The State of Children with Disabilities in Eastern Samar

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ABSTRACT

The study focused on children with disabilities (CWD) in Philippine society. It described the socio-economic conditions of CWD and their families, and the nature and extent of the problems they experienced. The findings from seven municipalities in Eastern Samar revealed that CWD come from big and poor agricultural families with low levels of education. Hearing, mental, physical and visual disabilities were the most common forms of disabilities of children. While majority of the families recognized that CWD have special needs, most families were unable to meet these needs because of economic difficulties and inaccessibility of programs and services. It is urgent to capacitate families of CWD to address their needs and develop positive coping behaviors through family-centered programs and services that will help alleviate their conditions and problems, raise their capabilities and expand their options. This will entail collaboration between various stakeholders in society and the community.

Key Words: children, children with disability, health, Philippines

Introduction

Persons with disabilities (PWD), especially children, are one of the most vulnerable sectors in society. More often, they are invisible,[1] marginalized, and unaccounted for, especially in the delivery of social services. If they are recognized, they are treated as objects of charity[1] and subjected to various forms of discrimination.

The World Health Organization (WHO) estimates that about 10% of the population of any country has disabilities.[2] This means that for every 10 persons, one experiences a form of disability. The WHO also estimates that about 10% of the world's children and young people have sensory, intellectual, or mental health impairment.[1] About 80% of them live in developing countries.[1]

Based on the 2000 Philippine census which included a survey of PWD, the proportion of disabled individuals was estimated to be 1.23% of the total population, much lower than the WHO estimates of 10%. About 30–40% of the total disabled population was children.[3]

Persons with disabilities, especially children, are commonly associated with various forms of deprivations which are often a consequence of poverty. This condition is considered to be a major cause of disability and a factor which makes children vulnerable to acquiring one.[4] The prevalence of disabilities among children 0 to 14 years tend to be highest in urban and rural poor communities where malnutrition, lack of access to potable water, unsanitary living conditions, and lack of access to basic social services like health, education, and housing are problems characteristic of everyday life.[2,4]

The lack of knowledge and skills of families in treating members with disabilities, especially children, and the limited opportunities available in the community to enable PWD to overcome their condition, be productive members of society, and live a life with dignity, contribute to the perpetuation of their highly disadvantaged position. Moreover, there is a dearth of programs and services, particularly in the rural areas, for PWD, including children, on account of their invisibility.[1,4] Changing people's views and attitudes through education and training is critical in improving the conditions of PWD. These are among the areas where the State can intervene in order to promote the rights and well-being of PWD, specifically poor children.

This study is an attempt to present the situation of CWD in Eastern Samar, one of the poorest provinces in the Philippines.[5] Specifically, it aimed to describe their socio-demographic profile, the types of disabilities experienced by children, and the nature of the problems and difficulties faced by the children and their families. It focused on rural families with children aged 0 to 17 years with physical, visual, hearing, neuro-motor, and/or mental disabilities as per record of the municipal health unit.

Methods

This descriptive, quantitative study which was undertaken for almost a year (2007–2008) primarily relied on the survey method in the collection of data. A pre-tested 7-page structured interview schedule was utilized as data-collection tool. A selected group of *barangay* (village) health workers (BHWs) in the study sites were trained and mobilized as interviewers.

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Study Sites

The study was conducted in the province of Eastern Samar, one of the six (6) provinces constituting Region VIII or Eastern Visayas in Central Philippines.

In 2000, Eastern Samar was one of the six (6) provinces in the Eastern Visayan Region included in the top 44 poorest provinces.[5] Ranked as the 17th poorest province in the Philippines,[6] Eastern Samar has 23 municipalities, most of which are classified as either fourth, fifth or sixth class, indicating the relatively low income generated by the local government units (LGUs).

Furthermore, Eastern Samar is part of the Eastern Visayan Region which had the largest proportion of PWDs in the 2000 census. The region ranked first with 1.74% of its population with disability. Poor vision was the most common type of disability recorded in the region.[7]

The research specifically covered seven (7) municipalities of the province, namely Balangiga, Dolores, Llorente, Oras, Quinapondan, Salcedo, and San Julian. These municipalities were chosen based on the following criteria: 1) project areas of MAG, 2) among the poorest municipalities of Eastern Samar, 3) have a relatively large number of CWD and 4) have local government officials who are open and/or supportive of the work of NGOs like MAG.

Study Respondents

A purposive sampling technique was used in the selection of the 916 study respondents (Balangiga – 75, Dolores – 210, Llorente – 63, Oras – 251, Quinapondan – 51, Salcedo – 131 and San Julian – 135). All families included in the rural health units' master list of households with CWD in the seven municipalities were interviewed for the study. The interviewees were either the head of the family or an adult member who was available at the time of the interview. The data-collectors also interviewed other households not in the list but referred by the interviewees, other members of the *barangays* or *barangay* officials who had prior knowledge of the presence of a disabled child in the family.

