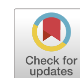
The health status and related interventions for children left behind due to parental migration in the Philippines: A scoping review



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Summary

Overseas Filipino Workers are hailed as modern-day heroes who enable their families to climb the socioeconomic ladder. Despite their financial contribution, labour migration often separates children from their parents during their most formative years of growth, threatening healthy development. Using the Joanna Briggs Institute's framework, a scoping review was conducted to identify the health outcomes of left behind children in the Philippines and health-related interventions. In total, 4440 records were collected from peer-reviewed articles and grey literature and 50 records were eligible for inclusion. The findings indicated that left behind children experience a vast range of poor physical (general health, hygiene, illness, and nutrition) and mental (behavioural, cognitive, and emotional) health outcomes. A total of 48 interventions were identified in 13 out of 17 geographic regions. Despite this geographic coverage, the evidence-based literature was limited with regard to whether these interventions have been effective. Additional research is needed to better understand children's health, evaluate existing interventions, and develop multisectoral programming.

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Introduction

Children who are separated from their parent(s) due to labour migration experience family fragmentation during their most formative years of growth. This may affect the adequacy of their rearing environment, as well as their physical and psychological development.[1] Healthy children require stable and secure environments for optimal brain development during and beyond childhood.[2,3] The Nurturing Care Framework recognizes that good health and adequate nutrition are fundamentally tied to responsive caregiving, safety, and early learning.[4] Primary caregivers therefore influence their children's developmental trajectories and play an active role in their physical and mental well-being.[5] The evidence indicates that parental labour migration produces mixed outcomes[6] and the impacts of this phenomenon in the Philippines context has yet to be synthesized, creating a key knowledge gap.

Parental labour migration is common globally, including across countries in Latin America, Europe, and Asia.[7] At present, the literature lacks consensus on whether labour migration has been wholly advantageous or disadvantageous on the health outcomes of left behind children (LBC).[8] For example, a study conducted by Frank and Hummer[9] indicated that transnational families in Mexico were more likely to have higher birth weights, and therefore greater nutritional outcomes, due to remittances received. Alternatively, a cross-sectional study in Sri Lanka found that two in every five LBC surveyed had a psychiatric disorder in addition to showing a greater vulnerability to psychopathology compared to non-migrant groups.[10]

The Philippines is one of the largest labour-sending countries and the fourth largest remittance receiving country worldwide.[11] Overseas Filipino Workers (OFWs) are cultural symbols of *bagong*

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bayani (*i.e.,* modern-day heroes) who have enabled their families to escape poverty and climb the socioeconomic ladder.[12,13] The latest national survey found that 2·2 million OFWs remitted approximately $4·21 billion USD to their loved ones from April to September 2019.[14] Approximately 12% of all Filipino households currently has or had a family member who is an OFW.[15]

While labour migration in the Philippines has a long and complex history that can be traced back to the early 1900s, formal overseas employment did not emerge until the Philippine government implemented the 1974 Labour Code.[16,17] This was later reformed into the labour migration program through the Migrant Workers and Overseas Filipino Act in 1995, which transformed the Philippines into one of the world's fastest growing economies within a single decade.[18,19] Now, remittances from labour migration comprise approximately 10% of the country's gross domestic product, which serves as the highest share amongst all Asian countries and outpaced foreign direct investments and agricultural exports.[11,20,21]

Although labour migration has facilitated upward social mobility amongst citizens, its efficiency has been criticized for jeopardizing the stability of the Filipino family.[22] The evolving labour market has also gendered the demand for workers, whereby 56.0% of women now comprise all OFWs.[23] The circumstances of parental labour migration challenges traditional family composition and reverses household gender norms.[24] These considerations are especially important to the Filipino context because the family unit is highly regarded as an integral support system for children. Familial cohesion in Filipino households is a key indicator for the severity of children's mental illness, suicide ideation, and help seeking behaviour.[25] Therefore, ruptures in the family that begin in early childhood may inform long-term behavioural, cognitive, and emotional health outcomes, regardless of whether they are separated from one or both parents.

There are an estimated 1·5 to 9 million Filipino children who lack adequate parental involvement.[26,27] Ruptures in the family that begin in early childhood may be associated with long-term physical, behavioural, cognitive, and emotional health outcomes.[26] While parental labour migration specifically aims to fulfil basic needs related to food and financial security, physical separation can fundamentally challenge the psychological needs of belongingness and intimacy.[28] Considering LBC may lack the opportunities to build positive caregiver-child relationships that satisfy their biopsychosocial needs during early development, it is paramount to investigate how this phenomenon may affect the physical health and mental-wellbeing of this vulnerable population.

The evidence regarding health outcomes and interventions for LBC in the Philippines has not yet been synthesized. An accurate understanding of the effects of parental migration is needed to inform future research, the development of effective interventions, and the implementation of policies which aim maintain the health, protection, and security of children. The current scoping review was conducted to synthesize the limited literature and answer three questions:

1. What is known from the existing literature about the health outcomes of left behind children due to parental labour migration in the Philippine context?
2. Are there interventions targeting these health outcomes that have been or are currently being implemented in the Philippines?
3. What are the research gaps on the physical and mental health needs of left behind children that need to be addressed in future studies?

