People Count

PLCPD POLICY BRIEF

Philippine Policies on Maternal, Newborn, and Child Health and Nutrition:

Towards Achieving MDGs 4 and 5

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Introduction

In the Philippines, 3.4 million pregnancies occur every year, half are unintended, one-third of which end in abortions.[1] An estimated 11 mothers die of pregnancy-related causes every day, most of these deaths could have been avoided in a properly functioning health care delivery system. Among the leading direct causes of maternal deaths in the country are: post-partum hemorrhage, hypertensive disorders of pregnancy, abortion-related complications and obstructed labor. Beyond the glaring data of mortality lies a huge toll of ill health and disability due to pregnancy-related complications and infant and child deaths and deepening poverty in families where a mother has died. It is estimated that for every maternal death there is at least 20 to 30 other women who suffer from serious complications, some of which are life-long. Maternal health conditions are the leading causes of burden of disease among women.

Based on the State of the World's Children 2009 report of the United Nations Children's Fund (UNICEF), the Philippines is among 68 countries, which contributed to 97 percent of maternal, neonatal, and child health deaths worldwide.[2] Statistics also show that almost half of the deaths of Filipino children under five years old is within the first 28 days of life'[3] According to UNICEF, complications in childbirth are brought by hemorrhage, sepsis, hypertension and abortive outcomes, which are actually preventable.[4]

Due to these reasons, monitoring and evaluation (M&E) system in health programs play a crucial role in addressing the issue of maternal, newborn and child health and nutrition (MNCHN) for the Philippines to achieve Millennium Development Goals 4 (Reduce child mortality) and 5 (Improve maternal health). This paper identifies and discusses currently available data used to monitor the potential and actual effects of Philippine government policies on maternal, newborn and child health and nutrition (MNCHN) status. In addition, recommendations will be made on how to better meet the data needs for timely analyses of the effects of policy on Filipino mothers and their children. The paper also identifies critical gaps in MNCHN services and suggests a set of priorities for action to extend

and strengthen them. The aim of this paper is to provide access to, and understanding of, this information to help legislators, policymakers, and health professionals to plan effective MNCHN programs and mobilize additional resources to improve the lives of Filipino mothers, newborns, and children.

Maternal, Newborn, and Child Health and Nutrition in the Philippines

The quality of care that both mother and newborn receive during pregnancy, at delivery, and in the early postnatal period is essential to ensuring women remain healthy and that children get a strong start.[5] Many stillbirths and newborn deaths could be averted if more women were in good health, well-nourished, and receiving quality care during pregnancy, labor, and delivery, and if both mother and newborn received appropriate care in the postpartum period.[6]

Most recent government surveys reveal the following state of MNCHN in the Philippines:

1. *Fertility Trends* - The current fertility rate, according to the National Demographic Health Survey (NDHS) 2008 preliminary results, is at 3.3.[7] The NDHS 2008 also reports that fertility levels in the Philippines declined gradually in the last 15 years. The declines in the fertility rates of women ages 25 to 34 have continued to be more noticeable. The fertility rates of women ages 15-19 and 45-49 have remained almost unchanged in the last 15 years while the rate of birth remains higher among women aged 25 to 29.

2. *Maternal Mortality Trends* - According to the 2006 Family Planning Survey (FPS), the maternal mortality ratio for the seven-year period prior to the survey was 162 deaths per 100,000 births.[8] This implies a slight decline from the level of about 172 estimated from the 1998 NDHS. However, because of the 95 percent confidence intervals around the point estimates of the two surveys, the apparent decline cannot be considered statistically significant. The 2008 NDHS did not collect maternal mortality data.

3. *Infant and Child Mortality Trends* - Preliminary results of the 2008 NDHS show that there has been a decline in under-five mortality rate in 15 years, from 54 deaths per 1,000 live births during the period 1988-1992 to 34 deaths per 1,000 live births in the period 2003-2007. The infant mortality rate has declined, from 34 deaths per 1,000 live births to 25 deaths per 1,000 live births.[9]

Box 1. Facts on maternal; and neonatal health in the Philippines:

- 160 women for every 100,000 births die.
- Roughly over 11 women die every day.
- 7 out of 10 deaths occur at child birth or within a day after delivery.
- 4 out of 10 deaths are due to complications and widespread infections
- For every death, 40 more women get sick.
- 8 out of 10 births in rural areas are delivered outside a health facility.

Source: UNICEF Philippines website, http://www.unicef.org/philippines/8889.html

4. *Immunization of Children* - The 2008 NDHS preliminary report shows that overall, 80 percent of children ages 12-23 months have received all of the recommended vaccinations. Immunization coverage is generally high for each type of vaccine: 94 percent of children have received the BCG vaccination, 93 percent have received the first DPT dose, and 92 percent have received the first polio dose. Coverage against measles is 84 percent. Only 6 percent of children have not received any immunization, a decrease from 8 percent of children not immunized in 2003.