A consent form was administered by the barangay health workers to all the adult study respondents prior to the interview.

Philippine Government's Human Rights Obligations and Accountability to CWD

The Convention on the Rights of Persons with Disabilities adopted by the United Nations General Assembly on December 13, 2006[8] and ratified by the Philippine Senate on April 15, 2008[9] is one of the newest international human rights instruments formulated and accepted by the international community. The document is significant in several respects: One, it categorically stipulates and asserts that persons with disabilities should be accorded the same rights and opportunities as the rest of the population. Although the covenant does not create "new rights" for PWD,[8] it reiterates and presents the human rights recognized in earlier international treaties like the Universal Declaration of Human Rights (UDHR), International Covenant on Civil and Political Rights (ICCPR), International Covenant on Economic, Social and Cultural Rights (ICESCR), etc. in the context of the situations, problems and difficulties faced by PWD. Second, the Covenant, as a legally binding instrument, makes States which have signed and ratified it legally bound to respect, protect and fulfill these rights. Similar to their obligations with earlier human rights instruments, States Parties should ensure that an enabling environment prevails in society and allows PWD, including children, a life of dignity, protection from all forms of inequities, discrimination and marginalization, and are able to realize their potentialities and capacities to the fullest. This includes the enactment of laws that are consistent and supportive of the rights of PWD. Third, the Covenant presents a new perspective to the concept of disability. It asserts that the condition "results from the interaction between a person's impairment and obstacles such as physical barriers and prevailing attitudes that prevent their participation in society".[8] Thus, this implies the critical role of the State in addressing these obstacles, including changing the dominant perceptions and attitudes of society toward PWDs.

Prior to the ratification of the Convention on the Rights of Persons with Disabilities by the Philippine government, its legal obligations to promote the rights of persons with disabilities, particularly children, have been established with its ratification of the Convention on the Rights of the Child (CRC) on August 21, 1990.[10] As stipulated in Article 23(1) of the Convention:[11]

> *States Parties recognize that a mentally or physically disabled child should enjoy a full and decent life, in conditions which ensure dignity, promote self-reliance and facilitate the child's active participation in the community.*

The two international human rights instruments provide the legal bases of the obligations and accountability of the Philippine government to CWD, not to mention the national or domestic translations of these treaties like the Magna Carta for Disabled Persons (RA 7277) and Accessibility Law (BP 344). It entails a commitment on the part of government to take immediate and progressive actions that may be in the form of enactment of laws, setting-up of structures and mechanisms, allocation of resources, provision of goods and services, and creation of a climate that protects and advances the rights of CWD.

Study Results

Socio-demographic profile

Table 1 presents the socio-demographic profile of the study respondents in each of the study sites. Except for Dolores where 41.4% of the respondents have 7 to 9 family members and an average family size of 7, at least 40% of the interviewees in the other municipalities have 4 to 6 members or an average family size of 6. In the seven municipalities, the smallest family size was 2 while the biggest was 16, specifically in Quinapondan. There were five families in Oras with at least 13 members. (Table 1)

More than a third of the respondents in all municipalities had 3 to 4 children in the family or an average of 4 children per family. At least one-fifth of all the children covered in the study had a form of disability. Moreover, the composition of the households in all municipalities was relatively young with more than half of them aged 18 years and below. (Table 1)

Table 1. Distribution of respondents by socio-demographic profile in the 7 municipalities, 2008

