Institute of Social Studies

GRADUATE SCHOOL OF DEVELOPMENT STUDIES

Maternal Health Service Provision in an Era of Decentralization. The Case of Zamboanga City, Philippines

A RESEARCH PAPER PRESENTED BY

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(Philippines)

In partial fulfillment of the requirements for obtaining the degree of

MASTER OF ARTS IN DEVELOPMENT STUDIES
SPECIALIZATION: POPULATION AND DEVELOPMENT

MEMBERS OF THE EXAMINING COMMITTEE

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THE HAGUE, NOVEMBER 2001

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for our very own Kristina who will someday be a mother...

ACKNOWLEDGEMENT

Anything with a beginning definitely has an end but before the end of this rare opportunity comes, I would like to thank some people who have in various ways motivated me to write this paper.

With deepest gratitude to the Netherlands Fellowship Programme for granting me the scholarship to join this post graduate course and to the Commission on Population, goes my profound appreciation for believing in me to pursue a higher degree of learning … this is really an exceptional break from office work.

Thanks to my friends back home ... Ann and Susan for being supportive and lending a hand with the needed data, at least it saved my sanity ... and with Rose ... thank you all for keeping the lifeline alive with stories and updates from miles away.

For the fruitful insights in this study, I would like to express my gratitude to my research supervisors, Loes Keysers and Eric Ross for the comments from the start of this writing. I deeply appreciate the supervisory skills and patience of Loes, without which I would not have accomplished this task. Thanks for believing that I can make this study, it sure encouraged self-confidence and inspired me to complete this piece of work.

To the Pinoy community at the ISS - *maraming salamat sa suporta sa lahat ng gawain at sa masasayang araw na kasama kayo.*

I can not miss to thank Bebot, my husband for the unwavering support, love and patience, and for standing in for my responsibilities for the last fifteen long months.

Finally, my profound gratitude to God the Almighty who I believe keeps the strength in me and is guiding me through all these times ... and without whom everything will be impossible.

Muchas Gracias!

MATERNAL HEALTH SERVICE PROVISION IN AN ERA OF DECENTRALIZATION

The Case of Zamboanga City, Philippines

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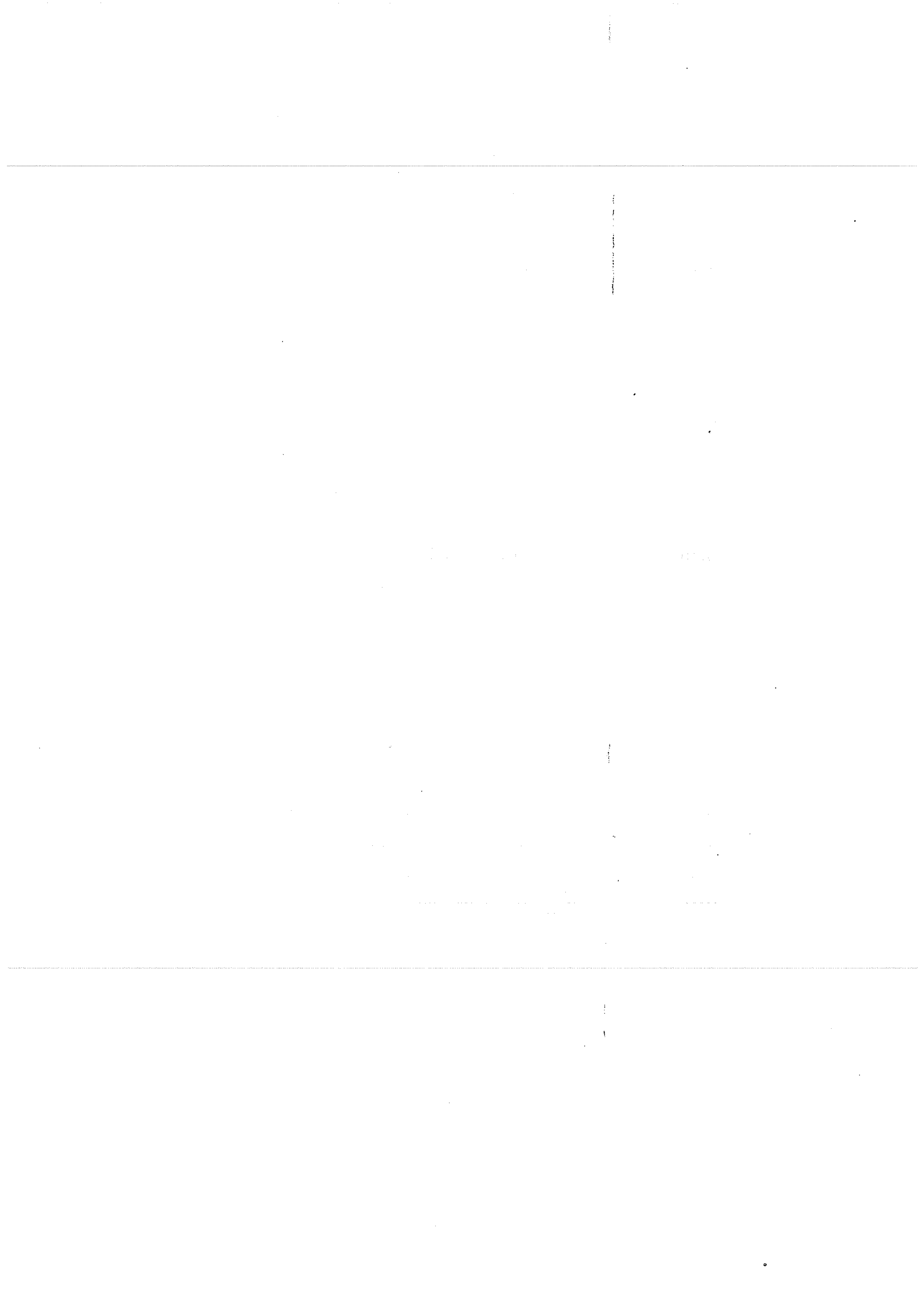
List of Acronyms

BHS	Barangay Health Station
BHW	Barangay Health Worker
CHO	City Health Office
DBM	Department of Budget and Management
DOH	Department of Health
FHSIS	Field Health Service Information System
IRRRAG	International Reproductive Rights Research Action Group
JHU	Johns Hopkins University
LGC	Local Government Code
LHB	Local Health Board
LDC	Local Development Council
LGO	Local Government Official
LGU	Local Government Unit
MMR	Maternal Mortality Ratio
NDHS	National Demographic and Health Survey
NHIP	National Health Insurance Program
NSCB	National Statistical Coordination Board
NSO	National Statistics Office
RFHO	Regional Field Health Office
RHO	Regional Health Office
RHU	Regional Health Unit



Chapter 1

Introduction

1.1 Background

The health of women has gained attention and has been the object of increasing concern in most parts of the world today. While motherhood is a positive and fulfilling experience for most women, childbirth remains the greatest single health hazard facing women in developing countries. This has brought the health of pregnant women up front in most health agenda because pregnancy and childbirth are associated with suffering, ill health, disability and even death. Complications of pregnancy and childbirth take the life of about one in every forty-eight women. According to the report on the State of the World Population (UNFPA, 2000), there are approximately 500,000 maternal deaths each year and ninety-nine percent of these occur in developing countries.

Various initiatives have been undertaken at different levels drawing attention to the extent and consequences of the poor health of mothers and at the same time, mustering action to deal with the high incidence of disability and death resulting from complications of pregnancy and childbirth. At the global level, the Safe Motherhood Initiative was launched almost fifteen years ago to respond to the problems of women particularly those associated with pregnancy. The Philippines, as a signatory to most international conferences and initiatives, reciprocated by revitalizing existing mechanisms, formulated policies and framework relative to national safe motherhood with enhanced efforts for consensus building among stakeholders. These efforts were geared towards "improving the well-being of mothers through a comprehensive approach of providing preventive, promotive, curative and rehabilitative health care" (DOH: http://www.doh.gov.ph/safemotherhood.htm).

Filipino women constitute almost fifty percent of the total population and a little less than fifty percent of the country's population belong to the working age group of 15 to 65. Accordingly, "improving the health of mothers can generate secondary benefits for children and other family members today and into the future" (Aitken, et. al.:1994 cited Kutzin: 1993, p.183). An untimely death due to complications associated with pregnancy which in most

cases are preventable means losing a productive worker and a primary caregiver. Thus, making the health of mothers particularly of pregnant women a primary concern is noteworthy for the death of a mother has profound impact on her surviving children, her family and also the community. This calls for a great commitment to investing in the health of Filipino pregnant women who are at risk and constantly engaged in the struggle for survival for themselves and for their families.

Widespread poverty has been aggravated by the policies of structural adjustment, which have resulted in the reduction of government expenditures especially health services through health sector reforms. This has gravely affected women since majority of the Filipino women belongs to more than 60% of the population living in poverty (Fabros: 1998). Since the Philippines is burdened with an increasingly large inherited foreign debt and is unsuccessful in meeting basic needs and services, the call for less centralized bureaucracy, less state intervention in the economy and decentralization of functions was heeded. The process of decentralization was made concrete through the passage of the Local Government Code of 1991 which was aimed to transform local government units into self-reliant communities and active partners in the attainment of national goals. Decentralization granted local government units more powers, authority, responsibilities and resources. Thus, the major responsibility for delivery of social services was then transferred from the national line agencies to the local government units through the process of devolution[1]. It is almost a decade since devolution of health services was implemented which was purposely to make local government units more powerful, independent and responsible.

With the commitment to the international initiative on safe motherhood coupled with the present economic situation and political administration, there has been an upsurge of interest in improving the health of mothers to address the incidence of death and disability brought about by complications of pregnancy and childbirth. The national mission statement of the safe motherhood initiative affirms that: "The Department of Health (DOH) in partnership with the Local Government Units (LGUs), private sectors and other agencies concerned with the health of mothers shall commit to lead and provide quality maternal

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[1] Refers to the act by which the national government confers power and authority upon the various local government units to perform specific functions and responsibilities (Nolledo: 1991).

health services to make pregnancy, childbirth and motherhood a safe experience for all mothers" (DOH: http://www.doh.gov.ph/safemotherhood.htm). This mission formulated since 1988 sets the implementation of strategies by program planners and implementors to improve the health of mothers and eventually reduce maternal deaths.

1.2 Statement of the Problem

In the Philippines, the situation of mothers although better than the average from developing countries has not changed much in the last five to ten years. There are 14 million Filipino women in the reproductive age group of 15 – 49 years. Of this, 9 million are married or have partners, while 6 million are considered to be at risk if they become pregnant which can be due to various reasons, from early to too many and high risk pregnancies including malnutrition. With an average fertility rate of 3.7[2], an estimated 2.3 million women are expected to get pregnant every year. (DOH: http://www.gov.ph/safemotherhood/alpha.htm).

Most maternal deaths could have been prevented however, the 1999 target of 50% reduction in maternal mortality from the 1988 maternal mortality ratio (MMR) of approximately 220 per 100,000 live births has not been achieved. The 1998 National Demographic and Health Survey (NDHS) revealed a ratio of 172 per 100,000 live births, which is still way too high and off target from the desired MMR of 110. Although statistics revealed a reduction in maternal deaths, underreported or misclassified non-maternal deaths have to be noted considering that maternal deaths represent approximately fourteen percent of all deaths to women aged 15 to 49. Approximately, 10 women die every 24 hours from causes related to pregnancy and childbirth (NSO: 1999).

In Western Mindanao, southern part of the country, statistics remain high with maternal mortality ratio at 200 per 100,000 live births in 1995. Infant mortality is recorded at 58.5 while under-five mortality is 82.8, comparatively higher than the national level at 48.9 and 66.7, respectively. Based on the 1998 NDHS results, the region's current fertility level remains relatively high at 3.9 children per woman, although total wanted fertility is expressed

[2] The average number of children that would be born to each woman during her reproductive years; it has gradually decreased from 4.1 as of 1990.

at one child less. With a contraceptive prevalence rate of almost 47%, the region is experiencing unmet need for family planning at 24% (NSO: 1999).

