# Filipino Women in Health Care and Welfare Services

# FILIPINO WOMEN IN HEALTH CARE AND WELFARE SERVICES

Printed in the Philippines

ISBN 971-1014-05-X

Published by the National Commission on the Role of Filipino Women,
1145 J.P. Laurel St., San Miguel, Manila, Philippines

## Contents

## List of Figures



## List of Tables

## Introduction

Health is one of the sub-themes of the UN Decade for Women. The goal of a better health is embodied in Item 97, of the UN World Plan of Action adopted at the International Women's Year Conference in Mexico City in 1975 where it is stated that "Improved access to health, nutrition and other social services are essential to the full participation of women in development activities, to the strengthening of family life."

This report is an attempt to assess the health situation of Filipino women during the Decade. It covers six chapters as follows:

Sections I, II and III:

Present the general health and welfare programs of the country, highlighting special programs/projects directed towards women.

Sections III and V:

Bring into fore the status and the participation of women in these general and special programs.

Section VI:

Summarizes the significant changes that took place during the UN Decade for Women in the health and welfare sectors in relation to women as beneficiaries of health programs and as agents in the delivery of health and welfare services. This section also highlights problems and obstacles that limit women's participation. Forward looking strategies are presented to further improve women's health and welfare beyond the Decade.

# I. GENERAL HEALTH SITUATION

## A. Covering Legislation

### 1. Constitutional Provision

The 1973 Constitution provides that "The State shall establish, maintain and ensure adequate social services in the field of education, health, housing, employment, welfare and social security to guarantee the enjoyment by the people of a decent standard of "living". (Art. II Sec. 7). Another provision states that "it shall be the responsibility of the State to achieve and maintain population levels most conducive to national welfare." (Art. XV Sec. 10).

### 2. National Development Plan

The Updated Philippine Development Plan, 1984-1987 in its statement of objectives concerning the health of the population provides that health policies and programs are "premised on the ultimate goal of eventually attaining and maintaining for the people (men and women) complete physical, mental and social well-being." One intermediate objectives for realizing this broad goal pertains to women and other nutritionally at-risk groups: "the increase in the levels of food consumption and nutrients intake of pregnant women, lactating mothers, infants, preschoolers, school-children and those who have been affected by the economic difficulties." Similarly, in its statement of broad programs and projects, the plan says that: "The implementation of programs to minimize problems related to pregnant women, lactating mothers, children and other vulnerable groups will be pursued".

These statements are echoed in the Plan's section on population and social services that: "The improvement of the nutritional status of children and lactating mothers will be a priority concern of day care and supplemental feeding program in the coming years".

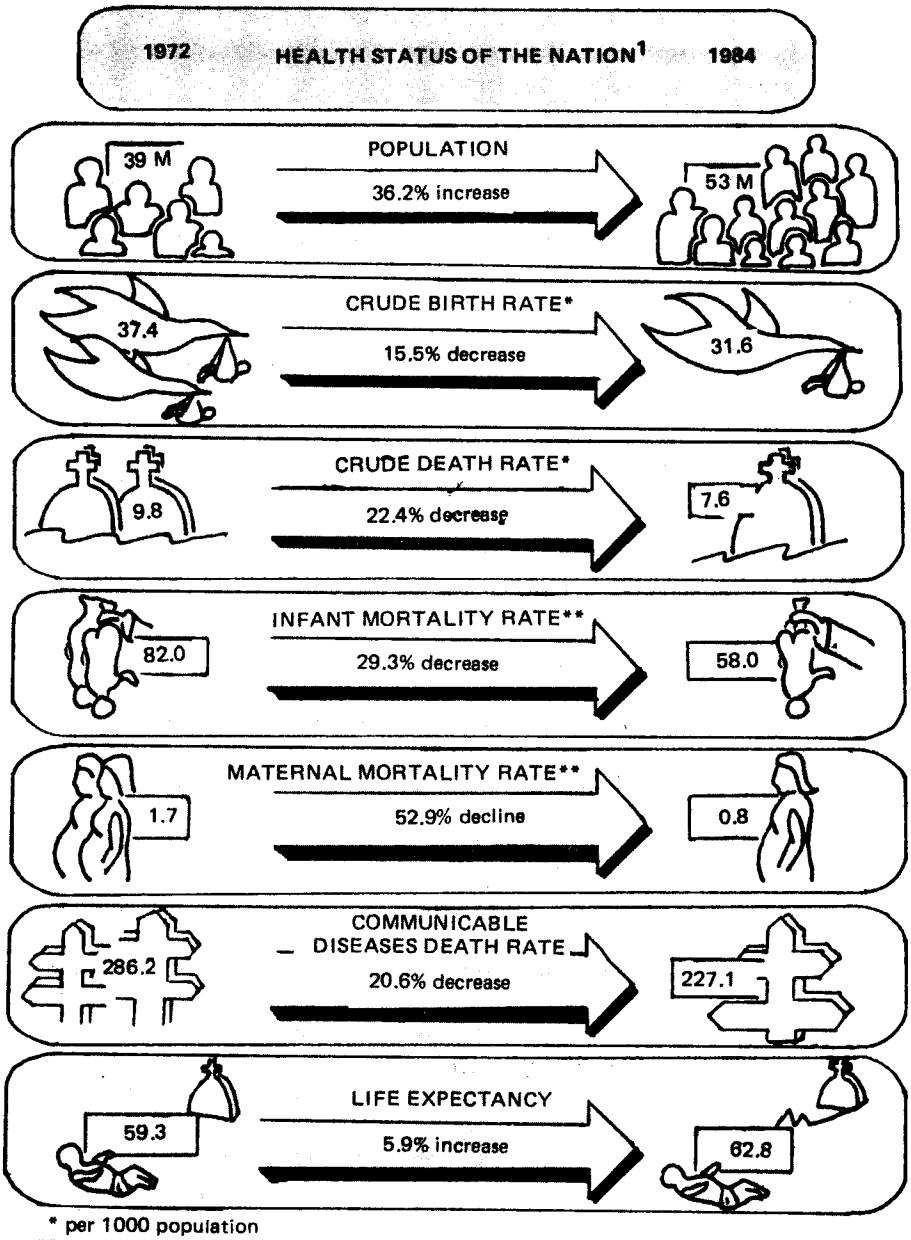
## B. Health Condition of the Country

The over-all health situation of the country has improved gradually during the decade. This is seen in the major health indicators such as a decline in CDR, IMR, MMR and an increase in life expectancy at birth between 1972 and 1984. Causes of morbidity and mortality also underwent some shifts.

The number of children born per every 1,000 population declined from 37.4 to 31.6 while the number of people dying went down from 9.8 to 7.6 per 1,000 population. Deaths of infants under one year (IMR) decreased from 82.0 in 1972 to 58.0 in 1984 while the incidence

of maternal deaths went down from 1.7 to 0.8 per 1,000 live births. By 1984, people could expect to live 3.5 years longer, with life expectancy at birth increasing from 59.3 to 62.8 years.

(Figure 1)




* per 1000 population
** per 1000 live birth
[1] Ministry of Health, Annual Report 1983

Deaths from communicable diseases declined from 286.2 in 1972 to 227.1 in 1984. On the other hand, death rates from cardio-vascular diseases and malignant neoplasms showed increases of 107.7 percent and 38.6 percent, respectively.

For the year 1983, the leading causes of morbidity were the following: acute respiratory infections, enteritis and other diarrheal diseases, tuberculosis, malaria and skin infections.

On the other hand, mortality was caused by selected diseases of the respiratory tract, pneumonias, tuberculosis, bronchitis and those of the digestive system and diarrhea together with cardio vascular diseases, malignant neoplasms and accidents. (Please see other data in next table).

Women represented 49.42 percent of the population in 1975 and 49.83 percent in 1980, but this is projected to decrease by some 0.6 percent in 1985.*

Expectation of life at birth for Filipino women was placed at 57.2 years in 1970 and is expected to increase to 64.9 years by 1985*.

Total fertility rate in 1975 was 5.2 but it decreased to 4.5 in 1980.[1]

Medically trained personnel (doctors, nurses and mid-wives) attended to 45.72 percent of the total livebirths in 1975 while traditional midwives (hilots) attended to 54.28 percent. In 1979, this proportion was reversed, as medically-attended livebirths increased to 53.74 percent with the traditional midwives taking charge of the rest of the deliveries during the period.[2]

It is highly likely that the increase in live births attended by medically-trained personnel may have contributed to the decrease in infant and maternal mortality rates.

Maternal deaths decreased from 1.4 to 1.14 between 1975 and 1979. Most of the deaths occurred among the 30-34 and 35-39 age groups with postpartum haemorrhage and toxemias of pregnancy infections as the most common causes.

---

[2] Vital Statistics, 1975 and 1979, NCSO.

Ten leading causes of death, by rank and percentage of female deaths to total deaths in 1975 and 1979, are as follows:

| Ten Leading Causes of Death | Rank 1975 | % F 1975 | Rank 1979 | % F 1979 |
|---|---|---|---|---|
| Pneumonias | 1 | 45.89 | 1 | 46.13 |
| Tuberculosis, all forms | 2 | 42.54 | 3 | 40.63 |
| Diseases of the heart | 3 | 44.71 | 2 | 44.87 |
| Diseases of the vascular system | 4 | 43.61 | 4 | 42.89 |
| Malignant neoplasm | 5 | 46.81 | 6 | 46.38 |
| Gastro enteritis & colitis | 6 | 41.67 | 5 | 43.23 |
| Avitaminosis & other nutritional deficiency | 7 | 46.45 | 10 | 46.58 |
| Accidents | 8 | 46.15 | 7 | 28.85 |
| Bronchitis & asthma | 9 | 44.08 | 9 | 44.73 |
| Peptic ulcer | 10 | 31.53 | — | — |
| Senility without mention of psychosis | — | — | 8 | 57.26 |

As in the past, more men than women died from these leading causes of death. In 1975, 43.38% of the number of people who died were women; in 1979, this went further down to 42.71%. Females aged 1-9 years had the highest percentage of reported deaths, followed by females under 1 year old and by females 65 years and over. The same pattern was observed in 1979.

Causes of morbidity remained the same for the two years, namely: influenza, bronchitis, diarrhea, pneumonias, tuberculosis (all forms), malaria, dysentery, malignant neoplasms, and infectious hepatitis.

## C. Investments in Public Health

Gains made in the attainment of a healthy nation are directly related to the investments made to achieve it. The sufficiency or insufficiency of such investments may be taken as a factor in assessing results. Improving the quality of water, drainage and toilet facilities, housing and cleanliness of the premises are therefore necessary means to attain a healthy nation. In this section, the positive impact on women of some of these investments is presented, though insufficiency of data has resulted in a limited discussion.

## 1. Hospitals/Health Centers and Medical Personnel

In a span of 10 years (1972-1982), government-owned hospitals increased from 254 with 22,325 bed capacity to 360 with 31,830 bed capacity. Privately-owned hospitals, on the other hand increased from 514 with 23,661 bed capacity to 1,127 with a total bed capacity of 38,573. However, the increase in the total number of hospitals and bed capacities in the country could barely keep up with the population increase. Thus, from 11.5 per 10,000 population it went up to only 13.9. Moreover, these hospitals remain unevenly distributed throughout the archipelago as they tend to be concentrated in urban centers.

The Ministry of Health has initiated some measures to equalize the distribution of health resources and consequently improve the delivery of health services in the country.

For instance, the disparity in the distribution of health facilities is being minimized by the establishment of rural health units (RHUs) of which there are 2,027 and 7,678 barangay health stations. These health centers provide basic medical services especially to the rural people. Thru the Bureau of Medical Services, the Ministry of Health is continuously lobbying for and monitoring/studying local ordinances, resolutions and proposed parliamentary bills which call for the establishment of hospitals especially in rural areas, the increase in the bed capacities of existing hospitals and the provision/improvement of other health facilities in the country.

One measure introduced in 1974 is the prelicensure requirements for medical and nursing graduates to render rural health services in undermanned rural health units and district hospitals for a period equivalent to one semester (four months).

The issuance of Letter of Instruction No. 948 in 1979 modified the program. The rural health practice program for nursing graduates became voluntary for four months while the program for medical graduates continued to be compulsory and was extended to six months. This modified program intends to enable the new medical and nursing graduates to get exposed to rural life and thereby generate their commitment to serve the rural people.

The Ministry of Health and other government agencies have also been continuously training paramedical personnel to support the services of medical personnel, particularly those assigned in rural areas.

As of 1984, there are 214,496 Barangay Health Workers, 10,387 Botica sa Barangay Aides, 13,037 Barangay Nutrition Scholars, and around 52,000 Barangay Service Points Officers.

## 2. Environmental and Sanitation Activities

### a. Water supply and sanitary toilets

Clean water is essential not only for drinking but also for personal hygiene and general domestic use. It should be available in adequate quantities to serve these purposes. A conveniently available safe water supply could be a major factor in reducing the daily drudgery of the housewife, conserving her strength and her time for more attention to the other needs of her children and home. Clean water contributes to the improvement of the quality of life by the protection it offers against dirt and disease.

Given this premise, continuous and intensified campaigns on the use of potable water and sanitary maintenance of existing sources of potable water supply were pursued. With the assistance of various government and international agencies, the population estimated to be supplied with water[3] increased from 42 to 83 percent between 1977 and 1983 for the Philippines. The improvement are significantly larger especially in rural areas.

| | 1977 | 1983 |
|---|---|---|
| Philippines, Total | 42 | 83 |
| Metro Manila Areas | 80 | 88 |
| Other Urban Areas | 49 | 85 |
| Rural Areas | 33 | 80 |

In terms of facilities, 57 provincial and 12 regional water analysis laboratories were established. Of these, thirty-nine (39) of the provincial and all the 12 regional water analysis laboratories are reported to be operational.

