HEALTH alert
ASIA - PACIFIC EDITION
Issue 14
2008
ISSN 0116 - 1202
HAIN
HEALTHLINK WORLDWIDE

Maternal & Child Health: the unpleasant truth

Mother and child has been a recurring theme in arts, owing mainly to the powerful images it evokes - that of the mother as a life-giving and caring creature, and that of the child as a personification of purity and innocence. But the adage of art imitating life certainly does not apply to this particular theme, for the truth about maternal and child health (MCH) situation is far from pleasant.

In the editorial, “The ties that bind: untangling the socio-political context of MCH,” the author provides an overview of the scope of the problem: high incidences of maternal and child deaths, and mother to child transmission of HIV. The article also dwells on the socio-economic and political factors that make maternal and child health one of the pressing health concerns worldwide.

“Domestic violence in Vietnam: situations and challenges” details the learnings of a Vietnamese organization in handling a gender-sensitivity and anti-violence against women (VAW) program. The article also provides a few insights on how other organizations can help eliminate gender inequality and VAW in their respective areas.

“Child Labor” is a comprehensive look at the global burden of child labor. It also discusses the different forms of child labor, including using children as child-warriors.

“Similarities and Differences of Traditional and Professional Health Care System in B’laan Communities” is a condensed thesis paper that explores the divergence and convergence between Western medicine and the traditional beliefs and practices of the B’laan tribe, an indigenous peoples living in the Philippine island of Mindanao.

“Too young, too curious” looks at adolescent reproductive health and how the lack of information and services makes the youth more vulnerable to sexually transmitted infections and early pregnancy.

The last article, “Early marriage: a different perspective for teenage pregnancy,” provides a different take on early pregnanyc by tackling the cultural factor behind early marriage.

The ties that bind: untangling the socio-political context of MCH

By Ross Mayor

How well a country provides for its citizens can best be reflected by the state of its maternal and child health (MCH).

Maternal and child health (MCH) is not an entirely new concern, but its inclusion in the Millennium Development Goals (MDG) gave its attainment priority status. Goal 4 calls for the reduction of under-five mortality by two-thirds by 2015, while Goal 5 aims to reduce maternal mortality rate by three-quarters.

Barely six years before the deadline, the global community still has a lot of catching up to do. At best, efforts to reduce maternal and child mortality ratios produce patchy results, with some countries attaining a level of success, while others further slide down the ladder.

Maternal health

According to The Millennium Development Goals Report 2007, while child mortality is on the decline, more than half a million women worldwide still die of pregnancy and/or childbirth-related complications every year.

The WHO brought to fore the health needs of newborns, which have been largely ignored.

In the Asia-Pacific region, South Asia posted the highest maternal mortality ratio of 546 deaths per 100,000 live births in 2000. East Asia, on the other hand, had the lowest ratio of 55 per 100,000 live births. From 1997 – 2002, 31 percent of maternal deaths in Asia was due to hemorrhage.

The availability of health services before, during, and after pregnancy is a key factor in reducing maternal death. In East and Central Asia, where maternal deaths are lower than in other Asian regions, the percentage of births attended by skilled personnel is significantly higher at 79 percent and 99 percent, respectively. South Asia, on the other hand, had the lowest percentage of 36 percent.

The socio-economic divide is very evident in the chasm between developing and developed countries. As a whole, developing countries have a maternal mortality rate of 450 per 100,000 live births, as compared to 14 per 100,000 live births in developed regions.

Child health

Child mortality rate is largely on the downtrend, owing mainly to an expanded immunization coverage. In a period of five years (2000 to 2005), deaths from measles have gone down by more than 60 percent.

However, more pressing concerns are needed to be addressed in order to make a significant and lasting impact on child health. A press release from the UN Economic and Social Commission for Asia and the Pacific noted that the region accounts for more than 65 percent of the world's undernourished children.

In the 2005 World Health Report, the World Health Organization called attention to the needs of newborns, which have been largely ignored. According to the report, every year, there are 3.3 million stillborns and four million newborns dying within 28 days after birth. Neonatal sepsis is identified as the leading cause of neonatal deaths, along with pneumonia.

HIV mother to child transmission

Mother to child transmission (MCT) of HIV is another grave concern facing both mothers and newborns.

Biologically, women are twice more than likely to be infected with HIV. Their vulnerability is further heightened by the fact that in a male-dominated society, women often do not have bargaining powers, making them easy targets for violence and coercion.

In Asia, the prevalence of pregnant women with HIV is below five percent, but given the fact that the continent

is host to majority of the world's population, the actual number is still a cause for concern. *(see table)*

Number of children at risk of being infected with HIV through MCT (2001)	
Region	**Figure**
Eastern Europe and Central Asia	5,000
East Asia and the Pacific	68,000
Middle East and North Africa	40,000
South Asia	160,000
Source: UNAIDS, 2001.	