Variables	Balangiga (n = 75)		Dolores (n = 210)		Llorente (n = 63)		Oras (n = 251)		Quinapondan (n = 51)		Salcedo (n = 131)		San Julian (n = 135)	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Family size														
1-3	8	10.7	13	6.2	3	4.8	21	8.4	1	2.0	5	3.8	6	4.4
4-6	34	45.3	84	40.0	30	47.6	120	47.8	21	41.2	62	47.3	64	47.4
7-9	24	32.0	87	41.4	24	38.1	83	33.1	20	39.2	50	38.2	60	44.4
10-12	8	10.7	23	11.0	6	9.5	22	8.8	5	9.8	13	10.0	5	3.7
≥ 13	1	1.3	3	1.4	0	0	5	2.0	4	7.8	1	0.8	0	0
Total	75	100	210	100	63	100	251	100	51	100	131	100	135	100
# of children (< 18 yrs.)		%		%		%		%		%		%		%
1-2	19	25.3	44	21.0	13	20.6	67	26.7	11	21.6	32	24.4	35	26.0
3-4	30	40.0	82	39.0	25	39.7	92	36.7	22	43.1	47	35.9	47	34.8
5-6	21	28.0	55	26.2	21	33.3	69	27.5	10	19.6	34	26.0	42	31.1
7-8	3	4.0	23	11.0	1	1.6	20	8.0	6	11.8	18	13.7	10	7.4
≥ 9	2	2.7	6	2.9	3	4.8	3	1.2	2	3.9	0	0	1	0.7
Total	75	100	210	100	63	100	251	100	51	100	131	100	135	100
Total no. of children covered	281chidlren in 75 families surveyed		883 in 210 families surveyed		262 children in 63 families surveyed		979 in 251 families surveyed		212 children in 51 families surveyed		535 in 131 families surveyed		534 in 135 families surveyed	
# of CWD covered	84	30%	235	27%	64	24%	306	31%	53	25%	147	27%	159	30%
Family members' age		%		%		%		%		%		%		%
0-4	48	10.0	192	13.3	48	11.5	244	15.1	50	13.1	118	13.5	104	12.0
5-9	89	18.5	241	16.8	90	21.6	274	17.0	59	15.4	159	18.2	151	17.4
10-14	91	19.0	271	18.8	90	21.6	280	17.3	61	16.0	164	18.8	173	20.0
15-18	53	11.0	179	12.4	34	8.2	181	11.2	45	11.7	92	10.5	106	12.2
19-24	36	7.5	102	7.1	23	5.5	127	7.9	31	8.1	46	5.3	29	3.3
25-29	20	4.2	66	4.6	5	1.2	72	4.5	17	4.4	36	4.1	37	4.3
30-34	26	5.4	84	5.8	16	3.8	96	6.0	28	7.3	45	5.2	52	6.0
35-39	32	6.7	78	5.4	23	5.5	89	5.5	13	3.4	55	6.3	51	5.9
40-44	29	6.0	73	5.1	25	6.0	85	5.3	21	5.5	41	4.7	55	6.3
45-49	14	2.9	64	4.5	14	3.4	52	3.2	11	2.9	31	3.6	41	4.7
50-54	14	2.9	34	2.4	17	4.1	47	3.0	14	3.7	22	2.5	15	1.7
55-59	14	2.9	19	1.3	6	1.4	20	1.2	7	1.8	17	1.9	15	1.7
60 – above	14	2.9	36	2.5	21	5.0	44	2.7	26	6.8	46	5.3	38	4.4
No answer	0	0	0	0	4	1.0	3	0.2	0	0	1	0.1	0	0
Total	480	100	1439	100	416	100	1614	100	383	100	873	100	867	100
Estimated Monthly Y		%		%		%		%		%		%		%
Below 1,000	21	28.0	1	0.5	5	8.0	5	2.0	1	2.0	23	17.6	0	0
1000-2999	46	61.3	100	47.6	34	54.0	151	60.2	22	43.1	69	52.7	81	60.0
3000-4999	6	8.0	77	36.7	5	8.0	55	21.9	16	31.4	19	14.5	35	25.9
5000-6999	1	1.3	19	9.0	5	8.0	24	9.6	8	15.7	7	5.3	11	8.1
7000-8999	1	1.3	3	1.4	0	0	3	1.2	0	0	5	3.8	1	0.7
9000-10999	0	0	3	1.4	1	1.6	3	1.2	2	3.9	2	1.5	4	3.0
≥ 11000	0	0	1	0.5	0	0	2	0.8	0	0	2	1.5	2	1.5
No answer	0	0	6	2.9	13	20.6	8	3.2	2	3.9	4	3.1	1	0.7
Total	75	100	210	100	63	100	251	100	51	100	131	100	135	100

Farming and farm-related work including coconut wine (tuba) gathering, mat weaving and copra processing, and construction/manual work were the most common sources of income of the family breadwinners in all the study sites.

On the other hand, housekeeping, farming and farm-related work, selling of food items, and working as domestic helpers were the most common economic activities reported by the respondents, many of whom are the spouses of the breadwinners.

At least 70% of the respondents in all the study sites had a family income of less than Php5,000 a month (US$119), supporting an average family size of 6 to 7 members and with at least one child with disability. This translates to at least 70% of the respondents in all the study areas living below the poverty threshold (Table 1). According to the National Statistical Coordinating Board (NSCB), in 2007, a family of five members should be earning a combined monthly income of Php6,195 (US$147) in order to meet their basic food and non-food needs for the year.[12]

Profile of Children with Disabilities (CWD)

Table 2 presents the socio-demographic profile of CWD in the seven municipalities. More than 80 percent of the families surveyed have one child with disability. However, there were 7 families in Oras, 3 in Salcedo and 2 in San Julian with 3 CWD. The Municipality of Oras had the biggest number of CWD surveyed at 306, followed by Dolores with 235. Quinapondan had the least number of CWD at 53. (Table 2)

At least a third of the CWD in Dolores, Oras and Salcedo were in the critical years of childhood falling within the age range 0 to 5 years. More than one-third of the CWD in Balangiga, Dolores, Llorente, Oras and San Julian were between 6 to 11 years while more than a third in Balangiga, Llorente and Quinapondan were in the age range 12 to 17 years. For those in the age range 12 to 17 years, aside from the challenges faced in relation to their disability, the girls, particularly, also had to cope with reproductive health challenges of puberty. (Table 2)