Zamboanga City, the focus of this study, a highly urbanized and commercial area in the Western Mindanao region, makes up 20% of the region's total population and has the highest population growth rate among the provinces and cities at 3.56% as of the year 2000. This growing city and commercial center in the region encourages the influx of migrants from neighboring areas which contributes to its increasing population with an increase of at least 26% in its population density since the last ten years. The city has recorded fluctuating trends in maternal deaths for the last fifteen years making up 15.3% of the region's total maternal deaths as of 1996. It has likewise recorded the highest percentages of infant and fetal deaths among the different structures in the region at 34% and 43%, respectively. Deaths among mothers and children are high despite the number of health personnel and facilities available.

Through the decentralization of basic services and facilities following the enactment of the 1991 Local Government Code, health services have been devolved to the local government units since 1992. These included implementation of programs and projects on maternal and child health care among other primary health care services, access to secondary and tertiary health services, and purchase of medicines, supplies and equipment. With this scenario of local governments taking charge of the provision of health services and the steadily increasing population growth rate within the last ten years, it would be interesting to find out how maternal health services have fared since decentralization. Considering the higher incidence of maternal deaths at the local level, it would be of relevance to health planners, policy makers and others involved in the delivery of maternal health services and concerned with the improvement of maternal health.

1.3 Research questions

Several factors or conditions contribute to the improvement or deterioration of maternal health service provision in any particular set up. For this study, the main question asked is: "under what conditions or circumstances will maternal health service provision be enhanced in a system of decentralization?"

Highlighting the case of Zamboanga City will further answer the questions:

- What factors contribute to the present availability of maternal health services?
- How do these services respond to maternal health needs?
- How do health policy implementation and provision of resources affect delivery of maternal health services before and after decentralization?
- Does decentralization improve quantity and quality of maternal health service provision?

1.4 Research Objectives:

The objective of this study is to analyze the maternal health service provision before and since decentralization of health services in Zamboanga City covering the period 1986 to 1998.

Specifically, the study intends to:

1. Analyze existing maternal health services before and since decentralization.
2. Compare the availability of resources for maternal health services (human, structural and financial) before and within the decentralization process.
3. Describe the utilization of maternal health services in terms of pre-natal care, delivery and post-natal care.
4. Analyze maternal health policy implementation within the period covered by the study.

1.5 Methodology and Sources of Data

This study utilized secondary data covering the period 1986 to 1998 for comparative purposes of the period before and since decentralization of health services. The baseline year will be 1986, after the Filipino people have gained back democracy following more than a decade of dictatorial rule. It is also within this period when the Constitution was revised and the 1991 Local Government Code was enacted that called for devolution of health services within six months from January 1992. The data were gathered from published and unpublished reports of the following agencies: Department of Health (DOH), National Statistical Coordination Board (NSCB), National Statistics Office (NSO), Department of

Budget and Management (DBM), Zamboanga City Health Office and research institutions. The data were mostly collected through correspondence from the Philippines and the Internet. The theoretical and conceptual aspects were obtained from available resources and literature in the Institute of Social Studies.

Since the study focuses on maternal health service provision, data processing includes qualitative and quantitative analysis with comparative analysis of data relative to physical, financial and human resources for maternal health care. These three factors which are related with health resources and facilities, trained health service providers and financial resources for maternal health are important for the provision of maternal health services. The resources assumed to have either improved or deteriorated since decentralization of health services can significantly affect maternal health at any level. Empirical data along these factors at the local level or the focus area of the study will be compared and analyzed to uncover the extent of maternal health services and utilization in terms of prenatal care, delivery and postnatal care. Simple research techniques such as rates and percentages shall be employed in the analysis. Health policy initiatives of the national government relative to maternal health, and health policies and other available documents of the local government will be reviewed and analyzed to ascertain significance of implementation.

1.6 Limitations of the Study

Because of time limitation and considering the availability of data for this study, not all the issues affecting maternal health can be addressed. This research will concentrate on the issues of maternal health service provision before and since decentralization of health services from mid-80s to the late 90s, particularly services provided in the public health sector. Although there are various factors which can likely affect maternal health service delivery with the autonomy granted to local government units, the analysis will deal only with factors from the provider side such as physical, financial and human resources, and health policies for maternal health. While clients' needs and access to health services including their financial capability to seek health care affect utilization of the same and eventually, maternal health, these aspects are not dealt in this study. The dearth of data on demand for maternal health services including quality of care which would require primary

data from clients in need of such services hindered an in depth analysis of the problem. However, utilization of health services in terms of prenatal, delivery and postnatal care are included in the analysis. Not withstanding these limitations, it is hoped that this study is able to meet its stated objectives.

1.7 Significance of the Study

The provision of maternal health services in the Philippines is not new and has been included in the packages of health services provided by the health sector from both government and private institutions. However, delivery of services is affected and influenced by several factors such as administrative and health policies, physical, financial and human resources. With devolution of health services, reforms in the health sector will most likely affect the health of mothers who belong to the poorer sector of the population. While mothers are principally responsible for the families' health and their own, it is realized that the government remains the primary provider of health services. Therefore, this study will fill the gap where health planners, program managers and service providers overlook aspects of maternal health service provision thus, negatively affecting maternal health. In a positive view, it will contribute insights among other local government units faced with similar situations to maintain or improve delivery of maternal health services.

1.8 Organization of the Research Paper

The remaining sections of this research paper are organized as follows: Chapter 2 presents a review related studies, relevant theories and concepts that will serve as bases for analysis. The framework of analysis for related variables serves as a guide in the analysis of related data. Chapter 3 discusses the maternal health service delivery in the Philippines including policies and initiatives to address maternal health. The institutional arrangements in the implementation of programs and delivery of health services are likewise included. Chapter 4 presents maternal health service provision in the focus area of the study considering the administrative and financial arrangements on health services. It includes analysis of maternal health service delivery and utilization in terms of prenatal, perinatal and

postnatal care before and since decentralization. Finally, Chapter 5 provides the lessons learned, conclusion and recommendations.

Chapter 2

Review of Related Studies on Maternal Health, Concepts and Framework of Analysis

2.1 Introduction

This chapter presents related studies on maternal health and cites situations on how decentralization has positively and negatively affected health service provision. The theoretical discussion includes the concepts used in discussing maternal health needs including decentralization of health services. To analyze the factors that will likely affect delivery of maternal health services since decentralization a comprehensive framework is constructed for the purpose.

2.2 Review of Related Studies on Maternal Health

Mothers bear the final responsibility of bringing up their children and care for the family, and continue to do productive work even in the advanced stage of pregnancy despite the health risks in order to ensure their survival and that of the family. This has come to a realization that women are considered an important asset to development and improvement of the economy. Thus the WHO 1998 World Health Report entitled "Life in the 21st Century: A Vision for All" contains the following statement in its executive summary... *"the future of human health depends a great deal on the commitment to invest in the health of women in the world today. Their health largely determines the health of their children who are the adults of tomorrow"*. Several studies have been conducted relative to maternal health ranging from the effects of childbearing to the quality of women's lives, the economic and psychological influences of family planning on the life of women, reproductive rights and problems on maternity care in urban settings.

As in most developing countries, pregnant women in the Philippines face problems related to pregnancy including childbirth. The high incidence of pregnancy-related deaths could have been prevented if the needs of women are given importance especially integrated

programs such as maternal and child health where the emphasis is more on the child and neglect on the maternal. However, improvement of women's health goes beyond the medical into corrections of existing cultural and social practices that affect the development of the female child that is brought along into adulthood. The support of everyone in the society especially that of women is needed to improve women's health.

In a study on the practice of reproductive rights conducted by the International Reproductive Rights Research Action Group (IRRRAG), it was found out that Filipino women initiate strategies to control their number of pregnancies, given their husbands' demands for sex and the church's as well as their husbands' prohibition of artificial birth control. Women feel that decisions about when and how many children to have belonged only to them. The need to make decisions is based not only on their personal health and economic constraints but on the fact that they carry the burden of childcare almost always alone (Fabros: 1998). This reiterates the fact that women's health concerns are just secondary to the children's welfare.

Other studies have concentrated on the effects of childbearing and use of family planning on women's lives, how contraceptive users become more engaged in productive and community work which have significant effect on their household assets and domestic labor burden (Cabaraban:1998; David: 1997; Adair: 1996). These studies support the theory that women's earnings are likely to be used to purchase goods and improve quality of life for the family. Significantly, due to economic difficulties, women are engaged both in the formal and informal sector and although household assets have improved, there's no improvement in maternal nutritional status when health priority is given to children and other members of the family (Adair, et. al. 1996).

These studies showed women's response to childbearing and control of their own fertility and how other significant factors such as economic and cultural affect women's health as mothers. Likewise, policies enacted by government for the health sector to effect further health gains consequently affect health service provision and utilization of health resources by target clients. In a case study on maternal and child health care in Uganda (Mwesigye: 1999, http://www.phrproject.com) where decentralization of government tasks,

authorities and resources brought along reform initiatives to give more political and administrative autonomy to decentralized districts, the impact of decentralization on maternal and child health services was examined. Although decentralization has granted more political and administrative powers, the implementation of vertical programs paralyzed bottom-up approach and decision making in local governments. This has led to failure in the increase of local revenues for health services with user fee rates not affordable by would-be users of maternal and child health services resulting to its low and declining utilization in the selected districts under study. The situation runs contrary to the expectation that maternal and child health services would improve and benefit from policies associated to decentralization.

The Philippine Local Government Code of 1991 (The Code)[3] paved the way for "an authentic and meaningful local autonomy based on effective decentralization of structures and functions of local government units (LGUs)"[4] (Nolledo: 1991, p. iii). These political subdivisions consist of provinces, cities, municipalities and *barangays*[5]. Decentralization of basic services and other functions to local governments included health care, thus, delivery of health services are now managed and controlled by local executive officials. Although the Department of Health cannot dictate to the LGUs on the type of service they should provide, this is facilitated through the establishment of relationships with the local health boards (LHBs), local development councils (LDCs) or local government officials (LGOs).

Health personnel at the start of The Code's implementation felt some apprehensions such as, local decisions may not support national reproductive health goals or central level may not agree with local priorities. In some instances, if the local government does not have sufficient funds, referral systems and outreach activities may discontinue or health benefits may not be given to health personnel. On the other hand, in a primary research conducted by Furtado (2001) among moderately poor to very poor communities in the southern part of the Philippines revealed that devolution has led to a deterioration in the quality of health care delivery. Responses ranged from the lack of available medicines at rural health units or

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[3] Otherwise known as Republic Act (R.A.) No. 7160, an act providing for a local government code approved in October 10, 1991

[4] Local government units (LGUs) are the territorial and political subdivisions of the State as referred to in the 1987 Philippine Constitution

[5] The barangay is the primary unit that plans and implements government policies, programs, projects and activities in the community

district hospitals to poor maintenance of equipment and lack of trained personnel. Frequent users of health care services in these areas perceived that health care services in their areas were slightly better if not much better at some point in the past. Health providers as well agreed that the resources for health care are insufficient to maintain the cost of medicines, equipment and other necessary provisions. Likewise, more than half of the respondents pointed out that the decline begin in the first year that health services have been devolved in 1993. This can be attributed to the poor information dissemination of the concept of devolution by government where those residing in the peripheries were unaware of the decentralization of health care. This was equally true with local government officials who were ill prepared with the process leading the way to poor administration and management compromising the well-being of the poor (Furtado: 2001).

However, positive results were identified based on the reproductive health pilot project in the province of Nueva Vizcaya, one of the many poor provinces in the Philippines faced with major problems in the health delivery system (Tadiar: 1999). These problems ranged from lack of medical supplies and equipment including poor clinical program, which hindered the will to provide adequate health care services. With foreign funding support, a reproductive health package was initiated with the integration of family planning, maternal and child health, nutrition and STD/AIDS. This program integration coupled with human resource development, upgrading of health service facilities and other logistical supports were aimed to facilitate the provision of reproductive health services to those in need. Furthermore, commitment from both government and private sectors were secured through a series of information and advocacy activities. Based on a review of the project, weaknesses and difficulties of the integrated reproductive health programme as a whole were identified but on the other hand health personnel have acknowledged potential advantages of the devolution of health programmes. Included are faster local decision-making and utilization of local health mechanisms and that health services can be more easily coordinated. Medicines, supplies and other needs for health service delivery are based on local health situation and LGUs are compelled to seriously address the issue of financial sustainability and maximize local revenue generation.

From a policy maker and health service provider point of view it is critically important to look at how policies and programs influence the provision maternal health service relative to the needs of clients that can significantly affect pregnancy and consequently maternal morbidity and mortality.