Improvement was not limited to the increase in the percentage of population supplied with water. Efforts were made to increase the participation of women in the planning

[3] 1984 Philippine Statistical Yearbook, NEDA

and carrying out of water supply and sanitation programs. Presidential Decree No. 198 known as the Provincial Water Utilities Act of 1978, as amended, mandated that of the five members of the District Board of Directors (the policy-making body of the District), one shall be "a representative of women's organization."

Furthermore, women as an integral part of the community are consulted on the following:

- setting up of faucet in the household and construction of additional pipe network and rehabilitation system;
- addition of flourine in the treatment process;
- designing of the Barangay Sanitation Facilities which include public faucets, bath-houses and laundry facilities in rural areas where houses are densely clustered;
- determination of the water distribution system in the area.

To reinforce the effort to safeguard health and improve living conditions through the provision of safe water supply, it is also necessary to ensure the proper disposal of human waste. For the convenience of women and for assurance of proper care, the construction of sanitary toilet facilities in the household was vigorously pursued.

In 1980, census data showed that of the 8 million occupied dwelling units, 82 percent have toilet facilities of various types. In 1972, this was known to be only 62 percent.

**b. Food sanitation**

Food sanitation activities were also carried out as part of the environmental sanitation program. Highlights of this activity were reported in a five-year food sanitation program report (1979-1983). Findings showed that there are a total of 267,247 food establishments in the country (excluding the National Capital Region), 90 percent of which (241,540) were operating with sanitary permits. A total of 271,966 food operators were registered, out of which 47.8 percent were given training. On the average two inspections per establishment were made per year during the five-year period.

## 3. Housing[4]

Filipinos generally own the houses they stay in. Between 1970 and 1980, however, there was an increase in the proportion of dwelling units which were not owned by their dwellers. Data showed that one out of every five dwelling units was either rented or occupied rent-free.

The rising cost of housing which paralleled the rising cost of living made it very difficult for the non-home owners to build their own house.

In answer to this difficulty, the government engaged in massive socialized housing programs under the National Shelter Program.

From 1979 to 1984, a total of 13,692 units in 233 sites nationwide were constructed by the BLISS (Bagong Lipunan Sites and Services) Development Corporation at an aggregate cost of ₱642.4 million. At present 6,201 units in 93 other sites throughout the country are still in various stages of construction.

By the end of 1986, the number of BLISS projects is expected to reach a total of 22,605 in 359 sites at an aggregate cost of ₱1,014.5 million.

Another program which was created to provide low-cost housing for the people is the Home Development Mutual Fund (HDMF) or PAG-IBIG. The fund was created by Presidential Decree 1530 on June 11, 1978. It is conceived as a savings system for all covered GSIS and SSS members who contribute three percent of their monthly pay to the Fund.

The provision of low-cost housing to its members now numbering about 2.1 million is PAG-IBIG's goal. To date, the Fund has reportedly reached 52,465 members as housing loan beneficiaries, with total loans valued at ₱3.68 billion.

---

[4] Data Source: BLISS Development Corporation, MHS, 1984.

## II. HEALTH PROGRAMS

From the point of view of national health efforts, the general health care programs of the country do not make any distinctions between males and females as beneficiaries of services. However, because of the biological "child-bearing" function with its attendant hazards and women's traditional and social roles as mothers, acknowledgment and recognition is given them as primary beneficiaries in the following health programs.

### A. Maternal and Child Health Care Programs

Under this program, efforts are focussed on ensuring a safe pregnancy and delivery for both mother and child, as well as special care for children.

Implemented by the Ministry of Health as a specific program and as a special project of some non-governmental organizations, this program with its five priority project components report the following accomplishments which have helped in the decrease of maternal and infant mortality rates:

#### 1. Maternal Care

This program is concerned with the provision of health care to women, before, during and after childbirth.

In 1981, the total outreach of the program registered 1,517,156 pre-natal and 979,451 post-natal consultations, reporting a 100 percent accomplishment of the target.

In 1983, however, a decline in the accomplishment was reported. Of the 1,069,450 pregnancies targetted for prenatal consultancies, only 968,892 (90%) were reached. Of the 773,620 expected delivery cases, 689,295 or 89.1 percent were attended to by the health personnel.

The decline in the outreach accomplishment of the project is attributed to the difficulty of the health personnel in reaching the clientele residing in far flung areas.

#### 2. Hilot Training

The traditional midwives (hilots) play a major role in providing maternal and child health care in the country since they attend to a large proportion of births especially in the rural areas. In 1975, they attended to 49.38 percent of the total livebirths

and in 1979, to 43.69 percent. There is, however, in their practice an element of risk since they have limited training. Cognizant of this situation, the Ministry of Health advocated the training of these hilots to make their practice less dangerous and to gradually bring them under the supervision of the health personnel.

The statistical yearbook of 1984 indicates that as of 1983, a total of 39,558 hilots were registered, of which 22,847 (58%) were already trained and are under the MOH's supervision.

The training of these hilots may have contributed to the decrease in the infant as well as the maternal mortality rates registered.

### 3. Pre-Natal and 0-6 Child Care

The provision of continuing promotive, preventive, and curative care to the pre-school children is undertaken through registration, periodic check-ups and monitoring of their health and nutritional status. The mothers record the health and nutritional status of their children using growth charts provided by the clinic staff. During their regular visits to the clinic, the children are provided with immunization services and other health care needs, while the mothers receive nutrition and health education, and family planning counselling. The clinic staff also treat simple illnesses and give referrals for major illnesses.

Under Six Clinics now operational in most hospitals and some rural health units in the country offer comprehensive care to 0-6 year old children. This project component was expanded through training of health personnel and provision of growth charts and weighing scales.

In 1983, out of a target 6,111,120 (0-6 years old children), 5,100,295 (83.4%) received child health supervision with the assistance of their mothers.

### 4. Promotion of Breastfeeding

Recent studies show that the incidence of breastfeeding in the country has gone down and children are weaned earlier.

Since breastmilk has been found to be best for a healthy baby, the maternal and child health care program has included the promotion of breastfeeding. For this, an interagency core group has been organized with the Ministry of Health as the lead agency. Its members have been drawn from representatives of various government and non-government agencies.

Efforts are directed towards monitoring the implementation of the International Code for Breastmilk Substitute since the Philippines is a signatory to this Code. Meanwhile, the adoption of the National Code on the Marketing of Breastmilk Substitutes is still awaiting approval.

### 5. Expanded Program On Immunization (EPI)

A nationwide evaluation of the EPI Program covering all levels of health care delivery was conducted in 1982 in collaboration with WHO and UNICEF. The findings showed that morbidity and mortality from the five (5) childhood immunizable diseases, namely: diptheria, pertussis, tetanus, tuberculosis and poliomyelitis showed a consistent downward trend while those from measles continued to remain high.

These trends are explained thus: the expanded immunization for measles just started in July of 1982 while those of the other five childhood diseases have been ongoing since 1978.

Efforts were thus escalated to reach a bigger population. In 1983, BCG immunization were given to 75.9 percent of the eligible 3-8 months old infants and 81.4 percent of school entrants, and DPT to 74.9 percent of eligible (3-14 months old) children.

However, polio and measles immunization only reached 57.6 percent and 51.7 percent of the eligible infants, respectively.

On the other hand, of the 672,110 pregnant women, 453,038 received the first dose of tetanus toxoid; 337,455 (50.2%) received the second dose and 337,399 (50.2%) were considered fully immunized.

## B. The Philippine Nutrition Program

### 1. Programs

The Philippine Nutrition Program continues to address itself to the improvement of the nutritional status of the population, especially the infants, pre-schoolers, school-children, pregnant women and nursing mothers through various programs in cooperation with governmental and non-governmental organizations, as follows:

**a. Food assistance**

Food assistance intervention under the PNP is an emergency measure, the objective of which is to improve the nutritional status of a malnourished individual by providing him adequate food to keep him alive.

In 1980, more than 9.6 million or 88.2 percent of the targetted 10.9 million individuals were reported to have benefitted from Food Assistance. Of this total, 3,100,489 or 32.3 percent were infants and preschoolers; 5,357,197 or 55.8 percent were school children; and 239,324 or 2.5 percent were pregnant and nursing women. An additional 903,966 were either children in institutions, or disaster victims and workers. Food Assistance outreach in 1980 was 17 percent higher than that of 1979.

The relatively low outreach to pregnant and nursing women may be due to difficulty in reaching them, while low outreach to children in institutions and the like may be due to unrealistic target setting. Moreover, it is highly probable that a greater number of individuals who were victims of natural disasters were reached but not properly monitored due to the emergency nature of the activity.

**b. Information education and communication**

Based on the reports submitted by the cooperating agencies in the PNP, a total of 12,365 nutrition classes were conducted with a total outreach of 339,157 homemakers. In 1982, a total of 1.1M homemakers were served through 90,000 homemakers classes and 256,892 home visits conducted by the field workers of both government and private agencies. Aside from the interpersonal approach, mass media through print, broadcast and audiovisual presentation were likewise used as vehicles to disseminate nutrition information to increase the level of nutrition awareness of the population. A total of 534 IEC materials like brochures, pamphlets, posters, newsletters, flipcharts and calendars were developed and distributed. Thirty-three radio messages were produced and aired while nineteen (19) Nutribuses equipped with video-tape recorders were fielded in eleven regions to reach people in 1,530 barangays.

## c. Health Protection

Health Protection in the Philippine Nutrition Program which relies heavily on rural health personnel consists primarily of two types of services: curative and preventive. Curative treatment is given to severely malnourished children with associated diseases through clinics, Rural Health Clinics or Home care service; preventive treatment is provided through the institution of appropriate measures to increase resistance to illnesses such as immunization, dietary and medical advice to mothers of malnourished children and to pregnant and nursing women; and health nutrition and child care education.

It was reported that the 160 hospital-based nutrewards established all over the country in 1980 admitted 2,542 cases, 53 percent of which were reported to have been fully rehabilitated. To supplement the facilities of the nutrewards, a total of 177 nutrihuts were built. In 1982, a total of 9,792 nutrihuts and nutrewards was reported. Undersix Clinics, numbering 159, provided services to 268,910 pre-schoolers, while free vitamins and medicines were provided to some 316,200 needy Total Maternal Care Health Program (TMCHP) recipients.

The School Health Guardian Program provided health protection services to more than 4.5 million school children in 1980 and 5.9 million in 1982. Activities included immunization, deworming and provision of dental, medical and nursing services.

Other services like the provision of iron supplements to anemic pregnant women, distribution of salt and administration of iodized oil injections to goiter cases in endemic areas were also undertaken. The goiter control project had an outreach of 104,756 pregnant and lactating women in 1982 while the anemia surveillance project examined and treated 6,507 pregnant and nursing women.

The limited outreach of several health protection activities like nutriwards or nutrihuts may be attributed to physical distance of the nutriwards or nutrihuts, absence of physicians and other medical personnel, and the inability of mothers to stay in nutrihuts with their children as required. With regard to specific nutrient deficiencies like Vitamin A deficiency, goiter and anemia, the apparently low performance may be due to the lack of a national program geared to reach a wider coverage.

### d. Food production

Food Production in the home, schools and communities was intensified during the year as a means to augment the income of families and increase food availability. Program activities in 1980 included crop/animal/fish production and dispersal, extension of loans and farm inputs to small farmers, and cultivation of garden/nurseries and orchards. During the year, 760,460 head of livestock and 261,154 kg. of seeds and seedlings were reported to have been distributed to farm families while more than 5,000 families received fingerlings for backyard fishponds.

In further support to the long-range goals of the PNP, rice-palay production through the Masagana 99 and corn production through Masaganang Maisan was strengthened, reaching 63.6 percent of the targets for the year. Vegetable production through Gulayan sa Kalusugan and Selective Food Production in the schools attained 93.4 percent of its target. Loans and inputs were extended to more than 700,000 farm families for the various food production programs and projects.

As a result of these various efforts, an increase in the calories and nutrient values of daily per capita available food supply was registered. From 1970 to 1981, percentage of sufficiency of calories per day in available food supply increased from 104.8 to 129.0; protein from 110.8 to 131.5 (grams per day) and fats from 104.3 to 126.0 grams per day (Table 4).

## 2. Private sector support to the PNP

Aside from the non-governmental institutions officially cooperating in the PNP, various women organizations also contributed to the program.

The Civic Assembly of Women of the Philippines, composed of 70 duly established affiliate organizations, has reported the following:

Information Education and Communication activities were conducted in the form of seminars, conferences, and symposia, and information materials such as pamphlets and fliers were distributed.

The CAWP also provided medicines and foodstuff to institutions and barangays, and encouraged backyard gardening as community activities.

Women groups especially the medical and other allied professional groups gave free medical services in institutions and in the barangays. Other groups also set up day care centers and free clinics.

The concerted efforts under the PNP resulted in an improvement in the nutritional status of the population in general and also in the nutritional status of children and pregnant and lactating women.

## 3. Accomplishments:

These improvements are documented in various studies and reports as follows:

### a. Nutritional Status of Children

The PNP program reported the data from index or randomly selected areas of the country on the weight for age survey covering 83,000 pre-school children in 1979. Findings revealed that 30 percent of those weighed were either moderately or severely underweight. In 1980, results of weighing nearly 92,000 in the index areas indicated a reduction in these underweight categories to 24.4 percent.

Data from the Malnutrition Prevention Project under the program also provide additional evidence on the impact of the preventive nutrition program on infants under 18 months. The main goal of this project is for at least 50 percent of the target infants both normal and moderately underweight to maintain 81 percent of standard weight or higher upon reaching 18 months. In 1980, 65 percent of said infants either maintained or improved their nutritional status while 74 percent of the underweight were found to have improved.

Furthermore, an evaluation of the Targetted Maternal and Child Health Program (1980) likewise showed positive impact among beneficiaries of the program. Of some 28,000 children sampled from each region of the country, 58 percent showed improvement in their nutritional status while 24 percent maintained their nutritional levels.