5. *Nutritional Status of Infant and Children* - The 6th National Nutrition Survey 2008 initial results show that among children under age five, 27.6 percent are underweight and 1.4 percent are overweight. Among pregnant and lactating women, 26.6 percent and 11.7 percent, respectively, are underweight. The prevalence of anemia among 6 months to below 1 year, and 1 year and 11 months old children, is at 66 percent and 53 percent, respectively. The prevalence of anemia among pregnant and lactating women is at 43.9 percent and 42.2 percent, respectively.[10]

   The 2008 NDHS results show that 8 percent of infants under two months old are not breastfed. Furthermore, only 34 percent of infants under 6 months old are being exclusively breastfed, most are mixed fed with other milk or plain water or given complementary feeding. By age 6-9 months, only 63 percent of infants are being breastfed with 58 percent receiving complementary food. Eighty percent of households (mothers) claim they are aware of iodized salt, but only 38 percent actually use iodized salt. The proportion of households whose salt tested positive for iodine is 56.4 percent.

6. *Childhood Illness* - Acute respiratory illness (ARI), malaria, and dehydration from diarrhea are the major causes of childhood mortality. In the 2008 NDHS, mothers were asked whether each child under age five had experienced cough with short, rapid breathing (symptoms of ARI), fever (symptom of malaria), or diarrhea in the two weeks prior to the survey and the treatment given to those who experienced the symptom. The survey results show that treatment was sought from a health facility or health provider for 50 percent of children with symptoms of ARI in the two weeks before the survey. The survey results also show that treatment was sought for 34 percent of children under age five who are reported to have had diarrhea in the two weeks prior to the survey, and 47 percent were given solutions prepared from packets of oral rehydration salts (ORS). Fifty-nine percent of children with diarrhea were given oral rehydration therapy (ORT), which includes solution prepared from ORS and recommended homemade fluids.

Global Mandates on Maternal, Newborn, and Child Health and Nutrition

The Philippines, together with the rest of the other nations, is a signatory to international conventions which recognize these rights such as the International Covenant on Economic, Social and Cultural Rights in 1976, the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) in 1979, the Convention on the Rights of the Child (CRC) in 1989, the International Conference on Population and Development (ICPD) in 1994, the Beijing Declaration, Platform of Action during the Fourth World Conference on Women (WCW) in 1995, and the Millennium Development Goals in 2000, among others. Most of these international conventions were ratified by the Philippine Congress/ Senate and, therefore, the country is bound to implement and report progress in achieving them.

International Conference on Population and Development

Access to reproductive health (RH) services is a human right. This is explicitly stated in the 1994 ICPD Programme of Action (PoA) of which the Philippine Government is a signatory to both. Against this background, the ICPD, through the PoA marked the willingness of the Philippine government, international community, and civil society to integrated SRHR concerns into all economic and social activities. The PoA of the 1994 ICPD, for example, calls on governments and international donor agencies to expand and transform existing programs, and to offer services that are comprehensive, integrated, universally accessible, and delivered in a manner consistent with health and rights objectives.

If maternal and neonatal mortality is to be reduced, a comprehensive program and strong political commitment are needed.

Effective advocacy to attract governments' attention and to mobilize resources is very important. Consistent with the principles of the 1994 ICPD, MDGs, and the UN's rights-based approach, three evidence-based approaches to maternal and neonatal mortality reduction have been recommended by UN agencies (i.e. WHO, UNICEF and the UNFPA) to address or avoid the delays in service delivery:

1. All women must have access to reproductive health services, including contraception to determine the number and spacing of their children;
2. Antenatal care, all deliveries, and post partum care must be attended by skilled birth attendant with timely access to quality emergency obstetric and newborn care, when needed; and
3. All mothers and newborns must benefit postpartum visits.

Millennium Development Goals (MDGs)

The Philippines has committed to fully support the Millennium Development Goals (MDGs) along with 191 other UN member states when it signed the Millennium Declaration in 2000, particularly on improved maternal and neonatal health by tracking progress on reducing maternal and child mortalities. The Goals include reducing under-five mortality by two thirds (Goal 4) and reducing maternal mortality ratio by three quarters (Goal 5) between 1990 and 2015.[11] In 2005, the UN General Assembly highlighted further the need to incorporate the attainment of universal access to reproductive health (RH) by 2015 under MDG 5.

Partnership for Maternal, Newborn, and Child Health

On September 12, 2005, the global Partnership on Maternal, Newborn, and Child Health (PMNCH) was officially launched. The PMNCH is an international alliance of some 280 governments, donors, NGOs, health care professionals, academics, and multilateral agencies. Its mission is to support the global health community to work successfully towards achieving MDGs 4 and 5 by advocating for national, regional, and global political commitments, and by raising funds to reduce maternal and child mortality. It enhances partners' interactions and uses their comparative advantages to: (1) build consensus on and promote evidence-based, high-impact interventions, and deliver them through harmonization; (2) contribute to raising US$30 billion (for 2009-2015) to improve maternal, newborn, and child health through advocacy; and (3) track partners' commitments and measurement of progress for accountability.[12]

Global Consensus for Maternal, Newborn, and Child Health

A new global Consensus for Maternal, Newborn, and Child Health, setting out five key action steps to save the lives of more than 10 million women and children by 2015, was launched on September 23, 2009 at a high-level event at the United Nations. The Consensus, strongly endorsed by the Group of Eight (G8) at its meeting in Italy in July, was agreed this year by a broad range of governments, NGOs, international health agencies, and individuals, through the PMNCH, and formally launched by Dr. Margaret Chan, Director-General of the World Health Organization (WHO).[13] The UN event, attended by several heads of state, heads of government, and other dignitaries, reflected the united political will of the international community.

