



IMMUNIZATION

SITUATION OF CHILDREN IN THE PHILIPPINES REPORT



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OF
CHILDREN
IN THE PHILIPPINES



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Seven in 10 children aged 12-23 months are fully vaccinated with basic antigens while 1 in 10 children received no vaccination at all.

There has only been a slight increase in the proportion of fully immunized children since 2013 but there has been a significant increase in zero vaccination over the same period. According to the national vaccination schedule, only six out of 10 of children aged 12-23 months and half of children aged 24-35 months are fully vaccinated.

Significant variation is observed among regions and children of mothers who have no education, or who are from the poorest wealth quintile, are less likely to have received any vaccinations.

Republic Act No. 10152, enacted in 2011, mandates free immunization for Filipino children against major diseases, complemented by other laws like the First 1,000 Days and Reproductive Health Act.

Immunization became mandatory among infants and children with the enactment of Republic Act No. 10152, the Mandatory Infants and Children Health Immunization Act, in 2011.

The act provides the legislative basis for comprehensive, sustainable, and free immunization of all Filipino infants and children up to five years old covering vaccine-preventable diseases such as tuberculosis, diphtheria, tetanus, polio, measles, mumps and rubella, among others..”

Other relevant laws and policies include the Republic Act No. 11148 or the First 1,000 days,

Republic Act No. 10354 on responsible parenthood and reproductive health, including guidance on vaccination.

There is an ongoing nationwide supplemental immunization campaign by the DOH called Chikiting Ligtas to vaccinate children against measles, rubella and polio.

In response to the COVID-19 pandemic, a COVID-19 Vaccination Program Act was passed in 2021 providing funding for a national vaccination programme against COVID-19 although vaccination is not mandatory.

Child Rights Situation Analysis

Immunization among children is monitored in: (i) the proportion of children fully vaccinated with basic antigens and those fully vaccinated according to the national schedule, (ii) the percentage of children aged 12-23 months who have received no vaccinations, and (iii) the percentage of children aged 12-23 months who have received BCG and measles-containing vaccines.

Data for these indicators is disaggregated by age, sex, residence, region, level of mother's education and wealth quintile. COVID-19 vaccination of eligible children has also been included in this analysis.

In 2022, 71.8 per cent of children aged 12-23 months were reported to have received the full doses of basic antigens just a few percentage points higher than that in 2017 and in 2013, at 69.9 per cent and 68.5 per cent, respectively.

Zero vaccination or the proportion of children that did not receive any vaccine increased to 11.2 per cent from 9.4 per cent in 2017 and 3.8 per cent in 2013. Six regions had a proportion of fully immunized children below the national average with BARMM registering the lowest proportion of a mere 18.1 per cent. BARMM also reported the highest proportion of zero vaccinated children with 6 in 10 children receiving no vaccination compared to the just 1 in 10 children overall.

There is little difference in the proportion of fully vaccinated children and zero vaccination by sex and residence. However, the proportion of full vaccination is generally lower in the lower wealth quintiles and among mothers with the least education while zero vaccination is highest in the same wealth and education categories.

Based on the national vaccination schedule, 59.4 per cent of children aged 12-23 months

and 49.9 per cent of children aged 24-35 months were fully vaccinated as of 2022. While there is not much difference by sex, the proportion of fully vaccinated children in rural areas per the national schedule is lower as is the case in poor households and in those whose mothers had the least education.

Children aged 12-23 months receiving BCG and measles-containing vaccines have declined. The proportion of children aged 12-23 months who received a dose of BCG vaccine, which is used to address tuberculosis, decreased to 87.8 per cent in 2022 from 90 per cent in 2017 and 95.4 per cent in 2013. The percentage of children that received at least one dose of measles-containing vaccine also dropped, although only slightly, in 2022 at 79.2 per cent from 80.4 per cent in 2017. Notably though, Region XI registered the steepest decline from 92.3 per cent in 2017 to 61.8 per cent in 2022 second only to BARMM with the lowest proportion of children receiving measles-containing vaccine at 21.9 per cent. There was not much difference in the proportion of BCG and measles vaccination between boys and girls and between urban and rural areas but lower percentages were observed among children in the poorest households and those of mothers with little education.

At least 80 per cent of 12-17-year-old and less than half of the 5-11-year-old children have received the full dose of the COVID-19 vaccine as of 2022.

Equity & Risk

EQUITY

Gender

There is not much difference by sex with regards to vaccination coverage in the Philippines.

