

STATE OF THE NATION

RESEARCH REPORTS



**Perla D. Santos Ocampo
Laurie S. Ramiro
Josefina G. Tayag
Nymia P. Simbulan**

THE FILIPINO CHILD: A HEALTH SITUATIONER

UNIVERSITY OF THE PHILIPPINES
CENTER FOR INTEGRATIVE AND DEVELOPMENT STUDIES
AND THE UP PRESS

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FOREWORD

In the aftermath of the 1986 EDSA uprising, many academics saw the opportunity to help substantiate the process of democratization by providing a range of policy alternatives based on studies and expert analysis. The State of the Nation Assessment Project (SONAP) of the University of the Philippines (UP) was conceived during the administration of UP President Jose V. Abueva to mobilize the manifold expertise of the University towards this end. Several groups of scholars were convened to examine the different aspects of the state of the nation.

This report presents the findings of the research team organized to assess the health situation of children in the country. It is based primarily on research conducted in 1989 and 1990 although some of the data presented had been updated.

The report on Filipino child health is not only useful because of the information it contains but also because of its disturbing conclusion. While there have been significant improvements in child health as measured by indicators of mortality and morbidity, the quality of life of surviving Filipino children continues to be threatened by economic uncertainty, poverty, and environmental hazards. For instance, the report reveals that one out of two preschoolers are undernourished and underweight; a significant number of children are exposed to health hazards as they contribute to the underground economy; and some suffer the consequences of armed conflicts. All of these imply that the prospect of actualizing our children's full human potential is dim.

In one of our visits to a far-flung barangay in the Visayas, we were appalled by the empty stare of malnourished children. If indeed half of the population of preschool children are not getting enough nutrients for their minds and bodies, it would be difficult for their generation to move the country forward. It will also be hard for them to substantiate the democratization process which requires an intelligent, literate, and organized citizenry at the grassroots. It is our hope that this report will move our leaders to surmount the structural and cultural obstacles to our children's well-being at all costs. The very survival of our society depends on this.

The University of the Philippines-Center for Integrative and Development Studies (UP-CIDS) acknowledges the efforts of the UP Manila research team led by Professor Perla D. Santos-Ocampo, M.D. in putting this report together, despite the logistical constraints. Several individuals also spent considerable energy to make this report see print. Bella Lucas supervised the publication process with the technical support of Stretch Payawal; Malu Calugay and Janet Yabes prepared the index; Josephine Padolina helped coordinate with UP Manila; and Jocelyn de Jesus provided editorial assistance.

As in all our UP-CIDS publications, the views and recommendations in this report are those of the authors whose academic freedom is upheld by the University.

Maria Cynthia Rose Banzon Bautista, Ph.D.

Executive Director

University of the Philippines

Center for Integrative and Development Studies

Diliman, Quezon City

*P*REFACE

Deep concern for the health of children provided the underlying motivation for this work. Although limited by time and logistical constraints, our research aimed to assess the health situation of Filipino children using data gathered from selected areas in Luzon, Visayas, and Mindanao in 1989.

The concept of health has a much broader scope than its everyday association with physical or mental well-being. As such, the assessment of the state of health of Filipino children is not confined to the destruction of pathogens. The impact on children's lives of poverty, ignorance, lack of social concern, corruptive influences, deficiencies in health care delivery, political indifference, the foreign debt problem and many more items in a Pandora's box of negative factors are discussed in this report.

It is our hope that this humble study will encourage others to pursue a more comprehensive and longitudinal research covering all provinces and cities. A more regular monitoring of the status of child health in the Philippines can serve as a guide to administrators, policymakers, legislators, researchers, health care and social service workers in their effort to deal with the health problems of Filipino children. Our children—the future generation of this country—deserve the best we can give.

The research project on which this report is based would not have been possible without the invaluable assistance given to our research team. In behalf of my co-workers, **Professor Laurie S. Ramiro**, Assistant Professor, College of Arts and Sciences, Department of Social Sciences (DSS-CAS), UP Manila; **Dr. Josefina G. Tayag**, Associate Professor, DSS-CAS, UP Manila; and **Professor Nymia P. Simbulan**, Assistant Professor, DSS-CAS, UP Manila, we wish to thank the following people:

- * Then UP president Dr. Jose V. Abueva for his inspiration and the UP Center for Integrative and Development Studies (UP-CIDS) for their managerial support;
- * Undersecretary Manuel Roxas of the Department of Health (DOH) whose letter of introduction facilitated our research in all the areas covered;

- * The various regional directors, provincial, district, municipal, rural and barangay health officers of Davao del Norte; Zamboanga City; Basey, Samar; Tolosa, Leyte; Iloilo City; Legaspi City; Dasol, Pangasinan; and the National Capital Region (NCR) who cannot be named individually but whose hospitality and cooperation we sincerely appreciated;
- * The various private practitioners and mother-respondents who gladly and patiently answered our questions; and
- * Our research assistants in different phases of the project: Ms. Lucille M. Bernadas, our conscientious and patient research assistant who frequently worked beyond the call of duty; our capable student assistant, Ms. Loren Hilario, and Ms. Laarni Quiles who likewise helped in many uncountable ways.

To all of them, our sincerest gratitude.

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THE FILIPINO CHILD: A HEALTH SITUATIONER

*I*ntroduction

It is said that a nation's greatest asset is its human resource, its people. They are the prime movers of society and the shapers of its destiny. They constitute the decisive element in the attainment of social and economic progress. Thus, it is important for the nation to develop quality human resource which means higher productivity, a more active participation in the achievement of society's goals and greater growth and development of the individual and the nation. This can be achieved by satisfying the people's basic needs and ensuring a better quality of life.

The promotion of the health of citizens is an important responsibility that will build quality human resource. A people's health essentially reflects that of the nation. The weaknesses and deficiencies, as well as the strengths and achievements of the health system mirror the kind of society it is part of—the nature of existing social structures, institutions and relationships. This is so since promoting the people's health is not limited to safeguarding their physical well-being, *i.e.* protecting them from various types of illnesses. The World Health Organization (WHO) defines health as “the state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.” More important, the state must create the conditions that empower people to take greater control over their own lives; where people are free to decide on their future, where they enjoy self-esteem and self-fulfillment, and where they are free from alienating forces. In other words, promoting the people's health means improving the quality of life and enhancing human growth and development.

Among the people, priority should be given to children aged 0 to 19 years. Aside from being the most vulnerable sector, they constitute almost half of the Philippine population (49.74 percent in 1988). Furthermore, the fact that children are going through the formative and critical phases of human growth and development requires that ample resources be allocated to them so that they can realize their physical and mental potentials to the fullest.

A nation's children is the wellspring of the quality of human resources needed to achieve and sustain long-term economic growth. Investing in them by nurturing their minds and bodies is investing in the future's producers of society's wealth.

The imperative of improving the health status of future generations of Filipinos motivated the research on which this Report is based. The study attempted to assess the state of child health in the country. Written in 1992, this Report was produced as part of the University of the Philippines-State of the Nation Assessment Project (UP-SONAP) of then UP President Jose V. Abueva. This Project aimed to evaluate various aspects of Philippine national life. Since UP Manila is the health center of the University system, this Report constituted a volume in a series of assessments from this campus of different areas of health concerns.

Statement of Objectives

The basic question of the study is: With all the legislations, both international and local, and programs launched by international agencies, the Department of Health (DOH), and various private institutions, has the state of the Filipino children's health shown signs of improvement? In response to this question, the research aimed to review existing policies and programs on child health in the Philippines; provide a situational report on the status of the health of children in the Philippines, including their physical health and sociopsychological well-being; make a survey of the perceptions, beliefs and practices of both the health professionals and the community on issues related to child health; and formulate recommendations to improve child health management in the Philippines.

Methodology

The study utilized a cross-sectional and evaluative design. It relied on existing records, statistics and other research documents relevant to child health. Data from both government and private organizations and international sources were used.

To give more significance to the secondary data, surveys, Focused Group Discussions (FGDs) and in-depth interviews of health professionals and members of the community, including mothers were conducted in 1989.

In selecting the respondents, a multistage sampling scheme was used. Representative regions from Luzon, Visayas and Mindanao were selected. To ensure a variety of perceptions regarding the issues at hand, the team saw to it that the regions were not adjacent to one another. From each region, at least one rural and one urban area were randomly chosen.

The following were the sample areas:

Luzon	NCR	: Manila
	Region I	: Dasol, Pangasinan
	Region V	: Legaspi City
Visayas	Region VI	: Iloilo City
	Region VIII	: Tolosa, Leyte
	Region VIII	: Basey, Samar
Mindanao	Region IX	: Zamboanga City
	Region XI	: Tagum, Davao del Norte

A total of 150 mothers as well as 69 government health workers were interviewed. Three (3) private pediatricians and five (5) traditional healers were also included in the list of respondents.

The analysis involved a triangulation of data derived from the use of both quantitative and qualitative methods.

Scope and Delimitations

Given the fact that child health is a broad phenomenon, this study focused on two important aspects, namely: physical health and the social psychological well-being of Filipino children. Physical health deals with morbidity and mortality issues while social and psychological health emphasize literacy and the situation of children in especially difficult circumstances (*e.g.*, child prostitution, children in armed conflict and child labor). Nutritional status was only briefly touched upon because another research group dwelt on this aspect more

thoroughly.

There were two limitations in the sample selection process. As noted previously, the ultimate sampling area was classified as either rural or urban. However, an urban area was defined as any municipality designed as "city" within the region regardless of population size, geography, demography and level of economic advancement.

The final choice of sampling unit (barangay/municipality) was limited by the accessibility of and the peace and order situation in the regions visited. While this limitation affected the external validity of the study, some significant trends in the data can still be established.

On the whole, the issues discussed and the sampling scheme used to obtain primary information were constrained by the availability of funds.

Chapter one

*L*egislations on Child Health

National Legislations

In a broad sense, legislation is a contemporaneous indicator of the state of health of a nation. Statute books are like diaries that tell of the nation's worries or problems — among which is health — and the corresponding remedies coming in the form of written commands from the lawmaker.

The Philippine experience is a case in point. In the first decade of this century, the country suffered considerable loss of lives from epidemics of cholera, typhoid fever, smallpox, and high death rates due to tuberculosis, malaria, beriberi and malnutrition. The legislators promptly responded to the call sounded by public health administrators and medical professionals for laws that would deal with these serious problems.

However, new problems cropped up later within the first quarter of the century. The killer influenza of World War I, for instance, took its toll on the population. In 1919 infant mortality increased suddenly to an all-time high of 207 per thousand live births. Guided by medical professionals the lawmakers then came up with the needed measures in support of preventive and curative efforts.

As the Philippines entered the second quarter of the century, the infant mortality problem demanded high priority. Heeding the recommendations of a national conference that tackled the problem, the Legislature provided for puericulture centers in localities all over the country. A determined war against tuberculosis (TB), fueled by the personal interest of then President Manuel L. Quezon, was also launched during this period.

The Tuberculosis Control Commission was established to complement the work of the Philippine Tuberculosis Society (1910), a private organization. Sanitariums for TB patients were put up in many places. The Philippine Charity Sweepstakes Office was also created by law to fund the anti-TB war. Such a vigorous fight against the so-called white plague is a

classic example of concerted and coordinated efforts to combat a national health problem the likes of which may not be seen again because today the political mind sometimes pretends to be as efficient as the medical mind in dealing with medical problems. In fact, the anti-TB war had shortly been derailed by dissensions and jealousies ignited by politics.

The legislative body, now known as the Congress of the Philippines, continued its health-supportive endeavors as the nation entered the second half of the century. The work was made more difficult by World War II, in which the country had been drawn into as an American colony. To be sure, the war compounded the malnutrition problem that had long plagued both the young and the old.

Little change in the typical infectious diseases was encountered at the onset of the third quarter of the century. The government steered rather expertly through this period, helped along by the experience of public health authorities and medical professionals. As far as public health activities were concerned, the more important legislative support was budgetary in nature. The national budget then was the whipping boy for various shortcomings.

Landmark legislation from 1951 to 1974 manifested the nation's concern for professional standards in health care delivery and for the quality of rural health. The Medical Act of 1959 sought to regulate the allied medical professions. The Philippine Medical Care Act passed ten years later provided for compulsory health insurance of private sector employees, and was completed by a law covering government workers. These historic statutes were initiated by the Philippine Medical Association.

The Congress provided for barangay health workers in response to the observation of the medical profession that most of the ailments in the rural areas could be managed by trained health personnel. Traditional midwives were trained by the government in the interest of maternal and infant health.

It was at the end of the third quarter of the century when Presidential Decree (PD) No. 603, the Child and Youth Welfare Code, was issued in recognition of the child as a national asset that must be protected and developed. The Code compiles in a single tome the laws governing the rights of a child and the responsibilities of its guardians to assure its health and development into maturity. The Code set the national framework for the delivery of basic services to the Filipino child while the Council for the Welfare of Children was created to program and coordinate these services.

Constituted in 1975 and vested with cabinet rank, the Council for the Welfare of Children was empowered to promulgate rules and regulations to carry out the Code and to tap the assistance of any ministry, government agency or private organization to facilitate the performance of its functions. The Council also worked for the issuance by then President Ferdinand E. Marcos of Presidential Proclamation No. 1604-A called the "National Plan of Action for the Development of Children and Youth." The Proclamation mandated the nationwide observance of the Decade of the Filipino Child in 1977-1987 during which the goals of the Plan of Action are to be attained. The proclamation also decreed the country's participation in the 1979 International Year of the Child. A National Conference for the Development of Children was called in 1980 and the plan was for such a conference to be convoked every five years.

The Child and Youth Welfare Code was a landmark legislation embodied in a decree promulgated during the martial law regime. While the authoritarian Marcos regime fell in the final quarter of the century, it had a prodigious production of decrees promoting child health. Many of these were issued in 1978, among them, PD 1567 which created day care centers in every barangay, PD 1565 which penalized the exploitation of minors; and PD 1543 which established the Foundation for Respiratory Diseases of Children with the ambitious objective of eradicating these major causes of mortality. "*Operation Timbang*" was launched under Letter of Instructions No. 441 in 1976 to monitor underweight and malnourished babies. The compulsory basic immunization of infants and children below eight was ordered under P.D. 976 *Lungsod ng Kabataan*, a medical center for the treatment of children and research in Pediatrics was instituted under PD 1561 in 1979.

Legislation by decree was also exercised by Marcos' successor, President Corazon C. Aquino, who issued a series of executive orders that had the force of law during the so-called revolutionary phase of her six-year term.

Executive Order No. 223 was issued in 1987 to strengthen the Council for the Welfare of Children and Youth. In the same year, Executive Order No. 123 was issued to reorganize the Department of Social Welfare and Development and to set up mechanisms to deal with an outbreak of serious problems relating to social welfare. Executive Order No. 51 promulgated the Philippine Code of Marketing of Breastmilk Substitutes in 1986. The Code which called for more intensive information dissemination on the value of breastfeeding and regulating the advertising, marketing and distribution of breastmilk

substitutes and other related products including bottles and teats (*Health Alert*, March 1992).

In 1987, Executive Order No. 234 brought about the reorganization of the National Nutrition Council. Proclamation No. 6 committed the country to the United Nations goal of Universal Child Immunization. The Year of the Protection of Filipino Exploited Children was declared by Proclamation No. 13. The same Proclamation created an inter-agency task force to focus national attention on the problem of child exploitation. Executive Order No. 82, in turn, created the Presidential Commission for the Urban Poor, a body charged with coordinating various services like health and nutrition as well as program of activities for street children. Ironically, this was the year when reports of the brisk activities of pedophiles were rampant.

Executive Order No. 269 was issued in 1987 to revise the Medicare Law. However, the revisions were not necessarily in the interest of children. One of the amendments the government introduced was the ouster of the president of the Philippine Medical Association (PMA) from his seat in the Medicare Commission as representative of the medical profession. Henceforth, the seat was available to any person deemed by the President of the Philippines to be a proper representative of the medical profession. In short, the representative of physicians became a political appointee that would serve a six-year term. He or she need not represent the PMA whose members take care of the majority of Medicare pediatric patients.

A redeeming achievement in presidential lawmaking during the Aquino Administration's revolutionary phase was Executive Order No. 209 which is known as the Family Code of 1987. This is a landmark legislation where members of the legislature collaborated with academe. The Code is an organized compilation of all laws, policies and regulations governing family life and carries important provisions bearing on the health and welfare of children. The Code not only guarantees the rights of children and the responsibility of the parents, the society and the state to them, but also the medical care to which they are entitled: prenatal, postnatal, nutrition and the prevention and cure of illness and rehabilitation of the disabled. The Code proves the point that in scientific matters — medical and sociological in this case — the best results can be obtained if the professionals remain free from political meddling.

The revolutionary phase of the Aquino administration ended with the promulgation of the 1987 Constitution which had a unique provision on

every person's right to health (Section 15, Article II). Relevant to children and the youth is the priority accorded to them by the State along with women, the elderly and the disabled. This is expressed in Section 11 of Article XIII and is reiterated with greater emphasis in Section 3(1) of Article XV mandating the state to defend "the right of children to assistance, including proper care and nutrition, and special protection from all forms of neglect, abuse, cruelty, exploitation and other conditions prejudicial to their development." Even the unborn children are safeguarded by the Constitution. The second sentence of Section 12 of Article II commands that the state "shall equally protect the life of the mother and the life of the unborn from conception."

With regard to the youth, Section 13 of Article II of the fundamental law declares : "The State recognizes the vital role of the youth in nation building and shall promote and protect their physical, moral, spiritual, intellectual and social well-being." The state provides children and youth free public education in the elementary and high school levels (Section 2, Article XIV).

The Constitution mandates a broad foundation on which the unborn, the infants, the children and the youth can stand and assert their fundamental right to be born, enjoy good health and grow into maturity. On that foundation has to be built the appropriate legislation and implementing policies. Some of these legislations are already in statute books that antedate the 1987 Constitution.

Proclamation No. 480 issued in October 1990, authorized the creation of an interagency National Committee on Education for All (EFA). Subsequently, a 10-year Philippine Plan of Action for EFA (1991-2000) was approved by the Cabinet which includes early childhood development activities, appropriate low-cost family and community-based interventions, and provision of universal access to primary education through formal and nonformal education.

Indeed we have practically all the laws needed to ensure and protect the health of Filipino children as the nation moves into the final decade of the 20th century. However, the political will of government to enforce the laws and the vigorous efforts of citizens and relevant professionals to uphold the interests of children remain to be seen.

International Legislation

The latest international legislation on child health and welfare is the historic United Nations (UN) Convention on the Rights of the Child which was adopted by the General Assembly in 1989. The Convention was ratified by the Philippine Senate the following year. Thus, it is now part of the law of the land (Section 2, Article II, 1987 Constitution). The 1989 Convention is a follow-up or extension of the Geneva Declaration on the Rights of the Child adopted by the UN in 1959 which recognized the fact that "the child, by reason of his physical and mental immaturity, needs special safeguard and care, including appropriate legal protection, before as well as after birth." The Convention defines a child as a person below the age of 18.

Article 24 of the Convention is concerned with child health which provides that :

1. State Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. State Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.
2. State Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:
 - a) to diminish infant and child mortality
 - b) to ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;
 - c) to combat disease and malnutrition including measures formulated within the framework of primary health care, through *inter alia* the application of readily available technology and through the provision of adequate nutritious foods and clean drinking water, taking into consideration the dangers and risks of environmental pollution;
 - d) to ensure appropriate pre- and post-natal health care for mothers;

- e) to ensure that segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents;
 - f) to develop preventive health care, guidance for parents, and family planning and services.
3. State Parties take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.
 4. State Parties undertake to promote and encourage international cooperation with a view to achieving progressively the full realization of the right recognized in this article. In this regard, particular account shall be taken of the needs of developing countries.

There is a provision enjoining kind consideration for handicapped children (Article 23) and those needing mental health treatment (Article 25). The entire Convention contains provisions indirectly promoting the health of children through socioeconomic means.

The Convention establishes a Committee on the Rights of the Child consisting of 10 experts elected by the State Parties. The committee shall monitor the implementation of the Convention by the countries adhering to it and make appropriate recommendations to the United Nations. Every one of these countries will be submitting not later than 1992 a report of implementation of the Convention.

Most of the provisions of the Convention already have counterpart provisions in Philippine laws as shown by the study of Venus-Maclang *et al.* (1990). The Philippine legislative track record is thus indicative of the Republic's concern for its children, as far as the lawgivers are concerned. But the translation of good intentions into reality belongs to the executive branch of the government with the active and meaningful support of the people, guided by the medical profession. It is the action aspect that the UN Committee on the Rights of the Child expects member nations to report on.

The Philippine government recently made other international commitments with respect to the health and welfare of children. A little more than a month after the Aquino Administration came into power in 1986, the President signed Proclamation No. 6 which adopted the United Nations goal of universal child immunization by 1990. The Department of Health and the Department of Social Welfare were ordered to team up to carry out this objective. Apart from this particular commitment, the Philippine government also committed itself to the International Labor Organization. In this connection, Executive Order Nos. 56 and 91 dealing with exploited and neglected children were issued in 1986.

The World Summit for Children was held during the second half of 1990 at the UN Headquarters. The call for this summit was made by the leaders of Canada, Egypt, Mali, Pakistan, Mexico and Sweden. The convenors were enjoined by 22 other nations to form a Planning Committee to prepare for the summit. Eighty heads of state met on September 30, 1990 and signed a declaration expressing their concern for the welfare and happiness of children and pledging "to protect the lives and to diminish the suffering of children, to promote the full development of their human potential, and make them aware of their needs, rights and opportunities."

An appeal to convene the summit was made by the United Nations Children's Fund (UNICEF) as 1980 was coming to a close, in the hope that the decade of the nineties would see the world acquit itself from the shame of large-scale deaths and widespread malnutrition of children. This could open a new era of health for the people of the 21st century. According to UNICEF, "The overall aim of the World Summit is to put children high and firmly on the agenda of the 1990s, giving them priority—or 'first call'—on the world's resources in good times or bad, war or peace."

As it turned out, however, there was less than unanimity on this objective. The harsh reality is that the government allocation for health in developing countries defers to budgetary allocations for military operations and debt service. Powerful states have yet to see some light and reduce military spending so as to make funds available for child health and welfare.

The Philippines failed to attend the Summit but eventually became a signatory on December 10, 1990. On the same day, President Aquino signed Proclamation No. 672 providing for the approval, adoption and implementation of a 10-year framework for a National Plan for Children in the 1990s.

The following year, in December 1991, an interagency committee completed the Philippine Plan of Action for Children (PPAC) for 1993-2000. Incorporated in this plan were the calls in the World Summit Declaration for Children and the UN Convention on the Rights of the Child. The PPAC was launched on February 14, 1992.

As one of her last official acts, President Aquino signed into law Republic Act No. 7610 or the Child Protection Law.

Chapter two

Current Programs on Child Health

Government Programs

The public health blueprint for the early 1990s is found in the national government's "Medium-Term Development Plan 1988-1992" in which one of the "priority areas of action" is the "formulation and implementation of an efficient response to the main causes of morbidity and mortality (*i.e.*, disease control and service delivery programs)."

Five "impact programs" are identified as priority areas: the Expanded Program of Immunization (EPI), Malaria Control, Tuberculosis Control, Schistosomiasis Control and Diarrheal Disease Control. The Department of Health (DOH) direction in regard to these is the correction of "specific program weaknesses and deficiencies," the implementation of which "will be increasingly localized and decentralized consistent with the respective five-year directional plans of these programs" (DOH General Information Kit, 1989).

Of the five important programs, those directly involving children are cases relating to EPI, diarrhea and tuberculosis. Pneumonia, bronchitis and measles, which count among the top 10 causes of morbidity and mortality among children, are cited in the public health blueprint but are not considered "impact" items. It should be noted, however, that the Health Department has launched a major program intervention in acute respiratory illness control. Such a program is expected to be comparable in scale and scope to the five impact programs.

The Department also proposes to provide "appropriate support" to programs on maternal, infant and child care; and nutrition with specific focus on mortality reduction, disability prevention and rehabilitation from malnutrition.

It will also effect the operational integration at service delivery level of services and programs in maternal and child health. Accordingly, "the concerns include reduced maternal morbidity and mortality, increased child sur-

vival and improved reproductive health among adolescents.” How the last concern will be brought about, has not yet been announced. It sounds like the encouragement of fertility at a time when government is pushing a population control program, albeit in the absence of clear guidelines.

The importance of guiding and training the people in health work is recognized in the national development plan. The Department expresses the point thus: “Health education programs will be implemented to raise public awareness and promote health-oriented behavior supportive of disease control and service delivery programs. A particular focus on anti-smoking, drug abuse prevention, breastfeeding, home management of diarrhea and acute respiratory illness, proper hygiene and sanitation, proper nutrition and other simple preventive and curative practices will be adopted.”

The Department briefly describes its program for children as follows :

Expanded Program for Immunization — Immunization of children under one year old against six diseases (TB, diphtheria, pertussis, tetanus, measles, poliomyelitis). Immunization of pregnant mothers against tetanus. Program involves vaccine distribution, vaccination rounds, public education and mobilization. Target is 90 percent coverage by 1992. Coverage in 1988 was 71 percent.

