

Philippine Financing for Millennium Development Goal No. 5: Improve Maternal Health

The Millennium Development Goals, according to the January 2005 Report of Jeffrey Sachs to United Nations Secretary General Kofi Annan, are the world's time-bound and quantified targets for addressing extreme poverty in its many dimensions – income poverty, hunger, disease, lack of adequate shelter and exclusion – while promoting gender equality, maternal health, education and environmental sustainability. (*Sachs, 2005 Report to the UN*)

Sachs, Director of the UN Millennium Project, believes that if Millennium Development Goal No.5 is achieved by 2015, the world will see two million mothers saved from mortality during childbirth. In the Philippines, annual maternal death figure is about 2,800 to 3,500, or between 130-178 deaths for every 100,000 live births, depending on whose figures one is quoting. Whichever number is quoted, it is regarded as high by international standards. It is the number that guides the Philippine government in achieving Goal No. 5.

What are the Maternal Health Targets for the Philippines based on MDG-5?

Maternal Health Targets as indicated by MDG 5 are:

- To reduce by three-quarters the maternal mortality rate between 1990 and 2015 (half by 2000, half by 2015);

- To increase access to reproductive health services to 60% by 2005, 80% by 2010, and 100% in 2015.

What is the Status of the Targets in the Philippines as of 2005:

- According to Rosario Manasan: maternal death rate per 100,000 live births in 1990 was 209; 172 in 1998; 163 in 2000; about 130 in 2005. Target by 2015 is 52. (*Manasan, 2002*) DOH quotes 178 per 100,000 live births in 2005.
- Contraceptive prevalence rate among Filipino Women is 48.9%

Maternal mortality can in fact be reduced without the need of first achieving high levels of economic development, according to UNFPA (www.unfpa.org) Most maternal deaths are preventable. The prevailing thinking among maternal health experts is that, programs to reduce maternal deaths should be based on the principle that every pregnant woman is at risk from life-threatening complications.

For the maternal death ratio to be reduced dramatically, all women must have access to high quality delivery care. “Such care has three essential elements: a skilled attendant at delivery; access to emergency obstetric care (EMOC) in case of complications; and a referral system to ensure that women who do experience complications can reach life-saving Emoc on time. And also that, no matter how skilled an attendant is, if she or he is performing deliveries in a setting without drugs, equipment and infrastructure to deliver Emoc – and cannot get her patients quickly to that care – some women will die. The large majority of maternal deaths are linked to this kind of unexpected complication.” (*Progress Towards the Millennium Development Goals, 1990-2005 Report, United Nations Department of Economic and Social Affairs*)

The Department of Health and MDG Goal No. 5

DOH Assistant Secretary Mario Villaverde indicated in his presentation at the UP National College of Public Administration and Governance (NCPAG) forum on *Financing MDGs in the Philippines* that “majority of the programs and projects in support to the MDGs are being spearheaded by the Department of Health although the main implementer of the programs and projects are the local government units.” (*Villaverde 2005*)

The Philippine Government implements MDG Goal No. 5 by way of its Women’s Health and Safe Motherhood Program (WHSMP). The first phase of the implementation of the program started in 1995, five years before the Millennium Development Goals were formally adopted by the United Nations, and until year 2002. The second phase began in 2005 and will continue until 2010.

Added to the services provided by the WHSMP programs are the DOH micro- nutrient supplementation for pregnant and lactating women, tetanus toxoid vaccination of pregnant women and the establishment of Basic Emergency Management Obstetric Care (BEMOC) and Comprehensive Emergency Management Obstetric Care (CEMOC).

Before proceeding to the discussion on the WHSMP implementation by the Department of Health (DOH), it would be useful at this point to define concepts used by the programs according to established references.

