A Colonial Identity of Caring Phenomenon in Philippine Public Health

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Abstract

The study illuminated the caring phenomenon within the provision of health services and the seek of care in Philippine public health. Using a qualitative approach, employing a hermeneutic-phenomenological design, specifically the Husserlian method for phenomenology a Gadamerian hermeneutics, this study was participated by 8 care providers and 8 recipients of care. It utilized generated themes from in-depth interviews which represented the current phenomena of Philippine public health being correlated with historical literatures and events to generate interpretation of what was found to be a colonial identity of care. Furthermore, the tangible manifestation of caring phenomenon in Philippine public health is built within the scaffold of a colonialism, lived and shared by the people through culture influencing and shaping today's society in its identity as a Filipino and in public health as caring phenomenon occurs.

Keywords: Colonial Identity, Public Health, Caring.

Introduction

The health care delivery system of the Philippines has constantly undergone change from one administration to another. At present, it centers on "All for Health, Towards Health for All" which harmonizes with the common goal of public health to prevent diseases and promote health (Stoven & Bassett, 2003). On the midst of this façade contrasts the caring experiences of Filipino clienteles while seeking healthcare among public health service providers. Quoted from the present health agenda, this poor quality and undignified care are synonymous among public health clinics and hospitals. Clients experience long waiting times, the lack of autonomy to choose a care provider of choice, unhygienic and deficient amenities, ethical issues on privacy and confidentiality along with poor records keeping, overcrowding, and worse, care of proletariat quality, consequently evident in accounts of Abbah (2014) and reports of social inequalities by the Child Fund International (2013).

Having been strung out by the healthcare architecture, this affects service delivery to the general recipients of care, mostly the poor and the underserved. The indigent population groups account 49% of the total population who are defined to have no visible means of income to sustain the daily needs of the family (SunStar Cebu, 2017). They are vulnerable groups threatened with their rights to access health care resulting to poor health outcomes, inequalities and disparities antithetical with the sustainable development goals, specific and sensitive to health (United Nations, 2017). Now, Repercussions lead to the increasing statistics of the different epidemiologic events from communicable diseases, chronic-lifestyle related conditions to social and public health issues of society (Scutchfield & Keck, 2009).

We are now left of being questioned on the role of caring. Where is the aspect of caring? In society and in public health today. Watson (2001) engaged care providers on the value of caring that, ideally intertwines between the client as the recipient and the health worker as the primary public health caregiver. Furthermore, in harmony with the World Health Organization (2006), the presented facts of the current health architecture and the influence of caring, increases the need to study the aspect of caring and its components to decease inequalities.

Methods

The study was conducted within the three (3) major cities of Region VII, Central Visayas, Philippines namely Cebu, Mandaue and Lapu-Lapu City within the 3rd trimester of 2018. This followed a Qualitative design imploring hermeneutic-phenomenological approach. Phenomenology was used to draw out experiences of caring from both groups of participants (Trochim, 2008), and hermeneutics provided interpretation of the said phenomenon (Gadamer, 1975). Scientific and ethical approval for the conduct of the study and the use of the proposed semi-structured grand tour questions in data gathering was granted by the Southwestern University-PHINMA research and ethics board. Transmittal letters were given to department heads of local health offices covered within the mentioned cities.

Upon data gathering a bot groups of participants followed a purposive-snowball sampling. Partners in the community who were barangay health workers were identified to aid in data collection referring the identified members of the 4P's program within their catchment area. The participants were provided with informed consents as the aims and processes of the study was explained. The agreeing participant was also informed that upon consenting to participate, confidentiality will strictly be upheld while interviews are done and recorded using a voice recorder, camera and a notebook to jot down important points for documentation. Interviews were done privately alone with the client on their respective houses. The grand tour question "Describe the experience while seeking care from public health care providers" was the primary data collection question of which follow-up questions were generated based from individualized verbalizations which facilitated the outpouring of verbalized experiences.