Political will is in fact the first of five pillars of the global Consensus, which lists the priority actions that are needed to accelerate progress on the MDGs for maternal and child health. They are: (1)

political leadership and community engagement; (2) a quality package of evidence-based interventions, delivered through effective health systems; (3) the removal of barriers to access, with services ideally being free at point of use for all women and children; (4) skilled and motivated health workers, in the right place at the right time; and (5) accountability for results.[14]

Legal Bases

1987 Philippine Constitution.

The Philippine constitution has mandated the state to provide a comprehensive and accessible healthcare program to every citizen. The constitution also prohibits any discrimination due to religion and beliefs. The State has the responsibility to provide information, assistance, and access to all types of FP methods. Thus, the government is expected to develop policies including health programs based on these general principles.

Under the 1987 Constitution Article 13, Sec. 11: The State shall adopt an integrated and comprehensive approach to health development which shall endeavor to make essential goods, health, and other social services available to all people at affordable cost. Moreover, Sec 14 states that the State shall protect working women by providing safe and healthful working conditions, taking into account their maternal functions, and such facilities and opportunities that will enhance their welfare and enable them to realize their full potential in the service of the nation.

Though not directly specifying the state duty on maternal and child health, the 1987 Philippine Constitution clearly mandates the government to promote it by fulfilling its mandate on the health of the people in general. Section 15 of Article II expresses this state's duty: "The state shall protect and promote the right to health of the people and instill health consciousness among them."[15]

It is only in the 1987 Philippine Constitution where health was enshrined as a fundamental right of all Filipinos, particularly the poor. In the 1973 Constitution, it was only included as part of the social services. In the 1935 Constitution, there was no mention of it.

1991 Local Government Code

With the passage of the 1991 Local Government Code (LGC), health services delivery was devolved to the LGUs. Corresponding to the new powers and functions of the different structures of the health sector are the new responsibilities that each LGU should assume. This assumption of new powers, functions, and responsibilities (to be discussed later in the institutional analysis) entails an institutional restructuring of the DOH as the main national agency responsible for overseeing health services delivery, financing, regulation, and governance of the health sector. The 1991 LGC mandates DOH to continue to "formulate policies, standards, and regulations, as well as provide tertiary care in tertiary hospitals and special hospitals, while the LGUs are responsible for the primary and secondary cases in the hospitals and some of the general tertiary hospitals, which are provided by the provincial hospitals"[16]

Complementing the new functionality of the LGUs are the local health boards (LHBs). These are special bodies that exist in all levels of LGUs, except in the barangays. An LHB is composed of the local chief executive (i.e., governor for the provincial health board,

city mayor for the city, and municipal mayor for the municipality) as chair; local health officer (i.e., provincial, city, or municipal health officer) as vice-chairperson; the committee chair on health of every local legislative body *sangguniang panlalawigan* (provincial board), *sangguniang panlunsod* (city board), and *sangguniang bayan* (municipal board), a representative from the private sector or NGO involved in health services, and a DOH representative (provincial, city, or municipality). The main function of the LHB is to formulate policies on budget allocations and act as advisory committee for the *sanggunian*.

Magna Carta of Women (RA 9710)

On August 15, 2009, Philippine President Gloria Macapagal-Arroyo signed Republic Act 9710, also known as the Magna Carta of Women, which is a comprehensive women's human rights law that seeks to eliminate discrimination against women by recognizing, protecting, fulfilling, and promoting the rights of Filipino women, especially those in the marginalized sectors. All rights in the Philippine Constitution and those rights recognized under international instruments duly signed and ratified by the Philippines, in consonance with Philippine laws, shall be rights of women under the Magna Carta of Women. These rights shall be enjoyed without discrimination since the law prohibits discrimination against women, whether done by public and private entities or individuals.

Features of the law include:

1. *Comprehensive health services and health information and education* covering all stages of a woman's life cycle, and which addresses the major causes of women's mortality and morbidity, including access to among others, maternal care, responsible, ethical, legal, safe and effective methods of family planning, and encouraging healthy lifestyle activities to prevent diseases;
2. *Leave benefits* of two (2) months with full pay based on gross monthly compensation, for women employees who undergo surgery caused by gynecological disorders, provided that they have rendered continuous aggregate employment service of at least six (6) months for the last twelve (12) months;
3. *Equal rights in all matters relating to marriage and family relations.* The State shall ensure the same rights of women and men to: enter into and leave marriages, freely choose a spouse, decide on the number and spacing of their children, enjoy personal rights including the choice of a profession, own, acquire, and administer their property, and acquire, change, or retain their nationality. It also states that the betrothal and marriage of a child shall have no legal effect.
4. *Review amendment or repeal of laws* that are discriminatory to women.
5. *Mandate access to information and services* pertaining to women's health.

There are several other national laws and issuances that support maternal and child health interventions and services in particular, and public health affecting maternal and child health in general. Among these are:

- Newborn Screening Law (RA 9288);
- An Act Increasing Maternity Benefits in Favor of Women Workers in the Private Sector (RA 7322);

- Magna Carta of Public Health Workers (RA 7305);
- Barangay Health Workers' Benefits and Incentives Act of 1995 (RA 7883);
- The Paternity Leave Act of 1995 (RA 8187); and
- Philippine Midwifery Act of 1992 (RA 7392).