2.3 Theoretical Discussion

In addressing the research question of this paper, this section will revolve around the key issues of maternal health needs relative to access to appropriate health care services that will enable women to go safely through pregnancy and childbirth. Service provision and the quality of maternal health care are discussed to shed light on the efforts of providers to meet the maternal health needs of clients. Theoretical discussion will further include decentralization of health service delivery as a major reform of the health sector and how this process affect maternal health service provision and utilization of such services by would-be clients.

2.3.1 Maternal Health Needs

> *"Maternal health encompasses positive or negative outcomes – physical, social or mental, in a woman from any cause related to childbearing or its management".* (Koblinsky, et. al.: 1993, p. 35 cited Graham and Campbell: 1990)

The right to health is a basic human right thus, every woman in her reproductive years is entitled to have her reproductive health needs met satisfactorily. The special contribution that women make to society through maternity and motherhood is recognized in many constitutions and human rights documents. The Universal Declaration of Human Rights in Article 25(2), addressing health and well being explains that: *"Motherhood and childhood are entitled to special care and assistance"* (Cook, et. al: 2001, p. 33). This requires governments to ensure access to appropriate health care for women are entitled to such protection and aid during a reasonable period before and after childbirth. As emphasized by Germain, et.al. (1994), to truly achieve reproductive health that respects human rights,

expanded approaches must be considered which include among others, *pregnancy and delivery services, postpartum* and gynecologic care and child health in addition to improvement of quality family planning services. The availability of maternal health services will enable women to bear and raise healthy children when they desire to do so. However, to meet this desire, changes are required as to who should be served, how services are to be provided in terms of quantity and quality of care.

The focus will be on maternal health needs before delivery (antenatal), delivery services and after delivery (postpartum). Antenatal care makes a significant contribution to maternal health, thus, includes those needs related to normal pregnancy and identification and management of risk factors and complications associated with pregnancy.

By engaging in healthy behavior[6] a woman can improve her own health and that of her child and the risk of maternal complications can be reduced. Pregnant women need to eat and rest more than they do when they are not pregnant. The family and community must know the danger signs that may arise during pregnancy, labor, and delivery and after delivery so that help for the mother can be sought early from the most appropriate place. This can be life saving in situations where access to facilities is limited and where women are at higher risk of complications. Dialogue between the woman and her health care provider should augment the information on health care promotion and help the family decide on the most appropriate and safest place for the mother to deliver. Antenatal visits (a minimum of four) will not only establish confidence between the woman and health care provider but provide essential services such as tetanus toxoid immunization and prevention of anemia through iron tablet supplementation and nutrition education. Identification and management of risk factors[7] and complications[8] through proper monitoring may prevent a complication arising or enable its early detection and management (WHO: 1996).

Prenatal care and proper nutrition are both useful and relevant designed to prevent serious complications of pregnancy. These are important in averting indirect maternal deaths

[6] This includes good nutrition, iron/folic acid supplementation, safer sex, cessation of tobacco and alcohol use
[7] May include among others, young age, nulliparity or grand multiparity, abnormal presentation and extreme social deprivation

by treating underlying diseases in the course of pregnancy. However, complications of pregnancy such as hemorrhage, hypertension and infection, obstructed labor, to name a few, can not be easily ruled out even in situations where prenatal care is of high quality. Screening of obstetric complications has turned to be ineffective since the problem persists on why obstetric complications develop in the great majority of cases. There are often no early warning signs that emergency complications are likely to occur. Unless access to emergency obstetrical treatment are ensured these life-threatening complications can lead to increasing maternal disabilities and death (Freedman and Maine: 1993).

Having safely passed through pregnancy and delivery, women remain at risk for post delivery complications. More emphasis is needed on care in the days after birth, considered a sensitive but neglected period, since this is the time when women are least likely to retain contact with health service providers. In developing countries where most women prefer to deliver at home, the risk of morbidity is high when complications such as hemorrhage occur sometime after childbirth. Every opportunity must be taken to educate women and their families about when and where to seek care since postpartum care should include the prevention and early detection of maternal complications as well as contraceptive advice to permit adequate maternal recuperation before the next pregnancy (WHO: 1999).

2.3.2 Service Provision and Quality of Care

The value of providing health services of adequate quality has been universally agreed, however, the care available to women especially in developing countries is considered far from satisfactory. Services are available but these may not be according to the needs of the clients or beyond what clients can afford. Likewise, the way clients are treated by the system providing health care can in turn affect health service utilization that can eventually result to poor health.

The quality of care framework below is adopted from the J. Bruce's framework (Hardon: 1997) however, it is modified to suit quality maternal health service provision for

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[8] anemia, hypertension disorders, vaginal bleeding in pregnancy, active or recurrent urinary tract infections, STD/AIDS are examples

prenatal and postnatal care and safe delivery. At the same time it tries to show the interaction between service providers and clients given the services provided and the needs demanded.

Quality of Maternal Health Service

Program Effort	*Services Received*	*Impact*
Policy/Political support	Maternal health services required	Client knowledge and use
Resources Allocated	Information/services given to clients Technical skill of service providers	Client satisfaction
Program Management	Follow-up care Appropriate referrals	Client health

*Adopted from J. Bruce's framework on quality of care for family planning (Hardon: 1997)

Factors under program effort include inputs for the provision of maternal health services from policy initiatives and political support relative to the maternal health services required and/or needed by clients. Service providers must see to it that these services are those required by clients and known to them to ensure its utilization such as antenatal visits, immunization and nutrition education.

Resource allocation in terms of physical resources such as birthing place or emergency obstetrical care services that is accessible to clients with appropriate and timely utilization of these services by pregnant women especially those at risk for complications (Maine: 1993). Clients including the families and community can be informed and educated along these services thereby improving access to care. Obstetrical services in primary health care units or hospitals must be managed by skilled and competent birth attendants secured with the necessary equipment and medical supplies required in emergency cases. Technical skills of service providers can be upgraded through training programs by strengthening midwifery skills of health professionals as well as traditional birth attendants including intensification of counseling skills. The availability of these resources may ensure client's safety and satisfaction.

Follow-up care and appropriate referrals from the stage of pregnancy until post delivery, as part of maternal health program management must be available. Strengthening the referral system at various levels through logistics and managerial support can help

guarantee safety from the risk arising from complications of pregnancy and with such services provided, safe motherhood can be ensured.

2.3.3 Decentralization of Health Service Delivery

For more than twenty years several countries have made efforts to decentralize government services including health. The process of decentralization is related to the global trend to local autonomy with the realization that development is a bottom-up approach with community involvement. That centralized planning resulted to limited flow of resources at the periphery and that programme delivery at the local level will take account of local needs (UNFPA: 2000).

> *"Decentralization means both reversing the concentration of administration at a single center and conferring powers of local government. [It] involves the delegation of power to lower levels in a territorial hierarchy, whether the hierarchy is one of governments within a state or offices within a large scale organization" (Smith: 1995, p.1).*

In the case of the Philippines, the Local Government Code of 1991 is the legal structure for the basis of decentralization that assumes the form of devolution. It is "the transfer of power to subnational political entities[9] that involves the creation or the strengthening of the subnational units of government, the activities of which are outside the control of the central government" (Ugaz: 1997, p. 3). In this respect, the process of devolution, that is, the transfer of health services, assets, liabilities, personnel, equipment and records to local government units is a major reform of the health sector in recent years.

The DOH which is the government agency mandated to provide health services to all Filipinos was one of those national agencies whose powers and functions were devolved. The Code specifies the basic services and facilities to be devolved from the DOH to various levels of LGUs. These comprise maintenance of health care facilities including secondary and tertiary hospitals, delivery of health services through the implementation of programs and

[9] In this case, the local government units (LGUs)

projects relative to primary health care, purchase of medicines, medical equipment and supplies.

Devolution of health service delivery from the national government to the LGUs elicited fear and anxiety from DOH employees and LGU officials, a concern on the effect of devolution on the quality of health service delivery. A deterioration in health services is expected because of several reasons which may include inadequate funds to sustain service delivery, politization of appointments of health professionals and limited career path for health workers which can all result to lower quality of health services. However on the bright side is cited the shorter and closer gap on the lines of responsibility and accountability between health implementors in the fields and their superiors in the LGUs (Borlagdan 1993).

In favor of decentralization is local participation that aims at efficiency, effectiveness and equity. Efficiency in the sense that services and investments should reflect the needs of the people. If services are implemented in consultation with the community, then user preferences will be reflected more closely and these services will be more effective in meeting user needs. Equity on the basis of equality in the contributions of individuals and on the basis of differences in the ability to pay. The distinction between the ability to pay and the willingness to pay is crucial in the effort to guarantee equitable access to services (Ugaz: 1997). The decentralization theory argues that it will bring benefits in allocative and productive efficiencies. Local bodies are expected to know and respond better to local demand thereby allocating efficiently scarce resources and improving satisfaction and welfare. In addition, local bodies are deemed to be able to deliver goods at a lower cost than national bodies.

However, in view of the positive stance towards the concept of decentralization, the subject is debatable in terms of interregional inequalities. Wealthier regions may be able to raise or mobilize more funds than poorer ones and thus improve staff working conditions or that, resources and power will be simply transferred from the center to the influential in the region (Standing: 1997, cited Kutzin: 1995). As emphasized by Standing (1997, p. 9) along this issue, "while many commentators have stressed the importance of community participation as a means to improve service quality and utilization, little attention has been paid to what happens within communities, in terms of how resource allocation decisions are

made and which groups benefit from them...[what] are the organizational support needs including developing greater participation of under-represented groups such as women".

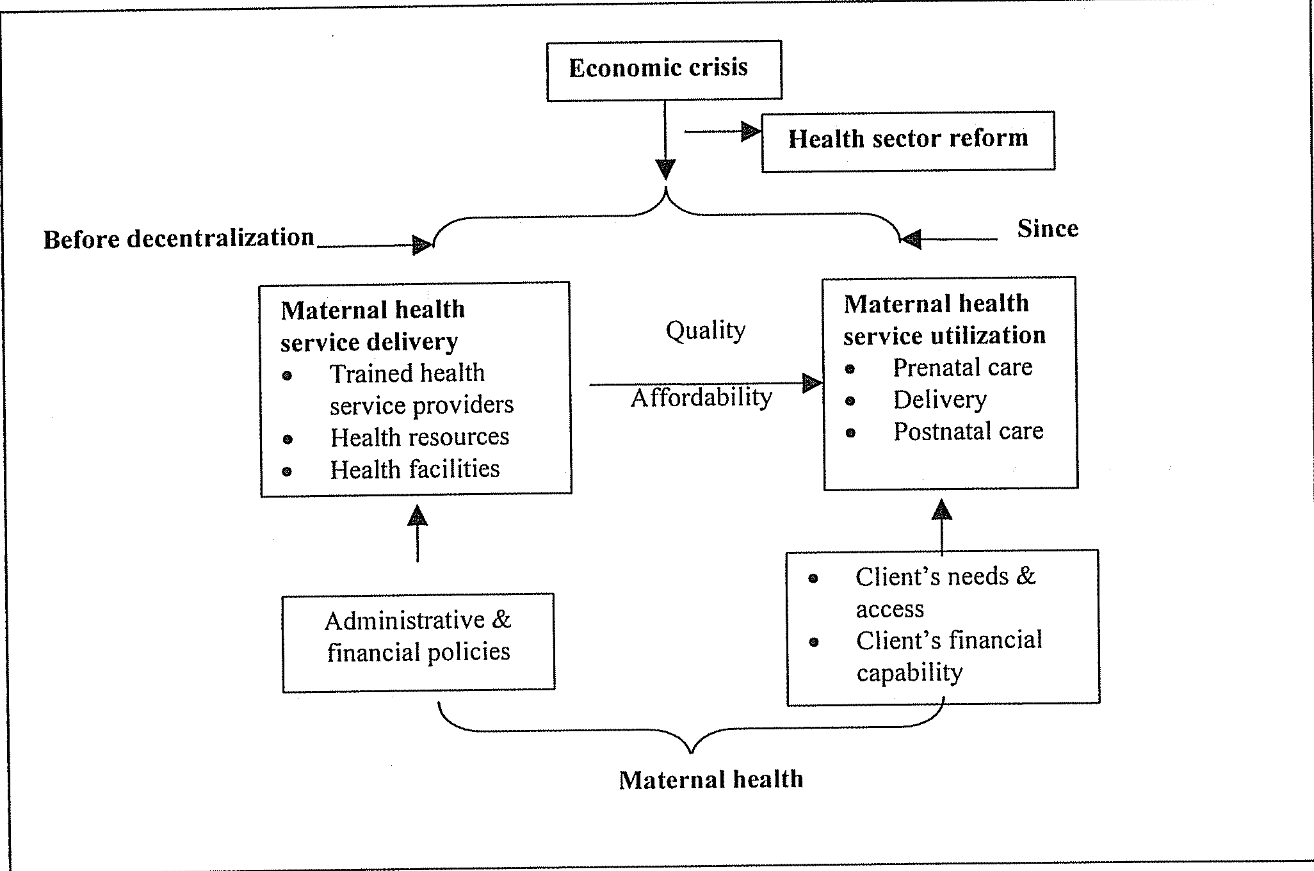
Provision of maternal health services is undermined with the advent of economic crisis, disproportionate investments by government in other sectors and centralized administration. Instead of expanding expenditures on public services such as health, it is contracting. Large variations in health status persist across population groups, people have unequal access to health services owing to physical and financial barriers. Quality of health care is wanting in most areas but appropriate care goes beyond the reach of ordinary people because of mounting cost of care. In order to address these problems the DOH developed the agenda for health sector reform 1999-2004. Among the major reforms stipulated in the document is the introduction of socialized user fees, promote the development of local health systems and expansion of the coverage of the National Health Insurance Program to extend protection to a wider population especially the poor.