### b. Nutritional status of pregnant and lactating women

In the surveys made by the Food and Nutrition Research Institute in 1978, findings showed an 85 percent prevalence of anemia among pregnant women. In 1982, it registered 48.8 percent indicating a decrease. The PNP has also contributed to the reduction of the prevalence of avitaminosis and other nutritional deficiencies – from a five-year average rate of 9/100,000 population (1977-1981) to 6.2 per 100,000 population in 1982 (1984 ESCAP Report).

Also, an FNRI study, (1979) on the weight changes among lactating mothers showed that the mean weight gain (9 kg.) of the mothers was comparable to the average weight gain (9.11 kg.) recommended for mothers. It also showed that the average weight gain of urban mothers was higher than that of rural mothers, although the difference was not significant.

## C. The Philippine Population Program

From a program that was predominantly contraceptive-oriented in its early years, the Philippine Population Program has shifted from a largely clinic-based approach to a community-based, people-centered program. Today, family planning does not merely relate to the regulation of the number of children born, but to the spacing and timing of births so that children are conceived at the least risk to the mother's life and health, are wanted and can be adequately cared for.

Presented here are the resultant legal measures, activities and achievements of the concerted efforts of various agencies and personnel, with highlights of program accomplishments from some cooperating agencies during the decade:

### 1. Legal measures

- Amendments to Republic Act 6362 – sought to strengthen the population/family planning program of the country;

- Presidential Decree No. 1013 – further amended Section 13 known as the Philippine Medical Care Act of 1969 to include reimbursement of expenses in connection with sterilization procedures, specifically vasectomy for men and mini-laparotomy for women, for GSIS and SSS members;

- 1976 – Presidential Decree No. 965 – required applicants for marriage license to attend counselling sessions on family planning and responsible parenthood.

- Presidential Decree No. 148 – amended the Women and Child Labor Law, whereby maternity leave benefits were limited to the first four deliveries. This resulted in the issuance of the Department of Labor Order No. 7 which outlined the family planning responsibilities of management and labor leaders.

- MOH Department Circular No. 214, s. 1978 – authorized trained nurses and midwives to dispense oral contraceptives directly without an examination by a physician, using the approved checklist.

## 2. Program Accomplishments

Though hardly noticed, concerted efforts from both government and private sectors have made significant gains in its fertility and development goals. Less children are now being born to Filipino families. The crude birth rate, the number of births per 1,000 population, dropped from 40 in 1970 to 34 in 1983.

From 1971 to 1983, about 2.8 million births were averted. Another 700,000 more births are expected to be averted in 1984 and 1985. Over 3.5 million births are, therefore expected to have been prevented in 15 years. This means that the country's dependency ratio (the number of dependents for every 100 productive persons) is lesser.

The results of family planning activities may be deduced from the number of acceptors of the various family planning methods. Data from 1977 to 1982 were compiled by POPCOM and given as follows by method and number of users in a given year.

**Family Planning Acceptors by Methods Used**[5]

| Year | Total | Sterilization Total %F | IUD | Pills | Condom | Rhythm | Inject-table | Others |
|---|---|---|---|---|---|---|---|---|
| 1977[1] | 316,450 | 34,531-89.8 | 27,038 | 124,142 | 103,302 | 20,261 | 2,817 | 4,359 |
| 1978 | 495,586 | 52,769-90.8 | 35,402 | 194,299 | 170,075 | 33,157 | 4,599 | 5,285 |
| 1979 | 472,537 | 48,143-95.5 | 40,128 | 203,395 | 147,427 | 25,464 | 4,488 | 3,492 |
| 1980 | 375,248 | 42,576-96.8 | 40,569 | 170,408 | 100,167 | 15,608 | 4,859 | 2,061 |
| 1981 | 424,743 | 61,514-97.0 | 47,916 | 191,673 | 100,263 | 15,615 | 5,922 | 1,836 |
| 1982 | 412,871 | 63,606-96.5 | 48,231 | 188,285 | 90,670 | 15,625 | 5,625 | 2,069 |
| All Years | 2,497,431 | 303,139 | 239,284 | 1,072,202 | 711,904 | 125,734 | 26,070 | 19,102 |

Family Planning has also contributed in some measures to the reduction of maternal and child mortality/morbidity.

[5] NEDA. 1984 Statistical Yearbook.

- Presidential Decree No. 148 – amended the Women and Child Labor Law, whereby maternity leave benefits were limited to the first four deliveries. This resulted in the issuance of the Department of Labor Order No. 7 which outlined the family planning responsibilities of management and labor leaders.

- MOH Department Circular No. 214, s. 1978 – authorized trained nurses and midwives to dispense oral contraceptives directly without an examination by a physician, using the approved checklist.

## 2. Program Accomplishments

Though hardly noticed, concerted efforts from both government and private sectors have made significant gains in its fertility and development goals. Less children are now being born to Filipino families. The crude birth rate, the number of births per 1,000 population, dropped from 40 in 1970 to 34 in 1983.

From 1971 to 1983, about 2.8 million births were averted. Another 700,000 more births are expected to be averted in 1984 and 1985. Over 3.5 million births are, therefore expected to have been prevented in 15 years. This means that the country's dependency ratio (the number of dependents for every 100 productive persons) is lesser.

The results of family planning activities may be deduced from the number of acceptors of the various family planning methods. Data from 1977 to 1982 were compiled by POPCOM and given as follows by method and number of users in a given year.

**Family Planning Acceptors by Methods Used**[5]

| Year | Total | Sterilization Total %F | IUD | Pills | Condom | Rhythm | Inject-table | Others |
|---|---|---|---|---|---|---|---|---|
| 1977[1] | 316,450 | 34,531-89.8 | 27,038 | 124,142 | 103,302 | 20,261 | 2,817 | 4,359 |
| 1978 | 495,586 | 52,769-90.8 | 35,402 | 194,299 | 170,075 | 33,157 | 4,599 | 5,285 |
| 1979 | 472,537 | 48,143-95.5 | 40.128 | 203,395 | 147,427 | 25,464 | 4,488 | 3,492 |
| 1980 | 375,248 | 42,576-96.8 | 40,569 | 170,408 | 100,167 | 15,608 | 4,859 | 2,061 |
| 1981 | 424,743 | 61,514-97.0 | 47,916 | 191,673 | 100,263 | 15,615 | 5,922 | 1,836 |
| 1982 | 412,871 | 63,606-96.5 | 48,231 | 188,285 | 90,670 | 15,625 | 5,625 | 2,069 |
| All Years | 2,497,431 | 303,139 | 239,284 | 1,072,202 | 711,904 | 125,734 | 26,070 | 19,102 |

Family Planning has also contributed in some measures to the reduction of maternal and child mortality/morbidity.

[5] NEDA. 1984 Statistical Yearbook.

## a. Government Sector

*Commission on Population (POPCOM)*

The Commission on Population which is the government's central policy-making, planning and funding agency for population matters, with the assistance and cooperation of 44 government and 55 non-governmental agencies and a network of around 52,000 Barangay Service Point Officers pursue activities which are developmental, preventive, supportive and integrative. This means that family welfare goals are integrated into the various health and social services of the government.

Its nationwide undertakings are reported as follows:

- Production of IEC materials in cooperation with selected communications media agencies. These include radio and television spots, jingles, multi-media packages, puppetry, stage plays and contests. The National Population Welfare Congress is also part of its IEC project.

- Service delivery carried out by two basic structures — the clinic services network and the community-based family planning service network, commonly referred to as the Outreach Project.

The clinic service network administered by the corresponding mother agency or institution offers all contraceptive services except abortion; provides medical screening/check-up of clients; management of complications; laboratory services and back-up support to other agency field-workers, including the Outreach Workers. As of December, 1980, there were 3,533 registered family planning clinics, including sterilization centers; 12 regional and national itinerant sterilization service teams to provide sterilization in areas not covered by static centers.

Outreach Project, on the other hand, is implemented in cooperation with the local government. Fulltime Outreach Workers (FTOWs) provide services, referrals, follow-ups, initial pill dispensation, and contraceptive resupply and establish Barangay Service Points (BSPs) manned by volunteer workers known as Barangay Service Point Officers (BSPOs). These BSPs serve as depots for contraceptives. As of December 1980, there were 3,320 Outreach personnel deployed and 45,332 BSPs.

- Conduct and funding of training programs implemented by other agencies. Training is conducted in the following areas: (1) management/supervision, research, and monitoring for program managers; (2) materials development for program managers, trainors, and media representatives; (3) production of IEC materials for IEC personnel (central and regional) and outreach workers; (4) family planning motivation for outreach workers; (5) counselling for premarriage counsellors; (6) trainors' training for program managers and outreach personnel; (7) preservice training for outreach workers in voluntary surgical contraception (VSC); (8) training of physicians in VSC procedures (vasectomy, minilaparotomy, and other procedures of female sterilization); (9) training of nurses/midwives as physicians' assistant on VSC procedures; (10) pill dispensation and rhythm instruction for outreach workers, doctors, nurses, and midwives; (11) IUD insertion for nurses and midwives; and (12) management of complications arising from method use for doctors, nurses, ourtreach workers and paraprofessionals.

- Conduct and funding of research activities. POPCOM funds exploratory, evaluative, action-oriented, operations, demographic, and biomedical researches.

*Ministry of Health (MOH)*

The National Family Planning Office (NFPO) of the MOH has the following objectives: (1) to integrate family planning services into the health care delivery system of the MOH; (2) provide family planning information, education, motivation, and services to all eligible couples who wish to space or limit childbirth; (3) to improve maternal and child health through proper birth spacing and eventually lower maternal and infant morbidity and mortality; and (4) to contribute to the reduction of the nation's birth and population growth rates.

Given these objectives, the MOH pursue various activities and projects as follows:

- Production and use of audio-visual aids such as flip charts, booklets, calendars, comic books, films and slide-and-tape presentation in their IEC campaign.

- Social preparation of SARIKAYA (a contraction of "SARILING KAKAYAHAN" which means self-help or self-reliance) project pilot areas and fielding of

SARIKAYA workers as volunteer IEC workers for health/family planning motivation.

- As of 1980, there are 1,547 rural health/family planning clinics (RH/FPCs), 196 hospital-based family planning clinics, 11 mobile family planning clinics, 14 sanitaria or skin clinics, 239 sterilization centers, one itinerant sterilization team and five comprehensive family planning centers operating under the NFPO. Manning these service outlets are a total of 1,572 doctors, 1,418 nurses, 3,679 midwives, and 493 SARIKAYA Workers.

  Services offered include: family planning motivation, follow-up, initial pill dispensation, contraceptive resupply, referrals, and instructions on family planning, health, nutrition, and contraceptives.

  Contraceptive methods provided include the pill, IUD, condom, vasectomy, minilaparotomy, foams, jellies, creams and injectables. Instruction on the use of rhythm is also given.

- Training activities undertaken include basic course on family planning to prepare health personnel in the management of the family planning programs in their areas, training of SARIKAYA workers to strengthen IEC support on health and family planning, and evaluation workshop for NFPO staff to assess and plan programs. As of 1984, of the total trained personnel, women comprised 82.5 percent.

- NFPO also conducts evaluative, action-oriented and operations researches.

*Ministry of Social Services and Development (MSSD)*

The MSSD's family planning program is undertaken by two of its bureaus namely: The Bureau of Family and Child Welfare (BFCW) and the Bureau of Youth Welfare (BYW).

- As part of the IEC campaign, the BFCW teaches the small size family norm and family life through the use of toys, songs, stories, and games and other audio-visual aids among the pre-schoolers in their day care centers all over the country. The BYW on the other hand, trains youth leaders in development communications.

- In service delivery, the BFCW provides family planning motivation, counselling, referrals, and follow-up services for married couples of reproductive age (MCRAs) through the Ministry's unit offices in all the municipalities. Value inculcation for preschool children is undertaken in day care centers.

The BYW, on the other hand, organized the youth into groups known as the Pag-asa Youth Movement. The movement's meetings are venues for IEC campaigns on such issues as population, health, and nutrition. The MSSD has several youth drop-in centers which offer varied services to the youths, such as: income generating projects, practical skills development and job placement; IEC on population, health and nutrition, environmental, energy and resource conservation; prevention of juvenile delinquency and drug abuse and referrals to appropriate agencies.

In 1980, a total of 579,226 youths were reached and served by the MSSD. The Ministry also conduct trainings in monitoring, evaluation and materials development for paraprofessionals and fieldworkers, while Program managers are likewise trained in supervision/management.

*Ministry of Education, Culture and Sports (MECS)*

The Ministry of Education, Culture and Sports (MECS) through the Population Education Program, developed, curriculum materials, trained teachers (mostly women) on population education and conducted research projects. The Ministry made official the integration of population education in the school curriculum.

Materials developed and printed consist of 55,000 copies of teacher guides in the elementary level; 30,000 copies of teacher guides in the secondary level; and 140,000 copies of population education reference materials.

*National Media Production Center (NMPC)*

The National Media Production Center has always been actively involved in promoting information, education, communication (IEC) activities on family planning issues. Themes such as responsible parenthood, delayed marriage, community self-reliance underlined in short motivational films

produced by NMPC. They also produce standard media materials for nationwide distribution such as posters and calendars.

**b. Private sector**

Other population efforts organized by the private sector, charitable institutions and community/civic action groups are as follows:

*The Population Center Foundation (PCF).*

PCF is a private agency whose activities include the conduct of studies designed to improve approaches to family planning. Among the researches/programs conducted include:

- Womanpower Development and Utilization. Started in 1977, this program aimed to broaden the role options available to rural women by providing them with opportunities to raise their economic and social status.

- Filipino Women in Family Planning. Women articulated perceived needs and designed appropriate family planning related projects which they themselves implemented. Funding assistance was extended by the agency to these women.

- Total Maternal Care Center (TMCC). Assistance to Hospitals. TMCCs offer sterilization services especially to high risk pregnancy cases.