Other MNCHN-related government issuances are:

- maternal package for normal spontaneous vaginal delivery in non-hospital facilities (PhilHealth Circular No. 6);
- supplemental guide for "*Garantisadong Pambata*" (DOH Circular 265-A);
- setting standard labeling for breastmilk substitutes, infant formula, other milk products, foods and beverages (DOH Circular 2008-0006);
- Bright Child Program (EO 286); and
- national commitment for "*Bakuna and Una sa Sanggol at Ina*" (EO 663).

Government Policies and Programs

Integrated Maternal, Neonatal, and Child Health and Nutrition Strategy

The health of mothers and children were placed at the center of health sector reform, consistent with the advocacy that all women have the right to safe and quality emergency obstetric services (EmOC) to prevent maternal and newborn deaths, and achieve the MDG target to cut maternal and child deaths by 2015.

With pregnancy and childbirth posing serious risks to Filipino mothers and their newborn, the country recognizes the need to accelerate the reduction in maternal and child mortality. In response to this need, the Department of Health (DOH) has initiated key health reforms for the rapid reduction of maternal and neonatal mortality through the DOH Administrative Order (AO) No. 2008-0029 on Implementing Health Reforms for Rapid Reduction of Maternal and Neonatal Mortality.[17] This mandates the implementation of an *Integrated Maternal, Neonatal and Child Health and Nutrition Strategy* within the framework of the F1. It adopts a unified strategic framework for maternal and newborn health that is linked with child survival strategies, maximizing the delivery of service packages, and ensuring a continuum of care across the life cycle stages. Under this strategy, all pregnancies are considered at-risk. Likewise, it takes into consideration the three major pillars in reducing maternal mortality and morbidity, namely, emergency obstetric care, skilled birth attendants and family planning.

AO 2008-0029, issued on September 9, 2008, outlines specific actions for national and local health systems to systematically address health risks with the end goal of rapidly reducing maternal and neonatal deaths. It states that the "strategy shall guide the development, implementation, and evaluation of various programs aimed at women, mothers and children, with the ultimate goal of rapidly reducing maternal and neonatal mortality in the country."[18] It aims to address service delivery, regulation, financing, and governance of the Philippines' health system. The integrated MNCHN strategy, implemented in all provinces and cities, is aimed to meet the following reproductive health (RH) indicators by 2010:

- increase CPR to 60 percent;

- increase the proportion of pregnant women having at least four antenatal care visits to 80 percent;
- increase skilled birth attendance and facility-based births to 80 percent; and
- increase percentage of fully-immunized children to 95 percent.

On September 18, 2009 the Philippines' Department of Health (DOH) announced that the three United Nations (UN) agencies - UNFPA, UNICEF, and WHO - have joined forces and resources to undertake a joint program on rapidly reducing maternal and neonatal deaths in the country and meet the MDGs. The new project, with the support of the Australian Agency for International Development (AusAID) is divided into two significant phases: the Transition period (2009-2011), which will cover the provinces of Eastern Samar, Ifugao, Lanao del Sur, Maguindanao, North Cotabato, and Saranggani, and the urban poor areas in Tacloban, General Santos, Taguig, Navotas, Parañaque and Makati; and the Full Operationalization Period covering the years 2011-2016.[19]

On December 7, 2009, the DOH released a new Administrative Order on the subject "Adopting New Policies and Protocol on Essential Newborn Care (ENC)," which details specific policies and principles to follow for all health care providers involved in newborn health care.[20] Consistent with AO 2008-0029, the newly-released AO will provide key behaviors and appropriately-timed interventions to make the post-natal period for newborns safer. It is also seen to help pave the way for a globally accepted, and evidence-based essential newborn care health system.

Women's Health and Safe Motherhood Project

As a measure to accelerate efforts on MMR reduction, the Philippine government has adopted Women's Health and Safe Motherhood as its flagship program under the sector-wide F1 for Health with the help of other stakeholders such as the World Bank, ADB, EU/GTZ, JICA, USAID, WHO, UNICEF, and UNFPA. The Second Women's Health and Safe Motherhood Project (WHSMP2) will contribute to the national goal of improving women's health by: Demonstrating in selected sites a sustainable, cost-effective model of delivering health services that increases access of disadvantaged women to acceptable and high quality reproductive health services and enables them to safely attain their desired spacing and number of children. The main objectives of the WHSMP2 in the Philippines are the following:

1. To increase the access of disadvantaged women of reproductive age to acceptable, high quality, and cost-effective reproductive health services and enable them to safely attain their desired spacing and number of children; and
2. To assist in the development and implementation of sustainable and replicable systems within the framework of the Health Sector Reform Agenda for financing and delivery of reproductive health services.

Family planning

A national mandated priority public health program to attain the country's national health development: a health intervention program and an important tool for the improvement of the health and welfare of

mothers, children, and other members of the family. It also provides information and services for the couples of reproductive age to plan their family according to their beliefs and circumstances through legally and medically acceptable family planning (FP) methods.

Philippine National Strategic Framework for Plan Development for Children, 2000-2025 (Child 21)

The health sector's contribution to the Philippine National Development Plan for Children defines the vision for children by 2025, formulates cost-effective interventions, and outlines a budget that will reflect contributions of different national and local government units, the private sector, NGOs, and international organizations. It serves as a framework for local government units (LGUs) in the formulation of their development plans. Children's Health 2025, a subdocument of Child 21, realizes that health is a critical and fundamental element in children's welfare.