Control of Diarrheal Disease — Early treatment of dehydration from diarrhea among children under six years old at home, at clinics and at hospitals. Program involves ORS (oral rehydration salts) distribution, health worker training, public education and mobilization as part of wide application of ORT (oral rehydration therapy).

Control of Acute Respiratory Illness (ARI) — Early diagnosis and treatment of ARI (pneumonias and related illnesses) among children under six years old at home, in clinics and in hospitals. Program involves drug distribution, health worker training, public education and mobilization as part of wide application of up-to-date ARI treatment protocol.

Under-Five Clinic Program — Provision of package of services to children under five at clinics and hospitals. Program involves growth monitoring, breastfeeding, in addition to child-targeted programs.

Dental Health Program — Fluoridation, dental treatment, public education to reduce incidence of dental caries and periodontal disease. Program involves dental care services primarily to children and pregnant mothers.

Vitamin A Deficiency Control Program — Administration of curative and preventive dose of Vitamin A to children under six with xerophthalmia or high risk of the disease.

Malnutrition Rehabilitation Program — Provision of supplementary food for second-and-third degree preschool malnourished children not in the Department of Social Welfare and Development (DSWD) day care centers. Also includes nutrition surveillance and medical intervention to prevent or cure disease due to malnutrition.

Many programs of the Health Department's "23 in 93" directly affect child health. Among these are:

- ☞ The cease-fire for children which calls for National Immunization Days on April 21 and May 19, 1993. Apart from the kickoff for the Polio Eradication project for nine million children, two million others will be given vaccines against measles, diphtheria, pertussis and tetanus and four million will be given tetanus toxoid.
- ☞ Mother- and baby-friendly hospitals will continue to encourage and sustain breastfeeding.
- ☞ Prevention of Micronutrient Malnutrition will be pursued through a rice enrichment program called Fortified Vitamin Rice or FVR containing Vitamin A, iron and iodine.
- ☞ Other "exciting" programs in the government's "23 in 93" are projects that deal with the most serious and urgent health problems of the nation. Inevitably these will redound not only to the improvement of adult health but also to the enhancement of child health.

Government Targets

The Medium-Term Philippine Development Plan sets the following goals in the field of health :

- ☞ Life expectancy to increase from age 64.0 in 1988 to age 65.2 in 1992.
- ☞ Infant Mortality Rate to be reduced from 52.9 per thousand live births in 1988 to 47.8 in 1992. [Note that the 1988 figure used here is that of the National Economic and Development Authority (NEDA) which is higher than the 30.4 rate claimed by the Department of Health (DOH). The development plan is also authored by NEDA with contributions from other departments.]
- ☞ The reduction of moderately and severely malnourished preschoolers from 18.5 percent in 1988 to 14.2 percent in 1992.
- ☞ Per capita energy intake to increase from 1,797 kilocalories in 1988 to 1,948 kilocalories in 1992.
- ☞ Total fertility rate to decline from 4.0 children in 1988 to 3.7 children in 1992.
- ☞ Family planning prevalence rate to increase from 46.56 percent in 1988 to 51.97 percent in 1992.
- ☞ Population growth rate to be reduced from an estimated 2.38 percent in 1988 to 2.21 percent in 1992. Expectations were high at the time the goals were set. Unfortunately, however, the current economic crisis poses an obstacle to the full realization of the goals.

Pediatricians' Participation

Filipino pediatricians, through the Philippine Pediatric Society (PPS), are fully supporting the government's child health goals. The PPS and other nongovernment organizations tapped by the Health Department readily give assistance with regard to child health problems. The PPS is currently focusing its attention on malnutrition, child exploitation, the needs of the fetus and the newborn, breastfeeding, school health and adolescence. These concerns often cover a broader scope than that of the DOH.

Besides being a major affiliate specialty society of the Philippine Medical Association (PMA), the PPS is deeply involved in international endeavors for the well-being of children. It is an affiliate of the International Pediatric Society which as of this writing, is headed by a Filipina as President who had headed both the PPS and the PMA. Among the affiliates of the Philippine Medical Association committed to child health are the Philippine Medical Women's Association, the Maternal and Child Health Association of the Philippines, and the Philippine Academy of Family Physicians. The PPS is also affiliated with many other international organizations like the Association of the Pediatric Society of the Southeast Region and the International Society of Tropical Pediatrics. The PPS's international linkages have enriched the knowledge and skills of Filipino pediatricians and have also enabled them to contribute to the world body of scientific knowledge in this area of specialization. Strong allies for child health are the Philippine Nurses Association and the Integrated Midwives Association of the Philippines.

Of equal importance is the continuing education of pediatricians and the maintenance of high professional standards. The PPS's principal mission is the upgrading of the Filipino pediatrician.

The UNICEF

It must be acknowledged that the Philippines is greatly indebted to the United Nations Children's Fund (UNICEF) for four decades of committed services to children all over the world.

UNICEF exerted great efforts for the Expanded Immunization Program in the country. UNICEF is deeply concerned with what it perceives to be the "alarming rate" of increase in infant mortality. The agency is currently designing remedial plans in 18 provinces most affected by IMR (infant mortality rate) increases. UNICEF has also assigned field personnel to work among children of an estimated 120,000 families victimized by armed conflict.

UNICEF's latest moves appear to confirm the pediatricians' perceptions that the government's IMR figures and projections may not be all that accurate.

The UNICEF is the advocate of "adjustment with a human face" appealing to the world powers to be fair and understanding with poor countries saddled by the billions of foreign debts, the servicing of which have been draining these countries of precious resources that should be used for child health. UNICEF has in fact enunciated the "principle of first call" so that child health will be given first priority in every nation's utilization of resources. The principle was presented at the recent World Summit for Children. Today, children all over the world are waiting to see if the appeal has at all moved world leaders who have yet to deliver.

The Third Programme of Cooperation between the Philippines and UNICEF (1988-1993) seeks to accelerate the delivery of basic services to children through three approaches: "the promotion of child survival and development programmes in selected depressed areas, the application of tested and cost-effective interventions through national programmes, and advocacy to promote greater understanding of the problems children face and a greater commitment to solving them."

Nongovernmental Organizations

An ever-increasing number of nongovernmental organizations are deeply involved in working for child health and welfare. A listing is available at the Departments of Health and Social Services and Development.

Chapter three

An Overview of the Child Health Situation

The Child Population

In 1988, Philippine child population (0-19 years) reached 29,165,821 (Department of Health, 1988). This number comprised 49.74 percent of the country's total population for that same year. The Philippines, therefore, has a very young population. Majority of children belonged to the 0-4 and 5-9 age groups. There were 3.02 percent or 1.8 million immunizable infants. Males exceeded females by a ratio of 1:0.95.

**Table 3-1 Age Structure of the Philippine Population
below 20 years, 1988**

Age	NUMBER			PERCENTAGE DISTRIBUTION		
	Male	Female	Both Sexes	Male	Female	Both Sexes
All Ages	29,374,454	29,253,466	58,627,920	50.10	49.90	100.00
Under 1 yr	907,963	865,182	1,773,145	1.54	1.47	3.02
1-4 yrs	3,424,540	3,272,431	6,696,971	5.84	5.58	11.43
5-9 yrs	3,969,949	3,623,041	7,592,990	6.77	6.17	12.95
10-14 yrs	3,634,562	3,438,436	7,072,998	6.19	5.86	12.06
15-19 yrs	3,011,332	3,018,385	6,029,717	5.13	5.14	10.28
Total	14,948,346	14,217,475	29,165,821	25.49	24.22	49.74

Sources : Regional Annual Reports, Department of Health, 1988.

The population of children has been estimated to have increased by about 1.2 million from 1987 to 1990. A decrease to 45.17 percent of children aged 0-17 years was expected in 1990 from the 1987 child proportion of 46.27 percent of the total population. By the year 2000, child population is estimated to increase by 9.37 per cent (Council for the Welfare of Children, 1992).

The Bicol region registered the highest percentage of children nationwide. This finding is made more significant by the fact that the level of poverty is highest in the Bicol region. Other depressed areas such as Western Mindanao and Eastern Visayas were next in child population density.

**Table 3-2 Proportion of Population Under 20 Years of Age,
by Region, 1980, 1986, 1988**

Region	1980	1986	1988	Population Change (in percent)	
				1980-1986	1986-1988
Philippines	53.08	51.00	49.74	-3.9	-2.5
NCR	49.33	44.80	42.85	-9.1	-4.3
(Metro Manila)					
Region I	49.49	48.10	49.66	-2.8	3.2
(Ilocos)					
Region II	52.12	49.90	52.58	-4.3	5.3
(Cagayan Valley)					
Region III	50.57	48.00	50.26	-5.1	4.7
(Central Luzon)					
Region IV	51.25	49.20	50.28	-4.0	2.2
(Southern Tagalog)					
Region V	52.48	51.10	55.52	-2.6	8.6
(Bicol)					
Region VI	50.37	49.20	51.95	-2.3	5.6
(Western Visayas)					
Region VII	50.68	49.30	50.06	-2.7	1.5
(Central Visayas)					
Region VIII	51.62	50.40	53.05	-2.4	5.2
(Eastern Visayas)					
Region IX	50.59	49.30	53.37	-2.5	8.2
(Western Mindanao)					
Region X	52.78	51.50	50.67	-2.5	-1.6
(Northern Mindanao)					
Region XI	51.12	49.70	50.56	-2.8	1.7
(Eastern Mindanao)					
Region XII	50.52	49.10	51.98	-2.8	5.8
(Central Mindanao)					

Source : Philippine Health Statistics, Department of Health, 1980, 1986, 1988

Child population decrease was evident in all regions between 1980 to 1986, with the National Capital Region (NCR) registering the lowest increment.

In 1988, eleven (11) of the 13 regions obtained an average increment of 4.3 percent in population growth. Bicol and Western Mindanao regions showed the highest growth while Central Mindanao and Metro Manila indicated the opposite trends. It seems that the government's "pro-life" campaign has attracted some following in the countryside.

Natality Statistics

The crude birth rate in 1988 was 26.7 per 1,000 population. Figure 3-1 shows an insignificant decrease in the crude birth rate from 1950 to 1988 (see Appendix B - Figure 3-1).

Total live births in 1988 numbered 1,565,372. Metro Manila, Northern Mindanao and Central Visayas registered the highest, with rates of 33.5, 29.5 and 29.3 per thousand population, respectively. Apparently, the proportion of those born and those who turned 20 years of age at any given year did not significantly differ.

About forty-three percent (43.0%) of births were attended by traditional *hilots* or traditional birth attendants (TBAs). Through all the years, births attended by TBAs have not significantly decreased (see Appendix B - Figure 3-2). It should be noted, however, that about 75 percent of TBAs have already been trained. Reasons of pregnant mothers preference for TBAs included proximity and trust in them.

Table 3-3 Reasons for "Hilot" Preference, 1978

Reasons	Percent of Responses
Nearest the house	50.3
Have confidence and trust	11.3
Transport difficulties in contacting nurse/ midwife	7.1
Hilot is related	6.5
Less expensive	3.9
Performs traditional rituals	3.1
Serves as helpers	2.1
Attends immediately	1.9
Gives daily massage	1.9
Easier to call at night	1.9
Visits daily	0.2
Other reasons/not stated	10.2

Source : Department of Health/National Demographic Survey

Most live births were born of mothers between ages 20 to 34 (see Appendix B - Figure 3-3). High-risk infants were more prevalent among mothers below age 15 and those above age 45.

Fetal Statistics

There has been an irregular trend in fetal death rates over the last 30 years. From a high of 12.7 per 1,000 live births in 1960 to a low of 6.2 in 1985, the 1988 statistics showed a fetal mortality rate of 6.8 percent (see Appendix B - Figure 3-4).

More fetal deaths were noted in the later stages of fetal life. Around twenty-five percent (25.0%) were 28-36 weeks old while 13.7 percent were 37 weeks and over (see Appendix B - Figure 3-5).

Late fetal death rate was highest among first, second and thirdborns and lowest as the sibling number increases. The same trend was found in all fetal deaths at any stage of development. Higher risks were found among the firstborns than among those born later. Cases of unwanted pregnancies, inadequate prenatal care and inexperienced parenting may have contributed to this.

Most fetal deaths also occurred among mothers who were 45 years old and above (see Appendix B - Figure 3-6). The most common causes were complications of the placenta, cord and membrane, short gestation and low birth weight, and intrauterine hypoxia and birth asphyxia.

Neonatal Statistics

The neonatal period extends from birth to 27 days. The Philippine Pediatric Society (PPS) statistics showed that majority of newborn cases admitted in PPS-accredited hospitals in 1986 and 1987 were those under 47 hours old (77.8 percent and 70.4 percent, respectively).

Table 3-4 Number of Cases, Newborn Discharge by Disease, PPS Accredited Hospitals, 1986, 1987

Age	1986		1987	
	No.	%	No.	%
0-47 hrs	4,820	77.8	5,212	70.5
2-6 days	770	12.4	1,022	13.8
7-13 days	67	1.1	555	7.5
14-27 days	537	8.7	607	8.2
TOTAL	6,194	100.0	7,403	100.0

Sources : PPS Annual Report
1986 PPS Registry of Childhood Diseases, 1987.

The ten (10) leading causes of neonatal morbidity were the following (in decreasing order): sepsis without meningitis, and hyaline membrane disease, ABO incompatibility, perinatal asphyxia, congenital anomalies, transient tachypnea, birth trauma, sepsis with meningitis, hypoglycemia and gastroenteritis.

Table 3-5 Neonatal Morbidity: Ten Leading Causes, 1986

CAUSES	NUMBER	%
Sepsis without meningitis	1,071	17.3
Hyaline membrane discharge	763	12.3
ABO incompatibility	696	11.2
Perinatal asphyxia	674	10.9
Congenital anomalies	638	10.3
Transient tachypnea	352	5.7
Birth trauma	287	4.6
Sepsis with meningitis	264	4.3
Hypoglycemia	179	2.9
Gastroenteritis	178	2.9

Source : Philippine Pediatric Society Annual Report, 1986

The neonatal mortality rates from 1960 to 1988 showed a steadily decreasing trend. From a rate of 34.9 per 1,000 live births in 1960, the figure went down to 13.0 per 1,000 in 1987 (see Appendix B - Figure 3-7).

The declining neonatal death rate was likely due to the introduction of tetanus toxoid immunization of pregnant women which was estimated by the United Nations Children's Fund (UNICEF) to have had a prevalence rate of 49 percent in 1987. Moreover, a good number of traditional midwives had already received training.

Most neonatal deaths occurred between birth to six days.

Infant Statistics

There were 1,773,145 infants (under one year of age) in 1988. This comprised 3.02 percent of the total population. There were 1.54 percent males and 1.47 percent females.

The five leading causes of infant morbidity in 1987, 1988 and 1989 were: bronchitis, diarrhea, pneumonia, influenza, and measles (see Appendix B - Figure 3-8).

**Table 3-6 Leading Causes of Morbidity
Among the Under-One Year Group
(rate/100,000 population), 1987, 1988**

Causes	1987		1988	
	Rate	Rank	Rate	Rank
Bronchitis	9,063.6	1	10,608.0	1
Diarrhea	7,964.7	2	8,322.8	2
Pneumonia	3,214.7	3	3,510.5	3
Influenza	2,839.2	4	3,273.9	4
Measles	861.3	5	742.7	5
Malaria	212.6	6	199.4	6
Accidents	160.7	7	154.1	8
Whooping Cough	165.3	8	144.9	9
TB (all forms)	143.7	9	159.2	7
Tetanus	61.0	10	64.4	10

Source : Philippine Health Statistics, Department of Health, 1987, 1988.

If the child health situation were to be gauged through the infant mortality rates (IMR), the data would show an improving trend. Figure 3-9 (see appendix B) gives both the Department of Health (DOH) data and the National Statistics Office-National Economic and Development Authority (NSO-NEDA) projections from 1960 to 1988. Note that the two summaries have different rates. As of 1988, the DOH found an IMR of 30.4 per 1,000 live births, whereas the NSO projected an IMR of 52.9 per 1,000 live births for the same year. The DOH data were based on the actual number of infant death registrations submitted to the census office in any given year (with 10 percent allowance for underreporting). IMR is defined as the ratio of the number of infant deaths to the total number of live births in any given year multiplied by 1,000. The NSO data were projections based on the 1980 census. The computations used the Coule and Demeny model which considered the projected life expectancies of each year. For both, however, the patterns of development were on the decreasing trend (see Appendix B - Figure 3-9).

The Task Force on Infant Mortality Rate undertook a study to improve the reliability and accuracy of vital health indicators. Their findings showed that from the period 1980-1990, the infant mortality rate at the national level was 61.0 per 1,000 live births. Eastern Visayas registered the highest IMR at 85.2 while Central Luzon's was the lowest at a rate of 44.5 per 1,000 live births.

The Philippines expects to attain an IMR of 50.28 (NSO-NEDA) by 1990 and an IMR of 37.56 by the end of the century. The target rate of 27 per 1,000 live births IMR for the country is hoped to be achieved by the year 2010.

Over a span of 20 years, pneumonia and other respiratory infections have not been dislodged as the foremost causes of infant mortality (see Appendix B - Figure 3-10). The same is true for diarrhea. However, the rates have been decreasing. More cases of septicemia and measles were also observed.

**Table 3-7 Infant Mortality: Ten Leading Causes
(rate/1000 live births) 1975-1988**

CAUSES	1975	1980	1985	1987	1988	AVERAGE
Pneumonia	12.8	11.4	10.4	8.5	8.0	10.22
Diarrhea	3.5	4.0	2.7	2.1	2.0	2.86
Respiratory Distress	0.7	5.5	4.9	4.6	4.1	3.96
Congenital Anomalies	1.3	2.4	1.6	1.4	1.5	1.38
Acute Bronchitis	1.7	1.0	0.7	0.5	0.4	0.86
Avitaminoses and other nutritional deficiencies	6.7	2.1	1.8	1.1	1.0	2.54
Measles	0.7	1.0	1.6	1.5	1.0	1.16
Septicemia	-	-	0.8	0.6	0.8	0.44
Meningitis	0.5	-	0.5	0.4	0.4	0.38
Birth Injuries	3.3	1.5	0.9	0.9	1.0	1.52

Source : Philippine Health Statistics, Department of Health, 1988

Most infant deaths occur during the first six days of life and between two and ten months.

As to the incidence of six immunizable diseases, the incidence rate of diphtheria has decreased from 1982 to 1988. In 1988, the incidence rate of diphtheria was 2.0 per 100,000 population. The same trends were observed for cases of pertussis and tetanus. Pertussis was common at a rate of 13.3 for every 100,000 population in 1988. The incidence rate of tetanus for the same year was 5.4.

Poliomyelitis has the least incidence among all six immunizable diseases. From a high of 2.3 in 1979, its occurrence became erratic until only 0.6 of a 100,000 population incurred poliomyelitis in 1988. This may be attributed to the help of nongovernment organizations (NGOs) such as the Rotary International whose main project for the past years has been polio-vaccination. It is highly probable that people were reached by the Rotary's Polio Plus Program, in addition to the government's efforts to eradicate the disease.

Measles has consistently been on the upsurge from 1980 to 1987. From a rate of 55.4 in 1980, it went up to 142.8 for every 100,000 population in 1987. A slight decrease was noted in 1988 (120.6/100,000). The high incidence of bronchopneumonia may be due to complications of measles. The incidence trend for tuberculosis (TB), on the other hand, was erratic. However, a drastic decrease was observed in 1986 (273.4), from a high of 285.5 in 1984. In 1988, despite increased immunization coverage, TB among infants was at a higher rate of 311.8 for every 100,000 population. On the whole, no definite trend can be established yet with regard to the impact of the expanded immunization program on the health of children. The trends fluctuate year after year.

The DOH target for Fully Immunized Children was 70 percent of the total 0-12 months infant population. As of 1989, only 70.98 percent of the targetted 70 percent of the total immunizable population has been achieved. Authorities have attributed this trend to logistical insufficiencies such as the lack of cold-chain facilities, especially in remote areas, and the shortage of vaccine supplies.

Such erratic trends may also be due to the fact that immunization had been limited only to 0-12 months infants. Majority of measles cases may have

occurred in children over one year old who were not immunized or given the necessary booster shots. The effects of environmental pollution, overcrowding, unhygienic practices and malnutrition should also figure into the analysis.

Childhood Statistics

About twenty-four percent (24.38%) of the total population in 1988 belonged to the 1-9 age group.

The child morbidity rate increased during the 1980s. Morbidity data from the DOH showed that bronchitis, diarrhea, pneumonia, influenza and measles were the most common childhood diseases for the 1-9 age group. The Philippine Pediatrics Society (PPS) also revealed that bronchopneumonia, gastroenteritis toxigenic/viral, measles, tonsillopharyngitis and intestinal amoebiasis were the most frequent infectious diseases of the under-fives. Among the noninfectious diseases, asthma, protein-energy malnutrition, surgical conditions and seizure disorders were the most common (see Appendix B - Figure 3-11).

**Table 3-8 Childhood Morbidity: Leading Causes by Age
(rate/100,000 population), 1987, 1988**

Causes	1987		1988	
	1-4 yrs	5-9 yrs	1-4 yrs	5-9 yrs
Bronchitis	3,399.3	1,089.6	3,989.9	1,279.4
Diarrhea	3,957.7	887.5	3,099.3	930.4
Pneumonia	1,002.2	293.7	1,097.5	321.8
Influenza	1,005.0	839.4	1,220.0	971.0
Measles	569.7	208.2	488.4	178.9
Malaria	111.4	142.1	104.8	133.7
Accidents	172.0	110.4	165.4	106.3
Whooping Cough	73.3	11.6	64.3	10.1
TB (all forms)	83.0	68.3	90.5	75.9
Infectious hepatitis	27.0	28.1	26.8	28.0

Source : Philippine Health Statistics, Department of Health, 1987, 1988.

**Table 3-9 Leading Causes of Childhood Diseases
(Infectious/Noninfectious), by Age,
PPS Accredited Hospital, 1986 (in percent)**

Causes	Infectious		Causes	Noninfectious	
	29 days - 4 yrs	5-9 yrs		29 days - 4 yrs	5-9 yrs
Bronchopneumonia	25.1	12.2	Energy protein undernutrition	22.5	7.0
Gastroenteritis toxicogenic viral	23.3	12.3	Asthma	19.6	26.0
Measles	7.9	-	Seizure disorders	13.8	4.2
Tonsillopharyngitis	5.2	7.1	Surgical conditions	11.3	15.7
Intestinal amoebiasis	4.5	-	Congenital heart disease	6.0	3.1
Influenza	3.7	-	Nutritional anemia	5.8	3.0
Gastroenteritis tissue invasive	3.4	-	Accidents/trauma	5.5	10.1
Intestinal parasitism malformation	3.1	7.5	Congenital	3.3	-
Urinary tract infection	2.7	3.9	Glomerulonephritis	2.7	8.1
Bronchitis	2.4	-	Leukemia	2.5	8.8
Gastroenteritis- acute	-	8.8	Rheumatic Fever	-	2.8
Dengue	-	8.2			
Typhoid Fever	-	4.9			
Lobar pneumonia	-	3.2			

Source : Philippine Pediatric Society Annual Report, 1986

Child mortality (1-4 years) has also been on the downtrend for the past years. It dropped by 45.5 percent from 1970 to 1980. It decreased from 667.3 for every 100,000 population in 1985, to 312.2 in 1990 (Council for the Welfare of Children, 1992).

Among the leading causes of child mortality were pneumonia, measles, diarrhea, accidents, diseases of the heart, bronchitis, TB (all forms), malaria, H-fever, influenza, whooping cough. Evidently, despite the registered high immunization coverage, measles and TB are still in the upward swing (see Appendix B - Figure 3-12).

**Table 3-10 Childhood (1-4) Mortality: Leading Causes
(rate/100,000 population), 1988**

Causes	Rate	Rank
Pneumonia	219.2	1
Measles	73.3	2
Diarrhea	44.4	3
Influenza	1.1	10
Malaria	1.5	8
TB (all forms)	1.8	7
Accidents	15.2	4
H-Fever	1.3	9
Whooping Cough	0.08	11
Bronchitis	6.9	6
Diseases of the heart	7.7	5

Source : Philippine Health Statistics, Department of Health, 1988.

The under-5 mortality rate (U5MR) is the latest socioeconomic indicator recommended by UNICEF which, according to sources, is a more reliable measure than infant mortality rates. Infants are better cared for than children at other ages. Moreover, the infant mortality rate is mainly affected by maternal health while U5MR includes other factors such as food resources, water and sanitation, poverty level and other environmental hazards.

Figure 3-13 (see Appendix B) provides the under-5 mortality rates for the Philippines, from 1960 to 1987. At a U5MR of 75 per 1,000 live births, the Philippines has been listed among the middle U5MR countries whose U5MRs range from 31 to 94. Between 1960 and 1980, there has been a 2.25 percent average annual rate of reduction. Between 1980 and 1987, a 1.94 percent reduction rate was noted. To achieve the UNICEF target rate of 43 per 1,000 live births, the Philippines should register an average annual rate reduction of 4.19 percent between 1987 and the year 2000. The Child Survival Index for the Philippines as of 1986 was 92.5 percent (UNICEF, 1987).

