Improve Maternal Health:

A move towards universalizing health care

▸ By MERCEDES FABROS

Summary

There is a movement in numbers but too insignificant. Pregnant women continue to die of preventable causes.

The most vulnerable women have been identified over the past years. We know where they are. Their regions down to their provinces have been located. Approaches and strategies have been thought out and the technology to prevent maternal death is known to all the medical and economic technocrats working on this. So why is there no dramatic decline in mortality rates? Where are the women? Why don't we hear their outrage?

Universalizing health care

As we ponder on our assessment, an interesting development has been the inclusion of universal health care as a priority agenda of our new President Benigno S. (Noynoy) Aquino. It is an opportune time for us women, and all stakeholders, to face the challenge and make sure that the new administration seriously pursues the agenda. High maternal mortality is symptomatic of a weak and inequitable health system.

Enduring features of the health landscape

Health and life are so inextricably linked that these rights have been recognized and enshrined in the Philippine Constitution and in all human rights conventions. Notwithstanding this recognition, government support and investment in health have been, for the most part, negligible, most notably in the past decade. Hence, practically more than half of the total health costs have been out-of-pocket expenditures.

Realities paint a dismal landscape of the health situation in our country, and point to inequity as the enduring problem of the health system: inequities in access to and availment of health care services which result in grossly unequal health outcomes. The rich have longer life expectancies, have fewer children, and have greater chances of surviving illness and disease, while the poor have shorter life spans, beget more children than they wish, and can hardly cope with the high cost of services. For them, getting sick is tantamount to a catastrophic event, which further sinks them into poverty.

Such disparities are reflected in all aspects of the health system: fragmented health services, mal-distribution of health facilities and workforce, low public financing and high out-of-pocket payments, low salaries of health personnel, and highly specialized medical training vis-à-vis inadequate primary health care.

To address these inequities, recommendations to reform the health system are directed towards Universal Health Care (UHC). Universalizing health care is a major step in addressing and sustaining efforts of reducing maternal mortality. This will ensure that no one is left behind.

However, transforming the health system through UHC will have to equally join hands with addressing the root causes of poverty and women's discrimination and subordination. Otherwise, universal health care will only be a bottomless pit.

Status and trend of MDG 5: ten years of accumulated failure

After ten years, of the eight goals that the Philippines committed to achieve by 2015, the Millennium Development Goal 5 (MDG 5): Improving Maternal Health remains to be the least likely to be met (see Table 1).

The MDG 5 indicators - maternal mortality ratio (MMR) and proportion of births attended by skilled health personnel - have either stagnated over the past decade or have incrementally increased but are still too insignificant to achieve the 2015 target.

Table 1: MDG 5 Indicators Achievement Status

MDG 5 Indicator	1993	1998	2003	2006	2008	2010 DOH target*	2015 target	Status
Maternal Mortality Ratio	209	172	-	162	-	-	52	Low
Access to Skilled Birth Attendants	-	56%	60%	-	63%	80%	100%	Low
Facility-Based Births*	28%	34%	38%	-	44%	80%	100%	Low
At least 1 Antenatal Care Visit	-	86%	91%	-	91%	-	-	Still
At least 4 ANC visits	-	77%	70%	-	77%	80%	100%	Still
ANC by Skilled Health Practitioner	-	83%	86%	-	88%	-	-	Still
Contraceptive Prevalence Rate	40%	47%	49%	51%	51%	-	80%	Low still
Modern CPR*	25%	28%	33%	36%	34%	60%	100%	Low still
Unmet Need for Family Planning	-	20%	17%	16%	22%	-	0%	Still
Adolescent Birth Rate	-	-	-	-	26%	-	-	No data

Source: 1993 National Demographic Survey; 2006 Family Planning Survey; 1998, 2003, and 2008 National Demographic Health Survey
*DOH targets for 2010 as part of MNCHN policy

MDG GOAL 5: Improve Maternal Health

Target A: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio
5.1 Maternal mortality ratio (52 maternal deaths per 100,000 live births by 2015)
5.2 Proportion of births attended by skilled health personnel

Target B: Achieve, by 2015, universal access to reproductive health
5.3 Contraceptive prevalence rate (CPR)
5.4 Adolescent birth rate
5.5 Antenatal care coverage (at least one visit and at least four visits)
5.6 Unmet need for family planning

To speed up its MDG 5 performance, the Department of Health (DOH) has included two (2) additional indicators (modern contraceptive prevalence rate and facility-based births alongside skilled birth attendants) and has set 2010 targets for these two indicators.

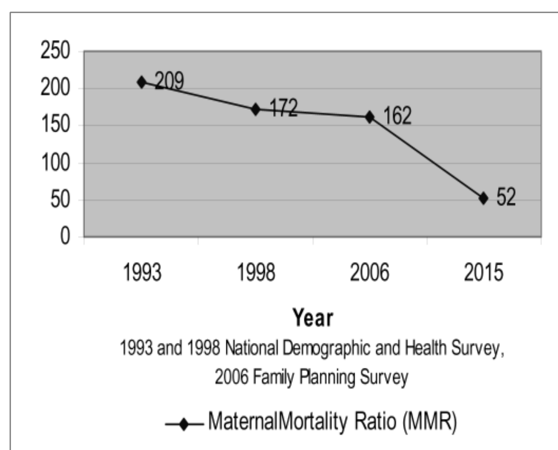
The Philippines is one of 55 countries that accounts for 94 percent of all maternal deaths[1] in the world. It is one of the highest in the region with just Cambodia and East Timor having more maternal deaths. Using a MMR of 200 per 100,000 live births for 2008, the University of the Philippines Population Institute projected the annual maternal death to be about 4,700 or 12 Filipino mothers each day. Filipino teenage mothers account for 20 percent of all maternal deaths in the country, a thousand of which are abortion related.

Over the past decade, the Philippines has not seen any significant decline in MMR. Maternal mortality ratios have not dropped since the 1990's.

The 1998 National Demographic Health Survey (NDHS),[2] placed MMR at about 172/100,000 live births with a confidence interval of 120 to 224. The 2006 Family Planning (FP) survey,[3] estimates that MMR is 162/100,000 live births with a confidence interval of 128 to 196 (see Figure 1). The latter drop is deemed insignificant by the National Statistics Office. In 2000, the World Health Organization (WHO) corrected the 1998 estimate upward to 200, a figure that seems to correspond more to alternative indicators.

Even if the country has an adjusted maternal mortality ratio of 162 per 100,000 live births, against the goal of 55-60 deaths per 100,000 live births this still shows slow progress. The rate of progress necessary to reach the 2015 target is more than 3 times higher than the actual rate of progress from 1990-2006, suggesting a considerably faster pace to reduce MMR is needed. This indicates that the government would have to exert additional effort relative to what it has done in the past if the Philippines is to attain the MDG 5.

Figure 1. Maternal Mortality Ratio



Among the leading causes of maternal mortality in the Philippines are post-partum hemorrhage, complications from sepsis or widespread infection, obstructed labor, pre-eclampsia and eclampsia, the hypertensive disorders of pregnancy, and complications of unsafe abortion. But almost half of the maternal deaths have not been recorded, so a significant portion of the causes of death remain unknown.

Disparities in MMR show a wide gap between poor and rich regions. The Autonomous Region in Muslim Mindanao (ARMM) and Northern Mindanao have higher MMR (320/100,000 and 224/100,000 respectively) than Metro Manila and Southern Tagalog regions (119/100,000 and 138/100,000).

[1] A maternal death is "the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration or site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental causes."
[2] based on the direct sisterhood method.
[3] based on the indirect sisterhood method.

Progress of work in improving maternal health care in the Philippines: policies and programs

During the last decade, the Philippines put new knowledge into action to improve health care services and respond to the pressing issue of maternal mortality. These efforts were not without pitfalls and controversies but the issue remains for the government to scale up its actions to realize the MDG 5.

