Children Australia
Volume 40 ▌ Number 1 ▌ pp. 10–15 ▌ © The Author(s) 2015 ▌ doi:10.1017/cha.2014.44

Commentary

Addressing the Multidimensional Impact of Child Poverty: A Model Programme in Pasay City, Philippines

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Living in poverty has lifelong consequences for children. In response to the obvious needs of highly vulnerable, impoverished children and youth in its neighbourhood, Community and Family Services International (CFSI) commenced the Park Avenue Initiative (PAI) which was aimed at addressing the impact of poverty through promoting and testing community-based initiatives in child protection, youth development, and opportunity-creation. Building upon research into the reproductive health (RH) practices of young people in the area, the PAI was expanded to include a new programme addressing RH and the high risk sexual behaviours engaged in by many youth. This article critically examines how poverty is impacting on children. It presents the PAI RH approach as an example of a programme which addresses many of the multiple risks poverty presents for children. The PAI RH programme takes a holistic perspective to address the co-morbidity of poverty risk factors. The programme works with children, their families and the community. The article concludes that programmes need to take an integrated approach to address the multidimensions of poverty and engage with children and their families in actions which are aimed at building individual resilience and strengthening communities.

■ **Keywords:** child poverty, child protection, reproductive health, community work, youth participation, best practice

Introduction

Poverty impacts upon children in a diversity of ways. Recent reports suggest that child poverty in some areas of society is growing (Reyes, Tabuga, Asis, & Mondez, 2014; UNICEF 2014). Reports on the growth of child poverty contrast with the positive trends of key indicators of child wellbeing. These indicators include evidence that the mortality rate of under-5-year-olds has declined from 90 deaths per 1000 live births in 1990 to 46 in 2013 (WHO, 2014). There are also positive changes in global school attendance figures, with the number of out-of-school children of primary-school age declining globally from 102 million to 57 million between 2000 and 2011 (UNICEF, 2014). The contrasting results highlight the multiple dimensions of child poverty and its consequences. These key indicators are evidence that worldwide trends for child wellbeing are changing in a positive direction. However, there is also evidence that many children still live in poverty. UNICEF (2013a) does not expect that the Millennium Development Goals (MDG) for education in 2015 will be met, and lack of education is a significant factor in poverty. The impact of poverty on the development of children will have lifelong consequences for them and for the global community. This paper presents a programme that has been designed and implemented to address the multidimensional impact of poverty on children and their communities.

Although school enrolment has improved worldwide, it is estimated that 120 million school-aged children could still be out of school in 2015. Moreover, an estimated 67 million children will not attend primary school and girls

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will continue to lag behind boys in school enrolment and attendance (UNDP, 2014). Furthermore, although literacy rates are improving worldwide, 122.2 million of the world's youth population are illiterate (UNESCO, 2012). While it is important to celebrate the improvement in mortality rates in 2013, it should also be noted that 6.3 million children under 5 years of age died of mainly preventable causes. The positive trends shown in the major health indicators can mask the fact that poverty is still a reality for many children, and not only for children living in economically poor countries. Recently, it has been identified that, since 2008, 2.6 million children in the world's most affluent countries have fallen below the poverty line (UNICEF, 2014).

Children are the most vulnerable members of communities. Poverty affects every aspect of their lives. The convergence between epidemiological and neurobiological evidence of the effects of childhood trauma identified by Anda et al. (2006) also showed that trauma can have lifelong consequences for children. Addressing the adverse conditions of poverty requires immediate action. It is the children who are experiencing poverty today who will be the affected youth in only a few years, and will become affected adults. Programmes are required which can mediate against the adverse effects of poverty for those children already living in poverty. To be effective, programmes need to address the multiple impacts of poverty for, as Anda et al. (2006) highlight, the 'prevention and remediation [of health and social problems] is likely to benefit from understanding that many of these problems tend to be comorbid' (Anda et al., 2006, p. 183).