The vision of Child 21 has been concretized through the formulation of the National Plan of Action for Children for the period 2005-2010, aimed at reducing disparities in development indicators for children. Subsequently, there will be a National Plan of Action 2011-2015 (Catching up with the Millennium Development Goals); a National Plan of Action 2016-2020 (Sustaining the gains); and a National Plan of Action 2021-2025 (Achieving the Child 21 vision).

Early Childhood Care and Development Program

Republic Act 8980, known as the Early Childhood Care and Development (ECCD) Act of 2000, defines the ECCD System as the full range of health, nutrition, early education, and social services programs that provide for the basic holistic needs of young children from birth to age six (6), to promote their optimum growth and development. It encourages the active involvement of parents and communities. The implementation of this system shall be the responsibility of the national government, LGUs, NGOs, and private organizations. The rearing of a child is a traditional role of mothers. With the enactment and implementation of this law, raising a child is no longer solely the responsibility of mothers. The community, the national and local governments, and other institutions are now obliged to assist in providing for the basic holistic needs of young children. ECCD programs include: child care programs; parent effectiveness seminars; child minding centers; family day care services; parent-child development programs; and kindergartens in public schools.

Promotion of Breastfeeding program / Mother and Baby Friendly Hospital Initiative

Realizing optimal maternal and child health nutrition is the ultimate concern of the Promotion of Breastfeeding Program. Thus, exclusive breastfeeding in the first four to six months after birth is encouraged as well as enforcement of legal mandates. The Mother and Baby Friendly Hospital Initiative (MBFHI) is the main strategy to transform all hospitals with maternity and newborn services into facilities which fully protect, promote, and support breastfeeding and rooming-in practices. The legal mandate to this initiative are the RA 7600 (The Rooming-In and Breastfeeding Act of 1992) and the Executive Order 51 of 1986 (The Milk Code). National assistance in terms of financial support for this strategy ended in 2000, thus LGUs were advocated to promote and

sustain this initiative. To sustain this initiative, the field health personnel has to provide antenatal assistance and breastfeeding counseling to pregnant and lactating mothers as well as to the breastfeeding support groups in the community; there should also be continuous orientation and re-orientation/ updates to newly hired and old personnel, respectively, in support of this initiative.

Food Fortification program

The Food Fortification program is the government's response to the growing micronutrient malnutrition, which have been prevalent in the Philippines for the past several years. Food Fortification is the addition of *Sangkap Pinoy* or micronutrients such as Vitamin A, Iron and/or Iodine to food, whether or not they are normally contained in the food, for the purpose of preventing or correcting a demonstrated deficiency with one or more nutrients in the population or specific population groups. Micronutrients are vitamins and minerals required by the body in very small quantities. These are essential in maintaining a strong, healthy, and active body; sharp mind; and for women to bear healthy children.

Expanded Program on Immunization

Children who are not fully immunized are more susceptible to common childhood diseases. The Expanded Program on Immunization is one of the DOH Programs that has already been institutionalized and adopted by all LGUs in the region. Its objective is to reduce infant mortality and morbidity through decreasing the prevalence of six immunizable diseases (TB, diphtheria, pertussis, tetanus, polio and measles).

Government Financing for MNCHN

Health care financing system refers to various structures, methods, processes and procedures in which financial resources are made available to fund health sector activities, and how it is used on the delivery of health services. The purpose of health financing is to make funding available, to set the right financial incentives for providers, as well as ensure that all individuals have access to effective public health and personal health care.[21] Poor women, their children, and families use public-funded maternal and child health (MCH) services worldwide. However, with the decline in public-funded health services and the growing role of private-financed systems, poor women and their children are at risk of falling through the cracks of business-driven health systems.[22]

Based on the 2003 Philippine National Health Accounts (PNHA) estimates,

Box 2. State of Health Care Financing in the Philippines

Current health financing:

- Total health expenditures only 3% of GNP
- 59% from out-of-pocket payments
- 16% from national budget (DOH and ODA)
- 13% from LGU budgets
- 11% from PhilHealth

We are not spending enough on health

- 3% of Phil GNP vs. WHO 5% of GNP standard

the Philippine national government expenditures for preventive and public health services went to programs for prevention of communicable diseases (34%) and non-communicable diseases (23%), and maternal and child health (9%). Similarly, expenditures of foreign-assisted projects mostly paid for programs for prevention of communicable diseases (32%) and non-communicable diseases (23%), and maternal and child health (22%).[23]

The recent increases in the Philippines national health budget (approximately 100% in 2008 and an additional 30% increase in 2009) are changing the way that the Department of Health (DOH) makes fiscal transfers to regions and local governments. Starting in October 2008 the DOH moved away from input-based allotments in favor of performance based block grants. The RHR Department is supporting a rapid assessment of two of these performance based grants: grants to fund reproductive health commodities; and women's health teams. Results will be used by the government as it plans to increase substantially the use of performance based funding modalities for reproductive health as well as other priority health programs.

PhilHealth

The Philippine Health Insurance Corporation (PhilHealth) is the government agency responsible for managing the National Health Insurance Program (NHIP). As such, it is a major source of financing health services through its various benefit packages including the maternal care package for normal deliveries and the new born screening package.