For rapid maternal and neonatal mortality reductions, the DOH on September 2008 mandated the implementation of an integrated Maternal, Neonatal and Child Health and Nutrition Strategy (MNCHN). All pregnancies are considered at risk and thus 'takes into consideration the three major pillars in reducing maternal mortality and morbidity, namely, emergency obstetric care, skilled birth attendants and family planning. The Philippines has taken a health system strengthening approach (HSS) to tackling MDGs 4 and 5. Maternal and child health services in the Philippines are implemented not through vertical programs, but through the existing financing and organizational mechanisms covering the Department of Health (DOH). In addition, there are ongoing innovative pilot programs such as: the pay-for-performance for barangay health workers to encourage more facility-based deliveries; the Sponsored Program, the PhilHealth Maternity Care Package, and more recently, the Conditional Cash Transfer Program (Pantawid Pamilyang Pilipino Program or the 4Ps) to address the demand-side barriers to the use of maternal and child health services.

Despite the presence of many instruments to comprehensively tackle MDGs 4 and 5, somehow these instruments are not working synergistically.

From a risk approach to an emergency obstetric care approach

For rapid maternal mortality reduction, the DOH shifted its approach from a risk approach to an Emergency Obstetric Care (EmOC) approach. The risk approach is based on the identification, within the total population of pregnant women, of those with a high risk of complications. It has been assumed that high-risk mothers can be identified during prenatal visits. However, studies have shown that more than 80% of maternal deaths were due to complications for which no antenatal screening was possible: puerperal sepsis, postpartum hemorrhage, and shock. These complications cannot be predicted or prevented, except those resulting from unsafe induced abortion. Several studies have also shown that the antenatal care's screening and predictive values are poor and have no direct value in the prevention of maternal death.

Therefore, all pregnant women are at risk of acquiring a life-threatening complication at any time during pregnancy, at delivery, or in the postpartum period. This is the main consideration in the emergency obstetric care approach Therefore, all pregnant women should have access – at any time, day or night – to health facilities that provide EmOC, a package of critical health services, which when provided immediately and competently can save women's lives.

About 85 percent of all maternal deaths are due to direct complications that require emergency obstetrics care. Emergency obstetric care has three essential elements: a skilled attendant at delivery; access to emergency obstetric care in case of complications; and a functioning health referral system in place to allow the unimpeded flow of services to any pregnant woman who needs them at any place and at any time.

Field data shows another picture:

While the Philippine government shows progress in reaching the targets for MDG 5 through programs and policies, field data proves otherwise. Looking at the trend of maternal deaths over the years, the indicator on maternal health status is disturbing. MMR went down to 172 deaths in 1998 from a 1993 baseline figure of 209 deaths.[4] Though the decrease continued, it was at a sharply diminishing rate, and in 2006 had only reached 162 deaths,[5] still far from the target of 52 deaths per 100,000 live births by 2015. Because of this, the Philippines Midterm Development Goal report (2007) admitted that the country is lagging behind and is experiencing difficulty in achieving MDG 5.

The struggle for improving maternal health in the country is challenging especially when not all people benefit. The National Commission on Indigenous Peoples (NCIP) admitted that indigenous communities are hardly reached by medical benefits and services. These include indigenous women living in remote and inaccessible areas that prevent them from getting sufficient and quality health services. It is estimated

[4] 1993 and 1998 National Demographic and Health Survey (NDHS)
[5] 2006 Family Planning Survey

that there are 12-15 million indigenous people (approximately 15-20% of the total population) belonging to 110 ethnic communities. The majority (61%) of indigenous people live in Mindanao, while a third (33%) are in Luzon, and the remaining (6%) population are in Visayas.

Maternal health

Health related practices that affect maternal health are: antenatal care (ANC), including iron supplementation and tetanus toxoid vaccination; delivery care and services; and postnatal care.

Antenatal care indicators include: type of provider, and number of antenatal care recipients, including whether a tetanus toxoid injection was received. Delivery services are assessed according to the person who assisted with the delivery, the place of delivery, and the number of caesarian sections.

Antenatal care

The DOH recommends that the first ANC visit should occur in the first trimester of the pregnancy for early detection of pregnancy-related health problems. Nine out of ten mothers (91%) received antenatal care from a skilled provider, in 2008. This was only a 5 percent increase over the 1998 figures (86%). The 2008 ANC results show that out of this percentage, 18 percent had fewer than the four recommended visits. The proportion of pregnant women who had three or more antenatal visits deteriorated from 1998 (77%) to 2003 (70%). The number increased in 2008 (77%) compared to 2003 but no higher than that recorded in 1998. Five percent of women received antenatal care from a traditional birth attendant, or hilot, while 4 percent did not have any ANC visits at all (see Table 2).

Table 2. Antenatal Care

	1998	2003	2008
Antenatal Care by Skilled Health Professional	86%	91%	91%
At least 4 visits	77%[6]	70%	77%
Informed of Danger Signs	33%	50%	69%
Tetanus Toxoid Injections	38%	37%	48%

Source: 1998, 2003, and 2008 NDHS

There are still more than forty percent of women who did not follow the recommended timing of the first ANC visit. Three in ten women made their first visit on the fourth or fifth month of their pregnancy, while one in ten had their first ANC visit when they were six or more months pregnant.

Regional variations in antenatal care coverage occur with ARMM exhibiting the lowest coverage (49.8%), followed by Zamboanga Peninsula (77.1%). Central Luzon (92.4%) and NCR (92.1%) have the highest antenatal care coverage. All other regions' percent coverage hovers between the 90's and the upper 80's. The ARMM also had the lowest number of pregnant women having prenatal check-ups with skilled health professionals at 47 percent compared to Central Visayas which at 97 percent had the highest percentage.

Births attended by a skilled health professional

A skilled attendant refers to "an accredited health professional, such as a midwife, doctor or nurse, who has been educated and trained to manage normal pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns[7]".

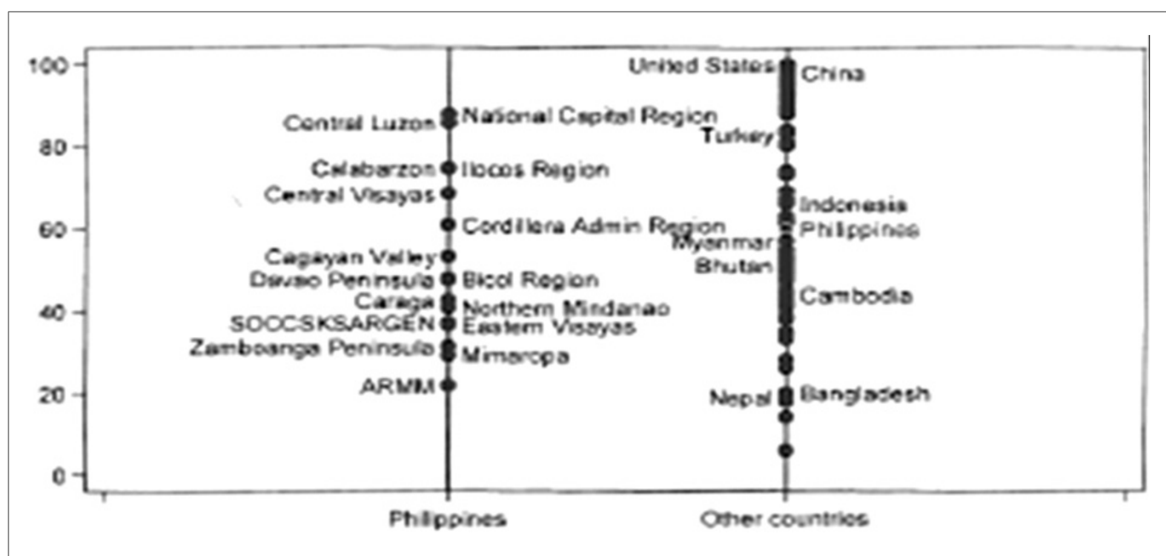
Traditional birth attendants (TBA) – trained or not – are excluded from the category of skilled healthcare workers. In this context, the term TBA refers to traditional, independent (of the health system), non-formally trained and community-based providers of care during pregnancy, childbirth and the postnatal period.