Definitions

Maternal Health is defined as “the sense of well-being related to the pre-natal, natal and post-natal periods of a woman’s life cycle.”(*Philippine Plan for Gender-Responsive Development [PPGD], 1995*)

“**Safe Motherhood** aims at attaining optimal maternal and newborn health. It implies reduction of maternal mortality and morbidity and enhancement of the health of the newborn infants through equitable access to primary health care including pre-natal, delivery and post-natal care for mother and infant, family planning, and access to essential obstetric and neonatal care.”(*World Health Organization, 1994*) “It is of immense importance because it affects the health of the next generation through its impact on children.”(*PPGD, 1995*)

Maternal death (or *maternal mortality*) is “the death of a woman while pregnant or within 42 days after childbirth (or termination of pregnancy), irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.” (*WHO, International Classification of Diseases, 1992*)

Pregnancy-related death is “the death of a woman while pregnant or within 42 days after childbirth (or termination of pregnancy), irrespective of cause of death” (*WHO, International Classification of Diseases, 1992*)

The **maternal mortality ratio** (MMR) is “the number of maternal deaths during a given time period per 100,000 live births during the same time period.” The **maternal mortality rate** is defined as “the number of maternal deaths in a given period per 100,000 women of

reproductive age during the same period and thus reflects both obstetric risk and the risk of being pregnant.” (*UN Dept. of Ecosoc World Population Monitoring, 2002*)

Another ***measure of maternal mortality*** is “the lifetime risk which measures both the probability of becoming pregnant and the probability of dying as a result of that pregnancy cumulated across a woman’s reproductive years. The lifetime risk can be estimated by multiplying the maternal mortality rate by the length of the reproductive period (around 35 years).”(UN Dept. of Ecosoc World Population Monitoring, 2002)

Family planning services and programs are aimed at “helping couples to meet their reproductive goals in a framework that promotes optimum health, responsibility and family well being, and respects the dignity of all persons and their right to choose the number, spacing and timing of the birth of their children.” (*ICPD, 7.14 [a]*) “Education and appropriate services regarding responsible planning of family size, with respect for cultural, religious and social aspects, in keeping with freedom, dignity and personally held values and taking into account ethical and cultural considerations must contribute to these health activities.” (*UN Agenda 21, 6.3*)

Skilled health personnel or skilled attendants are “doctors (who are specialist or non-specialist) and/or persons with midwifery skills who can handle normal deliveries and diagnose and manage obstetric complications. A person with midwifery skills is one who has successfully completed the prescribed course in midwifery and is able to give the necessary supervision, care and advice to women during pregnancy, labour and the postpartum period, to conduct deliveries alone, to provide lifesaving obstetric care and to care for the new-born and the infant.” ((*UN Dept. of EcoSoc World Population Monitoring, 2002*))

Women's health and safe motherhood is for “achieving a rapid and substantial reduction in maternal morbidity and mortality and reducing the differences observed between developing and developed countries and within countries.” (*ICPD, 8.20 [a]*)

**The Philippines Women's Health and Safe Motherhood Program: An Integrated
Women's Health Service
Delivery Model of the Department Of Health**

WHSMP I and WHSMP II Program Implementation Strategies

The government promotes maternal health through a two-pronged strategy that involves providing health services to pregnant women which is safe motherhood, and providing family planning services. The basic premise of **Safe Motherhood** is that childbirth must not carry with it the risk of death or disability for the woman and her infant. (*2nd Philippine Progress Report on MDGs, 2005*)

Based on the above premise, nine safe motherhood strategies were instituted:

- 1) **Training**
- 2) **Information dissemination**
- 3) **Social mobilization**
- 4) **Community participation**
- 5) **Promotion of gender sensitivity**
- 6) **Quality assurance schemes**
- 7) **Maternal Mortality Rate audit**

8) Upgrading of equipment for obstetric emergencies and**9) Making quality care accessible**

In 2001, the National Family Planning Policy promoted was as follows:

- 1) Family planning as a health intervention to promote the overall health of Filipinos;
- 2) Family planning as a means to prevent high risk pregnancies;
- 3) Family planning as a means to reduce maternal deaths particularly those related to post-partum hemorrhage and hypertensive disorders of pregnancy;
- 4) Family planning as a means to prevent abortions;
- 5) Family planning as a reproductive right for women, meaning it should be delivered to respond to the unmet needs and demands of women;
- 6) Family planning as a means towards responsible parenthood;
- 7) Family planning as a means to reduce poverty.

The government did, and is doing, WHSMP in two phases. WHSMP I from 1995-2002, and WHSMP II which is from 2005 to 2010.