2.4 Framework of Analysis

The provision of maternal health services in a system of decentralization and health sector reform in Zamboanga City will be analyzed following the conceptual framework below. As the country was experiencing economic crisis, it paved the way for the introduction of health sector reforms. However, before decentralization maternal health service delivery and health service utilization by pregnant women were already existing as part of the health package in health programs in general and is still existing since decentralization of health services. Delivery of maternal health services consisting of such variables as trained health service providers, health resources and facilities are influenced by several factors on the providers' side such as administrative and financial policies. The quality of such services according to the clients' needs and affordability by clients to pay for services or gain access to, influence maternal health service utilization specifically for prenatal care, delivery and postnatal care. Although interactions between health providers and clients occur within the whole system of decentralized health care, the focus of the analysis will deal more on the factors affecting health service delivery for pregnant women before decentralization and since

decentralization. Are there major changes that influenced maternal health to deteriorate or improve from a centralized to a decentralized system of health service delivery?

Figure 1: Framework of Analysis



Chapter 3

Maternal Health Service Delivery in the Philippines

3.1 Introduction

This chapter includes a discussion of the policy and program initiatives relative to maternal health and institutional arrangements at the national level including health financing to give a better understanding of how maternal health programs are implemented at the local level. By utilizing the framework of analysis above, national level perspective of maternal health will be analyzed.

3.2 Policy and Program Initiatives at the National Level

3.2.1 Safe Motherhood and Women's Health

a. Safe Motherhood Initiative

The Philippines following its commitment to the global Safe Motherhood Initiative launched in Nairobi, Kenya in 1987 hosted a Safe Motherhood Conference in 1988 which was a multi-sector gathering of key leaders from government, the private sector and non-government organizations. Concerned with the situation of mothers, the venue served to outline strategies to reduce maternal mortality ratio (MMR) of approximately 220 per 100,000 live births by 50% within a period of ten years. It is past the time frame but the MMR is still way above the target at 172 per live births (NSO: 1999).

With the vision of "healthy empowered Filipino mothers able to make decisions for themselves and their families and to contribute to socio-economic development" of the country, (DOH: http://doh.gov.ph/safemotherhood_alpha_safemotherhood_initiative.htm) several strategies were developed to accomplish its mission. To provide safe maternal health services and ensure the mother's safety before and after delivery, the strategies included the following:

- Training as a part of human resource development to have all births attended by a knowledgeable, caring and skilled health care provider
- Information Dissemination to make informed decision and promote better health-seeking behavior
- Social mobilization and community participation to encourage multi-sectoral cooperation and bottom-up approach to problem solving and decision-making
- Promotion of gender sensitivity at all levels
- Quality assurance scheme through the *Sentrong Sigla*[10] concept
- Upgrading facilities and equipment for obstetric emergencies since every pregnancy faces risk and there is no such thing as no risk pregnancy
- Making quality care accessible for every woman has the right to safe delivery and quality maternal care services

(DOH: http://www.doh.gov.ph/safemotherhood.htm)

The safe motherhood initiative is anchored on the four pillars of antenatal, clean and safe delivery, emergency obstetric care and family planning. It equips health providers with the proper information to be disseminated and those that should be known by pregnant women and their families.

b. Women's Health and Safe Motherhood Project

Relative to the Safe Motherhood initiative, the Women's Health and Safe Motherhood Project (WHSMP) is a five-year project launched in 1996 to be implemented in 77 provinces within the 16 regions of the country co-financed by five foreign donors and the Philippine government through the DOH. The project aims to provide technical assistance, material and financial inputs for the national and local levels along maternal care through micronutrients supplementation (iodine, iron and Vit. A) to pregnant and lactating mothers. It also provides obstetrical kits for midwives and traditional birth attendants including obstetrical drugs and supplies.

[10] Literally translated as "healthy center" is part of the quality assurance scheme of the DOH launched in the later part of 1998 with technical assistance from JHU and funding support from USAID. It is designed to assess a facility's preparedness to provide quality health services based on standards which include facility clinic hours, services provided and human resource. It is a conscientious effort by the government to achieve meaningful progress towards the improvement of the lives of women and families.

Improvement in the quality of services and accessibility of a selected number of first level referral hospitals, health units and barangay health stations are done through upgrading and renovation. Construction of maternity waiting homes and lying-in clinics in selected facilities and provision of necessary drugs, medical supplies and equipment is included in the project's civil works.

The project likewise aims to improve the quality and accessibility of health services for other reproductive health concerns such as reproductive tract infections and cancers. By establishing partnership with non-government organizations, local government units, local communities and the DOH, the capabilities of the various stakeholders for women's health issues will be strengthened. Putting all these together, the project is expected to contribute to the improvement of women's health by improving nutrition of women, prenatal attendance, referral services for high-risk pregnancies and eventually reducing maternal mortality. The LGUs are responsible for project implementation at the local level in accordance with project implementation agreements. However, since the project is considered a vertical program, it is managed at the national level through the regional health offices that monitor and undertake the regional implementation of the project.

3.3 Institutional Arrangements

Prior to devolution, just like other agencies with their specific mandate, the Department of Health was to provide health services to all Filipinos. It was divided into different administrative units – the central office based in Manila, the Regional Health Offices (RHO), the Provincial Health Office (PHO), the District Health Office (DHO) and the City/Municipal Health Office (C/MHO). The central office of the DOH undertakes among others the following functions:

- Formulating and setting policies and standards
- Designing and sourcing funds for national health programs
- Monitoring and controlling the implementation of national programs
- Licensing hospitals and analyzing food and drugs

- Monitoring and regulating the practice and operations of medical professionals and hospitals
- Designing and implementing training programs for health workers

In addition, it operates, equips and maintains large tertiary government hospitals usually located in the capital city. Since 1986, while the government offers a range of preventive, curative and rehabilitative services, the private sector furnishes mainly curative and rehabilitative care. Privately operated health care facilities are found mostly in urban areas and cater largely to the upper and middle-income groups. Government health care facilities are distributed among urban and rural areas and assign priority to and are more generally used by those with lower incomes. Various non-governmental organizations provide health care in depressed areas where they offer mainly primary care, maternal and child health including family planning and nutrition services.

The public health care delivery system as administered by the DOH is organized in a pyramidal structure. The regional health offices are responsible for monitoring, implementation of programs, outbreak of diseases, dissemination of health information and education, implementation of health programs for health workers and operating tertiary hospitals at the regional level. The provincial health offices serve as conduit of the department to the other offices lower down the administrative hierarchy. The primary health care facilities are available to the lowest level through barangay health stations (BHS) and rural health units (RHUs) which serve groups of municipalities. At the barangay level, midwives, nurses and physicians furnish preventive and simple curative care. Some RHUs are equipped with beds and limited operating room facilities while government health and hospital services are integrated at the district and provincial levels. A district health officer administers the district hospital and rural health units in each district. Likewise, a provincial health officer is responsible for the provincial hospital and the public health service network in each province.

Volunteer and paramedical workers have been trained to furnish limited health care services for the 20-30 households assigned to them. Traditional healers and birth attendants play important roles in the delivery of health care in rural areas where modern facilities are

often inadequate (Nuqui: 1991). Table 1 shows the service ratio of health care facilities and selected health personnel to population before and since decentralization of health services (see Annex A for absolute number).

Table 1 : Service Ratio of Health Care Facilities and Personnel to Population, Philippines, 1985-1995

Unit/Health Personnel	*Standard Ratio to Population*[a]	*1985*	*1990*	*1995*
Hospital	1: 60,000	1 : 26,500	1 : 35,027	1 : 40,361
Rural Health Unit	1: 20,000	1 : 24,157	1 : 26,450	1 : 30,562
Barangay Health Station	1: 5,000	1 : 6,019	1 : 5,980	1 : 6,075
Doctor	1: 20,000	1 : 6,901	1 : 8,168	1 : 33,816
Nurses	1: 20,000	1 : 5,461	1 : 5,910	1 : 25,469
Midwives	1: 5, 000	1 : 4,965	1 : 5,231	1 : 6,295
Total Population		48,098,460[b]	60,703,206	68,613,706

[a] As specified in health planning standards by DOH
[b] Population based on 1980 census

With devolution, basic services and facilities were specifically devolved from the DOH to LGUs. This included implementation of national programs and maintenance of provincial hospitals. Regional offices were converted into field offices whose main functions would be primarily to monitor health programs and provide technical assistance. For barangays, included in the devolution are the health services and maintenance of the barangay health center. For municipalities, health services to be devolved include the implementation of programs and projects on primary health care, maternal and child care, communicable and non-communicable disease control services, access to secondary and tertiary health services; purchase of medicines and medical supplies and equipment needed to carry out the mentioned services. The operation and maintenance of hospitals and other tertiary health services are devolved to the provinces (Borlagdan: 1993).

3.3.1 Health Financing

Several types of medical insurance schemes are currently available among which are:

- Compulsory (Medicare and Employee Compensation Funds) and social insurance covering mainly the employed population in both the private (through the Social Security System) and the government (through the Government Service Insurance System) sectors
- Medical insurance with personal insurance
- Insurance provided through health maintenance organizations (HMOs) of which only 7 were registered in 1985 and 20 in 1999
- Voluntary Medicare insurance covering the self-employed

The overall spending for health of about 3.5% of GNP is still below the World Health Organization benchmark of 5%. The state of health financing showed heavy dependence on family out of pocket spending for health services and bias towards hospital-based care which is more on the curative rather than preventive as shown in Table 2. With health care financing reforms the National Health Insurance Program will be the major payor of health services.

Table 2 : Total Health Expenditures by Use of Funds, 1991-1997

Year	Amount (in billion pesos)				Percent Share			
	Personal Health Care	Public Health Care	Others	Total	Personal Health Care	Public Health Care	Others	Total
1991	28.5	2.8	6.0	37.3	76%	8%	16%	100%
1992	32.6	2.9	6.2	41.7	78%	7%	15%	100%
1993	34.4	5.6	7.2	47.2	73%	12%	15%	100%
1994	39.9	7.0	8.5	55.4	72%	13%	15%	100%
1995	49.1	7.2	10.4	66.6	74%	11%	16%	100%
1996	57.7	9.3	10.8	77.8	74%	12%	14%	100%
1997	63.5	12.0	13.0	88.4	72%	13%	15%	100%

Sources: UP Economics (1991-1994); NSCB (1995-1997)

a. The National Health Insurance Program[11]

The National Health Insurance Program (NHIP) seeks to provide all citizens with the mechanism to gain financial access to health services thus serve as a means to help the people pay for health care services. The NHIP which establishes the Philippine Health Insurance Corporation will administer the program at central and local levels to prioritize and accelerate the provision of health services to the people especially the segment of the population that cannot afford such services. Among the five major reforms stipulated in the Health Sector Reform Agenda by the DOH is to expand the coverage of the NHIP. Social health insurance must expand to extend protection to a wider population especially the poor. Health insurance benefits must be improved to make the program more attractive and such improved benefits and services must be used to aggressively enroll members.