There are still a staggering proportion of births not being attended to by a skilled birth attendant: 36 percent of women were still assisted by hilots or TBAs alone. According to NDHS 2008, only 62 percent of births were assisted at delivery by health professionals: 35 percent by a doctor and 27 percent by a midwife or nurse.

The proportion of births attended by a health professional has remained consistently low at 60-62 percent from 2003 to 2008. It also registered a lower rate of increase during this period – only 2 percent, compared with a 4 percent increase during 1998-2003 (56-60%) It also remains lower than the target set by the DOH (80 percent by 2004). The target for 2010 (also 80%) is unlikely to be reached based on the recorded data.

[6] The figure is based on at least 3 prenatal care visits instead of the current standard of 4.
[7] World Health Organization (WHO).

Figure 2. Use of Skilled Birth Attendants within the Philippines and for Select Asian Countries



Source: WHO, NDHS 2008
Note: A skilled birth attendant is an accredited health professional including midwife, doctor and nurse.

There are large regional disparities in the use of skilled birth attendants. In urban areas, 78 percent of births are attended by skilled professionals, compared with 48 percent of births in rural areas. Eighty-seven percent of deliveries in NCR are assisted by health professionals (57 percent by a doctor and 30 percent by a midwife or nurse). In contrast, 80 percent of births in ARMM are assisted by a hilot, and only 19 percent of deliveries assisted by a skilled attendant. Interestingly, 12 percent of births in CAR are assisted by a relative or friend and 1 percent are delivered with no assistance (see Figure 2).

Many areas in our country have yet to see a skilled attendant. Women for the longest time have depended on TBAs and would pass on this custom to their daughters.

Many women prefer delivery with TBAs because they are more considerate of their needs and comfort, and are also easier to summon and are willing to visit them even in the middle of the night.

However, it has been recognized that having a skilled attendant during every birth is crucial to reducing maternal death, and this is an essential element of the EmOC strategy. But, the overall effectiveness of skilled attendants depends on their ability to access health facilities equipped to provide EmOC. Until that happens we will not be able to reduce the number of maternal deaths in this country.

The push for facility based delivery to prevent maternal deaths

Proper medical attention and hygienic conditions during delivery can reduce the risks of complications and infections that may cause the death or serious illness of the mother and the newborn. Hence, an important component of the effort to reduce the health risks is to increase the proportion of babies delivered in a safe and clean environment and under the supervision of health professionals. More importantly, emergency intervention needs to be easily within reach, assuming facilities are well equipped.

Only 44 percent of births in the Philippines are delivered in a health facility (see Table 3); 27 percent in a public health facility and 18 percent in a private health facility. More than half (56 percent) of births take place at home. These figures show an increase in the proportion of births occurring in a health facility from 38 percent in 2003 to 44 percent

Table 3. Facility-Based and Skilled Health Professionals-Attended Births

	1998	2003	2008
Facility-Based	34%	38%	44%
Skilled Health Professionals	56%	60%	62%
At least 4 visits	77%	70%	77%

Source: 1998, 2003, and 2008 National Demographic Health Survey

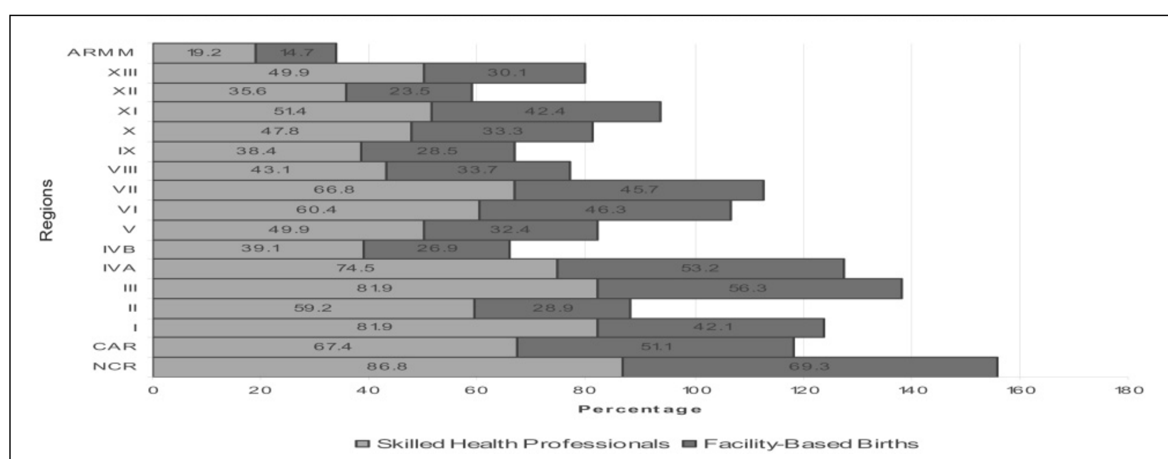
in 2008, and a decline in the percentage of births delivered at home from 61 percent in 2003 and 56 percent in 2008.

Across regions, delivery in a health facility is most common in NCR (69 percent). In five regions, at least 70 percent of births occurred at home: ARMM (85%), SOCCSKSARGEN (77%), MIMAROPA (73%), Zamboanga Peninsula (71%), and Cagayan Valley (70%) (see Figure 3).

The DOH target of increasing the percentage of skilled birth attendants and facility-based delivery to 80 percent by 2010[8] and 100% by 2015 may not be achieved, as the proportion of births delivered in a health facility increased only at a rate of 1 percent per year (34% - 44% from 1998-2008).

Delivery in a health facility is improving far too slowly. Between 2003 and 2008, the percentage of women in the lowest income quintile delivering in a health facility increased from only 10 percent to 13 percent (3% change in 5 years). For women in the highest income quintiles, the increase was almost 7 percent (77% to 83.9%). The overall percentage of deliveries taking place in a health facility increased from 37 to 44 percent (see Table 4).

Figure 3. Births delivered in a health facility and by skilled health professionals (%)



Source: 2008 National Demographic Health Survey

Table 4. Place of Delivery 2003-2008, NDHS (2003, 2008)

Wealth Index Quintile	Health Facility		Home	Other/ Missing	Total	Percentage Delivered in a Health Facility
	Public Sector	Private Sector				
2008 NDHS						
Lowest	11.5	1.5	86.8	0.2	100	13.0
Second	26.9	7.1	65.5	0.6	100	34.0
Middle	33	15.3	51.5	0.2	100	48.3
Fourth	39	29.7	30.9	0.4	100	68.7
Highest	29.4	54.5	15.8	0.2	100	83.9
Total	26.5	17.7	55.5	0.3	100	44.2
2003 NDHS						
Lowest	9.2	1.2	88.7	0.8	100	10.4
Second	20.4	4.4	74.3	0.8	100	24.8
Middle	32.2	11.1	56.2	0.4	100	43.3
Fourth	37.6	22.2	39	1.3	100	59.8
Highest	31.5	45.5	22.6	0.2	100	77.0
Total	24.2	13.7	61.4	0.7	100	37.9

[8] This is one of the Department of Health programs, Maternal, Neonatal and Child Health and Nutrition (MNCHN) targets for 2010 which aims to achieve 100 percent skilled birth attendants and facility-based births by 2015.

In terms of postnatal care, 77 percent of women had a postnatal checkup within two days after giving birth and 14 percent of the women received a postnatal check-up 3 to 41 days after delivery. Health professionals provide postnatal care to 60 percent of mothers. At the same time, a substantial proportion of mothers (31 percent) receive postnatal care from a traditional birth attendant. Health professionals are more likely to provide postnatal care to mothers of first-order births, mothers in urban areas, mothers with college degree or higher educational attainment, and mothers in the highest income quintile.

Achieve, by 2015, Universal Access to Reproductive Health

Total fertility rate

Many Filipino women are having more children than they want. Currently, the average total number of children a Filipino woman has during her reproductive years is 3.3, one child higher than the desired number of 2.4. There is large variation in fertility rates with women in the highest income quintile at 1.9 compared with 5.2 for women in the lowest income quintile.[9] Similar disparities are seen between fertility and education. Women with a college degree or higher educational attainment have 2.3 children, about half that of women with only elementary education at 4.5.