The leading causes of under-5 mortality were pneumonia, measles, unspecified causes of perinatal morbidity/mortality, respiratory conditions of the fetus and newborn, diarrhea, malnutrition, congenital anomalies, septicemia, birth injuries and meningitis.

Adolescent Health

By the year 2000, when today's children will have become adolescents, it is estimated that there will be over a billion comprising this category. The problems facing this age group will be increasing as rapidly as its numbers. Based on the population statistics of 1988, there were 13,102,715 adolescents in the entire population where 12.06 percent were between 10 and 14 years and 10.28 percent belonged to the 15-19 age group. Males exceeded females by 2.8 percent.

The DOH data showed that influenza, diarrhea and bronchitis had been the top three causes of morbidity among Filipino adolescents since 1975 through 1985. A majority of the leading causes of morbidity are still infectious in nature; only two of the ten are noninfectious — namely, accidents and diseases of the heart. The other causes of morbidity among the adolescent groups in 1985 were malaria, pneumonia, tuberculosis, measles and hepatitis.

Table 3-11 Leading Causes of Adolescent Morbidity, by Age, (rate/100,000 population), 1987, 1988

Causes	1987				1988			
	10-14 yrs	Rank	15-19 yrs	Rank	10-14 yrs	Rank	15-19 yrs	Rank
Bronchitis	464.7	3	313.0	3	534.5	3	363.0	3
Diarrhea	573.3	2	441.9	2	588.8	2	457.6	2
Pneumonia	76.8	6	62.4	7	321.8	4	82.4	7
Influenza	801.8	1	731.4	1	971.0	1	908.6	1
Measles	75.8	7	38.6	8	63.8	8	34.3	8
Malaria	175.1	4	210.3	4	161.4	5	195.5	4
Accidents	115.8	5	131.9	5	106.3	6	109.2	6
TB (all forms)	73.4	8	119.6	6	81.3	7	131.3	5
Infectious hepatitis	26.5	10	-	-	25.9	10	28.8	11
Schistosomiasis	44.2	9	36.3	9	38.0	9	31.5	9
Diseases of the heart	-	-	30.9	10	20.0	11	30.7	10

Source : Philippine Health Statistics, Department of Health, 1988

Among the different age groups, the 10-14 and 15-19 account for the lowest mortality rate. The most common causes of death are still preventable. For instance, in the 10-14 age group, pneumonia still ranked among the leading causes in 1987 and 1988. For the 15-19 age group, tuberculosis ranked first among the leading causes of mortality. Diseases of the heart continue to rank second for this age group (see Appendix B - Figure 3-14).

The other leading causes of mortality among the 10-14 and the 15-19 age groups in 1987 and 1988 were the following:

<u>For 10-14 years old</u>	<u>1987</u>	<u>1988</u>
1. Pneumonia	13.37	12.1
2. Accidents	7.57	12.1
3. Heart Diseases	6.99	6.6
4. Diseases of the nervous system including meningitis/ epilepsy	5.36	5.2
5. Diseases of the vascular system	4.91	3.8

<u>For 10-14 years old</u>	<u>1987</u>	<u>1988</u>
6. Malignant neoplasms including leukemia	3.4	4.1
7. Normal delivery and other complications related to labor, pregnancy & delivery	2.99	3.2
8. Measles	2.96	2.5
9. Diarrhea	2.61	3.8
10. Septicemia	2.05	2.2

For 15-19 years old

1. TB (all forms)	13.01	11.7
2. Heart Diseases	12.23	12.6
3. Pneumonia	10.63	9.7
4. Accidents	8.83	14.8
5. Diseases of nervous system including meningitis/epilepsy	6.29	5.12
6. Malignant neoplasms	5.69	6.7
7. Diseases of the vascular system	3.0	3.23
8. Septicemia	2.38	3.9
9. Typhoid Fever	2.11	2.5
10. Nephritis/nephrosis	2.02	2.4

The adolescent age group is not spared from the prevailing malnutrition problem in the country. The need to focus on the nutritional status of this age group is made doubly important by the fact that this period is characterized by increased growth, velocity and activity.

Factors directly affecting nutritional intake of the Filipino adolescent largely depend on the availability and allocation of various types of food in the family.

Based on the Second Nationwide Survey conducted by the Food and Nutrition Research Institute (FNRI) in 1982, the results showed the prevalence of moderate and severe underweight among the 7-14 age group.

Table 3-12 Percentage Distribution of 7-14-Year-Old Children

Level of % Standard Weight for Age	% of Total Subjects
110% and above	3.2
101% to 110%	5.3
91% to 100%	15.8
81% to 90%	28.8
71% to 80%	28.4
61% to 70%	12.7
60% and below	5.8
Total Subjects	100.0

Source: FNRI-NSTA (National Science and Technology Authority), Second Nationwide Nutrition Survey

Inevitably, the problem of malnutrition is always accompanied by iron deficiency anemia.

School children aged 7-14 have a 95 percent rate of dental caries. The World Health Organization (WHO) global indicator for 12-year-olds by the year 2000 is an average of not more than three decayed, missing and filled permanent teeth (DMFT). In the Philippines, the average dental caries indices are 8.0 DMFT for urban areas at 12 years and 6.0 DMFT for rural areas at the same age. The indices are 5.0 and 3.0 DMFT higher than the WHO global indicator of 3.0 DMFT.

Teen-age pregnancy is one of the more serious consequences of premarital sex especially in a predominantly young population like the Philippines. According to Philippine Health Statistics, in 1985, of the 1,437,154 total live births, 124,210, or 8.61 percent were pregnancies reported among Filipino women younger than 15 (and aged 15-19). Compared with a woman who delays childbearing until her 20s, the woman who has her first child before age 17 is likely to obtain less education, be out of work, have a lower-paying job and less income and be separated from her partner.

One factor that results in teen-age pregnancy, as revealed in the Three Adolescent KAP Studies by Mataragnon in 1982, is the inadequate sex-related knowledge concerning fertile days within the menstrual cycle. In this same report, 92 percent were aware of common contraceptive methods. However, there is poor knowledge of actual use. Some misconceptions of adolescents cited in the studies were as follows: the pill had to be taken either before or after contact, douching, standing up and taking the pill the day after having sex would prevent pregnancy.

According to the studies, the most commonly used contraceptives were condoms, pills, rhythm, withdrawal, foam and Cortal.

Abortion is still unpopular among 96.38 percent of single women, based on the Young Adult Fertility Survey. However, they would most likely agree to it when faced with an accidental pregnancy. Induced abortion cases admitted to hospitals in five regions show that the proportion among the 15-24 age group is greater than in other age groups, with 16.3 percent among teenagers and 27.3 percent among young adults, as shown in the Pregnancy Termination Study of Valenzuela *et al.*

Sexually transmitted diseases, particularly gonorrhea and syphilis, are still a problem for certain high-risk groups of sexually active adolescents. Data on these two diseases show the greater morbidity of gonorrhea as compared to syphilis particularly in the 15-19 age group.

Juvenile delinquency remains one of the most disturbing problems that has plagued our adolescents. Attendant to this problem is that of drug abuse and alcoholism, two factors often contributing to the rising criminality among the youth. Among the common prohibited drugs used are cough syrups, "shabu" or poor man's cocaine, marijuana, including chemicals like rugby and acetone. As for alcoholic beverages, popular drinks are beer, gin and whiskey.

**Table 3-13 Distribution of Cases
According to Alcoholic Beverage Used**

Type of Alcohol Used	No. of Cases
Beer	60
Gin	160
Whiskey	106
Rhum	16
<i>Lambanog</i>	10
<i>Tuba</i>	6

Source: Annual Statistics Report, 1986, Dangerous Drugs Board

The growth of urban slums spawns social problems including an increasing number of street children, young adolescents in the work force, out of school youth and sexual exploitation of children which adversely affect their health and educational opportunities. The ongoing insurgency in the country has also resulted in children as victims of detention, torture and killings, with adolescents trained to use firearms. A more detailed discussion of the condition of children and adolescents in especially difficult circumstances is presented in Chapter 4.

The Social and Psychological Well-Being of Surviving Filipino Children

The apparent improvement in mortality and morbidity rates should not mislead us to conclude that the child health situation has indeed taken great strides. The World Health Organization (WHO) has said that health is not just the “absence of disease or any infirmity” but also takes into consideration the “social well-being of the individual”.

It is imperative therefore to take a look at the social and psychological well-being of surviving Filipino children. In this study, three indicators will be dealt with, namely:

- ☞ the nutritional state of children;
- ☞ literacy and educational opportunities; and
- ☞ the condition of children in especially difficult circumstances.

The Nutritional State of Filipino Children

Malnutrition is a crucial factor that hinders the optimal development of the child's physical, cognitive and linguistic development, alertness and responsiveness, social relations and self-esteem. The following discussion examines some of the studies done in this field.

The United Nations Children's Fund (UNICEF) has noted a 21.9 percent under-5 second and third degree malnutrition in 1985 (UNICEF, 1989). The Food and Nutrition Research Institute, in its 1987 survey, showed that about 19.0 percent were underweight (severe and moderate), 22.0 percent stunted (inadequate height for age) and 16.6 percent wasted (inadequate weight for height). Consequently, 57.6 percent of preschoolers were considered undernourished.

Table 4-1 Undernutrition among Filipino Preschoolers (%)

Type of Under-nutrition	1979	1982	1984	1985	1987
Underweight (moderate and severe)	21.9	17.2	20.1	22.0	19.0
Stunted (inadequate height for age)	23.2	20.6	25.1	24.8	22.0
Wasted (inadequate weight for height)	13.8	9.5	13.3	14.3	16.6

Note: If we include first degree undernutrition (weight for age) about 70 percent of preschoolers would be considered undernourished. Note that the Philippines uses growth standards lower than those agreed by international bodies such as the World Health Organization (WHO).

Sources: Food and Nutrition Research Institute, 1979 and 1982 data.
National Nutrition Council, 1984, 1985, 1987. The 1987 data is unpublished and preliminary.
Health Alert/Facts of Health, 1st National Convention of NGOs for Health.

However, a recent regional nutrition survey of the Food and Nutrition Research Institute-Department of Science and Technology (FNRI-DOST) revealed that there was a general reduction in the prevalence rates of malnutrition among children six years and under, from 1989 to 1990. The proportion of those moderately underweight has gone down to 14 percent in 1990. Simple wasting decreased to 7.6 percent while severe chronic malnutrition, to 1.4 percent.

The Department of Education, Culture and Sports (DECS) School Health and Nutrition Center surveyed the nutritional status of public elementary school pupils from Batanes to Jolo. They found that one out of two public schoolchildren is undernourished and underweight. Out of 8,203,983 pupils weighed, 4,401,365 were found undernourished; 1,583,564 moderately undernourished and 2,603,852 mildly undernourished. Central Luzon

registered the most undernourished and underweight pupils with 514,538; followed by Southern Tagalog, with 484,676; NCR, 420,081; and Bicol region, 419,755 (*Manila Bulletin*, 8 Oct 1988).

Protein-energy malnutrition was 17.7 percent prevalent in 1987. This rate was 2.9 percent higher than 1982's prevalence rate of 17.2 percent. The protein and energy intakes in 1987 were 98.2 percent and 87.1 percent of RDA (recommended daily allowance), respectively, which were lower than the intakes in 1982. The calorie gap was more prominent than that of protein.

**Table 4-2 Prevalence of Protein-Energy Malnutrition,
1978, 1982, 1987**

Year	Prevalence (%)
1978	21.9
1982	17.2
1987	17.7

Sources : FNRI (1987)
Third Nationwide Survey, unpublished.
In F Solon, "Nutrition Factors in Child Survival & Development:
Their Implications to the Nutrition Program".

Vitamin A deficiency is a serious health problem in the Philippines. The 1982 nationwide FNRI survey revealed that nightblindness was 2.1 percent prevalent among the 2-6 age group, while Bitot's spot was common in 1.7 percent of these children. The 1987 survey, however, showed a decline. Vitamin A deficiency was common in 0.8 percent while Bitot's spot, in 0.3 percent of children. The prevalence of anemia (iron deficiency) in 1987 was 37.5 percent, almost at par with that of 1982. The incidence was higher in the rural areas, among children six months to one year of age and among pregnant and lactating mothers. The FNRI survey showed that almost 75 percent of all infants in the country suffer from iron deficiency anemia.

Iodine deficiency threaten child survival and development when it affects pregnant women in early pregnancy. It causes cretinism, deaf-mutism, and mental and physical retardation.. The prevalence rate of goiter in 1982 was 3.1 percent. The DOH and DECS conducted a survey in six selected regions in 1987 and found that of 12.91 percent of schoolers aged 7-17 years have goiter grade OB and above. Endemic goiter was common among the 10 percent of the surveyed population.

Nutrition has also been hampered by the fact that 69.3 percent of Filipino children (1982) had intestinal parasitism. More rural children (71.4 percent) than urban children (64.4 percent) needed deworming. Intestinal parasitism is caused mostly by unsanitary practices.

**Table 4-3 Prevalence of Intestinal Parasitism by Island Groups
Rural-Urban Areas, 1982**

Area	Percentage Positive for Parasites
Philippines	169.3
Urban	64.4
Metro Manila	63.4
Others	65.0
Rural	71.4
Luzon	66.3
Visayas	73.7
Mindanao	72.4

Source : FNRI/NEDA-UNICEF

Breastfeeding is one of the significant factors influencing child survival, if only for its nutritional value and immunologic effects. Studies have consistently shown that chances of child survival are greater among breastfed babies. To cite a few: between 1978 and 1983, 96 percent of those who were not breastfed were alive in 1983, compared to 88 percent of those who were not breastfed (Zablan, 1985). Moreover, a reduction in the incidence of diarrheal diseases among breastfed children was noted. However, despite the advantages, breastfeeding practice in the Philippines has been on the decline. Over a period of 10 years, the prevalence of breastfeeding decreased from 87 percent (1973) to 85 percent (1978) to 83 percent (1983) to 80.8 percent (1989). Breastfeeding was more widely practiced among rural mothers (87.8 percent), than among their urban counterparts (73.8 percent) although recent studies have shown that this decreasing trend has also significantly affected rural mothers. On the other hand, an increasing trend in breastfeeding practice was seen among urban and highly-educated women (Zablan, 1985). The prevailing malnutrition may thus partly be due to the decline in breastfeeding.

In summary, half of Filipino children are suffering from some degree of malnutrition manifested in weight, height or some form of avitaminoses and other nutrient deficiencies. These are also indicated by a lowered food consumption and nutrient intake. Per capita food consumption decreased particularly for starchy roots and tubers, green leafy vegetables, cereals and Vitamin C foods. The per capita energy intake of children six months to six years in 1987 was only 63.3 percent adequate (Council for the Welfare of Children, 1992).

Literacy and Educational Opportunities

Zero to six years of age are the most critical years in an individual's development. These are the formative years of life. Whatever is taught the child during these years will have tremendous effects on the kind of adult personality he or she will develop later.

The preschool years are, therefore, very important. Children should be placed under more enriching and stimulating environments. In 1989, only 2.25 million or 19.5 percent of the total of 11.54 million 0-6 age group received childhood care and were enrolled in development programs. These were children reared in day care centers, public preschools and experienced maternal training on early childhood care and development (Council for the Welfare of Children, 1992).

In 1988, there were 20,701 schoolage children from 6 to 20 years. Enrolment in the elementary school of children aged 7-12 years was 84.4 percent (1983) although participation rate in the primary level was 107.8 percent. This figure indicates that some children start school later than the compulsory age of seven. Participation rate in the intermediate level was 89.7 percent, an indication that not all primary children proceed to the intermediate grades.

The cohort survival rate in 1984-1985 was 65.43, 1.8 percent lower than the 1980-1981 level. This means that out of the total number of enrollees, only 65.43 percent survived grade six. The dropout rate was 2.72 percent. The remaining percentage might be due to academic failures. In any case, both the cohort survival rate and the dropout rate are considered the most appropriate indicators of the internal efficiency of the country's elementary schools.

Between 1978 and 1980, the number of out-of-school children increased by two percent a year. Between 1980 and 1983, however, the number increased by more than 50 percent, revealing drastic changes in family welfare during this period. The estimated number of out-of-school children in 1983 was about 1.25 million (DECS - NEDA - UNICEF).

These findings indicate that all Filipino children of school age had attended primary school, although it is not uncommon to see overaged ones enrolling in Grades 1 to 4. Dropout incidences became more prominent in the intermediate level. However, 65 percent of elementary enrollees had finished Grade 6. The number of out-of-school children increased drastically between 1980 and 1983, with a 50 percent increment over the previous years. This was due to the worsening economic crises during those years.

Special Problems

Child Labor

In the Philippines, widespread poverty, hunger, disease and illiteracy conspire to take their toll on the Filipino child. The phenomenon of child labor is a serious consequence of these social ills. At an early age the child is forced to abandon the privileges and benefits children normally enjoy such as play, sufficient sleep, care and attention. Instead, the child is made to per-

form adult roles to help augment the family income. This virtually robs the Filipino child of his/her innocence, childhood and idealism. It also has deleterious long-term effects on the child's health — that is to say, his or her physical, intellectual and psychological growth and development.

Notion of child labor

Generally speaking, children's participation in various forms of economic activities has always taken place in all types of societies as part of the division of labor. As such, it has been necessary for the group's survival. In earlier times, children used to work for free within their families. In the process of unconscious observation, association and imitation of adult members, as they work and play, they have learned the roles they will eventually assume when they grow up. This has formed an essential component of the child's socialization, his/her physical and intellectual development, and his/her integration into the social life of the community. This "on-the-job" training was carried out without exploiting children; harmful effects on them were also avoided, since the tasks performed were basically light, sporadic, enjoyable, interesting and educational (Mendelievich, 1979).

The notion of child labor emerged when paid child labor, *i.e.* the systematic exploitation of children by employers outside the child's family, became common. In contrast to jobs that are spontaneous and recreational in nature, the work given children eventually became exploitative since it required more physical and mental resources. The tasks are usually monotonous, strenuous, harmful or unduly prolonged, and usually imply a lack or abandonment of schooling, relaxation and general well-being (*ibid.*, 1979). These types of work usually lead to serious harmful effects and wreak irreparable damage to the children's health, physical, mental and psychological state.

Moreover, child labor is often casual labor. A significant number of children workers, particularly those employed in the garment and wood industries, do not receive benefits, insurance or social security payments. Their labor is also undervalued, receiving incomes much lower than those of adults, even where the two groups are engaged in the same tasks (Bequele & Boyden, 1988).

On the basis of the above conceptual framework, child workers could be any of the following types of children: (Bautista, 1986)

1. the formally working children ages 14 to 21;
2. street children who are 14 years and below and who are informally employed; and
3. sexually exploited children who are 14 years and below and who are also informally employed.

However, a fourth category could be added that of rural children 10 years and above who are mobilized for activities like *muro-ami* fishing.

History of child labor in the Philippines

As early as the Spanish period, child labor already existed in the Philippines. Children worked as farmhands in family and agricultural undertakings. They also tended small stores owned by the family and their relatives. The children usually did all these jobs for free. The case of Crispin and Basilio in Jose Rizal's *Noli Me Tangere*, who both worked as helpers in the church under Padre Damaso, are the best literary examples.

The children's early exposure to work during the Spanish colonial period, especially in the rural areas, is understandable since the values of helpfulness and responsibility-sharing were among those taught and inculcated in the young by family members in the early stages of their socialization. It was an accepted norm for children to be involved in work which was generally viewed as a training ground in the acquisition of knowledge and skills necessary for future roles.

Furthermore, the abuses of the Spanish colonizers — such as the collection of tributes and various forms of taxes even from children and old men, and the institution of forced labor— encouraged and perpetuated child labor. For example, in 1580, the Spanish authorities required all males between 16 and sixty to render service for forty days in the labor pool (*polo*). Each *polista* was supposed to be paid one-fourth *real* (one *real* is less than one peso) a day and given rice when working (Constantino, 1975; Agoncillo, 1961).

Child labor persisted under the American period. With the expansion of Philippine exports and the proliferation of industries and factories, the demand for labor increased. Children were employed in cigarette, candy and bottle factories, lumberyards and farms. In 1916, the first legislation concerning child labor was enacted (IBON, 15 Dec 87).

Generally speaking, child labor could be viewed both as a product and response to the mass poverty in Philippine society. Low wages, high unemployment and underemployment rates existing side by side with high prices of goods and services, are among the conditions which bring this phenomenon about. To meet the minimum basic needs and augment their income, families mobilize all their members, including children, who can possibly earn a living. On the other hand, children exposed to the adult world through work at such a tender age, more often than not, forego their education in exchange for the meagre income they earn. This eventually leads to very limited opportunities and deprives them of a bright future. Thus turn the vicious cycle of child labor.

Why children work

There are several factors that compel children to work. The most pressing reason is their desire to survive in a condition characterized by poverty, landlessness, hunger and disease. Every member of a poverty-stricken home, including children, is made to contribute to the meager family earnings to satisfy the barest requirements for survival.

The parents' wish to keep their children busy and away from vices and trouble is another reason for child labor. This is particularly true for children who have dropped out of school. Instead of wasting their time and energies in unproductive, oftentimes destructive activities that create more problems for the family, parents would prefer their children to work and be useful to them by contributing to the family income. However, this argument is valid only when the children find jobs which are based in their homes with close family guidance and supervision. Unfortunately, this is seldom the case. Joining the labor force at an early age normally provides the condition for children to be introduced and exposed to the dark side of the adult world of crime, gambling, alcoholism, prostitution and other antisocial activities.

Children are also made to work when they are performing badly in school and there seems to be no other option available to them. In many instances, a child worker is usually a poor student. Physical exhaustion, malnutrition and lack of interest contribute to his poor performance in school, eventually leading to his dismissal or dropping out.

The attitudes and behavior of the child's parents toward his/her school work also determine whether the child will continue with his/her schooling or not. In many cases, parents prefer their children to work rather than go to

school either because there is no school nearby or they cannot do without the income the working child brings in, or they cannot see the value or relevance of schooling to themselves and to the child (Mendelievich, 1979).

In general, children take up a particular job for one of the following reasons: (*ibid.*, 1979)

1. It is the only type of job open at the time they are looking for work. Urgent situations and desperation force children to hastily accept the first job they find or that is offered to them. Since their main concern is to earn some money to survive, the nature of the job and its effects on the child are not seriously considered. Normally, any job that enables the child to earn money is acceptable.
2. One or more members of the family are already doing that kind of job. Children usually reproduce the employment patterns of their parents. This is so since it is their parents who decide or choose their occupation (Bequele & Boyden, 1988).
3. The work in question does not call for any special qualifications. The work done by children often involves repetitive, mechanical and hazardous activities. Physical strength and endurance are among the important criteria for children to maintain their job.

Extent and nature of child labor

1. Statistics on child labor

No one really knows the exact number of working children in the Philippines. Government and private agencies have different figures of child-employees. Several factors could account for this ambiguity on the extent of child labor; one is the absence of a systematic and accurate reporting and recording system. It can be said that the official statistics on child labor is just a tip of the iceberg.

It is common knowledge that many employers violate labor standards such as the minimum age for employment and the minimum age for apprenticeship, *i.e.* 15 years and above, and at least 14 years, respectively. To reduce their production costs and maximize their profits through the use of cheap child labor, and to escape penalty for violation of labor laws, employers usually

tamper with the records submitted to the Department of Labor and Employment (DOLE). They either underreport the number of their employees by not including all those below 14 years of age or change the ages of the underage to comply with the laws. Furthermore, it is a practice among young people to falsely report their age, *i.e.* they claim that they are of working age when they are not, so as to get employed. This is one of the findings of Tidalgo and Teodosio (1981) in their study of apprentices.

Another factor that accounts for the inaccurate and unreliable picture of the extent of child labor in the country is the nature of the work where many child workers find themselves in. A big percentage of them work in the informal sector or in the underground economy, *i.e.* that part of the economy where individuals and firms operate outside the legal or formal business framework set by the government (IBON, 15 Feb 1989). Because of the government's failure to monitor this sector, child workers employed in various firms in the underground economy are not included in the official statistics of child laborers.

The number of child laborers has been fluctuating through the years. However, day-to-day observations will show an upward trend in the number of working children.

In 1988 according to the Bureau of Women and Young Workers (BWYW) and the Department of Labor and Employment (DOLE), there were about five million working children in the 5 to 14 age group. Of the five million, 3.9 million were found in the rural areas (*Manila Bulletin*, 8 Oct 1988). Out of the six million children aged 15-19 years, 2.4 million were employed. Of the 2.4 million child workers, 65 percent or 1.7 were males and 73 percent or 1.8 million were found in the countryside.

Recent estimates put the number of working children between 5 and 14 years old to seven million. They are found in garment and wood factories, in big agricultural plantations, in sweatshops and in the fishing industry (IBON, 15 Sep 1991).

A study conducted by the United Nations Children's Fund (UNICEF) in 1991 revealed that child labor is high among families with adult members who are underemployed or unemployed. The study further showed that the highest incidence of child labor is found in Negros Occidental, where 60 percent of the province's children work in sugar plantations and in coconut-based industries (*PDI*, 23 Jun 1991).