Methods

Protocol and registration

This scoping review was conducted following the Joanna Briggs Institute methodological framework.[29] Findings are reported using the Preferred Reporting Items for Systematic Reviews and Meta-Analyses Extension for Scoping Reviews (PRISMA-ScR) Checklist.[30] The review protocol was pre-registered on May 31, 2021, on the Open Science Framework (https://osf.io/n9td2/).

Search strategy for peer-reviewed and grey literature

The literature search for this scoping review was conducted from May 2021 to April 2022 using a comprehensive search strategy to capture peer-reviewed journal articles and grey literature. Peer-reviewed journal articles were captured from eight electronic databases: Web of Science, PubMed, MEDLINE, Embase, Emcare, the Global Health Database, the McMaster University Library, and the Philippine E-Journals Database. Peer-reviewed articles identified through citation searching were retrieved through Google Scholar. Broad search terms were used across all databases and included a four-concept strategy, such as the following: ("parental labour migration" OR ("migrant labor" AND parent*)) AND children AND (Philippines OR "Southeast Asia") AND (health OR well-being). Year limits ranged from database inception through April 21, 2022. Article reference lists were searched, and three authors were contacted directly to locate additional sources at the full-text review stage. The search strategy for these databases is included in Appendix 1.

Grey literature sources were identified through government websites; academic institution websites; local church association websites; international humanitarian organizations, such as international non-

governmental organizations (iNGOs), local NGOs and United Nation (UN) agencies; inter-governmental organizations; online news outlets; pre-print databases; and trial registries. Appendix 2 provides a full list of electronic sources and methods used to retrieve grey literature. The most recent search for grey literature sources was conducted on April 21, 2022.

Study selection and inclusion criteria

Only sources written in English were considered. For the purposes of this review, left behind children refers to children who were separated from at least one of their parents due to parental labour migration. Although children below 18 years old undergo clear transformative growth, the impacts of separation may persist throughout adulthood, and therefore left behind adult children and adults who were once LBC were also included. Migrant parents were considered as those who undertook overseas employment, regardless of occupation and location. All included sources were required to discuss the LBC population currently in the Philippines and mention the outcomes of interest.

The selection and screening phase were conducted by one pair of reviewers. Peer-reviewed journal articles were retrieved and imported into Covidence, which automatically identified and removed duplicate records. The titles and abstracts of the remaining peer-reviewed articles were then screened by the primary reviewer (GD) to determine whether the sources met the inclusion criteria. Grey literature sources were screened similarly, whereby the content was screened by locating keywords and determining whether the context met the inclusion criteria. The same reviewer then conducted the full-text retrieval and review process to further assess eligibility. All peer-reviewed and grey literature sources that were accepted for data charting and extraction were consulted by a second reviewer (BJH).

Data items, charting, and synthesis

A data charting form containing twenty categories was created in Excel to capture relevant content from each record. These categories are summarized and described in Appendix 3. Not all the information was available in each record, and therefore some information available was uneven across records. All data were extracted by one independent reviewer (GD) and cross-checked by a second reviewer (BJH) to ensure consistency. Descriptive summaries captured in the data charting form were transformed into tables that reflected the thematic analyses conducted during the extraction phase. Health outcomes were organized in two different tables. Summaries of specific health outcomes found in each record is also provided in Appendix 4. Interventions were organized in two different tables and two figures. One figure represented the Inter-Agency Standing Committee (IASC) pyramid. IASC was established by the UN General Assembly to propose guidelines on Mental Health and Psychosocial Support (MHPSS) for humanitarian agencies and NGOs working in emergency settings.[31] These guidelines propose mapping interventions onto a pyramid that depicts multi-layered supports which meet various needs of different groups. The pyramid is intended to promote the implementation of interventions that cover all levels of the diagram. Although LBC are not considered to reside in humanitarian settings, the intervention pyramid is an effective method to map MHPSS interventions that are needed within this population as they largely reside in contexts of extreme poverty. Summaries of specific interventions are also outlined in Appendix 5.

Results

PRISMA flow diagram

The search processes are summarized in Figure 1. A total of 4,440 records (690 peer-reviewed and 3750 grey literature) were sourced, of which only 192 records were deemed eligible after title, abstract and keyword screening. A total of 12 full texts were unable to be retrieved, leaving 180 records eligible for full-text retrieval and review. After screening, a total of 50 records (24 from databases and 26 from grey literature) were included for this review and data was charted accordingly. A total of 35 (70.0%) records only discussed health outcomes, 10 (20.0%) records only discussed interventions and 5 (10.0%) records discussed both health outcomes and interventions.

Summary of health outcomes

A total of 40 (of 50; 84·0%) studies presented physical and mental health outcomes (summarized in Table 1; see also Appendix 4). A total of 17 (42·5%) records provided physical health outcomes and 39 (97·5%) records discussed mental health outcomes. All the records that discussed health outcomes were observational by design.