On women's fertility preference, 54 percent of married women aged between15-49 years do not want another child and an additional 9 percent are already sterilized. Meanwhile, 19 percent of married women want to have another child but would rather wait two or more years. Thus, 82 percent of married women want to either space their births or limit children altogether. The ideal number of children for all women and those who are currently married is 2.8 and 3.1 respectively, slightly lower than the 2003 NDHS figure of 3.0 for all women and 3.2 children for currently married women.

Contraceptive prevalence rate

A critical assessment of risk, and one that affects women's fertility, is the adult lifetime risk of maternal death.[10] This is a function of both the likelihood of surviving a single pregnancy and the number of pregnancies an average woman has. In the Philippines, the lifetime risk of maternal death is 1 in 120 i.e. 1 woman in every 120 faces the risk of maternal death in the course of her lifetime. To reduce the lifetime risk, efforts can be directed towards either lowering the number of pregnancies or improving the chances of survival among pregnant women. Family planning programs help prevent maternal deaths mainly through reducing the number of pregnancies.

The importance of family planning to the lives of women cannot be emphasized enough. Women's access to effective contraception would avert 30 percent of maternal deaths, 90 percent of abortion-related deaths and disabilities, and 20 percent of child deaths.

At least 90 percent among married women have heard of the pill, male condoms, injectables, and female sterilization. On average, married women know eight methods of family planning. However, contraceptive use is low and has remained fairly stagnant over the last 5 years.

The NDHS in 2008, revealed that the contraceptive prevalence rate (CPR) or the proportion of women using any FP method is 51 percent whether traditional (16.7%) or modern (34%) (see Figure 4). This figure is still far from the target rate of 80 percent for 2010. Half of married women and 70 percent of all women of reproductive age still don't use any method at all.

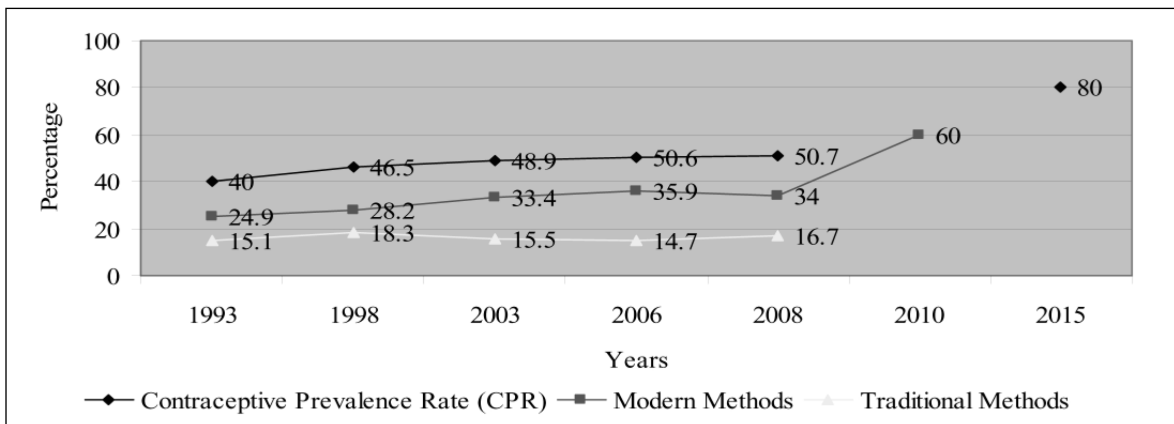
The portion of all married women of reproductive age using modern methods barely increased by 6 percent from 1998 to 2008, while the use of traditional methods decreased by less than 2 percent, which produced a minimal rise in CPR of less than 5 percent. In 2006, younger married women (15 to 19 years) use contraceptives less (23.3%) compared to older women 35 to 39 years of age (58.2%). The oldest age group (45 to 49 years) was twice more likely to use contraceptive than the adolescent married women.

Poor and less educated women from rural areas, particularly those who live in ARMM and other poor regions are more unlikely to use family planning methods. Contraceptive use ranges from a low of 15 percent of married women in ARMM to a high of 60 percent in Davao.

As to the source of contraceptives, government facilities provide contraceptive methods to 46 percent of users, while 51 percent obtain their method from

[9] NDHS. 2008.
[10] the probability that a 15-year-old female will die eventually from a maternal cause.

Figure 4. Trend in Contraceptive Prevalence Rate (CPR) through the years



Source: 1993 National Demographic Survey, 2006 Family Planning Survey
1998, 2003, and 2008 National Demographic Health Survey

private medical sources. The most common single source of contraceptive methods is the pharmacy, which supplies 40 percent of users of modern methods.

The most widely used method is the pill (16%) followed by, female sterilization (9%), and condom (2.3%). Natural family planning methods - rhythm (6%), Lactational Amenorrhea Method (LAM) and other methods (1%) are the least preferred. Long-term contraceptive methods such as sterilization and IUD are preferred by older women, while pills and injectables are more popular to younger women.

The Philippines has one of the most appallingly low rates of male contraception in Asia: condom users as a proportion of all contraception users is very low at 1.6 percent while male sterilization is even lower at 0.1 percent. This is nowhere near the desired ideal of having both men and women share equal responsibility over sexual and reproductive health decisions.

These trends indicate the need to actively promote family planning most especially for low-income households. Over 50% of women do not have access to contraceptives and family planning methods. Without access to family planning services, the actual number of children of poor families generally exceeds the desired family size and thus they are exposed to the risks that accompany pregnancy.

Only 67 percent of all births in the Philippines are planned. The rest are either miss-timed or unwanted. Fifty-four percent of married women do not want an additional child but 49 percent of them are not using any form of family planning method.

Unmet need for family planning

Women who intend to space or limit births but are not using family planning methods have an unmet need. The unmet need for family planning was 22.3 percent in 2008, representing an increase of five percent from the 2003 figure of 17.0 percent (see Table 5).

Among the regions, the unmet need was highest in ARMM (33%), and lowest in the Davao Peninsula (15%). It is slightly higher in rural areas (24 percent) than in urban areas (21 percent). Also, the older the woman (36 percent among women aged 15-19 compared to 18 percent among women aged 45-49), the more educated (college attainment), and wealthier she is, the lower the unmet need.

According to the 2006 Allan Guttmacher study, 41 percent of unwanted pregnancies, and 17 percent of miss-timed pregnancies resulted in induced abortions.

Table 5. Unmet Need for Family Planning

	1998	2003	2008
Unmet need for family planning	19.8%	17.0%	22.3%
Total demand for family planning		69%	73%
Total Fertility Rate	3.7	3.5	3.3
Total Wanted Fertility Rate	2.7	2.5	2.4
Unplanned pregnancy	45%	44%	36%
Unwanted pregnancy	18%	20%	16%
Mistimed pregnancy	27%	24%	20%

Source: 1998, 2003, and 2008 NDHS

Abortion

Worldwide abortion rates have declined because unintended pregnancy rates are down in all regions of the developing world. Yet, abortion rates in the Philippines are still relatively high and continue to increase in some areas.

In the Philippines, abortion is illegal and prohibited under all circumstances. There is no exception, not even for victims of rape or to save the life of the mother. Twenty percent of maternal deaths are due to unsafe abortions, and two-thirds of Filipino women attempted induced abortion. Unsafe abortion is the 4th leading cause of maternal death. It is estimated, by the 2006 Allan Guttmacher report that more than half a million Filipino women desperately resort to unsafe abortion, exposing them to grave risks to health and life.

The majority of women who experienced abortion, are married, Catholic, and poor. The reasons why women resort to abortion are the following: economic cost of raising a child (72%); they have enough children (54%); and that the pregnancy occurred too soon after their last one (57%). In 2008, adolescent pregnancy accounted for 17 percent of an estimated 560,000 induced abortions.

The rigid anti-abortion stance by religious conservatives has been used to fuel an aggressive misinformation campaign which equates family planning modern methods with abortion. Sadly, this thinking found support from the previous national leadership and some local executives, thus compromising if not denying women's access to much needed reproductive health services in their daily life.