Half of MCT cases occur during delivery. This is a particular challenge in developing countries where majority of births are not attended by skilled personnel and the risk of infection is far higher.

Untying the knots

Like all other health issues, MCH also has a socio-political and economic dimension. Maternal and child deaths are preventable, but how come millions are dying? It is not a coincidence that developing and least developed countries also have the highest number of maternal and child mortality.

Poverty is the biggest stumbling block in the fight against maternal and child deaths. Malnutrition makes a pregnant woman and her children more prone to illnesses, but going to bed hungry is an all too common reality in poor regions.

Even access to education, which has been proven to have significant impacts on maternal and child health, is a luxury for the world's poor.

Developing nations rely mainly on foreign loans to prop up their economies. The social cost of such loans is steep: reduction in budget for key social services, including health. Thus, public hospitals and health institutions in developing nations are largely understaffed and lack equipment and supplies. Patients also have to pay for whatever services they are going to avail. In the Philippines, it is not unusual to see two mothers sharing a bed, or two newborns sharing a crib in government hospitals.

Under the current economic order, everything has a tag price – including health services. For millions of people struggling to eke out a living, paying for health services – no matter how badly needed – is simply not an option. In an increasingly commercialized world, talks about equitable access to health care have been thrown out the window.

As governments renege on their responsibility to provide health care to their citizens, women and their children have been largely left on their own. And the results are disastrous. In the 2008 World Health Report, the World Health Organization is categorical in stating that globalization has "(put) the social cohesion of many countries under stress, and health systems, as key constituents of the architecture of contemporary societies, are clearly not performing as well as they could and as they should."

Religion and cultural beliefs also play an integral part. Maternal and child health is an integral component of reproductive health (RH) and rights, but RH remains to be a sensitive issue. Preventing unplanned pregnancy can reduce maternal deaths by one quarter, but a substantial number of women across the globe still has unmet needs for family planning. In Asia, unmet needs for family planning range from a low of 7.6 percent in Iran, to a high of 30 percent in Thailand. The gap in the delivery of RH information and services will have a particular resonance in light of the fact that more and more young girls are becoming pregnant; as well as the growing cases of mother to child transmission of HIV.

Walk the talk

The needless deaths of millions of mothers and children bear down hard on the global community's moral conscience and psyche. The reduction of maternal and child deaths is a tough task requiring not only medical interventions, but a holistic approach that would question the existing social inequities that make mothers and children at risk of dying.

Sources:

http://www.mdgasiapacific.org/files/shared_folder/documents/fs_nca_mdg_goal5_en.pdf

http://www.un.org/millenniumgoals/pdf/mdg2007.pdf

Asia-Pacific Making Progress in Meeting the Millennium Development Goals But Falls Behind Other Regions in Some Target Areas, Says New Report. http://www.unescap.org/unis/press/2007/oct/g38.asp

Ahmadi Aliyar and Jalil Iranmahboob. Unmet need for family planning in Iran. http://iussp2005.princeton.edu/download.aspx?submissionId=51915

The World Health Report 2008. WHO. http://www.who.int/whr/2008/en/index.html

Israel, Ellen and Mary Kroeger. Integrating Prevention of Mother to Child HIV Transmission into Existing Maternal, Child, and Reproductive Health Programs. Technical Guidance Series. http://www.pathfind.org/site/DocServer/Technical_Guidance_Series_3_PMTCTweb_01.pdf?docID=242

Domestic violence in Vietnam: Situations and challenges

by **Vu Song Ha, MD.MPH, Hoang Tu Anh, MD, MSc., Quach Thu Trang, MA**
Consultation of Investment in Health Promotion (CIHP)

A multisectoral and holistic approach to ending VAW is slowly breaking down gender inequity in Vietnam.

Though national level statistics on gender-based violence do not exist, existing research shows that domestic violence is a problem in Vietnam. A number of recent studies in North Vietnam suggest that about one third of women experience domestic violence, and one in every three abused women suffer more than one kind of violence[1].

Social norms and cultural attitudes pose a challenge in program intervention. Violence against women is a socially acceptable behavior amongst Vietnamese men; it is seen as a punishment for their wives when they transgress the traditional roles. In addition, Vietnamese women are expected to quietly endure the hardships and protect the harmony and reputation of the family. Many abused women, therefore, do not seek support.

Multisectoral action against domestic violence

Vietnam has made many efforts in response to this issue. In 2007, the government issued a Law on Domestic Violence Prevention and Control, which clearly defined domestic violence as "any intentional action by a family member to cause damage or potentially cause damage in terms of physical, spiritual, and economic damages to another family member" and provides a legal framework for the intervention and prevention of domestic violence. The National Standards and Guidelines on Reproductive Health also have regulations on this issue. Different cause-oriented groups have also banded together in 2007 to form the Domestic Violence Prevention Network in Vietnam. The network aims to maximize the voices and strengths of organizations and individuals working on domestic violence.