Most physical health evidence (n=12, 70·6%) included outcomes involving nutritional status. These outcomes referred to indicators, such as height, weight, body mass, hunger, and food insecurity. While food insecurity was a common theme found in the records, instances of disordered eating (i.e., under- and over-eating) due to psychosocial outcomes were also mentioned. General health status related to abuse (i.e., physical and sexual) resulting in injury and non-specific health symptoms such as headaches, stomach-aches, and sleep disturbance were identified in 6 (35·3%) included records. Evidence of hygiene-related outcomes were found in 2 (11·8%) records. The hygiene problems discussed highlighted issues related to children's skin,

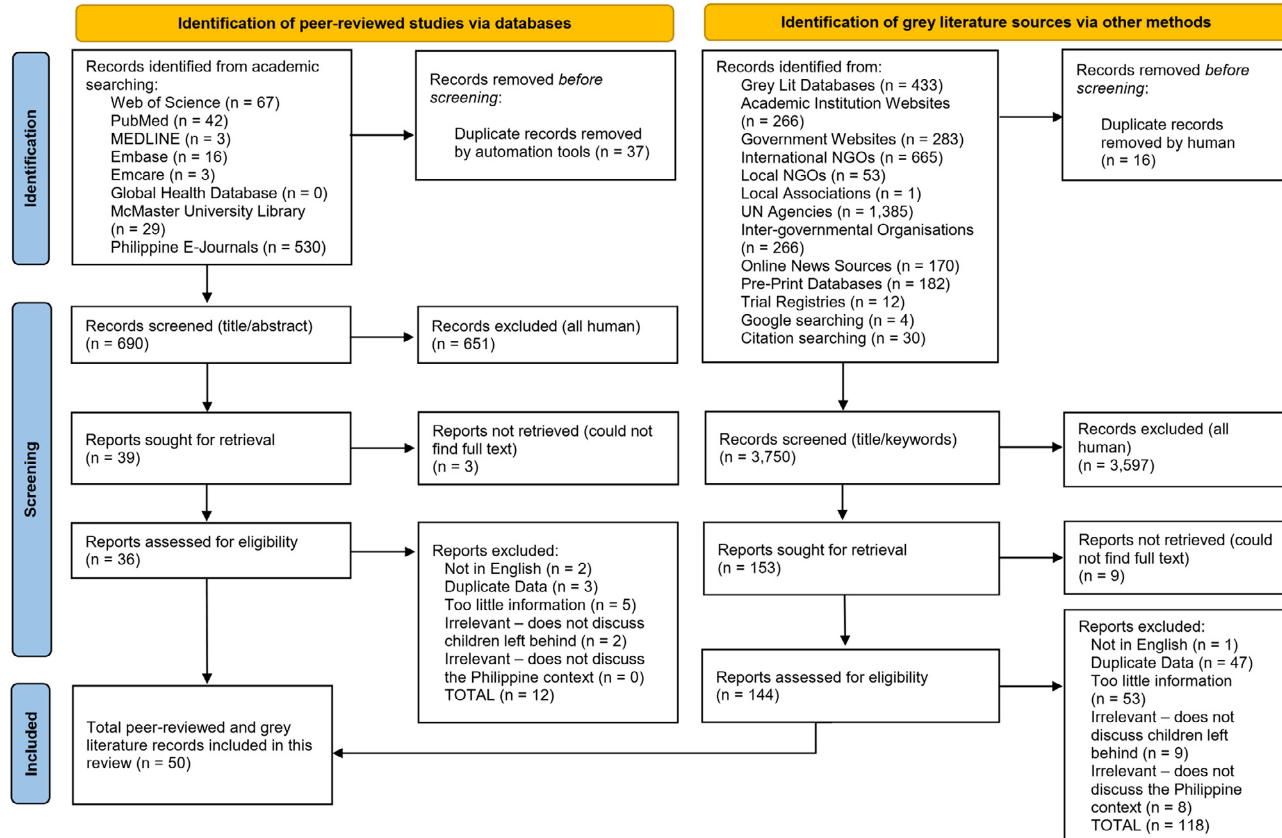

Figure 1. Preferred reporting items for systematic reviews and meta-analyses (PRISMA) flow diagram.

Health Outcome	n	%
Physical Health	**17**	**42.5**
Nutrition	12	70.6
General Health Status	6	35.3
Illness	3	17.6
Hygiene	2	11.8
Mental Health	**39**	**97.5**
Emotional	38	95.0
Behavioural	26	66.7
Cognitive	3	7.5

***Table 1*: Summary of health outcomes discussed in included studies (*n* = 40).**

scalp, ears, and nose. Likewise, illnesses were found in 3 (17·6%) records, such as HIV/AIDS, urinary tract infections, measles, mumps, and hepatitis.

In terms of mental health, broad terms including *psychological* and *psychosocial* outcomes were categorized further to align with emotions, behaviours, and cognitive processes experienced by LBC. Evidence of behavioural outcomes were identified in 26 (66·7%) records. Conduct problems were highlighted, including addictive behaviours (i.e., alcoholism, smoking, substance use); premarital and unsafe sex; disobedience and delinquency; physical aggression and violence; absenteeism from school; intentional under- and over-eating; and intimacy issues. Some evidence also indicated positive behavioural outcomes, such as independence and obedience.

