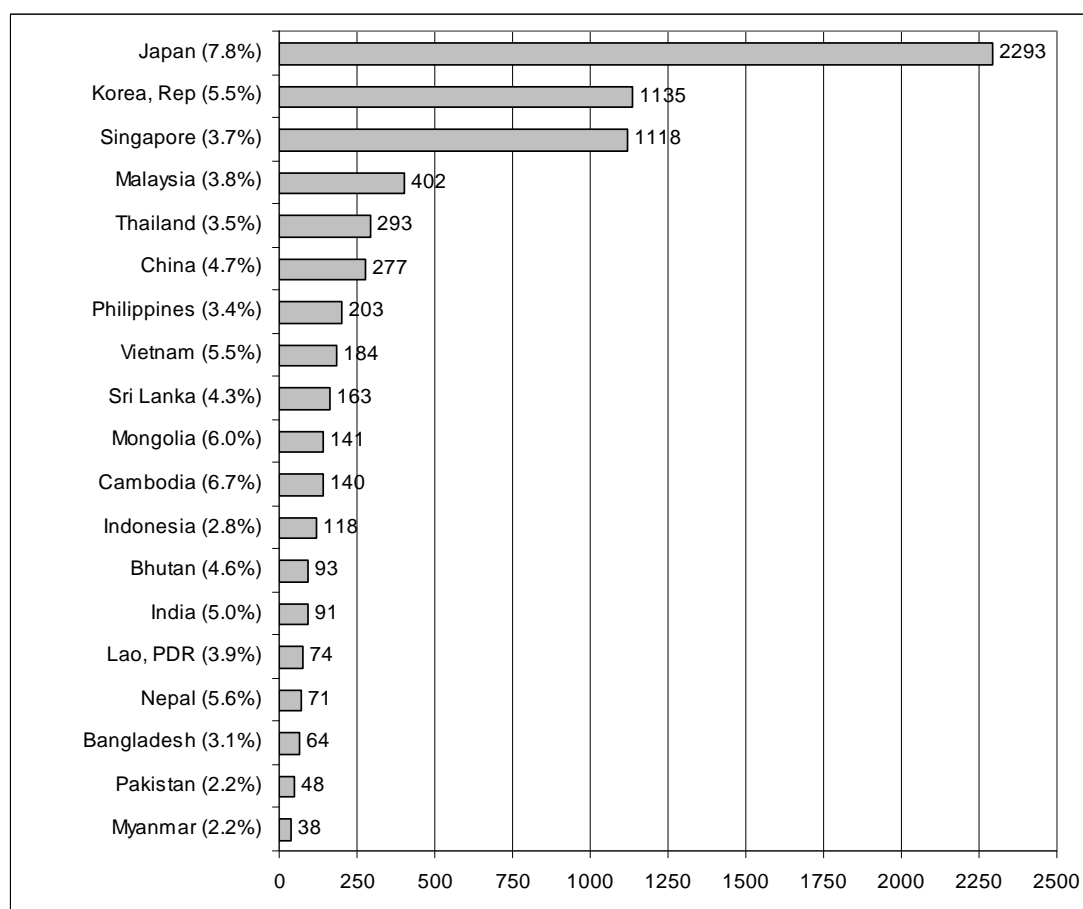
Midwives	16,173	16,451	16,612	16,543	17,196	16,967		136,036
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¹Source: National Statistics Coordination Board

²Source: Profession Regulation Commission¹⁶⁶

In 2004, the total per capita expenditure on health care was Intl \$293 (3.4% of GDP).¹⁶⁷ Among the countries of CSE Asia, this figure falls within a spending range of Intl \$2,293 in Japan (7.8% of GDP) and Intl \$38 in Myanmar (2.2% of GDP) (Figure 3).