Except in Llorente where equal numbers of boys and girls with disability were recorded, more than half of the CWD in the other municipalities are boys. (Table 2)

More than 75 percent of the CWD are children of the head of the family followed by the grandchildren of the family head (Table 2). Most of the CWD in all seven municipalities either had several years of or completed elementary education while at least one-fourth had not gone to school. Those classified under "Not applicable" are the children aged 0 to 2 years. (Table 2)

Types of disabilities

Many of the children have multiple disabilities as presented in Table 3. Among the most commonly recognized and reported types of disabilities are the following:

1. Hearing, voice and speech disabilities like speech defect, cleft palate/lip and muteness,
2. Mental disabilities like mental retardation, epilepsy and cerebral palsy,
3. Physical/orthopedic disabilities like club foot/feet, crab hand/foot, and
4. Sight/visual disabilities like cross-eyes.

One-third (33.2%) of the children in Dolores while 28.4% in Oras have asthma, a dominant type of respiratory disability among children. (Table 3)

Most of the respondents shared that they learned about the child's disability while observing the child grow up, at birth, and from the information relayed by a medical doctor/specialist.

Treatment and Perceptions of CWD by the family

The behavior of family members upon learning about the child's disability is typical of most Filipino families. The most common reactions of the family were:

1. Consulted and/or sought help of a doctor/medical specialist,
2. Resignation since the family had no money for medical consultation and medicines, and
3. Acceptance of the condition as God's will.

Meanwhile, the interviewees shared that on the part of the child, the latter did not mind the disability and acted like any normal child. However, among the negative effects on the child of his/her disability were increased irritability, low self-esteem and self-confidence, high dependence on others, and difficulty moving around.

Among family members, while the respondents say the child is treated like any normal child and family members were not bothered by the child's condition, they also recognized the negative effects on the family of having a child with disability. These include difficulties encountered in taking care of the child and meeting the child's special needs, additional economic burden on the family, and the limitation on family activities.

It is important to note that the behavior, perceptions, and attitudes of both the child and family members toward the disability are greatly influenced by the nature and gravity of the health condition.

As shown in Table 4 on the family's perceptions on and response to special needs of the child, majority of the interviewees in all the municipalities said CWD have special needs. However, at least a third of the respondents in Llorente (36.5%) and Salcedo (33.6%) claim otherwise. More than half of the respondents in Balangiga (93.3%), Dolores (80%), Oras (91.6%), Quinapondan (56.9%) and San Julian (74.8%) admitted that the family is unable to provide the special needs and that they need help. In Llorente, close to half (46 percent) of the interviewees said the family does not provide for the child's special needs. (Table 4)

Table 2. Distribution of CWD by socio-demographic profile in the 7 municipalities, 2008

Variables	Balangiga (n = 75)		Dolores (n = 210)		Llorente (n = 63)		Oras (n = 251)		Quinapondan (n = 51)		Salcedo (n = 131)		San Julian (n = 135)	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
No. of CWD per family														
1	67	89.3	188	89.5	62	98.4	203	80.9	49	96.1	118	90.1	115	85.2
2	7	9.3	20	9.5	1	1.6	41	16.3	2	3.9	10	7.6	17	12.6
3	1	1.3	1	0.5	0	0	7	2.8	0	0	3	2.3	2	1.5
4	0	0	1	0.5	0	0	0	0	0	0	0	0	1	0.7
Total	75	100	210	100	63	100	251	100	51	100	131	100	135	100
No. of CWD identified	84 CWD		235 CWD		64 CWD		306 CWD		53 CWD		147 CWD		159 CWD	
Age of CWD														
0-5 years	10	11.9	80	34.0	11	17.2	101	33.0	14	26.4	52	35.4	47	29.6
6-11	33	39.3	82	34.9	23	36.0	109	35.6	15	28.3	43	29.2	59	37.1
12-17	37	44.0	65	27.7	28	43.7	85	27.8	20	37.7	46	31.3	45	28.3
18	4	4.8	8	3.4	2	3.1	11	3.6	4	7.5	6	4.1	8	5.0
Total	84	100	235	100	64	100	306	100	53	100	147	100	159	100
Sex of CWD		%		%		%		%		%		%		%
Female	31	36.9	103	43.8	32	50.0	133	43.5	23	43.4	62	42.2	75	47.2
Male	53	63.1	132	56.2	32	50.0	173	56.5	30	56.6	85	57.8	84	52.8
Total	84	100	235	100	64	100	306	100	53	100	147	100	159	100
Relationship of CWD to Family Head		%		%		%		%		%		%		%
Child	74	88.1	210	89.4	55	85.9	260	85.0	42	79.2	120	81.6	131	82.4
Sibling	1	1.2	2	0.8	0		6	2.0	0	0	1	0.7	2	1.2
Grandchild	5	5.9	11	4.7	9	14.1	29	9.5	9	17.0	20	13.6	14	8.8
Relatives	4	4.8	11	4.7	0	0	9	2.9	1	1.9	5	3.4	10	6.3
Others	0	0	0	0	0	0	0	0	1	1.9	0	0	0	0
No answer	0	0	1	0.4	0	0	2	0.6	0	0	1	0.7	2	1.3
Total	84	100	235	100	64	100	306	100	53	100	147	100	159	100
Educ'l Background of CWD		%		%		%		%		%		%		%
Not gone to school	19	22.6	70	29.8	20	31.3	83	27.1	17	32.1	36	24.5	43	27.0
Pre-school	6	7.1	16	6.8	6	9.4	44	14.4	2	3.8	24	16.3	7	4.4
Elementary	38	45.2	91	38.7	22	34.4	118	38.6	21	39.6	47	32.0	69	43.4
Elem graduate	2	2.4	6	2.6	2	3.1	4	1.3	2	3.8	0	0	3	1.9
High school	13	15.5	16	6.8	5	7.8	11	3.6	7	13.2	17	11.6	18	11.3
HS graduate	4	4.8	2	0.8	1	1.6	2	0.6	1	1.9	0	0	0	0
College	1	1.2	1	0.4	0	0	0	0	0	0	1	0.7	2	1.3
NA	1	1.2	30	12.8	4	6.2	43	14.1	3	5.7	18	12.2	17	10.7
Unclear answer			1	0.4	0	0	0	0	0	0	0	0	0	0
No answer			2	0.9	4	6.2	1	0.3	0	0	4	2.7	0	0
Total	84	100	235	100	64	100	306	100	53	100	147	100	159	100