Only 3 (7·5%) records discussed cognitive outcomes. Negative cognitive outcomes referred to poor memory, poor emotional intelligence, and difficulties communicating, listening, expressing feelings, and establishing relationships. Two sources indicated adequate cognitive abilities in LBC, specifically referring to communication skills.[28,32]

The majority of sources (n=38, 95·0%) discussed emotional outcomes. Given the broad range of feelings expressed by LBC, a comprehensive list of emotional outcomes is provided in Table 2 and categorized using the Positive and Negative Affect Schedule for Children (PANAS-C).[33] Both positive and negative affect were reported in the included records. Positive emotions identified referred to feelings of love, happiness, gratitude, acceptance, optimism, motivation, and support amongst LBC. The most common positive emotions were acceptance and gratitude (n=12, 31·6%), and strength (n=11, 28·9%). Alternatively, negative emotions significantly dominated the evidence. This included feelings of sadness, shame, discontent, anxiety, guilt, misery, stress, fear, loneliness, anger, depression, resentment, confusion, and overall difficulty coping. The most common negative emotion was the feeling of loneliness identified in 28 (73·7%) records. Evidence of indifference or apathy towards parental separation was also identified in 6 (15·8%) records.

Emotions	n	%
Positive Affect		
Strong (i.e., emotional resilience, managing stress, coping well, supported)	11	28.9
Indifference/Apathy	6	15.8
Happy (i.e., happy, loved)	5	13.2
Excited (i.e., optimistic, hopeful)	2	5.3
Alert (i.e., motivated)	1	2.6
Other (i.e., acceptance, gratitude)	12	31.6
Negative Affect		
Lonely (i.e., loneliness, longing for intimacy, missing family, emptiness, incompleteness, abandoned, neglected, orphaned, distance, disconnect, alienated, excluded, feeling different than others, feeling robbed of, loss of intimacy)	28	73.7
Sad (i.e., sad, sorrow)	11	28.9
Miserable (i.e., hopeless, powerless, suffocated, emotional abuse/trauma, distress, psychological suffering/burden/impairment)	11	28.9
Mad (i.e., anger, annoyance, frustration, angst)	10	26.3
Jittery (i.e., stress, strain, discomfort)	10	26.3
Upset (i.e., dissatisfaction, discontent, unhappy, being punished)	9	23.7
Nervous (i.e., anxiety, worry, nervous)	9	23.7
Gloomy (i.e., melancholy, depressed, emotional pain/hurt, unwanted, unaccepted, unloved)	9	23.7
Ashamed (i.e., embarrassed, loss of self-esteem, poor self-perception, inadequacy, insecurity)	8	21.0
Afraid (i.e., fear)	4	10.5
Guilty (i.e., guilt, remorse)	3	7.9
Other (i.e., jealous/envy/resentment, denial, confusion, social withdrawal/seeking solace, pessimism, suspicion, difficulty coping)	16	42.1

***Table 2*: Range of emotions experienced by children left behind in included studies (*n* = 38).**

Summary of interventions & the IASC pyramid

Out of 50 included sources, 15 (30·0%) discussed 48 distinct interventions that explicitly supported the physical and mental health outcomes of LBC. The largest proportion of interventions were delivered by local NGOs, whereby 10 distinct groups provided most of the educational and psychosocial support interventions identified. Likewise, one church association delivered various educational and psychosocial support interventions. Several interventions were also implemented by multi-sectoral teams comprised of academic institutions, government agencies, local NGOs, and UN agencies. Table 3 provides a summary of these 48 interventions, which were further divided into four distinct categories to reflect the levels of the IASC Pyramid. Figure 2 also maps the 48 interventions identified onto the most applicable level of the IASC pyramid.

Type of Intervention	n	%
Level 1: Basic Services & Security	**4**	**8.3**
Livelihood & Welfare Assistance	2	4.2
Medical/Dental Insurance	1	2.1
Shelter for Children Facing Abuse	1	2.1
Level 2: Community & Family Support	**29**	**60.4**
Peer Counselling/Support	7	14.6
Workshops/Seminars for Children	5	10.4
Parenting/Caregiver Training	4	8.3
Extra-Curricular and Social Activities	3	6.3
Youth Camps	3	6.3
[a]OFW Family Networks	2	4.2
Pre-Migration Preparedness Seminars	2	4.2
Teacher's Training	2	4.2
Training for Community Mentors	1	2.1
Level 3: Focused, Non-Specialized	**6**	**12.5**
Individual Counseling	4	8.3
Peer Counselling/Support	1	2.1
Therapy & Mindfulness Sessions	1	2.1
Level 4: Specialized Services	**9**	**18.8**
Peer Counselling/Support	4	8.3
Individual Counseling	3	6.3
Therapy & Mindfulness Sessions	2	4.2

***Table 3*: Types of interventions discussed in included studies (*n* = 48).**

[a] Note. OFW = Overseas Filipino Workers.

The lowest proportion of the interventions identified met the criteria for the first level of the IASC pyramid, which includes basic services and security programs. This included 4 (8·3%) health and safety interventions which comprised of livelihood and welfare assistance mostly provided by social workers; medical and dental insurance coverage provided by a government agency, the Overseas Workers Welfare Association; and one program provided temporary shelter for children facing abuse and exploitation.

