Health insecurity: a GMA legacy

► By MERCI L. FABROS*

AMONG the MDG targets, those directly related to health are the least likely to be met. Progress has been either slow or stagnating, while gains run the risk of reversal.

No mother or infant deserves to die at childbirth. This is a matter of right that the state is duty-bound to honor by any means possible. But government has been failing to deliver even only on its most basic MDG commitment to save mothers and infants.

Poverty and inequity are at the core of health insecurity. Filipino mothers who have less in life have less chances of surviving childbirth. And if they do survive, they are likely to be consigned to a life of health insecurity.

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Lack of progress

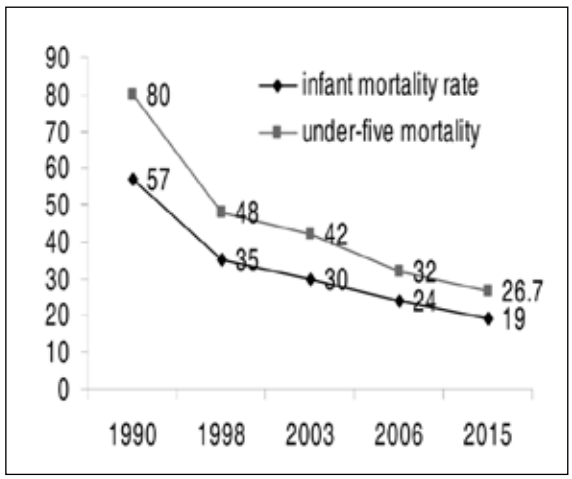
The Philippines has the worst health performance in the Asia, with infant mortality rate (IMR) and maternal mortality rate (MMR) being among the highest in the region. The state of maternal health is alarming, with MMR barely moving in the last five years and worsening in many poor provinces.

The maternal mortality target cannot be achieved by 2015. If we are to achieve our MDG target for maternal health, we need to reduce the maternal mortality rate (MMR) at a faster pace than our historical performance (based on actual rate of reduction between 1993 and 1998). Efforts to significantly reduce maternal mortality should be doubled in order to hit the target of reducing maternal deaths to 52 deaths by 2015 from 162 deaths per 100,000 births (2006 Family Planning Survey).

Maternal death and the slow decline in MMR are consequences of wide disparities in access to essential social services. Acute disparities, which tended to be hidden in national averages, manifest across regions. ARMM, Mimaropa, Eastern Visayas, Bicol and the Zamboanga islands have very high maternal and child mortality rates and the highest malnutrition rate in the country. Rich areas pull up national averages, failing to capture the reality of poverty and poor health conditions in these areas.

Goal 4: Reduce child mortality

The Philippines is reportedly on track to meeting the goal of reducing under-five mortality, claiming a high likelihood of meeting the target of 26.7 deaths per 1,000 live births by 2015.



Under-five mortality rate (U5MR) was 80 deaths per 1,000 live births in 1990, declining to 48 in 1998, 42 in 2003 and falling further to 32 deaths per 1,000 live births in 2006. Infant mortality has also been decreasing from 57 deaths per 1,000 in 1990, to 35 in 1998, to 30 in 2003 and 24 in 2006.

Year	Under 5 Mortality Rate (per 1,000 live births)	Infant Mortality Rate (per 1,000 live births)
1990	80	57
1991	77	55
1992	74	54
1993	72	52
1994	69	50
1995	67	49
1998	48	35
2003	42	30
2006 (FPS)	32	24

Source: National Statistics Office – 1998 & 2003 data: National Demographic and Health Survey; 1990 to 1995 data: TWG on Maternal and Child Mortality- National Statistical Coordination Board

Although there has been a decrease in both under-five and infant mortality rate, it is still high compared to other countries in the region. A recent survey by the National Statistics Office revealed that in 2003, "a child born in the Philippines is at greater risk of dying than children born in other Southeastern Asian countries".

Gains in under-five mortality at risk

Neonatal and Postneonatal Trend

Neonatal and postneonatal death, which makes up 71.4 percent of under-five mortality, registered the barest improvements over the past two decades. The combined number of deaths during the neonatal and post neonatal periods is almost thrice the number of deaths among 1-4 years old (12/1000 LB).

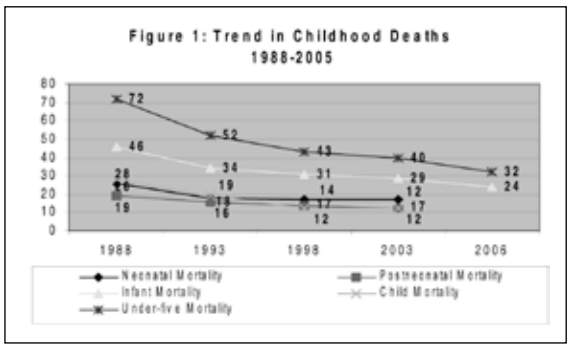
Neonatal Deaths. Of the total under-five deaths (42/1000 LB), more than two-thirds (29/1000 LB) occur before the children turn one year old. Of these, majority (17/1000 LB) die within 28 days upon birth, occurring mostly within the first week.

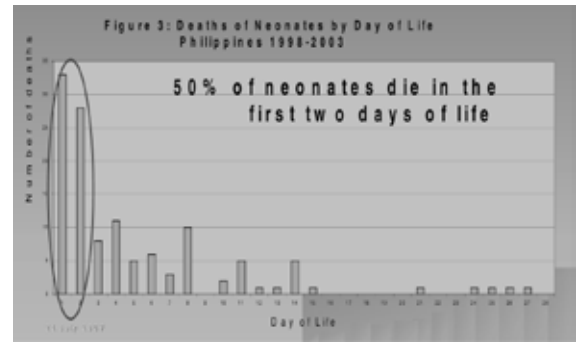
Further breakdown of the neonatal deaths by day of life shows that half of the neonatal deaths occur

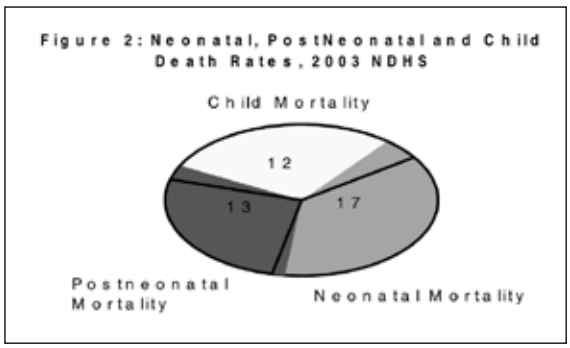
Infant and Child Mortality Rate in the Philippines & Other Countries,1990 & 2003

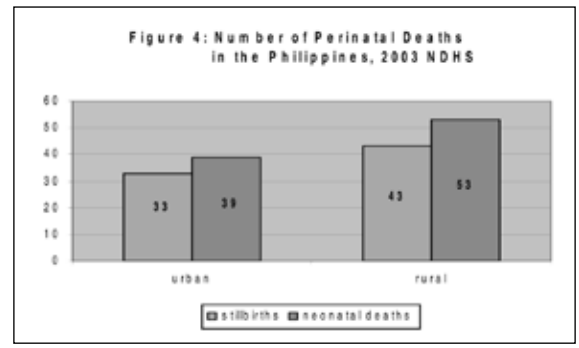
Country	Infant Mortality Rate (per 1000 live births) 1990	Infant Mortality Rate (per 1000 live births) 2003	Under 5 mortality rate (per 1000 live births) 1990	Under 5 mortality rate (per 1000 live births) 2003
Vietnam	36	19	51	23
Singapore	7	3	8	3
Thailand	34	23	40	26
Malaysia	16	7	21	7
Brunei	10	5	11	6
Philippines	**34**	**29**	**66**	**40**

Source: NSO, DHS 2003









during the first two days of life. This emphasizes how crucial is the quality of care that must be provided to newborns at this earliest stage of life outside their mother's womb.