Adolescent birth rate

Prevalence of pre-marital sex among the young people is another concern raised by the Young Adult Fertility and Sexuality Survey (YAFSS).[11] The report indicated report that there was an increase in the overall prevalence of pre-marital sexual activity from 18 (1994) to 23 (2002) percent among the young people 15-19 years of age.

Due to the involvement of young people in risky sexual behavior coupled with reduced use of contraceptives, adolescents, especially the females, tend to experience reproductive health problems. The 2008 NDHS results showed that 8 percent of women 15-19 years of age had begun bearing children and the majority of them were poor and from the rural areas. Other studies show that 46 percent of abortion attempts occur among young women of which 30 percent are attempted by women aged 20-24, and 16 percent by teenagers aged 15-19.[12] Teenage pregnancies account for 17 percent of induced abortion cases.

Although our youth are having their sexual debut at increasingly younger ages, they do so without sufficient knowledge on reproductive health, particularly the consequences of early and unprotected sex. Curious and eager to know more about sex, they seek information from unreliable sources like their peers and pornographic materials, unable as they are to get that from socialization agents like their family or school. Worse, some of them learn about sex from actual experience, without fully knowing how one could get pregnant or contract sexually transmitted diseases. Access to accurate and appropriate information and services on many aspects of sexual behavior, reproductive health, and sexuality is needed by our adolescent and youth.

However, officials of the Catholic Church have strongly opposed the inclusion of sex education in the curriculum of public schools, arguing that by doing so would arouse young people's curiosity about sex, encourage them to try premarital sex, and promote their promiscuity.

Financing gaps

Public spending on health in the Philippines is below the level of other comparable income countries, even though adequate public financing is promoted as the most effective health financing mechanism to promote equity. In 2007, the Philippines spent 6.8 percent of government expenditures on health compared with the average of 9.9 percent of government expenditures for the East Asia Region (see Figures 5 and 6).

Increases in public spending on health in the last few years have mainly taken place at the central government level, including the expanded DOH public health program for LGUs. Local government spending has stagnated in real terms over the last decade, which has important equity implications for the poor. As a share of total LGU spending, the contribution for health declined from 12 percent in 2002 to 9.5 percent in 2007. Cities and towns are spending less, with only 7.5 percent and 7.7 percent respectively, of their total

[11] based on YAFSS data from 1994-2002.
[12] Cabigon and Singh. 2005.

Figure 5. Public Spending on Health as a percent of GDP in Selected Comparator (1995-2007)

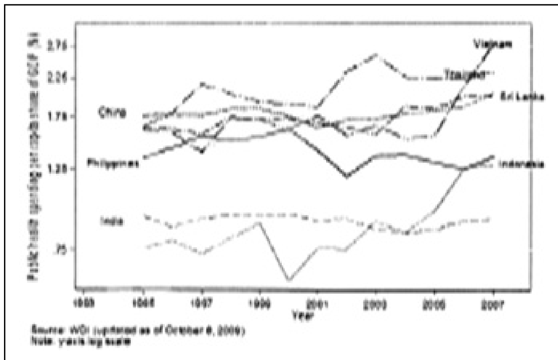
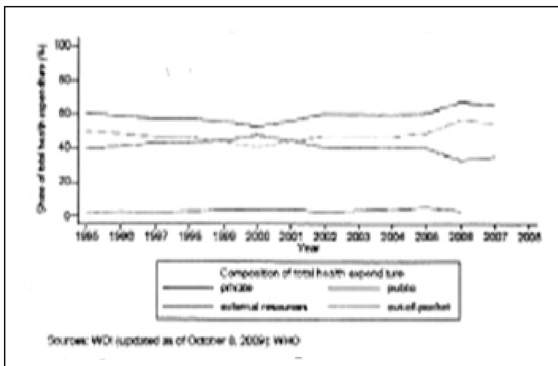


Figure 6. Public and Private health spending in the Philippines, 1995-2008



2006 expenditures going to the health sector. Since the Internal Revenue Allocation (IRA) and intergovernmental fiscal systems do not fully reflect the fiscal capacity and need, many LGUs in reality have very limited fiscal space to finance any expenditure whether in health or other sectors.

However, the most worrisome trend in national government health sector spending is the sharp drop in real per capita DOH spending on public health by 22% yearly from 1998-2006. Real per capita DOH spending on public health went down from Php 40 in 1999 to Php 7 in 2006 before rising to Php 11 in 2007-2008 and Php 51 in 2009-2010. Public health services tend to deteriorate in accordance with the decline in government spending.

High out-of-pocket expenditure.

Out-of-pocket (OOP) payments for health services are increasing in the Philippines. From more than 54.3 percent of the total health expenditure of Php 234.3 billion, only 26.3 percent came from government (13.0% National and 13.3% local government units) with the Philippine Health Social Insurance at a poor 8.5 percent. Half of this or around Php 117 billion went to purchasing pharmaceuticals. The percentage of household expenditures is increasing. Recent NDHS data shows that economic barriers as a reason for households deciding not to seek care still constitutes a significant factor for utilization of health services.

The country's total health expenditure showed improvements from 2005 to 2007, but at decelerating growth rates both at current and constant prices, the total outlay for health went up from Php 198.4 billion in 2005 to Php 234.3 in 2007, registering a growth rate of 9.1 percent in 2006 and 8.3 percent in 2007.

Discounting the effect of inflation, total health expenditure grew at only 4.6 percent in 2006 and even slower at 4.0 percent the following year. When considered on a per capita basis, these growth rates translate to miniscule increases in per capita health spending of Php14 in 2006 and Php11 in 2007.

The level of health expenditure in 2005 to 2007 was within the target of 3 to 4 percent of GNP set as part of the National Objectives for health 2005-2010. However, the ratio exhibited a decreasing trend from 3.4 percent in 2005 to 3.2 percent in 2005 to 3.2 percent in 2007.

Pinoy households continued to bear the heaviest burden in terms of spending for their health needs as private out-of-pocket surpassed the 50 percent mark in health expenditure share in 2006, reaching 54.3 percent in 2007. Private households thus contributed and estimated Php 97.6 billion to the total health expenditure in 2005 and Php127.3 billion in 2007.

Government came in a far second in health spending contribution, with the national government and the local government units (LGUs) footing almost equal shares of 13.0 percent and 13.3 percent in 2007, respectively. It is worth noting that the LGUs spent more than the national government in 2006 and 2007. Total government expenditure on health care goods and services increased from Php 58.5 billion in 2005 to Php 61.5 billion in 2007, registering an annual growth of only 2.6 percent.

Health expenditure from social insurance barely grew from Php 19.4 billion in 2005 to nearly Php 20.0 billion in 2007, indicating an average annual growth of only 1.6 percent. Thus, instead of picking up as targeted, the social insurance share in health spending

went down from 9.8 percent in 2005 to only 8.5 two years later.

Poor households largely rely on public hospitals, whose quality of care is problematic and patient responsiveness is low. Consumer surveys conducted in 2005 and 2006 indicated that people chose private hospitals over public ones since they perceived the latter as providing better quality care. Due to financing barriers, however, poor people do not have access to private hospitals, creating inequity in access to care. Public hospitals (DOH and LGU) suffer from many problems, including inadequate financing, poor allocation of resources, lack of quality benchmarks and standards, and limited accountability. Access to good quality primary care is also uneven, and when available, people often bypass the primary level to seek care in hospitals, as there is no effective referral system. Global experience shows that high utilization of good quality primary health care services is equity-enhancing.

Although largely perceived by the public as providing good quality care, available information shows that the quality of care in private hospitals is mixed. The Philippines has private health care facilities that are accredited by international organizations such as Joint Commission International. At the same time, there exist many small private facilities, including some that serve the poor, where the quality of care is uneven and unregulated.

The threat of climate change

The threat of climate change is now gaining momentum and likewise posing great burdens to women. Climate change is manifested in the increase of extreme weather conditions such as, droughts, storms or floods, and developing countries like the Philippines will likely experience greater adverse impacts. These impacts will vary not only across the region but also between generations, income groups and occupations as well as between women and men.