2. *Areas of work*

Although there are no sufficient data on the distribution of child laborers in terms of areas of work, studies have shown that roughly 70 percent are employed in agriculture. Many of them are found in rice, coconut, sugar, pineapple, banana plantations or are engaged in fishing (Rivas, 1986). The rest are unevenly distributed in manufacturing, services, and in wholesale and retail trade (Del Rosario, 1986).

In the rural areas, about 70 percent of child laborers are unpaid. They are either assigned as farmhands or helpers in the family enterprise, performing such tasks as tending the store or running errands or doing actual production work in various cottage industries.

In the fishing industry where the *muro-ami* fishing method is used, child workers abound. This illegal fishing technique introduced in the country in the 1930s by Japanese fishermen is widely used in commercial fisheries in the rich fishing grounds of Palawan. Children, mostly out-of-school boys between ages 11 and 19 are hired as swimmers and *pescadores* or divers. Most of them come from the Visayas, specifically Cebu, Dumaguete, Negros Occidental and Siquijor.

In the urban areas, child workers are usually employed in the underground economy, also known as the invisible, informal, unorganized, small-scale or illicit sector. Aside from being accessible, the child workers can easily infiltrate this sector because of the following reasons:

- a. Jobs available to children in the underground economy require very little training or skills. Children acquire the skills on the job or are trained by their parents. Examples are the children employed in the garments and wood-based industries and the street trade.
- b. Working hours are flexible, ranging from a couple of hours a day for peddlers to as long as 24 hours (Saturdays and Sundays included) during peak seasons in the case of children employed in the garment industry. Normally, the number of working hours determine the earnings of child workers.

- c. The capital needed to put up a business in the informal sector is very minimal. The desire to augment their income, unstable and irregular sources of income, and joblessness, encourage family members to put up a small business where children are mobilized and hired as helpers or sellers.

Aside from the features mentioned above, jobs classified as part of the underground or unorganized economy provide minimal earnings. A study conducted by Professor Jose Gatchalian of the University of the Philippines - School of Labor and Industrial Relations (UP-SOLAIR) noted that the average earning in Metro Manila is only 40.00 pesos per day which definitely is not enough to cover the most basic needs. Individuals depend so much on their daily earnings for sustaining their trade or small business. To illustrate, the money peddlers use to buy the goods to be sold the following day is usually derived from the earnings of the previous day (IBON, 15 Feb. 1989).

A particular breed of urban-based working children who have elicited public attention and concern are the street children. According to Dr. Edilberto Dizon of UP, these are children between 8 and 18 years old who are driven to the streets either because they are separated from their families and therefore need to support themselves or are forced to augment their families' low income. Most of them come from broken homes, very poor families and/or are runaways because of physical or sexual abuse at home (*PDI*, 13 Jun 88 and 20 Aug 89).

In 1989, the estimated number of street children in the Philippines was 86,000, accounting for three percent of the child population of the cities. According to a study, approximately 20,000 of them aged 4-16 were engaged in prostitution.

Out of the seven million population of children in Metro Manila, an estimated 50,000 to 75,000 were street children. At least 3,000 were child prostitutes (*Children Under Especially Difficult Circumstances: The Philippine Scenario*, 1986).

Street children are mostly found in market places as *cargadores*; in busy streets selling cigarettes, candies, flowers, newspapers and magazines, cleaning rags; guarding parked cars; calling out passengers to board public utility jeepneys; and as beggars, scavengers, baggage boys or shoeshiners. Others may be found in small factories doing odd jobs like distributing raw materials and rendering petty services.

3. Terms of employment and working conditions

Generally, child labor is casual labor, a technique resorted to by employers to minimize their costs and maximize profits. Aside from receiving only about one third of the legally legislated minimum wage, child workers do not enjoy security of tenure. Moreover, they also do not receive social security and other work benefits and privileges due regular workers. They are among those keeping longest hours but being paid the lowest. This situation is common to small and unregistered firms in the garments and wood-based industries, in pineapple and banana plantations, in sweatshops and in the fishing industry.

In the garments and wood industries, the child workers are mostly casual workers and therefore, are unprotected by labor laws. There are no written contracts. Only verbal agreements are made between the employer and the parents who represent the child.

Generally, the working hours for child workers vary because of several factors. One factor is the nature of employment — *i.e.* whether the child is a wage-earner, which involves an employee-employer relationship, or is self-employed. For wage-earners like those working in the wood-based and fishing industries and in plantations, the working hours are more definite and less flexible since these are usually set or dictated by the employer. Self-employed workers are freer with their work schedule although they must consider the times when their potential customers are at their most numerous and must adjust their working hours accordingly to ensure maximum profits (Mendelievich, 1979).

Children in pineapple and banana plantations work for eight hours a day, six days a week. To meet production quota, they are made to work overtime during their rest days with corresponding overtime pay (Rivas, 1986).

Children in Benguet's vegetable industry work from nine to ten hours a day, six and a half days a week with Sunday afternoon as rest period.

In the wood industry, most children work between 15 and 25 hours a week, although there are some who work fulltime spending at least eight hours a day.

For both wage-earners and self-employed street children, the work schedule varies depending on whether they go to school or not. Some of them are out in the streets selling their wares as early as 3:00 a.m. Majority of them work half day and others work before and after classes and during weekends. The average length of work of those in school is five hours a day (Romero, Arellano and Dayacus, 1986).

On the other hand, the out-of-school children work longer or an average of eight hours a day.

Another factor is whether the children are in school or out of school. Working students generally work less compared to the out-of-school children since the former normally work before and after classes, during school holidays and on weekends.

Remuneration of child workers is generally very low. An example is the condition of child laborers in Benguet's vegetable farms who receive an average of 25.00 pesos a day when the legal minimum wage for farm workers is 58.50 pesos a day.

The same exploitative situation is experienced by child workers in the clothing industry. In urban areas, children are paid 12.50 pesos for each crocheted blouse they make and in the provinces they are given P8.00 for every *barong tagalog* they embroider. Compare this with the wholesale price of the *barong tagalog* which is 350.00 pesos each and its retail price which is from 750 pesos to 1,500 pesos depending on the outlet (Institute of Industrial Relations, UP, 1986).

Not only are child workers disadvantaged with respect to wages received and terms of employment. Much worse are the working conditions they find themselves in and the various occupational risks and hazards they face.

Compared to adults, child workers are more prone to job-related accidents and injuries which may seriously affect their health and overall physical and mental development. For one, they have frail bodies which are often not fit and ready for the kind of work they do. Also, their capacities and needs make them more susceptible to occupational injuries owing to inattention, fatigue, poor judgement and insufficient knowledge of work processes. Furthermore, the equipment, machinery, tools and layout of most workplaces are designed for adults and not for children (Bequele and Boyden, 1988).

Studies have shown that agriculture is one of the most hazardous sectors for the physical safety and health of child workers. This is so because of the prevalence of dangerous modern machinery; prolonged exposure to heat, sunlight, dust, wind and insects; the almost constant physical effort that agricultural work demands; and contact with various chemical products, such as fertilizers and pesticides, whose detrimental effects may not be immediately known. They are also at risk from endemic and parasitic diseases, diseases of the respiratory tract, dermatosis and fatal accidents (Mendelievich, 1979). The absence of protective devices put the children in a more precarious state.

For example, figures from the Cordillera Environmental Concerns Committee, reveal that an average of 34 children and adults were treated each year at the Benguet General Hospital in La Trinidad for pesticide poisoning. Child workers are hired to handle harmful chemicals and to spray these in vegetable farms through the use of a backpack sprayer which contains around eight to 10 liters of pesticide. This job is done by children without using protective gears required by the Fertilizer and Pesticides Authority (FPA) such as gloves, overalls, long pants, safety glasses, goggles or face shields, masks, rubber boots and hats (PDI, 23 Aug 91).

The case of children working at the *consignaciones* or fish drop-off points and markets of Navotas and Malabon is another example of the kind of exploitative working conditions children are subjected to. Employed as fish vendors, fish cleaners, scavengers, *cargador* (hauler/stevedore) and all purpose helpers, their working hours range from eight to as long as 14 hours. Fish haulers usually work from 9 p.m. to 9 a.m. the following day. Thus, it is not surprising to learn that these children commonly suffer from upper respiratory diseases like, colds, cough, fever and influenza. They also have difficulty sleeping and are generally sickly. These were the findings of a study conducted by the Department of Social Welfare (PDI, 7 Jun 1993).

Child workers involved in the *muro-ami* fishing operation and who are taken away to sea lasting from five to 10 months, are subjected to inhuman, unsanitary and congested living conditions on the fishing vessels, a fact which has made them vulnerable to different types of diseases. Common diseases include typhoid, gastroenteritis, beriberi or vitamin B deficiency, respiratory ailments such as tuberculosis, bronchitis and pneumonia, headaches, fever, coughs and dysentery. Respiratory ailments, ruptured eardrums and damaged auditory nerves are associated with deep-sea diving; children who act as swimmers and divers are made to engage in this activity with very minimal protective equipment. On the other hand, beriberi results from the unbal-

anced diet which are provided to child workers in fishing vessels.

Their food mainly consists of very low-quality fish and uncleanly cooked corn-grits. Respiratory ailments such as pneumonia result from the wearing of wet clothes and the lack of protective gear. Gastroenteritis, typhoid and dysentery are caused by unclean drinking water and poor hygiene like the use of dirty plates and cooking wares and utensils (Oosterhout, 1986).

For child laborers in the clothing industry, the occupational health hazards they experience include pricking, backache, eyestrain, upper respiratory diseases, urinary infection, anemia, ulcer, headache, stomach ache and allergy. Urinary infection results when children suppress the need to urinate so as to avoid disrupting their work during peak seasons. Allergy is caused by dust coming from textile and fabrics (Ruiz, Dimaano and Rayala, 1986).

Street children are also in a similar bind. A study released by the Bureau of Women and Minors (BWM) revealed that fatigue, exposure to cold air and/or rain, dust, and heat from the sun, make street jobs more hazardous for children than others. Included in the list of job risks faced by children in street trades were police harassment and extortion and accidents which were considered the biggest risks (*Malaya*, 9 Sep 88 and BWM, 1971).

Aside from the nature of the work child workers are involved in, the occupational risks are further heightened by the conditions at the workplace. In both the rural and urban areas, it is common to find child laborers working in awkward positions and housed in poorly lighted small factory buildings with even poorer ventilation, noisy and/or with damp and unclean surroundings. The work environment is polluted and contaminated with dust and gases. Children are crammed together with other workers, without adequate security, special resting areas, medical facilities, water for washing, adequate toilet facilities, etc. (Mendelievich, 1979).

Child Prostitution

Among street children is a group of child workers who have elicited public concern, not only because of their growing number but also because of the very serious damage wrought by the so-called "oldest profession". These are the child prostitutes.

Child prostitutes are male and female children with ages 7 to 15 years

who render sexual services to anyone willing and able to pay any amount of money (Magno, 1984). They constitute about one-fourth of street children or about 20,000 of the 86,000 street children in the country in 1989.

In Metro Manila, there are at least 3,000 child prostitutes roaming the streets of M.H. del Pilar, A. Mabini, Robinson Complex, Makati Commercial Center, Harrison Plaza, Rizal Park, Pasig, Caloocan, Plaza Moriones and the Araneta Center in Cubao. Outside Metro Manila, they are found in Puerto Galera in Mindoro; in Poro Point in San Fernando, La Union; at the Mactan International Airport in Cebu; in Pagsanjan, Laguna; in Boracay Island, Aklan; in Bacolod City; in Buhi, Camarines Sur; in Bulusan, Sorsogon; in Cavite and in the cities of Angeles and Olongapo, where the two biggest American military bases in the country were located (*Children Under Especially Difficult Circumstances: The Philippine Scenario*, 1986).

Profile of child prostitutes

Majority of child prostitutes belong to the 14-16 age group, although there have been reported cases of younger children engaged in this trade. The youngest known child prostitute in the Philippines is aged five (Tan, 1987).

Majority of child prostitutes come from poor families who were forced to enter this trade to augment their family's income or to provide for their most basic needs in the case of children who are runaways and/or orphans. This is evidenced by their parents' occupation which usually are manual with irregular income, like washing clothes, carpentry, jeepney or taxi-driving, factory work, food vending, singing at nightclubs and yes, prostitution (Magno, 1984).

Like many of the street children, they are products of broken homes or are among the five million victims of child abuse throughout the country, if not runaways. Many of them come from isolated impoverished barangays and the coastal fringes of the Visayas, recruited by unscrupulous individuals and brought to urban centers on the pretext that they will be provided with jobs as domestic helpers or sellers. Eventually, they are lured into prostitution to supplement their meager daily earnings.

Most child prostitutes have not entered school or are high school undergraduates.

Aside from selling their bodies, child prostitutes are also involved, usually during the day, in the underground economy — as vendors of flowers, cigarettes, newspapers; watch-your-car and shoe shine boys.

Nature of work of child prostitutes

The main clientele of child prostitutes are pedophiles, *i.e.*, people, male or female, who derive sexual gratification from children. Most of these clients are European tourists.

Child prostitutes, especially those found in the tourist belt, earn from 50 pesos to 300 pesos per client for short-time services which usually last for two or three hours. Fees vary, depending on the nature of the services provided and the classification of the child prostitute. Services requiring more efforts on the part of the child prostitute — being sodomized, engaging in sexual intercourse or having gadgets inserted into his/her sexual organs — command higher fees. If the child is a virgin, she commands a price that could reach as high as 1,200 pesos (Magno, 1984).

The earnings of child prostitutes are not limited to cash. They also receive gifts for themselves and their families, such as clothes, shoes, jewelries, toys, food, household appliances and even vacation trips with their clients to resorts.

In the process, child prostitutes acquire different skills which eventually become an integral part of the job. They learn to steal from clients, to distinguish the sadist from one who is not. They also learn to take prohibited drugs, shabu or “poor man’s cocaine,” sniff rugby or smoke marijuana which help desensitize them to the oppressive and traumatic effects of their job.

Child prostitution subjects the child to dehumanizing and brutalizing conditions that have serious repercussions on his/her physical, intellectual, psychological and moral growth and development. The social environment of child prostitutes exposes them to different types of hazards and diseases: physical abuse infections, venereal diseases and AIDS (acquired immune deficiency syndrome). The case of 12-year-old Rosario Baluyot who died of infection from a vibrator inserted into her vagina by a European client in 1987 is among the well-publicized incidents.

Furthermore, aside from being made to do acts which their frail bodies are physically unprepared for, child prostitutes work long hours. In many instances, they are forced to skip meals when unable to find a customer, which further exacerbates their already malnourished state and weakens their resistance and defenses against various forms of infections and diseases.

The child prostitute's premature entry into the adult world has serious psychological effects. He/she is deprived of adequate education and training which greatly restricts him from making a significant contribution to society. His/her exposure to a decadent lifestyle cultivate distorted values and the acquisition of vices like smoking, drug abuse, alcohol drinking, and criminal activities.

Factors affecting child prostitution

Child prostitution is a form of child labor resorted to by children and their families as a means of economic survival. Widespread poverty, landlessness and unemployment are important factors perpetuating child prostitution in the country. Thus, economic reasons principally force children to engage in the oldest profession.

The story of Pagsanjan, Laguna, one of the country's tourist spots which was a known haven of pedophiles during the 1980s, reveals that because of poverty, even parents have pimped for their sons and daughters in exchange for material and financial support. This was one of the findings of the Council for the Protection of Children in Pagsanjan (CPCP), a nongovernment organization working in the area to safeguard children's rights and interests. The CPCP discovered, among other things, several papers signed by parents allowing their child or children to go with Mark Harvey, a pedophile operating in the town who has been arrested and detained following a raid by immigration agents in his house. As one resident has said: "*Mababait nga ang mga turistang iyan. Binibigyan kami ng pera, hanap-buhay, kasi daw sa kanilang bansa, napupunta lang sa gobyerno ang kayamanan nila pag walang pamamanahan. Kaya pumupunta sila rito. At least napapakinabangan natin ang pera nila.*" [Those tourists are good. They give us money, jobs, and according to them, in their country their wealth only goes to the government if they have no heirs] (PDI, 15 Aug 1989, 17 Aug 1989).

Prostitution in the country persists also because individuals — many of whom are underworld characters and into this business either as pimps, opera-

tors or owners of prostitution houses, bars, clubs or massage parlors — enjoy the protection of government officials and police authorities. In many instances, these officials and law enforcers are the real owners and operators of business establishments that peddle child and adult prostitutes. Through dummies, these unscrupulous individuals rake in profits from these illegal activities since they receive a certain percentage of the daily or monthly income of the establishment.

As shown in the records confiscated by immigration agents from Harvey, several top local officials and policemen were among those protecting suspected pedophiles.

The mindlessly aggressive tourism program of the government is another factor that has perpetuated child prostitution in the country. An article in a European gay magazine, *Spartacus*, describes Pagsanjan, Laguna, as follows: "The delightful thing about this place is that in the population of about 3,000 to 4,000, every young man below 20 years old is gay, attractive and waiting to be of service to tourists ... In the villages, hundreds of young boys are available though not all of them are gay. One could say that the boys of Pagsanjan are a rental industry themselves" (Magno, 1984).

Children in Armed Conflict

Filipino children have suffered most from the 24-year-old insurgency problem in the country (1969-1993). They have become not mere spectators, but victims of the armed conflict, bringing about the phenomenon of children of war. This is in addition to their being victims of poverty, hunger and disease.

Children aged 0-14 comprise about 50 percent of civilian victims in the civil war raging in the countryside. From 1986 to 1989, about two million children were directly or indirectly affected by military operations, with more than one million of them killed in the insurgency war by bombings, strafings, raids or attacks either by government or rebel forces. It has been estimated that annually, about 120,000 children are affected by the conflict, with majority as victims of massive displacements and evacuations. In fact, more than 4.5 million of them have been displaced by the increased militarization in the rural areas since 1986.

Aside from being victims, an increasing number of children are recruited as combatants and are mobilized for war-related activities. Government soldiers recruit children as young as 11 years old into paramilitary forces. The guerrilla forces, on the other hand, use children as couriers and helpers (Collins, 1989).

Profiles of children of war

Majority of these children are found mainly in the countryside where the fiercest battles between the military and the rebel forces are fought and intense military operations are carried out.

Majority of them belong to low-income families, being the sons and daughters of peasants, agricultural workers and settlers.

Effects of war on children

War affects the physical, mental and psychological status of children. Physically, they are subjected to or threatened with death, injury and disease as a result of bombardments, strafings, abuses, harassments, displacements and food blockades. For example, as a result of *Operation Thunderbolt*, a counter-insurgency operation launched by the Armed Forces of the Philippines (AFP) from April 24 to May 31, 1989, in southern Negros Occidental, more than 200 innocent children have since died because of the unsanitary conditions, overcrowding, lack of proper ventilation, insufficient food and inadequate medical provisions and facilities in the evacuation centers where most of them were housed following massive bombardments in their barrios. The weak and malnourished state of many of these children have made them vulnerable to outbreaks of epidemics in the evacuation centers. Among the major causes of children's deaths were bronchopneumonia, tetanus and diarrhea (Teacher's Assistance Program, Oct 31-Nov 30, 1989).

The same fate befell the children of Marag Valley in Kalinga-Apayao as a result of *Operation Salidummay*, the massive military offensive launched by the AFP in this northern Luzon province in October 1990, to wipe out the New People's Army (NPA) guerrillas in the area. *Oplan Salidummay* claimed the lives of more than 120 persons, 117 of whom were children; the forced evacuation of more than 1,600 persons, including children, from their bar-

rios; and the loss and destruction of millions of pesos worth of houses, personal belongings, crops, grains, work animals and farmlands.

Moreover, as a consequence of the armed conflict, the children's education is disrupted or permanently stopped, thus stunting their intellectual growth and development. They also experience intense psychological and emotional stresses for fear of losing their parents, loved ones and their homes. Their exposure to and participation in killings and other forms of violence could very well distort their morality and values. And, no thanks to the mass media, a "war culture" has emerged and developed among millions of children which has justified the use of aggression and violence in resolving conflicts and problems (Marcelino, 1989).

Studies have shown that the children's psychological development is greatly affected because of the constant state of stress, tension and fear. They usually exhibit multiple signs of serious trauma, despair and helplessness. The disruption of family life and the failure of adults to perform protective roles also exacerbate the children's confusion. They feel abandoned and thus have to fend for themselves and their siblings (Marcelino, 1989).

*P*erceptions, Practices and Beliefs on Child Care: Survey Results

Findings from existing data seem to reveal that the Filipino children's physical health is improving, as evidenced by the decreasing trends in mortality rates for all age groups. The results, however, point to morbidity as attributable to communicable diseases, a situation that has prevailed over the last 50 years. Socially and psychologically, many Filipino children are victims of neglect, abuse and exploitation, either as effects of poverty, environmental pollution, moral decay, sociopolitical conflicts and the war in the countryside.

An attempt was made to obtain some primary qualitative support to the abovementioned findings. Interviews were conducted with mothers and health professionals in the community. How do health professionals assess the child health situation today? What are the gaps in the implementation of health policies and programs? What are the beliefs and practices of mothers regarding child care? What improvements in child care practices were attributed to government sponsored health programs?

Results of Interviews with Health Professionals

Majority of the health professionals reported a "better," "improving," "much improved" child health situation. The following indicators were cited:

1. There was a decreasing incidence of child death in most communities observed. These deaths were mostly due to epidemics of measles and its complications, such as pneumonia and diarrhea. Birth and death rates also decreased and in times when there were fluctuations, there was no sudden increase or decrease in both rates.
2. An increased health consciousness among the people was noted.
 - ☛ More mothers now have their children immunized.
 - ☛ An increasing number of pregnant mothers seek prenatal care.

- ☞ Mothers bring their healthy children to clinics, unlike before when they only sought the doctor for sick babies and children.
 - ☞ Urban, middle and upper class mothers are now aware of the importance of breastfeeding, although mixed feeding is still predominant.
3. More logistical support is being poured into child survival programs and maternal care. Examples are the Expanded Program of Immunization, the Control of Diarrheal Disease, the feeding programs for children and now the Acute Respiratory Infections program.
 4. More policies are formulated to ensure the care and protection of infants and children. Examples are the Breastfeeding Code, the Day Care Law and the Labor Code.
 5. Health administration is better, at least in terms of greater decentralization. Regional directors have been delegated authority to disburse certain amounts of money on top of the regular budget. They do not merely follow instructions from above but can now freely input their assessments and recommendations based on grassroots' experiences.

Perceived Gaps in Implementation

1. Despite breakthroughs in medicines, facilities and manpower, critical shortages still occur. There is always a shortage of medicines, especially antibiotics. Hospital beds and facilities fall short of actual needs.
2. *Hilots* (traditional births attendants) would like to be trained, but it was reported that there were no training kits available.
3. Many doctors are frustrated knowing that prescribed medicines will not be bought or will be taken at less than the prescribed ideal dosage.

4. Diagnostic facilities are not always available. One doctor reported having to perform a dilatation and curettage (D and C) without gloves.
5. Many personnel positions remain vacant for lack of takers. The ratio of medical personnel to the population is extremely low. The average population served by physicians in field health services is 59,730. It is no wonder that many Filipinos resort to traditional faith healers or self-medicate.
6. The only medical personnel often encountered by the majority of the Filipinos at the barangay level is the midwife. Those interviewed claimed to be overworked, overburdened and underpaid. The midwife takes charge of the implementation of all health programs. The ideal ratio for midwives to the populace is 1:5,000 but this can reach as high as 1:10,000 and can cover a dispersed catchment area. Monitoring of patients and/or house visits are limited by inadequate and often delayed transportation allowance, transportation difficulties, inaccessibility and remoteness of the catchment areas, the unstable peace and order and poor weather conditions.
7. There seems to be a lack of time for health education of the populace. A midwife's day is normally for curative treatment in the mornings and recording and reporting in the afternoons. During the last quarter of the year, midwives usually spend half of their time attending seminars and training programs.
8. While barangay health workers have been tapped to assist midwives, taking care of at least 20 residents and conducting house-to-house campaigns, when necessary, there are hardly any incentives available, except to call on their sense of commitment to public service. Most have remained inactive.
9. Treatment protocols and other program guidelines change quite often. Mothers and the health personnel find it difficult to keep track of the changes. The result is a high degree of noncompliance. Examples are the changing treatment protocols for the management of diarrhea in children (from antidiarrheals to ORT); discouraging the use of cough medicines; and in terms of program guidelines, the ever-changing system of recording and reporting.