Women's Health and Safe Motherhood Program (WHSMP) I: 1995-2002 – What it accomplished

WHSMP I was implemented in a span of seven years and directly affected maternal and child health services. This included family planning, prenatal, delivery and postnatal services, cancer detection, violence against women and children, reproductive tract infection (RTI) and sexually transmitted diseases (STD) health services. Equipment such as ultrasound, colposcopy examination beds and others were procured for the improvement of services.

Clients noted a big improvement in the delivery of women's health services. There were positive changes in facilities too. Training gave health providers adequate skills and knowledge to make them more confident in performing their duties and in using the new and upgraded facilities. Health providers were introduced to emergency obstetric services which allowed them to handle complicated obstetric conditions. Availability of supplies and equipment was noted.

New services were introduced such as cancer screening, women and child protection units and RTI/STD management. Training materials were standardized.

Members of the communities noticed an increased awareness of women's health concerns. With the upgrading of facilities and better knowledge and skills by health providers, and better access to equipment and supplies, there was a corresponding increase in utilization of services and the level of satisfaction among clients.

Data analyzed from 1998 to 2003 indicated positive trends in the following areas: a higher proportion of births attended by health professionals; a bigger percentage of births delivered in a health facility; a wider prenatal and postnatal care coverage with the help of the National Health Insurance Program; an increase in the percentage of those injected with tetanus

toxoid; and the provision of iron tablet supplements for pregnant women and nursing mothers brought down maternal anemia in pregnant women for the same period.

How WHSMP I Was Funded

Women's health services had been limited by underinvestment. Upgrading of facilities and services could not have been possible without external funding. **P1,947,710,950.00** came from the five major donor agencies namely: the World Bank, the Asian Development Bank, the Kreditanstalt für Wiederaufbau (KfW), the Australian International Aid for Development (AusAid), the European Union, and counterpart money from the Government of the Philippines. **P495,549,222.00** was the Philippine government's contribution. However, while the allotment for **WHSMPI** was **P1,947,710,950.00**, the amount invested on **WHMP I** from **1995 to 2002** was only **P1,546,623,564.33**. Of obligations incurred, **P1,265,589,618.97** came from Loan Proceeds and **P 281, 032,946.36** was GOP counterpart. *(Annexed is the Statement of Allotment and Obligations Incurred from 1995-2002)*

According to Dr. Ma. Virginia Ala, Officer-in-Charge of the DOH, Bureau of International Health Cooperation, **P401,087,385.27** was unspent for WHSMP I and was reverted back to the Department of Budget and Management for two reasons:

- 1) In seven years, six Secretaries of Health took charge of DOH – Dr. J. Flavier, Dr. J. Tan, Dr. Ramiro, Dr. Reodeca, Dr. Estrella, Dr. A. Romualdez and Dr. M. Dayrit. Every DOH Chief Executive had to study pending programs before proceeding with implementation and continuity was disrupted. Money therefore was also unspent while program was on hold or was inactive.
- 2) Supervising Health Officer Zenaida Recidoro of the DOH National Center for Disease Prevention and Control added that aside from the first reason,

implementation of the program was nationwide. A large number of local government units were unprepared for WHSMP I due to lack of personnel with medical and technical skills and a lack or absence of medical facilities and equipment to implement the program.

Women's Health and Safe Motherhood Program II: 2005-2010

WHSMP II is basically to provide quality women's health and safe motherhood services as an important component of the LGU's health service package. Health, according to DOH, is essentially a local issue. WHSMP must therefore ensure that structural, health-facility and human resource capacities necessary to deliver health services are installed and maintained at appropriate levels of the local health delivery system.

The specific objectives of WHSMP II are to:

- a) Improve the quality and coverage of women's health and safe motherhood services;
- b) Strengthen the capacity of Local Government Units (LGUs) and the private sector to manage the provision of these services and of the Department of Health (DOH) to provide policy, technical, financing and logistics support;
- c) Improve the fiscal impact for women's health services, with the development of appropriate and sustained financing mechanisms and establish technical expertise at strategic levels and areas, consistent with the primary strategy of the Health Sector Reform Agenda (HSRA), which is sustained investments for effective public health technologies;

- d) Enhance the effectiveness and sustainability of health interventions through the participation of local communities, the private sector and nongovernmental organizations in the project; and
- e) Expand the knowledge base upon which to draw policy and technical guidance for women's health program.
- f) Success in the implementation of the program will provide the blue-print for succeeding WHSMPs in other provinces and other local government units in the future.