A programme implemented by CFSI in Pasay City, Philippines, is presented here as a model for programmes that seek to address the impact of poverty. The programme is being described in this paper to demonstrate how effectively addressing problems in poor communities can be facilitated by an integrated relational approach to influence positive change in the community and strengthen the community. It is suggested that, all too often, programmes implemented in poor communities aim to address one social problem and ignore the comorbidity of the problems that can become embedded in poor communities.

The Context

Pasay City, Metro Manila is one of the local government areas that makes up metro Manila in the Philippines. Although there is a high level of poverty in the Philippines, there is evidence of economic improvements in the country. The gross domestic product (GDP) growth in 2013 was at 7.2%, 'Yet poverty remains a core issue for many communities. In 2009, 13.4 million or over a third of all children aged below 18 in the Philippines were living below the poverty line in the Philippines' (Reyes et al., 2014, p. i). Moreover, 'longitudinal data show that a non-negligible number of families move in and out of poverty and this vulnerability poses risks on children's wellbeing' (Reyes et al., 2014, p. i). Although the majority of children in poverty in the Philippines live in rural areas, 'the annual rate of increase in urban locations is alarming at 4.48 percent, almost twice the rate of increase in the rural areas. While it is imperative to focus efforts at the rural areas, interventions that aim to reduce poverty in the urban areas are also urgently needed' (Reyes et al., 2014, p. 11).

The Headquarters of CFSI is located in Pasay City, Metro Manila. Pasay City is highly urbanised, being a crowded inner-city area with a large population of urban migrants. There are areas of high levels of poverty and unemployment in the local government area. Many local children do not attend school and are at risk of violence, exploitation, prostitution, trafficking and substance abuse. The signs of poverty in the area are clearly visible and include: very young children and youths wandering the streets day and night; and poor families living in tin shanties in one or two rooms or in the street. Many homes have no running water or electricity, or, if they do have utilities, it is often because the houses are illegally linked up to utilities. This latter situation presents high risks to child physical safety. Many school-aged children who do not attend school, and even pre-school-age children, work to supplement the family income. Poverty goes beyond mere lack of income or assets for these children and their families. 'Their situation speaks of a roster of factors that range from lack of appropriate skills to inability to control fertility intertwined with lack of job opportunities and other economic problems' (Reyes et al., 2014, p. viii).

The Organisation

CFSI is a humanitarian organisation with headquarters in Pasay City, Metro Manila, Philippines. Some CFSI staff live in the area and all staff know the area from daily contact with the local community. Even though the focus of CFSI is national and international, the management of the organisation recognised the need to work with the community where the office is located. As an organisation, CFSI is committed to peace and social development, with a particular interest in the psycho-social dimension of achieving these goals. It is this aim that informs all programmes designed and implemented by CFSI. The Chief Executive Officer, Dr Steven Muncy, has led the development of the approach, which is the framework for all CFSI programmes. CFSI works internationally, primarily but not exclusively in the Asia and Pacific Region. The philosophy of CFSI is 'Every person is unique, with inherent worth and dignity, equal and inalienable rights, the need to be meaningfully connected to others, and the potential to contribute to the well being of the human family' (CFSI, http://www.cfsi.ph/who-we-are/about-cfsi/).[1]

CFSI Early Activities in Pasay

In 2002, in response to the visible signs of poverty in its neighbourhood, CFSI commenced the Park Avenue Initiative. Named after the street in Pasay where the offices are

located, The Park Avenue Initiative is aimed primarily 'at child protection, youth development and opportunity-creation through community mobilization and the provision of information and services' (CFSI, http://www.cfsi.ph/). Initially, the programme commenced as an education activity to encourage the local children to become engaged in education and to attend regular school. The programme sought to engage parents to support their child's attendance at school and encouraged participation of parents in diverse ways, including community education and also assisting families to gain livelihood assistance. It was recognised that many children do not attend school because the family needs them to gain an income to contribute to the family's subsistence. If the family is able to gain an adequate income through other activities, they are more likely to encourage the children to go to school. The early days of the Park Avenue initiative is told through the story of a 6-year-old child and is recorded in the short film *CFSI rebuilding lives*, which can be accessed at https://www.youtube.com/watch?v=Q_WTnSzSxYQ (see also Box 1).