Perinatal Deaths. The Philippines also suffers from a substantial number of perinatal deaths at 24 per 1000 pregnancies as reported in 2003 (NDHS).

Declining Proportion of Fully Immunized Children

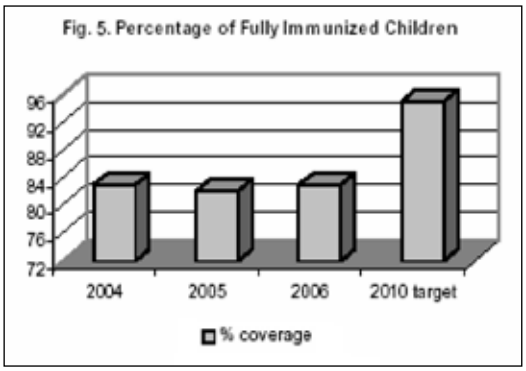
The improvement in the national averages of child health outcomes—in terms of lower infant and child mortality rates—has been attributed to the immunization program of the government since the 1990s, when a 90-percent coverage of fully immunized children (FIC) was achieved.

However, the proportion of fully-immunized children dipped from 71.5 percent in 1993, to 72.8 percent in 1998 to 69.8 percent in 2003 (NDHS). Also, while the proportion of the fully-immunized children as per the FHSIS reached 84.8 percent in 2004, that figure is still lower than the 95-percent target for the year (National Objectives for Health (NOH), DOH 1999). Moreover, the actual number of reported measles cases

in 2004 is 13,034. This is four times higher than the target number of cases for that year (NOH, DOH).

In addition, the proportion of children (7 percent) aged 12-23 months without vaccination remained at 8 percent (1998 NDHS).

Percentage of Fully Immunized Children



Source: Congressional Planning & Budget Department
2008 Budget Briefer

Declining Immunization Coverage Against Measles (under one year old)

Year	Proportion of children under 1-yr old immunized against measles
1990	77.9
1991	87.5
1992	89.6
1993	88.3
1994	87.1
1995	83.7
1996	89.8
1997	88.9
1998	84.8
1999	87.9
2000	86.5
2001	81.7
2002	76.0
2003	
2004	
2005	
2006	

Source: Department of Health-National Epidemiology Center/Field Health Service Information System (FSHIS)

Micronutrient malnutrition

In developing countries, the problem of malnutrition has been the cause of death of 60 percent of children less than five years old. Micronutrient malnutrition, particularly vitamin A, iron and iodine deficiencies, has been found to be prevalent in the Philippines (National Nutrition Survey, Food and Nutrition Research Institute, 1993, 1998, and 2003).

Various forms of malnutrition continue to afflict Filipino children as well as adults (National Nutrition Council). These include Protein-energy malnutrition (PEM), Iron Deficiency Anemia (IDA), Iodine Deficiency Disorders (IDD) and Vitamin A Deficiency Disorders (VADD).

Prevalence of Undernutrition by Age Group, 2003

Population group/Indicator	Percent
0-5 years old	
•□□□□□□□□*Underweight*	26.9
•□□□□□□□□*Stunting*	30.4
•□□□□□□□□*Wasting*	5.5
6-10 years old	
•□□□□□□□□*Underweight*	26.7
•□□□□□□□□*Stunting*	36.5
Pregnant women	26.6
Adults, 60 years and above	23.6

Source: National Nutrition Surveys of DOST-FNRI in 2003

Among preschoolers, 0-5 years old

- ➢····· 27 out of every 100 preschoolers are underweight
- ➢····· 30 out of every 100 are stunted or has lower height than that of normal
- ➢····· 5 out of 100 are wasted or thin

Among school-age children, 6-10 years old

- ➢····· 26 out of every 100 are underweight
- ➢····· 32 out of every 100 children are stunted

Based on the same survey, the prevalence of anemia among infants 6 months to less than one year is 66.2 percent (FNRI 2003), higher than in 1998 (56.6 percent). In addition, the prevalence of vitamin A deficiencies among children 6 months to 5 years of age increased from 35.3 percent in 1993 to 40.1 percent in 2003. Note that the prevalence of VADD increases by 20-24 percent a child's risk of dying with diarrhea and measles.

List of Nutritionally Vulnerable Regions (Fivims, 2004)

Island Groups	Luzon	Visayas	Mindanao
Cluster 3 Vulnerable (V)	**Region 1** ▪····***La Union*** **CAR** ▪····Abra ▪····Ifugao ▪····Mountain Province ***Calabarzon*** ▪····Quezon ***Mimaropa*** ▪····Marinduque ▪····Occ. Mindoro ▪····Palawan ▪····Romblon ***Region 5*** ▪····Albay ▪····Camarines Norte ▪····Camarines Sur ▪····Catanduanes ▪····Sorsogon	***Region 6*** ▪····Aklan ▪····Antique ▪····Iloilo ▪····Negros Occidental ***Region 7*** ▪····Bohol ***Region 8*** ▪····Leyte ▪····Eastern Samar ▪····Northern Samar ▪····Samar ▪····Southern Leyte	***Region 9*** ▪····Zamboanga del Sur ***Region 10*** ▪····Camiguin ▪····Misamis Occi. ▪····Lanao del N. ***Region 11*** ▪····Davao del N. ▪····Davao del Sur ***Region 12*** ▪····Cotabato ▪····Sarangani ▪····South Cotabato ▪····Sultan Kudarat **Caraga** ▪····Agusan del Norte ▪····Agusan del Sur ▪····Surigao del Norte ▪····Surigao del Sur
Cluster 4 Very Vulnerable (VV)	**CAR** ▪····Apayao	***Region 6*** Capiz ***Region 7*** ▪····Negros Oriental	***Region 9*** ▪····Zamboanga del Norte ***Region 10*** o Bukidnon ***ARMM*** ▪····Lanao del Sur ▪····Maguindanao ▪····Basilan
Cluster 5 Very, Very Vulnerable (VVV)	***Region 5*** ▪····Masbate		***ARMM*** o Sulu o Tawi-Tawi

Source: NNC 2006 Briefing Kit; www.nnc.gov.ph

Food insecurity scenario

Based on the results of the Food Insecurity and Vulnerability Information and Mapping Systems (Fivims) under the National Nutrition Council (NNC), food insecurity in the Philippines is prevalent in varying degrees in 49 provinces: with 38 provinces labeled Vulnerable, 8 provinces Very Vulnerable, and 3 provinces Very, Very Vulnerable as shown. Only 18 provinces (23.4 percent) and (13 percent) were not vulnerable and less vulnerable, respectively.

These nutritionally vulnerable provinces are also some of the country's poorest provinces, and nine of them belong to the top 10 poorest provinces in the country (NSCB, 2003).

Breastfeeding and IMR

Breastfeeding in the first hour of birth can prevent 22 percent of neonatal deaths, while breastfeeding within the first day of life prevents 16 percent of neonatal deaths (Journal in Pediatrics, Ghana). Almost half of deaths of children under-five are neonatal deaths. In the Philippines, there has been no change in the prevalence of breastfeeding since 1993, which is 87 percent in 2003 (NDHS). This figure includes children

who were breastfed for only an hour, a day or a week, and includes as well those children given liquid or food other than breastmilk within the first 72 hours of life (3.4 million Filipino children). Exclusive breastfeeding is down to 6 percent and a staggering 15 percent of infants were never breastfed.

According to Unicef and the World Health Organization (WHO), the Philippines is one of 42 countries that account for 90 percent of under-5 deaths globally. The Department of Health said that of these deaths, "16,000 deaths could be prevented with, first, the initiation of breastfeeding in the first hour of life; second, by exclusively breastfeeding the infant for the first six months; and third, for a mother to continue with breastfeeding and appropriate complementary feeding until a child reaches two years of age" (Babao-Guballa, 2007).