10. Persistent traditional values and beliefs which often run counter to scientific medical practice have also been observed. Among these are ignorance of simple sanitation and health practices, dependency attitudes, even lack of initiative and willpower to escape through one's effort from the morass of poverty and deprivation. The following were some of the beliefs relayed by health personnel :

- ☞ Some mothers refuse to breastfeed. "*Nag-fever lang ng isang linggo, ayaw na, infected na daw. Malapsaw na raw and gatas. Ang colostrum ayaw nila at itinatapon. Tapos, diluted pang masyado ang bottle-fed milk nila.*"
- ☞ There is resistance to injections especially for measles. *Malulunod daw.* Parents reportedly fear that injections for measles might worsen the illness or cause death. However, when the child catches pneumonia and is brought to the doctor, it is usually too late. Meanwhile, the doctor gets blamed.
- ☞ Some mothers continue to use binders. At times they put ashes on umbilical cords which cause tetanus.
- ☞ If bitten by dogs, mothers go to the "*herbolario*" (traditional healer) who applies some kind of stone on the site of the bite as this is believed to absorb the toxicity.
- ☞ Notified ahead of time and reminded again and again, still some two or three mothers would not go to the health center because it is harvest time or they claim to be too busy. Some will not immunize their children because of the perceived side effects of immunization.
- ☞ Parents still talk of *barang* or *kulam* (witchcraft).
- ☞ As long as there is something to eat, parents do not worry about balanced diets. They would rather sell than eat their chicken and buy *lawlaw* (*alamang*) because it is cheaper and would last them longer. They overcook or simply boil their vegetables.

- ☞ The Muslims are especially resistant to modern practices and resort to their *panday* (Muslim traditional birth attendant), *orasyon* (prayers) and traditional beliefs and practices. They use bamboo slits and then put ashes, sometimes cow dung on newborn cords, a practice that has led to tetanus cases.

Results of Interviews with Mothers

Demographic Profile of Respondents

One hundred and fifty (150) respondents were interviewed. Four out of ten were from the urban areas while six out of ten were from the rural areas. Forty-eight (48) percent belonged to the 25-35 age range, and 37 percent to the 36-50 bracket. Thus, the bulk of the respondents have had experience in bringing up their children and are not too old to have forgotten how.

Of the total respondents, 37.33 percent attained college degrees; 36.67 percent reached high school levels; and 22 percent finished only elementary grades. About two (2) percent have graduate or postgraduate degrees and 1.33 percent obtained a vocational education. The majority (69.33 percent) have resided in the area for the past 10 years, or even since birth.

Most respondents were housewives (66 percent) and a few were professionals (8 percent) or rank and file employees (8 percent). Some had businesses of their own (14 percent) while the rest (4 percent) did menial jobs such as washing clothes, being household help, and vending.

Seventeen (17) percent of the total respondents had incomes of 1,000 to 3,000 pesos. Eleven (11) percent earned less than 500 pesos; 7 percent, 501 to 1,000 pesos; while the majority (62 percent) reported no personal income. The total family income was 1,000 to 3,000 pesos for 47 percent and less than 1,000 pesos for 23 percent. About 15 percent reported earning 3,000 to 5,000 pesos and 9 percent above 5,000 pesos. Five (5) percent of the families cited having no income or an irregular one. Please note that a big percentage of the respondents had incomes below the set poverty line of 5,000 pesos per month. The family size for 57 percent of the women respondents was two to four

children. Nineteen (19) percent had five to seven children; 18.67 percent had one child and 5 percent had eight to ten children.

The male spouses were mostly between the ages of 25 and 50 just like their wives. Thirty (30) percent graduated from the elementary grades; 36 percent from high school; and 25.33 percent from college. More wives were college graduates (37.33 percent) as compared to their husbands (25.33 percent).

Concepts of Health

The respondents stated that a healthy child must have a good physical appearance: bright eyes, smooth skin, beautiful appearance, height proportional to body, clean and neat, stout and with good appetite. A good number mentioned the absence of any infirmity. To maintain a healthy child, one should give proper nutrition, keep the child clean and give him or her vitamins. Proper nutrition means serving the child a balanced diet of green and leafy vegetables, meat and fruits.

Mortality/Morbidity Data

Mother-respondents reported measles to be the most serious illness contracted by their children (23.97 percent), followed by bronchopneumonia, diarrhea and convulsions — presumably all complications of measles. Cases of measles are cared for at home and seldom brought to the hospital. Mothers most often administer medication before bringing the child to the doctor or the health center when his condition fails to improve. Self-medication is mostly in the form of over-the-counter drugs and herbal concoctions.

Child deaths in the family were mostly due to abortions/miscarriages and measles.

Prenatal Care

Table 5-1 Distribution of Respondents
by Belief in Prenatal Care

Belief in Prenatal Care	Number of Respondents	%
YES	137	91.33
NO	13	8.67
TOTAL	150	100.00

Of the total number of mother-respondents, 91.33 percent went for prenatal care. Foremost reasons for seeking prenatal care included : caring for the baby and the mother; avoiding complications; getting vitamins; having tetanus toxoid injections; and ensuring the baby's proper positioning.

Midwives at the health center and private doctors were mostly sought for prenatal care. But the *hilot* was simultaneously consulted with health practitioners at certain stages of pregnancy, specifically, during the first and last trimesters and the postpartum phase.

Beliefs and Practices during Birth

More than half of the mother-respondents preferred to give birth at home. Fifty-eight (58) percent actually delivered at home; and 35.33 percent in the hospital. Home deliveries were mostly attended by midwives (37.33 percent), *hilot* (31.34 percent) and by doctors (29.33 percent).

Mothers who preferred home deliveries gave the following as main reasons: greater privacy (*di nakatiwangwang na maraming nanonood, di-inaakitang parang baboy*); support from the family; less costly (expense ranged from 50 to 200 pesos); more accustomed to the *hilot*; greater and exclusive attention given by the *panday* or the *hilot*; and more convenient, especially for *multiparous* mothers.

About 73 percent mentioned they had no difficulties during delivery. About 27.33 percent experienced problems such as protracted and difficult dry labor, eclampsia, premature deliveries, placenta previa or hemorrhage, in which case they were rushed to the hospital.

Postnatal care was provided by midwives (35 percent), *hilots* (34 percent) and doctors (25 percent); a few by mothers and in-laws or their husbands. Postnatal care meant eating good food, fruit and vitamin intake; being up and about shortly after giving birth and exercising (although one should not work too hard); use of herbal medicines; and, *hilot* care, including *pausok* (drying up of wounds through smoke from under the house or through the application of guava leaves) and a massage to allow the uterus to assume its normal position.

Other postnatal practices included: the hanging or burial of the placenta and cord; not bathing for two weeks to one month (or until bleeding stops) and bathing is usually done with a herbal bath *banas*, *orasyon* and massage; not being caught in the rain (*gagalisin*); not permitting a menstruating person to enter the room of the new mother lest the latter suffers from a stomach ache; fish should not be eaten to avoid profuse bleeding; not eating food with *gata* so that the flow of mother's milk will not stop; and giving the *panday* a chicken and a new plate for the return of the body's "beautiful" figure.

Breastfeeding or Bottlefeeding?

Table 5-2 Distribution of Respondents by Type of Feeding

Type of Feeding	Number of Respondents	%
Breastfeed	113	75.33
Bottlefeed	19	12.67
Mixed	16	10.67
No Response	2	1.33
TOTAL	150	100.00

Seventy-five (75) percent of the mother-respondents breastfed; 12.67 percent bottlefed; and 10.67 percent resorted to mixed feedings. Breastfeeding is preferred because it is: economical; clean and more healthful; convenient for night feeding; the nutrients eaten by the mother are received directly by the child; mother's milk is the best milk; a closer relationship is fostered between the mother and child; and the baby refuses the bottle.

**Table 5-3 Distribution of Respondent
by Period of Inception of Breastfeeding**

Period of Inception	Number of Respondents	%
a few hours after delivery	83	64.35
when there is milk already	2	1.55
1-3 days after delivery	40	31.00
4-5 days after delivery	2	1.55
2-3 weeks after delivery	2	1.55
T o t a l	129	100.00

About sixty-four (64) percent started breastfeeding a few hours after birth; 31 percent one to three days after or when milk starts to flow; about 5 percent waited for four to five days or even as long as two to three weeks.

**Table 5-3b Distribution of Respondents
by Period of Weaning from Breastfeeding**

Period of Weaning	Number of Respondents	%
less than 1 month to 1 month	15	11.63
3-6 months	11	8.53
7-12 months	5	3.87
1-2 years	70	54.26
2-4-6 years	13	10.08
until a child likes to breastfeed or when he/she starts eating solids	6	4.65
when the mother gets pregnant	5	3.88
until delivery	1	0.77
not ascertained	3	2.32
T o t a l	129	100.00

Of those who breastfed, 11.63 percent stopped before the month was over or before the child was three months old; 54.26 percent weaned only after one to two years; 10 percent took even longer, two to four to six years; 8.53 percent stopped breastfeeding at three to six months and 3.87 percent at seven to twelve months.

Reasons for weaning included: stoppage of milk; need to work; and the baby bit or hurt their nipples.

Meanwhile, those who bottlefed gave as reasons for weaning: insufficient milk; having to work or too much work; and the baby's refusal to take the bottle.

Immunization

Table 5-4 Immunization Record

Immunization	Frequency	%
fully immunized	90	60.00
partly/not completed	10	6.67
not immunized, <i>napabaya</i> (forgotten), <i>nakaligtas</i> (missed), makes no difference anyway	11	7.33
not all children but most	12	8.00
then, anti-TB and small pox only	6	4.00
anti-polio	9	6.00
DPT only	9	6.00
not ascertained	3	2.00
T o t a l	150	100.00

Sixty (60) percent of the respondents' children had been fully immunized. About seven (7) percent said that their children were not at all immunized. Usually, only the younger ones received their shots. About 6.7 percent started immunizations but failed to complete them. Others only had polio, DPT, tetanus, and TB vaccinations. Measles immunization, therefore was the most neglected. Majority of these immunizations were administered in the health centers.

There was a general recognition among the mothers of the advantages of immunization. The reasons they gave for having their children immunized were: to protect them from diseases; to provide strong resistance; to comply with the doctor's orders; and to stop the midwife's persistent nagging.

Family Planning

Family planning was practiced by 65.33 percent while 24.67 percent did not. Some six percent still had reservations while four percent practiced it only lately.

Table 5-5 Belief in Family Planning

Belief in Family Planning	Number of Respondents	%
YES	98	65.33
YES BUT	9	6.00
NO	37	24.67
ONLY LATELY	6	4.00
T o t a l	150	100.00

The usual methods used were rhythm, self-control or the natural method (33 percent); pills (24 percent); condom and the intrauterine device (IUD) (19 percent); ligation (11 percent); and withdrawal and depoinjection (6.6 percent). Interesting cases of failed family planning attempts surfaced in the interviews, such as the IUD (intra-uterine device) being forced out or ejected by menstruation or cell tissues having grown around it which naturally contributed to the respondents' anxieties and apprehensions.

Table 5-5B Family Planning Methods

Methods Used	Number of Respondents	%
Rhythm, self-discipline natural method	40	33.10
Pills	29	23.97
Ligation	13	10.70
Condom	12	9.92
IUD	12	9.92
Withdrawal	4	3.30
Depoinjection	4	3.30
Tried IUD but failed, "lumabas, di hiyang"	4	3.30
Tried pills but stopped	2	1.65
<i>Hilot</i>	1	0.83
T o t a l	81	100.00

Asked why family planning was resorted to, the usual reply was to properly space pregnancies which was good for the mother and her children's future.

Traditional Beliefs and Practices

Seventy-one (71) percent of respondents practiced or followed traditional beliefs.

The reasons cited were: the older generations knew better or will get angry; the in-laws, mothers and husbands said so; "It might be true and nothing will be lost anyway"; "Yes, it is true, it happened to me"; and fear of dying should they refuse to accede.

Twenty-three (23) percent admitted not practicing nor believing in traditional practices because they live in a modern age; traditional practices have been disregarded without dire consequences; they trust in God rather than in practices; and of outright disbelief in the efficacy of traditional practices.

Traditional medicine was used by 79 percent of the respondents. The *hilot* was mostly frequented by 63 percent, *herbularios* by 20 percent and the faith-healers by the rest. Sprains and unexplained, recurrent or unremedied illness of the respondents were brought to the attention of such healers. They were also consulted in relation to malevolent spirits. Pregnancy and deliveries involved other visits to traditional healers as did allergies.

Medicinal plants were used most often by nine out of ten respondents. Their reasons were these plants have proven to be effective, have been tested and tried, have been taught by the center and contained no toxic chemicals.

The respondents identified at least 56 herbal medicinal plants used for aches and illnesses ranging from wounds, skin irritations, scabies, coughs and colds, diarrhea and all sorts of stomach aches, fever, rheumatism, inflammation, toothaches, boils and many others.

Childhood Problems

Not so many problems were presented by the mother-respondents regarding their young children. Among their adolescent children, however, drug addiction (7.45 percent), alcoholism (3.72 percent), *barkada* (7.98 percent), poor performance in their studies (2.66 percent), gambling (2.13 percent), and stubbornness (5.13 percent) were among the problems the mothers in the sample cited.

**Table 5-6 Distribution of Respondents
by Problems with Adolescent Children**

Problems with Adolescent Children	Number of Respondents	%
<i>"inom, alak"</i> (drinking)	7	3.72
<i>"barkada, istambay"</i>	15	7.98
<i>"di nakapag-aral, problema sa pag-aaral"</i>	5	2.66
drugs sometimes	14	7.45
<i>"sugal, bisyo"</i>	4	2.13
heterosexual pursuits	1	0.53
menstrual period	1	0.53
hardheadedness	10	5.32
no problem, my children are OK	37	19.68
no response	94	50.00
T o t a l	188	100.00

It is interesting to note that in typical Filipino families, neglect and exploitation were never recognized as child abuse. If present, these were denied, and any form of punishment was justified as part of parental discipline. Such punishments were even perceived as manifestations of parental love and concern for their children.

Some parents admitted having encouraged their children to work as household or farm helpers. But they claimed, they only did so: in exchange for employers' supporting their children in school; if they were familiar with the employer, who was normally a richer relative; if they could no longer sustain the needs of the child; and to help augment the family income.

Child prostitution was not common in the communities visited although a number of respondents had heard of children being sexually abused by foreign pedophiles. Neither did the mothers have any personal experiences with the wars in the countryside since most of the respondents were taken from the more central municipalities of the region — a limitation that this study admits.

Values

The values instilled in the children included traits such as respectfulness (22 percent); obedience (18 percent); kindness (19 percent); being helpful (6 percent); hard work and industriousness (6 percent); praying and not doing wrong (4.9 percent); studying hard (4.61 percent); being disciplined (3.74 percent); not being quarrelsome (2.88 percent); good manners and right conduct (2.31 percent); and kissing of hands and respect for elders (2.31 percent). Being nationalistic was mentioned by an insignificant group. Civic consciousness was hardly mentioned.

Most parents considered themselves successful in instilling desired values (66.25 percent); 32.5 percent admitted only partial success; and 1.25 percent, not at all.

Conclusions

In sum, the interview results did not reveal much of a deteriorating health situation as evidenced by frequent occurrences of serious illnesses nor of deaths (only a fifth of the respondents so reported). Otherwise, "by the grace of God" children grow up without too much trouble.

Although mothers still adhere to many traditional beliefs and practices, certain inroads have already been made into their health consciousness. They realized the value of prenatal care; they practiced breastfeeding and correct timing for weaning (although often the economic factor prevails); they pre-

ferred to have their children immunized; they understood the importance of family planning; they consulted doctors and the health centers more often.

In this respect, health centers operating at the grassroots level have improved people's health consciousness. Midwives have been known to conduct house-to-house campaigns, community assemblies and training programs for mothers (*e.g.* mothers' class) when resources permit these activities. Otherwise, they hold their health education classes in clinics. The barangay health workers have, therefore, facilitated the improvement in health consciousness.

There have been incremental changes in certain aspects of child health care in the specific regions studied. However, these are hardly dramatic. There are no leaps and bounds, nor great strides, as revealed by the informants themselves. So much more remains to be done, as problems and obstacles persist that detract the achievement of optimum health care.

*A*nalysis and Discussions of Research Findings

The previous chapters noted encouraging trends in the area of child health. These include a decreasing incidence pattern in morbidity and mortality rates for all stages of child development; a drop of 2.25 percent in the average annual rate of reduction in morbidity between 1960 and 1980 and of 1.94 percent between 1980 and 1987; and a decline in infant mortality rate (IMR) from 93 per 1,000 live births in 1970 to 50.2 per 1,000 live births in 1990.

However, it is also significant to note that the leading causes of mortality and morbidity have not changed since 50 years ago. Philippine gains in reduced IMR still lag behind other countries. Sri Lanka posted a 34 IMR in 1987; Argentina, a 32 IMR, Panama, a 23 IMR and Malaysia, a 24 IMR. Communicable diseases such as pneumonia, measles, tuberculosis and diarrhea are still the major causes of illnesses and deaths of Filipino children, attesting to a relatively unchanged child health scenario.

It is true, as the research findings showed, that the health situationer compared to five years ago has indeed improved, is better, or is improving as reported by health personnel at the regional, provincial, district, municipal and barangay levels. Health consciousness has also been raised, as revealed by the perceptions and practices of mother-respondents on child care.

But all these are more of quantitative and incremental improvements. So much remains to be done in terms of several indicators, among them, the nutritional status and educational attainment of Filipino children, the sociopsychological dimensions of child health, better health delivery systems and more intensive health education and value formation among mothers.

The occurrence of special problems, such as insurgency and armed conflict, child labor and child prostitution, have all hampered the achievement of an optimum quality of life for Filipino children. These conditions must be corrected. One out of two public school children is undernourished and underweight. About 57.6 of the preschool population are either stunted, wasted or underweight.

Although almost all children are able to enter Grade One, it is not uncommon to find overaged children in the primary grades. The incidence of dropouts starts mostly at the intermediate levels. Only 65 percent of elementary enrollees eventually graduate from grade school.

Moreover, children find themselves in especially difficult circumstances which expose their frail minds and bodies to all forms of risks and untold sufferings.

Their becoming part of the labor force at such an early age makes them easy prey for exploitation and abuse, including sexual abuse in the case of child prostitutes. The tremendous workload they shoulder and their premature exposure to the adult world are wreaking detrimental — in some cases irreversible — effects on their physical and mental growth and development. The country's 24-year-old insurgency problem has also added to the list of children's problems. Besides being victims of violence, they are also recruited as combatants or messengers for war-related activities. Physically, children are not only threatened with death, injury and disease but also have delayed schooling or none at all. The constant stress, tension and fear they are subjected to results in serious psychological trauma, state of despair, fear, helplessness and a confused state of mind.

The trends in child health indicators and the circumstances Filipino children find themselves in underscore the fact that provisions for child health and welfare as well as the accomplishments in this field cannot be discussed outside the context of Philippine underdevelopment. The country's level of income as well as the priorities set by government are critical determinants of child welfare because they impose limits on household expenditures, government expenditures, and the overall socioeconomic conditions of Filipino families and communities. The next sections, therefore, discuss child health within the wider national context.

Deteriorating Economic Conditions

The economic conditions of the country have worsened after the 1986 EDSA Revolution. Statistics show that the living standards of Filipinos have actually deteriorated through the years.

In 1971, the number of families living below the poverty line was 49.3 percent of the total number of families for that year. The incidence increased

to 59.3 percent in 1985. Results of the 1988 Household Survey further showed that 49 percent of Filipino families still lived in impoverished conditions with a poverty threshold of 2,709 pesos per month. The poorest majority of Filipinos share only 5.2 percent of the total family incomes in 1988 while the minority rich control 49.6 percent.

The average family income may have increased 22 times compared to the 1961 level, but in real terms this doesn't mean anything, considering that the peso's purchasing power slid down to 0.219 as compared to 1978's one peso (NSO).

The income needs of Filipino families fall far short of the minimum requirements for a decent life. In 1987, based on the estimates of the National Wages Council, the minimum daily income for a family of six was estimated at 122.41 pesos. This rose to 156.86 pesos in October 1989 and was estimated to be about 200 pesos in the early part of 1990 (PDG, 2 Jan 1990, p.9). As of August 1992, according to the IBON Databank, a family of six had to earn 5,581.65 pesos a month in order to meet their basic needs.

For Metro Manila where it is considerably more expensive, the poverty and food thresholds have been pegged at 5,531.50 pesos and 2,884.25 pesos, respectively, a month for a family of six.

The estimated minimum requirements for families to live decently falls far short of the legislated minimum daily wage of 127.83 pesos (IBON, 28 Feb 1993).

This is on the assumption that the legislated minimum daily wage is being properly implemented by legislators. The Department of Labor and Employment has reported that thousands of businesses violate the minimum wage law. It is not surprising therefore that as of August 1992, 47 million Filipinos, or about 80 percent, lived under extremely poor conditions.

As if lowered and devalued family incomes were not enough problems, there was also a continuous rise in the prices of goods and services by 13.8 percent between 1985 and 1988. Medicinal and pharmaceutical products rose by almost 29 percent and medical services by almost 20 percent between 1985 and 1988.

In so many ways, health is dependent on medicines, unless one relies completely on herbal concoctions and prescriptions handed down by *herbolarios*. The implementation of the 1990 National Drug Policy has failed however to provide much-needed drugs at affordable prices to most Filipinos. In fact, the common observation is that even with the Generics Law, the prices of medicines, especially antibiotics, were increasing rather than becoming affordable.

A possible reason is the fact that multinationals and large foreign drug companies continue to dominate and control the Philippine drug industry. Of the 40 leading drug manufacturers, 32 are multinational corporations (MNCs). Among these MNCs are Abbott Laboratories, Zuellig Pharma, Pfizer Laboratories, Wyeth-Suaco Laboratories, Inc. and Ciba Geigy Philippines, Inc. In 1988 these MNCs accounted for 74 percent of total sales and 80 percent of total profits in the industry (*Health Alert* 95, July 1989).

Health Resources and Budget

The research findings noted the lack of logistics so that many health centers and health personnel are forced to render medical care with minimal resources. Health manpower to population ratios computed by the United Nations Children's Fund (UNICEF) reveal the state of service delivery in the country. In 1985 there was one doctor for every 6,413 Filipinos. Government health facilities were manned by 6,315 physicians at a ratio of 1:999. With 9,112 nurses, the ratio to the populace is 1:6.365. There were 10,827 midwives for an average of 5,367 people per midwife; rural sanitary inspectors numbering 2,355 take charge of an average of 12,463 people each, while the ratio for dentists to the population is 1:4,700.

Health centers, the health-implementation agencies at the grassroots level on which so many depend for their health needs, service an average of 28,323 people. Hospital beds numbering 47,701 to service 58 million Filipinos mean a ratio of one bed for every 1,215 patients.

Most health personnel, particularly nurses and doctors are poorly paid, work in inferior conditions and lack opportunities for professional growth. These factors have contributed to the aggravation of the country's "brain drain" phenomenon.

A 1987 survey conducted by the Alliance of Health Workers found that about 85 percent of public health workers receive a monthly salary of less than 3,000 pesos, which places them way below the poverty line (*Health Alert* 95, July 1989).

While the Philippines is the world's premier exporter of nurses and the second-leading exporter of doctors, a study by the Philippine Nurses Association (PNA) showed that 30 to 40 percent of the need for nursing personnel is unsatisfied. In the Philippine General Hospital (PGH) alone, the turnover rate of nurses is 100 a week (*Health Alert* 95, July 1989). Meanwhile, according to the same PNA study, one out of every two Filipino nurses is abroad, with over 90,000 seeking employment outside the country.

Doctors who have emigrated mostly to the United States range from 9,000 to 10,000 (Philippine Agenda, 16-31 July 1989). This could partly explain why many positions for Municipal Health Officers and Resident Physicians for rural areas have remained vacant for many years. Small wonder then that the only medical personnel often encountered by the rural folks is the underpaid and overworked rural health midwife.

A very low priority for health is apparent in the national budget.

A proposed budget of 9.5 billion pesos for 1989 was cut down to 7.4 billion pesos. Wrong priorities for the country may be gleaned from the fact that the defense allocation in the budget are three times that for health. From 1987 to 1989 this higher premium on defense and the debt burden persisted as shown by the following table:

**Table 6-1 Budget Allocations,
Selected Government Agencies, 1987-1989**

Items	Levels (in billions)			Percent Distribution		
	1987 :	1988 :	1989 :	1987 :	1988 :	1989
Education, culture & manpower dev't.	17.0	21.9	29.9	10.9	11.5	13.1
Health	4.1	6.0	7.3	2.6	3.1	3.2
Defense	12.6	16.8	20.8	8.1	8.8	9.1
Debt burden	77.8	86.8	100.4	50.0	45.5	43.0
Total	155.5	190.7	228.9			

Source : Department of Budget and Management

The percentage of total income allocated to medical care in 1988 dropped to 1.67 percent from 2.1 percent in 1985. As a priority concern of the government, health care was regarded as less important, next only to tobacco, alcohol and taxes.

Political Dimensions of Child Health

The previous discussions have shown that the government has not been wanting in terms of legislations directed at promoting child health. In addition, the Medium-Term Philippine Development Plan of 1987-92 provides for the expansion and improvement of basic social services, with priority given to the population living in subsistence conditions (cited in UNICEF, 1987: p.138).

In April 1986, as a sign of government support for the breastfeeding and immunization campaigns launched by the Health Department with the active assistance of the World Health Organization (WHO), President Corazon C. Aquino proclaimed June 1986 to May 1987 as the Year of the Protection of Exploited Filipino Children. Subsequently, in August 1986 the President created a task force to formulate a national plan of action for the protection of children in especially difficult circumstances such as children in armed conflict, working and street children, sexually exploited, abused and abandoned children.