The care providers were health workers from primary care facilities within the locale. Informed consent was provided and the aims and process of the study was discussed. Upon consenting to participate, the care providers were informed that interviews will be done with aid of a recorder, camera and a notebook to jot down important points. Interviews were done privately after office hours to avoid disruption of health center operations. The grand tour question "Describe the meaning of caring when rendering it to clients" was the primary data collection question of which follow-up questions were generated facilitating further verbalization of experiences.

Data analysis

Prior to the data gathering stage, bracketing was done to detach the researcher from biases, preconceived beliefs and assumptions which may influence the rawness of the experience and to capture the essence of the data being presented. In building the descriptions on the experiences, generated verbalizations were categorized using Colizzi's method of writing of themes that followed: 1) Having a picture on the whole data content where the researcher constantly reviews and familiarizes the transcripts of experiences. 2) In each transcript, significant statements that relate to the studied phenomenon are extracted, transcribed and coded. 3) The transcribed statements are then used to formulate constructs of thought. 4) These constructs of thought are arranged and categorized to generate sub-themes and themes following an inductive approach. The generated themes were analyzed using Husserl's descriptive phenomenology to describe the detailed experiences both from the recipients of care and the provider. It is to emphasize and highlight the lived experiences of participants without utilizing and considering any theories before data gathering which may influence the rawness of the data. Data saturation from 8 recipients of care and 8 care providers was achieved. This was evident with the repeated experiences, as well as no new information was being gathered after 3 consecutive phases of interview. The claim for rigor of saturation is well evident and supported as Creswell (1998) noted that phenomenological studies can achieve saturation with a 5-25 participant involvement of which Morse (1994) suggested that the average number of participants is at 6.

To provide interpretation of these lived experiences, Gadamerian hermeneutics was utilized. Paterson & Higgs (2005) suggested to involve 3 steps: 1) Reflection on the ontological perspectives happen. This is by attuning the gap of understanding between the shared consciousness of the past with the present experiences the participants have. 2) Historical literatures and antecedent experiences are bridged with the present horizons that generates emerging interpretations. 3) With the bridge of gaps, the illuminated phenomenon

quenches the need for understanding of the aforementioned. The emerging interpretation of the phenomenon shapes the shapeless imploring the hermeneutic spiral and circle to generate a model that details the patterns of occurrences within the experiences of the recipients of care with the provider.

Results

The recipients of care

A total of 3 themes were generated from the specified qualitative method. 337 accounts of verbalizations that contained subthemes were recorded in the codebook representing statement that uncovers the phenomenon. The essential themes are (1) The government as a care provider, (2) Standards that define me and (3) In my own ways. Each essential theme is evidenced by 32 to 76 accounts, present among the verbalizations of all 8 recipients of health care which signifies saturation. Further discussion of the themes is represented along with the subthemes inclusive of the evidenced representation of the verbalized accounts.

Theme 1: The government as a care provider

The government on health sectors presents a major role in the delivery of care. The theme discusses not just the physical structure of the government but also the internal and external influences and characteristics that composes it. As described by the informants, these consists the front liners in care delivery system, the day-to day operations of the facility, the allocation of services to the public and to the facility itself. Highlights of the theme determines the constraints the government has including the lack of supplies such as medications, materials and equipment's, the bureaucratic structure hastening the seek for care, the public health staff's insensitive behaviors and the lack of human resource to cater into the needs of the clienteles. This is well reinforced in Abbah's (2014) detailed picture on the diversity of treatment among public health facilities that, rather than quality care, health workers are seen with usurious tendencies and insensitive behaviors. These results to long waiting times, the lack of autonomy to choose a care provider of choice, unhygienic and deficient amenities, ethical issues on privacy and confidentiality, poor records keeping, overcrowding and poor-quality care (Department of Health, 2017)

As verbalized by a recipient of care "when we went to the trauma department at the emergency room, we weren't catered. We went there early in the morning and it was already late afternoon when we were entertained"