Box 1 Case vignette.

Ruby (the name is a pseudonym) was 6 years old when her life and vulnerability were captured in a video entitled *CFSI changing lives*, which can be viewed at https://www.youtube.com/watch?v=Q_WTnSzSxYQ.

At the time she became known to CFSI, Ruby lived with her brother and extended family. She was cared for by her grandmother, who was in poor health. Her mother was in jail. Ruby did not attend school as she had to work in the market selling plastic bags to contribute to the earnings of the family. She worked in the market day and night. The video illustrates her extreme vulnerability to abuse and sexual exploitation. It was also of concern that Ruby was being denied the opportunity to meet normal developmental needs such as education.

Ruby is now 14 years old. She is attending formal classes at primary school, and will soon graduate. Over the years she has intermittently dropped out of school due to several difficulties, such as her grandmother's dwindling health condition. Her grandmother's ill health necessitated Ruby providing direct care assistance to her and taking on everyday chores, including caring for younger children in the family, as well as obtaining an income to make ends meet. Time and again, the difficulties brought about by their precarious living condition demotivated Ruby to go to school. CFSI provided counselling and financial assistance, and Ruby has continued in school. She is now a youth volunteer with the RH programme and she is demonstrating leadership abilities. Without the programme it is almost certain that Ruby would have dropped out of school. The programme has also provided greater protection to prevent her becoming entangled with the potential risks existing in the community, such as prostitution, early pregnancy and child trafficking. Ruby continues her involvement in the CFSI Park Avenue Initiative programme, either by being a participant in activities or by leading her peers, such as encouraging them to engage in the programme activities.

The programme also worked with the family to assist the grandmother to set up a small business, which can provide the family with sufficient income and releases Ruby, her brother and cousins to attend school.

There is no doubt that the risks to Ruby are still present in the community. However, her experiences in the programme have assisted her to be more resilient, and more equipped to face these challenges and avoid the risks.

The Model Programme

Inability to control fertility, high-risk sexual behaviours – particularly in young people – and high levels of sexual assaults and family violence in the community, are exacerbated by poverty; and the presence of these social problems increases the barriers to escape the relentlessness of poverty. These factors exist in areas of Pasay. In 2012, CFSI undertook research into the reproductive health (RH) practices of young people in the area. This baseline research found an 'alarming number of youth exhibited sexually high risk behaviors that led them to early pregnancy, sexually transmitted infections (STI) and/or diseases, domestic violence, and the consequent social, economic and psychological effects of these conditions' (CFSI, 2014b, p. 6). The research highlighted misconceptions and a general lack of information about reproductive health issues. CFSI commenced a programme to address this issue '... with the aim of decreasing the number of youth engaging in risky sexual behaviours, increase the knowledge of youth about their Reproductive Health (RH) with the participation of their parents' (CFSI, 2014b, p. 6). The research also highlighted that young people in the community did not utilise local health services in relation to RH, as they did not trust the services to assist them. Therefore, the programme was also designed to increase youth access to RH services and products by addressing the 'trust issues' between the youths and the public service providers, as well as addressing the social stigma attached to someone going to hygiene clinics seeking RH services. It was this aim that influenced the inclusion of the peer-to-peer and family-centred counselling approach programme design, described below. Although the focus of the programme was reproductive health practices, it was recognised that such an issue could not be addressed effectively in isolation to other social issues faced by the community, and the design and implementation of the programme aimed to strengthen the community.