Case study:
An integrated model for gender-based violence prevention in community and clinic settings

Organizations have come up with innovative ways to deal with the challenge, as can be gleaned from the example of the Consultation of Investment in Health Promotion (CIHP), a local NGO in Vietnam.

Since May 2006, CIHP has been implementing the Ford Foundation- funded action and research project "Integrated Model for Responding to Gender-Based Violence (GBV) in Clinic and Community Settings" in seven communities in Cua Lo town, Nghe An province - a costal center province in Vietnam. The project design focuses on the creation of a comprehensive network for behavior change communication (BBC) as well as support to abused women through a variety of institutions. After two and a half years the project has had many significant achievements:

- 80 percent of female clients visiting district hospitals were screened.
- Counseling center provided 195 counseling sessions for 77 abused women.
- A total of 202 abused women were supported.
- Hundreds of BCC sessions were organized for local men and women. Dozens of articles, reports were included in local news papers, radio and television.
- Many IEC materials, including guidelines to support abused women and intervene in GBV cases, stories of abused women, were developed and widely distributed.
- A number of campaigns on GBV were

Art as a therapy. Some of the women supported by CIHP *(The faces of the women were intentionally blurred to protect their privacy.)*

Photo courtesy of CIHP

organized at commune and district levels.
- Local people perceive that they have both the right and the obligation to intervene in GBV cases.
- More women who experience violence seek support and identify options available to them to change their relationship with their abusive partner.
- Local authorities started to punish abusive men. About ten men, who repeated their abusive behaviors for 2nd or 3rd time, were requested to pay fine, to learn laws on DV, and to undertake public work in commune area.

There are a number of lessons learned:

- It is very important to move from "reconciliation" to "comprehensive and effective support". Domestic violence is often intervened by reconciliation groups composed of local authorities and representatives from mass organizations such as women's union. The "Reconciliation" approach focuses on persuading both sides to make compromises and promotes harmony. Therefore, it often reinforces traditional gender inequity norms, limits choices of women and ineffectively addresses violence. The "comprehensive support" means not only reconciliation but also providing knowledge on laws, guidance on the procedure for intervening and support for abused women, challenging gender stereotypes, as well as creating a strong network between reconciliation group and police, health and legal systems.

The "Reconciliation" approach focuses on persuading both sides to make compromises and promotes harmony.... it often reinforces traditional gender inequity norms, limits choices of women and ineffectively addresses violence.

- The introduction of laws on domestic violence plays a substantial role in the prevention and intervention on domestic violence. Due to lack of knowledge of the laws, members of the supportive group work mainly based on personal experiences and sometimes struggle with insufficiency in recording evidence, preparing legal documents, and intervention toward abusers. Training on laws and consultation with police and court helps members of the supporting system provide better support for abused women. Local people have indicated that since they heard about the laws on domestic violence, they know that they are protected from violence. Some women told us that they used the laws on domestic violence to indirectly warn their husbands.

- Women's empowerment through self-help groups, life skills, creative training in arts and proactive involvement in social activities is crucial for preventing and ending violence. Self-help groups provide opportunities and a supportive environment for women to share their situations, feelings, struggles, and seek for support. These groups also help women to improve their knowledge, change their attitudes toward gender stereotypes, and domestic violence. Through art and proactive activities women will gain more self-esteem, and be able to analyze their situation and make choices for themselves.

- Involving men, particular male abusers, in project activities is challenging. While the project has conducted several communication sessions and events on gender equality and domestic violence, most of participants are women. Many men still have the opinion that domestic violence is a family issue, and they do not need to worry about it. In addition, among those men attending project activities, almost all of them are non-violent and they actively participate in many activities. Several abused women expressed that they wished somebody in the project could talk with their husbands or make them attend the communication sessions. It seemed that male abusers have avoided meetings and events where GBV is discussed.

- Last but not least, creating a women-friendly, anti-violence environment is needed. In the cultural and social context of Vietnam, responses of women and men toward violence depend very much on the attitudes of family members, neighbors and staff of the supporting system. When a member of the support system has the attitude of tolerating violence, blaming women, and opposing divorce, women feel reluctant to speak out and men have more power to use violence. Efforts, such as forums, discussions in media, BBC campaigns, to challenge male-favorable gender roles, norms, stigma and discrimination toward divorce, expand the choices for women.

Source:

Vu Manh Loi et al. 1999; Population Council 2000, 2001; Luke et al, 2007, The proposal for the project of development of Domestic Violence Law (document No. 2330 TTr/UBXH) sent to the National Assembly by the Committee for Social Affairs of the National Assembly dated, 30 August 2006. Thi, 2006.

Child Labor

by Barny Rivera

Poverty forces millions of children to work; putting their lives - and their future - on the line.