- Masculinity/Feminity Concepts and their Bearing on the National Population Program, Phase II. This is a program designed to reach the Filipino male with family planning messages-e.g. a 30 second radio-T.V. commercial and a 30-min. drama series.

*Family Planning Organization of the Philippines (FPOP)*

The FPOP has a nationwide network of volunteer-organized units or chapters and has been a member of the International Planned Parenthood Federation since November 1969. The FPOP undertakes an education program among Filipinos on the need for and benefits derived from family planning; conducts training programs which would meet the growing need for women and adequately trained

manpower to give quality family planning services; helps provide clinic facilities for family planning services, sex education, marriage counselling, and birth spacing anywhere in the Philippines; conducts activities that would study, evaluate, and help direct the program of the organization; seeks financial assistance and/or support in any form to attain its objectives; and coordinates and establishes a working relationship with local and international organizations, agencies, and individuals that promote family planning and demographic studies.

Accomplishments of the FPOP show that in 1980, under the IEC component, 289,909 persons were reached. IEC activities included seminars for youth groups, adult volunteers, would-be acceptors and women; home visits, follow-ups, counselling, radio programs and echo seminars.

Under the service delivery program, FPOP operates 45 family planning clinics, three commodity assisted family planning clinics, nine sterilization centers (six of which are for both minilaparotomy and vasectomy, and three for vasectomy only), five itinerant sterilization teams and four counselling centers. Its service delivery staff includes 26 doctors, 20 nurses, 18 midwives, 64 fieldworkers, and 8 medical technologists. Outreach services offered include motivation, follow-up, initial pill dispensation, contraceptives resupply, referrals, instructions on family planning, health, nutrition, contraceptives, parasite control, and environmental sanitation. Informal education and income-generating activities are also conducted.

Under the training component, a program on volunteer development and involvement is being implemented and a year-round enlistment of chapter volunteers is made. Furthermore, specific trainings are conducted on: monitoring and evaluation for program managers; materials development, counselling, and others.

*Institute of Maternal and Child Health (IMCH)*

The Institute of Maternal and Child Health has family planning as one of its service units. Its two main areas of operation are training and family planning clinic services with the following goals: (1) to continue assisting the National Population Program in reducing the population growth rate; (2) to promote the health and welfare of mothers, young adults, and children through maternal and child health

and family planning with focus on couples who have no children or those with as many as three; (3) to provide pre- and in-service training for multi-disciplinary workers to help them acquire or strengthen their knowledge, attitudes, and skills in delivering family planning services; and (4) to promote increased awareness, understanding, and acceptance of population and family planning through the Instant Sagot (Instant Reply) Service and projected pilot integrated community activities.

Some of the Institute's program accomplishments in family planning are as follows:

- Production of flip charts, booklets, posters, learning modules, and jingles for its IEC campaign;

- Operation of 265 comprehensive clinics which include family planning and counselling units, one mobile family planning clinic, and two itinerant sterilization teams. Its service staff is composed of 265 doctors, 120 nurses, 410 midwives, and initial group of 60 trained satisfied acceptors, known as "Siyahan Suri" who help in information dissemination and motivation activities.

- Training for program managers and doctors; motivation for doctors, nurses, midwives, fieldworkers, and paraprofessionals; counselling for fieldworkers, doctors, nurses, and midwives; trainers' training in pill dispensation, and IUD insertion for nurses and midwives, and in vasectomy for doctors; and instruction on the use of rhythm for field workers.

As of 1984, IMCH projects include the establishment of Barangay Health and Family Planning Newsstand; family planning related income-generating projects; mobilization of more volunteer workers (Siyahan Suri/Village Health Aides and Hilots); Close supervision of acceptors, gathering of data on births from local registration office.

Total number of clients served for the year was registered at 474,525.

*The League of Women Voters of the Philippines, Inc.*

Piloted a project (1980) in the recovery of family planning failure involving women defaulters and drop-outs due to diminishing use of family planning methods. This project which benefited 106 mothers was carried out in coordination with government and other private agencies.

## D. The Primary Health Care Program

The Philippines as one of the signatories of the World Health Organization has endorsed and supported the Primary Health Care Declaration as a global strategy to attain better health. On 6 September 1981, the Philippines became the first country to launch the PHC on a nationwide scale. The PHC was thus integrated into all the health programs of the country taking into consideration the following objectives:

1. To mobilize communities and make them participate effectively in identifying their health needs and in providing for their needs through self-reliance and self-determination;

2. To maintain health by promoting optimum standard of living and good health practices;

3. To democratize access to essential health sources by providing a channel for broadening the base of citizen and community participation in basic health care;

4. To sensitize and organize communities into functional entities to be able to participate effectively in planning for health and development;

5. To provide needed technical, institutional and logistic support to sustain community interest at the barangay and municipal levels.

Of the 38,015 barangays targetted for initiation to the PHC, 36,371 (96%) barangays were made aware of the need for changes if they have to survive as a people.

For the 6,671,924 households (HH) in the 12 regions of the country, a total of 214,696 Barangay Health Workers (BHWs) were trained, making the ratio of a BHW to HH, 1:31. Of the total BHWs 80-85% were women.

Although this program is geared to the entire population regardless of sex, it is noted that there are more women participating in the implementation of the program.

## III. WOMEN WORKERS AND THEIR HEALTH CARE: LEGAL ASPECTS

### A. Legal Mandate

The legal mandate for the protection of the health of women workers is based on Article II in the declaration of Principles and State Policies of the 1973 Constitution which requires the state to afford protection to labor regardless of sex, race or creed and to assure them, among others, of "just and humane conditions of work."

The social concept underlying such mandate is of concern to both men and women. However, there are measures which are exclusive to women workers. These are the protective measures concerned with their social and biological roles.

Such concerns are embodied in the Labor Code, specifically the prohibition against night work and provision of facilities for women workers*; and Presidential Decree 1202 which amended the Social Security Law, integrating maternity benefits into the Social Security System.*

Family Planning services, though not exclusive to women, are made available to them.

Under the Rules of the Code, employers who habitually employ more than 200 workers are required to provide free family planning services to their employees and their spouses which include, but are not limited to, the application or use of contraceptives.

The MOLE, in coordination with appropriate agencies of government and the private sector, develops and prescribes incentive bonus schemes to encourage family planning among female workers in any establishment or enterprise.

### B. Administration and Enforcement of Measures

Administration and enforcement of these protective measures and general labor laws including occupational safety and health in all establishments and workplaces lie with the Ministry of Labor and Employment. Within the Ministry, the function is the concern of several agencies such as the Bureau of Working Conditions (BWC), Bureau of Women and Minors (BWM), Institute of Labor and Manpower Studies (ILMS), Employees Compensation Commission (ECC) and the thirteen Regional Offices of the MOLE.

---

* Please see details of these legislations in "Women Workers in the Philippines" sectoral report.

Compliance with general labor laws, including those of health and safety is effected through various approaches.

- Information dissemination and workers' education programs are undertaken to appraise workers as well as employers of the requirements of law and to minimize the occurrence of work-connected accidents, injuries and sickness.

- Tripartite conference and consultative meetings are conducted to stress to significance of the health and safety program and its effects on workers' productivity and economic growth.

- Safety Committees are created at the plant level. Composed of representatives of labor and management, these committees are tasked with the development, implementation and maintenance of safety and accident prevention measures in the work area.

- Field inspection is undertaken upon receipt of complaint. The regular field inspection approach to ascertain standards on general health and safety was suspended by the MOLE).

- A one-fund concept known as the State Insurance Fund (SIF) system was established to ensure compensation liabilities of employees with the State. The SIF is funded by mandatory contributions from employers which are collected by the SSS and GSIS.

## C. Some Date on Workers' Health and Welfare

A survey on health services and hazards in industry (Jorge 1976-1978) showed that big companies hire the services of a physician, nurse, dentist and safety engineer on a fulltime basis and in medium and small-sized companies on part-time basis to attend to the health needs of the workers. Protective equipment were also found to be used in industries especially in the production of petroleum and coal products, chemicals and electrical equipment (where most women workers are) and tobacco.

Compensation benefits have always been a part of the regular employment package. Data from the Economic Compensation Committee reveal that as of August 1984, an amount of ₱106 M has already been settled by the GSIS for government claimants and the SSS for the private claimants.

The compensation benefits include income, medical, and rehabilitation benefits broken down as follows: ₱90M in compensation for disabilities and deaths; ₱16M in medical services; ₱.2M in rehabilitation benefits in the form of physical therapy, vocational training and job placement services.

During a recent Tripartite Conference on the Improvement of Working Conditions and Environment, the need for the workers' protection not only from the abuse of the employers but also from unsafe and hazardous workplaces was stressed.

This need may expand the list of "strikeable" issues to include the existence of grave hazards to health and safety in a workplace.

A recent report[6] stated that Filipino women involved in work-related accidents in industries increased due to the rise in the number of violation in health and safety standards and policies set by the MOLE for the protection and safety of workers. The same report stated that the share of female workers in the record of accidents went up from 1.45 percent of the 6,639 accidents in 1980 to 2.52 percent of accidents in 1983.

On the other hand, the violation rate of safety standards in establishments decreased from 21.4 percent to 11.1 percent from 1979 to 1983 this is assumed to be due to continuing education on occupational health. However, from January to November 1984, the rate increased again to 13.4 percent involving 5,822 establishments, probably due to the economic crisis. At the Bataan Export Processing Zone where 71 percent of the workers are females, violations of occupational health and safety standards have also been reported.

According to one survey,[7] "a woman worker who enters the garment, textile, food and electronics industries is carefully screened for good health but, ironically, leaves the factory in poor health." The survey also indicated that positions occupied by women as machine operators in electronics and textile industries; as sewers in the garment industry; as catchers, stampers or operators of packing machines in the tobacco industry; and as spinners, winders in the textile industry are labor intensive and require dexterity. Management, however, views them as the "unskilled" type and are therefore undervalued.

It is also observed that workers hesitate to resort to filing complaints to avoid the inconvenience of attending hearings and the cost of hiring a counsel. If they file complaints at all, the issues are predominantly on wage and wage-related standards and rarely as regards violation of health and safety standards.

---

[6] Asst. Minister Liwayway Calalang, Bulletin Today, 17 March 1985.
[7] Center for Women Resources, Bulletin Today, 26 March 1985.

## IV. SOCIAL WELFARE PROGRAM

The Social welfare program of the country has two major components namely: social welfare services designed for the most disadvantaged citizens; and the social security program designed for the protection of the working population and their dependents.

The Social Services programs are the major concern of the Ministry of Social Services and Development (MSSD) while the social security services are administered by the Government Service Insurance System (GSIS) which serves the needs of workers in the government sector and the Social Security System (SSS) for the private sector workers.

Following is a description of these two program components as they relate to women.

### A. The Social Welfare Services

Among the 5,412,642 needy persons serviced by the MSSD in 1981 2,808,673 or 52 percent were females.

On the outreach headcount by client category and sex for the Philippines, the tables shows that the female clients served in Project IV, (2.59 million or 47.8% of the total) constitute 49.81 percent.

**Summary Outreach Headcount by Client Category and Sex for the Philippines: 1981**

| CLIENT CATEGORY | TOTAL | MALE | FEMALE |
|---|---|---|---|
| PROJECT I | | | |
| Family Heads & Other needy adults | 1,061,465 | 423,133 | 638,332 |
| Children | 969,649 | 454,741 | 514,908 |
| PROJECT II | | | |
| Youth | 613,004 | 337,998 | 275,006 |
| PROJECT III | | | |
| Disabled and Special Groups | 182,181 | 90,216 | 91,965 |
| PROJECT IV | | | |
| Distressed | 2,586,343 | 1,297,881 | 1,288,462 |
| TOTAL | 5,412,642 | 2,603,969 | 2,808,673 |

Source: Journal of Philippine Statistics, Volume 33, No. 3 Third Quarter, 1982.

Family heads and other needy adults and children (Project I) accounted for 2.03 million or 37.5 percent. Of this number, women family heads and needy adults represents 60.1 percent, most of whom were under employed and jobless. On the other hand, 0.97 million children, mostly underweight, were served, of which 53.1 percent were females.

Youths (Project II) extended social services were about 0.6M accounting for 11.3 percent of the total clientele. In this project category, 44.8 percent served were young women, most of whom were out of school and pre-delinquents including those with behavioral or emotional problems.

The least number assisted were the disabled and special groups which accounted for only 3.4 percent (0.18 M), most of whom are the elderly women. (Table 5).

**1. Programs for mothers**

A social welfare program designed with the interest of the mothers in mind is the Day Care Service. Basically, this is a child care service that entails an arrangement called "substitute mothering." This is temporarily provided for pre-school children during part of the day when mothers cannot attend to their pre-schoolers for one reason or another. Supplemental feeding designed to benefit the malnourished children is a basic component.

As of 1983, a total of 8,737 day care centers were reported, enabling 636,751 pre-schoolers, mostly coming from poor families, to avail of the services offered. A possible implications of this is an increase in the number of mothers who were partly relieved of their mothering roles and given the opportunity to contribute to family income. Furthermore, more mothers were given the chance to develop as individuals as they were given the opportunity to train and benefit from programs in nutrition, home management, child development and care with the accompanying supplemental feeding and other activities. More women were likewise able to benefit from other social and economic programs such as:

- Family Day Care, whereby non-working mothers within a neighborhood are trained in early childhood enrichment so that they can be licensed to babysit on a part-time basis for at least five children at a time, especially those from 0-2 years of age.

- Drop-In-Homes, whereby volunteer mothers, grandmothers or young teenagers in a neighborhood are trained to babysit without pay or for a certain fee based on parent's capacity to pay.

- Rolling Day Care Centers, whereby volunteers set up a play center for a group of not more than 10 children who cannot be accommodated in the regular day care centers.

- Supervised neighborhood plays, manned by volunteers or out-of-school or retired and qualified elderlies who supervise play activities for pre-schoolers in designated places within their neighborhood for a certain number of hours daily.