To Meet the Objectives, WHSMP II Must Accomplish the Following, in Specified Areas:

- A) Service Delivery in the areas of maternal and child care particularly emergency obstetric services, family planning, diagnosis and treatment of RTIs and STDs and other women's health problems;
- B) Institutional development including:
 - 1) information, education and communication (IEC) programs to promote attitudes and practices that would improve women's health;
 - 2) training for public sector health care workers in program management (such as planning and development) and in delivering women's health services;

3) development and installation of an improved national or regional public health logistics system for the DOH to ensure the efficient procurement and delivery of commodities to end users;

4) support to the DOH in project management.

C) Community Partnerships which support local communities and NGOs working with LGUs and the DOH in planning and implementing community-based women's health services;

D) Policy and Operations Research to conduct studies on women's health and related service delivery questions.

WHSMP II Implementation Strategies

The Department of Health seeks to develop a model of integrating women's health service delivery that is cost effective, gender sensitive and culturally acceptable. For maternal care, WHSMP II uses the currently practiced risk approach that considers all pregnant women to be at risk of complications at childbirth. This requires:

a) More skilled deliveries by professional health practitioners;

b) Midwife-led teams of traditional birth attendants (TBAs) and barangay health workers (BHWs) reaching all pregnant women with essential pre-natal care and birth plans;

- c) More normal deliveries at basic health facilities and more referrals of emergency obstetric cases to intermediate level facilities;

For their family planning program, DOH says it is based on four major principles:

- 1) Respect for the sanctity of life;
- 2) Respect for human rights;
- 3) Freedom of choice and voluntary decisions; and
- 4) Respect for the right of clients to determine their desired family size.

The DOH Family Planning Program requires:

- a) Increased outreach at barangay level by midwife-led teams of traditional birth attendants (TBAs) & barangay health workers (BHWs) identifying potential family planning clients;
- b) More public hospitals able to conduct frequent, regular and high quality, outreach through itinerant teams for non-scalpel vasectomies (NSV);
- c) Increased number and reliability of static outlets for IUD insertions and bilateral tubal ligations at affordable cost;
- d) Barangay to barangay door to door family planning campaign to provide services whenever and wherever needed.

To note, there is confusion in the government's appreciation of what "**sanctity of life**" means. This doctrine is derived from natural law, and popularized by the teaching of the Catholic Church, which says that every marital act must be open to the transmission of human life. Vasectomy and tubal ligation destroy and impede the reproductive functions of husband and wife. The procedure effectively kills the flow of life and therefore violates the "sanctity of life." It also violates the married couple's right to found a family and decide for themselves how many children they will have. Every such violation could actually trench on several moral principles.

For STI/HIV Control, the plan is as follows:

- a) Integration of the assessment of STI risks and symptoms into family planning and antenatal visits, during labor and delivery and post partum care;
- b) Targeted services to registered female sex workers by upgrading and expanding services provided by Social Hygiene Clinics;
- c) Foster public-private partnership to control STIs, through NGOs and OFWs; with private providers to disseminate treatment guidelines and with LGUs to support distribution of a subsidized pre-packaged syndromic STI treatment;

For Adolescent and Youth Health, it will:

- a) Use of peer facilitators to provide BCC (Behavior Change Communication) on sexuality and reproductive health;

- b) Transfer experience from successful NGO-led programs already tested in the country on effective and sustainable ways to reach the youth.
- c) Multi-sectoral teams of professionals at the provincial level with the appropriate skills to track the needs of the youth.
- d) Establish teen centers to provide a location for adolescents and youth to congregate and discuss their concerns with the help of peer counselors and to serve as a base for organizing outreach services;
- e) Establish measures to prevent early childbearing among adolescents by creating a safe and supportive environment through the promotion of delayed marriage and childbearing, expanding access to education and training, and providing income-earning opportunities.