PhilHealth provides a viable source for financing FP and maternal and child health services and products. The range of PhilHealth benefit packages include a maternity care package for normal deliveries that includes the first cycle of oral contraceptives, the first dose of injectable contraceptive postpartum, and the first dose of BCG for the infant. Philhealth also covers IUD insertion and voluntary sterilization. PhilHealth benefit packages also include a newborn care package that covers the cost of newborn screening. However, utilization of these benefit packages remains low. Furthermore, the issues on accreditation and reimbursement still need to be addressed.

FOURmula One for Health and MNCHN

In 2005, under national leadership of the DOH, based on a deeper understanding of

Box 3. Health Insurance Coverage

The Philippines' 2008 National Demographic and Health Survey (NDHS) included a module of questions concerning health care utilization and costs. Based on the NDHS 2008 results, only 42 percent of Filipinos are covered by some form of health insurance.

Source: National Statistics Office (NSO), and ICF Macro, 2009. National Demographic and Health Survey 2008. Calverton, Maryland: NSO and ICF Macro.

the requirements of implementation, and coordinated support from development partners, the Government formulated a new health reform implementation strategy, known as "FOURmula One for Health" (F1). The strategy organizes the reforms into four implementation components, namely: Health Financing, Health Sector Regulation, Health Service Delivery (covering both public health and hospital reforms), and Health Sector Governance in Health (covering DOH's internal management and its sector coordination and leadership role, of stewardship over the whole health system). The new implementation strategy emphasizes the role of PhilHealth's national social insurance program as the main lever to effect desired changes and outcomes in all four implementation components at national and local levels.

The objective of financing reforms under F1 is to secure more, better, and sustained investments in health to provide equity and improve health outcomes, especially for the poor.[24] Mobilizing additional resources for health will entail increasing revenue generation capacities of health agencies without compromising access by the poor. This may include revenues from user fees and charges for personal health care and regulatory services, and rationalized use of real property assets belonging to government health agencies.

F1 specified clear targets and identified priority projects and activities of the DOH for the medium and long term, emphasizing the needs to focus attention toward the attainment of the MDGs and the National Objectives for Health (NOH) for 2005-2010.

Monitoring and Evaluation

Government commitments to maternal and child health can be monitored using financial indicators and policy approvals. Investment in maternal health programs can be tracked by measuring inputs (such as midwifery training), outputs (such as the number of midwives posted) and processes (such as the uptake of skilled delivery care).[25] These indicators are necessary for planning, implementing and monitoring initiatives to improve maternal health.

The F1 strategy coordinates health reform more closely with public expenditure management and governance reform, including public procurement reform, and measures to increase transparency and accountability in public expenditure management. Reform implementation planning has been integrated with the formulation of a medium term Health Sector Expenditure Framework, and the annual budget process. A performance monitoring framework for DOH, PHIC, and convergence provinces, will link budgeting and resource allocation to outputs and intermediate results.

The DOH budget for family planning and maternal and child health has significantly increased in the last two years. While the DOH does not have a specific line item for procurement of contraceptives, the General Appropriations Act of 2008 has an earmark in the DOH budget P180 million to the DOH for operational costs associated with providing contraceptive services; P30 million for the routine functions of DOH in support of FP and, through congressional initiative, another P150 million to be sub-allocated to LGUs for purchasing RH commodities and conducting FP seminars.[26] The GAA of 2008 again had an earmark

in the DOH budget of P2 billion for contraceptives and related training, promotional and other costs. P1.2 billion of this earmark is for contraceptives and downloaded to the LGUs to facilitate LGU procurement of contraceptives. The guidelines for operationalizing this financing mechanism, while already developed, have yet to be fully understood by DOH staff and have yet to be uniformly applied across regions, with the exemption of ARMM where guidelines may have to be adjusted to respond to realities in the region.

Monitoring at the Local Level

Since 1991, DOH has also had to deal with the implementation of the Local Government Code, which devolved responsibility for the provision of social services, including health and family planning, to local government units (LGUs). LGUs are subdivided into 81 provinces, 136 cities, 1,495 municipalities and 42,008 barangays as of December 31, 2008.[27] The LGUs are grouped into seventeen (17) regions based on their geographical locations.

Provinces and cities are responsible for planning, overall coordination of population/family planning/maternal and child health (MCH) activities, and for family planning services provided through provincial and city hospitals. Municipalities are responsible for delivery of family planning/MCH services through a network of clinics and outreach services. Nearly all provinces and cities have a Population Office and a Health Office and staff responsible for planning and monitoring of family planning-related activities. These offices are also responsible for coordinating the efforts of NGOs to ensure the broadest possible coverage for services and to facilitate information transfer to the local and national MIS. The DOH has retained responsibility for overall monitoring and evaluation of local programs, projects, facilities, setting of standards, and for technical support services such as logistics, training, IEC, and information systems.

At the local level, a number of LGUs have budgets for FP and maternal and child health, including the procurement of contraceptives and essential maternal and child health drugs and supplies. This makes the LGU a significant market for private sector products. However, issues around procurement and willingness of suppliers to serve the LGU market still need to be addressed. Equally important is the availability of private sector providers in the community. While these are available, there is very little appreciation of the role of private sector in the delivery of basic public health services. Hence, the private sector is rarely tapped for family planning and maternal and child health services and local environments for private sector practice are not always favorable. Local policies for mobilizing the private sector in the delivery of public health still need to be developed and regulating systems are not strong.