## 2. Institutional Care Program

The MSSD accredits various organizations desirous of operating institutions/centers for children, youth, the disabled, the aged, unwed mothers and other special groups aside from maintaining or supervising institutions/centers for these groups of clients.

In 1984, MSSD reported a total of thirty institutional facilities for the care of these special groups. These facilities are categorized as: Reception and Study Centers (6), Regional Youth Rehabilitation Centers (10), Vocational Rehabilitation Centers (4), and Residential Facilities (10).

Of the ten residential facilities, the following are specifically for the care of women:

*Marillac Hills*

Various programs and services are maintained for the proper care, training and rehabilitation of delinquent girls. However, with the widespread increase of drug dependency, victims of white slavery, exploited girls and unwed mothers, this center has expanded its programs to answer the demand to assist these girls and prevent their becoming burdens of society.

*Home for Unwed Mothers*

Two institutions are maintained by the MSSD to accommodate young mothers during their period of crisis and adjustment.

## 3. Partnership with Non-Government Organizations (NGOs)

The MSSD also reports that the increase in the number of beneficiaries of the social welfare programs and services of the government is partly credited to the support extended by the NGOs, of which some are women organizations.

In 1983, the 2,824 NGOs registered an outreach totalling 4.8 million persons. Distribution is as follows: Child Welfare – 36,648; Family Welfare – 82,594; Youth Welfare – 791,490; Rehabilitation – 115,252; and Assistance – about 3.8 million.

B. Social Security Programs

Social Security as a part of the social welfare program of the country is designed to benefit the working population of the country.

One feature of the program which is beneficial to working women is the integration of the maternity benefits into the Social Security System (SSS) in 1977. Presidential Decree No. 1202 with the accompanying amendment to the Social Security Act (R.A. 1161 Sec. 14-A) enacted this integration.

In 1983, total benefits paid by the GSIS amounted to over ₱1.2B in the form of social insurance such as life and retirement benefits, property insurance medicare, and employees compensation.

The SSS on the other hand, reported for the same year, total benefits paid amounting to ₱1.1B representing payments for social security, medicare and employees compensation. Of this, ₱61,668,000 were given as maternity benefits to 62,416 claimants. As of 1984 number of claimants for maternity benefits totalled 391,075 (Table 6).

# V. STATUS AND PARTICIPATION OF WOMEN IN THE DELIVERY OF HEALTH CARE AND SOCIAL SERVICES

With the increasing complexity of modern health and social systems, the role of women in health care and social welfare services has considerably expanded. They have played various roles and exercised varying degrees of responsibilities in both organized and volunteer sectors.

## A. Women in Health Care

### 1. Organized Sector

Within the context of the Philippine experience in health care, women have increasingly been drawn into organized health efforts, either at community level or at provincial, regional and national level.

The leadership of women in organizd health efforts is manifested in their roles as city/provincial/regional health officers, medical directors, chiefs of hospitals, bureau directors and project managers. In these roles, women have been involved in all aspects of health management, including policy formulation, program planning, project development and service delivery or patient care.

Women's participation in these processes may be related to decision-making in all aspects of health care; that is, either she participates as one imbued with direct decision-making responsibility/ authority or as one who provides the technical support leading to the decisions made. Such technical support includes tasks like research, analysis of data and applying scientific methods to arrive at a national decision regarding health-related matter

Data however, show that the extent of participation of women in the planning, programming and delivery of health services is far from ideal. There seems to be a general tendency to appoint men rather than women to key posts in the health system's hierarchy, as shown in the notable male-preference in key posts at central, regional and provincial as well as city levels.

**Distribution of Key Positions in the Ministry of Health (As of October 1984)**

| Posts | Total | Male | Female | % F |
|---|---|---|---|---|
| Minister | 1 | 1 | 0 | – |
| Deputy Minister | 3 | 3 | 0 | – |
| Assistant Minister** | 3 | 2 | 1 | 33.3 |
| Advisers in the Office of Minister | 7 | 0 | 7 | 100.0 |
| Directors, Central Office | 10 | 5 | 5 | 50.0 |
| OIC, (central office) | 4 | 1 | 3 | 75.0 |
| Asst. Directors, Central Office | 7 | 4 | 3 | 43.0 |
| Chief, Central Office | 40 | 22 | 18 | 45.0 |
| Regional Health Directors | 12 | 11 | 1 | 8.3 |
| Asst. Regional Health Directors | 8 | 6 | 2 | 25.0 |
| Provincial Health Officers | 76 | 61 | 15 | 19.7 |
| Asst. Provincial Health Officers | 71 | 66 | 5 | 7.0 |
| City Health Officers | 59 | 49*/ | 10*/ | 2.0 |

* 1979 data
** As of May 1985

**a. Women in key positions in the MOH**

As shown in the table, there is a very low female-preference in such posts as Regional Health Directors, City and Provincial Health Officers as indicated in their very low representation. On the other, there seems to be a decidedly female preference for such posts as Advisers to the Minister (females occupy all positions) and Officers-In-Charge, where out of four positions, three are occupied by women. Note that there is apparently less sex discrimination at the central office level than at the regional, provincial and city levels.

For the position of Provincial Health Officers, women comprise only 19.7 percent. The percentage of women is even lower in the case of Assistant Provincial Health Officers (7.0 percent).

**b. Women in government and private hospitals**

The same pattern is observed in the distribution of chiefs of government hospitals (Table 8). Again, males dominate the positions of chiefs of hospitals at all levels whether primary, secondary or tertiary. It is also noted that as one goes higher in the hierarchy of hospital classification, less and less women are designated as chiefs of hospitals. **At the**

**lowest or primary level, there are 32 females for every 100 male chiefs of hospital. At the secondary level, the ratio is down to 16 females per 100 males. Finally, at the tertiary level, the ratio goes further down to 11 females for every 100 males.**

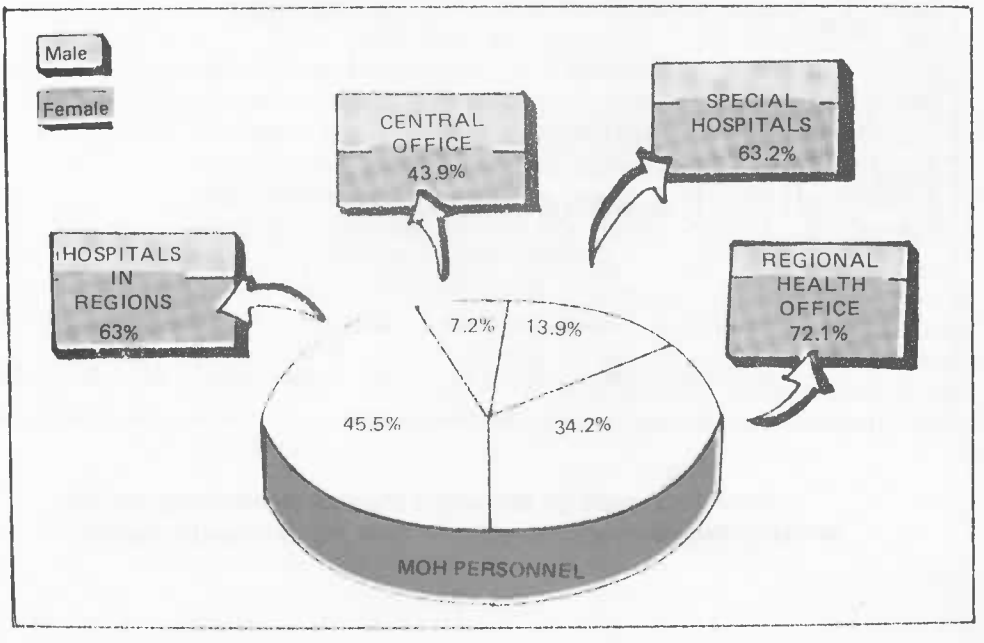
In the case of private hospital administrators/owners, male dominance is still evident, but to a lesser degree than that observed in government hospitals (Table 9). Also, the level of participation of women administrators in private hospitals seems to be more uniformly distributed at all levels. Thus, it is observed that at the primary level, there are 36 females for every 100 male administrators; at the secondary level, the ratio is 26 females per 100 males, and at the tertiary level, there are 28 females for every 100 male administrators.

### c. Women personnel in the Ministry of Health

On the whole, women constitute the majority force in the Ministry of Health. Female employees in the Ministry greatly outnumber their male counterparts. Of the total 51,993 employees, females number 34,383 or 66 percent (Table 10). It appears therefore, that while men dominate the top posts in the Ministry of Health, women comprise the bulk of the work force as shown in figure 2.

Figure 2

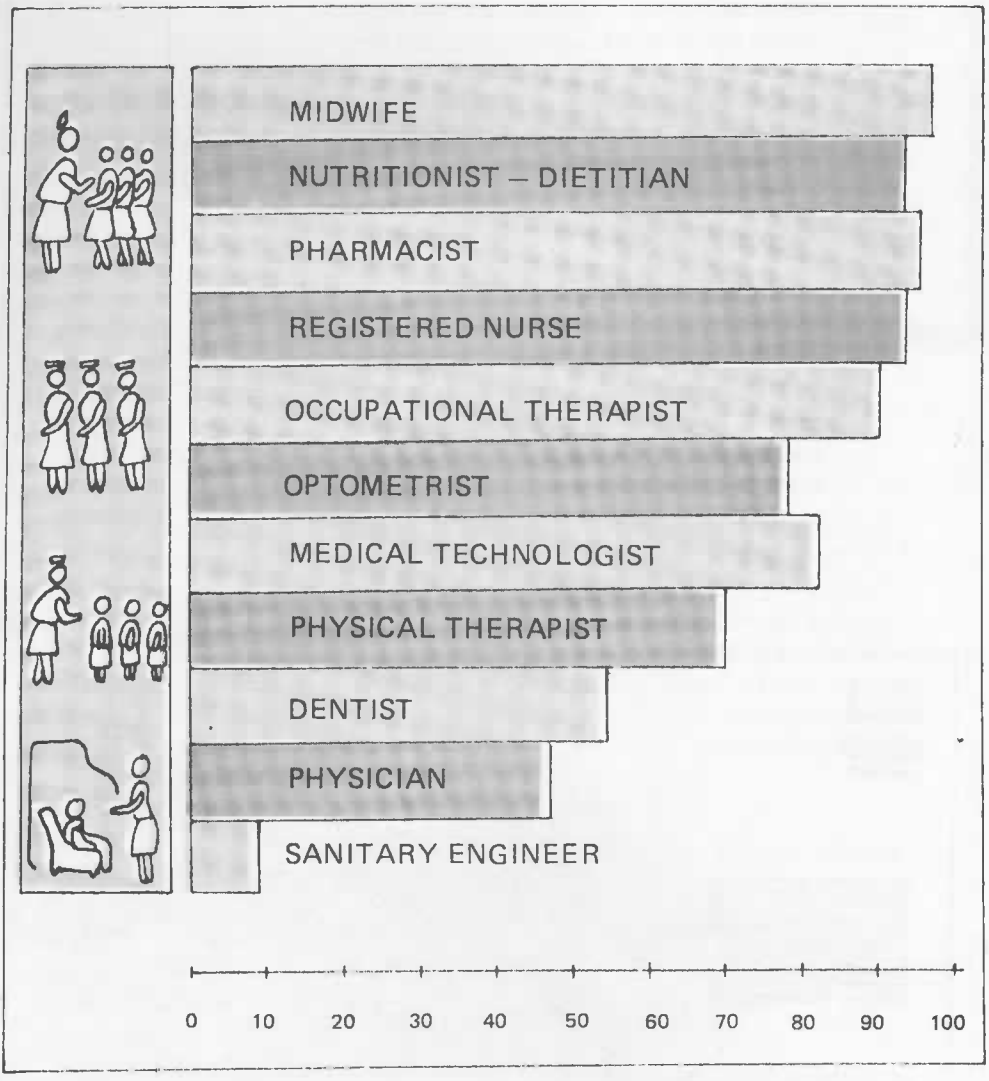
Distribution of MOH Personnel by Sex



**d. Women in the medical and allied medical professions.**

From 1975-1983, data from the Professional Regulation Commission show the percentage of registered licensed women in the medical and allied-medical professions as follows:

Figure 3
Women in the Medical and Allied Medical Professions




Note that most of the allied medical professions except sanitary engineers and physicians, are predominantly female.

These fields however connote lower status, prestige and income since among the health professionals, the doctors receive all the best.

During the decade it is to be noted that women started to get into male-dominated professions such as that of sanitary engineering. Their percentage may be small, but it is a step forward. Female doctors comprise half of the total number of doctors. This is a great achievement considering that until a few years ago, there was discrimination against women enrolling in some medical schools.

To illustrate, one medical school gave only 25 percent of the available slots to females. To eliminate this discrimination, the admission policy was revised in the late '70s making grades as basis for admission. However, because more females had higher grades, about 60 percent of the students accepted every year were females. This resulted to another change in the policy, that of having equal or 50-50 quota for males and females.

## 2. Women Volunteer Health Providers

In the Philippines, the health care delivery system is made possible partly through volunteer workers which are generally of two types:

### a. Program-specific volunteers:

These volunteers are those who are recruited to assist in the implementation of a specific program. For instance, the Ministry of Health has its network of Barangay Health Workers who deliver Primary Health Care especially to mothers and children. The Botica sa Barangay Aides assist in the community's medicinal needs. The National Population Program's counterpart for the Health care volunteers are the Barangay Service Point Officers, whose tasks include providing motivation, referral, follow-up of drop-outs among family planning acceptors, and re-supply of condoms and pills. The Nutrition Center of the Philippines, on the other hand, fields Barangay Nutrition Scholars to take care of the nutrition programs and services. Figure 4 show women's re presentation.

These fields however connote lower status, prestige and income since among the health professionals, the doctors receive all the best.