In November 1986, the National Milk Code (National Code for Marketing of Breastmilk Substitutes) aimed at promoting breastfeeding among mothers was also enacted by the Aquino Administration. However, three years after its passage, the Milk Code remains largely unimplemented. Hospitals continue to violate the policy by allowing milk company representatives ("med reps") to give free samples of infant-formula products and baby books directly to mothers or indirectly through doctors or nurses (*Health Alert* 83, 15 Oct 1988).

Mention has also been made in the previous chapters of the five impact programs of the DOH such as Maternal and Child Health, Expanded Program on Immunization (EPI), Control of Diarrheal Disease and Dental Health.

These good intentions, notwithstanding, the child health situation has not improved in substantial qualitative terms as already discussed. With an

EPI immunization rate of 70.98 out of an eligible population of 1,856,806 in 1988 or .98 above the minimum target set for the year, the mortality rates of immunizable diseases particularly measles and tetanus continue to be high and way above global rates (1988 DOH Annual Report cited in *Health Alert* 95, July 1989). Measles incidence has rapidly increased through the years.

Malnutrition remains a major problem among 70 percent of preschoolers in 1987 despite the fact that growth standards are even lower than those prescribed by international agencies like WHO.

The steady increase in the number of births attended by *hilots* both in urban and rural areas is an indication of the rising costs of hospitalization and private doctors, if not the persistence of traditional beliefs and practices.

The number of out-of-school children and unprotected children workers continues to rise because of low incomes and unstable, irregular sources of income.

What is clearly lacking is the political will not only to end the country's status of underdevelopment but also to implement all health laws pertaining to children.

Recent intensified military operations, bombardments, strafings, economic and food blockades have had their greatest effects on children and increased the number of "internal refugees" or people forced to leave their homes, farms and properties as a result of intensified military operations and bombings carried out by the Armed Forces of the Philippines (AFP) in various parts of the archipelago. The number of such families could easily come up to thousands; in 1988 alone there were an estimated 55,287 families or 337,522 individuals displaced (*PDG*, 17 Sep 1989, p. 17).

The gloomy outlook for Filipino children today is rooted in the nature of the economic, political and cultural structures prevailing in the country. Inequality, poverty, powerlessness and injustice are the very conditions that perpetuate poor health especially among children.

Cultural Dimensions

The Filipino child's health hinges not only on economic and political factors. High gross national product (GNP), for instance, does not always translate to better health conditions, as shown by some Middle Eastern countries with high national incomes. Economic advantage does not automatically guarantee optimum health for the citizenry.

Widespread poverty has its concomitant "culture of poverty" which only makes things more miserable for the Filipino child.

This study has pointed out the predominance of erroneous ideas and traditional beliefs and practices bordering on the superstitious. Traditional family and community beliefs on health and illness generally have adverse effects on the medical care innovations introduced by outside agencies.

In a male-dominated society like ours, the mother's level of knowledge is crucial to child health. This is so since she is primarily responsible for taking care of and bringing up the children in the family.

The mother's social milieu is replete with influences affecting her attitudes and behavior towards maternal and child care. Her educational background (which is often inadequate), the presence of elders in the household with their traditional beliefs and practices, and the mass media, all come into play in the different aspects of child care like nutrition, immunization, sanitation, illness, *etc.*

Aside from the family, the mass media is another socializing agent which has greatly contributed to the sad state of children's health. It has been instrumental in the dissemination of certain misconceptions and wrong practices in relation to child health. Housewives and other family members are bombarded daily with all sorts of consumer products that cultivate distorted values and a consumer-oriented lifestyle. Food industries, for instance, have used the mass media to promote junk food and artificial milk formulas as the best way to bring up healthy and intelligent children: among these products are instant noodles, fruit juices and chocolate milk.

Even the drug industry has recognized the role of mass media in boosting its sales and profits by propagating the so-called "pill culture." Many

Filipinos have been made to believe that "there is a pill for every ill" and the more serious the disease, the more medicines should be taken (IBON, 1986). As a result, many people have become so-called pill poppers; this has also led to the reduction of the threshold for pain. Take for instance ordinary cough and colds, ailments that are essentially self-limiting, meaning that these run in due course and thus people need not take medication. In the market are cough and cold remedies which are generally inessential and yet enjoy popular patronage. In 1984, some 240 million pesos were spent for cough and cold preparations, making such drugs among the top sellers, second only to antibiotics (IBON, 1986).

Through false advertising, erroneous ideas and wrong practices related to health and illness are propagated by drug companies who, in turn, reap tremendous profits. The truth of the matter is that drug companies spend millions of pesos on promotions, advertisements and marketing of drugs and pharmaceutical products which are passed on to the consumers at exorbitant drug prices. One study estimated that for every peso paid by the public on drugs, about 20 to 50 centavos go to promotional expenses (Gabunada, 1983).

The elitist and commercialized character of education and training for health professionals also bears on the state of children's health in the country. The very high cost of medical and nursing education have made doctors and nurses view their profession as a business instead of a public service. To recoup educational expenses, these health practitioners charge exorbitant fees to patients, if they don't leave the country in search of higher salaries and better working opportunities abroad and/or stay in urban centers where there is a concentration of population that they can service.

Moreover, the western and curative orientation of the health professions have added to health care's inaccessibility and its insensitivity to the real needs of the people. The training received by doctors, for example, with emphasis on the use of advanced technology and equipment, usually in a hospital setting, have made it difficult for them to adapt to situations that fall short of the requirements of the environment they have been oriented to.

In conclusion, the Filipino child's health is determined by the interrelationship and dynamics of several factors, namely economic, political and cultural. Dealing with the major problems besetting children's health entails resolving the nation's fundamental economic, political and cultural ills. Only by decisively doing so can we expect to shape a bright and better future for the Filipino child. Decisions made today will become tomorrow's realities. And the Filipino child has waited for too long for its own good.

Chapter seven

*R*ecommendations

The improvement of child health is the responsibility of society and its government, of the citizenry through group or individual action and of parents and their children. It is also the responsibility of the family of nations through official action and through the efforts of international professional and charitable organizations.

But such a formidable array of protective barriers may mislead one into presuming that nothing could possibly harm the child. In the event of injury or sickness, the child would promptly be restored to health. Unfortunately, not all of these safeguards are in place, and are often unrealized. It would seem that the world, the nations, the helping organizations, the parents and their children are spending only part of what they should in terms of resources and attention to the total effort for child health.

From this premise may be drawn the reasonable expectation that if everyone performs his or her role a little better, child health can also advance a little better. And if everyone seriously took the adage that the world owes the child the best it can give, there would be a golden era of an optimum possible level of child health. Therefore, the key to the desired child health improvement is that good intentions should be matched by good deeds to the limits of resource and ability.

This study has pointed out the factors that continue to detract from significant improvements in child health and recommends the following courses of action:

1. The Government still carries the heaviest burden as mandated by the Constitution. "It needs to protect and promote the life of the mother and the unborn from conception" (Sec. 2, Art. II). It "shall endeavor to make health services available to all the people at affordable cost (Sec. 11, Art. XIII). And in the spirit of all

these constitutional provisions, it shall have a national health policy and obviously shall enforce the policy.*

However, all of these constitutional provisions are so broad, and need to be restated so as to respond to particular problems and concerns, either by implementary or ancillary legislation or by the issuance of executive policies or instructions.

It has been previously noted that there actually exist in Philippine statute books a plethora of laws concerning health. It is recommended therefore that a review commission be formed composed of representatives of the Department of Health (DOH) and the Philippine Medical Association and its affiliate societies with legal guidance from the Department of Justice and the Integrated Bar of the Philippines. The Commission could be formed with the following goals in mind:

- ☞ To scan the volume of laws and prescribe the means for effective application of these;
- ☞ To identify those that are outdated and need revision;
- ☞ To enact new laws that are needed to complete the statutory support for the constitutional declarations. An example of these new laws is one that specifies the help to be given to injured, suffering or abandoned children in areas of armed conflict; and
- ☞ To codify all statutes relating to child health. It is necessary to have a Code of Health with a distinct chapter on Child Code, just as we have a Civil Code, a Penal Code, a Code of Commerce and Family Code. A Health Code enforceable by the year 2000 would mean legally protected health for all, including children. Codification will have the added advantage of coordination and interrelating all laws and regu-

* The reader is referred to the concise but comprehensive Philippine Plan of Action for Children entitled "The Filipino Children: 2000 and Beyond" prepared for the Welfare of Children and adopted on 31 January 1992 (Appendix A).

lations pertaining to health and impetus provided for health jurisprudence.

2. The aspect of implication and application of laws pertaining to Child Health rests squarely on the Health Department and in some measure on the Department of Social Welfare and Development.

It is recommended that :

- ☞ Dependable professionals should be chosen for top level positions in these departments, especially at the DOH;
- ☞ While the department head is a political appointee, undersecretaries, assistant secretaries and occupants of other key positions should be career officials and beyond politics;
- ☞ Logistics should be an intrinsic and concomitant element of intents and purposes. All public health projects should thus be adequately funded and the budget sufficient for health needs;
- ☞ For a cash-strapped economy like the Philippines, there should be further rationalization of the use of logistics. Thus, allocations for luxuries should be deferred. Among these items are unnecessary official travel and costly vehicles. Money for such should be allocated to grassroots health implementation;
- ☞ Public organizations and nongovernment organizations (NGOs) dealing with health should participate in budget hearings. This has yet to be done . It should be recognized that the health budget does not belong exclusively to the Department of Health but to all the people;
- ☞ To augment meager health funds, private organizations or NGOs, both medical and nonmedical explore the possibility of establishing foundations to support child health and welfare projects. Certain foundations can promote health

education which entails costly instructional materials. Others can concentrate their efforts on young minds in school to produce supplementary health education materials tailored to regional or provincial needs, and in the local language if necessary.

3. The health professions have an important role to play and have exerted efforts to contribute in the improvement of child health. The principal actor here is the Philippine Pediatric Society with the encouragement of and coordination with the Philippine Medical Association and its other affiliate specialty societies. It is further recommended that :

- ☞ Pediatrician manpower should be increased; there should be more of Filipino pediatricians. If general practitioners have neither time nor opportunity to earn an accreditation in the specialty of pediatrics, they can at least gain capabilities in the management of the major pediatric problems of their locality;
- ☞ Pediatric subspecialties, especially in surgery, cardiology and gastroenterology, should be developed;
- ☞ Pediatric research should be encouraged especially at the local level, with results actually applied to concerned areas;
- ☞ Research results should be publicly disseminated and not allowed to gather dust. All it takes is some thoughtful individual or society to collate all these research data from as far as 50 years back to serve as information for doctors and sourcebook for science writers in the mass media; academic institutions, especially medical schools could play this role of collation and dissemination of research results; and
- ☞ The Philippine Pediatric Society can learn from the experience of countries with which it has contacts through its

membership in the International Pediatric Association. In other countries,

- ➡ mothers are required or motivated to keep booklets of medical attention or services for their children from birth to a certain age , say preschool;
- ➡ growth and treatment of individual children, including immunizations are also monitored;
- ➡ such *librettas* can produce the pediatric profile of a country or locality therein and provide invaluable data to pediatricians, policymakers, health implementors and even parents and teachers; and
- ➡ such a booklet is a veritable passport to enrolment in elementary grades, particularly in our country. The booklet may carry the child's fingerprints for identification purposes and serve as an acceptable document in lieu of lost birth certificates.

4. The following steps or measures are also recommended to further improve child health:

- ☞ use of the proposed under-5 (U5MR) mortality rate as a more accurate indicator of the state of a nation's children

This indicator has the following advantages. To quote from the State of the World's Children(1990):

It measures an end result of the development process rather than an "input" such as school enrolment level, per capita calorie availability or the number of doctors per thousand population—all of which are means to an end.

Secondly, the U5MR is known to be the result of a wide variety of inputs: the nutritional health and the health knowledge of mothers; the level of immunization and ORT use; the availability

of maternal and child health services(including prenatal care); income and food availability in the family; the availability of clean water and safe sanitation; and the overall safety of the child's environment.

Thirdly, U5MR is less susceptible than say, per capita GNP to the fallacy of the average. This is because the natural scale does not allow the children of the rich to be one thousand times as likely to survive even if the man-made scale does permit them to have one thousand times as much income. In other words, it is much more difficult for a wealthy minority to affect a nation's U5MR and it, therefore, presents a more accurate, if far from perfect, picture of the health status of the majority of the children .

- ☛ **sustained protection of breastfeeding and the strict implementation of the Code for Marketing of Breastmilk Substitutes and the “baby-friendly” hospital initiative for hospitals and maternity units**

It has been noted that the incidence of breastfeeding continues to decline inspite of promotion campaigns. Breastfeeding's advantages are well-documented. Bottled babies are 15 times more likely to die from diarrheal disease and four times more likely to die from pneumonia than babies exclusively breastfed.

- ☛ **family planning should be encouraged and knowledge further disseminated as an important promoter of child health**

One of the goals of the 1990 World Summit for Children is that by the year 2000, all couples should have “information on the importance of responsible planning of family size and the many advantages of child spacing to avoid pregnancies that are too early, too late, too many or too frequent.”

Family planning can have a profound effect on both maternal and child health and deaths, the quality of life and the occurrence of malnutrition, including birth weights, and

eventually, even on the great planetary problem of environmental degradation. Family planning should not be denied anyone and the knowledge and the means to plan births, with consideration for religious, cultural and societal mores and customs, should be provided to people.

- ☞ *hilot* training should continue until such time that professional health workers will be available for mothers

This research noted that almost half of deliveries continue to be attended to by *hilots*.

- ☞ education and literacy should be continuously provided

In the last couple of decades, the sad state of Philippine education has contributed to a decreasing literacy rate. Basic education for all is a necessary precondition for an economic takeoff. Providing basic education has been proven to be economical with far-reaching effects on people's attitudes, more enlightened civic, social and political participation, and a better capability to take care of one's self, including his health.

5. Other important factors affect the quality of life of Filipino children, particularly those found in especially difficult circumstances such as working and exploited children and children of war.

Below are some recommendations in relation to this issue :

- ☞ The scarcity of data on children and adolescents in especially difficult circumstances stresses the need to devise an efficient and effective information management system. This will help determine areas requiring systematic and thorough studies to help policymakers and legislators come up with relevant and necessary programs and policies for children and adolescents.
- ☞ The widespread, oftentimes unchecked, violations of employers of labor laws and standards regarding the minimum age for employment, and terms and conditions of

employment, make children vulnerable to exploitation. Thus, there is a need for close coordination between government agencies like the Labor Department and the Health Department. This way, there can be a more effective monitoring system that will help ensure strict compliance with labor laws and standards affecting children. Violations of existing labor laws concerning children and adolescents should be meted with stiffer penalties.

- ☞ There should be closer coordination between the government and the private sectors, particularly nongovernment organizations (NGOs), to examine the problem of children in especially difficult circumstances and to recommend appropriate strategies and measures to effectively deal with these problems. The NGOs support should be tapped and maximized by the government considering the former's depth and breadth of work among children.
- ☞ Particularly for sexually exploited children, a strengthening of institutional structures and mechanisms for their treatment, rehabilitation and sanctuary should be made. One way of doing so is through the formulation of appropriate legislative measures.
- ☞ As a signatory to the United Nations' Declaration on the Rights of the Child, the government and its agencies should take concrete measures to ensure its effective implementation. Human rights violations committed against children and adolescents, for instance, will have to be stopped. Mechanisms to monitor the conduct of the various parties involved in the internal conflict persisting in the country will have to be set up. Moreover, concrete steps will have to be taken to make the conflicting armed opposition groups, on the one hand, and the Philippine military, on the other abide by the provisions incorporated in Protocols I and II which stipulate the proper conduct of war and how children are to be protected, to which the Philippine government is a signatory.

So much more remains to be done to improve child health in the Philippines. Our recommendations are only meant to ease the present conditions and make further improvements. In the end, political will, inspired leadership, and a nation's priorities and its health care delivery system are essential factors in determining adequacy of health care. A more enlightened and empowered people can demand and work for better health for all. An increased health consciousness and the means to bridge the gap between knowledge and behavior are an imperative.

Children need all the attention and care they can get for they are the hope of tomorrow. Let it not be said that we have failed them.

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*A*PPENDIX A

Commitment to the Filipino Child
This is Part III of The Filipino Children: 2000 and Beyond
Philippine Plan of Action for Children
prepared by the
Council for the Welfare of Children
31 January 1992

The existing legislations, policy and program initiatives under the National Plan of Action 1990-1992 are subject to review and, where still relevant, would be sustained. On the other hand, the Philippines commits a Plan of Action for the rest of the 1990s that will address the gaps and adjust legislations and policy measures as well as program initiatives to ensure the fulfillment of the declaration on the Survival, Protection and Development of Children and the pursuit of the standards set in the Convention on the Rights of the Child.

3.1 *Family Care and Alternative Parental Arrangements*

Children should grow up in a family, in an environment that facilitates their socialization and provides affective, emotional, and moral security and stability. The rights and responsibilities of parents or the extended family, or other persons legally responsible (e.g., adoptive parents or legal guardians) to direct and guide the child according to his/her development capacities to exercise his/her rights shall be respected.

3.1.1 Legislative and Policy Measures

The rights that parents have over their children are based on their responsibility to promote the welfare of their children. Government may intervene in the family to protect children under its "parents patriae" and police powers since the child is not able to protect himself/herself. This refers to children in especially difficult circumstances for whom alternative parental arrangements are ensured.

Conditions of poverty, however, undermine the obligation of the family to care for their children such that corresponding assistance shall be provided.

- a) Legislations shall be enacted to ensure rehabilitative services and stricter sanctions on erring parents or parents who fail in their responsibilities toward their children including child support obligation of the absent or erring parents.
- b) The Appropriations Act shall ensure funds for the financial support of poor families to care for children.
- c) Social security measures particularly with regard to nutrition, clothing, housing and other benefits for solo parents and other needy parents shall be covered by law.
- d) Both parents and substitute parents have common responsibilities for the care and development of the children. However, appropriate assistance in the rearing of the children is expected from the State, including financial or material assistance particularly with regard to minimum requirements for nutrition, clothing and housing.
- e) The separation of children from their families shall be prevented and shall not be against their will:
 - 1) if separation is necessary for the child's best interests or is due to circumstances beyond control, appropriate alternative care, e.g., adoption, foster family care or residential care within the children's cultural upbringing shall be provided;
 - 2) competent authorities shall determine in accordance with applicable law and procedures that the separation is for the best interest of the child, as in the cases of abuse or neglect and exploitation. Such law and procedures shall be passed.
- f) Support and financial assistance to meet the special needs of the children under alternative care shall likewise be ensured by legislation.
- g) The legal capacity of licensed/accredited social workers to remove a child from parents caught in the act of abusing, exploiting or neglecting a child for protective custody without court action shall be legislated with the corresponding funds for the special needs of the children.

- h) Further, to ensure that the separation of a child, Article 87, PD 603 shall be amended to authorize the Department of Social Welfare and Development to accredit/delegate the chairman and members of the Barangay Council for the Protection of Children to assume protective custody of children to be separated from their parents until appropriate placement is decided by a social worker.
- i) When parents are living separately and a decision has to be made as to the child's place of residence, Articles 204, 213, 214, 216, 217 of the Family Code shall guide the action. However, the rights of the child who is separated from one or both parents to maintain contact, when indicated, shall be supported by legislation.
- j) The child shall be informed of the whereabouts of his/her parents when the separation is due to detention, imprisonment, exile, deportation or death while in custody of the State, if such action is not detrimental to the well being of the child. This action shall be covered by legislation.
- k) There shall be an integration of concepts on responsible parenthood in school curriculum to prepare children when they would be parents themselves and in pre-parenthood counselling for prospective parents.
- l) There shall be a legislation to require licensing not only of child caring facilities but also of child care providers, e.g. *yaya*, domestic helpers, dormitory personnel, etc.
- m) The rights of the child to preserve his/her identity, nationality, name and family relations and to be provided assistance and protection to reestablish his/her identity shall be recognized by law. This shall include the prevention of the simulation of births and the preservation of the confidentiality of birth certificates and faithfulness of the entries with the corresponding penalties for violation thereof.
- n) Reunification or maintenance of personal relations of a child with his/her parents who live in another country shall be ensured un-

less otherwise curtailed for the best interests of the child or is inconsistent with the rights of others. Legislative measures to govern this action are indicated to include appropriate provisions in citizenship and immigration especially of unaccompanied child refugees.

- o) Adoption of children shall be processed only by the Department of Social Welfare and Development which will determine in accordance with applicable law and procedures and reliable information that adoption is for the best interest of the child. Further, the parents, relatives and legal guardians, the child himself when indicated, shall have given their informed consent after due counselling.
- p) Inter-country adoption shall be considered only if the child cannot be adopted or cannot be placed in foster care or in other suitable placements in the country and such arrangements shall be covered by bilateral or multilateral agreements of the governments or state welfare departments. Further, the right of the child to enjoy standards of care equivalent to, if not better than, those existing in the Philippines and that the placement is carried out by competent authorities and does not involve financial gains for those involved, shall be ensured through bilateral/multilateral agreements of the governments concerned. The passage of the legislation on inter-country adoption with such conditions to augment the provisions of Article 184 of the Family Code is reiterated. There shall be a definition of competent authorities, informed consent and information considered pertinent to financial gain.
- q) Private adoption shall not be allowed and penalties for anyone including members of the child's family who are involved shall be meted out by law.
- r) Children who are deprived of family care and protection, including medical treatment or schooling out of the country or out-of-town, shall be provided alternative care and assistance to include dormitory arrangements, foster family care, kafalah under Islamic law, placement in suitable residential accommodations or adoption. Continuity of the child's positive upbringing and ethnic,

religious, cultural, and linguistic background shall be provided by law. Corresponding budgetary allocation for these purposes shall be legislated.

- s) Preserving the family unit, on behalf of children during evacuation or of refugees, shall be assured and corresponding policies or legislative measures shall be enacted.
- t) The issuance of a family card for each child with corresponding indicators of well being and development shall be required by law. This shall include growth monitoring.

3.1.2 Programs Proposed

The corresponding program initiatives or interventions are proposed to carry out the commitment to children in the 1990s:

- a) Rehabilitative Parenting Services for parents who cannot be benefited by current Parent Effectiveness Services to ensure that they are able to assume their responsibilities as parents and develop nurturing attitudes toward their children;
- b) Supervised Extended Family and Surrogate-Parent Care to preserve the traditional/cultural relevance of the extended family while providing alternative parental care for the child;
- c) Surveillance and Protective Custody by the accredited Barangay Council for the Protection of Children and by accredited social workers;
- d) Supervised Information of Parental Visits for children separated from one or both parents in country or abroad to maintain family relationship;
- e) Supervised Registry of Births and Maintenance of Family Cards to prevent simulation of birth and faithfulness of entry of information on the child while monitoring child development.
- f) Assistance in Acquisition of Status refers to activities related to immigration or citizenship status of child to be reunited with parents;

- g) Improved Child Placement Services to include promotion and mandatory supervision of local adoption, inter-country-adoption, inter-country foster care for children needing medical treatment or on scholarship abroad, dormitory arrangements, subsidized foster family care, day care, home aide service or other alternative care for children;
- h) Special Social Services to Solo Parents to include emotional support, psycho-social adjustment, social security measures and child support obligation of the absent parent when indicated;
- i) Task Oriented Family Counselling refers to building of skills in decision making and preparing family members to attain emotionally balanced relationship and create a facilitating environment for children;
- j) Aid to Families in Economic Crisis to include immediate provisions for food, clothing, shelter and medicine to families with children and corresponding assistance for income generating activities to prevent children from being separated from the family;
- k) Pre-Parenthood Orientation for couples preparing to be parents prior to marriage and during pregnancy.
- l) Supervised Parent-Effectiveness Peer Counselling refers to groups of parents counselling one another about parent effectiveness under supervision of a social worker; and,
- m) Media-Based Family Development to include review of the implications of media releases to family life and parental responsibility towards children.

3.1.3 Research Agenda

- a) Research on solo parenting, overseas employment of one parent, unwed motherhood, separated and widowed parents and implications to children
- b) Values dissemination by media and implications to family life

- c) Alternative aid to families in economic crises
- d) Evaluation of existing and proposed programs on family care
- e) Research on long term consequences of local adoption and inter-country adoption and foster care

3.1.4 Goals and Targets for Family Care and Alternative Parental Arrangements

Ensuring that the Filipino child will be reared in a nurturing family setting with proper parental guidance, the concerted thrust of government and non-government organizations shall be geared towards the promotion of family stability. The State shall take the lead in providing substitute parental arrangements approximating that of a complete home environment.

Along this line, the following are the major targets annually :

- a) Promotion of responsible parenthood for 80 percent of disadvantaged families and reduction in the number of abandoned and neglected children by 80 percent;
- b) Rehabilitation of erring parents by 60 percent as a result of Rehabilitative Parenting Service and return of 80 percent of children to the family.
- c) Provision of special social services to 70 percent registered solo parents resulting in improved child caring;
- d) Availability of improved child placement services for 80 percent of children in care;
- e) Provision of aid to families in economic crises and income generation for 80 percent of families registered; and,
- f) Maintenance of family cards for 90 percent of children born in the 1990s, children in day care centers and elementary schools.