Based on the monitoring of 87 municipalities and 41 independent cities conducted by the United States Agency for International Aid and Development (USAID), and the University of the Philippines School of Economics, the total amount released by the DOH to LGUs, as of May 15, 2009 amounted to P90,131,728.94 or 60.09 percent of the P150 million DOH budget

sub-allocated to LGUs under the GAA 2008 for purchase of RH commodities and conduct of FP seminars. Seventy seven percent of the municipalities and 63 percent of the cities that have been monitored have already accessed the funds.[28]

Policy Gaps

Low government expenditures for health

In 2005, the Philippines' total health expenditure went up by 9.4 percent, from P165.3 billion in 2004 to P180.8 billion in 2005. However, the share of health expenditure to GDP was lower at 3.3 percent in 2005 compared to 3.4 percent in 2004. It is still below the 5 percent standard set by the WHO for developing countries.[29] The WHO database showed total per capita expenditure on health in the Philippines was at $177 from 2000–2004. This is relatively low by comparison to neighboring countries like Malaysia ($355) and Thailand ($257).[30]

With increasing costs of health care, aggressive marketing of social health insurance, and growth of HMOs, health financing has become a major concern to ensure optimal mobilization of financial resources for health care. Health financing is one of the major programs under the F1 Framework that aims to acquire better and sustained health investments and provide equitable services and improve health outcomes especially for the poor.[31]

Lack of a comprehensive newborn health program

Instead of a comprehensive newborn health program, various interventions are embedded in maternal or child health programs. The scattered efforts weaken the potential political will and fiscal 'dedication' needed for adequate implementation, monitoring and evaluation.[32] All the above factors have created large gaps in maternal and newborn health. For example, antenatal care is limited, with low rates of tetanus toxoid immunization and iron and iodine supplementation, with virtually no folic acid supplementation. As a result, a large number of babies, including low birth weight infants, are at higher risk for morbidity and mortality. Coupled with this are low exclusive breastfeeding rates and poor feeding practices contributing to high neonatal, infant, and under-five mortality rates.

Lack of a national reproductive health law

In the Philippines, the passage of a national law to address the RH care needs of women still remains a major challenge. The devolution of health services, alongside the present administration's policy of leaving the responsibility of providing RH services to LGUs, resulted to major disparities in access to RH services. While some LGUs already have their own RH ordinances, there were recorded cases of local public health facilities denying women of information and services on the full range of contraceptive methods in other LGUs.

Government promotes natural family planning only

The Philippine constitution has mandated the state to provide a comprehensive and accessible healthcare program to every citizen. The constitution also prohibits any discrimination due to religion and beliefs. The separation between the church and state is mandated as well. There are many non-

Catholics the state must also serve. The State has the responsibility to provide information, assistance, and access to all types of FP methods. Thus, the government is expected to develop policies including health programs based on these general principles.

The government violates the constitution when it promotes and emphasizes particular programs that are discriminatory to certain groups either because of religious or political beliefs. The government's promotion of the natural family planning (NFP) method over the other methods available to our people is a de facto violation of our constitution in this regard. This policy is obviously designed to please the Roman Catholic church.

Policy Options and Recommendations:

Strengthen monitoring system at national and local levels

At the national level, policies and plans concerning maternal, infant, and child mortality outcomes should be monitored, including legislation and reforms, policies, and programs that promote healthy pregnancy, contraceptive services, and gender-based violence prevention. Equally important are indicators of stakeholder participation in determining and monitoring progress, which includes their role in communication, organization, training, supervision, planning, local and social management, emergency networks and referral systems, and budget appropriations.

National monitoring systems should, therefore, include:

- Advocating with national and local authorities the importance of having systems for regular maternal, infant, and child mortality monitoring;
- Selection of indicators and procedures, by consensus;
- Design and implementation of local and national maternal, infant, and child mortality monitoring plans; and
- Performance audits and maternal, infant, and child mortality monitoring processes.

Monitoring at the local level provides information for planning and improving interventions, and for building consensus among stakeholders: service providers, policymakers, women, community leaders, and local authorities. Local monitoring should include indicators of access to quality obstetric care, as well as socioeconomic determinants of risk of maternal deaths, such as health infrastructure, institutional and social responsibilities, levels of local government commitment, and community participation.

The monitoring of maternal, infant, and child death is the responsibility of health workers and community members who should represent different sectors and groups (age, sex, and ethnicity) to ensure the participation of the populations most affected by maternal, infant, and child deaths.

These stakeholders should organize committees that provide immediate information and actions for interventions to local authorities and program managers at the local, district, and health center levels. Monitoring committees play an important role in:

- Strengthening the information systems by involving community organizations;
- Selecting priority areas for intervention;
- Strengthening administrative

structures and resources for intervention implementation; and
- Introducing complementary methods of analysis such as qualitative research.

Increase investment for maternal and child health facilities and personnel

Essential to the MNCHN strategy are facilities that can provide basic emergency obstetric and neonatal care (BEmONC). These facilities operate on a 24-hour basis, and are accessible within 30 minutes of travel, equipped with communication and transportation systems for referrals. Every BEmONC facility should have a physician, nurse, and midwife. Also essential to the MNCHN strategy are the comprehensive emergency obstetric and neonatal care (CEmONC) facilities which are accessible within one hour travel time, operational on a 24-hour basis, and capable to carry out emergency responses. A CEmONC facility should be staffed with at least one obstetrician/surgeon, pediatrician, anesthesiologist, six nurses, medical technologist, and six midwives.[33]

Part of the additional investment needed to reach MDGs 4 and 5 should be allocated to recruit, train, equip, and deploy more health workers. Targets should be set for expanding the number of trained and properly equipped health workers in the country, particularly to meet the needs of the poorest and most marginalized communities.