During the decade it is to be noted that women started to get into male-dominated professions such as that of sanitary engineering. Their percentage may be small, but it is a step forward. Female doctors comprise half of the total number of doctors. This is a great achievement considering that until a few years ago, there was discrimination against women enrolling in some medical schools.

To illustrate, one medical school gave only 25 percent of the available slots to females. To eliminate this discrimination, the admission policy was revised in the late '70s making grades as basis for admission. However, because more females had higher grades, about 60 percent of the students accepted every year were females. This resulted to another change in the policy, that of having equal or 50-50 quota for males and females.

## 2. Women Volunteer Health Providers

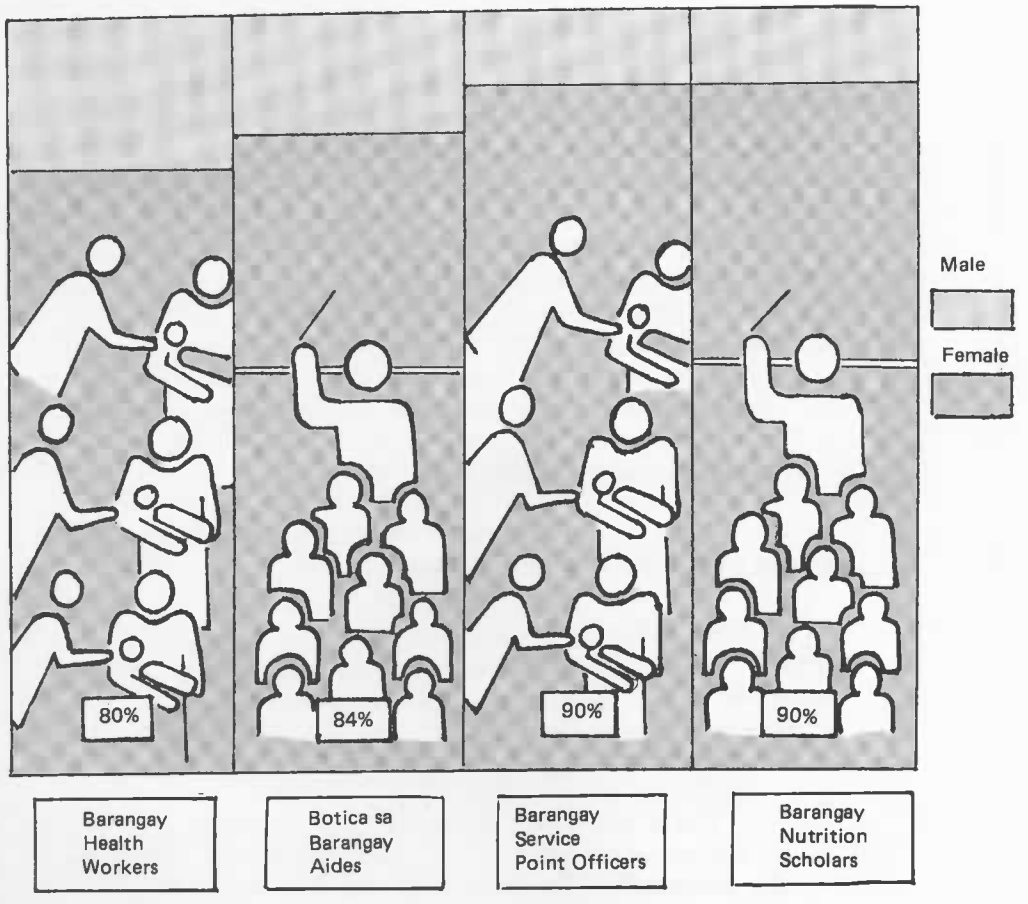
In the Philippines, the health care delivery system is made possible partly through volunteer workers which are generally of two types:

### a. Program-specific volunteers:

These volunteers are those who are recruited to assist in the implementation of a specific program. For instance, the Ministry of Health has its network of Barangay Health Workers who deliver Primary Health Care especially to mothers and children. The Botica sa Barangay Aides assist in the community's medicinal needs. The National Population Program's counterpart for the Health care volunteers are the Barangay Service Point Officers, whose tasks include providing motivation, referral, follow-up of drop-outs among family planning acceptors, and re-supply of condoms and pills. The Nutrition Center of the Philippines, on the other hand, fields Barangay Nutrition Scholars to take care of the nutrition programs and services. Figure 4 show women's re presentation.

Figure 4

**Program Specific Volunteers**




These volunteers come from the local community. They undergo various trainings to prepare them to assume their respective responsibilities.

**b. Women as individual or as members of women organizations.**

Many more women, either as individuals or as a member of a woman's organization, volunteer their services in carrying out health programs. These women and women's organizations such as the Civic Assembly of Women of the

Philippines, and its affiliates like the Philippine Medical Women's Association, Nutritionist-Dietician Association of the Philippines and the community-based grassroots organizations of mothers have greatly contributed to the improvement of the health status of the women and the whole population.

These organizations have undertaken different activities and programs in support of the maternal and child health care, nutrition, population and environmental sanitation programs. Financial and administrative support of these programs is borne by these organizations themselves or in coordination with other community resources.

Their involvement is not limited to sponsoring or undertaking health programs. They also represent women in meetings and conventions either at the local or national levels. The nurses' organization for example is starting to be more active in taking up issues which have direct or indirect implications on health. Nurses can now be seen in strike areas, in mass actions, and in rallies and demonstrations. They and other women health workers are now among the Philippine mass base, answering to the health needs of the masses.

### 3. Participation of Women in Decision-Making

As in the organized sector, women's participation as program-specific volunteer health providers reflects the same pattern when it comes to decision-making. In the operations of the Primary Health Care Program of the Ministry of Health, there are a total of 214,696 Barangay Health Workers, 80 percent of whom are women. But in the Primary Health Care Committee which is the decision-making body of the program, women's representation is only 41 percent.

From this situation, it may be inferred that the nature of women's participation in health care tends to be concentrated in the work force rather than in the decision-making arena. This would indicate that insofar as health care is concerned, women are getting the job done, but men are directing the work.

From the data in both organized and volunteer sectors, there are some indications, however, that women may be indirectly involved in a lot of decision-influencing tasks as implied by the set-up. There are more women providing technical and advisory

support to the appointed decision-makers. As indicated in Table 6 all seven advisers in the Office of the Minister are women and of the four Officers-In-Charge at the Central Office, three are women. Under this set-up and given the unique Filipino culture, it is not inconceivable that while important decisions in health care may have been given the stamp of authority by the male boss, the decisions themselves may have been made by the women who comprise the bulk of the work force. At any rate, once the decisions have been made, the task of transforming these into action is again largely done by women.

## B. Women's Participation in the Delivery of Welfare Services

The Philippines in the past years has been continuously experiencing economic dislocation, increasing the level of indigence among the population, exacting a heavy toll among the working masses whose income has either decreased or totally wiped-out as a result. This situation has also greatly affected the housewives who by tradition are the budget and finance manager of the family.

To alleviate the impact of this situation on the lives of thousands of the poor, the disabled and other special groups including housewives, the Ministry of Social Services and Development (MSSD) stepped up its services to become relevant to the needs of the times and stretched its funds to accommodate the millions seeking assistance.

For the past years, the MSSD despite the many crises it has met has continued to serve an increasing clientele in its various programs earlier discussed. Infact, it even surpassed its planned target outreach of 4.2 million by 21 percent in 1983.

The Ministry acknowledges the role the NGOs played. Their coordination and participation to augment limited resources were a great help especially in bringing about an equitable distribution of benefits to both urban and rural clients.

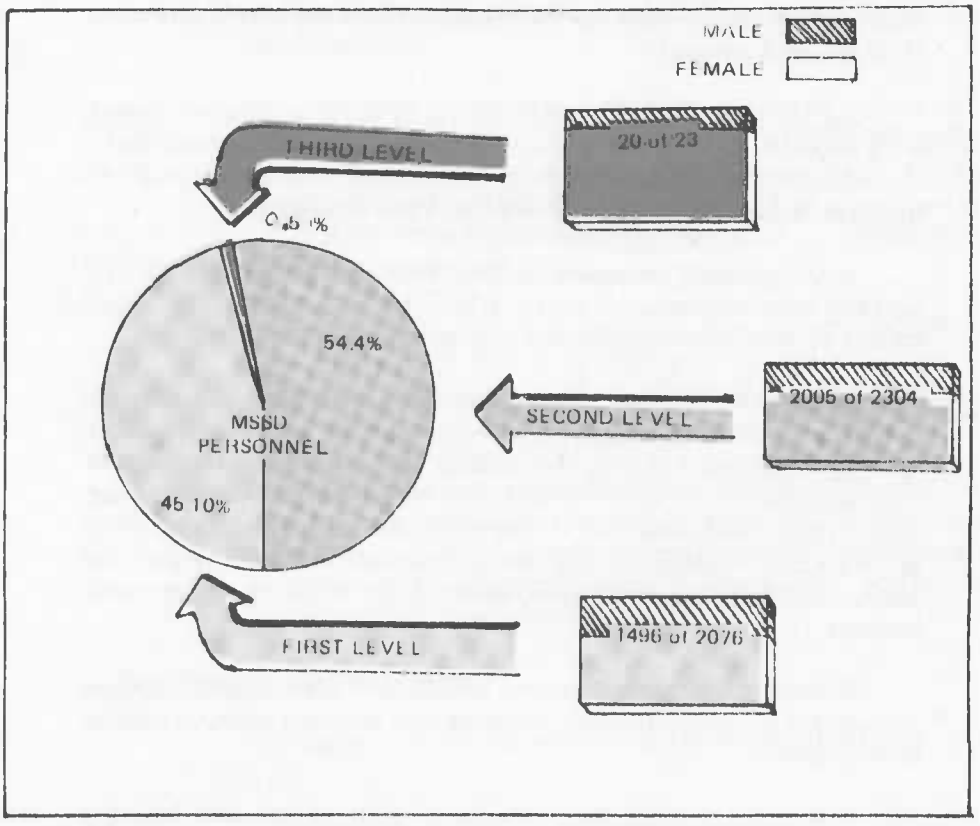
Such success in meeting the needs of the clientele in these times of crisis is also largely attributed to the participation of women. Of the 18 ministries in the government, the MSSD is one of the two ministries headed by a woman. As indicated in figure 4, most of the key positions are also occupied by women.

Furthermore, the total personnel in the Ministry (Table 11) also show that women represents 76.5 percent. Of these, women occupy 87.0 percent of the 0.5 percent decision-making posts (Third Level); 80 percent of the 54.4 percent of the professional, technical and scientific positions (Second Level); and 72.0 percent of the 45.10 percent of the clerical, trades and crafts and custodial service positions (Third Level).

With women in high posts and in all other posts directing and managing the programs and services, the female-dominated MSSD has proven that women can achieve so much despite all the challenges it meets along the way.

**Figure 5**

**Distribution of MSSD Personnel by Level & by Sex, 1984**




First level –

includes clerical, trades, crafts and custodial service positions which involve non-professional or sub-professional work in a supervisory capacity requiring less than four years of collegiate studies.

Second Level –

includes professional, technical, and scientific positions which require at least four years of college work up to the Division Chief level.

Third level –

includes positions in the Career Executive Service. For statistical purposes this includes executives of public enterprises, specifically those who occupy positions not lower than Assistant Department Managers.

# VI. ASSESSMENT

## A. Gains Made

Efforts to improve the health conditions of the population in general as well as of the women in particular recorded some improvements. Health statistics from 1972 to the middle of 1984 reflected a decline in the Crude Birth Rate by 15.5 percent; Maternal Mortality Rate by 52.9 percent and the Infant Mortality Rate by 29.3 percent.

An increase in the life expectancy of the population is noted, with women gaining more years than the men. There was also a decrease in the prevalence of communicable diseases although an increase in the cardio-vascular diseases was registered.

A 0.7 percent decreases in total fertility rate represents 13.5 percent improvement. Likewise, a 0.67 percent decrease in female deaths to total deaths represents 1.5 percent improvement.

Furthermore, public investments in environmental sanitation particularly the provision of safe water supply increased its clientele by 41 percent during the decade. An increase in the population supplied with water would also mean less burdened housewives, water being essential in domestic chores. It would also mean an improved quality of life since clean water offers protection against dirt and diseases, it being essential for drinking and personal hygiene.

Efforts to increase sanitary toilets have also helped decrease prevalence of communicable diseases and brought about a cleaner environment.

Investments in welfare programs such as housing facilities showed an increase in the number of affordable housing units for the middle income families. With this increase of affordable housing units more women (especially married) will have the chance of owning a house.

### 1. Women as Agents

Improvements can also be seen in women's participation in the delivery of health and welfare services as follows:

a) An increase in the number of trained hilots was registered thereby increasing the number of clientele in the maternal

and health care programs and in the rate of attended delivery (in births). Of the total 39,558 hilots in the country, 22,847 are already trained and are under the supervision of the MOH with women comprising about 85-90 percent.

b) An increase of women physicians and women professionals in medical and other allied professions was noted between 1975 to 1983. Women doctors now comprise 50 percent while in other allied medical professions they comprise 66 to 99 percent.

c) The number of women volunteer personnel continues to increase in the various health programs of both government and non-government agencies. At present, the Barangay Health Workers (BHWs) numbering 214,696 are servicing 6,671,924 households making the ratio of BHW to the number of household, 1:31.

d) an increased number of training for women health care implementors in the organized and volunteer sectors thus increasing the number of qualified and competent health personnel.

e) increased economic opportunities are available for more women. The training and volunteer work these women render qualify them to seek employment in medical institutions and in some cases, self-employment as in the case of the hilots and other health personnel.