The largest proportion of interventions met the criteria for the second level of the pyramid, whereby 29 (60·4%) of the interventions were part of strengthening community and family support programs. These programs were often delivered by trained laypersons or self-help and included educational training and psychosocial support interventions. These interventions also aligned with IASC's definition of level two being comprised of programs that use social networks to provide peer support, educational activities, social events, and youth camps.[31] For instance, extra-curricular and social activities were identified as relevant psychosocial support interventions because they were intended to act as "a healthy diversion from loneliness," which "help [LBC] build and strengthen their social support.[34]" Programs from the government and local NGOs created OFW family networks in order to ensure "social capital" and provide a system of support amongst those with similar lived experiences.[35] Similarly, youth camps were identified to allow children to connect with one another and participate in formation-building activities. These camps were often facilitated by clergy, teachers, counselors, psychologists, and social workers.[36] Educational programs were also included in this category, such as parenting and caregiver training intended to support LBC at home; pre-migration preparedness seminars as a prevention strategy; training teachers to provide support in schools; training for community mentors who

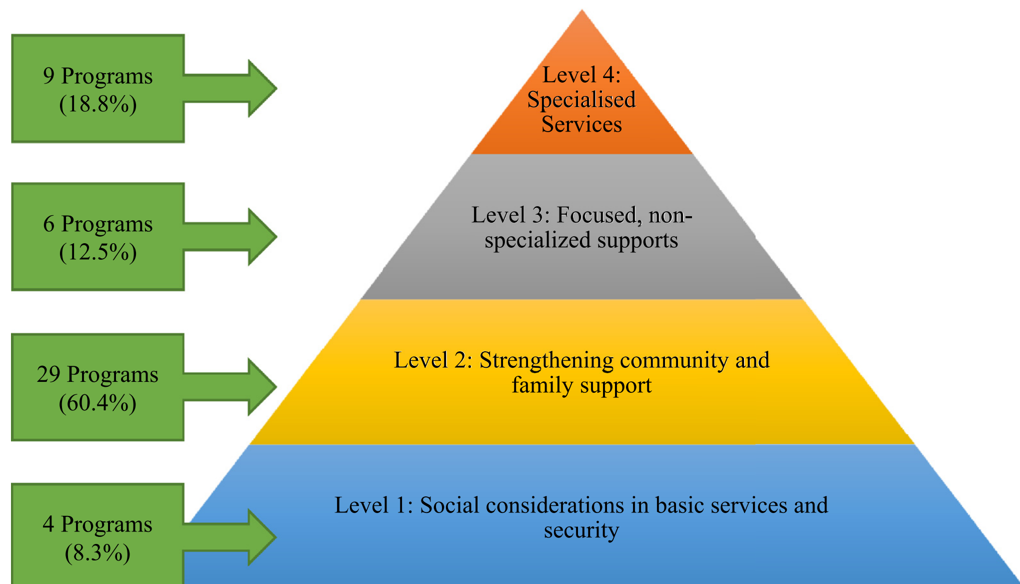

Figure 2. Inter-agency standing committee (IASC) intervention pyramid.

frequently engaged with the target population; and tailored workshops and seminars for LBC usually conducted in schools.

There were few interventions that met the third level of the pyramid concerning focused, nonspecialised support programs. This included 6 (12·5%) individual counselling, peer support, and therapy interventions that provide basic psychosocial support through trained laypersons, such as teachers, and community mentors, rather than mental health professionals. Therapy and mindfulness sessions were specifically coordinated by local NGOs.

The fourth level of the pyramid concerning specialized services were found in 9 (18·8%) interventions. These interventions also comprised of individual counselling, peer support, and therapy intervention. However, these psychosocial support activities were specifically provided by mental health professionals, such as psychologists and counsellors.

Regional locations of interventions

The Philippines is divided into 17 distinct administrative and autonomous regions.[15] Table 4 and Figure 3 provide the number of identified interventions found in each region compared to the distribution of OFWs who migrate from this region. A total of 38 out of 48 interventions identified were found in 13 out of 17 regions of the country. The exceptions were the 3 (6·3%) health and safety interventions that are implemented by the government for LBC nationwide. The regional locations of 7 (14·6%) interventions were unspecified.

The majority of interventions were found on the Islands of Luzon, which is comprised of eight regions. Of which, the National Capital Region and Region 4A: Calabarzon hosted the majority of interventions with 13 (27·1%) interventions and 11 (22·9%) interventions, respectively. The only interventions available in the Visayas islands were found in in Region 6: Western Visayas. On the Mindanao islands situated at the southernmost part of the country, most interventions were identified in Region 11: Davao and the Autonomous Region in Muslim Mindanao with 4 (8·3%) interventions, respectively. No interventions were identified in 4 out of 17 regions—specifically Region 2: Cagayan Valley, Region 4B: MIMAROPA, Region 7: Central Visayas, and Region 8: Eastern Visayas.

Discussion

Summary of evidence

This scoping review synthesized the available information available in both peer-reviewed and grey literature regarding the health of LBC in the Philippines, as well as health-related interventions targeting this population. Significant gaps were identified in the current literature, which suggest areas needed for future research. Below we summarize these key findings and make recommendations for future directions.