On midwives, nurses and doctors:
- Upgrade skills of midwives, nurses and doctors for BEONC, BEmONC and CEmONC
- Mandates for midwives
- Develop as team of professionals
- Midwives at basic level
- Midwives, nurses and doctors at BEmONC and CEmONC

On TBAs and community health workers:
- Defining roles and incentives in "women's health team"
- Training TBAs as professional midwives
- Regulating TBA practices

The World Bank estimated that a total of three US dollars per person a year can provide basic family planning, maternal, and neonatal health care to women in developing countries.[34] The services would include:
- Routine maternal care for all pregnancies, including a skilled attendant (midwife or doctor) at birth;
- Medical training for traditional birthing attendants might be one way to help provide this service;
- Emergency treatment of complications during pregnancy, delivery, and after birth;
- Postpartum family planning and basic neonatal care;
- Educating women and their communities about the importance of maternal health care, and according women the social status to make health care decisions and seek medical attention;
- Any form of education, even 6 years worth of education for girls can drastically improve overall maternal health;[35]
- Research on social and psychological factors affecting maternal health; and
- Development of better interventions (and evaluations of interventions) for complex problems (e.g., behavioral, social, biological, cultural) arising in marginalized communities.

Expand PhilHealth's enrollment coverage

The NHIP should be further strengthened by expanding enrollment coverage, improving benefits and leveraging payments on quality of care. As the lead implementer of the health financing reform component, PhilHealth needs to recognize that changes in enrollment, benefits, and provider payments need to be well orchestrated to become effective. Moreover, PhilHealth has to recognize that it operates in local markets and would have to continue engaging partners at that level.

Involve health care professionals and their organizations

Health care professionals and their organizations have central roles to play in the partnership for promoting MNCHN. These organizations represent highly trained professionals (physicians, nurses, midwives, and pharmacists) with the following rules:

- They serve in all sectors: public, private, and non-governmental;
- They provide informed leadership in MNCHN, and constitute the core of health care for mothers, newborns, and children at national and local levels;
- They also have vital roles to play in the education and training of all levels of health care personnel.

Stronger involvement of males in MNCHN issues and services

Although Filipino men become visible in MNCHN issues, their roles often are peripheral. MNCHN advocates should seek the active involvement of men in finding solutions to the following problems in the country: (a) ending gender inequities; (b) promoting adequate child spacing intervals; and (c) reducing the levels of teenage pregnancy.

Promote public-private partnerships

In an increasingly business-driven health care environment, public health advocates face the major challenge of how to integrate health programs with population-based social, economic, psychosocial, and environmental services. To integrate these services, MNCHN advocates should emphasize the role of public-private partnerships at local, national, and international levels in addressing MNCHN issues. The ultimate goal of the partnership is to harness scarce public and private resources and to coordinate the use of such resources to meet the needs of MNCHN clients.[36] A public-private partnership can only be considered a success if it leads to measurable improvements in the health status of defined MCNCHN target populations. NGOs, multinational corporations, professional associations, and community-based organizations will become essential participants in these partnerships.

Pass a national reproductive health law

Couples have the right to information and access to the right contraceptive method at the right time and at the right place. Furthermore, it is estimated that there are

3.1 million pregnancies in the Philippines every year, half of which are unplanned, with one third ending in abortions. The passage of a RH national law seeks to bring down cases of maternal deaths by allowing better access to services on RH and FP, making FP commodities affordable, and providing information and education to women and couples on pregnancy and family planning. Strategies to reduce high levels of newborn mortality should be linked to policies and strategies in related fields, such as reproductive health, safe motherhood, child survival, and early childhood development, and incorporated in national health plans.

Conclusion

The health of women and their newborns and children are inextricably entwined. Neonatal deaths are frequently the result of poor maternal health, inadequate care during pregnancy, inappropriate management of complications during pregnancy and delivery, poor hygiene during delivery and the first critical hours after birth, and lack of newborn care. Several factors such as women's status in society, their nutritional status at the time of conception, early childbearing, frequent and closely spaced pregnancies, and harmful practices are deeply rooted in the cultural fabric of societies and interact in ways that are not always clearly understood.[37]

Government must be committed to support health programs of health-system administration at the national and local levels. Reductions in maternal, newborn, and child mortality are needed at the LGU level to achieve the ambitious MDG of reducing maternal and child mortality by three quarters and two-thirds, respectively, by 2015.

The issue of the sustainability of existing MNCHN program commitments must also be addressed. Enshrining national commitments in a legal framework can provide the necessary continuity in support of scaling up the continuum of care beyond the political lifespan of its initial champions. Development of maternal, newborn, and child health approaches should take place within a national policy framework (e.g. through a reproductive health law). This longer-term political agenda requires partnerships between government, civil society organizations, and development agencies to maintain the political momentum, overcome resistance to change, and mobilize resources. A well functioning health system also requires accountability mechanisms and checks and balances. Finally, sustained investment in both time and resources is required over many years to steadily take MNCHN programs to scale.

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