This social insurance program shall serve as a means for the healthy to pay for the care of the sick and for those who can afford medical care to subsidize for those who cannot. It shall initially consist of the Medicare program and gradually expand to constitute one universal health insurance program for the entire population so all persons eligible for benefits under the Medicare program are automatically made members of the NHIP. The program is limited to paying for the utilization of health services by covered beneficiaries or purchasing health services in behalf of such beneficiaries.

To enroll indigents to the NHIP, local government units will be encouraged to join the indigency program of the Philippine Health Insurance Corporation (PhilHealth). The LGU will pay a counterpart of the total premium of P1,188.00 per member while PhilHealth will pay the rest. Depending on the classification of the area, LGU counterpart could range from 10-50% of total premium. To signify their interest, LGU will sign a memorandum of agreement with DOH and PhilHealth and assign a person to oversee and coordinate.

Assessment of the coverage of the NHIP among the poor in the population is beyond the scope of this study, however, unless local government officials will make health insurance

[11] Enacted through Republic Act No. 7875 in February 14, 1995 – an act instituting a National Health Insurance Program for all Filipinos and establishing the Philippine Health Insurance Corporation.

a priority among their programs only then can the poor ones afford public health services that require fees.

3.4 Standards of Maternal Health Services

Across all health care services the standard requirements on health facilities and personnel apply as attested by the health planning standards to be implemented by local government units (see column 2 of Table 1. p. 25). The standard ratio to population of health facilities and human resources for health provision will be used to analyze the availability of such resources at the local level to meet the health needs of clients.

Other health standards specific to maternal health programs include clinic services offered and provided in health facilities such as antenatal and postpartum care, maternal care and delivery, information, education and communication through bench conferences and distribution of materials and referral of cases to the next level health facility. Training programs of health providers include at a minimum midwifery skills, physical assessment of clients and counseling skills including family planning.

Chapter 4

Maternal Health Services in Zamboanga City

4.1 Introduction

Maternal health services and delivery in the focus area of this study will be discussed in this chapter. An overview of Zamboanga City is presented to give a clear perspective of the area including its history, demographic and socio-economic conditions that may affect demand and utilization of health services specifically for maternal health. Likewise, this chapter describes maternal health service delivery in the city relative to the health policies and programs specified by the national government as well as those implemented by the local government.

4.2 The Study Area - Zamboanga City

4.2.1 Historical Background and Location[12]

Zamboanga City is a well-known melting pot, a product of the mixture of many cultures from Chinese, Malaysian, Spanish and Caucasian blood. It was in June 23, 1635 that marked the change of the name of the place from "Samboangan"[13] to its present name. For almost three hundred years, the Spaniards held over what is now Zamboanga City with Fort Pilar as the center of settlement. In 1898, a year after the Treaty of Paris, the Philippines was ceded to the United States of America and the Americans occupied the city. It was during the American period in 1901 when the settlement was formally organized into a municipality under Public Act No. 135.

Under the United States rule in the early 1900s, Zamboanga City was the governing capital of the Moro Province, encompassing the entire island of Mindanao and Sulu Archipelago. On September 15, 1911, the legislative council of the Moro Province passed

[12] Gathered from the Zamboanga City Master Development Plan (1997 – 2012), Volume II by the University of the Philippines Planning and Development Research Foundation, Inc. (UP PLANADES)

Act No. 272 converting the municipality of Zamboanga into a city with a commission form of government.

On October 12, 1936, Zamboanga was honored with a chartered city status under Commonwealth Act No. 39 with the island of Basilan as part of the territory. At one point it was noted to be the largest city in the world, area-wise, not discounting its strategic importance as a center of government and commerce. It was on November 22, 1983 when Zamboanga was declared a highly urbanized city[14] in accordance with the provision of the Local Government Code of 1983.

The City of Zamboanga is situated at the southernmost tip of the Zamboanga Peninsula in the Western Mindanao Region (Region IX), southwestern part of the Philippines. One of the 4 cities in the region (in addition to 4 other provinces), it has an aggregate land area of 1,483.385 sq. km. which encompasses 25 small islands in addition to its 98 barangays of which 30 are urban[15] and 68 considered rural barangays .

Declared as one Congressional District, Zamboanga City is represented by a lone Representative in Congress. Since the beginning of formal political administration in 1916, men have dominated political leadership in the area. It was only in 1998 when the city elected a woman to be its Local Chief Executive along with thirteen (13) regular members of the *Sangguniang Panlungsod*[16].

This LGU is governed by the Local Government Code of 1991 that refers to the city council as the legislative body of the city. Included among its powers, duties and functions are the "enactment of ordinances, to approve resolutions and appropriate funds for the

[13] *Samboangan* comes from the Malay word "sambuan" meaning the long pole used to moor the frail boats or *vintas*. Other versions have it that Zamboanga could have been derived from the Malay word "jambangan" which means a "pot or place of flowers".

[14] A city that meets the following requirements: (a) minimum population of 200,000 inhabitants as certified by the National Statistics Office, and (b) with the latest annual income of at least fifty million pesos as certified by the city treasurer. Based on the 1980 census, Zamboanga City exceeded the minimum requirement with a population of 343,722.

[15] Locational classification of barangays within the seven-kilometer radius of the city center.

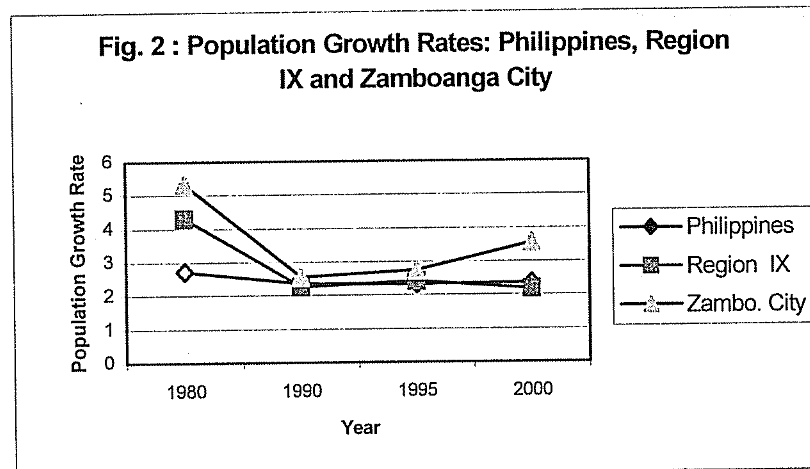
[16] Otherwise known as the official city council comprising of the vice mayor as presiding officer, 12 officially elected council members, the president of the city chapter of the *Liga ng mga Barangay* (Association of Barangay Councils) and president of the *Panlungsod na Pederasyon ng mga Sangguniang Kabataan* (Youth Group).

general welfare of the city and its inhabitants" (LGC 1991 Sec. 458, p. 210). Under Section 18 of the Code the local government unit likewise has the "power and authority to establish an organization that shall be responsible for the efficient and effective implementation of the development plans, program objectives and priorities" (LGC 1991, p. 14). Furthermore, it is "authorized to create its own sources of revenue and to levy taxes, fees and charges which shall accrue exclusively for its own use and disposition...[to] have a just share in national taxes...[have] an equitable share in the proceeds from the utilization and development of the national wealth and resources within its respective territorial jurisdiction..." (LGC 1991, p. 14). In addition to certain provisions on local government taxation and upon the majority vote of all members of the city council, the city mayor is authorized "to negotiate and contract loans and other forms of indebtedness" (LGC 1991, p. 213). The exercise of these corporate powers for an efficient and effective city government as provided in the Code is still under the supervisory authority of the President to ensure that the local government unit acts within the prescribed powers and functions.

The Code has further authorized the devolution to LGUs of certain functions exercised by the national government such as those relating to health and social welfare including records, equipment, personnel and other assets. From 1992 onwards, the city government gradually discharged functions and responsibilities relative to health program implementation and delivery of primary health care services in addition to maintenance of health facilities and devolved hospitals. Likewise, wages and benefits of devolved health personnel came under the responsibility of the local government. Although regional offices were retained for monitoring purposes and to provide technical assistance to the local government unit, the task was extensive considering the funds or resources available. This has contributed to the apprehension of devolved health personnel relative to implementation of health programs including benefits and wages. However, the city managed to continue delivery of services with the assurance from the national government to augment basic services and facilities if inadequate to meet the requirements of the population.

4.2.2 Demographic and Socio-Economic Profile

The city's population of 343,722 in 1980 reached 601,794 in 2000 due to the increasing population growth rate of 2.6% (1980-1990) to 3.12% (1990-2000). The population of Zamboanga City comprises 19.5% of the total population of the Western Mindanao region and with this increasing population growth rate, it is estimated that in a span of only 22 years, the city's population will double and reach more than 1 million by the year 2022. At present the average household size of 5.23 is higher than the national and regional averages of 4.92 and 5.19, respectively. While the country experienced a steady and consistent decline in population growth, both Region IX as a whole and Zamboanga City posted patterns of change in their population growth rates (see Figure 2 and Table A.1 at Annex A).



Source: National Statistics Office (NSO)

At present, this population size is already exerting pressure on existing resources and is compounded by rapid urbanization. Most agricultural lands are being transformed to commercial and residential zones to meet the demands of the 80% population in the urban areas. Overall population density is 1,298/sq.km. which is extremely higher than both the regional and national averages of 174.7/sq.km. and 228.7/sq.km, respectively. As of 1995, the age-sex structure of the population depicts a very young population where 37.7% belong to the ages 0-14 years, 59.6% belong to the 15-64 age group and 2.7% aged 65 years and above. Although the sex ratio has been more or less equal at 100, the dependency burden is still high at 68/100.

Among the factors that could have contributed to the large population size of the city are fertility and migration. The reported contraceptive prevalence rate of 61% is the highest among the provinces and cities in the region. However, even with the overall decreasing levels of fertility in Western Mindanao from 4.46 in 1993 to 3.9 in 1998[17], the birth rate in Zamboanga City is declining at a slower pace as reflected in the crude birth rate (CBR) of 27.2 in 1991 and 23.4 in 1996.

In addition to the mobility of the population within rural *barangays,* increasing population growth results from movements or in-migration to the city that is encouraged by employment opportunities through the expansion in growth and industrial centers in the area. These movements take the form of migration of farmers to new arable lands in another rural area, movements of landless farmers from depressed barangays to join the urban informal sector, including transfer of residence due to peace and order problems in the area of origin.

The employment rate in the city has not improved much (88% to 89.2%) since the last ten years and labor force participation rate has even decreased from 56% to 51.5% from 1995 to 2000. The situation contributes to the high percentage (38.5%) of families below the poverty threshold[18] where poverty level in the rural areas has been found to be generally higher than the urban poverty level. This supports the fact that as of 1997 medical care is not considered a priority among families with less than 1% of the total expenditures allotted to health care while food and rent for occupied dwelling units take the biggest share.

The presence of several educational institutions in the city invite young people from neighboring provinces and cities within the region for better education and thus in turn contribute to the region's literacy rate. Aside from being able to provide vital land transportation access to all the major cities of the country, Zamboanga City is a busy international port, strategically located and accommodates local inter-island shipping and international ocean-going vessels and ferries. This increases its participation for economic

[17] Based on the 1993 and 1998 National Demographic and Health Survey conducted by the National Statistics Office

[18] The annual per capita income required or the amount to be spent to satisfy nutritional requirements (2,000 calories) and other basic needs which is P11,046 within Region IX as of 2000 (NSCB).

growth in the Brunei, Indonesia, Malaysia and Philippines' East Asia Growth Area (BIMP-EAGA). This is likewise interrelated with the process of rapid urbanization and even with the lack of data on migration, based on observations, the influx of migrants in the city is on the rise. Meeting maternal health needs of both women residents and migrants is therefore a great challenge for authorities in charge of health provisioning considering the increasing number of clients and limited availability of services and resources.

4.3 Maternal Health Service Delivery in Region IX and the City of Zamboanga

Although there are various institutions providing maternal health services such as non-government and private institutions, this section will highlight programs and activities provided by government institutions particularly at the primary level of health care. The Regional Field Health Office IX[19], the regional arm of the DOH in Western Mindanao has redefined its functions to program monitoring and provision of technical assistance since devolution. The decentralization process has likewise affected the role of the City Health Office in Zamboanga City.