Behaviours leading to poor physical health outcomes

The findings from this review indicated that physical health outcomes were deeply interconnected with behaviour. The evidence revealed that LBC often adopted poor health behaviours, such as over-eating, alcohol misuse, smoking, illicit substance use, and experienced untimed pregnancy. Reliance on remittances were highlighted as directly financing the treatments of serious medical conditions such as measles and hepatitis.[28] However, the lack of longitudinal data makes it particularly difficult to discern whether remittances alone can mitigate the risk of acquiring long-term communicable and non-communicable diseases related to these behaviours. Adolescent abuse of alcohol, tobacco, and illicit drugs has been associated with chronic conditions, long-term injuries, heart disease, and various cancers.[37] Similarly, injection drug use and unsafe sex especially place LBC at an increased risk of acquiring sexually transmitted diseases, such as HIV/AIDS.[37–39]

These results may be compounded by poor health-seeking behaviours uncovered in the literature. Despite the government providing subsidized health insurance to all OFW families, Edillon[40] indicated that visits to physicians and dentists decreased as children got older and were contingent on whether illnesses required immediate attention. However, once physical examinations were conducted, hygiene issues were frequently identified amongst LBC.[1] Extended kin left to care for LBC may be less attentive to hygiene issues in comparison to primary caregivers, which allows these problems to go unnoticed. Nonetheless, poor health-seeking behaviours and inadequate disease surveillance may provide additional insight into why health-related data is lacking in the literature.

Mental health outcomes

In regard to LBC mental health outcomes, additional safety and security risks emerged in the literature. While some studies have highlighted LBC as more independent and responsible, the lack of parental guidance contributes to extreme conduct problems and social maladjustment.[39,41–46] A massive variation was also identified in the emotions expressed by LBC. Evidence from this review shows that parental separation is most likely to be associated with feelings of loneliness, anxiety, and melancholy amongst Filipino children. It is worth noting that emotions serve as a proxy for mental health, as no studies were conducted to identify the prevalence of common mental disorders in Filipino LBC. In comparison, LBC in China were found to have greater prevalence of depression and anxiety than

Region of the Philippines	Number of interventions (n)	Percentage of interventions (%)	[a]Percentage of OFWs from regions (%)
LUZON			
National Capital Region (Metro Manila, Quezon City)	13	27.1	9.7
Cordillera Region (Abra, Baguio)	4	8.3	1.9
1: Ilocos (Ilocos, Ilocos Sur, La Union, Pangasinan)	1	2.1	8.8
2: Cagayan Valley (Batanes, Cagayan, Isabela, Nueva Vizcaya, Quirino)	0	0.0	6.2
3: Central Luzon (Aurora, Bataan, Bulacan, Nueva Ecija, Pampanga, Tarlac, Zambales)	14	29.2	13.3
4A: Calabarzon (Batangas, Cavite, Laguna, Quezon, Rizal)	11	22.9	20.7
4B: MIMAROPA (Marinduque, Occidental Mindoro, Oriental Mindoro, Palawan, Romblon)	0	0.0	1.5
5: Bicol Region (Albay, Camarines Norte, Camarines Sur, Catanduanes, Masbate, Sorsogon)	9	18.8	4.0
VISAYAS			
6: Western Visayas (Aklan, Antique, Capiz, Guimaras, Iloilo, Negros Occidental)	9	18.8	9.0
7: Central Visayas (Bohol, Cebu, Negros Oriental, Siquijor)	0	0.0	5.1
8: Eastern Visayas (Biliran, Eastern Samar, Leyte, Northern Samar, Samar, Southern Leyte)	0	0.0	2.0
MINDANAO			
9: Zamboanga Peninsula (Zamboanga del Norte, Zamboanga del Sur, Zamboanga Sibugay)	3	6.3	1.6
10: Northern Mindanao (Bukidnon, Camiguin, Lanao del Norte, Misamis Occidental, Misamis Orientalr)	3	6.3	2.7
11: Davao Region (Davao de Oro, Davao del Norte, Davao del Sur, Davao Occidental, Davao Oriental)	4	8.3	3.7
12: Soccskargen (Cotabato, Sarangani, South Cotabato, Sultan Kudarat, Gensan)	3	6.3	5.7
13: Caraga Region (Agusan del Norte, Agusan del Sur, Dinagat Islands, Surigao del Norte, Surigao del Sur)	3	6.3	1.9
Autonomous Region in Muslim Mindanao (Basilan, Lanao del Sur, Maguindanao, Sulu, Tawi-Tawi)	4	8.3	2.3
Nationwide	4	9.0	N/A
Not specified	6	13.6	N/A

***Table 4*: Regions of the Philippines providing interventions included (*n* = 48).**

[a] Note. Percentages received from The Philippine Statistics Authority[14] N/A = not applicable.

children in non-migrant households, with rates ranging between 12·1 to 51·4% and 13·2 to 57·6% respectively.[47] Prevalence studies are needed in order to quantify the burden of mental health challenges and to enable comparisons with other LBC from other countries.