The programme essentially used a psycho-social approach within a rights framework, with an aim of empowering the community. The process of developing the programme included identification of the problem to be

addressed, research to provide evidence of the issue, designing the programme, which built upon existing relationships with the community, and addressing the comorbidity of social problems in the community. The implementation of the programme first focused on encouraging people in the community to engage with, and lead, the implementation. The final step of the programme was an internal and external evaluation of the process and outcomes of the programme. The significance of the problem of reproductive health and high-risk sexual behaviour has been identified previously as a factor that acts to prevent families moving out of poverty. Reproductive health behaviour is important in the community because it impacts significantly on the health of mothers and children, and also impacts upon the ability to address poverty conditions.

The RH programme introduced by CFSI built on relationships which CFSI had already established with the community. The programme was designed as an integrated approach to influence factors that were impacting on RH practices. That is, there were a number of programme components which, together, addressed the comorbidity of issues that affected reproductive health and sexual behaviour in the community. The design of the programme was influenced by an aim to empower the community through provision of knowledge, influencing change in behaviour and facilitating access to more responsive services.

The first step of the programme was to engage the community, with this engagement beginning through the initial research to identify the issue. The implementation of the programme commenced with selecting 38 youths and 29 adults to form a pool of community volunteers. The process of selection of the volunteers was designed as an extensive recruitment process. The individuals were interviewed in groups and were selected based on their demonstrated leadership potential and communication skills. The selected volunteers were given capacity building training prior to commencing the programme. The output of the training was a team of skilled volunteers able to share in the delivery of the programme to the community, and to facilitate RH seminars in the community. Moreover, the knowledge and skills the training provided to these volunteers, or community leaders, could be transferred to addressing other social problems in the community.

The volunteers/community leaders became role models in the community in relation to supporting young people in decision making in relation to RH. Moreover, it was found that the volunteers began practising family planning to avoid unplanned pregnancy.

Programme Components

The programme components are described in this section. It should be noted the implementation of all the components was essential to the programme design. The degree of poverty in the community is highlighted by the multiple and comorbid negative factors that exist in the community. To be effective, the programme needed to engage with the community and empower the community to address poverty.

The individual programme components are:

Peer-to-peer counselling. Youth volunteers were trained to provide leadership in the community to their peers. The programme sought to have health information made available to the community members outside traditional health institutions. The use of peer counsellors provided young people access to a trusted person in whom they could confide. The youth volunteers were able to provide accurate information in a youth-friendly manner and to facilitate referral of the young person to formal health institutions if required.

Family counselling. The programme engaged parents of the children and young people through provision of counselling. There was recognition that if the behaviour of children was to change, their parents needed to be engaged. The programme provided health information to parents. At the same time, the parents were given access to guidance and counselling to support and facilitate improved communications between them and their children. For example, 'A Family Support Worker [i.e., a programme volunteer] mentioned in a focus group discussion that she learned how to better deal and communicate with her teenage children. She learned that the most effective way to communicate with her children was through listening sincerely and showing them empathy' (CFSI, 2014, p. 5).

Partnerships with service providers. Forming partnerships with service providers was an important component of the programme design. The involvement of the service providers in the programme strengthened the collaboration between agencies and thus promoted appropriate referrals and sharing of information, all of which benefited the community. The programme recognised that one organisation could not effectively address the issue alone. Rather than services and agencies working in isolation, the programme brought together local and national organisations in the community to make expert information available and to develop clear pathways to services for community members.

Building relationships across the community. A direct service was provided for children and young people. Direct service was built into the programme and included social/recreational and educational activities aimed at encouraging out-of-school youths to return to school, and also to support those young people at risk of dropping out of school. The social/recreational and educational activities had a dual benefit. The activities brought together young people from different barangays (local government areas). There was a history of conflict between the youths of different barangays. Sharing activities in the programme resulted in young people developing relationships with those from other neighbourhoods. This, in turn, influenced the

early development of a sense of community, and recognition that peers from different areas faced the same social problems. Thus the opportunity to address these issues as a larger group was established. The recreational activities also gave young people additional skills, such as learning to swim – an activity that most children in these areas would normally never learn. Educational activity assisted young people to engage in school, and many returned to school.