4.3.2 Administrative and Financial Arrangements for Maternal Health Service Delivery

a. Regional Field Health Office (RFHO)

Implementation of health programs in Zamboanga City before the devolution of health services to local government units in the early 1990s was done with the assistance of the RHO. It was designated to undertake the following tasks that include among others, implementation of special projects, disseminating health information and education, monitoring and compiling data on the implementation of national health programs. In addition, it was responsible for the implementation of training programs among health workers, monitoring and reporting the outbreak of diseases, analyzing food and drugs, licensing hospitals including operation and maintenance of tertiary hospitals.

[19] Initially called Regional Health Office (RHO) before decentralization of health services

In 1990, The RHO serviced 5.3% of the country's population in five provinces including Sulu and Tawi-Tawi and four cities through its hospitals, rural health units and barangay health stations. Some 1,524 health care personnel including physicians, nurses, midwives and sanitary inspectors managed the various health facilities in the region. Deployment of health personnel through special projects such as the Philippine Health Development Project complemented the region's resources on health personnel particularly the hard-to-reach and depressed areas which include the island barangays and other areas in armed conflict (DOH, 1991).

In 1990, since the DOH was responsible for the general administration including personnel benefits, regional operations of public health services and hospital operations, in addition to locally-funded and foreign assisted projects, national funds appropriated for Region IX was at a total of P272,559,000. Under the regional operations services, operating expenditures included salaries and benefits of personnel, maintenance and other operating expenses relative to the implementation of the primary health care program, extension of medical and health services for regional hospitals, sanitaria, district and municipal hospitals. In addition to medical and health services extended to provincial health offices, the appropriation also included subsidy to indigent patients for confinement in private tertiary hospitals for special treatment. Of this total amount only 1.18% is appropriated for the primary health care program which implements maternal health care.

In the advent of devolution of health services and with emphasis on the role of local government units and technical assistance from the Regional Health Offices, in 1996 Region IX was allocated funds for general administration and support and operational maintenance service of retained hospitals. The P159,389,000 (58% of the total amount in 1990) regional allocation included fund assistance in the primary health care program of local government units (4.3% of total budget), local health board liaison and coordination as well as hospital-based women's health desk. Higher budgetary allocation is noted in 2000 at P279,455,000 where although 83% of the regional budget is allocated to hospitals, emphasis is likewise given to inter-LGU collaboration through local health management and support to the local health board. Through the years the budget allocation for the region from the national government has actually been reduced in real value. Considering inflation and the goods that

money could buy based on 1990 prices, the budget for 2000 is only 55% of the 1990 budget allocation. However, the reduced functions of the RHO relative to program implementation since the LGU is the provider of health services have to be considered.

Among the health programs implemented by the Regional Health Office, maternal health program is one, integrated into the Maternal and Child Health Program (MCHP). Activities included the registration of pregnant mothers; records keeping; provision of prenatal care such as tetanus toxoid immunization, food supplementation and micronutrient supplementation with iron tablets, vitamin A and iodine. Trained health professionals and birth attendants likewise performed delivery and childbirth services in hospitals, rural health units and homes. Postpartum services including food supplementation and initiation into breastfeeding were conducted which goes hand in hand with food assistance and nutrient supplementation for undernourished children.

The Expanded Program on Immunization (EPI) focused on the immunization of infant and mothers aimed at reducing the number of deaths caused by immunizable diseases. Furthermore, activities such as promotion of birth control methods such as the pill, inta-uterine devices (IUD), injectables, condoms, vasectomy, bilateral tubal ligation and natural methods including basal body temperature, cervical mucous and sympto-thermal methods were among those carried out under the Family Planning Program (FPP).

These programs are monitored by the technical division of the Regional Health Office that is divided into different sections with Maternal and Child Health included. The DOH Annual Report of 1991 highlighted the construction and renovation of several hospitals and barangay health stations within the region to respond to better delivery of health services. These health facilities are considered stations of health personnel and where both the sick and well seek assistance to ascertain their health status.

The RHO has been responsible for the conduct of capability building programs for health workers. Series of training and consultative meetings were conducted along health education and information campaign, health planning in collaboration with non-governmental organizations, and management service capabilities. The Family Planning Program had the most number of training courses conducted in terms of basic and refresher courses, although

there are no specific training programs for maternal health care alone aside from basic training courses on family planning, the following are provided especially for midwives:

- Role of midwives for safe motherhood
- Safe motherhood – The core of midwifery practice
- Scientific symposium and safe motherhood clinical research

Collaboration with non-government organizations giving health a priority complemented service delivery where volunteer barangay health workers (BHWs) in communities selected as project areas in Zamboanga City were trained on Basic Health Care.

In the early part of 1990, the Department of Health developed the Field Health Service Information System (FHSIS), a data monitoring and information system. Through the regional health office, training program for computer operators in addition to consultative meetings among implementors and supervisors were conducted for effective monitoring and data gathering necessary for health planning purposes. This was aimed to improve the process of data recording from the old system to effectively implement and monitor health programs.

After the devolution, the regional health office was converted into a field office whose main function is primarily to monitor the implementation of health programs, provide training services and technical assistance on a need basis.

b. City Health Office

The City Health Office is one of the major departments in Zamboanga City that presently provide preventive and curative health care to more than 600,000 population. Even before devolution of health services in 1994, a City Health Officer who is a certified and qualified medical practitioner heads the department. The assistant city health officer is a medical professional as well and both oversee the functions of the five divisions in the department, namely, field health service, nursing, sanitation, administrative and technical (See Annex B on organizational structure). Although attempts were made to reorganize the

structure of the city health office, a very slight change has been made since devolution that is concerned with malaria control services.

The technical services division looks into services such as dental care, family planning, social hygiene that takes into account treatment of sexually transmitted diseases, medical services, nutrition, general laboratory, x-ray, and food and drugs. With qualified professionals such as physicians, dentists, nurses, midwives, medical technologists and radiologists, most of these services are provided in the health office located in the urban center of the city. The statistics and planning section of the department runs under this division but is directly under the assistant city health officer. The administrative division is responsible for personnel and records keeping including property and supply as well as other miscellaneous services. The field health service division together with nursing and sanitation are considered the frontliners in the delivery of primary health services at the grassroots level.

A medical officer manages a rural health unit (RHU) in coordination with a public health nurse, midwife, sanitary inspector and medical technologist since malaria control services including drugs regulation are lodged in the rural health unit. The RHU is considered a central health station in a health district and is directly responsible to oversee program implementation at the barangay health station (BHS) which in some cases are more than three under an RHU depending on the coverage of the area.

A midwife who provides primary health care services manages a barangay health station in collaboration with community volunteers trained in basic health care. The barangay nutrition scholar is trained to provide nutrition education to mothers of undernourished children and assist in supplemental feeding and nutrition. The barangay health worker (BHW)[20] trained in basic health care including health information dissemination and the trained *hilots*[21] who are provided with the necessary equipment and health education for safe home deliveries. Among these volunteers, the BHWs who are actively and regularly performing their duties are entitled to benefits and incentives such subsistence allowance, access to loan and continuing education (http://203.172.12.3/ra7883.htm).

[20] A person who has undergone training programs under any accredited government and non-government organization and who voluntarily primary health care services in the community after having been accredited to

Table 3 presents the number and service ratio to population of health facilities and human resource under the field health service of the City Health Office. On the other hand, Figures 3 and 4 show the availability of these resources in the city including those in private and government hospitals in comparison with three other provinces in the region.

Table 3. Number and Service Ratio of Health Facilities and Selected Health Personnel, Zamboanga City, 1995 and 1998

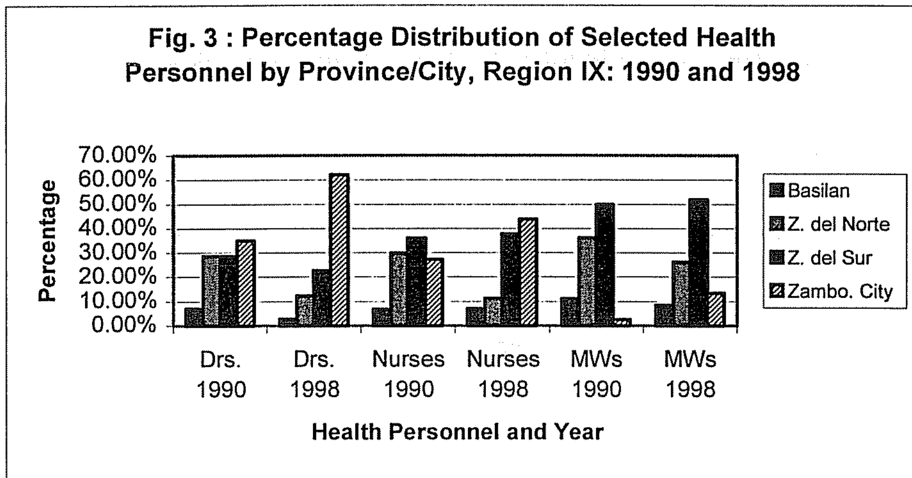
Indicators	1995		1998		Standard Service Ratio
	No.	*Service Ratio to Pop.*	*No.*	*Service Ratio to Pop.*	
Rural Health Unit	16	1 : 31, 946	16	1 : 31, 946	1 : 20,000
Brgy. Health Station	80	1 : 6, 389	73	1 : 7,001	1 : 5,000
Medical Health Officer	18	1 : 28, 396	17	1 : 30,067	1 : 20,000
Public Health Nurse	29	1 : 17, 625	29	1 : 17,625	1 : 20,000
Rural Health Midwife	90	1 : 5,679	99	1 : 5,163	1 : 5,000

Source: City Health Office, Zamboanga City; 1998 population was based on 1995 census

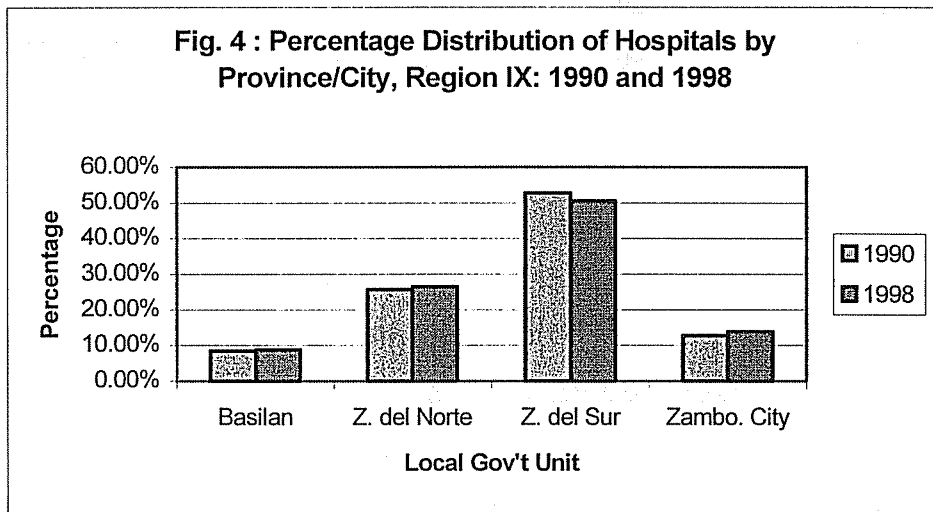
Although the time frame may be short and there is no data before the devolution of health services, however, devolution started between 1993 and 1994 in Zamboanga City so the following data will suffice to show the health service ratio in the city. Service ratio for nurses is within standard requirements while there is slight improvement in the ratio of midwives to population. The data further shows that government facilities and the number of service providers do not meet the standard requirement set. Computations were based on the official census data of 1995 for both periods which further shows that with the present population growth rate the city is experiencing, the health service ratio would even be less favorable.

function as such by the local health board in accordance with the guidelines promulgated by the Department of Health (Republic Act. No. 7883, Section 3: 1995)

[21] Traditional birth attendants (TBAs) trained and provided with the necessary delivery kits who assist the midwife or conduct separate home deliveries including postpartum care.



Source: NSCB



Source: NSCB

There is considerable improvement as to the number of health personnel and hospitals in Zamboanga City where increase in the number of midwives which are considered frontliners in the delivery of primary health services at the barangay level is noticeably high. It may likewise be attributed to increasing concern for maternal health care with the advent of the Safe Motherhood Initiative alongside Maternal and Child Health Program. The hospital bed ratio to population has improved, relative to the increase in the number of secondary and tertiary private hospitals which shows emphasis in the delivery of curative health care in the

urban setting. . Zamboanga City has the highest number of doctors and nurses compared to the provinces in the region.