Breastfeeding does not only save the child, but the mother as well. Due to the hormonal effects of breastfeeding, a mother develops lactational infertility, a period when the mother does not become pregnant. The more the infant suckles and is exclusively breastfed, the greater the effect.

The mother also develops lactational amenorrhea, a postnatal period when the mother does not menstruate due to the same hormonal effects of breastfeeding. Lactational amenorrhea reduces menstrual blood loss, thus prevents anemia by conserving the mother's iron stores. Longer birth intervals reduce the risk of maternal and infant mortality.

Breastfeeding immediately after delivery increases the levels of oxytocin, which stimulates contraction of the uterus, thereby reducing blood loss and risk of hemorrhage, a major cause of maternal mortality.

Goal 5: Improve maternal health

Target 6: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio.

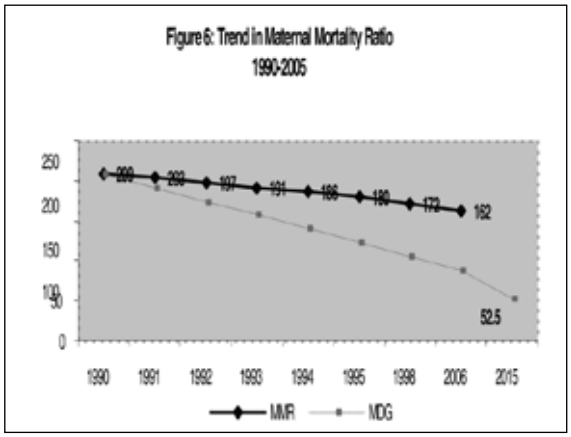
While there has been some progress in child mortality targets, improvement in maternal health is nil. Maternal death remains a significant cause of death in the Philippines, comprising 14 percent of the total deaths of women aged 15-49 years old (2003 PPR on MDG). MMR is unacceptably high and yet decline in maternal death over the past 20 years has been very slow at 22.5 percentg or at 1.6 percent per annum over 18 years (2006 FP Survey).

Maternal Mortality Rate, 2001 data

Country	Ratio
Philippines	170
Thailand	44
Malaysia	41
South Korea	20
Japan	8

Source: Dr. Manuel M. Dayrit's presentation on the International Conference on Population and Development at 10 (4 October 2004 t the Heritage Hotel)

Although MMR has declined from 209 in 1993 to 162 in 2006, the rate of reduction is still critically off-track, given the MDG target of 52 maternal deaths per 100,000LB.



MMR is higher in poor provinces. Regional figures show MMR at 320/100,000 to 119/100,000. The MMR for ARMM is 320/100,000 in 1998, nearly three times the rate in Metro Manila (ADB, 2005). The morbidity picture reflects this regional disparity.

Life-and-death issues for mothers and children

Access to EmOC

About 85 percent of maternal deaths are due to direct complications that require emergency obstetrics care (EmOC). Such care has three essential elements: a skilled attendant at delivery; access to emergency obstetric care (EmOC) 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.

Access to this package of critical services is sorely lacking, especially for poor women.

Abortion dilemmas

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 services that terminate a pregnancy are nonexistent. Thus, women resort to illicit abortions and run the risk of acquiring life-threatening complications. Unless contraceptive commodities and FP services become more available and accessible and women are provided quality post-abortion care, this country will not be able to lower its maternal mortality.

In the Philippines, about 3.1 million pregnancies occur each year and nearly half of these pregnancies are unintended and about one-third ends up in abortion. In 1994, abortion reached a total of 400,000 cases, with teenagers accounting for 17 percent of these cases. Based on DOH records, abortion has also become the fourth leading cause of maternal mortality, representing 12 percent of all maternal deaths resulting from complications related to abortion. It remains the third leading cause of hospital discharges.

Fertility and mortality

Reducing the number of pregnancies prevents maternal deaths. "One in three deaths related to pregnancy and childbirth could be avoided" if all women have access to FP/contraceptive services, as pointed out by UNFPA.

Contraceptive use among married women has almost tripled over the last three decades, although the Contraceptive Prevalence Rate (CPR) or the proportion of women using any FP method in 2006 is 50.6 percent, a rate that has not changed in the last six years. Based on the FP Survey in 2001, only half of Filipino married women are using FP methods. For every 100 married Filipino women who are not using any FP method, nine do not want more children and eight want to space births.

Filipino women have consistently had one more child than they wanted (NDHS 1993, 1998, and 2003). In 2003 an average Filipino woman wanted 2.5 children but had actually 3.5 children, higher among rural women at 4.3 compared to urban women at 3.0. The difference between the desired and actual number of children translates to about 800,000 unwanted births.

The unmet need for family planning in the Philippines is at 15.7 percent in 2006, of which 8 percent is for spacing. The level of unmet need has declined from the 20 percent level in 1998; 17 percent in 2003; and 15.7 percent in 2006 (Philippines National Demographic and Health Survey 2003).

The Population Commission also pointed out an increasing incidence of teenage pregnancy. Reports show that 10 percent of all births involve girls from ages 15-19; and 23 percent of adolescents aged 15-24 engage in premarital sex.

The use of any FP method increases with rise in wealth and educational status. More than half of women with at least a high school education use contraceptives, compared with less than one in five women with no formal education.

More than two thirds of current users of modern methods get their contraceptive supplies from public sources (67 percent), 29 percent from a private medical source and 3 percent from other sources. Compared with data from the 1998 NDHS, there has been a decrease in reliance on the public sector (from 72 percent) and an increase in use from the private sector (from 26 percent). The Botika ng Barangays do not include in their list essential and affordable family planning commodities.

Maternal mortality could drop by 20-35 percent given access to full information, options, effective contraception.

The DOH Natural Family Planning Program

The Catholic Church has been a dominant influence on the government's family planning program. The

government's declaration of natural family planning as its flagship program is one clear indication. As a result, the DOH has to manage countervailing natural and artificial family planning programs, budget, personnel, processes and outcomes.

The DOH is taking a tentative position towards artificial contraception, if not shying away from it altogether. Thus, an unclear delineation of family planning responsibilities has ensued between the national and local government units. Donated contraceptive commodities are being phased out.

The Popcom tells LGUs and the public that natural family planning is its de facto policy, contradicting policy pronouncements by national government about informed choice.

Low quality and under-funded government health services

Geographic maldistribution of health resources, low quality of government facilities, inadequate funding, health expenditures dominated by personal health and out-of-pocket payments are outstanding features of the Philippine health service system.

Quality health care services, both preventive and curative, are the cornerstone for building human capital. The 2002 Annual Poverty Indicator Survey (APIS) showed that the health facilities most utilized by the bottom 40-percent income bracket were the public health units in both rural and urban areas. The poor tend to go to government-run primary facilities rather than private clinics or hospitals for their health needs because private health facilities are prohibitively expensive. Access is a major problem. Quality private health care is centered in urban areas.

There are wide disparities in the allocation of health resources. Two main factors play a role in access: availability of facility/personnel, and affordability. Health facilities and personnel are mostly unavailable, poorly distributed, and unaffordable.

Availability of facilities

Considering a population of 87 million, about 700 to 800 BEmOCs are needed to cover those far-flung areas and island municipalities. However, the country has only 169 BEmOC facilities, with a measly 33 CEmOC facilities.

List of Provinces with corresponding BEmOC and CEmOC facilities

Provinces	BEmOC Facilities	CEmOC Facilities
Capiz	19	2
Ifugao	29	2
Isabela	5	4
Masbate	6	2
Mindoro Oriental	18	3
Msamis Occidental	7	3
Mt. Province	20	3
North Cotabato		
Romblon	9	5
Sorsogon	12	2
South Cotabato	11	1
Sultan Kudarat	24	3
Surigao del Sur	9	3
Total: 13	169	33

Source: Presentation of Director Yolanda Oliveros, National Center for Disease Prevention (NCDP), DOH 2007 at WomanHealth Philippines Roundtable Discussion on Maternal Mortality Reduction (MDG5) and the 2008 Health Budget, 25 July 2007, AIM

Based on the recently concluded consultative workshop on BEmOC, a total of 177 CEmOC and 709 BEmOC facilities are needed using the recommended facility population ratios. Most of the provinces and key cities have existing CEmOC facilities but they need upgrading. As to progress on BEmOC, only about 12 percent of the minimum target of 90 facilities is being developed. Training facilities for BEmOC have already been identified in strategic areas across the country.