Child labor is actual manpower coming from people below the age of 18. It is work that exceeds a minimum number of hours, depending on the age of a child and on the type of work. For children aged five to 11, beyond one hour of economic work or 28 hours of domestic work per week already constitutes child labor. The hours increase as the child becomes older. For children 12 to 14 years old, 14 hours of economic work or 28 hours of domestic work per week is considered child labor. For minors 15 to 17, the minimum is 43 hours of economic or domestic work per week.

It comes in different forms. Children can work as household help or as workers in farming and fishing industries. Some are given work in quarries, mines, brick kilns and construction sites. On an even more dangerous note, children are increasingly becoming more involved in the drug trade or serve as providers of sex services. It is reported that children living in the poorest households are most likely to be involved in child labor, especially those in the rural areas.

While accepted as illegal and condemned in society, experts claim that child labor thrives steadfastly in underground economies because employers can get away with paying underage workers less than their adult counterparts.

Who is affected?

As if a disease, child labor is widespread across the globe and sees no boundaries. According to the International Labor Organization (ILO) there are about 250 million economically active children worldwide; 153 million of these workers are in Asia. Around half of the economically active children are working full time and 30 to 46 million are in exploitative conditions. In Asia, many of these child laborers are hidden.

One in six children in developing countries is engaged in child labor. The numbers are alarmingly high, and they even get bigger. In least developed countries, 30 percent of all children are engaged in child labor.

The highest instances of child labor occur in the sub-Saharan Africa, where one in three children aged five to 14 are working. Inversely, the lowest rates are in the Central and Eastern European region, producing one in every 20 children. In the East Asia and Pacific, ten percent of children are involved in some form of child labor. Higher percentages are found within South Asia with 13 percent of the minor population subject to exploitation.

In these cases it is reported that boys are far more likely to be engaged in child labor, especially those of the economic kind. On the other hand, girls are those who are burdened with the household chores.

Different kinds of child labor

One of the worst forms of child labor is the commercial sexual exploitation of children. The United Nations Children's Fund (UNICEF) estimates that about one million children are lured or forced into the sex trade in Asia every year. More horrifying to know is that many of these children are introduced into the work by people known to them. Both children and adults are trapped in these circumstances for a myriad of socio-economical reasons such as poverty or unemployment.

In Southeast Asia, Thailand is believed to receive a large number of children trafficked from neighboring Asian countries, the majority of whom comes from Burma. Reports estimate that the number of Thai children working in the sex industry is somewhere between 27,400 and 44,900, including both foreign and ethnic. In Indonesia, children are brought to Singapore, Malaysia, and Taiwan for domestic and farm work or those in small factories.

In the Philippines, girls as young as 14 years old are persuaded by their parents to work in Japan as entertainers. The passports are tampered to change the date of birth so as to meet the age requirement.

Another form of child labor seen in Asia is known as

child servitude and child debt bondage. Although seen as a problem, its roots can be found within the socio-cultural and political structures in some parts of South Asia. Bonded children are delivered as payment of a loan, sometimes favors given in advance. Children are treated as slaves and never know when their debt will be considered paid. In India, Nepal, and Pakistan - countries where the caste system is observed - there are still families and children from the lowest castes indebted to the landowners and upper class caste.

Many children from poor families are also engaged in child domestic work, some of them as young as eight years old. Many of them are victims of trafficking and bonded by debt to their employers. Domestic child laborers are among the most difficult to reach as they are hidden in the privacy of households. Aside from exposure to the hazards of heavy household work, most of them are also victims of verbal, physical, and sexual abuse.

"Without access to...education, child laborers become youth with poor employment prospects who cannot lift their families out of a poverty trap, become parents who cannot give their children a better life."

Children are not only exploited in private industries and homes. Some are sent to the front lines as child soldiers, used as spies, porters or helpers in camps. Not being able to withstand the harsh environment, they are often subjected to abusive treatment. Burma, Sri Lanka, India, Indonesia, the Philippines, and Nepal are only some of the countries that have documented involvement of children in conflicts.

Health consequences of child labor

A study conducted by the Institute for Labor Studies in the towns of Sta. Fe and Ormoc in Leyte, Philippines showed that child-farmers became more sickly after they started to work. Most of their health complaints include fever, cough, and flu.

While such sicknesses can easily be diagnosed, experts said that more studies are needed to assess the long-term impact of labor on a child's health since some of the illnesses may manifest itself later on, when the child is already grown up. The ILO also cautions against using the same set of standards when talking about the work hazards and risks faced by child and adult laborers. Although both the child and adult laborers face the same risks, the ILO maintained that "the work hazards and risks that affect adult workers can affect child laborers even more strongly."

When looking at the health impacts of child labor, it is important to go beyond the physical manifestations of ill health; it is equally important to pay attention to how the experience would affect their cognitive, mental, emotional, and behavioral developments later on in life.