Theme 2: The standards that define me

The second theme discusses on the verbalized objectification upon seeking care. It is best described as care that is generic that falls below the quality standard set being reflective on the client's account of experiences drawn from their social status. In this theme, 2 sub-themes emerge, further dissecting the thought of experiences: (1) Injustices, which refers to the encountered prejudice, insensitive treatments, favoritisms and actions a client experiences upon seeking and receiving care to a public health facility. (2) I am poor: Self-pity, a rationalized construct of the mind that a client looks in and reflects in to upon being prejudiced, judged and unjustly catered. McTavish (2016) stated that the poor have limited access to healthcare in most countries including the Philippines. These specified population groups are often denied to access these government provision subjecting to heavy burdens of emotions, physical and financial constraints to address the needs they are deprived of.

Injustice

Evident in the practice of health, clients seek care among the different facilities situated within their communities. In the venture to seek care, result to an interaction and a series of multi-factorial events a seeking client experience. With these, one subtheme emerged in the midst of the experience. Accounts of injustices, prejudice, judgement and insensitive behavior were identified, haunting and constantly feeding the consciousness and the ill feeling of judging oneself based on a social status.

As verbalized by a recipient of care "that's true, some doctors in public hospitals would yell and would tell you "do you want to die!" especially when you have conceived and delivered several times. It's a matter of explaining that is delivered in a calmly manner. As simple as that, a person can understand"

I am poor: Self-pity

In lieu of the first subtheme, "injustice", this subtheme ventures on the mental and emotional aspect the client bears from within. Mental, in a sense that the current standard subjects these clients to build preconceived thought within themselves about the quality of care they are entitled to. This construct emanates through an emotional state of self-pity.

As verbalized by a recipient of care "I was able to tell myself that it's not that I'm arrogant, but it so happened that I wasn't able to finish any degree. We will all die and go to the same place and in that place, it won't be a gauge of profession."

Theme 3: In my own ways

The theme presents the deflection of healthful outcomes to its opposite. These are practices that in the client's own way compensates with the poor quality of care they are receiving. This details the health seeking behaviors, motivations and outcomes possessed by the client while on the process of seeking and receiving care. This branches out to 3 subthemes namely, (1) Rewards vs. Punishment, (2) Denial and Self Diagnosis, and (3) Alternatives I make. Inequality in healthcare and access to it poses a role in the picture of the Philippine healthcare structure. With this, traditional medicine has been seen as a practice among the natives of the Philippines rooted from their ancestral influences (World Health Organization & Department of Health, 2012).

Rewards vs. Punishment

One of the factors that were reflected on this subtheme was the recipient's membership of the Pantawid Pamilyang Pilipino Program or 4P's. monthly visits for monitoring at the nearest health center was one of their obligatory duties. This state of obligation urges these clients to visit the health facility in return for rewards like complete reimbursement of monthly allotment, rice allowance and schooling for their dependents. Failure to meet the expected criteria results to punishment.

As verbalized by a recipient of care "you have to visit for the service so that you're-allotment won't be inadequate, that's why you have no choice"

Denial and Self-Diagnosis

With identified factors that lead to illness and morbidity, and the factors mentioned relating to health practices, denial and self-diagnosis was one of the themes that emerged. This reflects the client's initial action to address the presenting stress which is to deny, delaying the seek for care, leading to self-diagnosis. With these health outcomes, denial exists hand-in-hand with self-diagnosis among these population groups.

As verbalized by a recipient of care "I don't know. His oxygen levels can't reach his brain because he was dehydrated that's why it happened"

Alternatives i make

The third subtheme talks alternatives and methods done by the client to answer the previous subthemes that results to the existing outcome of health behavior. Factors include, unmet needs from the government service they took which leads them to rather seek in less costly private clinics, facilities and non-professional health practitioners, the lack of supplies and medications within health centers and some referrals of neighbors and family members where interventions are rooted in social practices which may be taboo to the medical perspective.