3.2 *Basic Health and Nutrition, Social Security, and Safe Environment*

3.2.1 Legislative and Policy Measures

- a) The right of the child to the enjoyment of the highest attainable standard of health and facilities for medical treatment shall be defined, if possible, through legislation indicating the standards thereof and extent of full implementation against which to measure progress for year 2000;
- b) A legislation to identify practices prejudicial to the health and nutrition of children and establishing monitoring system thereof shall be enacted;
- c) The danger and risks of environmental pollution shall be considered and more effective legislation to prevent the same shall be enacted;
- d) Appropriate prenatal and postnatal care to diminish infant and child mortality shall be covered by legislation that provides adequate budgetary allocation;
- e) Legislation on the development and implementation of primary health care by local governments shall be enacted;
- f) Periodic review of treatment provided a child for his/her physical or mental health shall be a subject for policy of the government;
- g) Social security measures, including social insurance, shall be insured especially for children who are without parents. Legislation to subsidize same shall be enacted;
- h) Legislative provisions to ensure children a standard of living adequate for their physical, mental, spiritual, moral and social development shall be proposed considering that parents have the primary responsibility to secure the same. Grants to support programmes with regard to nutrition, clothing and housing shall be legislated for local governments to provide;

- i) Health insurance for children;
- j) Compulsory immunization against immunizable diseases including hepatitis B for children below 8 years old shall be legislated; and,
- k) A law protecting the life of the unborn considering the widespread availability of abortifacient drugs and devices shall be provided.

3.2.2 Programs Proposed

Programs for health and social security are in place. What would be needed to support the legislative measures besides adequate funds are :

- a) Sustained health and nutrition surveillance;
- b) Expanded breastfeeding programs;
- c) Family nutrition and community-based primary health and nutrition intervention;
- d) Free medical treatment for the medically indigent children, low cost medicine and health insurance;
- e) Expanded hygiene and environmental sanitation programs to include solid waste management;
- f) Safe drinking water provision;
- g) Woman-focused health and nutrition program;
- h) Support food assistance, food production, micronutrient supplementation and nutrition education;
- i) Expanded growth monitoring program.

3.2.3 Research Agenda

- a) Review of primary health care's non-formal education/training effectiveness
- b) Review of health care delivery system

3.2.4 Targets for Basic Health and Nutrition, Social Security and Safe Environment

- a) Reduction of infant mortality rate from 61.0 per 1,000 livebirths in 1990 to 37.6 by 2000;
- b) Reduction of child mortality rate from 5.3 per 1,000 child population in 1990 to 4.4 by 2000; and continuing immunization;
- c) Reduction of maternal mortality rate from 0.8 per 1,000 livebirths in 1990 to 0.6 by 2000;
- d) Access to safe drinking water supply by 97 percent of Metro Manila populace, 96 percent in urban areas and 93 percent in rural areas;
- e) Access to means of environmental sanitation (toilet construction and garbage/sewage disposal) by 94.3 percent of the rural population;
- f) Reduction in the prevalence of severely or moderately underweight preschoolers from 14.0 percent in 1990 to 7.0 percent by 2000;
- g) Reduction in the prevalence of severely and moderately underweight children, 7-10 years, with weight less than or equal to 70 percent of the standard weight-for-age from 5.5 percent in 1990 to 2.0 percent by 2000;
- h) Reduction in the rate of low birthweight to less than 10 percent;
- i) Virtual elimination of the consequences of iodine deficiency disorders in hyper-endemic areas;
- j) Virtual elimination of Vitamin A deficiency and its consequences, among others, night blindness; and,
- k) Provision of low cost medicine and promoting health insurance for children.

3.3 *Basic Education, Leisure, Recreation and Cultural Activities*

The urgency of providing basic education to all children as a strategy for accelerating individual and social development has soured the Philippine government to join the worldwide movement on Education For All. A major boost to its advocacy is the declaration of the 1990s as the Decade of Education For All (EFA), in line with global effort to meet basic learning needs of children and their parents in the 1990s and beyond.

As espoused in the Philippines' Education For All - Program of Action, (1991-2000), education of the Filipino is anchored on the philosophy of humanism and egalitarianism. Its primary goal is directed towards achieving universal basic education.

3.3.1 Legislative and Policy Measures

- a) Policies that will improve the quality and relevance of basic education and accelerate its provision to the rural poor, the urban slums, cultural communities, refugees, women, the disabled and other disadvantaged groups shall be enacted;
- b) Policies shall be issued to facilitate the development and accreditation of innovative delivery mechanisms for basic education particularly in areas where the aforementioned disadvantaged groups are located;
- c) Likewise, policy measures shall be instituted for the establishment of a viable system that will ensure continuum of the formal and non-formal education. In doing this, there shall be a corollary policy that the provision of basic education shall be pursued with due respect to the culture and heritage of the communities;
- d) To further ensure quality education, entrants shall be given physical, medical and mental examinations upon enrolment;
- e) The Anti-Truancy Law shall be reviewed with the end in view of strengthening the monitoring of compliance to free elementary education and include stronger sanctions on parents who do not send their children to school.

3.3.2 Programs Proposed

- a) Aside from increasing the provision of relevant educational components to (i.e., teaching-learning equipment and facilities, textbooks and other instructional materials; training, retraining and other opportunities that will continually upgrade/update the capabilities of teachers), innovative programs shall be developed and existing ones vitalized to adequately respond to the needs of children in especially difficult circumstances. The development of more viable and relevant education shall be accompanied by a strong and timely accreditation program. There shall be provision for the special need of disadvantaged children within the school setting. This means providing them with school-based health, nutrition and informational services.
- b) While basic education is free, there shall be a supplementary program of subsidizing the most disadvantaged groups so that the other cost of education such as transportation, food and school materials are provided for.
- c) Furthermore, the values education program shall have to be intensified with focus on developing consciousness and pride in our cultural heritage, respect for human rights, love of work, and concern for ecological balance.
- d) Educational programs which will promote scientific literacy and thinking shall be pursued to ensure the preparation of our children to take on the responsibility of sustaining the country's development.
- e) To ensure relevance and effectiveness of education, consultation with the end-users or the students and new graduates shall be a built-in component/activity.
- f) Lastly, the expansion of early childhood care and development services shall be accelerated through the home-based approaches as well as the Day Care Service. Early Childhood Care and Development services shall be further strengthened as a focal point of values education since, as previously mentioned, the first six years of life is considered as the formative years.

3.3.3 Research Agenda

- a) Study on the most effective delivery of non-formal interventions by the different sectors
- b) Study on the disparity between male and female literacy levels and reduction in regional disparity
- c) Reverse relation between grade level and achievement rate
- d) Study on the relevance of education

3.3.4 Targets for Education, Leisure, Recreation and Cultural Activities

- a) Access to early childhood care and development services by 90 percent of the total population;
- b) Attainment of 100 percent participation rate in the elementary level;
- c) Improvement in the cohort survival rate from 68.33 percent in 1990 to 80.0 percent by 2000 in the elementary level;
- d) Improvement in the achievement level from 64.0 percent in 1990 to 75.0 percent in 2000 in the elementary level;
- e) Increase in basic literacy rate of out-of-school children and parents from 89.9 percent to 98 percent by the year 2000;
- f) Increase in the functional literacy rate of out-of-school children and parents from 73.2 percent to 85 percent;
- g) Reduction in the disparity between male child and female child literacy levels; and,
- h) Expansion of leisure, recreation, cultural and sports activities in 80 percent of the barangays/villages in every city and 50 percent of the barangays in every municipality in view of the widening responsibilities of local government units.

3.4 Protection of Children in Especially Difficult Circumstances

Recognizing the immediate need of children in especially difficult circumstances, the general thrust shall be on providing greater opportunities for their protection and total development. Specific attention shall be given to increasing the access of children in cultural communities to basic social services; protection and rehabilitation of abused, neglected, exploited and abandoned children; reduction in the incidence of delinquent youth, youth offenderd and drug dependents; banning of children in hazardous occupations/situations; and the promotion of the concept of children as Zones of Peace.

3.4.1 Legislative and Policy Measures

- a) Legislations shall be enacted to protect children at all levels from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment, sexual abuse and exploitation. Such legislations shall designate the Barangay Councils for the Protection of Children as the agents for the information campaign, prevention, surveillance, early detection and protective custody of children and the social workers of both DSWD and NGOs as the providers of service for the physical and psychological recovery and for the reintegration of the children so affected.
- b) Further, the legislation shall provide that psycho-therapy and other rehabilitative services prior to the return of the child to the parents or social preparation for the transfer of parental authority to the State from the erring parents will be handled by competent social workers.
- c) In addition, legal provisions establishing prenatal abuse, sexual abuse and exploitation, trafficking and sale of children, torture, physical violence and use of children in armed conflict as crimes and corresponding penalty shall be set. Priority allocation of resources (*e.g.*, competent personnel and funds), shall likewise be legislated.
- d) The special needs of a mentally or physically disabled child shall be recognized and assistance extended to ensure that the child achieves the fullest possible physical and psychological recovery and social reintegration. Such concern shall be covered by legis-

lative measures to ensure preferential attention for subsidy, competent staff and other resources. It shall be a policy to link with other countries for exchange of information and technology concerning methods of rehabilitation, vocational service and other special protection measures for disabled children.

- e) While there are some ethnic, religious or linguistic minorities, children belonging to these groups shall not experience discrimination of any kind and should enjoy their own culture, practice their religion or use their own language during their childhood. Such a condition shall be backed by legislation.
- f) Legislative measures against abduction, sale, child trafficking or the illicit transfer and non-return of children abroad, as in the cases of pedophiles and illegal inter-country adoption, shall be enacted. These shall include the requirement for bilateral or multilateral agreements to monitor and prevent these unfortunate situation of children in foreign lands. However, emphasis shall be given on alternative care and protective measures as in foster family care and adoption within country.
- g) The minimum age for admission of children in part-time and light economic activities, and categorically define such activities and conditions of work (e.g., work shall not interfere with schooling or endanger health, work for cultural and artistic pursuit and not for purposes of promoting alcoholic drinks, cigarettes or violence) shall be legislated to protect children from exploitation by their own parents and employers and ensure their physical, mental, social, spiritual, and moral development. Such legislation shall provide appropriate sanctions to ensure compliance.
- h) Children and pregnant women shall be prevented from using narcotic drugs and psychotropic substances and in the production and trafficking of such substances and more effective legislation for the protection of children and stricter sanctions against drug trafficking should be passed. This legislation shall include surveillance and early detection by the Barangay Council for the Protection of Children, rehabilitation services by social workers and other specialists.

- i) Legislations shall be enacted to eliminate torture or other cruel, inhuman or degrading punishment of children, even by parents. Such shall apply not only for youth offenders but also for those who commit offenses not punishable by law. Further, the arrest, detention, or deprivation of liberty of a child who committed an offense shall be used only as a last recourse and for the shortest appropriate period, taking into account his/her developmental needs. Such conditions, in addition to the child's being separated from adult criminals, and maintaining contacts with his/her family, having prompt access to legal and other guarantees for upholding the rights of the accused, shall be the subject of review in aid legislative measures that should be passed.
- j) Measures to ensure that children do not participate in armed conflict and other hostilities and that children are protected from armed conflicts shall be legislated. Further, measures for the physical and psychological recovery and social reintegration of children who have been adversely affected by armed conflict shall be provided. Similarly, special protective measures for children victims of natural disaster are in order.
- k) Juvenile and Family Courts and deputize Katarungang Pambarangay (Village Courts) to decide on cases involving children in especially difficult circumstances shall be established.
- l) Foster care or apprenticeship homes, homeaides or other supplementary care arrangements for neglected and abandoned children shall be subsidized.
- m) Legislative authority of the DSWD for out-of-court declaration of abandonment in uncomplicated cases shall be enacted.
- n) Vagrancy of children shall be discriminalized.
- o) The protection of and assistance to refugee children who are unaccompanied by parents or relative shall be covered by legislation which takes into consideration the principle of non-discrimination of any type and the applicable international law; and bilateral agreements with countries of origin as well as cooperation with U.N. bodies and competent inter-governmental and non-governmental organizations. Differential treatment of unaccompanied

children shall be clearly defined with the end goal of reunification, temporary placement under foster family care or adoption when appropriate.

3.4.2 Programs Proposed

Children under especially difficult circumstances shall not only have the aforementioned legislations but also the following programs to ensure the principle of the best interest of the child.

- a) Early detection, surveillance, intervention programs and enforcement of laws for the prompt protection of the abused, neglected, exploited, and all other children under especially difficult circumstances;
- b) Differentiated physical and psychological recovery and social reintegration program for each category of children under especially difficult circumstances;
- c) Rehabilitation and social preparation program for the disabled children;
- d) Specialized program for ethnic children to ensure non-discrimination of any kind; and
- e) Working children program to develop work ethic, appropriate vocational skills and counselling services;
- f) Psychotherapy and rehabilitation program for parents of children under especially difficult circumstances that are complicated;
- g) Expanded dangerous drugs program to amend ineffective existing ones;
- h) Expanded release on recognizance and diversion program for youth offenders;
- i) Comprehensive program for children in situations of armed conflict;
- j) More access to livelihood and social credit schemes and promote cooperative association among parents of streetchildren;

- k) More preventive and community-based programs focused on values education for families of children, under especially difficult circumstances when the situation is not complicated;
- l) Reunification and specialized treatment program for unaccompanied refugee children and evacuated/displaced children.

3.4.3 Research Agenda

- a) Follow-up study of streetchildren to include crime rate, if
- b) Study on more efficient ways of solving the streetchildren problem disaggregated according to causes or categories of children, e.g., abandoned, delinquent, victim of sexual abuse or exploitation, etc.
- c) Follow-up of study of youth offenders on suspended sentence
- d) Study on the effects of apprenticeship on 7-17 year old children
- e) Study on the adjustment of sexually exploited children
- f) Study on the adjustment of children who are victims of armed conflict
- g) Study on incidence of each category of children under especially difficult circumstances

3.4.4 *Goals and Targets for the Protection of Children In Especially Difficult Circumstances (CEDC)*

The incidence of CEDC cannot be determined except from service data and projections. Recognizing the immediate need of children in especially difficult circumstances, the general thrust shall be providing greater opportunities for their protection and total development. Specific attention will be given to increasing the access of children in cultural communities to basic social services; protection and rehabilitation of abused, neglected, exploited and abandoned children; reduction in the incidence of delinquent youth, youth offenders and drug dependents; banning of children in hazardous occupations/situations; and the promotion of the concept of children as

Zones of Peace.

Specifically, the targets for the protection of children in especially difficult circumstances are as follows :

- a) Provision of supplementary or substitute parental care for 50 percent of neglected children;
- b) Adoptive placement of 80 percent of abandoned children who are legally free for adoption;
- c) Placement of 70 percent of abandoned children in substitute parental care arrangements;
- d) Protection and rehabilitation of 70 percent of the reported abused, exploited children;
- e) Banning of children in hazardous occupations/or situations by 80 percent;
- f) Provision of basic services to 80 percent of children in situations of armed conflict; and,
- g) Physical and psychological recovery and social reintegration of 60 percent of CEDC.

3.5 *Fundamental Civil Rights of Children*

This area of concern refers to the rights of the child to a name and nationality and preservation of his/her identity, to freedom of expression, thought, conscience religion, association and of peaceful assembly and the protection of the child's privacy and unlawful attack on his/her honor and reputation.

3.5.1 Legislative and Policy Measures

- a) The birth of the child determines his/her identity. Thus, there is a need to register the child immediately after birth to enable him/her to acquire the said identity. Hence, a legislation designating the Barangay Councils for the Protection of Children as the body responsible for the early and accurate registration of a child's birth

shall be enacted. A policy shall also be issued to designate and train a birth attendant to be responsible for birth registration. A periodic review of the civil registry system shall also be undertaken to respond to the changing conditions.

- b) A system of regulation among the various print, broadcast and other media of information shall be legislated. The local government units shall issue local ordinances that will define a system of monitoring and imposing penalties against any party responsible over the infringement on the fundamental civil rights of the child.
- c) Similarly, rights of the parents/guardians to extend directions in relation to the evolving capacities of the child shall be defined. A legislation shall also be enacted to define the right of the child to freedom of association and peaceful assembly. The same shall also set the legal age of the child when he/she shall be allowed to join peaceful assemblies and associations.
- d) On the other hand, the arbitrary interference and the exception to the child's right to access to information shall be defined.
- e) Legislation shall be enacted to encourage the involvement of older children in public and civic affairs and their participation in decision-making which affect and are relevant to their well being as well as to establish the system and organization to formalize their participation especially at the community and the local government levels.

3.5.2 Programs

- a) Community-based registry of births and maintenance of family cards for children;
- b) Development and expansion of incentive schemes for the private sector to produce appropriate learning/educational materials on the fundamental civil rights of children;
- c) Intensification of information campaigns among children on their rights and responsibilities in the exercise of their freedoms; and
- d) Barangay children's movements or community participation in

improving inspectorate/monitoring system to ensure compliance to policies on media regulations.

3.5.3 Research Agenda

Study of the implications of the pursuit of civil rights of children on the four areas of concern as follows :

- a) Family Care and Alternative Care
- b) Health and nutrition, social security and safe environment
- c) Basic education, leisure, recreation and cultural activities
- d) Protection of children under especially difficult circumstances

3.5.4 Goals and Targets for Fundamental Civil Rights of Children

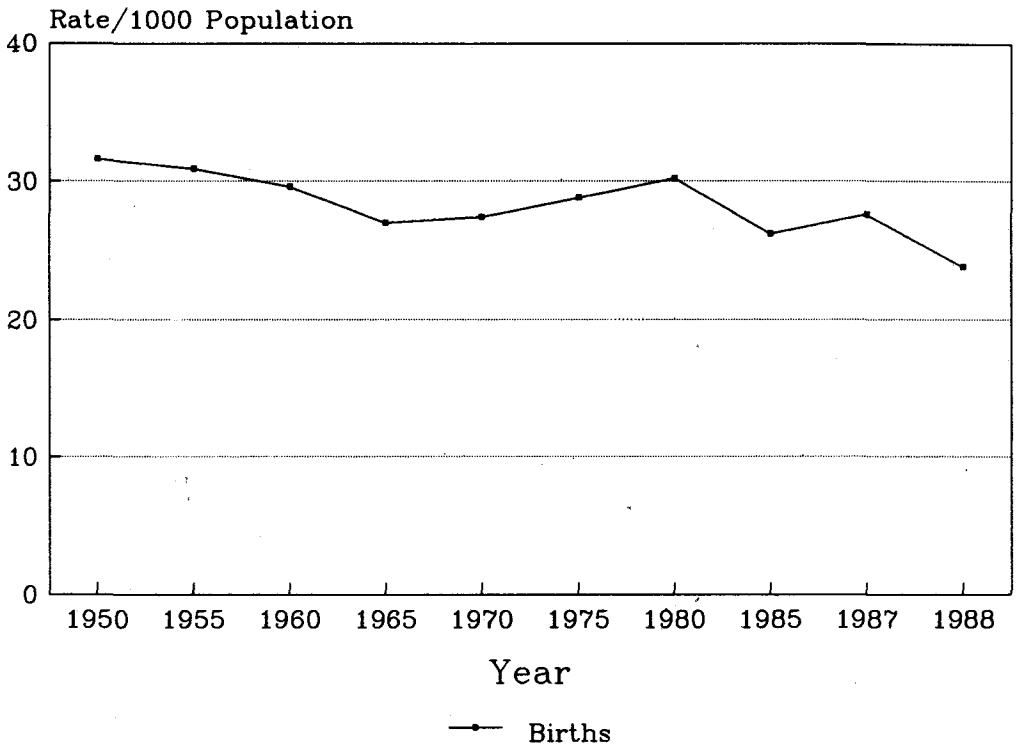
- a) Provision of venue for the child's opinion to be heard and considered for planning and policy formulation at 50 percent of all municipal governments and 80 percent of all city governments; and
- b) Increasing 20 percent participation of children in community child-related projects at barangay level.

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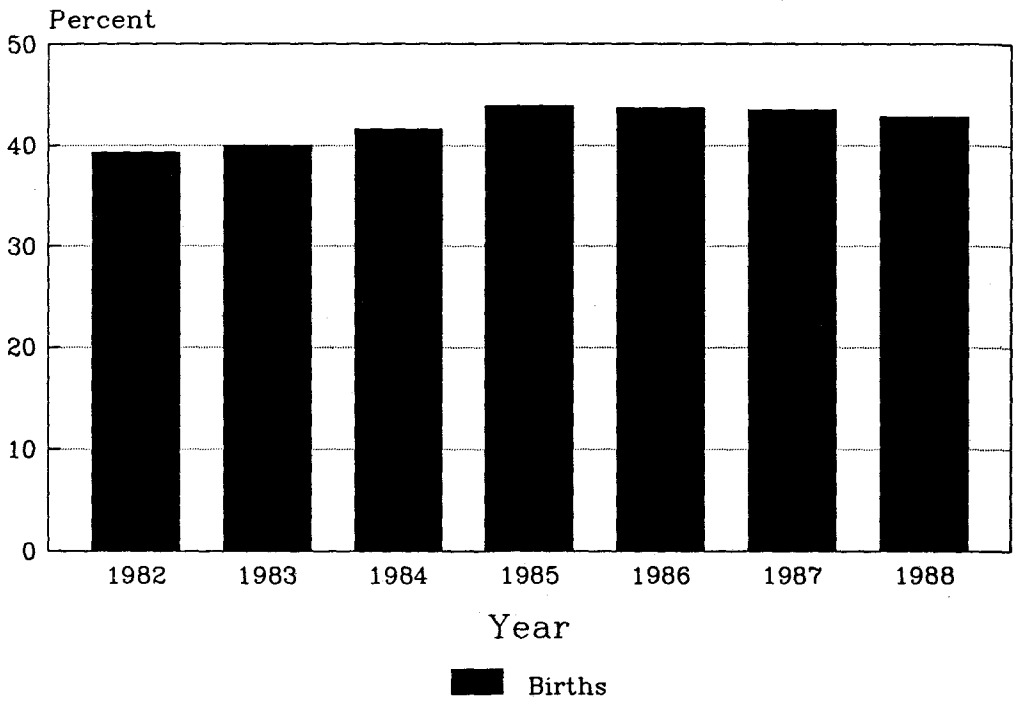
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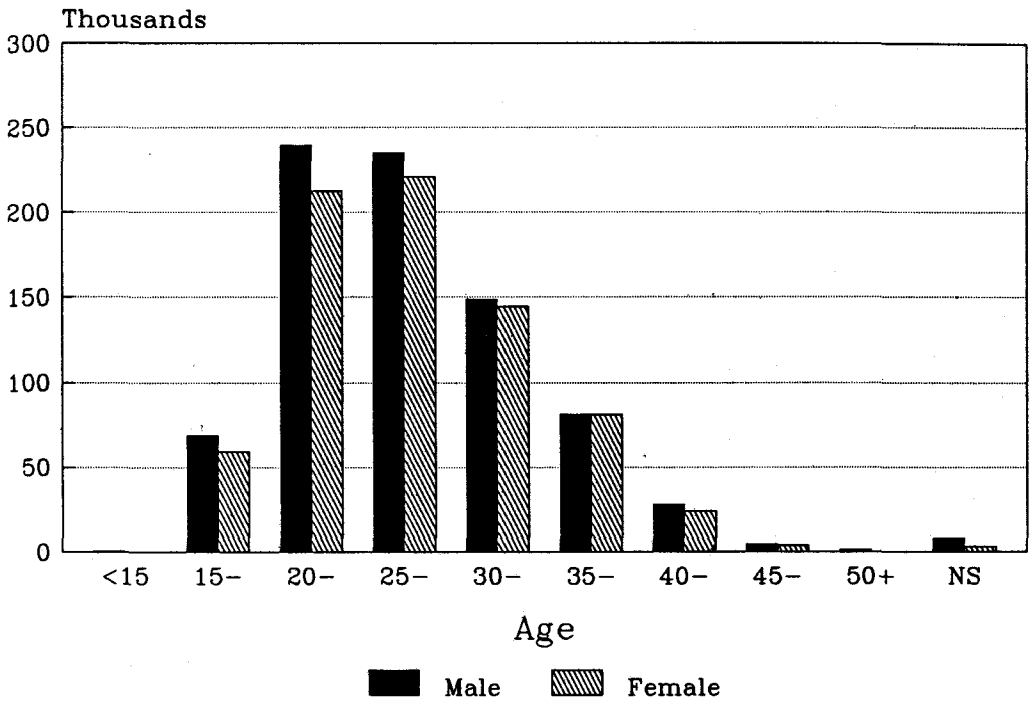
Source: Philippine Health Statistics, Department of Health, 1988