Eight of 19 medical centers are located in Metro Manila, with the rest scattered across provinces. There are only 12 regional hospitals in the country's 16 regions. Almost all specialized hospitals are situated in Metro Manila (11 out of 12), except for one in Cebu (V. Bautista, UP Press; 2002).

Unequal distribution and lack of health service providers

Health personnel are sorely lacking and unequally distributed in rural and urban areas. Only 10 percent of doctors, dentists and pharmacists, 20 percent of medical technicians, and 30 percent of nurses practice in rural areas (World Bank, 2001c).

The ARMM, Region X1 (Southern Mindanao) and Caraga are the most deprived of doctors (Philippine Statistical Yearbook 2004). The National Capital Region (NCR) has the most number of doctors, nurses and dentists.

Regional Distribution of Health Human Resources employed in the government sector: Philippines, 2002

Region	Doctors	Nurses	Dentists
CAR	85	159	33
NCR	658	745	540
Region 1	158	203	96
Region 2	175	267	58
Region 3	297	382	161
Region 4	350	648	256
Region 5	190	338	85
Region 6	226	433	112
Region 7	229	379	115
Region 8	153	233	109
Region 9	90	196	55
Region 10	99	189	71
Region 11	79	161	71
Region 12	84	158	32
ARMM	69	99	23
CARAGA	79	130	54
Phil.	3,021	4,720	1,871

Source: 2004 Philippine Statistical Yearbook, NSCB

Delivery assistance

The presence of a skilled attendant at delivery is an essential element of the EmOC strategy for reducing maternal mortality. At the same time, it is a process indicator that is used as a global benchmark to monitor progress towards the goal of maternal mortality reduction as agreed upon at ICPD+5. It has also been adopted by the Social Watch International as an indicator of the Basic Capacity Index.

Year	Proportion of Births attended by skilled health personnel
1990	58.8
1991	59.7
1992	59.7
1993	60.0
1994	60.9
1995	62.7
1996	64.1
1997	65.0
1998	69.2
1999	69.5
2000	69.0
2001	69.1
2002	67.0
2003	60.0

Source: National Statistics Office 1993 & 1998 data: National Demographic & Health Survey; 1995 to 1997 & 1999 to 2002 data: Family Planning Survey

Coverage of births attended by a health professional has increased in the last five years from 56 percent in 1998 (NSO, DOH, and Macro International Inc. 1999), to 59.8 percent in 2003. This is way below the target set by DOH at 80.0 percent in 2004.

In Metro Manila, professional health workers attended to 92 percent of births; in contrast, in ARMM, only 16 percent of births were attended by health professionals. The 2002 MCHS shows that TBAs *(hilots)* are still the most reliable resource during childbirth, delivering 39 percent of total. For poor Filipino families, TBAs continue to be the cheaper alternative to professional midwives. However, TBAs are only able to provide very basic essential obstetric care and their

Percentage of Live Births Delivery Assistance by Birth Attendants (in percent)

	1993	1998	2003	ARMM	MIMAROPA	EASTERN VISAYAS
Health professionals	52.8	56.4	59.8			
Doctor	26.0	30.9	33.6	8.5	13.7	16.4
Nurse/midwife	26.8	25.5	26.2	0.8 /12.4	3.2 / 12.4	1.4 / 18.2
Traditional birth attendant	45.3	41.3	37.1	76.6	66.3	62.3

Source: NDHS cited in 2007 DOH Paper

functional knowledge is limited to assisting normal childbirths.

A skilled attendant, according to the WHO, refers to "an accredited health professional, such as a midwife, doctor or nurse, who has been educated and trained to proficiency in the skills needed to manage normal pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns". Traditional birth attendants (TBA)—trained or not — are excluded from the category of skilled health-care workers. In this context, the term TBA refers to traditional, independent (of the health system), nonformally trained and community-based providers of care during pregnancy, childbirth and the postnatal period.

Stagnating and deteriorating key maternal interventions

Antenatal health care

NDHS shows that overall, 88 percent of women had antenatal care. There are regional variations in antenatal coverage, with ARMM exhibiting the lowest coverage (49.8 percent), while the Zamboanga Peninsula has 77.1 percent. Central Luzon (92.4 percent) and the NCR (92.1 percent) have the highest antenatal care coverage. However, key maternal interventions have not improved across the years but have generally stagnated, if not deteriorated. Women did not receive comprehensive and quality care

Given such high antenatal rate in antenatal clinic, policy makers and program managers ought to exploit and maximize the opportunities that such rates present. If strong linkages between antenatal care and EmOC are established, then women will at least have a chance of surviving complications that arise during pregnancy and childbirth.

DOH recommends all pregnant women to have at least four prenatal visits, with emphasis that for early detection of pregnancy-related health problems, the first antenatal checkup should occur in the first trimester of the pregnancy. The 2003 NDHS shows that almost three fourths (70.4 percent) of women had at least four prenatal visits, but only a little more than half (53.0 percent) had their first visit during the first trimester. The percentage of children whose mothers received two or more doses of TT immunization during pregnancy has been decreasing from 42.2 percent in 1993 to 37.3 percent in 2003.

Only half (49.1 percent) were informed of pregnancy complications and 57 percent were not told where to go for proper care. Though the percentage of women receiving iron supplementation is quite high, issues on the late takeup of the iron tablets/syrup (usually on the fourth to fifth month of pregnancy) and the compliance with completing five months of supplementation remain a challenge in the quality of prenatal care being accessed by the pregnant women.

Disturbing is the noncontinuity of services from prenatal to delivery to postnatal. Of the total 87.6 percent of pregnant women who sought prenatal care from a health professional (2003 NDHS), only 59.8 percent of all births were attended by a health professional during delivery.

Postnatal care. The DOH recommends that mothers receive a postpartum checkup within two days of delivery, considering that most deaths occur during the first 72 hours postpartum. The 2003 NDHS

Time of Maternal Mortality, Philhealth MCP/NSD

	Ratio
72 hours postpartum	72
Day 1-6 postpartum	12
Week 1-7	10
Pregnancy	6

Source: Dr. Manuel M. Dayrit's presentation on the International Conference on Population and Development at 10 (4 October 2004 t the Heritage Hotel)

Health-related Practices Affecting Maternal Health

Maternal Health Practice	NDHS 1993	NDHS 1998	NDHS2003
Pregnant women with at least 4 prenatal visits	52.1	77**	70.4
Pregnant women with at least 2 doses of TT	42.2	37.8	37.3
Women w/ at least 1 post natal visit within one week after delivery		42.7	51.1
Women w/ postpartum check-up			

Source: NDHS
** with at least 3 prenatal visits

reported that one in three women (34 percent) did not receive post natal check-up at all.

Mass exodus of health personnel

Poor pay and poor working conditions in the country are driving health professionals abroad. The continuous exodus is beginning to weaken the ability of the local health system to provide quality health care. While health posts can be refilled, the burden and cost of training new staff to become competent in delivering health services is a major concern. In addition, the Department of Health-Health Human Resource Development Bureau (DOH-HHRDB) reported that the health human resource network in the Philippines is challenged by the following issues and concerns: (i) much lower salaries for public health professionals compared to those in the private sector; (ii) inappropriate or outdated skills, thus creating a skills gap; (iii) unevenly distributed available workforce; (iv) poor working conditions; and (v) limited opportunities for career progression.

The health system is also faced with the challenge of steadily increasing number of out-migration cases among health workers.