Funding for WHSMP II

For WHSMP II, which is from 2005 to 2010, the World Bank component is expected to be approximately **P 802,367,300.00** with a Philippine Government counterpart of approximately **P133,156,700.00** or a total of **P946,442,500.00**. The investment will be spent on a range of inputs (*see WHSMP II schedule of funding, as annexed*), including:

- Construction or upgrading of first level referral and primary health care centers;

- Package of equipment for upgraded facilities;
- Training for health providers of upgraded facilities;
- Technical and financial support for development and implementation of IEC and advocacy initiatives in women's health;
- Development of clinical practice guidelines; and
- Operational researches in women's health.
 - It will also place reliable and sustainable support systems for service delivery as follows:
 - a) Drug and Contraceptive Security – through market segmentation, procurement, logistics and management systems, and social marketing;
 - b) Safe blood supply;
 - c) Behavior change intervention through advocacy and communication and performance-based awards and incentives;
 - d) Sustainable financing of local health services and commodities through diversification of funding sources and market segmentation;

- e) Human Resource Management and Development which will include capacity and capability building and establishing a network of training providers.

For the year 2005, **DOH** also will fund other maternal health related services such as micronutrient supplementation for pregnant and lactating mothers at P16,000,000.00; tetanus toxoid immunization of pregnant women at P37,599,277.00; reproductive health services at P54,281,000.00 or a total funding of **P107,880,277.00** added to the yearly allocation for WHSMP II. Official Development Assistance for 2005 is **P11,230,000.00**. (***DOH WHSMP II Schedule of Cost of Investment is Annexed***)

As we speak of improving maternal health, maternal deaths are also results of complications arising from various causes. One of them is complication from cardiovascular disease. To give true meaning to improving maternal health as a millennium development goal, I propose that the DOH focus attention on critical areas that seriously impact on women's health.

Other DOH Critical Reform Areas In Women's Health

1. The biggest killers of women are cardiac and vascular diseases, cancer, respiratory diseases. 60-75% of deaths among women are caused by the above diseases. Women's health reform programs must focus on these killers and propose measures to bring down the number of deaths.
2. Girls need proper nourishment from infancy and childhood so that their normal reproductive functions are not impaired at childbearing age. Likewise, if our girls are to be competitive in the work-place, their brains have to be literally nourished from childhood. Needless to say, unhealthy and uneducated mothers produce unhealthy and disadvantaged children.

3. The contraceptive prevalence rate has gone down to 48.9% from 49.5% along with our growth rate, which has gone down from 2.36% to 1.9%. Lesser women are using contraceptives. The World Health Organization through its International Agency for Research on Cancer (IARC) has confirmed on July 29, 2005 that all estrogen-progesterone oral contraceptives (OCs), the most commonly prescribed contraceptives, are highly carcinogenic. (***Copy of WHO press release annexed***)

4. Majority of the maternal deaths have been attributed to the absence of skilled health personnel and dependable health facilities during childbirth, not to their inability to contracept. Only 60% of childbirths have been attended by health professionals, 40% only by doctors and 38% delivered at a health facility. Health reform must be intensified in this area.

5. Among the youth, the DOH does not teach sexual restraint or continence but promotes contraceptive use for “safe sex.” Consistent and advanced studies in the US and Africa have shown that the most effective way to curb teen pregnancies and the spread of HIV is through continence.

If the government must promote women's health, statistics must be the guide for promoting our women's well being. DOH must look at the biggest killers of women and see how these affect their maternal functions. And in the light of the new findings of the World Health Organization on contraceptive pills as being highly carcinogenic, the family planning component of the Women's Health and Safe Motherhood Program must be reviewed for the hazardous effects and the real the danger the continued use of pills will inflict on the lives of women.

Prospects for Meeting the MDG target for Maternal Health?