As verbalized by a recipient of care "when they become sick, I give them medications on the previous prescription one of my child had. I adjust the dose based on who will take the medication. For example, if

my one of my child was given 1 tablespoon, I'll give half a tablespoon to the other. Also, sometimes, I give medications referred by my neighbors, it's effective though."

The care providers

On the care provider's perspective, 2 themes emerged, generated from the qualitative method employed. A total of 316 significant accounts drew the themes that describe the inquired perspective which were recorded in the codebook representing the phenomenon. The essential themes comprise, (1) Patterns and paradox of caring experience, and (2) Rise of unmet needs. Each essential theme is evidenced by 40-88 accounts, present among the verbalizations of all 8 care providers signifying data saturation. Further discussion of the themes is represented along the subthemes inclusive of the evidenced representation of the verbalized accounts.

Theme 1: Patterns and paradox of caring experience

This theme tackles patterns of health as well as paradoxical characteristics innate in a care provider. This details the given efforts to alleviate and augment the health of the cared population along with the covert and overt responses a care provider feels and manifests. This in return, may manifest positivity or negativity evident through paradoxical shifts of feelings and responses. This transcends to 3 subthemes namely: (1) Transference, likened to a movement of neuronal movement analogy by Van Wyk (2003). He defined the analogy as a structure of neuronal systems moved from one to the other maintaining its integrity. This concept well speaks on the maintenance of care integrity among care providers which in their perspective may seem to be governed with quality that results to movement of caring experience from one client to another. This experience on the transference of caring may negate the essence of it resulting to a (2) paradox and worse (3) aggression.

Transference of experience

Patterns of banked experience translates into transference, nourished by the daily encounters of a care provider upon carrying the accompanying roles as a caregiver. In its operational definition, it contains the carried strategy learned from one client to another. Its further funnels to the paradoxical experiences a care provider has whenever new encounters of caring occur. These subjective responses are overtly channeled, evident in actions rooted either in fulfillment or frustration.

As verbalized by a care provider" How would I do that? Cut my body into pieces? All I'm saying is, to follow my health teachings. You constantly give these teachings and some won't understand your efforts. It's fulfilling, you'd be happy with the experience that you can help them not just physically but emotionally but that, they just need to appreciate the health teachings you give and follow it."

Paradox of my feelings

As the process of caring occurs, empathy becomes a key area for of concern. In this subtheme, it focuses on the paradoxical phenomenon of caring subjected and carried out as these care providers cater to the needs of their recipients. The generation of the paradoxical perspective rooted its beginnings from transference of experiences that, ideally, the means of action is to care, but there, in reality exists the counterpart of it. Subjected to the different circumstances, the paradox of unacceptable responses and behavior are overtly observed and described alongside with the empathic encounters between the recipient and the care provider.

As verbalized by a care provider" they have a lot of reasons, because of this and that, because they are busy. It's just a matter of effort and that makes me furious"

The responsive receiver: aggression behind responses

In the occurrence of the caring phenomenon, paves for its responses. There was a variation of responses found, but, saturation of aggressive actions, transactions and behaviors prevailed among the said encounters of caring phenomenon.

As verbalized by a care provider "The patient became angry and said, he'll burn this health center because they arrive late and they'll take a bath and the nurse isn't there also. They are insensitive"

Theme 2: Rise of unmet needs

Reflective of which are the evidences on the rise of unmet needs from encompassing factors and to the alternatives being ventured by the client to address the unmet need. These themes are well described and contained within the perspective of the care provider overlooking their care recipient's practices and health outcomes. Emerging silhouettes of these unmet needs are from the financial difficulties each poor Filipino client experiences forcing them to postpone care seeking initiatives, resolving in unhealthful behaviors and alternatives (Son, 2009).

Silhouettes of the unmet

The unmet is shadowed by different factors occurring within the health care delivery to its clients, mainly the underserved. This subtheme deals on the factors that leads to poor health outcomes influencing the care of the provider. Most accounts that share this subtheme details on the characteristics of the government as the care provider, and the alternatives and behaviors a client ventures, healthy or not, in order to self-address health and the unmet needs.