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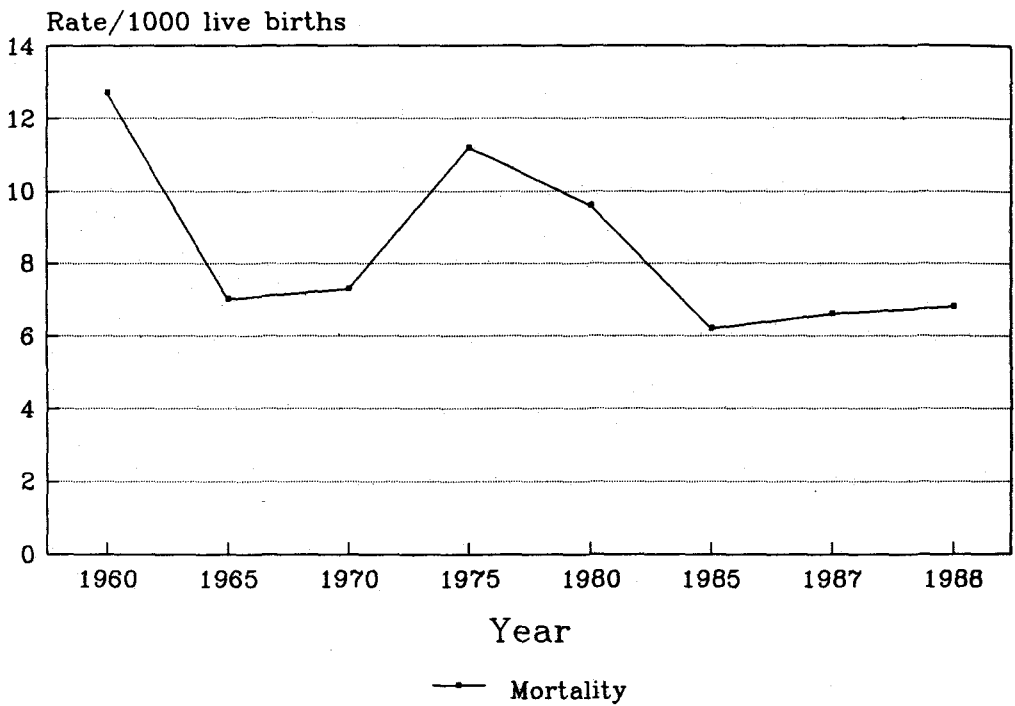
Source: Department of Health, 1988

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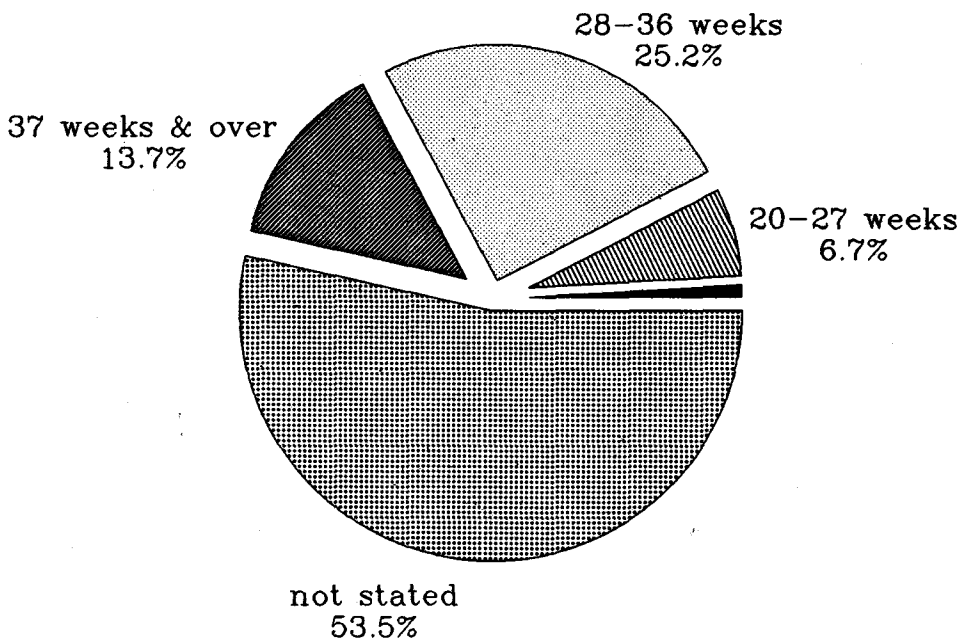
Source: Philippine Health Statistics, Department of Health, 1988

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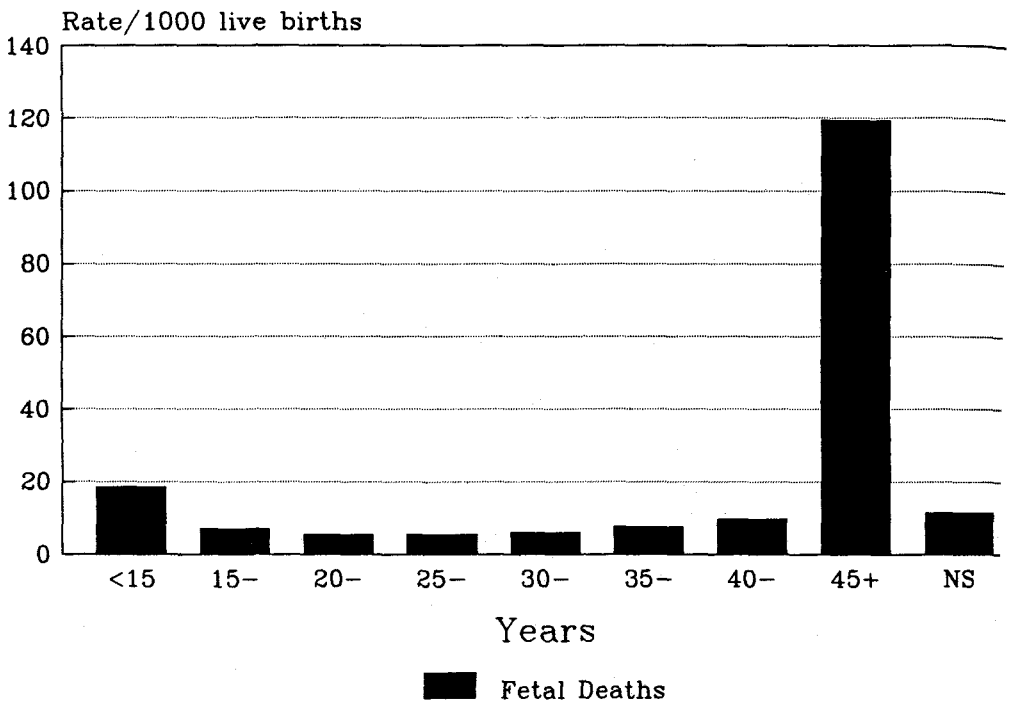
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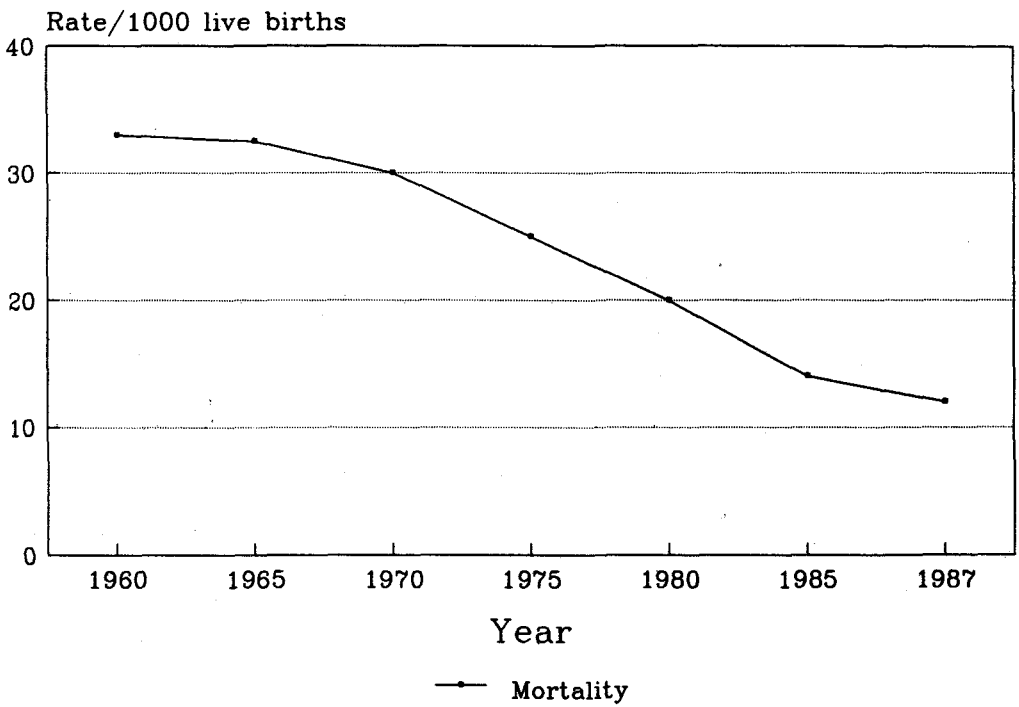
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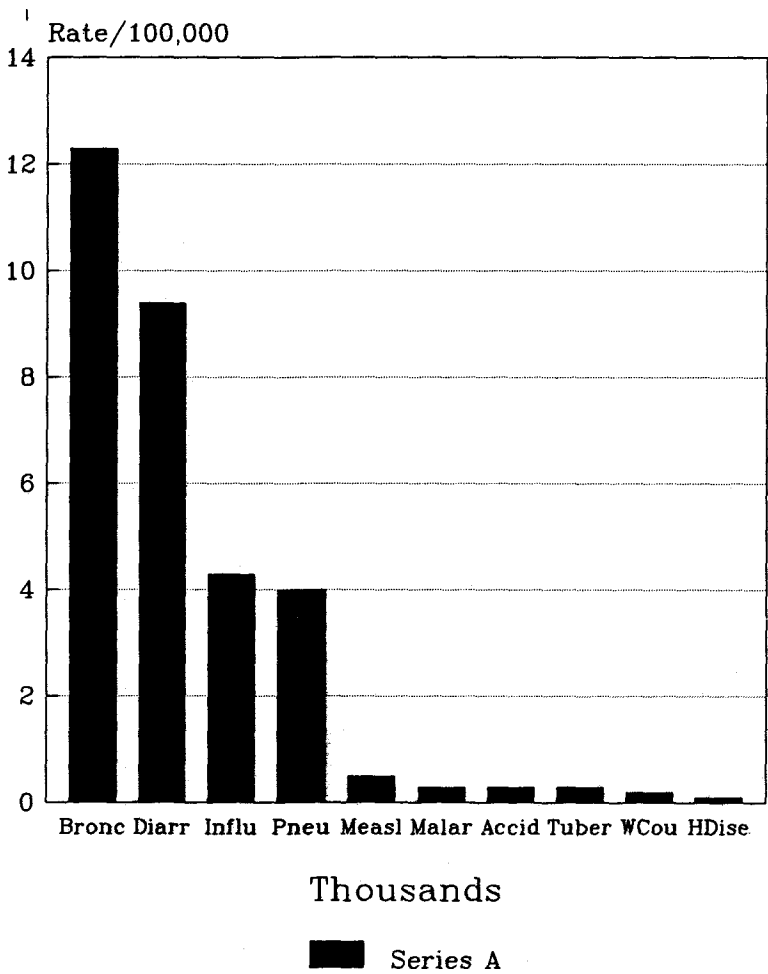
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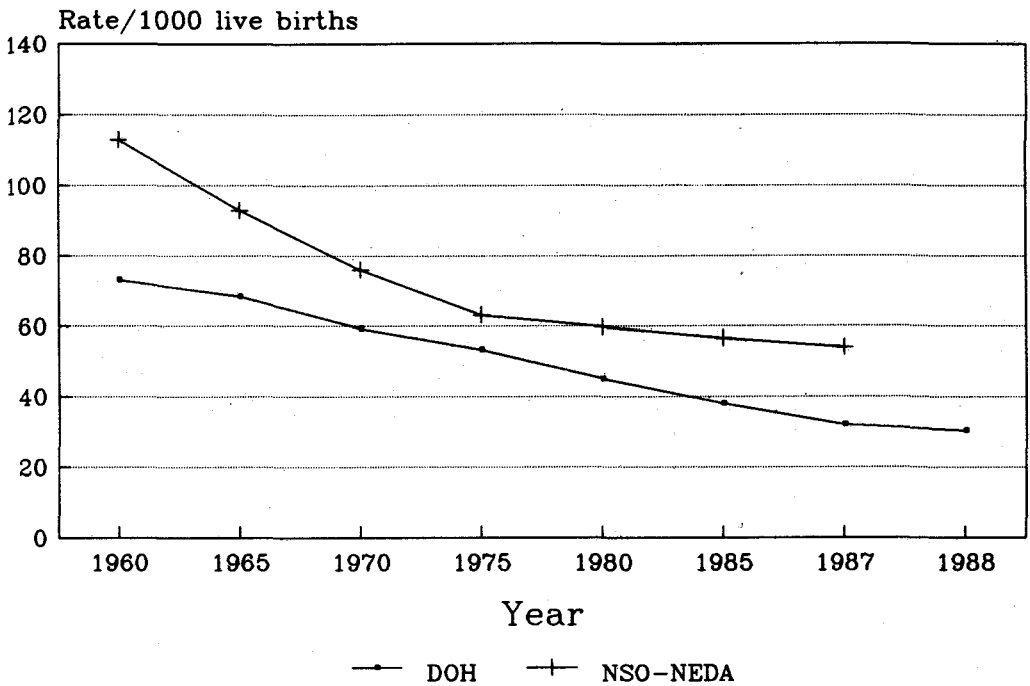
Source: Atlas, United Nations Children's Fund, 1988

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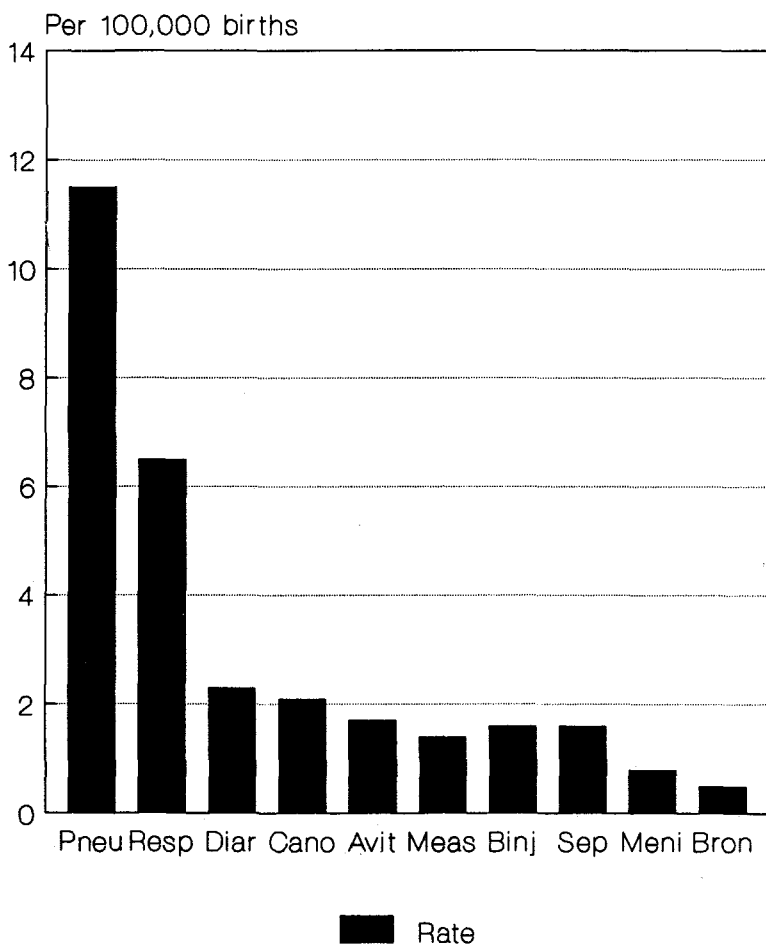
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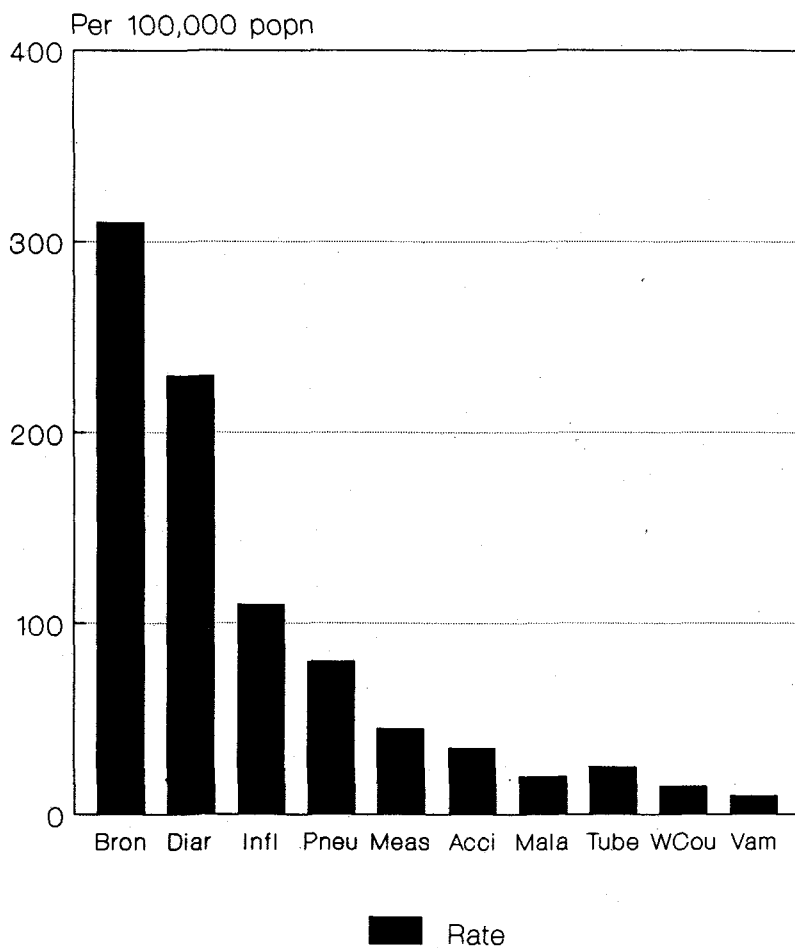
Sources: Department of Health (DOH) and National Statistics Office (NSO)/
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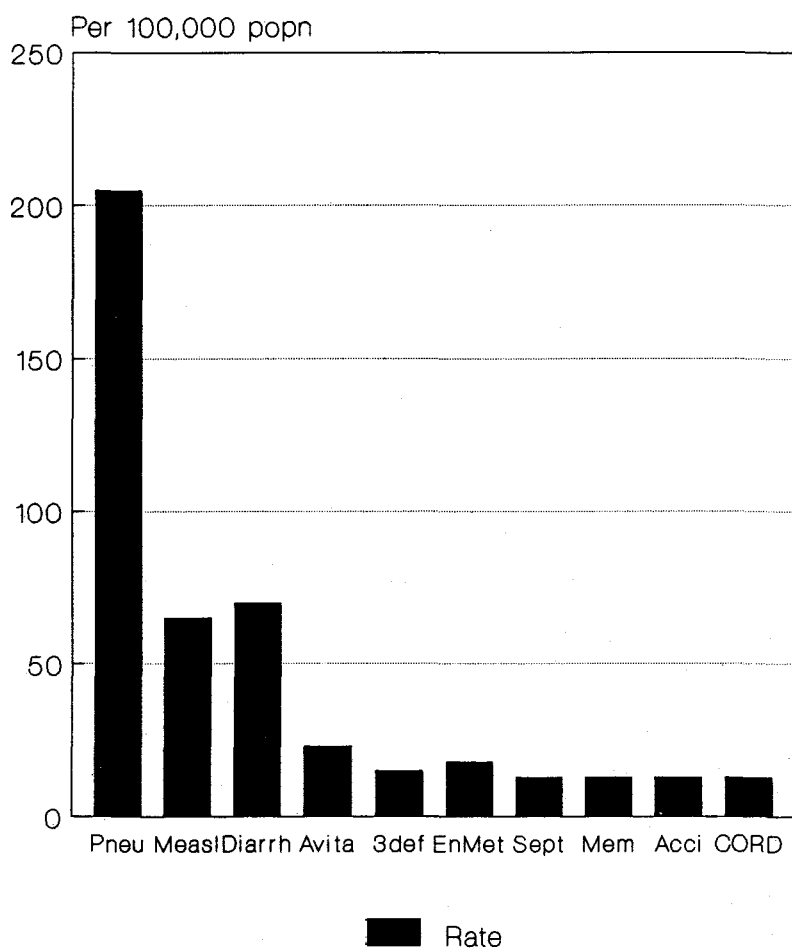
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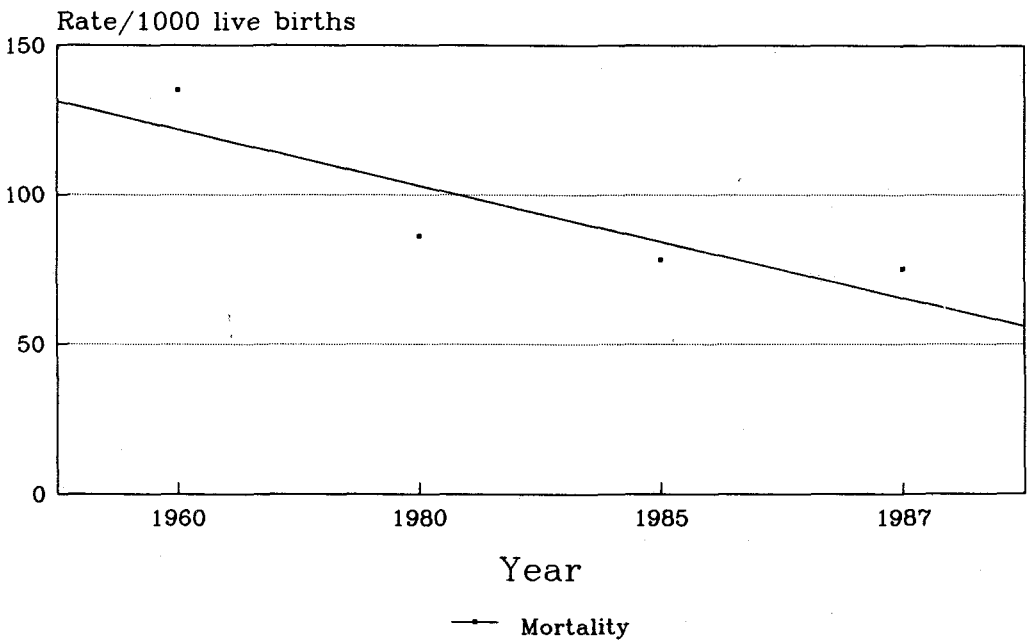
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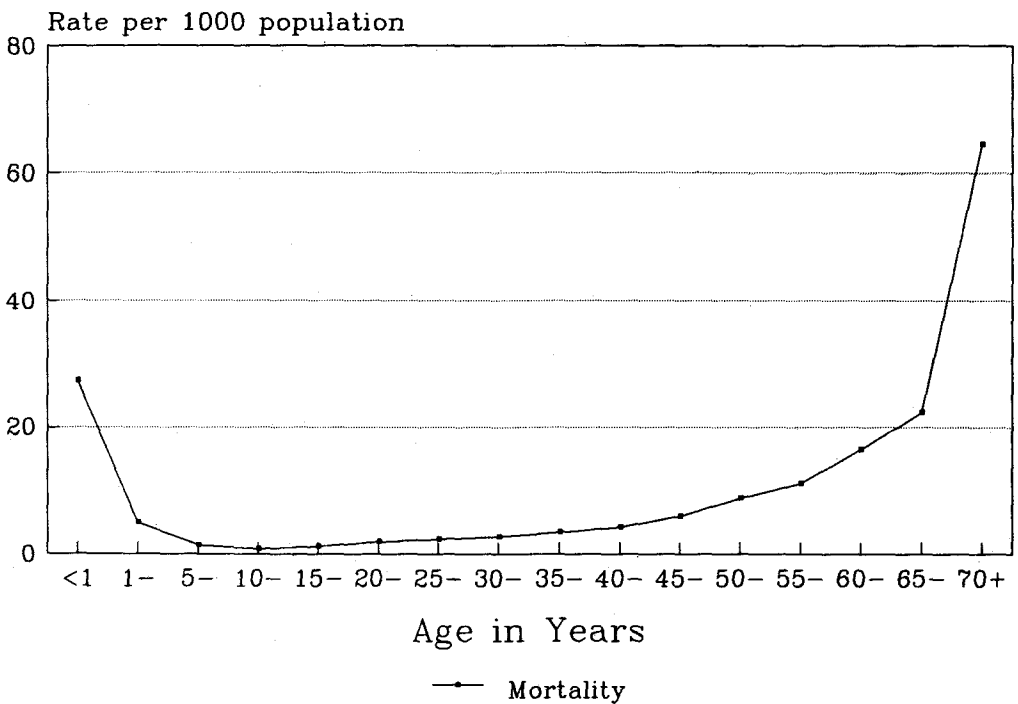
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