Climate change poses different impacts on women and this includes their health. Rising temperature will cause increase of malaria transmission. Pregnant women are more physiologically attractive to mosquitoes than non-pregnant women.[13] The same study found that there is an increased incidence of pregnancy eclampsia during climatic conditions characterized by low temperature, high humidity, or high precipitation, with an increased incidence especially during the first few months of the rainy seasons which influence agricultural produce. Being dependent on their lands and resources, drought or excessive rainfall would severely diminish or cause the extinction of their traditional food and medicinal sources. Similarly, climate change mitigation and adaptation initiatives implemented on the same land and resources they are tilling, without taking into consideration local traditions and practices, would make them more vulnerable to changes that may further aggravate their health condition.

Why there has been no significant decline in maternal mortality: hindering factors

Poor women face a higher risk of dying from pregnancy related causes simply because they lack access to the existing knowledge, technology and services that can save their lives. High maternal mortality and morbidity rates are symptomatic of a weak and inequitable health system in which health facilities are unaffordable, out of reach, under equipped or simply non-existent. Such a system also tends to impose user fees on women and ask them to bring their own supplies, for labor and delivery, to the hospital.

Problems in accessing health care

Many factors can prevent women from getting medical advice or treatment for themselves when they are sick. Information on such factors is important in understanding and addressing the barriers women may face in seeking care during pregnancy and at the time of delivery. In the 2008 NDHS, women were asked what hinders them in obtaining medical advice or treatment when they are sick.

The problem cited most often was lack of capacity to pay. The charging of fees for attendance at antenatal care and for the use of midwives has discouraged many women from using these services, as they lack the financial resources needed. Moreover, mothers cite the high cost of delivery in a facility as a reason why they decided to deliver at home. Findings also reveal that the high cost of transportation going to the hospital and food for the caregiver/watchers during the mother's entire stay in the hospital, discouraged facility-based deliveries. Financial considerations constrain women's effective access to critical services during pregnancy, particularly before and after childbirth (see Table 6).

[13] WHO. 2009.

Table 6: Maternal Services by Wealth Index, 2008 NDHS

	QUINTILES				
1. Assistance during delivery	**Lowest**	**Second**	**Middle**	**Fourth**	**Highest**
Medical doctor	9.4	24.4	34.5	55	77.1
Nurse	0.7	2.1	2.4	1.7	0.7
Midwife	15.6	29.1	38.9	29.3	16.6
Hilot	71.4	42.8	23.7	13.6	5.1
Relatives, friends, others	2.3	1.3	0.4	0.1	0.3
No one	0.4	0.2	0.0	0.0	0.0
2. Place of delivery	**Lowest**	**Second**	**Middle**	**Fourth**	**Highest**
Government hospital	11.5	26.9	33	39.0	29.4
Government health center					
Private facility	1.5	7.1	15.3	29.7	54.5
Home	86.8	65.5	51.5	30.9	15.8
Other	0.2	0.6	0.2	0.4	0.2
3. Delivered by C-section	1.3	5.1	7.3	15.5	27.7
4. Number of births	1,686	1,460	1,219	1,114	880
5. Current use of contraceptives (any method)	40.8	52.7	54.0	55.8	50.0

Source: NSO, MACRO. 2008. NDHS.

There are large income-related disparities in the utilization of health services. Poor women are consistently unable to access maternal and reproductive health services. The women in the highest quintile are about 9 times more likely to have a medical doctor assist them during delivery and are 37 times more likely to deliver in a private facility than women in the lowest quintiles (see Table 6).

Another gauge of poor women's inability to gain effective access to life-saving services is the low percentage of women, about 1.3 percent, who had delivered by caesarean section (C-section). This figure is way below the 5-15 percent range based on the proportion of complications requiring C-sections among a group of women giving birth. Below 5 percent would indicate women are dying or suffering from a disability because they are not receiving treatment; above 15 percent may indicate that women are receiving C-sections for reasons other than those strictly required by their medical condition or fetal indications. Apart from C- sections, poor women are not able to access other services even if these were available.

The rate of caesarian operations is also an indicator of access to essential obstetric care. One in ten live births (10 percent) were delivered by C-section, which is an increase from the proportion reported in the 2003 NDHS (7 percent).[14] The occurrence of caesarian operations varies across regions, from 2.7 percent in ARMM to 16.3 percent in CALABARZON. The proportion of deliveries by C-section in CALABARZON has increased seven percentage points, from 10 percent in 2003.

The data in Table 6 shows that the use of any FP method increases with increasing wealth index quintile from 37 percent for women in the poorest quintile to 54 percent for those in the fourth quintile. Interestingly, it declines to 51 percent for women in the wealthiest quintile.

It also highlights the relationship between birth intervals and the mother's economic status. It reports that the mother's economic status has a positive association with birth intervals. Women in the poorest quintile have the shortest interval, while those in the wealthier quintiles have the longest (29 and 34 to 35 months, respectively).

Accessibility to health centers and information on maternal health and facilities and/or services remains a challenge in improving maternal health especially in the rural areas of the country. A report in 1990, then again in 2009, stated that women in rural areas have to travel

[14] NSO, ORC Macro, 2004.

longer to health care centers in contrast with women in town centers. Areas are difficult to access due to the geographical landscape of the country. In areas where public transportation is available, the trips are often long, infrequent and costly. The barriers affect access patterns for both routine and emergency care.

More than 80 percent of women in the Zamboanga Peninsula, CARAGA, and Central Visayas cited concerns on the availability of health care personnel, supplies and medicines as serious problems in getting health care services.

Apart from observed lapses by the government in providing obstetric services, some traditional beliefs hinder positive achievements on maternal health in the country. Among these are the prevalent beliefs that pregnancy is a natural occurrence and not a condition posing risks; and the belief that the death of a mother is fated and not because of the lack of sufficient medical care. Dying in pregnancy and delivery is still considered 'in the nature of things' (isang paa nasa buhay at isang paa nasa hukay).

Data also reveals that decision to seek care from health facilities is often made only when the delivery has become difficult or when complications arise.

Barriers because we are women

Focusing purely on a health perspective without a gender analysis of the issue, means that the reasons women do not access these services may not be identified and therefore addressed.

Poor women consistently are unable to access services, information, supplies, and facilities that could prevent maternal death.

The services are inaccessible not only because often they cannot afford treatment but because as women, they do not have the time or the social support (women's mobility, getting permission to go for treatment, not wanting to go alone, no companion, childcare support) to utilize the service.

Home deliveries provide women with a sense of privacy and comfort, as the woman is not forced to lie on a delivery table with her genitals publicly exposed. Moreover the family does not need to worry about child care support during home deliveries, unlike during facility-based delivery when the father and/or other family members are forced to leave the children at home to take care of the mother and her newborn.

However, the barrier is often that the women lack the decision making power to choose to use available services. Women's decision and assertion is therefore a vital factor in accessing services.

Besides the problems of geographic location or economic access, indigenous approaches and respect for tradition is critical in situations like childbirth. Indigenous women have preference for traditional midwives or birth attendants. The preference emanates from familiarity of the other in terms of values, beliefs and background. The feeling of respect and understanding is there in terms of the manner of delivery wherein indigenous women significantly become part of the cultural heritage of the community. The need for those who provide health care and other services to indigenous peoples may need to be trained in the relevant culture.

In dealing with impoverished areas not reached by obstetric services, the ADB surmised that "provision of maternal health care in remote areas will involve a higher cost per person than in more accessible areas. Nevertheless, improving maternal health should be an integral component of national programs on equity grounds.[15] The ADB reveals that a strategy that will likely have high impact on maternal health care is a judicious combination of traditional and modern approaches to maternal care.

Addressing under-utilization of health services.

The quality and access of government health services are the most pressing issues from the point of view of women. Even with upgraded EmOC facilities and presence of skilled attendants, increased utilization is not ensured. EmOC does not operate in a vacuum; instead it is embedded in the health system. Therefore, there is a need to review the health system practices and behaviors that prevent utilization of services. The perception of the community on the health system, and how they feel when they go to the health center, contributes to their unwillingness to deliver in a health facility. There is a need to understand and address the true bottleneck of service under-utilization.