Developments in the prevention of child labor

Fortunately, the ILO says child labor is on the decline for the first time across the globe. The reports state that "Asia is one of the regions where the number of working children has dropped significantly," with five million less working children in the Asia-Pacific region. Thailand, Malaysia and China are among the countries where child labor has considerably declined.

Economic growth in certain countries played an important role in the reduction of child labor. However, the ILO estimates there are still more than 122 million children working in Asia. In some countries, the number of child laborers has gone up in the past few years.

There is still hope, however. The ILO believes that these forms of child labor could be wiped out worldwide in ten years. The most imminent cause, poverty, should be reduced.

The importance of education in eradicating child labor cannot be overly emphasized. In a press release, Guy Thijs of the ILO Regional Office for Asia and the Pacific, warned that failure to send child laborers to school would condemn them in a cycle of poverty. "Without access to free quality education, child laborers become youth with poor employment prospects who cannot lift their families out of a poverty trap, become parents who cannot give their children a better life," he said.

Sources:

http://www.hurights.or.jp/asia-pacific/no_25/02childlabor.htm

http://www.voanews.com/burmese/archive/2006-05/2006-05-04-voa4.cfm

http://www.abs-cbnnews.com/features/01/08/09/asia-must-act-prevent-growth-child-labor-expert

Child Labor in Agriculture: Causes, Conditions and Consequences (The Case of Child Laborers in Sta. Fe and Ormoc, Leyte). http://www.ilsdole.gov.ph/PAPs/ResCon/rcon_01vw1.htm.

Similarities and Differences of Traditional and Professional Health Care Systems in B'laan Communities

Condensed by Katha Berza from the original study *"Convergence/Divergence Between Traditional and Professional Health Care System: Case of B'laan Communities in Davao del Sur"* by Anderson V. Villa, MA, MHSS, Social Science and Education Division, College of Arts and Sciences, Ateneo de Davao University, Philippines

This study examines the convergence and divergence of traditional and professional health systems among the B'laan communities in the municipality of Sarangani in the context of their child health care services. The B'laan is an indigenous tribe living in the southern island of Mindanao, in the Philippines.

Background of the Study

The Alma Ata Declaration in 1978 enunciated health as a basic human right. This reserves the right of individuals to access the highest attainable standard of health through the provision of basic health and social services. Specifically, the principle has defined access to health care as the affordability, accessibility, availability, and cultural acceptability of health care services amongst peoples across cultures. It also identified the roles of governments, non-government organizations (NGOs), and international institutions in providing the health care needs to achieve a better health for all. This international pact also identified the basic elements of health that are vital to the management and provision of services to the people.

The Department of Health (DOH) reported that the most common diseases among children in the indigenous communities are curable but are not given adequate attention because of the social and cultural factors. Such factors present several challenges in the formulation of policies and programs to address the health care needs of indigenous children. Quite a number of health models have already been pushed forward; one of which is the integration of the modern or professional and the traditional or indigenous health care systems in the Philippines.

Integration of Traditional and Professional Health System

Bodekar (1994) introduced four main ways which traditional medicine has interfaced with modern medicine. These are: (1) Monopolistic – modern medical doctors have the sole right to practice medicine; (2) Tolerant – traditional medical practitioners are not officially recognized but are free to practice on the condition that they do not claim to be registered medical doctors; (3) Parallel – practitioners of both modern and traditional systems are officially recognized. They serve their patients through equal but separate systems; and (4) Integrated – modern and traditional medicine merged in medical education and jointly practiced within a unique service.

In the late 1990s, policy interest in traditional approaches to health care has led to a resurgence of interest, investment, and program development in many developing countries, (Bodekar, 1994). In fact, there are already 14 countries and areas in the region that have developed official government documents that recognize traditional medicine and its practice. This is a welcome development since a decade ago, only four countries (China, Japan, the Republic of Korea and Vietnam) have done so. In the Philippines, the "Traditional and Alternative Medicine Act" was signed in 1997. It states that it is the policy of the State to improve the quality and delivery of health care services to the Filipino people through the development of traditional and alternative health care and its integration into the national health care delivery system. The act also created the Philippine Institute of Traditional and Alternative Health Care to accelerate the development of traditional and alternative health care in the Philippines (World Health Organization, 2002).

Similarities and Differences in B'laan Health Care System

B'laan mothers view traditional and professional health system as a separate entity; each with its own ways and methods to identify and cure diseases. Both traditional and professional child health care services, however, are relatively accessible and are recognized among their communities. Such finding has been corroborated by WHO (2002) which claimed that the traditional health systems in the world are either recognized, supported, integrated or neglected in the mainstream health services. In contrast, the professional health system is given more credence. Thus far, integration of the traditional and professional health systems has not been formally recognized in the local government. Lack of support from the local and regional governmental level either impinges or disrupts the process of integrating both systems. In this study, convergence is examined in the light of the Blaan mothers' perceptions.