Deployment of Health Workers Abroad, 1995-2003

Year	Doctors	Nurses	Midwives	Caregivers
1995	69	7,584	161	No data
1996	47	4,734	142	No data
1997	82	4,242	113	No data
1998	55	4,591	149	No data
1999	59	5,413	66	No data
2000	27	7,683	55	No data
2001	61	13,536	190	465
2002	129	11,867	312	5,383
2003	112	8,968	276	18,878

Source: Figure derived from POEA, CFO records, 2005; ILO Study, 2004

The outflow of Filipino midwives in the last decade started in 1992; it slowed a bit in 2000 and reached its peak in 2002. While the outflow of nurses and caregivers has steadily increased over the years, a sharp turn of caregiver outflow was reported in 2003 when the movement tripled in number.

The disappearing doctor paradox

The migration of doctors-turned-nurses has seriously changed the assumptions for the Philippine health system for the next decade.

A sizable number of government health worker plantilla positions remain unfilled. Around 200 hospitals have closed down in recent years; 800 hospitals have partially closed one to two wards (PHA, November 2005). Also, the nurse to patient ratios in provincial and district hospitals is 1:40-1:60.

We can no longer build up the Philippine health system assuming that there will be doctors in the countryside. A highly functional, next-generation, doctorless system has to be evolved to serve areas without doctors and to complement the services provided by the remaining physicians.

Where does this bring us in terms of ensuring a skilled birth attendant is present by the side of the woman during the critical periods?

Out of the total 42,000 barangays, only 16,000 have at least one midwife. Midwives attend a significant percentage of birth deliveries.

Addressing underutilization of health services by poor women and children

While skilled attendants may influence the outcome of pregnancy, their overall effectiveness lies in their ability to immediately access facilities that provide basic or comprehensive EmOC.

The quality and access of government health services are the most pressing issues from the point of view of the 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 health system practices and behaviors that prevent utilization of services. The perception of the community on the health system, how they feel when they go to the health center, contributes to their unwillingness to deliver in a health facility. That is understanding the true bottleneck to using services.

In a 2002 WomanHealth study "What Women Want in Terms of Quality Health Services", women were asked about problems of utilization of health services. Inadequate health service facilities, discriminatory attitudes of service providers and insufficient personal resources combined to create a low level of utilization of health services and a low level of satisfaction with these services.

More than any other facet of health services, good interpersonal relations was emphasized time and again as an important factor in 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 service providers who did not treat them with dignity and respect. Women responded feeling degraded and widely exposed in an assembly line-like delivery.

The geographic maldistribution, the generally low quality and underfunded government facilities, and the burden of paying for services deny poor women and children effective access to critical health interventions during pregnancy, particularly before and after childbirth. In urban slums, women are near hospital facilities but they do not utilize.

This is where it is probably most pronounced but GPS data conservatively show that over half of home deliveries occur near a health facility.

Health facility delivery in ARMM and Zamboanga Peninsula are lower than the rest of Mindanao, which in turn are lower than the Philippine average.

	1998	2003	ARMM	Zamboanga Peninsula	Mimaropa	Eastern Visayas	Bicol
Health Facility	34	38					
Home	66	61	88.4	83.8	83	79.3	76.3
Govt. Hospital			6.3	10.9	13	14.7	15.7
Govt. Health Center			0.5	1.0	0. 6	0.7	0.7
Private			3.9	3.7	2.1	5.3	5.5

Source: NSO, DOH, and Macro International Inc., 1999

2003 NDHS reveal 38 percent of live births were delivered in a health facility, and 61 percent were born at home. These figures show an increase in the proportion of births occurring in a health facility (34 percent in 1998) and a decline in the percentage of births delivered at home (66 percent in 1998) (NSO, DOH, and Macro International Inc., 1999).

Delivery in a health facility is most common in NCR (70 percent). On the other extreme, only 6 percent of births in ARMM are done in health facilities. In 10 regions, at least 70 percent of births occurred at home, with ARMM (88 percent), Mimaropa (83 percent), and Zamboanga Peninsula (84 percent) registering the highest percentage.

Over 90 percent of women from the poorest quintile gave birth at home while a mere 20 percent of the richest quintile had home births. (WHO Fact Sheet, 2007). More so, less than 20 percent of poor mothers were assisted during delivery by trained health professionals, e.g., a doctor, nurse or midwife, while more than 80 percent of mothers from the richest quintile received assistance.

A tale of disparities: An issue of poverty, gender and inequity

Statistics are blind to inequity. Disparities are hidden in the national averages which fail to show the picture of maternal and child mortality in the country.

Poor women and children consistently are not able to access services. Access to health care services is fast becoming an issue of inequity, with poor Filipino women unable to access the services, information, supplies and facilities that could prevent and reduce maternal and child mortality. The services are inaccessible because often they cannot afford treatment or, because as women, do not have the time or the social support to avail themselves of the service.

Improving equity within countries would prevent 40 percent of all child deaths.

Poverty and maternal and under-five child mortality

The disproportionate number of women and under-five child mortality among poor households is borne by the environmental risk and hazards that the poor mostly endure in their living areas. The major causes of child deaths in developing countries, in particular in South Asia and Southeast Asia, reveal the link between maternal and child mortality and poverty. Major causes of deaths in the region are found to have been largely contracted and transmitted in conditions of poverty such as crowded living quarters, intergenerational malnutrition, indoor and outdoor air pollu-

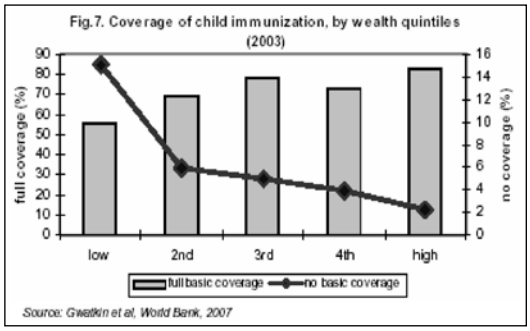
tion, unsafe drinking water, and improper sanitation. (WHO, 2006).

Poverty is the greatest threat to maternal and child survival and is a formidable obstacle to the achievement of the MDGs by 2015. Poor women and children are more exposed to health risks and have lesser access to preventive and curative interventions compared to those in the higher socioeconomic strata.

One of the important findings of the 2003 NDHS documents the inability of poorer women and children to access health services.

When cross-national data is applied, findings show that immunization programs disproportionately benefit the richest quintile than the poorest quintile; and that about 15 percent of the children in the poorest quintile have no basic coverage compared to only 2 percent in the richest quintile (Gwatkin et al, WB 2007).

Coverage of child immunization by wealth quintiles

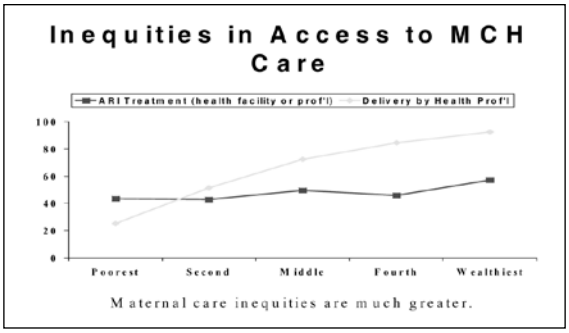


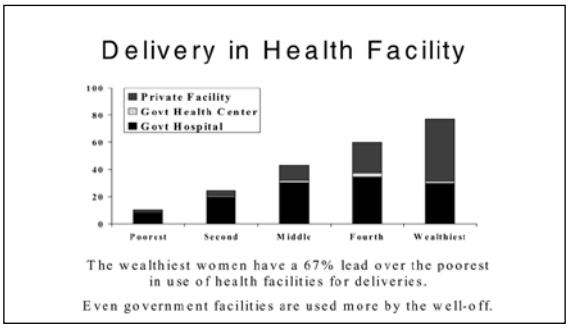
Source: Congressional Planning & Budget Department 2008 Budget Briefer

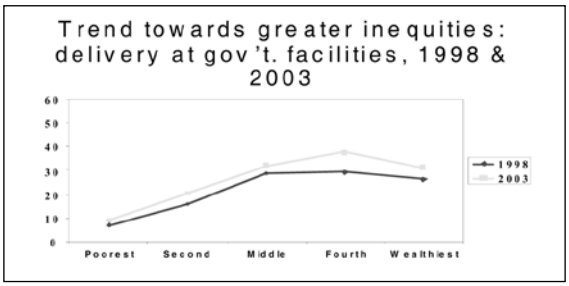
The following figures show poorer women in the lowest quintile have the least access to skilled birthing attendants; doctors, nurses, and midwives to assist them during delivery, as well as access to health facilities, including public facilities.