For the first target which is to reduce the maternal mortality rate by half by 2015, it appears eminently achievable. The Zero Maternal Death Project in Gattaran, Cagayan provides a model other municipalities and cities could follow to achieve the target. By setting up birthing centers in far barangays of the municipality with assured motherhood services, putting in place a Barangay council ordinance requiring pregnant women to give birth only in birthing homes with skilled birth attendants, installing a highly functional and reliable referral system to the municipal hospital with 24-hour service, ready to provide the necessary medical response to complications and the presence of community drugstores which assured availability of medicines and supplies for birthing requirements, made the project a total success. (***Gattaran project report annexed***)

Makati City, as a local government unit, also has a maternal health program which has allowed the city government to keep its maternal death rate at 3 deaths annually. With an efficient maternal health delivery system and an ever-increasing focus on the health requirements of its citizens, the city continues to commit itself to a zero-maternal death target as a health reform objective. (***Case study is annexed***)

For the second target, I have very serious reservations that this could be achieved. Money is not enough. There is need for an intensified advocacy and information- education campaign and budgetary support to finance the implementation of MDG 5. The WHO announcement regarding pills as highly carcinogenic is a problem as it will be totally unwise for DOH to push this method for spacing childbirth. The statistical increase in the incidence of cancer among women gives credence to the WHO findings and may just keep women away from using contraceptive pills. Aside from the medical and scientific arguments, the moral prohibition on the use of contraceptives among the faithful of the most numerous Church will also not help achieve the target.

Conclusion – Is There Funding for Maternal Health? And is the Funding Adequate to Achieve MDG Goal No. 5?

Asst. Sec. Mario Villaverde reported during the forum on financing MDGs that programs to improve maternal health in the Philippines include reproductive health and family planning services, micronutrient supplementation for the pregnant and lactating women, tetanus toxoid vaccination of pregnant women and the establishment of BEMOCs (Basic Emergency Management Obstetric Care) and CEMOCs (Comprehensive Emergency Management Obstetric Care). “Improving access to modern contraceptive methods for an estimated 11.8 million married couples of reproductive age would entail an amount of **P4,604 billion** annually with only around **P54 million** provided by the DOH and more than **P1 million** support coming from ODA. A huge amount of **P4.548 billion** is needed to address the budget gap.” (*Villaverde 2005*)

“Under micronutrient supplementation for pregnant and lactating women, around **P155.86 million** is required to provide Vitamin A capsules and Iron tablets to 2.6 million lactating women and 3.03 million pregnant women. **Only P16 million** from DOH and **P7.758 million** is available from ODA to address this need. A **gap of P132 million** needs funding support.” (*Villaverde 2005*)

“The tetanus toxoid vaccination of pregnant women is under the EPI and the funding for vaccine procurement of around **P37.599 million** is covered by the DOH.” (*Villaverde 2005*)

“The establishment of BEMOCs and CEMOCs is being funded by foreign agencies amounting to **P2.292 million** annually. A **gap of P26.220 million** per year is needed to finance the capability building of frontline workers for this program.” (*Villaverde 2005*)

An estimated amount of **P4.826 billion** is needed to improve maternal care in the country annually and only a small portion, around **P0.1 billion** is being funded by the DOH and donor agencies. An amount of **P4.707 billion** is necessary to **finance the gap** in improving maternal health in the Philippines, according to DOH's Villaverde. (***DOH Cost Estimates attached***)

With respect to the 5-year Women's Health and Safe Motherhood Program II, funding at close to **P1billion** has been provided by the World Bank and the Philippine Government counterpart fund. The program is at least assured of continuity and completion though, very definitely, dependent on foreign assistance.

"Meeting the resource requirements for the MDGs will entail collaborative effort of the national and local government units as well as the civil society especially in the areas that are lagging behind in reaching the goals and targets." (***Villaverde, 2005***)

Local government units and non-government sector participation has not been factored in arriving at funding sources for maternal health. Although "based on the Philippine National Health Accounts of 2003, the LGUs exceed DOH in financing the annual health expenditures in the Philippines." (***Villaverde 2005***)

What happens at the end of WHSMP II? Dr. Marivie Ala very happily explains that WHSMP would have accumulated sufficient data and experiences to allow a maternal health blueprint that could be used by other local government units to enable them to operate autonomously without foreign funding. There is also a proposed scheme to allow health centers to accept consignments of family planning merchandise for distribution without the government having to assume the cost of commodities. The entry of PhilHealth coverage as soon as upgrading of health facilities in the provinces has been implemented will also enable

local government units to continue working on the government's commitment to meet the targets set by MDG 5.

In the meantime, the conclusion we can derive from everything that has been said thus far is, there is funding available for MDG Goal 5 – but not enough.

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