Traditional Health Care Services in Blaan Community

Traditional Health Care Services in Blaan Community	Traditional medicine Traditional healers
• Curative ▪ Herbal medicine ▪ Tayhop/Spitting ▪ Hilot • Preventive – wearing of 'anting-anting' or 'kwentas' (amulets against evil spirits)	• 'mananambal' or 'tya mulong' – more in the provision of herbal medicine • 'mananagna' or 'mtoc' – fortuneteller, knows who causes an illness • 'mananabang' or 'tya fanday' – birth attendants

Professional Health Care Services Provided by RHU

Child Health Care Services	Other Health Services
• Immunization services (BCG, OPV, DPT, hepatitis, measles) • Provision of Vitamin A and deworming • Free toothbrush (dental)	• Some medicines for common diseases: paracetamol, amoxicillin, some oresol, etc. • Insecticides-Treated Nets (ITNs) for Malaria

In terms of the provision of services and/or service delivery system, findings also showed that both the traditional and the modern health care systems offer preventive and curative measures to address health problems accordingly using its own method and regimens. As such, it can be concluded that a convergence has been reached when it comes to this aspect. Curative nature of the traditional health care involves the provision of herbal medicine through 'tayhop' and hilot.

Preventive medicine is practiced through the provision of 'anting-anting' or special amulets to prevent untoward attacks from supernatural forces or evil spirits, as well as from witchcrafts. In the professional or modern health system, the curative care revolves around the provision of modern drugs while its preventive counterpart focuses on the free provision of immunization and vaccines.

Furthermore, the Blaan's traditional health care system is characterized by its simple and informal nature. It is not time-bounded as compared to the professional health system where a system or a protocol has to be followed in the provision of services such as service providers' specific work schedule and immobile work areas. However, both systems of health care are seen in the context of which is best needed in a specific situation and which can offer immediate remedy.

Similarities and Differences in Concept of Health and Illness

Blaans view their children's illness as caused either by sudden climate changes and by supernatural beings, or by dirty environment. As discussed by Tan (in Palaganas et al, 2001), using personalistic theories, people assume that illnesses are caused by a supernatural being or a non-human called witch. Similarly, results of this study indicated that the Blaan community still adheres to this mystical belief of supernaturalism. In addition, the hot-cold paradigm is also very prevalent in the community of Blaans, which according to them, the sudden changes in the climate and incorrect transition from hot to cold temperature can cause illnesses in the children (Jimenez et al. 1999; Palaganas et al., 2001).

However, even with this perceived influence, Blaan mothers still see the traditional and professional health system as an integral part of their daily survival. Findings show that traditional health system serves as an alternative to the professional health system when it fails to address the mothers' child health concerns and vice-versa. As Hammond (1994) argued, the utilization of indigenous healing methods appears rather to be a product of a perceived failure on the part of biomedicine to adequately identify and treat certain illnesses.

Conclusions

Generally, there is still an existence of divergence between the traditional and professional health systems and that there are significant factors that sustain these differences. The convergence in the Blaan child health care system is demonstrated specifically with the presence of health and service providers in both health systems (as previously presented in the two tables). Each system has its counterpart with that of the other.

The traditional healers are seen in the same way as the medical professionals such as the nurses, midwives and other health workers. Divergence is more observed when it comes to service provision and the nature on how respondents/patients avail of the services provided by both systems. Convergence is somehow demonstrated in their concept of health while divergence is more seen in the Blaan mother's concept of illness.

Too young, too curious

Adolescence is a period marked by confusion, as adolescents try to make sense of the changes in their physical appearance, as well as to establish their own identity. It is a crucial stage where being curious is not enough; that curiosity has to be satisfied, and the consequences can often be dire. One of the pressing concerns facing adolescents is the rise of unwanted pregnancy and incidences of sexually transmitted infections (STI) among this particular age group.

Sexual initiation among adolescents is occurring at a younger age; the typical age for boys is 13 and 14 for girls. More alarming, most of first time sex were either unplanned or non-consensual. The 2002 Young Adult Fertility and Sexuality Study (YAFS) conducted in the Philippines showed that 57 percent of first time sex fell in the unplanned or non-consensual category.

For unplanned - and therefore unsafe - sex, the risk of unwanted pregnancy and/or getting STI becomes higher. The 2001 ESCAP Population Data Sheet showed that adolescent fertility rate in the Asia-Pacific region stands at 36 births per 1,000 females 15 to 19 years old. South and Southwest Asia registered the highest rate of 57 births per 1,000; while North and Central Asia registered the lowest with 37 births per 1,000.

Teenage pregnancy – with its attendant risks and the prospect of abortion – is now becoming a global health threat. A report from the World Health Organization's Western Pacific Region Office showed that in developing countries, pregnant women below 18 years old are two to five times more likely to die than pregnant women 18 to 25 years old. Young mothers are not the only ones at risk; morbidity and mortality risks are higher among infants born to young mothers.