It is also important to note that some LBC reported being accepting, grateful, and happy about their circumstances. In fact, Graham and Jordan[44] found that LBC surveyed were either happier or reported similar happiness compared to children of non-migrants. These outcomes may be mediated by parent-child relationship maintained through frequent use of digital communication.[48] Maintaining intimacy through virtual communication plays a critical role in ameliorating children's negative emotions.[49] Likewise, gratitude can be attributed to the modern-day hero narrative unique to OFWs, wherein children have expressed deep appreciation for the sacrifices their parents make in order to finance their education and support their livelihoods.[50,51]

The lack of health-related interventions

Of the 50 sources synthesized in this review, none included data from a clinical trial or evaluation studies. The findings from this review indicate that the programs currently being implemented may lack sufficient evidence for their effectiveness. Evidence from other contexts include a multisectoral, government-led intervention in Sri Lanka specifically aimed to ameliorate negative impacts of parental labour migration. Their Coordinated Care Plan includes multiple risk assessments at the pre-migration phase to identify at-risk children and provide them with consistent support delivered by case managers, community personnel, and primary health care workers.[7] Likewise, evidence from rural China shows the development of local Children's Centres targeting and supporting the psychosocial well-being of LBC between 7 to 15 years old.[52] The existence of these programs in other contexts indicates a recognition of

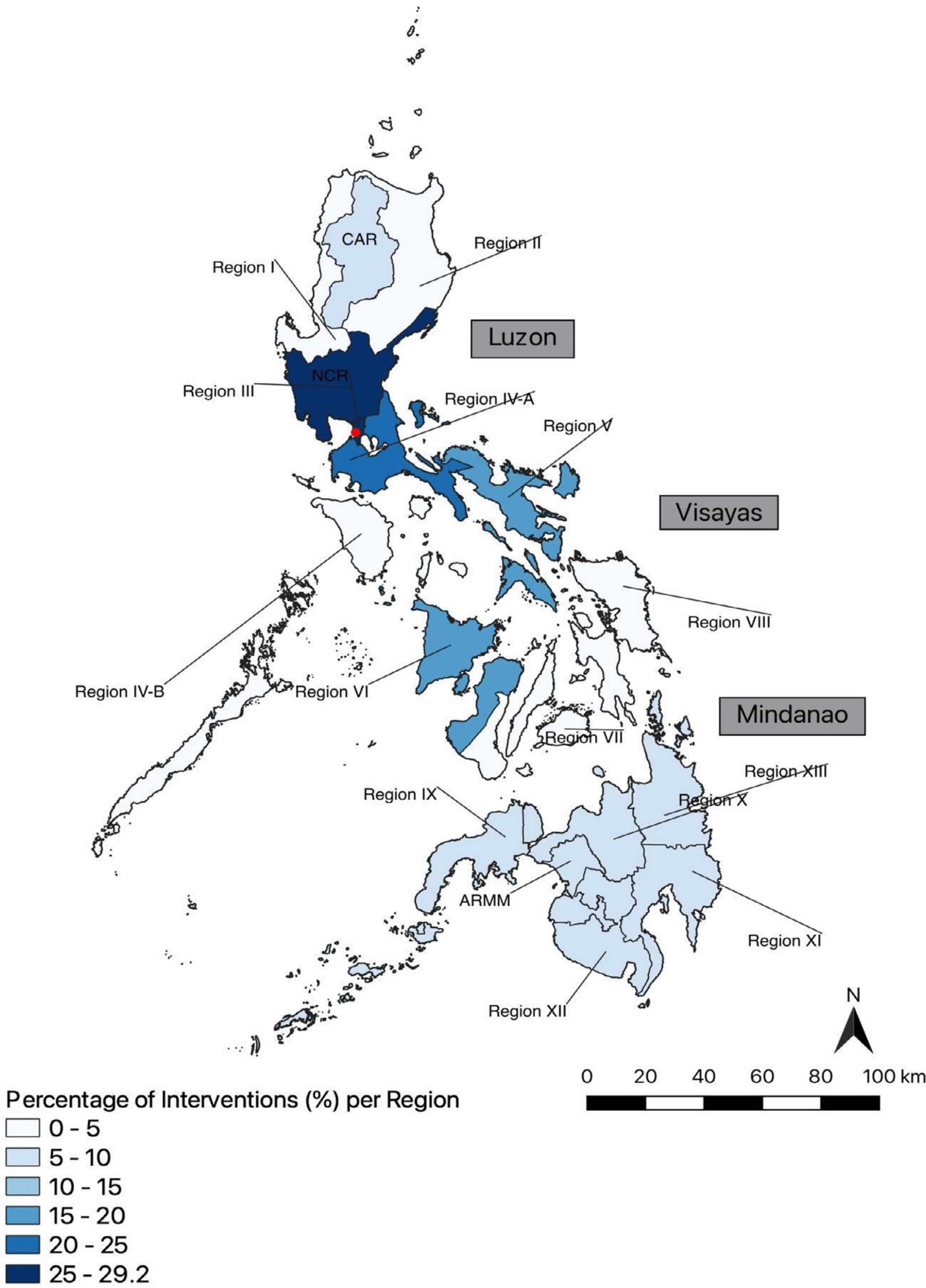

Figure 3. Density of interventions available in the Philippines.

the burden associated from parental separation, but similar government-institutionalized interventions remain absent in the Philippines.

In total, there were 20 distinct organizations and multi-sectoral teams identified as major sources of support to LBC. Most interventions were provided by local NGOs—of which, ATIKHA served as a key partner in the field. While ATIKHA provides general psychosocial and educational services, it remains the only civil society organization that has collaborated with government agencies and international partners to scale interventions.[53] Nonetheless, these health-related interventions are largely confined to specific areas in the Philippines. Most interventions were located in the regions where most OFWs originate from: Region 4A, Region 3, and the National Capital Region. However, 4 out of 17 regions that export 14·8% of OFWs collectively were found to lack psychosocial or educational interventions altogether.[14] Most interventions were also established in urban centres, leaving much of the rural population without adequate support. It is also worth noting that the Philippines is comprised of 7,641 islands, which creates physical barriers to accessing the already limited support services. Therefore, LBC may be forced to travel by plane or boat to receive relevant services, thus creating a key barrier that prevents this population from seeking and receiving any assistance at all.