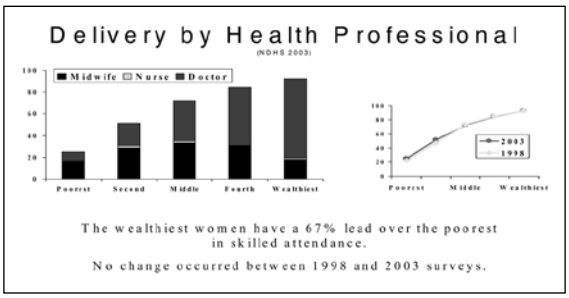
The women in the highest quintile are about 9 times more likely to have a medical doctor assist them during delivery and are 38 times more likely to deliver in a private facility than women in the lowest quintiles.

Another gauge of poor women's inability to gain effective access to life-saving services is the low percentage of women—about 1.7 percent—who had delivered through a caesarean section. This figure is way below the 5-15 percent range as the proportion of complications requiring caesarean 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 caesarean sections for reasons other than those strictly required by their medical condition or fetal indications. Apart from caesarean sections, poor women are not able to access other services even if these are being provided.









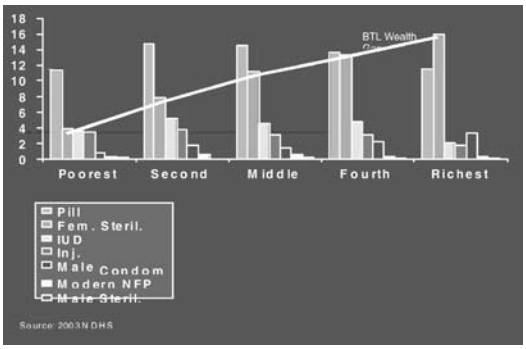
Maternal Services by Wealth Index, 2003 NDHS

	QUINTILES				
1. Assistance during delivery	**Lowest**	**Second**	**Middle**	**Fourth**	**Highest**
Medical doctor	8.6	21.0	37.4	52.6	73.2
Nurse	0.5	1.7	1.8	0,6	1.2
Midwife	16.0	28.7	33.2	31.2	18.0
Hilot	68.9	45.4	26.3	13.3	7.0
Relatives, friends, others	4.9	2.4	1.1	1.4	0.6
No one	0.4	0.2	0.1	0.0	0.0
2. Place of delivery					
Government hospital	8.7	19.6	30.4	34.6	29.9
Government health center	0.5	0.8	1.8	3.0	1.6
Private facility	1.2	4.4	11.1	22.2	45.5
Home	88.7	74.3	56.2	39.0	22.6
Other	0.1	0.3	0.2	0.3	0.1
3. Delivered by C-section	1.7	3.4	6.8	10.8	20.3
4. Number of births	1,858	1,590	1,352	1,162	993
5. Current use of contraceptives (any method)	37.4	48.8	52.7	54.4	50.6

Source: NSO, MACRO. 2003. NDHS

FP and wealth quintiles.

Are poor women equally protected?



Highly marginalized urban poor. Urban poor mothers and their newborns are highly marginalized – with high disease burden, unable to enjoy access to basic life saving interventions and have poor access to the greater determinants of health.

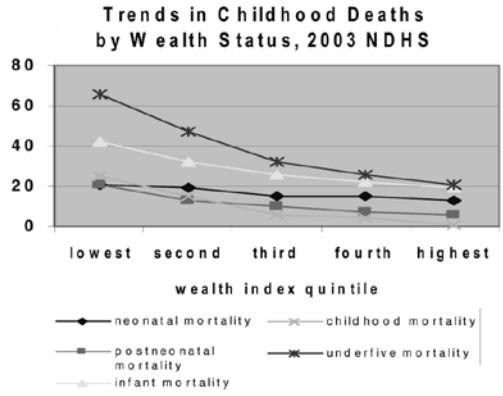
The disparity of health status among different socioeconomic and regional groups is evident: the IMR among the poorest quintile of the population is more than twice the level of the richest quintile, and more than thrice for under-five mortality rate. (Gwatkin et al, World Bank, 2007). Inequities in health status also result from location differences. For example, the richest quintile in rural areas has an IMR that is twice that in urban areas. Geographically, there were regions that in 2006 had infant mortality rates exceeding the

Disease burden and limited access of the urban poor

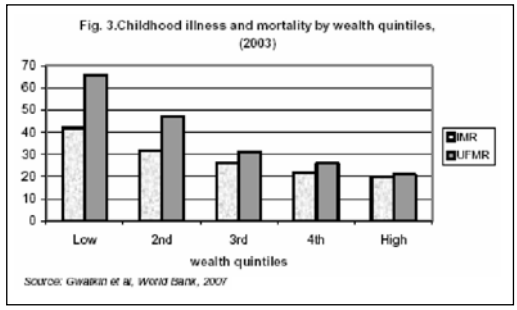
High Disease Burden	Limited Access to Basic Life Saving Interventions	Poor Access to Greater Determinants of Health
• 1 of 3 pregnancies are unwanted • one of 5 women began childbearing below 18 years of age • 9 out of 10 children are born less than 3 years apart • 25 % of children are malnourished	• 70% deliver at home by an unskilled attendant • 2/3 do not use any form of contraception • 2/3 do not exclusively breastfeed less than 6 months of age	• 2/3 have at most an elementary education; • 1/4 functionally illiterate • 2/3 do not have their own toilet • 2/3 do not have electricity

national average of 24 deaths. These were Cordillera (29), Mimaropa (32), Bicol (26), Eastern Visayas (29), Zamboanga (38), Davao (28), Caraga (28), and the ARMM (31).

The under-five mortality rate is 2.7 times higher among the poorest compared to those in the highest income quintile. The IMR among the poorest households is also 2.3 times higher than those in the richest quintile. The same pattern is seen in the rates of neonatal and post neonatal deaths.



Childhood Illness and Mortality by Wealth Quintiles (2003)



Source: Congressional Planning & Budget Department 2008 Budget Briefer

Mortality levels in urban areas are much lower than those in rural areas (24 deaths per 1,000 live births compared to 36 deaths per 1,000 live births). Similarly, the rate of perinatal death is slightly higher in rural areas than in urban areas. Of total perinatal deaths in 2003 (NDHS), 76 were classified as stillbirths and 92 were early neonatal deaths.

Since the poor primarily frequent government primary facilities, improving the quality and access of their services, with an emphasis on those services mainly demanded by the poor (particularly maternal and child health services and treatment of communicable diseases) would strongly enhance the propoor nature of health services. (World Bank, 2001c).

In order to stop exodus of health workers and provide quality service, health service providers (HSPs) should first be satisfied with their jobs. A key to the success of service delivery is HSPs satisfied with their work, the facilities and the services they render. HSPs must be treated as "internal clients" with their own needs and expectations. The technical and interpersonal dimensions of service delivery are dependent on the job satisfaction of providers.

Maternal death is a litmus test of any health delivery care. If the health system of a country cannot save the lives of mothers and newborns, it is doubtful whether it can save the lives of the rest of the population too.