Women, when queried on problems of utilization of health services in a study "What Women Want In Terms of Quality Health Services" replied: Absence or inadequate health service facilities, discriminatory attitudes of health providers and insufficient personal resources combined to create a low level of utilization

[15] ADB. 2007.

and a low level of satisfaction with these services.

More than any other facet of health services, good interpersonal relations were emphasized time and again as an important factor in the poor women's continued use of a health service. Services that were inadequate - meager facilities, insufficient medical supplies and limited personnel - were as critical an issue as health providers who did not treat them with dignity and respect. Women responded that they felt degraded and widely exposed in an assembly line-like delivery system.

The disjointed and disconnected health service

With high antenatal care coverage, MMR should have been dropping since the mid-90's if risk-screening and prediction were effective in reducing maternal deaths. Yet, MMR in this country has not declined significantly in the past decade. The gap among the indicators show the failure of the government to further connect the women to the health delivery system, as well as to provide the services needed.

Antenatal care does have other purposes. It could serve as the locus for the delivery of other services such as tetanus toxoid immunizations and information on the danger signs of pregnancy and the benefits of birth preparedness. It could also be a conduit for the distribution of contraceptives and impregnated mosquito nets.

Given such high attendance rates in antenatal care clinics, policy makers and program managers ought to exploit and maximize the opportunities that such rates present. What is interesting is that despite the relatively high antenatal care performance women still are not assisted by skilled birth attendants, nor do they give birth in health facilities. In an ideal health system, the MDG 5 indicators particularly those of ANC, facility-based births and access to skilled birth attendants should support and complement each other.

Moreover, if strong linkages between antenatal care and EmOC are established, e.g., through practical ways such as promoting FP, talking with skilled attendants, identifying danger signs, making birth plans, then women will at least have a chance of surviving the complications that arise during pregnancy and childbirth.

Administrative orders lack coherence and synergism resulting in weak or absent policies and programs that are crucial to reducing maternal death.

It seems that health-related administrative orders were done arbitrarily, giving a strong sense of disjointedness. There is a policy on natural FP, separate from a policy on the FP program; a safe motherhood policy, separate from the reproductive health policy; a policy on the prevention and management of complication of abortion, separate from all other policies. There is no coherent whole. There is no synergism.

The slow progress in contraceptive prevalence rate stems mainly from two policies implemented during the previous Arroyo administration. First, with the Natural FP Program, AO No.132, S.2004, the national government focused its FP policies and resources on natural family planning only. This stems from the pressure exerted by the national government to align its FP policies with the Catholic Church's stand on contraception giving rise to Natural Family Planning as a "distinct, discrete personality all its own and as separate from the existing FP program". Notwithstanding, the government, through the POPCOM, has sent a strong signal to LGUs and the public at large that natural FP is its de facto policy. The DOH is tentative in its position towards artificial contraception and has virtually shied away from it. Much more crucial than these implementation problems is the question of the effectiveness of natural FP methods. Studies to date have shown conflicting results.

This resulted in splitting the natural and artificial FP methods into two separate programs, separate budget lines as well as to two cadres of health workers who promote natural and artificial FP methods separately. This split in turn has resulted in problematic operational issues such as the costs of funding two cadres of health workers and the fostering of unhealthy competition for clients between natural and artificial FP health workers. Anecdotal evidence shows that confusion arises among clients as to the effectiveness and appropriateness of the methods they should use.

This schizophrenic scenario is set against the backdrop of two important events: the national government's delegation to the LGUs of preparing and implementing FP programs and the USAID gradual phasing-out of donated contraceptive commodities at the end of 2008. The withdrawal of USAID funding threatened the ability of the government, particularly poor municipalities, to meet its contraceptive needs.

For the past forty years, the bulk of the country's total requirements for family planning commodities have been financed by external donors. U.S. Agency for International Development (USAID) was the largest contributor, shouldering 80 percent (annual average of US$ 3,000,000 for the past 36 years).

However, USAID, with the concurrence of the Philippine government, decided to withdraw and gradually phase-out donations of FP commodities. The phasing-down of donated contraceptives started in 2004 and completed in 2008. In 2004, the supplies of condoms gradually tapered down until they eventually ran out, pill donations completely phased-out in 2007, and injectables, in 2008.

In 2004, POPCOM projected the phasing-out will affect an estimated 4.6 million women of reproductive age who use modern methods of contraception. It will also affect another 2.3 million women who are currently not using modern methods but reported their intent to use. Further, some 18.8 million young Filipinos (15 to 27 years of age) who have had a premarital sex experience are likewise going to be affected by the phase-down.

Contraceptive Self-Reliance Strategy, AO No.158, s. 2004.

In response to the decision of donors to phase out donated contraceptives, the Department of Health issued AO No.158, S.2004, Guidelines on the Management of Donated Commodities under the Contraceptive Self-Reliance Strategy (the second policy implemented during the previous Arroyo administration implicated for the slow progress in contraceptive prevalence rate). CSR is an attempt on the part of government to put in place a set of measures that would ensure continued use and increase of contraception and other FP methods to eventually eliminate unmet need.

In addition, the CSR strategy aims to reduce public sector dependency and increase local government units and private sector participation. In turn, this would enable the government to focus on public family planning services and supplies for the poor, and move those who can afford it to the private sector.

The Contraceptive Self-Reliance Program (DOH AO 158 2004) states that the Government shall act as guarantor of last resort assuring that contraceptives remain available for current users who depend on donated supply. After 6 years, principally, the government failed to fill in the gap caused by the withdrawal of USAID supplies. It refused to spend for modern contraceptives. The government, in the face of opposition from the Catholic Church, has taken the position that it would not use its funds to purchase contraception. Worse, it even impounded the Php 2 billion budget allocation for family planning in the 2008 General Appropriations Act. By default, the government's position goes against the spirit and intent of RH approach.

Managing the complications of abortion in health facilities is a medico-legal case.

As abortion is illegal in the Philippines, the Post Management of Abortion Complication (PMAC) policy is the next best effort that the DOH could do. Implementation of this policy, however, faces severe challenges. In the first place, post-abortion cases are considered "medico-legal" and obligate the attending health staff to report these to the police or the designated authorities. Thus, there is a tendency for health staff to refuse to manage these women in need. If, on the other hand, health staff takes on these cases, they deliberately miss-classify them as either medical or surgical cases or consciously make omissions that suggest induced abortions. Once again, they obviate the need to file forms with the police. Data on post-abortion cases are therefore difficult to find in health facilities.

Reproductive Health Bill

There is a lack of a clearly pro-poor reproductive health policy. While the national policy on the reproductive health (RH Bill) has been languishing in legislative debates for two decades now, to date there are 51 local ordinances, including 4 provincial laws (Aurora, Sulu, Ifugao, Mountain Province) in support of reproductive health service provision and LGUs have been taking advantage of performance grants in part for providing family planning services. However, performance is patchy in a policy environment which varies arbitrarily from LGU to LGU and supply is subject to political and other whims.

Responsibility relegated to the LGU

The responsibility of crafting, funding and implementing basic services including reproductive and family planning programs has been relegated to the LGUs. Thus, we are witness to uneven reproductive and family planning policies and programs across LGUs. Emergency obstetric care services are either not functioning properly or non-existent in most poor areas. Note that these areas are the greatest contributor to maternal mortality.

The DOH supported the provision of FP services and contraceptives of LGUs, and has worked with LGUs on how to operationalize the Contraceptive Self Reliance guidelines. Budget has been allocated since 2007 for capacitating LGUs on their reproductive health services including the provision of family planning.

Although the delivery of public health services is largely devolved to LGUs in accordance to the provision of the Local Government Code, however, the good nature of public health services suggests that the central government cannot fully abdicate its role in this subsector despite devolution.

PhilHealth Support

PhilHealth has approved the inclusion of Maternity Health Package as an outpatient service in 2001, after years of covering only inpatient care. However, it has not included in its package of benefits oral contraceptives and injectables. Oral contraceptives and injectibles listed in the Philippine National Drug formulary, however, are compensable when prescribed but only during hospital confinement. To respond to this problem, LGUs may use capitation funds to procure oral contraceptives for the use of their enrolled indigent member.