Disability	This situation analysis has not been able to determine any data which disaggregates by disability under this subdimension.
Subnational	<p>There are major differences in immunization coverage by region. Of particular concern is the low coverage of fully vaccinated children in the BARMM region, at a mere 18.1 per cent for basic antigens and 14.9 per cent according to the national schedule among children aged 12-23 months, and 14.3 per cent of children aged 24-35 months fully vaccinated per the national schedule. BARMM has the highest zero vaccination (basic antigens) at six in every 10 children compared to only 1 of 10 nationwide.</p> <p>This disparity in BARMM is reflected across other immunization indicators and may be due to generally poor coverage of health facilities and services in the region.</p>

Others	<p>Wealth and education level affect vaccination coverage. The proportion of children who have been vaccinated is markedly higher for those in the highest socioeconomic class compared to those in the lowest. Similarly, the proportion of children who have been fully vaccinated is significantly higher when mothers have a higher level of education.</p> <p>For both age groups, the proportion is significantly higher among mothers who have completed post-secondary or college education, as compared to mothers who have received no education, or have been educated to Grade 1-6.</p>
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RISK

Natural hazards	Natural disasters can significantly disrupt routine immunization. It can reduce the likelihood of receiving timely age-appropriate immunization against vaccine-preventable diseases such as polio, tuberculosis and measles, placing children at greater risk for these infectious diseases.
Conflict	Those displaced by conflict often face risks of disruption to their access to routine health services, including routine immunization. This is a risk particularly to those in conflict-affected areas like Mindanao.
Health Crisis/Pandemic	<p>Any pandemic, or a similar health emergency, will significantly negatively impact the response for routine immunization. This was witnessed as a severe impact of the COVID-19 pandemic in the Philippines, which saw routine immunization sidelined. The pandemic also precipitated a strategy shift from school-based to community-based immunization for adolescents, which has contributed to low coverage of vaccines like HPV since this change as a result of vaccine hesitancy.</p> <p>Implementing preparedness plans for such an event would also be a challenge, posing risks to how effectively this work would be conducted as health workers</p>

do not always have the capacity to undertake regular new trainings. It is reflected that the development of a contingency plan to strengthen demand generation during potential health crises would be beneficial.

Legislation & Policy Analysis

Republic Act No. 10152 also known as the Mandatory Infants and Children Health Immunization Act was enacted in 2011.

The act provides the legislative basis for the adoption of a comprehensive and sustainable immunization programme for all Filipino children and infants. Under the act mandatory basic immunization is covered for the following vaccine-preventable diseases: tuberculosis; diphtheria; tetanus; pertussis; poliomyelitis; measles; mumps; rubella; hepatitis-b; H influenza type B (HIB); and other such diseases as determined by the Secretary of Health. The law further states that mandatory basic immunization for such diseases will be provided free of charge “at any government hospital or health center for infants and children up to five (5) years of age”. Also of relevance are Republic Act No. 11148 - which aims to strengthen maternal, neonatal, child health and nutrition for the first 1,000 days of life, including through age-appropriate immunization - and Republic Act No. 10354 which provides a national policy on responsible parenthood and reproductive health, including guidance on vaccination.

In 2021, the government passed the COVID-19 Vaccination Program Act. The act provided funding for a national vaccination programme against COVID-19, in the process covering both the procurement and the administration process including the issuing of vaccine cards to all recipients of the vaccine. Currently, there is no legislation in the Philippines for mandatory immunization against COVID-19 although vaccinations are strongly encouraged.

More recently, the government has also worked with partners including WHO and UNICEF to launch the Chikiting Ligtas, a nationwide supplemental immunization campaign to vaccinate children against measles, rubella and polio. The DOH has also worked with the Department of Education to develop policies on school-based immunizations.

Bottleneck Analysis

Demand

- **Education and communication.** This is a major bottleneck that limits immunization coverage in the Philippines. In 2021, a national survey found that 6 in 10 Filipinos were vaccine hesitant.

The spread of vaccine-related misinformation during the height of the COVID-19 pandemic has been attributed as a reason for this skepticism which has also impacted the coverage of routine immunization. However, it has also been suggested that some parents also now believe that the COVID-19 vaccine is the only one that needs to be administered to children, and that other routine vaccines are unimportant or harmful.

Education has also been cited to have a correlation with an individual's propensity to be vaccinated and is a factor that could explain the lower routine immunization coverage among lower educated populations, as described in the Child Rights Analysis for this subsection.

- **A lack of finances to travel to health care facilities.** This is particularly a bottleneck in more deprived regions and among families affected by issues like unemployment. Social protection schemes go some way to providing safety nets for these families, but the reach of these programmes varies significantly across the Philippines. Furthermore, this is likely to be a bottleneck particularly for families with children with disabilities who may need greater accessibility requirements, or with parents with disabilities who are more likely to have employment challenges.
- **Continued fear of contracting COVID-19 when accessing health care facilities.** This was reported to be a bottleneck impacting demand for health care services.
- **Cultural beliefs.** It is noted that in some regions cultural and religious beliefs contribute to vaccine hesitancy, for example in BARMM. That said, religious leaders have been working with the BARMM government to seek to overcome this bottleneck.