Table 3. Distribution of types of disabilities among children in the 7 municipalities, 2008

Types of disabilities	Balangiga (n=84)		Dolores (n=235)		Llorente (n=64)		Oras (n=306)		Quinapondan (n=53)		Salcedo (n=147)		San Julian (n=159)	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Mental	23	27.4	38	16.2	20	31.2	56	18.3	17	32.1	49	33.3	41	25.8
Sensory	3	3.6	21	8.9	5	7.8	19	6.2	11	20.7	2	1.4	6	3.8
Hearing, Voice & Speech	58	69.0	129	54.9	31	48.4	143	46.7	27	50.9	68	46.2	63	39.6
Physical / Orthopedic	16	19.0	32	13.6	15	23.4	41	13.4	14	26.4	31	21.1	26	56.0
Sight / Visual	13	15.5	28	11.9	12	18.7	29	9.5	19	35.8	21	14.3	34	21.4
Skin / Face	0	0	3	1.3	5	7.8	19	6.2	4	7.5	7	4.8	10	6.3
Respiratory	3	3.6	78	33.2	0	0	88	28.7	0	0	23	15.6	13	8.2
Others, e.g. stunted growth, congenital heart disease, hernia, urethral opening defect	6	7.1	11	4.7	2	3.1	13	4.2	2	3.8	7	4.8	7	4.4

However, although more than half of the respondents in all the municipalities recognize that the CWD have special needs, economic difficulties of the family and the physical inaccessibility of programs/services for CWD have been the most cited reasons for the family's inability to meet these needs.

Furthermore, as presented in Table 4 on the respondents' knowledge on the presence of services and

programs for CWD, majority of the interviewees in Llorente (57.1%), Oras (61%), Quinapondan (52.9%) and Salcedo (55%) acknowledged the existence of programs and services for CWD, while more than half of the interviewees in Dolores (53.8%) and San Julian (88.1%) claimed they did not know of any program and services for CWD. More than three-fourths (77.3%) of the respondents in Balangiga did not have any answer. (Table 4)

At least 70% of the respondents in all the municipalities except Llorente and Oras were not able to provide an answer as to the types of programs and services they know and/or have utilized for CWD. For those who admitted knowing programs and services and had utilized these, the most commonly cited programs are those provided by the BHWs and rural health units, non-government organizations, and government agencies like the Department of Social Welfare and Development (DSWD) and the Department of Health (DOH). Moreover, the responses of the interviewees in most of the municipalities revealed that a limited number of institutions and organizations were known to the families to be providing programs and services to CWD in their area.

In Llorente, 46% of the interviewees were unable to identify the particular programs and services they said they knew or had utilized for their child. For those who had been able to avail of services for CWD, the most commonly mentioned were services provided by NGOs like Plan Philippines.

The respondents who had utilized programs and services for CWD acknowledged that these helped lighten family problems and assisted the family in the medical needs of the children.

On the other hand, providing more funds, assigning responsible staff who know how to deal with and provide services to CWD, and establishing programs/services for CWD in the *barangay* were among the top suggestions given by the interviewees to improve the programs/services.

Awareness of the rights of CWD

Table 5 presents the responses of the interviewees on whether they were aware of the rights of CWD. Majority of the respondents in all seven municipalities claimed to know the rights of CWD. In Oras, almost all of the 251 interviewees (99.2%) said they were aware of the rights of CWD; 98% in Quinapondan and 90.1% in Salcedo responded positively (Table 5). The high level of awareness on the rights of CWD as illustrated by the high percentage of positive responses given by the respondents, most of whom are mothers, is confirmed by the specific rights enumerated by the respondents below.