Ideally, the City Health Office should have a section that conducts capability building programs and training needs assessment for its health personnel. However, what is practiced is that the RFHO still conducts trainings and program coordinators in the city health office are the ones who choose the participants. Accordingly, priority is given to newly employed personnel but refresher courses are also provided to old employees. For whatever maternal and child health related training programs, midwives are being sent to attend.

Through its statistics and planning section, the City Health Office is responsible for the submission of vital statistics reports including morbidity statistics to the RFHO through the FHSIS. In addition, health resources statistics including personnel are submitted on a regular basis that the RFHO forwards to the DOH Health Intelligence Service.

Zamboanga City is governed by the Local Health Board headed by the city mayor as chairperson, the city health officer as vice-chair and the chairperson of the committee on health of the city council. The private sector is likewise represented together with a representative of the Department of Health. It is the role of the local health board to propose to the city council in accordance with the standards and criteria set by the DOH, annual budgetary allocations for the operations and maintenance of health facilities and services in the city.

Available data show financing of the city health office at P1,000,000 to P14,000,000 for medicines alone in 1990 and 2000, respectively showing an increase in budget allocation. Although the consumer price index based on the 1990 prices showed increased allocation but it is not much considering the present value of the peso, inflation and increasing population in need of services. The situation may improve with the increase in internal revenue allotment (IRA)[22] of the city from P88,594,888 in 1990 to P756,767, 291 in 2000.

[22] 40% share in gross collection of the Bureau of Internal Revenue based on population (50%), land area (25%) and equal sharing (25%)

The city funds mainly pay for the salaries, wages, allowances and other benefits of officials and employees and provide for the expenditure necessary for the proper conduct of programs, projects, services and activities of the city government as stipulated in the local government code.

4.3.2 Maternal Health Service Delivery and Utilization

Since devolution of health services started in early 1994, there is no significant difference in the implementation of maternal health program by the City Health Office (cited by A. Cortez per interview with nursing personnel of the City Health Office, September 2001). However, the present integrated maternal and child health program is one of the elements of reproductive health that is the primary focus since the late 1990s. But not all elements are being implemented for various reasons from inability of health personnel to implement related programs because of the lack of skills and poor grasp of the context of reproductive health including lack of funds.

However, with the assistance from the regional health office, efforts are made to integrate the elements of reproductive health into the existing health programs in addition to training and orientation of health managers and service providers to reproductive health. The existing maternal health program before and since devolution of health services includes prenatal care with tetanus toxoid immunization, delivery services and postpartum care, baby-friendly hospital and breastfeeding program. The introduction of user fees are not officially declared especially in primary health care facilities, in as much as these are considered government facilities. But free services from primary health care facilities have not affected the incidence of maternal mortality since it is still fluctuating. However, health workers have to mobilize resources for the maintenance of health facilities including medical supplies through donations from clients.

Maternal mortality rate has increased from 1.12 in 1990 to 1.33 per 100 live births in 1991 but has been gradually fluctuating until the late 1990s. The leading causes are postpartum hemorrhage, toxemia of pregnancy and hypertension complication during pregnancy and childbirth, among others. Table 4 presents some health indicators that

prompted health implementors to strengthen the maternal and child health program in such a way that proper assessment and case-holding of pregnant women with regular follow-up of identified high risk cases are emphasized.

Table 4. Health Indicators: Zamboanga City
1990 – 1998

Indicators	1990[a]	1992	1994	1996	1998[a]
Crude Birth Rate	16.87	27.2	25.2	23.4	22.4
Crude Death Rate	2.33	5.4	4.2	4.4	4.7
Infant Mortality Rate	22.76	27.0	19.8	21.9	12.55
Neonatal Mortality Rate	n.a.	12.6	9.7	10.4	10.0
Maternal Mortality Rate	1.12	1.3	0.5	0.7	1.12

Source: [a]Department of Health; Zamboanga City Master Development Plan (1997-2012, p. 16)

a. Pre-natal Care

Prenatal care is provided by qualified health personnel in all health stations from the rural health units down to the barangay health stations in terms of check-ups, micronutrient supplementation and tetanus toxoid immunization. Since the number of pregnant women are increasing, improvement in the utilization of prenatal care is observed from 64.6% in 1991 to 69.7% in 1999 although a slump is observed with a lower percentage (33.4%) prenatal visits in 1995 where MMR is observed to be lower during this period[23].

The data in Table 5 likewise shows an increase in the number of pregnant women given tetanus toxoid immunization from 52.6% in 1995 to 74.7% in 1999. This may be attributed to the efforts made by health workers along health information and education that leads to the fact that when more services are provided there is fewer incidence of morbidity and death.

Table 5. Prenatal Care, Zamboanga City, 1991-1999

Indicators	1991	1995	1999
Eligible population	15,989	17,602	19,940
Pregnant Women w/ 3 or more prenatal care	10,335	5,886	13,912
Pregnant Women given TT2 plus	na	9,259	14,895

Source: Department of Health Annual Reports

[23] This may be attributed to misrecorded cases although the FHSIS has been adopted by the CHO

b. Perinatal Care

The local government of Zamboanga City maintains only one hospital with a bed capacity of ten. Although the city has a total of five government hospitals since 1989 up to the present the remaining four are retained hospitals and maintained by the DOH. Rural Health Units are suppose to provide lying-in clinics for pregnant or postpartum cases since it is a part of maternal services. However, out of the 16 RHUs distributed throughout the area only 5 provide for lying-in services. Three of these are located within the urban areas while the remaining two are located on each side of the east and west coast of the city. Table 6 presents the percentage of natality by place of birth and attendance at birth in the city from 1991 to 1995. Since barangay health stations are not equipped to provide lying-in services, trained health providers therefore conduct home deliveries. An increase in the number of home deliveries is observed and TBAs attend to more deliveries than nurses do.

Health personnel practice referral system to the next level of health care in cases of risks and complications. For women who are in need of emergency obstetric care, referrals are made to either primary or tertiary hospitals that are located within 2 hours from the first level referrals. The location of these health facilities is responsive to Administrative Order No. 79 of the Safe Motherhood Policy, which states that all deliveries should be attended by askilled attendant[24]and is within 2 hours from the first level referral or well-equipped hospital. This can be true to clients within the mainland of the city but may pose a problem for high-risk women in island barangays or in hard-to- reach areas with rugged terrain

Table 6. Percentage Natality by Place of Birth and Attendance at Birth, Zamboanga City, 1991-1995

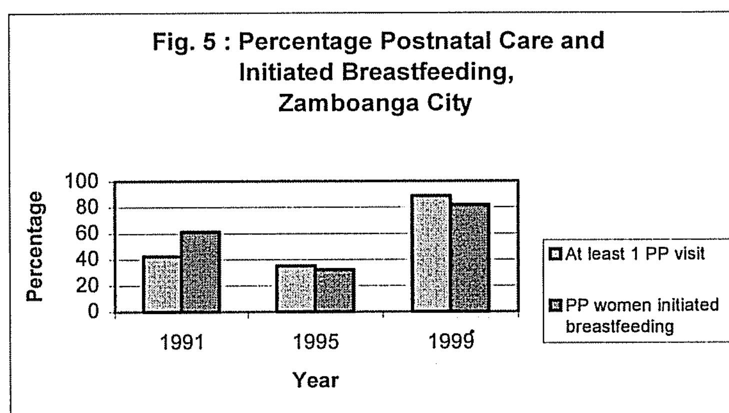
Indicators	1991	1995
Place of birth		
• home	50.09	56.64
• hospital	48.45	42.22
• other	1.46	1.15
Attendance at Birth		
• Physician	48.32	37.22
• Nurse	3.72	9.09
• Midwife	29.31	35.89
• Hilot (TBA)	15.66	17.54
• Others	2.98	0.26

Source: Department of Health Annual Reports

[24] One with the training and educational background or accredited by the DOH (doctor, nurse, midwife or TBA) to perform safe and clean deliveries.

c. Postpartum Care

The percentage of postpartum visits by the eligible women has increased from almost 43% to 89% from the periods 1991-1999. Likewise, the practice of breastfeeding is initiated during these visits especially on the first for safety and the newborn's protection including economic reasons. Along these two areas, the decrease in the number of visits is noted in 1995 that may have resulted from the devolution of health services that started in the city in 1994.



Source: Dept. of Health Annual Report

4.4 Conclusion

The availability of such factors as health resources, facilities and trained health personnel are necessary for the delivery of effective and efficient services to clients, in this case pregnant women who may be at risk and need the appropriate care.

In the case of Zamboanga City, the City Health Office implements programs related to maternal health as specified by guidelines coming from the Department of Health and there has not been a policy passed by the local government specific to maternal health. Although budget allocation for the city health office is made on a yearly basis, the availability of financial resources specifically for maternal health services is not disaggregated. Its integration within the broad Maternal and Child Health program of the city can be a reason in addition to the fact that no specific allocation per health program is made.

Although there is an increase in the budget allocation for health, as in the case of increasing number of health facilities and health personnel but these are still below the standard service ratio set by the government. Budget allocation has just slightly increased in real value considering the increase in prices of goods and services within the last ten years.

The training courses conducted for health personnel, although a handful are specific for maternal health care, are still conducted by the Regional Health Office which in this case has not be decentralized. Since local governments should be responsible for the capability building of their human resources and welfare of its people, this must be given priority for the effective delivery of services.

The practice of a good referral system reduces the risk to life associated with complications of pregnancy especially in emergency obstetrical care. Although Zamboanga City meets the requirement for well-equipped facilities to be within 2 hours reach of the referring level, the data on efficiency of the system is not available for discussion in this in this study and therefore may require further research.

Improvements in the utilization of health resources as well as provision of care for both prenatal and postpartum are clearly shown in the available data, although depressions are observed in between periods. This can be attributed to the onset of devolution and transition period of program implementation as well as health personnel that may have affected records keeping which resulted to misrecording of cases.

The increasing number of home deliveries does not only suggest economic difficulties among clients but also limited accessibility of birthing facilities since only a third of birthing stations are operational and majority are found in the urban areas. The city retains only one primary hospital which is not strategically located to be accessible to all, besides private or tertiary public hospitals are available but may require fees for the use of facilities. Although cultural and personal reasons are not to be ruled out since some women find it more comfortable to give birth at home rather than hospitals. Considering traditional rituals during childbirth suggest the increase in attendance of *hilots* in child birth not discounting those

residing in the island *barangays* or rural areas where the road network hinder accessibility to the nearest facilities.

Data on postpartum care are limited to breastfeeding initiation which is helpful for uterine involution but concentrates care on the baby and limits that of the mother who can still be considered at risk for postpartum complications.

Zamboanga City has not fully gone through the whole decentralization process since devolution accorded only power and authority to perform specific functions. But with the technical assistance including financial from the national agencies at the regional level, the LGU is starting to learn how to cope with its health needs.

Chapter 5

Lessons and Conclusion

5.1 Summary and Conclusion

The discussion of maternal health services and delivery at the national level and at the focus area of the study was guided with the concepts of maternal health needs, service provision and decentralization of health service delivery. The national level perspective provided a clear picture of how a well-grounded policy paves the way for the implementation of programs down to the local level, in this case, the safe motherhood initiative in response to the health needs of pregnant women. Equipped with the organizational structure, human and financial resources and program initiatives, the Department of Health can initiate and implement policies from the national level. With decentralization of health services at the local level several factors have to be taken into consideration since local government units, autonomous as they are, are not homogeneous and they have their own set of development priorities. But guided with these health policies, implementation and coordination mechanisms, programs are still implementable at the local level given that finances and human resources are available to carry out such programs.

Zamboanga City being the commercial center in the Western Mindanao region has good probability for economic growth such that health program implementation including maternal health service provision is doing well. The increasing number of facilities, health personnel and financial resources is a good manifestation although it has yet to meet the standard requirements set at the national level. Within the period of the study, it is noteworthy that health financing is shouldered by the local government in as far as field health services among rural health units and barangay health stations are concerned which include among others, maternal health care. Introduction of user fees proposed at the national level has not been made official in rural health units for services such as prenatal care, immunization and perinatal services. However, voluntary donations for whatever service rendered are accepted to replace used medical supplies which in a way maintain the availability of medical supplies in health units. The same may not be true to 5th or 6th class municipalities that can only

depend on their local resources for the implementation of health programs. Local government units with lower income and share from the allotment of the national government will have a difficult time managing resources for health facilities including paying for wages and benefits of the health workers.