Family planning contraceptives have never been included as essential drugs. According to a study by the Philippine Population Management Program, 46 percent of family planning expenditures are still out-of-pocket.

Conclusions and Recommendations

"Women are not dying because of diseases we cannot treat. They are dying because societies have yet to make the decision that their lives are worth saving" (Dr Mahmoud Fathalla)

Despite the fact that technical solutions to most of the problems associated with mortality and morbidity in pregnancy and childbirth are well-known, 4,700 women still die due to complications developed during pregnancy and childbirth every year. With the Safe Motherhood initiative of 2005 and the MNCHN which was launched in 2008, the Philippine government shows progress in attaining MDG 5 through programs and policies, but field data proves otherwise. Health outcomes (total fertility rate, CPR, and unmet need) have not significantly improved. Adolescent births and unsafe abortions have not diminished.

Since most obstetric complications cannot be predicted or prevented, except those that result from unsafe induced abortions, all pregnant women are at risk of acquiring a life-threatening complication and they must have access – at any time, day or night – to health facilities that provide life-saving emergency obstetric care. Access to this package of critical services is sorely lacking, especially for poor women.

Women continue to die from the complications of unsafe abortion. Given that contraceptive commodities are unavailable and unaffordable, unwanted pregnancies remain to be a problem in this country where abortion is illegal and where services that terminate a pregnancy are non-existent. Thus, women resort to illicit abortions and run the risk of acquiring life-threatening complications. Until such time that contraceptive commodities and FP services will be made much more available and accessible than they are now; and until such time that women are provided quality-post abortion care, this country will not lower its maternal mortality ratios.

Over all government spending on health still remains low. The significant increase in attention to RH and maternal death issues in terms of greater awareness, better internal cohesion, and high-level engagement underscores the need to ensure that **investments must be made. And investments must be directed towards solutions** that are technically seen as essential to reducing maternal mortality. At the minimum, this would include improved access to quality family planning services, skilled birth attendance, emergency obstetric care, and postnatal care for mothers and newborns

But central to making these services accessible is addressing inequities in a functioning health system. Dr Alberto Romualdez and Dr Ernesto Domingo who drew up recommendations to reform the health system towards **Universal Health Care** state:

"This means that every Filipino should have access to high quality healthcare that is efficient, accessible, equitably distributed, adequately funded, fairly financed, and directed in conjunction with an informed and empowered public. The overarching philosophy is that access to services is based on needs and not based on the capability to pay."

"There should be one standard care for all, regardless of their capacity to pay. Every citizen is all entitled to quality health services and packages that are available. Equity refers to both horizontal and vertical equity. For those with equal health needs, they have equal access to the health care of the same quality. Similarly, there should also be equal access to health care across the different social and economic classes."

Beyond these, what is needed is the sustained commitment and strong political will of the government to ensure that strong systems and services are in place.

Box 1. Safe Motherhood: a brief history of the global movement 1947-2002

Ratified by 177 states, the Convention of the Elimination of Discrimination Against Women is the principal legal instrument addressing women's rights, among them, the right to life-saving services during pregnancy and childbirth. Article 12 states:

States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to FP.

Notwithstanding the provisions of paragraph I of this article, States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.

Elaborating further on Article 12, General Recommendation 24 urges states to eliminate discrimination in women's access to health care. The Committee notes that:

"…it is the duty of States parties to ensure women's right to safe motherhood and emergency obstetric services and they should allocate to these services the maximum extent of available resources."

To ensure that these rights move towards their progressive realization, policies and programs must promote evidence-based and focused interventions to reduce maternal mortality and morbidity and give priority to vulnerable groups such as poor and indigenous women.

Within this framework of women's rights, the occurrence of women dying during pregnancy and childbirth egregiously stands out.

Maternal deaths are not like any other deaths. Pregnancy is not a disease but a physiologic process that only women experience. Women will continue to bear children and will continue to require access to skilled care and life-saving obstetric services. Failure to provide such care and services therefore constitutes discrimination because only women face this risk.

This framework, therefore, allows the translation of human rights from abstractions to concrete applications. Human rights, after all, embody needs, presuppose responsibilities, and delineate accountabilities.

A woman's and a man's right to a wide range of FP services, for instance, presupposes government's responsibility to provide such services. A woman's right to emergency obstetric care presupposes a government's responsibility to ensure that she has access to these life-saving services. And a woman's right to information and education on FP and the danger signs of pregnancy presupposes a government's responsibility to make sure that not only does she have the correct information but that she is indeed able to act on it.

The Government of the Philippines, supported by the international community and development partners, is thus duty-bound to provide FP and life-saving emergency obstetric care to women who need them. Central to making these services accessible is a functioning health system. Beyond these, what is needed is the sustained commitment and strong political will of the government, international agencies, and development partners to ensure that strong systems and evidence-based services are in place.

Maternal deaths are not like any other deaths. Pregnancy is not a disease but a physiologic process that only women experience. Women will continue to bear children and will continue to require access to skilled care and life-saving obstetric services. Failure to provide such care and services therefore constitutes discrimination because only women face this risk.

A*bout Zahr, Carla. 2003. Safe Motherhood: a brief history of the global movement 1947-2002. In Rodeck, C. (ed) 2003. Pregnancy: Reducing maternal death and disability 2003; 67: 13-25.*

Most of the maternal mortality of the last decade could have been prevented with a coordinated set of actions, sufficient resources, strong leadership and political will. For a variety of reasons, maternal health has not emerged as a political priority, and even though there is a growing shared understanding on the solution it has not been framed in a way that has been able to generate political commitment and subsequent action.

Policy reforms are never easy as they entail drastic changes in entrenched political power relationships and vested interests. Good institutions and policies don't occur overnight but rather evolve slowly. A strong-willed and well-intentioned national leader is the key. Or a discerning and enlightened citizens can induce a change in the leadership to a reform-minded leader. We should bring the campaign to our people. Let this be the political project of the women.

As such, the following are the doable measures for the government to focus on in order to ensure safe and joyful childbirth for all women:

1. Achieve Universal Health Care as promised within the next three years, shift the relative weight of public spending from tertiary services that cater to the affluent to basic services and public health that benefit the poor;
2. **Reform and strengthen the National Health Insurance Program (NHIP) so that it keeps to its mission of achieving social solidarity and equity.** Revamp the Philippine Health Insurance Corporation to ensure full cover-

age for all Filipinos, particularly that of the maternity care package by including coverage for all pregnancies;

3. Steadily expand the revenue base toward raising health spending to 5%-of-GDP; and
4. Make the Reproductive Health Bill a priority of the Aquino administration to insulate Family Planning and Reproductive Health services from political trade-offs and religious control.

But at this time, what is urgently needed is a convergence of efforts to ensure that women go through pregnancy and delivery safely. EmOC and FP services have to be in place; health systems must be functioning and revitalized; and universal health care must start to be realized. If the DOH is able to do this resolutely and single-mindedly, the Philippines can achieve the target in 2015. This is the race that can be won.

But much, much more, partner with the organized women. For after all, we are the number one stakeholders of MDG 5. Together let this be our political project. So that beyond the anonymity of numbers and statistics that have to be reported to the United Nations, are the faces of our mothers, sisters, daughters and friends. Then for sure no one is left behind. For if maternal death is preventable, one death is just too many. This is the race that should be and must be won.

Let us now report to our sisters…to establish or revitalize health systems that can provide EmOC and FP services.

References:

ADB. 2007.

Cabigon and Singh. 2005.

DOH targets for 2010 as part of MNCHN policy.

Family Planning Survey. 2006.

Guttmacher, A. 2006.

National Demographic Health Survey. 1993, 1998, 2003, and 2008.

National Demographic Survey. 1993.

Philippines Midterm Development Goal. 2007.

WHO. 2009.

Zahr, C. 2003. Safe Motherhood: a brief history of the global movement 1947-2002. In Rodeck, C. (ed) 2003. Pregnancy: Reducing maternal death and disability 2003; 67: 13-25.