Adolescents are also prone to STIs. In a presentation, Dr. Suman Mehta, Global HIV and AIDS Coordinator of UNFPA, reported that nearly a third of people living with HIV and AIDS are young people, and that half of new cases involved the young. Moreover, an estimated 111 million new cases of STI infection among the youth are reported every year. In China, STI prevalence among 15 to 19 years old is at 79.45 percent. The WHO, has in fact, stated that "the current epidemiology of STI and HIV suggest that they are diseases of young people."

Non-consensual sex

Non-consensual sex presents a particular challenge, since studies have shown that women whose first sex was coerced are more likely to experience subsequent coercive sex. In addition, they are more likely to be sexually active. Non-consensual sex has far reaching effects, affecting a woman psychologically and mentally. Studies in India and Ethiopia showed that sexually-abused teenagers often drop out of school or suffer from poor academic performance. The women are also more likely to be depressed and to commit suicide. Even young boys fall prey to non-consensual sex, either with an older male acquaintance or relative, or an older and more sexually-experienced female.

Breaking the taboo

Different social institutions have been actively speaking on the need to protect the youth from sexual proclivity, but the reality is that there is a growing and unmet need for reproductive health services and information among the youth. Ideally, information should come from the parents, but in the Asia-Pacific context, sex remains to be a taboo issue. Often, parents and guardians are ill-equipped to give appropriate counseling to their wards, and the youth are forced to obtain the information from unreliable sources.

"...adolescents who grew up in a loving and caring household, and who have parents whom they look up to as role models, are less likely to engage in premarital sex."

Despite their limited knowledge and their reluctance to discuss sex and sexuality with their children, parents can still influence their children to be more circumspect. A literature review conducted by the WHO and the John Johns Hopkins Bloomberg School of Public Health and other institutes showed that adolescents who grew up in a loving and caring household, and who have parents whom they look up to as role models, are less likely to engage in premarital sex.

Admittedly, providing services and information is just a part of the solution. Looking at the bigger picture, a more holistic intervention is required to ensure that the youth are protected. Non-consensual sex, for instance, often has socio-economic, political, and even cultural determinants. Poverty forces young boys and girls to prostitution,

next page

Early marriage: a different perspective for teenage pregnancy

by Amanah Busran Lao

In the Philippines, an early pregnancy is not commonly cited as something that has resulted from early marriage.

The prevalence of early marriage in Autonomous Region in Muslim Mindanao (ARMM) in the Philippines is difficult to monitor considering that there is insufficiency of data due to low rate of registration of births and marriages.

One recent research by Nisa Ul Haqq Fi Bangsamoro (NISA) and Al-Mujadillah Development Foundation (AMDF), which was conducted in Sulu, Basilan, Maguindanao, Tawi-Tawi, Lanao del Sur and Shariff Kabunsuan, has found out that the youngest bridal age is nine. Out of 598 respondents, 17 percent aged from nine to fourteen and 83 percent were at the range of fifteen to seventeen upon marriage.

At present, close to 40 percent of the respondents are raising one to three children, 27.9 percent with four to six, 19.2 percent attend to more than seven children, while 13.7 percent do not have children yet. This illustrates that the younger a girl marries, the more she will likely to bear many children.

The study identified six determinants on why early marriage is happening in the region. These are:

- religious beliefs
- cultural practices
- economic conditions
- personal circumstances
- forced/arranged marriage,
- and political reasons.

Many consider early marriage as a protection against *Zina* (extramarital and premarital sex) and is perceived to be an effective way in following the *Sunnah* (the way and the manners of Prophet Mohammad). This is also to preserve the chastity of women to protect the family's honor. In addition, there is also a widespread perception that women are weak and in need of protection.

Forty-one percent of the respondents have revealed that they were motivated by the idea that the husband would be a good provider and 30.10 percent confessed that a dowry was seen as an economic opportunity. More than half of the girl-brides who admitted having romantic relationships with their would-be husbands said that peer influence and the need to escape from parental control have been factors in the decision to marry early.

Majority of the respondents (86.2 percent) said that their marriages were arranged while 34 respondents confided that they were abducted. A small percentage cited political reasons and these are: to forge political alliances and settle family disputes.

The prevalence of early marriage in ARMM can be a major possible reason why this region has one of the highest maternal mortality rate (MMR) in the Philippines.

too young...from page 10

which makes them all the more vulnerable. Forced or arranged marriage – often done as payment for a debt - also makes a young girl vulnerable to coercive sex.

Gender issue is also a dominant factor, since women are often the victims of coercive sex. There is a widespread belief that young women should preserve their virginity until they are married, while young boys are expected to be sexually active and to have multiple female sex partners.

The issue of teenage sex and adolescent reproductive health will always be a fodder for debate, but families and other key social institutions can no longer afford to turn a blind eye on the issue.