The presence of an active local health board which serves as an advisory body to the local council on matters of health financing and maintenance is a good mechanism in the local government for the planning and implementation of health programs. Such advisory body with the proper coordination from the regional health office can look into the implementation of maternal health policies outlined by the national government. It can also be instrumental in the development of health policies based on the local needs. Likewise, health service providers can be granted with the wages and benefits due to them including in-service training and education necessary for effective health education and delivery of services. However, since the city mayor including members of the health committee of the city council manages the local health board, politicization of health services for more votes can not be set aside. It can be speculated that when the health sector is given priority with effective programs and adequate financing, it may be beneficial to the population as a whole particularly women who are the major health seekers. This can positively work both ways but when local decision making is encouraged with decentralization, it can also be self-serving to politicians in power and will definitely affect women when health is given the least priority in development programs.

The data showed increase in health resources and number of health personnel since decentralization but there is still the question of fluctuating rates of maternal deaths despite this improvement in the quantity of health services. Services may be present but it is not conclusive that such factors can influence maternal health. There is the need to look into the quality of services provided if these are what pregnant women actually demand. The study failed to look into this aspect because of dearth of data from the local level. Although services are free in rural health units fees are required in public hospitals of which majority are maintained by the national government and are undergoing health sector reforms to improve quality of service and to recover costs. This is one factor that encourages home deliveries especially in the rural areas where most of the service is free. However, women in the urban

areas, educated and employed prefer to pay for services in hospitals where service is perceived to be better and of good quality.

Although figures show steady increase in the country's spending for health, it still does not make health a priority given the meager share to health expenditure out of the other public services. There is no clear disaggregation for maternal health services since health budget encompasses implementation of general health programs including maintenance of regional hospitals. However, aside from national funds, foreign funds are pouring in the city for health programs that fund local researches whose data are used for planning purposes and implement programs based on priorities of the funding agency.

The presence of a working organizational structure with a clear maternal health policy coupled with the necessary funds and political will to carry out programs and activities are major conditions that can improve delivery of maternal health care in a situation that has undergone decentralization of health services. Improvements along these conditions can not be attributed to decentralization alone since such things are bound to happen when people are committed to work for the common goal of improved health. But with decentralization decision makers and program managers can quickly respond to the people's felt needs within a shorter period of time given that such factors are readily available. For Zamboanga City, a well-organized health structure is present and growing trying to meet the health needs of clients. Funds are available but needs proper appropriation according to the needs of the health sector. The city legislators are not keen in coming up with local health policies particularly those affecting maternal health but health programs are guided by policies drawn at the national level. However, the Master Development Plan of the city has drawn development strategies on health that includes safe motherhood and childcare. The political will to carry out effective programs and activities lay in the hands of city officials who are elected in office for a term of three years and has her/his set priority programs during the term. Continuous advocacy for maternal health among local officials and coordination with the local health board will heighten the awareness on maternal health needs.

5.2 Recommendation

With decentralization, local government units should learn to be independent of support and assistance from the national government and eventually develop a sense of ownership of its various programs and activities and be able to implement them effectively. To further improve the provision of maternal health services in Zamboanga City for the enhancement of maternal health the following are recommended:

- Strengthen local health board for maintenance and sustainability of financial resources for health, which presently is enjoying foreign funding, and is in danger of instability once funding support cease. Increasing the budget for health since inflation is inevitable and to serve as a buffer so that when foreign funds are withdrawn programs can still continue its implementation. Local government units are empowered to mobilize resources, however, networking with international and national donors should be maintained for maternal health.

- Policy recommendation through the local health board on the budget for health insurance of the local government unit share for indigents in preparation for transition from free to paid services especially in hospitals for emergency obstetric care. Through the health sector reform agenda, public hospitals will eventually be granted management and fiscal autonomy and will be operating out of their own earnings which means payment of user fees as a revenue enhancement measure of hospitals to improve efficiency and quality of services.

- Institutional capability building program is the city health department's responsibility for its health service providers since knowledge and skills have to be upgraded periodically. Since health services are decentralized and regional field health offices are being reorganized and downsized, institutionalization of this program in the city health department should be seriously considered.

- Upgrading the knowledge and skills of health professionals including field volunteers such as barangay health workers and nutrition scholars is necessary since these people are

rendering first level of care in coordination with midwives (see organizational chart). These are closely linked with people in the community since they belong too belong to the same community. Traditional birth attendants should likewise be monitored for clean and safe perinatal care after trainings. Unreported maternal deaths caused by failure in assessment of high risk cases are contributory to the fluctuating maternal mortality rates.

- Further research is recommended particularly on the demand side for maternal health since this study has limited its investigation on the provider side of maternal health service. Getting first hand information from clients who are direct users of the service might provide a clear picture of the quality of services being provided and if these are what the clients really need.

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Table A.1. Total Population and Population Growth Rates: Philippines, Region IX and Zamboanga City

Area	1980		1990		1995		2000	
	Pop.	PGR	Pop.	PGR	Pop.	PGR	Pop.	PGR
Philippines	48,098,460	2.71	60,703,206	2.35	68,613,706	2.32	76,498,735	2.36
Region IX	1,973,267	4.31	2,459,690	2.25	2,794,659	2.42	3,091,208	2.18
Zambo. City	343,722	5.34	442,345	2.55	511,139	2.74	601,794	3.56

Source: National Statistics Office (NSO)

Table A.2. Number of Government and Private Hospitals and Selected Health Personnel,Region IX and Zamboanga City, 1990 and 1998

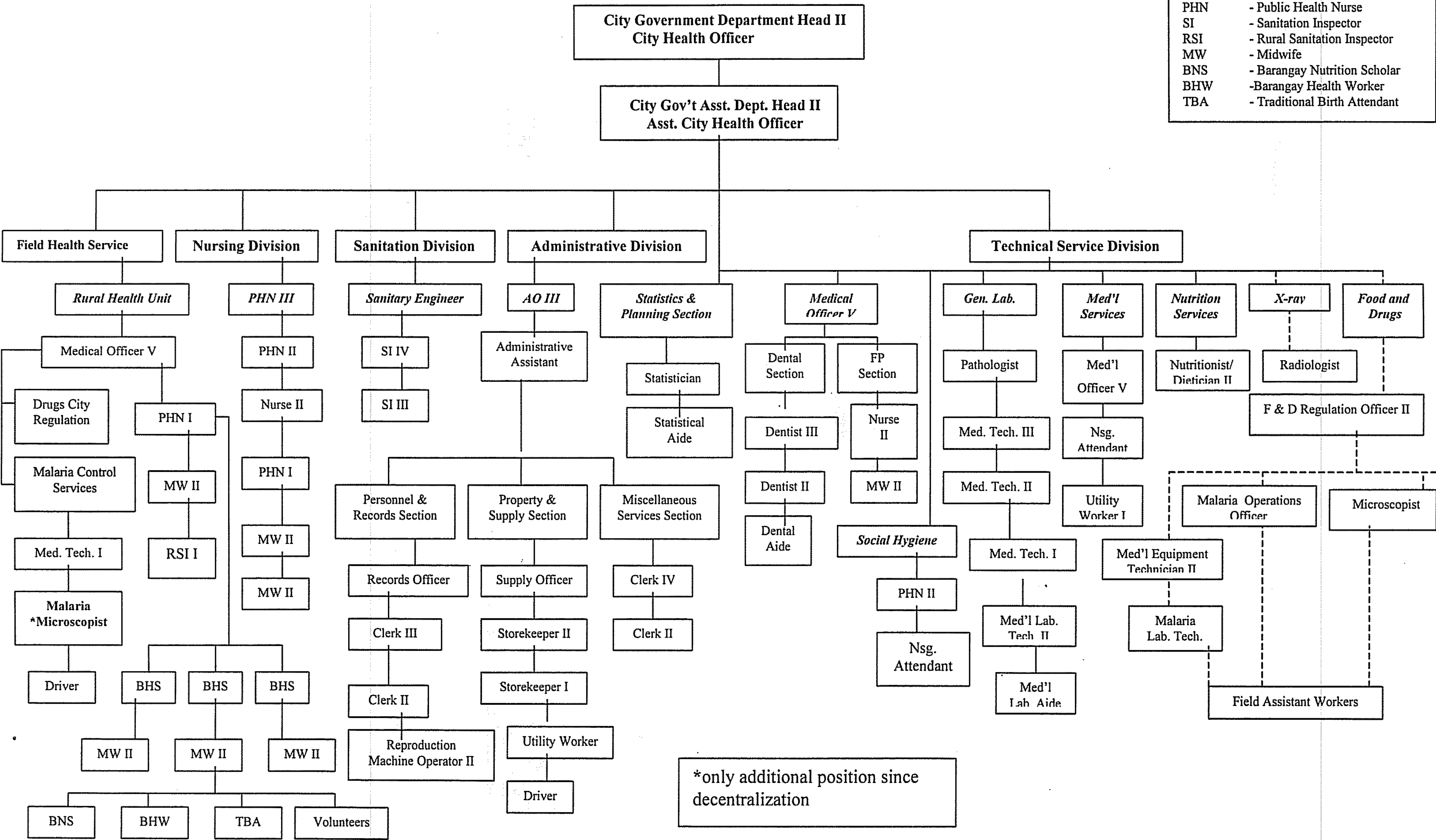
Indicator	1990		1998	
	Region IX	Zambo. City	Region IX	Zambo. City
Hospitals	70	9	79	11
• Government	28	5	28	5
• Private	45	4	51	6
Bed Capacity	1,954	465	2,030	474
• Government	1,065	320	1,045	270
• Private	889	145	985	204
Bed to Pop. Ratio	8	10	7	9
Physician	293	104	217	135
Nurse	453	124	354	155
Midwife	494	13	735	98

Source: National Statistics Coordination Board (NSCB)

Table 8. Percentage of Postnatal Care and Initiated Breastfeeding, Zamboanga City 1991-1999

Indicators	1991	1995	1999
Eligible Population	12,344	15,088	17,092
At least 1 PP visit	42.52	35.34	88.70
PP women initiated breastfeeding	61.16	32.25	81.93

Source: Department of Health Annual Report


ORGANIZATIONAL CHART
City Health Office, Zamboanga City
Legend:
AO - Administrative Officer
PHN - Public Health Nurse
SI - Sanitation Inspector
RSI - Rural Sanitation Inspector
MW - Midwife
BNS - Barangay Nutrition Scholar
BHW -Barangay Health Worker
TBA - Traditional Birth Attendant
City Government Department Head II
City Health Officer
City Gov't Asst. Dept. Head II
Asst. City Health Officer
Field Health Service
Nursing Division
Sanitation Division
Administrative Division
Technical Service Division
Rural Health Unit
Medical Officer V
Drugs City Regulation
Malaria Control Services
Med. Tech. I
Malaria *Microscopist
Driver
PHN I
MW II
RSI I
BHS
BHS
BHS
MW II
MW II
MW II
BNS
BHW
TBA
Volunteers
PHN III
PHN II
Nurse II
PHN I
MW II
MW II
Sanitary Engineer
SI IV
SI III
AO III
Administrative Assistant
Personnel & Records Section
Records Officer
Clerk III
Clerk II
Reproduction Machine Operator II
Property & Supply Section
Supply Officer
Storekeeper II
Storekeeper I
Utility Worker
Driver
Miscellaneous Services Section
Clerk IV
Clerk II
Statistics & Planning Section
Statistician
Statistical Aide
Medical Officer V
Dental Section
Dentist III
Dentist II
Dental Aide
FP Section
Nurse II
MW II
Social Hygiene
PHN II
Nsg. Attendant
Gen. Lab.
Pathologist
Med. Tech. III
Med. Tech. II
Med. Tech. I
Med'l Lab. Tech II
Med'l Lab Aide
Med'l Services
Med'l Officer V
Nsg. Attendant
Utility Worker I
Nutrition Services
Nutritionist/ Dietician II
X-ray
Radiologist
Food and Drugs
F & D Regulation Officer II
Malaria Operations Officer
Microscopist
Med'l Equipment Technician II
Malaria Lab. Tech.
Field Assistant Workers
*only additional position since decentralization