Status of women

A woman's health, educational and economic status has a significant bearing on whether or not she and her newborn dies during or after childbirth.

It is important to remember that basic social services are characterized by strong complementarities— that is, the impact and effectiveness of each basic social service component is enhanced by the availability of other basic social services. The interplay of complex socioeconomic, health service, and cultural factors (poverty, population, unemployment, poor economic condition, access to services, religion, among others) accounts for the death of children and women.

Childhood mortality is inversely related to the mother's education level and wealth status. The IMR for children whose mothers have no education is 65 deaths per 1,000 live births, compared with 15 deaths per 1,000 live births for children whose mothers have college or higher education.

Assistance by a health professional during delivery is more common for lower-order births, births in urban areas, births of wealthier women, and births to better-educated mothers. The largest gaps in being assisted by a health professional during delivery are between the poorest women and the wealthiest women and between women with no education and those with the highest educational levels. While 25 percent of women in the poorest quintile and only 11 percent of women with no

education are assisted by a health professional during delivery, the corresponding proportions for women in the wealthiest quintile and those with college or higher education are 92 and 86 percent, respectively.

Women of reproductive age with little or no elementary education are the ones not reached by prenatal services, safe deliveries and post-partum care. They are also the women with less or no access to family planning and reproductive health services; and those likely to undergo unsafe abortion. They are also the women whose infants die before they reach the age of one or whose children under-five years old hardly benefit from formal health services when they have acute respiratory infections and diarrheal diseases.

The unceasing efforts to raise women's overall status are definitely worth pursuing. Women's status has been found to influence infant and child mortality rates through women's ability to control resources and make decisions. Consequently, they bring women and children closer to gaining access to health care.

Overall trends in childhood death rates show that the number of deaths increases as the wealth index of mothers lowers.

Maternal fertility patterns and children's survival risks have been known to have a strong relationship. Generally, infants and children have a greater probability of dying if they are born to mothers who are too young or too old, if they are born after a short birth interval, or if they are of high birth order.

The vicious cycle of malnutrition: Intergenerational effects

The poor health and nutritional status of a woman significantly influences her risk to maternal mortality and the potential of fetal development for survival and growth development after birth. Undernourished women tend to give birth to small, low-birth-weight babies, who are likely to turn out undernourished as well.

Putting gains at risk: Letting women die

Maternal and under-five death is highest among women with little or no education and lowest among mothers in the highest wealth quintile.

One death too many

Maternal death is tragic because it is avoidable. While it is tragic in itself, it has severe public health impact not only in numbers, but triggers other adverse consequences in families, orphaned children, loss of family care provider, and infant and child mortality. Society suffers much more when a woman dies therefore there is a collective value in reducing maternal death. What is profoundly contemptuous for women is that pregnancy is not a disease but a physiological process, and therefore women have the right not to die due to pregnancy and childbirth.

The survival of newborn children is inextricably linked to the health of the mother. Nowhere is this more evident than in the high risk of death for newborn and infants whose mothers die in childbirth.

Older children are not immune. Children under-10 are more likely to die following the death of their mothers than those whose mothers were alive. Further, a World Bank study reveals that the risk of death for children under 5 years is doubled if their mothers die in childbirth, and at least 20 percent of the burden of disease among children under the age of 5 is attributable to conditions directly associated with poor maternal and reproductive health and the quality of obstetric and newborn care. So for each of those 4,100 women who die in the Philippines, it is reasonable to assume that at least as many children suffer and a significant number of them die.

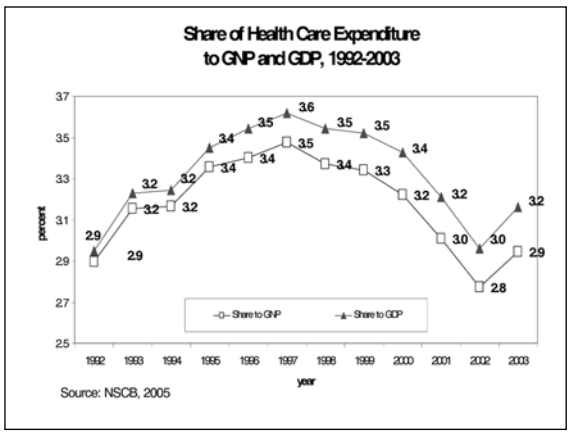
Cost estimates of key health interventions needed

The upgrading of and making EmOC a key feature of health facilities requires investments that focus on improving the functioning of existing health facilities.

The World Health Statistics 2007 of the World Health Organization ranks the Philippines as one of the worst in the world in providing health services to its people. Meanwhile, not surprisingly, the latest MDG Philippine Progress Report acknowledges the poor performance of the health sector, threatening the health-related MDG goals. Cited as one of the largest factors responsible for this poor performance is the low and ineffective public spending for health.

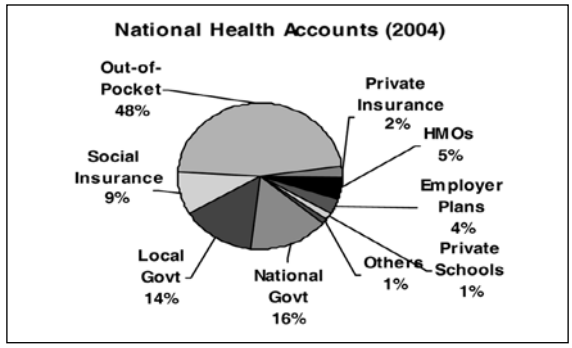
In a recent interview, WHO former representative Dr. Jean Marc-Olive noted that the Philippines has the lowest investment on health compared with other countries of the world. Underinvestment in health and the high cost of care drive impoverished households deeper into catastrophic poverty.

The country's share of health spending does not come close to the standard recommended by the WHO for developing countries, or 5 percent of GDP committed to health spending.



Almost 50 percent of health spending of Filipinos today is mainly financed through out-of-pocket payments. This is against the dismal 16 percent and 14 percent covered by the national and local government, respectively.

The high out-of-pocket expenditures and the overall low-level of health spending is the most undesirable mixed source of financing health. This is the main reason poor people are denied access to effective health services, making people poorer and more ill, and heightening the lack of financial protection. If we want to improve access and use of health services by the poor, the current health financing is unacceptable. Out-of-pocket expenditures (coming from people) should be

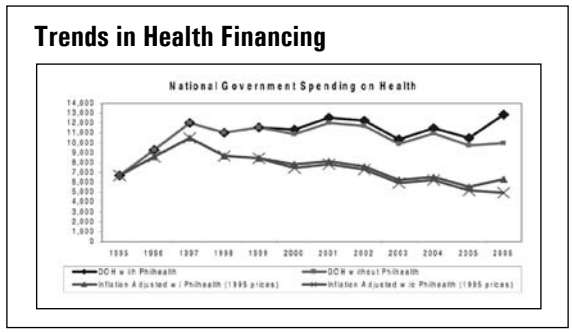


lessened and the government should be made to cover a much larger share in the total health expenditure.

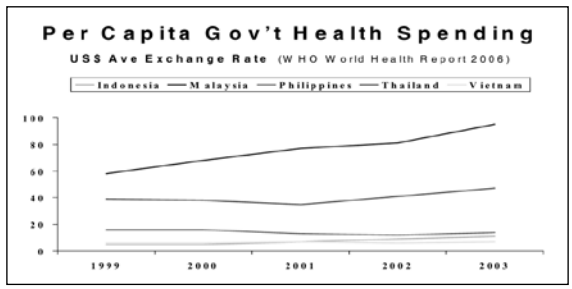
Declining share of DOH budget

Health is a low priority in the Arroyo regime as seen in the declining share of the DOH budget from 1999 to 2006.

National government spending on health deteriorated consistently since 1999. In nominal terms, the DOH budget decreased by 1.2 percent yearly on average from PhP 11.5 billion in 1999 to PhP 10.0 billion in 2006. The contraction of the DOH budget is even more pronounced when it is adjusted for inflation, 6.9 percent yearly on average in the period 1998-2006.