**2. Women as Beneficiaries.**

Increased concern for women as beneficiaries is shown in the following:

a) Greater participation of non-governmental and private institutions in promoting better health care for the nation by supporting existing health and welfare programs of the government and/or their undertaking new or additional ones to benefit specifically the women.

b) Expansion of the Family Planning Programs to include a male-specific campaign in birth control rather than a solely female-oriented approach. This supports recent studies on family planning methods which reveal that the use of male-oriented approaches such as the condom and vasectomy or male sterilization is less expensive and involves less health risks.

c) Implementation of legal measures supportive to women such as the Presidential Decree No. 198* and the maternity leave benefits provision of the Labor Code.

d) Adoption of the Primary Health Care Concept thus making health services relevant and more responsive to the changing needs of women and children.

d) Increased concern of government with regards to the health and the nutritional status of children, pregnant and lactating women as shown by the various studies conducted and in the accomplishment reports of the various coordinating agencies.

B. Problems/Obstacle encountered

While there are achievements in the participation of women in promoting better health for the population and access to health programs and services, the present situation warrants further improvements.

Through the ages women have been socially and culturally charged with the responsibilities of promoting better health in the family, despite the other roles they play such as the pursuit of their own professions. In the interplay of these roles, women are torn between becoming good mothers and home managers or being successful health leaders. In becoming good home managers, they have to give more time to the family, committing less time to their work which generally will suffer. On one hand, if she chooses to become a successful health leader, then it would mean less time for the family. It seems however, that social and cultural pressures and the lack of support from their partners in life in sharing the responsibilities in home management leave most women not much choice but to devote more time to home management and little time to their work. This may explain why despite women's increased participation only few women seem to have to combined both roles successfully and thus enhance her professional career by landing a top-level decision-making position. Not that there have been increases in the number of women health personnel in both the organized and volunteer sectors. Majority of them, however, are found in lower level positions.

Legislations for the protection of pregnant and lactating women are incorporated in the Labor Code in recognition of the risks to which they are exposed with regard to their biological function of childbear-

*It provides that one of the Directors of the District Local Water Utilities must be a member or representative of a women's organization.

ing. It is, however, disheartening to observe that this special function of childbirth serves as a deterrent factor for women to be given hospitalization insurance and benefits which they badly need with the rising cost of hospitalization and other medical care. Private and government insurance agencies offering hospitalization benefits exclude childbirth. Even the Philippine Medical Care Program limits hospitalization benefits coverage to caesarian childbirth excluding normal deliveries.

It is a fact that during the decade an increased number of programs undertaken by women groups has contributed greatly to the national development of the country. However, it is also observed that among these women organization and among the women themselves, there is that lack of consciousness and efforts to improve their own health status. As in the maternal and child health care, especially in the promotion of breastfeeding, campaigns are always directed towards having a "healthy baby", "your baby's health", "future" and others. Most of the time, the breastfeeding mother's health which is as important is relegated to the background and if given attention, only on a very limited scale.

It has been universally accepted that breastmilk is the best food for the infant since it is natural and free from contamination. Voluminous research have also established that a breastfed baby is less prone to allergies, infections and diseases. Despite these encouraging results, limited support is given the program. Although the Philippines is already monitoring the International Code for Breastmilk Substitutes' as a signatory, the National Code is still waiting approval. It is also observed that efforts extended to this program are uncoordinated, thus lessening the desired impact.

As far as access to health care and welfare services is concerned, there is no discrimination problem against women. Rather, the health and welfare related problems of women as beneficiaries is more a function of the weaknesses of the health care and welfare delivery system and the state of over-all development. This access problem can be traced to a number of factors, as follows:

*Increasing cost in the standard of living*

The increasing cost of living, and particularly of food, compounds the problem of malnutrition among children and the pregnant and lactating mothers.

*Lack of adequate health information on women's health needs*

Adequate attention has been given women as regards their child-bearing function and as their role as mothers. But in their other special health needs, not much has been done due to lack of supporting information.

For instance, there is considerable awareness and concern about sex violence committed against women in the hospitality industry, as well as the health hazards faced by working women in industries. However, no comprehensive program or policy has yet been adopted to answer these needs.

*Highly centralized program management limiting flexibility of program implementors to be responsive to local needs.*

In the delivery of health services, overcentralization of authority and executive responsibility limits effective and adequate delivery at the community level. It also tends to lead to an overconcentration of personnel, institutions and facilities in urban centers, and a resultant maldistribution of resources. Central planners/authorities sometimes become too far removed from the common man, and lose touch with the needs and expectations of special groups.

Also, the present system of reporting health statistics does not fullfill the requirements from the central office thereby not giving the full picture.

*Deficiencies of communication and transport*

Many problems in the delivery of health services to rural areas are the consequence of poor transport and communications. These include insufficient supervision of the staff, lack of consultation and referral facilities, inadequate supplies of drugs and other health requirements, feelings of isolation and neglect among the staff, and shortage of information about needs and possibilities.

*Lack of clear priorities*

Clear, concise and logical priorities within health care systems are rarely laid down. For example, scant attention is given to the balance between curative, preventive, and promotional activities and the division of resources among them. A balance is not always established on objective ground between personal health services, environmental health services, and community-oriented activities. As a consequence, curative services and, more generally, personal services tend to receive undue emphasis, even when better results might be achieved by some other use of the same limited resources.

## C. Forward Looking Strategies

In the preceding section of the report, aspects of the health and welfare services and programs were singled out as factors which limit or hinder women's full participation in the delivery of these programs, or their access to these services as beneficiaries. This section presents ways of dealing with these limitations or obstacles in the context of some successful approaches, some which would need to be tested out for effectivity.

To answer the aforecited problems and issues in the health sector, the following current and forward looking strategies are proposed:

1) The present economic crisis is expected to be felt for quite some time. It is essential that programs along research and development of indigenous and cheaper substitutes for medicines, food products and technology should be given due support and encouragement. Generation of adequate health information for policy and public awareness should be made available regularly. A health information network would be very valuable for this purpose.

2) Training and mobilizing volunteer workers as in the case of Barangay Health Workers, Barangay Nutrition Scholars and women NGOs and other groups could help beat the rising cost of medical services as well as enhance community awareness on health and nutritional practices. Through the Primary Health Care program, the government can intensify its training of other paraprofessionals.

3) Government, with the assistance of the private sector, should continually adopt new strategies for motivating families to avail of family planning methods. As the usual procedures involve mostly women motivating other women, men motivating other men should be explored to intensify use of male-specific methods.

4) Government can minimize undertaking high-cost programs and services for the few and promote low-cost services that will reach a much larger proportion of the community.

5) Health education campaigns stand to benefit from the integration of concepts regarding roles of men and women in the curriculum, which aims to eliminate stereotyped-sex roles in family health care activities. Coordination with private and government agencies for support of these campaigns should be sought for greater program impact.

## BIBLIOGRAPHY

Calalang, Liwayway. "Women Workers and their Health Care: Legal Aspects." 1984

Cayapas, Eleo. "Promoting Workers' Welfare Through Employees' Compensation." A paper presented at the National Tripartite Conference on the Improvement of Working Conditions and Environment. January 10-16, 1984.

Civic Assembly of Women of the Philippines (CAWP). 29th Anniversary Program, 1975.

_____ 30th Anniversary Progam, 1977

_____ 31st Anniversary Program, 1978

_____ 32nd Anniversary Program, 1979

_____ 33rd Anniversary Program, 1980

_____ 34th Anniversary Program, 1981

_____ 35th Anniversary Program, 1982

_____ 36th Anniversary Program, 1983

Commission on Population. Annual Report, 1974-1975.

_____ Annual Reports, 1979, 1980, 1981, 1982

_____ Population Forum. First Issue, 1984

Constitution of the Republic of the Philippines, 1973 as amended.

Focus Philippines. "The National Shelter Program." May 1984

Fidelino, Rachel. "Working Conditions of Filipino Women Workers." A paper presented at the National Tripartite Conference on the Improvement of Working Conditions and Environment. January 10-16, 1984.

Go-Silayan, Aurora. "Women's Access to Health Care and their Participation in the Delivery of Health Care Services." A paper presented during the Public Forum on the U.N. Convention on the Elimination of all Forms of Discrimination Against Women. Quezon City Sports Club, 1984.

Jose, Francisco." Survey of Health Services and Hazards in Industry." A paper presented at the National Tripartite Conference on the Improvement of Working Conditions and Environment. January 10-16, 1984.

Magno, Feliciano H. "Contributor to Underdevelopment." Daily Express 12 March 1985.

Marcos, Pres. Ferdinand E. "A Bayanihan Approach to Public Health Welfare." Philippines Daily Express 1 June 1985.

Ministry of Health. Annual Reports 1980, 1981, 1982, and 1983.

_____ Health Plan 1983-1987

_____ Philippine Health Statistics, 1979.

Ministry of Human Settlements, BLISS Development Corporation, "Summary of Completed Projects Report." 1984

Ministry of Social Services and Development Digest. Volume 7 No. 10, 1984.

_____ Annual Reports 1980, 1983.

National Census and Statistics Office. Vital Statistics, 1975 and 1979.

_____ Journal of Philippine Statistics. Volume 33, No. 3 Third Quarter, 1982.

National Economic Development Authority. Updated Philippine Development Plan, 1984-1987

_____ 1984 Philippine Statistical Yearbook, 1984.

National Commission on the Role of Filipino Women. Women in the Philippines: A Country Report. 1980

_____ (Compiler and Editor) Philippine Reply to UN Questionnaire to Governments. (World Conference to Review and Appraise the Achievements of the UN Decade for Women: Equality Development and Peace, 1976-1985).

_____ A Study on the Participation of Women in Health Care, 1984

_____ Filipino Women: Facts and Figures, 1985

_____ Annual Reports 1976 to 1983

_____ Report on the Appraisal of the Achievements of the United Nations Decade for Women in the Philippines. September 1983

Nutrition Center of the Philippines. Annual Reports 1979, 1980, 1981

Philippine Nutrition Program. Annual Reports 1980 and 1982.

National Science and Technology Authority, Philippine Council for Health Research and Development. Inventory of Completed Health Researches," 1980-1984

Population Center Foundation. Initiatives in Population, Volume 7, No. 2, 1983

_____ Initiatives in Population, Volume 7, No. 3, 1983

_____ Directory of Agencies with Population Activities. 1980.

Rodriguez, Marcia C. "Hazardous Job Bared: Women Workers' Health Sacrificed? " Bulletin Today, 26 March 1985.

Social Security System. Annual Report 1983

Solon, Florentino Dr. "Existing health Conditions of Women and their Participation in the Delivery of Health Care Services." A paper presented during the Public Forum on the U.N. Convention on the Elimination of all Forms of Discrimination Against Women. Quezon City Sports Club, 1984.

UNICEF. Health and Basic Services, Key to Development. UNICEF SCARO, New Delhi.

# Appendices

# TABLE 1. HEALTH STATUS OF THE NATION (1972-1984)

| | 1972 | 1984 | % Change |
|---|---|---|---|
| Population | 39,040,100 | 53,165,800 | 36.2% increase |
| Crude Birth Rate* | 37.4 | 31.6 | 15.5% decrease |
| Crude Death Rate | 9.8 | 7.6 | 22.4% decrease |
| Infant Mortality Rate** | 82.0 | 58.0 | 29.3% decrease |
| Maternal Mortality Rate ** | 1.7 | 0.8 | 52.9% decrease |
| Communicable Diseases Death Rate | 286.2 | 227.1 | 20.6% decrease |
| Cardio-Vascular Diseases Death Rate | 69.5 | 144.4 | 107.7% increase |
| Malignant Neoplasms Death Rate | 27.4 | 38.0 | 38.6% increase |
| Life Expectancy | 59.3 | 62.8 | 5.9% increase |

*per 1,000 population
**per 1,000 live births

No. of Hospitals

## TABLE 2 – GOVERNMENT AND PRIVATE HOSPITALS, NUMBER AND BED CAPACITY, PHILIPPINES: FY 1972-1973 TO CY 1983

| YEAR | Total | No. of Hospitals | | Total | Bed Capacity | | Bed Capacity/ 10,000 pop. |
|---|---|---|---|---|---|---|---|
| | | Gov't. | Private | | Gov't. | Private | |
| 1972-73 | 768 | 254 | 514 | 45,986 | 22,325 | 23,661 | 11.5 |
| 1973-74 | 845 | 275 | 570 | 65,045 | 39,451 | 25,594 | 15.8 |
| 1975 | 969 | 363 | 606 | 69,774 | 41,692 | 28,082 | 16.5 |
| 1976 | 1,036 | 366 | 670 | 75,600 | 44,525 | 31,075 | 17.6 |
| 1977 | 1,150 | 371 | 779 | 79,621 | 45,161 | 34,460 | 17.8 |
| 1978 | 1,165 | 328 | 837 | 66,154 | 29,975 | 36,179 | 14.4 |
| 1979 | 1,410 | 335 | 1,075 | 70,891 | 31,050 | 39,841 | 15.2 |
| 1980 | 1,428 | 345 | 1,083 | 70,129 | 31,850 | 38,279 | 14.5 |
| 1981 | 1,450 | 353 | 1,097 | 64,995 | 32,120 | 32,875 | 13.1 |
| 1982 | 1,487 | 360 | 1,127 | 70,403 | 31,830 | 38,573 | 13.9 |
| 1983 | 1,416 | 361 | 1,055 | 62,740 | 31,930 | 30,930 | 12.0 |

## TABLE 3 FOOD ASSISTANCE OUTREACH BY POPULATION GROUP 1982

| Population Group | Estimated affected Population | Targetted | | Outreach | |
|---|---|---|---|---|---|
| | | Number 000 | Percent % | Number 000 | Percent % |
| Infants and Pre-School children | 1,756.3 | 1,034.3 | 58.9 | 917.2 | 88.7 |
| School Children | 1,513.6 | 4,998.3 | 330.0 | 5,204.1 | 104.1 |
| Pregnant and Nursing Women | 2,051.2 | 63.8 | 3.1 | 62.1 | 97.5 |
| Total | 5,321.1 | 6,096.4 | 114.6 | 6,183.4 | 103 |

Source: National Nutrition Council Annual Report 1982.