As verbalized by a care provider "Mothers don't finish the course of immunization schedule. It's a big problem because if that unimmunized child becomes sick on that particular condition, that child will be the carrier of the condition and could spread it to others"

Health outcomes

From the alternatives becoming silhouettes of the unmet produces the expected health outcomes. These health outcomes comprise the resultant effect and its impacts to the individual and to the general population. These outcomes have been identified by the care providers as a threat endangering the health of its clienteles.

As verbalized by a care provider "That's why we have a lot of communicable and non-communicable cases. Upon giving instructions to finish or comply to the course of treatment, most of them won't finish or comply with it."

Hermeneutic result

Hermeneutic spiral of caring phenomenon

Correlation of the past and the present

Society and humans in an epistemological view is born with no pre-programmed state. Coupling and broad groupings into communities builds data banked experiences giving birth to culture (Subhani & Osman, 2011). Likewise, the Philippines shared the similar beginnings with a rich pre historic culture. Yet, everything was about to change when colonizers invaded the wetlands of the Philippines. The series of historical events following culture modification led to a so-called construct of "colonial mentality and identity" (Mulder, 1997). Drawing from history, the early Philippine society was pressed to attune with the Spanish culture that resulted in oppression and injustices. This translated within the caste system of yesterday's Spanish regime being evident within the factions of society, the "Indios" who were the marginalized, the middle class and today's "illustrados" and the "peninsulares" or elite. From that oppressing mentality that circulated within society for a reckoned 300 hundred years, it paved for the people to unconsciously adapt and "be like the Spaniards". The implied mentality fed the consciousness of Filipinos that up until the present time, lingers within the minds of most Filipinos and has influenced the aspects of society including healthcare (Morente, 2015).

Discussion

The series of historical events following culture modification led to a so-called construct of "colonial mentality and identity" (Mulder, 1997). On this common ground, we look into the role of an archetypal psyche of consciousness (Van Wyk, 2003), the collective unconscious which as explained by Jung (1959) being universal and shared by many rather than individual. This breakthrough understanding has provided explanation that historically banked experiences ticks for recognition unconsciously in the form of unconscious behaviors, which rather explains why culture is patterned within coupled groups and communities of people (Subhani & Osman, 2011). As in the case of the banished pre-colonial culture of the Philippines, J. P. Rizal (as cited in Derbyshire, 1912, Mulder, 1997, Morente, 2015) proves basis as to its existence of being a "Social Cancer". We can see patterns of tinges about its influences in today's society, as in the case of public health. This reflects within the generated themes about both studied groups where these care providers, may be likened with the "Ilustrados" who were pre-programmed with their socially grounded, authoritative rights and professional judgement of "what is right for a client". Meanwhile, the socially determined population groups reflective of the "Indios" are subjected to vulnerability (Macahiya, 1969). Likened with the poor, the thematic accounts prevailed social injustice for these oppressed group while they seek care and receive services which at its firmness influences the rise of unmet needs, health disparities, medical taboos from quack doctors, alternative medicines, and worse, morbidity and death which is well supported by concurrent studies reported by the Philippine Statistics Authority (2018), Department of Health (2014) and Abbah (2014) in his written experiences regarding social determinants and public health. The recognized blueprints from collectivism (Jung, 1959) are residue of the mind's evolution and are the scaffolds of the colonial identity within the Philippine Culture shaping the "Filipino" in us (Mata De Young, 1998). It becomes an unending event and an undeniable fact that the works of the past comprise our present and becomes, and will become the culprit of the varied factors that influence our self and the society.

Conclusion

This illumination of caring phenomenon in Philippine public health provides an understanding that the culture defines caring. Caring in the sense how a care provider delivers the function in the need to answer human needs and the client's interaction to the built interpersonal relationship. The collective unconscious played an important role in cultivating culture and society which gave shape and metamorphosis to caring in public health. This legacy of the past became part of today's identity that undeniably this phenomenon are from the influences of the pre-colonial and colonial era the country had.

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