Figure 3 Total expenditure on health per capita (intl \$) shown also as a percentage of GDP



Source: World Health statistics 2007

In the National Health Accounts for 2005, the per capita health spending was 3.3% of GDP, down 0.1% from 2004. This figure remains below the 5% standard set by the WHO for developing countries. On the other hand, the share of health expenditure to GNP remains at 3.1% which is within the Philippine National Objectives for Health target of 3% to 4%.¹⁶⁸

Also in 2005, the share of government on health expenditure declined to 29% which is below the target of 40% based on the Health Sector Reform Agenda (HSRA). Moreover, the government's target to depend less on out-of-pocket payments and

provide more social health insurance is still far from being realized as the share of out-of-pocket payments increased to 59% while the share of social insurance payments increased only slightly to 11%. Based on the HSRA, the target for out-of-pocket payments is 20% whereas the social insurance target is 30%.¹⁶⁹

Notwithstanding the challenges to the public health system in the Philippines, a number of strengths and opportunities have been identified. These include:

- Government commitment to poverty reduction: targets set in the Medium-Term Philippine Development Plan 2005-2010
- Commitment of government, public and private partners to the Millennium Development Goals
- Health reform targets for improvement in delivery, regulation and financing of health care; improved coordination of activities
- The Philippines Health Promotion Programme; progress in the healthy city initiative with engagement of local governments and communities
- Strong tradition of gender equality and education
- Effective emergency response capacity, as demonstrated during the severe acute respiratory syndrome outbreak
- Lessons learned from previous health sector reforms
- Increasing local government support for health programmes¹⁷⁰

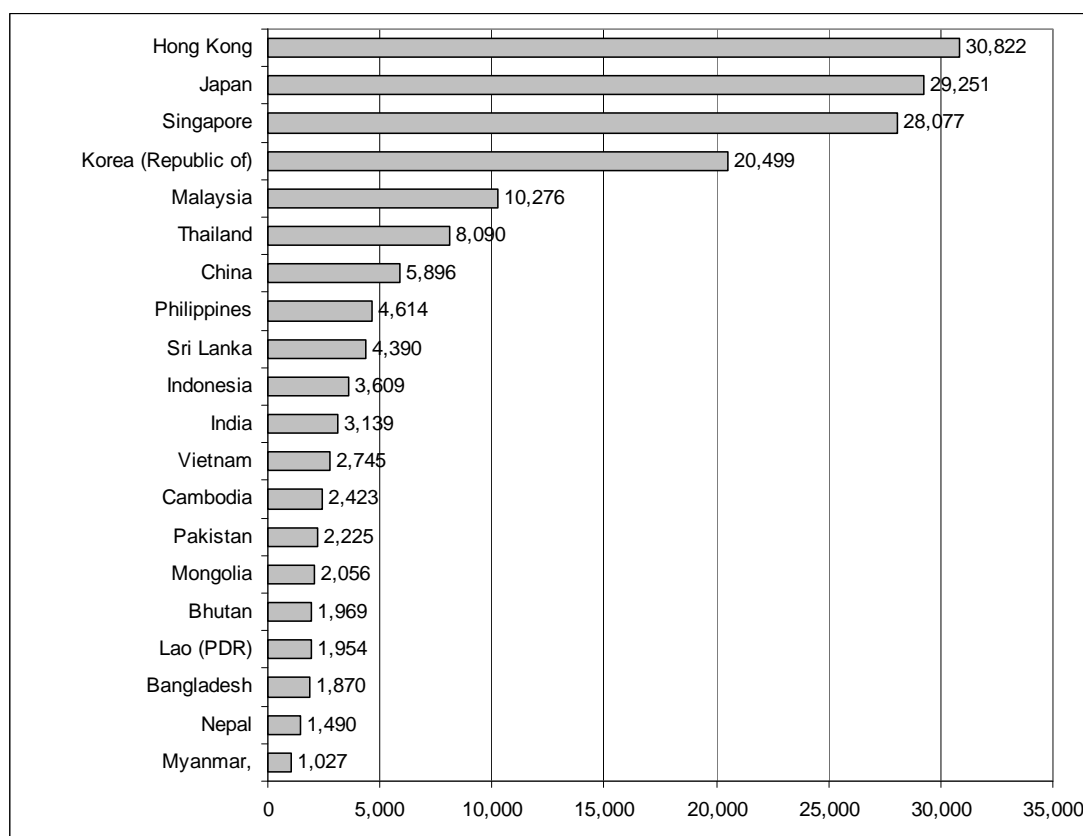
Political economy

According to the United Nations Development Report 2006 (figures for 2004) the Philippines' Gross Domestic Product (GDP) per capita is US \$4,614. This falls within the range of US \$30,822 (Hong Kong) and US \$1,027 (Myanmar) in countries of central, south and east Asia (Figure 4).