Table 4. Distribution of respondents based on family's perception on child's special needs in the 7 municipalities, 2008

Variables	Balangiga (n=75)		Dolores (n=210)		Llorente (n=63)		Oras (n=251)		Quinapondan (n=51)		Salcedo (n=131)		San Julian (n=135)	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
CWD have special needs														
Yes	72	96.0	195	90.3	40	63.5	245	97.6	46	90.2	86	65.6	130	96.3
No	3	4.0	21	9.7	23	36.5	4	1.6	5	9.8	44	33.6	5	3.7
No answer							2	0.8			1	0.8		
Total	75	100	216	100	63	100	251	100	51	100	131	100	135	100
Family provides child's needs														
Yes	1	1.3	6	2.8	2	3.2	1	0.4	2	3.9	11	8.4	3	2.2
No	4	5.3	21	10.0	29	46.0	16	6.4	19	37.2	20	15.3	19	14.1
Yes, but not all; family needs help	70	93.3	168	80.0	23	36.5	230	91.6	29	56.9	36	27.5	101	74.8
Child has no special needs	0		13	6.2	9	14.3	3	1.2	1	2.0	63	48.1	10	7.4
No answer			2	1.0			1	0.4			1	0.8	2	1.5
Total	75	100	210	100	63	100	251	100	51	100	131	100	135	100
Knowledge of programs & services for CWD														
Yes	7	9.3	94	44.8	36	57.1	153	61.0	27	52.9	72	55.0	13	9.6
No	10	13.3	113	53.8	27	42.9	95	37.8	23	45.1	57	43.5	119	88.1
No answer	58	77.3	3	1.4			3	1.2	1	2.0	2	1.5	3	2.2
Total	75	100	210	100	63	100	251	100	51	100	131	100	135	100

Table 5. Distribution of respondents based on awareness of the rights of CWD in the 7 municipalities, 2008

Variables	Balangiga (n=75)		Dolores (n=210)		Llorente (n=63)		Oras (n=251)		Quinapondan (n=51)		Salcedo (n=131)		San Julian (n=135)	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Awareness on rights of CWD														
Yes	41	54.7	183	87.1	50	79.4	249	99.2	50	98.0	118	90.1	88	65.2
No	34	45.3	25	12.0	11	17.5	2	0.8	1	2.0	12	9.2	45	33.3
No answer			2	0.9	2	3.2					1	0.8	2	1.5
Total	75	100	210	100	63	100	251	100	51	100	131	100	135	100

Health workers particularly the BHWs and midwives, and the mass media were cited as the most common sources of information about the rights of CWD by the respondents in all the study areas.

Among the rights of CWD enumerated by the interviewees were:

1. Right to special attention from parents/given their special needs
2. Right to quality health care/right to be cured/treated
3. Right to education like a normal child
4. Right to be protected (from violence, abuse, bad intentions, etc.)
5. Right to play or be with friends/fellow children
6. Right to live together with "good" parents/family/right to be loved
7. Right to material support and protection from the government/other agencies
8. Right to identity/nationality/to be registered
9. Right to food/be given appropriate nutrition
10. Right to life and dignity
11. Right to freedom to express one's thoughts and be heard
12. Right to live in a decent abode
13. Right to organize or be with organizations
14. Right to development or enhance one's talents
15. Right to rehabilitation

The enumerated rights virtually cover the basic rights of children recognized in the Convention on the Rights of the Child (CRC) and classified into the four domains of children's rights namely, the right to survival, to development, to protection from harmful influences, abuse and exploitation, and to participation in the family, cultural and social life.[13]

Most of the interviewees in all the study areas either had not heard of laws on CWD or did not give any answer as shown in Table 6 on the awareness of specific laws for CWD. In Balangiga, Dolores, Llorente, Oras and San Julian, more than two-thirds had not heard of the Magna Carta for Disabled Persons.[14] Close to a third and 35.3% of the respondents in Oras and Quinapondan, respectively, said they had heard of the law. (Table 6)

More than half of the interviewees in Balangiga, Dolores, Llorente, Oras and San Julian said they have not heard of the Child and Youth Welfare Code.[15] Oras and Quinapondan had the highest percentage of respondents, i.e., 44.6 and 25.5%, respectively, who claimed they had heard of the law. (Table 6)

Except for Quinapondan and Salcedo where more than two-thirds of the respondents had no answer, more than three-fourths of the interviewees in the rest of the municipalities said they had not heard of the Accessibility Law.[16] Oras and Dolores had the highest percentage of respondents who claimed having heard of the law at 19.5 and 14.8%, respectively. (Table 6)