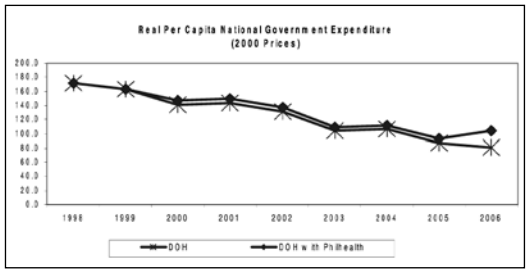


In terms of real per-capita government health spending, the Philippines is one of the lowest among Southeast Asian countries.



As illustrated in the figure below, the 9-percent annual decline in real per capita DOH spending (in 2000 prices) is—from PhP 172 in 1998 to PhP 81 in 2006.

Trends in Health Financing



Expenditures on public health interventions are deemed critical in ensuring that the MDG health targets are met, as well as ensuring that equity considerations in health care delivery are fulfilled. However, the pattern of DOH budget distribution has not changed over the years. Hospital services consistently eat up more than 50 percent of the DOH proper budget. On the other hand, the financing trend on public health service delivery allocation has largely remained measly below 15 percent.

Because of this, there was no significant improvement in the spending for vital public health programs such as the prevention and control program of major diseases like TB, malaria and other vaccine-preventable diseases. These are mainly prevalent infectious diseases which require a substantial amount of investment to make an impact, not to mention the EmOC needs.

Where is the money?

In spite of the national government's commitment and pronouncements to the MDGs, resources and finances are yet to be allocated by the Philippine government. There has been so little budget allocated for health-related MDGs by the government and these are thus actually donor-driven or backed up by outside sources (ODA).

In a recent study, Dr. Rosario Manasan estimated that the amount of resources needed to support the attainment of the MDG on public health is equal to P8.96 billion (or 0.13 percent of GDP) for 2007 and equal to a cumulative total of P104.4 billion (0.08 percent of GDP) for 2007-2015. This estimate still

MDG Goals, Targets and Corresponding DOH Programs

Goals	Philippine Target	Health Programs/ Activities With Direct Impact On MDGs	Needed Funding/Gap (DOH) Estimate Annually (In PhP) 2005
Goal 1. Eradicate extreme poverty and hunger	Target 2 Halve the proportion of population below the minimum level of dietary energy consumption and halve the proportion of underweight under five children	• Micronutrient Supplementation/ *"Garantisadong Pambata"* • Breastfeeding and Complementary Feeding Program • Nutrition Education and Information Dissemination	
	Target 3 Halve the proportion of people with no access to safe drinking water of those who cannot afford it by 2015	• Environmental Health	
Goal 4. Reduce Child mortality	Target 6 Reduce children under five mortality rate by two thirds by 2015	• Integrated Management of Childhood Illnesses • Expanded Program on Immunization • Micronutrient Supplementation *(Garantisadong Pambata)* • Breastfeeding and complementary Feeding program • Newborn Screening Program	Cost P1,469,938,544 DOH 370,544,000 ODA 3,500,000 Gap P1,095,894,544

MDG Goals (continuation)

Goals	Philippine Target	Health Programs/ Activities With DirectImpact On MDGs	Needed Funding/Gap (DOH) Estimate Annually (In PhP) 2005
Goal 5. Improve maternal health	Target 7 Reduce maternal mortality rate by three quarters by 2015	• Tetanus toxoid immunization to pregnant women • Provision of Iron to Mothers	Cost P4,760,729,673 DOH 107,880,277 ODA 11,230,000 Gap P4,706,817,950
	Target 8 Increase access to reproductive health services to 60% by 2005, 80% by 2010 and 100% by 2015	• Gender and development • *Ligtas Buntis* • Establishment of Basic and Comprehensive Maternal and	
Goal 6. Combat HIV/AIDS, malaria and other diseases	Target 9 Halt and reverse the spread of HIV/AIDS by 2015	• Promotion and Prevention of AIDS prevention services • Provision of Drugs and Other Logistic Supplies	Cost P 358,263,587 DOH 22,899,667 ODA 163,377,920 Gap P 181,976,000
	Target 10 Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases	• Malaria Control • TB Control Program • Establishment and Strengthening of TB Networks	Malaria Cost P1,727,102,970 DOH 19,200,000 ODA 364,400,890 Gap P1,353,602,080 Tuberculosis Cost P 606,877,000 DOH 166,877,000 ODA 261,200,000 Gap P 178,800,000
		Total	**Cost P8,922,911,774** **DOH 687,400,944** **ODA 803,708,810** **Gap P7,517,090,574**

falls short, as it does not capture the shift to EmOC strategy.

At the rate that the budget allocation to public health has been progressing or decelerating, it is clear that current levels are inadequate.

Summary Costing for Health-Related MDGs, based on DOH Computation of 2005

MDGs Programs And Projects	Total Cost (P)
Reduction Of Child Mortality	1,469,938,544
Improve Maternal Health	4,825,928,227
Combat HIV AIDS, Malaria And Other Diseases	2,692,233,557
HIV/AIDS	358,253,587
Malaria	1,727,102,970
Tuberculosis	606,877,000
Grand Total	**8,988,100,328**

A point to consider is that although there may be increases in the budget allocation, and prioritizing investments in health conditions that affect the poor more are justified, it is not always the case that the intended beneficiaries–the poor–are able to secure the most benefits from these interventions. As indicated earlier, even health services, e.g. child immunization, attended delivery, etc. that tend to address "diseases of the poor" have been captured more by the well-off than by the poor.

Conclusion: Winning the battle in worse-off areas

If the government is to sustain and accelerate health gains of recent years, especially in the context of achieving the MDG targets in 2015, it is imperative that policy attention and available resources focus on health areas that would yield the optimum health

impact. It is important that these new set of policy initiatives adequately address critical issues of health inequities since most of the deficiencies in the health indicators are occurring in the poorest segments of the population.

The evidence presented here clearly shows that poor people have worse health outcomes than the better-off, and that publicly-financed health care has not been able to reach its intended beneficiaries. Given the relative disempowerment of the poor that limits their availment of intended benefits, new initiatives for health programs and strategies should consider the following important points:

Increase and prioritize investments in health conditions that affect the poor more. Focusing on family planning, EmOC, immunization, infectious diseases, infant and child mortality, maternal ill-health, and malnutrition is a strategy to improve the health of the poor women and children and reduce poor and nonpoor health differences.

Prioritize investments in types of services that are likely to benefit the poor. Primary health care, public health interventions, and preventive or promotive (rather than curative) services can improve the health of the poor.

Prioritize investments in regions or areas where the poor are concentrated (geographic targeting). Resources should be reallocated in favor of poorer geographic areas, and to the lower tiers of service delivery. Health infrastructure should be expanded to provide more service delivery points where the poor live, especially in remote rural communities. The number and reach of outreach clinics should be increased. Services can be tailored to the needs of vulnerable groups, such as slum dwellers, migrant, etc.

Reduce barriers to financial access. When universal provision of subsidized care is considered too costly and/or not effective in reducing poverty, one alternative is targeted subsidies. Targeting is primarily an attempt to increase fairness in financing. From another perspective, it involves redistributing resources and transferring purchasing power to the poor without increasing public spending.

International agencies and donors can help prevent maternal and infant deaths by improving the quality of aid.

Health is a right. There needs to be a reorientation in policy towards this view. The government is duty-bound to provide the health system which ensures that pregnant women and children can access quality health care, especially life-saving emergency obstetric care. It should be held accountable for every woman who dies because the health services she needed were not available or accessible. Health providers must view the provision of services as an obligation.

Policies and standards must be set at the highest level of government and forcefully implemented. In the absence of such leadership there is little hope of achieving health security for our people, or even only the minimum MDG health targets. ■