Youth-driven communication strategies. The programme consulted with young people to obtain their input regarding the most effective way of communicating important messages to children and youth in the community. The issues addressed included: understanding abuse and family violence, and the impact of sex texting and family violence. The ways of communication that young people suggested, and then engaged with, included use of social media and a photo-story project in which young people portrayed issues of family violence.

Evaluation. An internal and an external process and outcome evaluation were undertaken. The purpose was to identify how the programme has been implemented, its outcomes and the lessons learnt.

In summary, the programme had a core focus on reproductive health and sexual behaviour and implemented the tasks within a relational, empowering approach, which addressed the comorbidity of social issues impacting on children and young people. The programme was designed to ensure that new knowledge and skills were owned by the community. Individuals were given training to take leadership roles in the community. These people were supported to bring about change in their community. Moreover, the programme also addressed developmental needs of individual children and young people. The engagement of the community in these activities created greater safety for children and young people, and increased the likelihood of their developmental needs being met.

The programme was evaluated, with the evaluation results showing an increase in sufficient RH knowledge of some young people, particularly regarding HIV transmission, prevention of early pregnancy, sexually transmitted diseases/infections, family planning methods (especially use of condoms) and some myths about sex. They also displayed sufficient knowledge of children's rights. It was also found that many of the out-of-school young people who engaged in the programme decided to return to school and/or to join a government health promotion programme. The evaluation also identified lessons learnt from the implementation of the programme and made a number of recommendations to strengthen the impact of the programme.

Summary

The programme is presented as a model to address the comorbidity of the adverse effects of poverty when addressing a specific condition affecting the community. It is important to note that CFSI was engaged in the community prior to the commencement of this programme. There was already a level of trust from the community. Working with a relational approach is a core approach for all CFSI programmes. Moreover, CFSI had an existing understanding of the needs and the strengths of the community, having worked with the community over a number of years. It is important that the organisation introducing a programme establishes a relationship with the community and that the program is implemented with the community. CFSI undertook research to test an initial observation regarding RH and to gain more evidence of the issues to be addressed. While, for this programme, the specific behaviour change to be addressed was reproductive health, the programme design and implementation influenced broader positive changes in the community. The engagement and training of community volunteers provided capacity building to the individual volunteers and had a ripple effect through the sharing of the volunteers' knowledge and role modelling. The programme skilled-up leaders in the community. The leaders obtained skills that they can continue to utilise, to influence the community to address other social problems following the completion of the program. The use of peer counsellors created new local networks and pathways for young people to share their concerns and to be supported to seek help. The development of these helping behaviours provided opportunities to strengthen community behaviour. The partnerships with existing service providers aimed to promote collaboration between services and the sharing of expertise between the services, as well as supporting more effective services for young people. The provision of direct services to families to improve communication between parents and children assisted parents in parenting practices and supported change in RH behaviour in young people. The educational and recreational programmes facilitated young people's engagement in education and also contributed to building a stronger community identity. The programme itself modelled a relational approach to empowering communities and individuals.

Conclusion

Poverty has a multiple and cumulative impact on children, their families and communities. Global macro-economic and social policies are required to eradicate poverty. However, individuals living in poverty can also be supported to bring about change in the local conditions and behaviours that poverty imposes on them. This is significant because children in poor communities lose out on having their developmental needs met and this has lifelong consequences for them. The programme developed by Community and Family Services International (CFSI) models an approach to address a significant factor in a poor community. This integrated and holistic relational approach has the potential

to empower the community to bring positive changes to the lives of children and families.

Endnote

[1] A more detailed description of the CFSI conceptual framework can be found in Frederico et al. (2007).

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