Discussion

The state of children with disabilities in the Philippines as shown in the study results is characterized by various forms of deprivation, inequity, and exclusion, primarily because of poverty.[1,4]

The research findings reveal that most of the CWD in the seven (7) municipalities of Eastern Samar come from families that are economically and socially disadvantaged as illustrated by their socio-demographic profile. Not only do the CWD come from big families with an average family size of 6 to 7 members, 3 to 4 of whom are children, more than 40% of their family members had just reached or completed elementary education. Moreover, the CWD come from families who live below the poverty threshold with a monthly family income of less than Php5,000 (US$119). With farming and farm-related work, and construction/manual

Table 6. Distribution of respondents based on knowledge of laws pertaining to CWD in the 7 sites, 2008

Heard of the following laws	Balangiga (n=75)		Dolores (n=210)		Llorente (n=63)		Oras (n=251)		Quinapondan (n=51)		Salcedo (n=131)		San Julian (n=135)	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Magna Carta for Disabled Persons (RA 7277)														
Yes	3	4.0	33	15.7	1	1.6	81	32.3	18	35.3	22	16.8	10	7.4
No	72	96.0	173	82.4	59	93.6	166	66.1	8	15.7	65	49.6	124	91.9
No answer	0		4	1.9	3	4.8	4	1.6	25	49.0	44	33.6	1	0.7
Total	75	100	210		63	100	251	100	51	100	131	100	135	100
Child & Youth Welfare Code														
Yes	11	14.7	42	20.0	9	14.3	112	44.6	13	25.5	23	17.5	14	10.4
No	64	85.3	161	76.7	53	84.1	132	52.6	9	17.6	42	32.1	120	88.9
No answer	0		7	3.3	1	1.6	7	2.8	29	56.9	66	50.4	1	0.7
Total	75	100	210	100	63	100	251	100	51	100	131	100	135	100
Accessibility Law (BP 344)														
Yes	6	8.0	31	14.8	1	1.6	49	19.5	2	3.9	3	2.3	5	3.7
No	69	92.0	171	81.4	58	92.1	192	76.5	14	27.5	15	11.4	129	95.6
No answer	0		8	3.8	4	6.3	10	4.0	35	68.6	113	86.3	1	0.7
Total	75	100	210	100	63	100	251	100	51	100	131		135	100

work among the principal sources of income, it is not surprising that most of the families are unable to satisfy the barest necessities. In an environment characterized by constraints in resources, families have likewise been unable to meet the special needs of CWD.

The most common forms of disabilities among children in the study sites are related to sensory, voice, and speech defects like cleft lip/palate, and cross-eyes; mental functions in the form of mental retardation, epilepsy and cerebral palsy; and neuromusculoskeletal and movement-related functions like club foot/feet and crab hand/foot.

The CWD in the study areas are in the critical years of childhood. While at least a third are five years of age and younger in Dolores, Oras and Salcedo, more than one-third are between 12 to 17 years in Balangiga, Llorente and Quinapondan and are also confronted with reproductive health challenges, particularly the girls. Moreover, they often receive little or no information about health, life skills, and sexuality, putting them at greater risk of sexual abuse and of acquiring sexually transmitted infections, including HIV/AIDS.[17]

At least one fourth of the children, mostly boys, have not gone to school, a condition typical of CWD in developing countries like the Philippines. According to UNESCO, 90% of CWD in developing countries are out of school,[18] reinforcing their exclusion and state of dependence, especially in rural areas.

Information on the child's disability was acquired by the family in the course of observing the child grow, at birth, and as pointed out or diagnosed by a medical doctor. Although the initial response of families upon learning about the child's health condition include consulting or seeking the help of a doctor, a common reaction also of many of the families to the disability/ies as dictated by their impoverished state is inaction and resignation. Not doing anything and accepting the child's condition as God's will illustrate the family's powerlessness, a prevalent behavior and attitude among Filipinos, particularly the poor, who are often economically and socially ill-equipped to understand the cause of the child's disability/ies, much less assist the child to reduce, if not overcome, the negative consequences of the impairment. Moreover, the general attitude of accepting the child's health status as a God-given condition reinforces the views on CWD as a burden and unproductive members of society. The UN Special Rapporteur on Disability stressed the need to change society's attitudes toward disability and this would require "ridding society of prejudice and discrimination and breaking down walls of superstition and ignorance".[1]

Such discriminatory views and inadequacies of the family are aggravated by the inability of families to provide for the special needs of CWD as admitted by a significant percentage of the respondents. More than half of the interviewees in 5 out of the 7 municipalities registered the need for assistance of the family in providing for the special requirements of the child with disability since they are unable to meet all these needs primarily because of the poor condition of the family, and the physical and economic inaccessibility of programs/services for CWD.