Supply

- **Diversion of resources.** During the height of the COVID-19 pandemic, the provision of routine immunization was de-prioritized in order to give way to COVID-19 responses. This has resulted in a backlog for routine immunization programmes.
- **Women and girls have limited access to health care facilities due to gendered norms of household responsibilities.** Prevailing gendered norms which view women and girls as the primary duty bearers of household responsibilities are a major bottleneck for the realization of women and girls' access to health care services. For instance, it was reported that women often cannot take the time out to travel to health care facilities due to childcare responsibilities.
- **Inadequate provision of adolescent-friendly health services at health care facilities.** This is a significant bottleneck, as it impacts adolescents' demand for health care services. Even for those in contact with the health system, the

assistance received is often inadequate and fails to address their needs. For instance, a 2019 study found that teenage girls who were in contact with the health system still continued to use no contraception, or used traditional and other less-effective methods as they did not receive adequate family planning counselling.

- **Inadequate supply chains for health.** Bottlenecks throughout the health sector supply chain remain an important challenge. These include bottlenecks in the financing, procurement, delivery and storage of medical supplies. The lack of reporting on supply usage was also reported to be a major issue, which leads to issues of tracking procured commodities for health. Evidence shows that these bottlenecks have led to delays in the delivery of health services, including child immunization and reproductive health services.
- **Limited access to health care facilities due to long travel distances and inadequate transport links, particularly in rural areas.** The number and distribution of accessible health care facilities varies greatly by province and municipality. For instance, a 2019 UNICEF study highlighted that all study participants from San Jorge, a first-class municipality in Region XIII, had a travel time of less than 15 minutes to a health facility, while of those from Dipolog, a third-class municipality in Region IX, a lower 46.2 per cent were this near. This bottleneck is particularly important given that poorer families often lack the necessary finances to travel to health care facilities, as identified in the Immediate bottlenecks. This is a key bottleneck with regards to seeking treatment for acute malnutrition in early childhood.
- **A lack of technical capacity among rural populations to carry out social development programmes such as health promotion activities.** These programmes and activities rely heavily on local participation. While this is positive in improving the localization of social development initiatives, it has also been identified as a key bottleneck. Local populations are often engaged in the implementation of programmes without being given the necessary skills and knowledge needed to effectively carry out their responsibilities, which leads to inefficiency.

Enabling environment

- **Limited coordination between national and local levels of government.** The provision of health services is devolved in the Philippines, and thus requires robust coordination and coherence between different levels of government.

While the introduction of policies and passing of laws happens at the national level, LGUs are the main duty bearers for implementation. Although a range of policies and laws have been introduced, there are major gaps in implementation due to issues of capacity, financing, human resources and motivation at the LGU level. At the root of these issues is the overarching bottleneck of a lack of coordination between national and local levels of

government. As reported by one key informant, “there is a major disconnect in what the national government tells LGUs what they should do, versus what they can do.”

Another key informant, a national government stakeholder, noted that knowledge and capacity-transfer from the national to the subnational needs to be a top-down process with national government agencies leading these efforts. It was, however, also noted that national agencies lack the budgetary requirements to do this widely and therefore rely on LGUs to seek technical assistance as and when needed.

- **Varying LGU capacities and appreciation at subnational level limits LGUs’ capacity to implement nutrition and health laws.** LGUs are the main duty bearers for the implementation of national laws and policies on health. However, some LGUs suffer from a lack of capacity in terms of human resources, technical skills and the necessary budgets for adequate implementation.

A commonly cited bottleneck across KIs conducted under this situation analysis was that decision-making on focus areas within LGUs relied heavily on the LCEs. As such, LCEs’ willingness, motivation, and ability to prioritize health and nutrition issues is a major determinant of the realization of an LGU’s prioritization of health service delivery. While it is difficult to ascertain the extent of this bottleneck, it was suggested that LCEs often make decisions on these matters based on political factors rather than population needs. Furthermore, as LGU elections are held every three years, there are regular changes in health staff and leadership.

This is reportedly a significant bottleneck, as knowledge and expertise around health at LGU level fluctuates regularly. For partner organizations, this turnover also requires the rebuilding of relationships to carry forward collaborative endeavours.

- **Inadequate progress indicators being measured and a resultant lack of robust data being collected to inform policymaking.** This is a critical bottleneck, as without the right data, it is difficult to determine where challenges lie and how they should be addressed. Furthermore, it is essential that data be disaggregated in order to inform more targeted policymaking.

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