During the 1990s, the Philippines were less severely affected by the Asian financial crisis than its neighbouring countries, aided partly by its high level of annual remittances from overseas workers. Between 2002 and 2006, average GDP rose to about 5% reflecting the resilience of the service sector together with improved exports and agricultural output. Yet against the background the country's high population growth rate and unequal distribution of income, more sustained growth will be required to make any significant progress in the alleviation of poverty.

The Philippines' consistently large budget deficit has produced a high level of debt, and this has forced Manila to spend a large portion of the national government budget on debt service. Credit rating agencies have at times expressed concern about the

Figure 4 Gross domestic product in US dollars: countries in central, south and east Asia, 2004



Source: United Nations Development Report, 2006

Philippines' ability to service the debt, though central bank reserves appear adequate. The implementation of the expanded Value Added Tax (VAT) in November 2005 boosted confidence in the government's fiscal capacity and helped to strengthen the peso, making it East Asia's best performing currency in 2005-06.

This improvement has continued during 2007. In a 2008 press release, the Philippine National Statistical Coordination Board reports:

In an environment of benign inflation, low interest rates and a strong peso, the Philippine economy sustained its impressive streak of lofty growths that started in the first quarter of the year [2007]. Fourth quarter growth of GDP stood at 7.4% from 5.5% last year, propelled by the robust performances of Trade, Agriculture and Fishery, Private Services, Construction and TCS, with the rest of the sectors posting positive growths.

The seasonally adjusted GDP, now on its 27th quarter of positive growths, accelerated to 1.8 percent from 1.0 percent in the previous quarter.¹⁷¹

Concluding comments

In the Philippines, hospice and palliative care development is making progress after a chequered history that began with a groundswell of enthusiasm and the unequivocal

support of government: a factor which later waned, leading to a loss of momentum and a reduction in service provision. In a country with insufficient investment in health services, a weak primary care system, high migration rate among health professionals, and widespread poverty - particularly among the indigenous population - such support is crucial if a quality service is to be available to Filipino needy at the end of life.

There are encouraging signs. Public awareness of hospice-palliative care is increasing. The number of service providers has risen to its highest level. Individuals are supplementing their initial training by enrolling on the APHN/ Flinders course. Highly motivated volunteers, both young and not-so-young, provide psychosocial support to patients and their family, or perform other tasks that support the delivery of care. The national organisation has become invigorated, exploring new ways of supporting its members, engaging with government, and seeking the means to encompass palliative care within the public health system. The DoH interest in founding a hospice in Davao, together with its commitment to increase the availability of morphine and other analgesic drugs, are indicative of a growing interest.

Yet if hospice and palliative care services are to become more widely available, there is a need to build firmly on government interest. Although resources are scarce, the provision of palliative care for indigenous people chimes with the Indigenous People's Rights Act and is in keeping with the government's package of support for this vulnerable section of the community. It is important, too, that the DoH commitment to the increased availability of pain relieving drugs comes to fruition, and benefits those who most need them. Questions may also be asked about the wisdom of establishing a half billion peso hospice in Davao when a building is under construction in Iloilo, and could be completed at a fraction of the cost (around 25 million). The cheaper option would also provide important information about the viability of a free-standing hospice and its role in the Philippine health system.

On the broader front, collaborative models such as the Ayala Alabang-Parish of St James initiative, Palcare-JIREH and CHILD House-PCSO et al point to the possibility of sustainable innovations based on shared interests and mutual understanding. Moreover, developments at places like The Medical City demonstrate that hospice care has a part to play in any wide-ranging health service provision. Consideration may now be given as to whether progress would accelerate through the appointment of an advocacy officer – perhaps part-funded and under the umbrella of the national association – to keep hospice-palliative care in the public eye, nurture fledgling services, and keep end of life issues on the agenda of government.

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