Most persons with disabilities, including children, in developing countries like the Philippines, have limited access to health, rehabilitation or support services since funds, personnel, and equipment are often scarce.[1,19] Commonly, programs and services are concentrated in urban areas and expensive.[1] Moreover, family members are often ill-prepared and ill-equipped, intellectually, psychologically and socially, in handling a disabled child. The caregiving function of parents, for instance, "takes on an entirely different significance when a child experiences functional limitations and possible long-term dependence"[20] resulting to more demands and strains on the physical and psychological health of caregivers, most especially mothers.[20,21]

While there are numerous laws intended to promote the rights and welfare of CWD, there are problems and weaknesses in the effective implementation of these laws, especially in making available and accessible programs and services for CWD in the rural areas. Not to mention "ill defined policies, objectives and an ambiguous position on the part of the national governments" which "often exclude or fail to ensure the provision of welfare services for CWD, across different regions of the world"[1] as pointed out by the UNICEF.

Furthermore, there is government's failure to raise people's awareness on the existence of laws for CWD including the responsibilities of government agencies/institutions toward disabled children, as evidenced by the ignorance of more than half of the respondents regarding existing laws intended for CWD. Ironically, majority of the respondents in all seven municipalities claim to know the rights of CWD and were able to specifically identify these rights. However, they have very limited knowledge on the legal bases of these rights domestically.

While family members have learned to accept the child's disability/ies by treating him/her as any normal child and by not being bothered by the child's health condition, many have also registered the negative effects of the disability/ies on family members. The most frequently mentioned negative effects were the difficulty of caring and nurturing a disabled child; the economic burden on the family due to the special needs of the child like medicines, aids, consultations, etc.; and the limitations on family activities imposed by the child's health status. The negative effects imply additional economic and emotional load on the family in the midst of their impoverished condition.

Poverty and disability form a vicious cycle. On one hand, poverty makes people, especially children, highly vulnerable to disability due to lack of access to food and

clean water, health goods and services, education, and safe and clean environment.[1] On the other hand, the presence of a disabled person or child further aggravates the poor status of the family because of the economic and social needs the family has to respond to in the course of caring for the disabled member of the family. As pointed out by the World Bank, "PWD account for up to one in 5 of the world's poorest people".[1] Aside from family members who are said to experience "significantly greater caregiver burden",[20,21] the disability also affects the child's emotional and physical dispositions as shared by the respondents. Among the most common negative consequences demonstrated by the child are being irritable and sensitive, helplessness and difficulty moving around, and low self-esteem and self-confidence. It can be gleaned that some of these problems like limitations in the child's mobility and activities, and low self-esteem, may be due to a physical and social environment that is discriminatory and unresponsive to the needs of disabled children. For instance, mobility aids, devices and assistive equipment like wheelchairs, ramps, and disabled-friendly gadgets and facilities, are not commonly available in rural communities.[19]

While they are cognizant of the special needs of a child with disability/ies, most of the families are unable to meet these needs primarily because of economic limitations and physical inaccessibility of programs and services. Both factors can be linked to the government's weakness in complying with its human rights obligations to its young citizens with disability, a commitment made by the Philippine government when it ratified the Convention on the Rights of the Child and the Convention on the Rights of Persons with Disabilities. As a State Party to these conventions, the government is compelled to create an enabling and inclusive environment for CWD. This includes recognizing the fundamental rights and freedoms of CWD and ensuring that their full potentials are developed and realized.[1] It also entails building the capabilities of carers, public health officials and staff, at the village and municipal levels to effectively respond to the needs of CWD and their families, and setting-up relevant programs and services.[22,23]

However, since health has never been a priority of the State, both at the national and local levels, as evidenced by the low health budget annually, it is not surprising why public health programs and services for disabled children have not been given the appropriate attention and resources. Ironically, the gap in addressing the needs of CWD is being fulfilled by non-government organizations (NGOs) which often have insufficient and limited resources.

As suggested by the interviewees, establishing programs and services for CWD, allocating funds, and assigning responsible and competent health staff, were among the aspects identified by the respondents that need improvement in order to meet the necessities of CWD in the community. Essentially, these recommendations mean making the government more visible and its presence felt in the study areas.

Conclusions and Recommendations

The study results affirm what are already known about the conditions and problems of CWD in the Philippines.[2,24] Economic and social deprivations, exclusion and discrimination are the main features of the lives of CWD and their families.[1] Poverty has made it difficult for the CWD and their families to meet their basic needs, access programs and services, expand their options, and experience a life with dignity.

Critical in addressing the needs of CWD and their families, and reducing their vulnerabilities is raising the family's standard of living by making available decent jobs and sustainable sources of income to family members. It is also important that community-based rehabilitation programs and services guided by a biopsychosocial framework and that are family-centered[20] are physically and economically accessible to CWD and their families to be able to raise their capabilities and expand their options.[19-25] These measures will assist family members assume a positive view and attitude toward the disability/ies of their children, and provide them the necessary knowledge, skills and social support which will allow them to competently address their predicament and enable them to adapt empowering coping behaviors.[26] All these requirements entail collaboration between various stakeholders including CWD, their families, communities, civil society organizations and the government.

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