Given the economic benefits of parental labour migration, LBC are often excluded from the government's social protection policies under the premise that financial stability gained through remittances can provide basic necessities.[54] However, the only interventions that actively looked to ameliorate negative outcomes of LBC were subsidized medical insurance and welfare assistance. One intervention consisted of a national campaign meant to ensure the safety and protection of LBC by providing them emergency shelter. The existence of this program is evidence that the government is clearly aware that this population faces an increased risk of abuse and exploitation due to parental absence.[55] However, whether this intervention has been effective at protecting LBC remains unclear.

Recommendations

Limited epidemiological data has been reported on the health status of LBC in the Philippines. The lack of high-quality data limits our understanding of the health challenges experienced by LBC. The population has also not been enumerated, so it is impossible to consider the scope of resources needed to invest in supporting the well-being of LBC. Reports from other countries, including Sri Lanka,[7] Vietnam,[56] Romania,[57] and Nigeria[58] suggest that LBC experience health disparities compared with their peers whose parents have not migrated. Efforts are needed to quantify the burden of ill health among Filipino LBC and develop interventions to ameliorate their unmet health needs. Future research will benefit from disaggregating experiences and considering multiple variables, such the age and length of separation, the gender of the child, and their sibling ranking. The gender of the migrant parent, their occupation, and geographic location may also influence outcomes given the absence of mothers have been more likely to elicit feelings of abandonment.[28] For instance, children whose parents migrated during their infancy were less likely to encounter poor mental health outcomes because the parent-child relationship had not solidified into a secure attachment style.[42] Future comparative and longitudinal research could provide these insights and map changes in health outcomes over time.

The findings from this review also indicate a significant need to increase the availability, accessibility, and evaluation of health-related interventions. Psychosocial supports identified in this review are structured similarly to the *IMIFAP (Yo quiero Yo puedo)* programme in Mexico, which has created Child Development Centres for LBC to participate in community support groups and life skills workshops where they are able to express and manage their emotions.[59] However, future research should prioritize the evaluation of existing interventions to assess whether programs in the Philippines have shown similar effectiveness within other parental labour migration contexts. Future programs may also benefit from establishing interdisciplinary partnerships with local NGOs and trusted community leaders who would have the experience and expertise to develop, deliver, and expand support services to LBC—especially in regions currently lacking interventions.[56,60] For instance, this research would be invaluable towards informing future programs developed through the newly established Philippine Department of Migrant Workers.[61]

Limitations

This was the first scoping review conducted to synthesize the health status of Filipino LBC. There are several limitations worth noting. First, this review only included literature published in English, which is also the second official language of the Philippines. While this allowed for the retrieval of important national documents, relevant literature published in other languages or dialects may have been excluded. For instance, information about additional interventions provided by local NGOs may have been shared using local dialects on different social media platforms. Second, several key primary sources regarding health outcomes were only available through physical publications archived in the Philippines, which prevented remote electronic access and retrieval. Third, it is worth noting that a critical appraisal of the included studies was not conducted. This is especially important when considering how health outcomes were studied and given that no

evidence was available regarding the effectiveness of the identified interventions at ameliorating physical and mental health outcomes of the target population. Fourth, only interventions that explicitly targeted health outcomes were considered, which primarily excluded financial interventions that may indirectly support the wellbeing of LBC.[40,62–65] Finally, the IASC pyramid was developed for mapping interventions in emergency humanitarian settings rather than for children facing parental separation from migratory processes. Therefore, mapping previous and existing interventions using this framework may not be optimal. Despite these limitations, this scoping review provides a starting point for future research on the health of LBC.

Conclusion

This scoping review synthesized the available peer-reviewed and grey literature regarding the physical and mental health outcomes for LBC in the Philippines, as well as health-related interventions intended to prevent and ameliorate negative outcomes. The findings indicate that LBC demonstrate both positive and negative physical and mental health outcomes. Parental separation has been shown to affect general health, hygiene, illness prevalence, nutrition, behaviour, cognition, and emotional well-being. LBC experience a vast range of negative emotions, but few comparative studies are available to assess how their physical and mental well-being compares with children in non-migrant households. Moreover, few health-specific interventions are widely available, and no evaluation studies have been conducted to assess the effectiveness of existing programs. To gain a better understanding of this phenomenon, more comparative, longitudinal, and clinical trials are needed. Future research must also reflect on the diversity of children's separation experiences by considering children's age, gender, care arrangements, and the demographic data of their migrant parent(s). The development of effective interventions may benefit from encouraging multi-sectoral collaboration and engaging key community organizations such as churches and school.

Contributors

Georgia B. Dominguez - conceptualization/study design, methodology, data collection, data analysis, data interpretation, writing - original draft/review/editing.

Brian J. Hall - supervision, conceptualization/study design, methodology, data collection, data analysis, data interpretation, writing - review/editing, funding Acquisition.

Editor note

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Supplementary materials

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