Sources:

Adolescent Reproductive Health in the Asian and Pacific Region. Asian Population Studies Series No. 156. http://www.unescap.org/esid/psis/population/popseries/apss156/chap1b.asp

Adolescent sexual and reproductive health. http://www.wpro.who.int/sites/rph/data/adolescent.htm

Sexual coercion:Young men's experiences as victims and perpetrators. http://www.who.int/reproductive-health/adolescent/docs/population_syntheis2.pdf

The adverse health and social outcomes of sexual coercion: Experiences of young women in developing countries. http://www.who.int/reproductive-health/adolescent/docs/population_syntheis3.pdf

Helping Parents Improve Adolescent Health. Youth Lens #25 in a series. http://www.fhi.org/NR/rdonlyres/

MCH Resource List

Millennium Development Goals Report 2007. New York: United Nations, 2007. In 2000, 189 countries signed the Millennium Declaration to achieve MDG targets set by 2015. This report presents an assessment of global progress to date. It highlights key achievements and at the same time, it also draws world leaders to address areas where key challenges are seen. E-copy is available from http://www.un.org/millenniumgoals/pdf/mdg2007.pdf.

Pocket Book of Hospital Care for Children Guidelines for the Management of Common Illnesses with Limited Resources, 2005. Edited by H Campbell. A handy pocketbook of guidelines to treat common and serious illness in children. It is aimed at doctors, senior nurses and senior health workers. It gives WHO guidelines for care as inpatients or outpatients in small hospital where basic laboratory facilities and inexpensive drugs are available. Available from WHO bookorders@who.int and Teaching-Aid-at-Low-Cost £4.50, info@talc.uk.org. TALC, PO Box 49, St. Albans, Herts, AL1 5TX, UK,

The State of Asia-Pacific's Children 2008 is a regional edition of UNICEF's The State of the World's Children 2008 report. Complementary to the global report, it examines child survival in Asia-Pacific and highlights the need to place child health at the heart of the region's development and human rights agenda. It also outlines programs, policies and partnerships that can accelerate progress towards the Millennium Development Goals. Available from http://www.unicef.org/publications/index_45086.html or write to Unicef pubdoc@unicef.org or write to: Distribution Unit, Division of Communication, UNICEF, 3 United Nations Plaza, New York, NY 10017, USA.

New from HAIN:

Primary Health Care Approach to Sexual & Reproductive Health and Rights, 2008. A thin book providing a holistic framework to sexual and reproductive health and rights issues by anchoring discussions on the primary health care approach. Designed for health workers and advocates, it illustrates how SRH and other key social issues are interrelated. Available from HAIN at hain@hain.org

Internet resources:

http://motherchildnutrition.org/ - a site on Mother, Infant and Young Child Nutrition and Malnutrition

http://www.talcuk.org/books/newborn-and-child-health.htm - offers a wide range of resources in different media at a low cost.

http://www.maqweb.org – a site supporting research and evidence-based interventions to promote access and quality of reproductive health and family planning services

Source is an international support centerproviding free online access to 25,000 comprehensive references to information sources and organizations in the field of international health and disability issues, with links to full text resources provided where possible. The focus is on grassroots information from developing countries, and subjects include HIV and AIDS, primary health care, poverty, disability and development, evaluation, training, health communication, and information management. Search Source at **www.asksource.info.**

HEALTH ALERT ASIA - PACIFIC is a quarterly newsletter on health and development issues published by Health Action Information Network (Philippines) in collaboration with Healthlink Worldwide (UK).

Editorial Staff

EXECUTIVE DIRECTOR	Edelina P. Dela Paz
MANAGING EDITOR	Joyce P. Valbuena
ASSOCIATE EDITOR	Ross M. Mayor
RESOURCE CENTER COORDINATOR	Noemi B. Leis
LAY-OUT	RJ Ilusorio
ILLUSTRATION	Boy Dominguez

Subscription details

If you would like to be put in the mailing list to receive Health Alert Asia - Pacific, please write to:

Health Action Information Network (HAIN)
26 Sampaguita St., Mapayapa Village II
Brgy. Holy Spirit, Quezon City 1127 Philippines

Telefax: (63-2) 952-6409
Email: hain@hain.org
Website: www.hain.org

You may also view and download issues of Health Alert Asia-Pacific at www.hain.org

Reproducing articles

HAIN (Health Action Information Network) is a Philippine NGO involved in research and information on health and development issues. Registered with the Securities and Exchange Commission 127593.

Healthlink Worldwide (formerly Appropriate Health Resources and Technologies Action Group or AHRTAG) is a UK-based international development agency which supports the goal of health for all by promoting primary health care. Registered charity (UK) no. 274260.

Opinions expressed in this newsletter do not necessarily represent those of HAIN or Healthlink Worldwide. The mention of specific companies or of certain manufacturer's products does not imply preference to others of a similar nature. A person's health status should not be assumed based on his or her article or photograph.