## TABLE 4 CALORIE AND NUTRIENT VALUES OF DAILY PER CAPITA AVAILABLE FOOD SUPPLY, PHILIPPINES: 1970 to 1981

| Year | Grams per day | | Calories per day | | Protein (Grams per day) | | Fats (Grams per day) | |
|---|---|---|---|---|---|---|---|---|
| | Value | Percent of sufficiency | Value | Percent of sufficiency | Value | Percent of sufficiency | Value | Percent of sufficiency |
| 1970 | 1,001.7 | 99.6 | 2,097 | 104.8 | 54.2 | 110.8 | 26.4 | 104.3 |
| 1971 | 965.7 | 96.0 | 2,123 | 106.2 | 54.9 | 112.3 | 26.4 | 106.7 |
| 1972 | 950.9 | 94.5 | 2,047 | 102.4 | 52.8 | 108.0 | 27.8 | 122.3 |
| 1973 | 992.3 | 98.6 | 2,108 | 105.4 | 54.4 | 112.1 | 31.0 | 103.3 |
| 1974 | 1,068.7 | 106.2 | 2,259 | 112.9 | 56.6 | 115.7 | 31.6 | 105.3 |
| 1975 | 1,094.3 | 105.4 | 2,290 | 112.6 | 69.5 | 136.3 | 33.5 | 119.6 |
| 1976 | 1,144.0 | 110.2 | 2,389 | 117.5 | 61.7 | 121.0 | 36.6 | 130.7 |
| 1977 | 1,209.1 | 110.5 | 2,417 | 118.5 | 62.9 | 122.1 | 41.0 | 143.9 |
| 1978 | 1,322.4 | 120.8 | 2,500 | 122.7 | 63.3 | 122.9 | 38.8 | 136.1 |
| 1979 | 1,335.0 | 122.0 | 2,504 | 119.5 | 66.1 | 128.3 | 38.3 | 136.1 |
| 1980 | 1,420.1 | 129.8 | 2,692 | 131.1 | 68.6 | 133.2 | 38.2 | 134.0 |
| 1981 | 1,403.6 | 128.2 | 2,637 | 129.0 | 67.7 | 131.5 | 35.9 | 126.0 |

## TABLE 5 – SUMMARY OUTREACH HEADCOUNT BY CLIENT CATEGORY AND SEX FOR THE PHILIPPINES: 1981

| Client category | Total | Male | Female |
|---|---|---|---|
| Total | 5,412,642 | 2,603,969 | 2,808,673 |
| Project I | | | |
| Family Heads and Other Needy | | | |
| Adults | 1,061,465 | 423,133 | 638,332 |
| Jobless | 282,094 | 111,812 | 170,282 |
| Underemployed heads of families | 310,010 | 137,406 | 127,604 |
| One-parent families | 49,544 | 19,605 | 29,939 |
| Families (member) with problem of relationships | 176,242 | 65,805 | 110,433 |
| Other needy adults who head families | 238,573 | 86,960 | 115,613 |
| Others | 5,002 | 1,541 | 3,461 |
| Children | 969,649 | 454,741 | 514,908 |
| Abandoned | 3,776 | 1,844 | 1,932 |
| Orphaned | 2,721 | 1,401 | 1,320 |
| Neglected | 2,477 | 1,277 | 1,200 |
| Poor children with behavioral/ emotional problems | 13,893 | 6,862 | 7,031 |
| Normal weight | 237,719 | 109,778 | 127,941 |
| Underweight | 664,171 | 312,844 | 351,327 |
| Others | 44,892 | 20,735 | 24,157 |
| Project I I | | | |
| Youth | 613,004 | 337,998 | 275,006 |
| Pre-delinquent including those with behavioral/emotional Problems | 41,874 | 23,587 | 18,287 |
| Youthful offenders | 6,028 | 5,418 | 610 |
| Mentally retarded | 1,386 | 757 | 629 |
| Unwed adolescents | 3,105 | 765 | 2,340 |
| Drug dependents | 4,424 | 2,871 | 1,553 |
| Others | 41 | 18 | 23 |

## TABLE 5 – SUMMARY OUTREACH HEADCOUNT BY CLIENT CATEGORY AND SEX FOR THE PHILIPPINES: 1981

| Client category | Total | Male | Female |
|---|---|---|---|
| Project III | | | |
| Disabled and Special Groups | 182,181 | 90,216 | 91,965 |
| Physically handicapped | 57,218 | 31,565 | 25,653 |
| Elderly | 103,645 | 48,908 | 54,737 |
| Mendicants | 5,071 | 2,432 | 2,639 |
| Drug addicts/alcoholic | 2,433 | 1,530 | 903 |
| Recovered mental patients | 803 | 445 | 358 |
| Released prisoners | 2,332 | 2,141 | 191 |
| Negative hansenites | 2,099 | 1,064 | 1,035 |
| Disadvantaged women | 3,999 | ... | 3,999 |
| Mentally/emotionally disturbed | 4,355 | 2,008 | 2,347 |
| Others | 226 | 123 | 103 |
| Project IV | | | |
| Distressed | 2,586,343 | 1,297,881 | 1,288,462 |
| Victims of natural disasters | 1,144,997 | 591,325 | 553,672 |
| Evacuees | 158,517 | 85,327 | 73,190 |
| Returnees | 52,127 | 40,624 | 11,503 |
| Refugees | 1,044 | 646 | 398 |
| Repartriates | 774 | 449 | 325 |
| Nomadic cultural communities | 88,567 | 44,360 | 44,207 |
| Squatters | 58,597 | 29,246 | 29,351 |
| Individuals in crisis situations | 174,971 | 83,191 | 91,780 |
| Resettled individuals | 62,472 | 33,051 | 29,421 |
| Others | 175,075 | 87,553 | 87,522 |
| Malnourished children | 669,202 | 302,109 | 367,093 |

**TABLE 6 NUMBER OF CLAIMANTS FOR MATERNITY BENEFITS**

| | |
|---|---|
| 1978 – | 25,199 |
| 1979 – | 54,342 |
| 1980 – | 53,626 |
| 1981 – | 61,397 |
| 1982 – | 67,055 |
| 1983 – | 62,416 |
| 1984 – | 67,040 |
| TOTAL | 391,075 |

Source: Actuary Division, SSS.

**TABLE 7 DISTRIBUTION OF KEY POSITIONS IN THE MINISTRY OF HEALTH (As of October 1984)**

| POSTS | Total | Male | Female | % F |
|---|---|---|---|---|
| Minister | 1 | 1 | 0 | – |
| Deputy Minister | 3 | 3 | 0 | – |
| *Assistant Minister | 3 | 2 | 1 | 33.3 |
| Advisers in the Office of the Minister | 7 | 0 | 7 | 100.0 |
| Directors, Central Office | 10 | 5 | 5 | 50.0 |
| OIC, (central office) | 4 | 1 | 3 | 75.0 |
| Asst. Directors, Central Office | 7 | 4 | 3 | 43.0 |
| Chiefs, Central Office | 40 | 22 | 18 | 45.0 |
| Regional Health Directors | 12 | 11 | 1 | 8.3 |
| Assistant Regional Health Directors | 8 | 6 | 2 | 25.0 |
| Provincial Health Officers | 76 | 61 | 15 | 19.7 |
| Asst. Provicial Health Officers | 71 | 66 | 5 | 7.0 |
| City Health Officers | 59 | 49** | 10** | 2.0 |

# TABLE 8
## SEX DISTRIBUTION OF CHIEFS OF GOVERNMENT HOSPITALS, BY REGION AND BY CATEGORY OF HOSPITALS PHILIPPINES, 1981-82

| REGION | PRIMARY* | | | SECONDARY* | | | TERTIARY*** | | | ALL CATEGORIES | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | MALE | FEMALE | M/F RATIO[1/] | MALE | FEMALE | M/F RATIO[1/] | MALE | FEMALE | M/F RATIO[1/] | MALE | FEMALE | M/F RATIO[1/] |
| I | 8 | 5 | 62 | 17 | 3 | 17 | 9 | 3 | 33 | 34 | 11 | 32 |
| II | 11 | 3 | 27 | 24 | 6 | 25 | 2 | 0 | – | 37 | 9 | 24 |
| III | 15 | 4 | 26 | 24 | 3 | 12 | 7 | 0 | – | 46 | 7 | 15 |
| IV | 10 | 4 | 40 | 40 | 6 | 15 | 24 | 5 | 20 | 74 | 15 | 20 |
| V | 14 | 2 | 14 | 12 | 3 | 25 | 5 | 1 | 20 | 31 | 6 | 19 |
| VI | 10 | 6 | 60 | 10 | 2 | 20 | 8 | 0 | – | 28 | 8 | 28 |
| VII | 3 | 3 | 100 | 18 | 1 | 5 | 8 | 0 | – | 29 | 4 | 13 |
| VIII | 7 | 3 | 42 | 23 | 3 | 13 | 7 | 0 | – | 37 | 6 | 16 |
| IX | 7 | 0 | – | 12 | 5 | 41 | 4 | 0 | – | 23 | 5 | 21 |
| X | 2 | 1 | 50 | 14 | 3 | 21 | 6 | 1 | 16 | 22 | 5 | 22 |
| XI | 7 | 1 | 14 | 11 | 1 | 9 | 6 | 0 | – | 24 | 2 | 8 |
| XII | 4 | 0 | – | 12 | 0 | – | 2 | 0 | – | 18 | 0 | – |
| ALL REGIONS | 98 | 32 | 32 | 217 | 36 | 16 | 88 | 10 | 11 | 403 | 76 | 19 |

1/ No. of females per 100 males

Source of Basic Data: Hospital Licensure Records, Bureau of Medical Services, MOH, 1981-82

N.B. – Excludes hospitals whose records did not clearly indicate sex of chief of hospital

* Primary Hospitals – levels of services equivalent to skills of a general practitioner. He has no surgical capacity

** Secondary Hospital – has surgical capacity but no specialty. Also no training capacity.

*** Tertiary Hospital – has basic specialties in obstetrics, surgery, medicine and pediatrics, with teaching/training (residency) capacity. There are three levels of tertiary hospitals, i.e., provincial level, with 4 basic specialties and 3 sub-specialties and with research as well teaching/training capacity; and medical center, with highly specialized services including training and research and nuclear medicine.

# TABLE 9
## SEX DISTRIBUTION OF ADMINISTRATORS/OWNERS OF PRIVATE HOSPITALS BY REGION AND CATEGORY OF HOSPITAL PHILIPPINES 1981-82

| | PRIMARY* | | | SECONDARY* | | | TERTIARY*** | | | ALL CATEGORIES | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| EGION | MALE | FEMALE | M/F RATIO[1/] | MALE | FEMALE | M/F RATIO[1/] | MALE | FEMALE | M/F RATIO[1/] | MALE | FEMALE | M/F RATIO[1/] |
| I | 44 | 11 | 25 | 29 | 4 | 13 | 5 | 0 | – | 78 | 15 | 19 |
| II | 45 | 17 | 37 | 14 | 3 | 21 | 0 | 2 | – | 59 | 22 | 37 |
| III | 65 | 19 | 29 | 31 | 8 | 25 | 16 | 0 | – | 112 | 27 | 24 |
| IV | 57 | 36 | 63 | 72 | 18 | 25 | 41 | 14 | 34 | 170 | 68 | 40 |
| V | 51 | 19 | 37 | 22 | 9 | 40 | 10 | 3 | 30 | 83 | 31 | 37 |
| VI | 13 | 1 | 7 | 6 | 0 | – | 12 | 1 | 8 | 31 | 2 | 6 |
| VII | 20 | 6 | 30 | 10 | 9 | 90 | 9 | 4 | 44 | 39 | 19 | 48 |
| III | 13 | 3 | 23 | 10 | 1 | 10 | 3 | 0 | – | 26 | 4 | 15 |
| IX | 18 | 10 | 55 | 14 | 3 | 21 | 2 | 0 | – | 34 | 13 | 38 |
| X | 50 | 12 | 24 | 19 | 2 | 10 | 7 | 2 | 28 | 76 | 16 | 21 |
| XI | 25 | 11 | 44 | 7 | 4 | 57 | 4 | 4 | 100 | 36 | 19 | 52 |
| XII | 30 | 14 | 46 | 13 | 3 | 23 | 4 | 2 | 50 | 47 | 19 | 40 |
| LL EGIONS | 431 | 159 | 36 | 247 | 64 | 26 | 113 | 32 | 28 | 791 | 255 | 32 |

/ No. of females per 100 males

Source of Basic Data: Hospital Licensure Records, Bureau of Medical Services, MOH, 1981-82

N.B. Excludes Hospitals whose licensure records did not clearly indicate sex of administrator/owner, unlicensed hospitals also excluded

## TABLE 10. MOH PERSONNEL BY SEX (1984)

| | T | M | F |
|---|---|---|---|
| Central Office | 3,730 | 2,091 | 1,639 |
| Special Hospital | 6,796 | 2,499 | 4,297 |
| Regional Health Office | 17,799 | 4,255 | 13,544 |
| Hospitals in the regions | 23,668 | 8,765 | 14,903 |
| | 51,993 | 17,610 | 34,383 |

## TABLE 11 MSSD PERSONNEL BY OFFICE, BY LEVEL AND BY SEX
**(As of December 31, 1984)**

| | THIRD LEVEL | | | SECOND LEVEL | | | FIRST LEVEL | | |
|---|---|---|---|---|---|---|---|---|---|
| | T | M | F | T | M | F | T | M | F |
| Office of the Minister | 5 | 0 | 5 | 72 | 15 | 57 | 162 | 89 | 73 |
| Bureaus | 7 | 0 | 7 | 73 | 17 | 56 | 48 | 23 | 25 |
| Regional Offices | 11 | 3 | 8 | 2359 | 467 | 1892 | 1886 | 468 | 1398 |
| Totals | 23 | 3 | 20 | 2504 | 499 | 2005 | 2076 | 580 | 1496 |

Source: Personnel Division, MSSD