

Mothers and their Unborn

In the Philippines, there are about three million women getting pregnant every year. In developing countries, about 85 percent of all pregnancies are expected to progress to full term. The NDHS 2003 revealed that about 44 percent of women are pregnant with their first child at ages 20-24 years and 6.1 percent at ages 15-19 years. Because all pregnancies are considered at risk, all deliveries should be attended by professional and skilled health workers in health facilities to ensure that pregnancy outcome is safe and uneventful as far as possible.

In 2003, the mean number of children ever born to a Filipino woman upon reaching the age of

40-49 years is 4.3 with an average total fertility rate (TFR) of 3.5 children per woman. MIMAROPA has the highest TFR of 5.0 followed by Eastern Visayas at 4.6 while NCR has the lowest TFR of 2.8. The actual fertility rate of 3.5 exceeded the desired fertility rate of 2.7 by almost one.

The high fertility rate coincides with the low contraceptive prevalence rate of 47.3 percent among all Filipino women of reproductive age (15-49 years old) and 70.6 percent among married women. The age group 35-39 years has the highest percentage of using contraceptives while the 15-19 years old have the lowest percentage of ever using any contraceptive method.

Among currently married women in 2003, it was found that 48.9 percent use any form of contraceptive method and 51.1

Table 4.8 Wanted Fertility Rate, Total Fertility Rate and Mean Number of Children Ever Born to Women Age 40-49 Years by Region Philippines, 2003

Region	Wanted Fertility Rate	Total Fertility Rate	Mean Number of Children Ever Born to Women Age 40-49 Years
NCR	2.0	2.8	3.2
CAR	2.7	3.8	4.7
Ilocos	3.0	3.8	3.9
Cagayan Valley	2.6	3.4	4.1
Central Luzon	2.4	3.1	4.1
CALABARZON	2.3	3.2	3.8
MIMAROPA	3.6	5.0	5.1
Bicol	2.6	4.3	5.5
Western Visayas	2.7	4.0	4.9
Central Visayas	2.6	3.6	4.4
Eastern Visayas	2.9	4.6	5.4
Zamboanga Peninsula	2.6	4.2	4.9
Northern Mindanao	2.8	3.8	4.8
Davao Region	2.2	3.1	4.6
SOCCSKSARGEN	3.0	4.2	5.0
Caraga	2.8	4.1	5.4
ARMM	3.7	4.2	5.2
Philippines	2.7	3.5	4.3

Source: National Demographic and Health Survey, 2003

Table 4.9 Percentage of Married Women and All Women Age 15-49 Years Who Ever Use Any Contraceptive Method by Age Group Philippines, 2003

Age Group	Percentage of Married Women	Percentage of All Women
15-19	36.8	4.0
20-24	61.0	31.8
25-29	71.5	56.6
30-34	75.8	66.5
35-39	76.5	69.7
40-44	72.2	66.5
45-49	67.7	63.1
TOTAL	70.6	47.3

Source: National Demographic and Health Survey, 2003

Table 4.10 Percentage of Currently Married Women Age 15-49 Years Who Ever Use Any Contraceptive Method Philippines, 2003

Contraceptive Method	Percentage of Married Women
Any method (traditional or modern)	48.9
Modern method	33.4
Female sterilization	10.5
Male sterilization	0.1
Pill	13.2
IUD	4.1
Injectables	3.1
Male condom	1.9
Mucus/Billings/Ovulation	0.1
LAM	0.3
Traditional method	15.5
Calendar/Rhythm/Periodic abstinence	6.7
Withdrawal	8.2
Other	0.6
Not currently using	51.1

Source: National Demographic and Health Survey, 2003

percent do not use any form of contraceptive method at all. Of all the currently married women who use any form of contraception, 33.4 percent use any modern method of contraception and 15.5 percent use any traditional method of contraception.

This situation leads to more pregnancies and deliveries among Filipino women. Pregnancy is a physiologic process that entails risks to both the mother and the unborn. At greater risk are women getting pregnant below 18 years old and those who are more than 35 years old. Chronic illnesses such as iron deficiency anemia, tuberculosis, hypertension, cardiovascular disorders, diabetes in pregnancy are risks that could harm the mother and the unborn.

Based on the 2004 NOH targets, of the four maternal risk reduction targets monitored through the NDHS 1998 and 2003, none were achieved, though a lesser proportion of women seem to be at risk. The percentage of pregnant women with at least four prenatal visits decreased from 77 percent in 1998 to 70 percent in 2003. In addition, pregnant women who received at least two doses of tetanus toxoid also decreased from 38 percent in 1998 to 37 percent in 2003. However, births attended by health professionals increased from 56 percent in 1998 to 60 percent in 2003. There was also a notable

Table 4.11 Health-Related Practices Affecting Maternal Health Philippines, 1998 and 2003

Maternal Health Practice	NDHS 1998	NOH Targets 2004	NDHS 2003
Pregnant women with at least 4 prenatal visits	77%	80%	70%
Pregnant women with at least 2 doses of tetanus toxoid	38%	80%	37%
Births attended by professional health providers	56%	80%	60%
Women with at least 1 postnatal visit within one week of delivery	43%	80%	51%

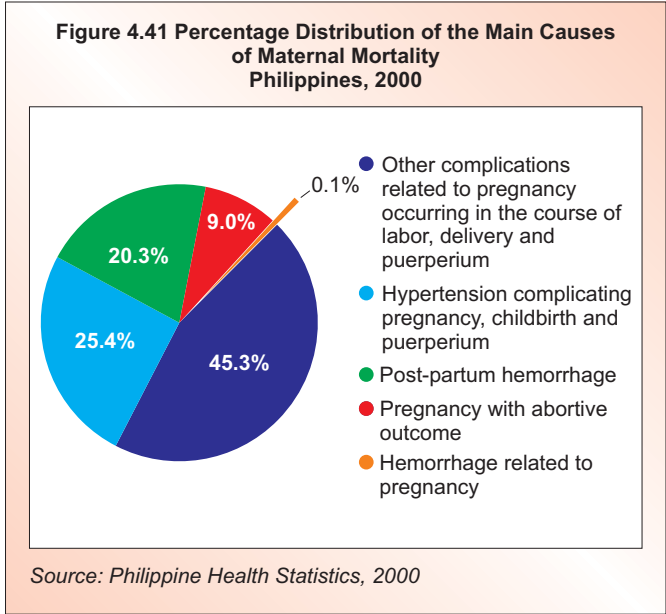
Source: National Center for Disease Prevention and Control, DOH, 2005

increase in the percentage of women with at least one postnatal visit from 43 percent in 1998 to 51 percent in 2003. In addition, only 77 percent of pregnant women received iron supplementation during pregnancy while only 45 percent of postpartum women received a dose of Vitamin A.

The Philippines intends to reduce the maternal mortality ratio (MMR) by

three-quarters by 2015 to achieve its millennium development goal. This means an

MMR target of 90 deaths per 100,000 live births in 2010 and 52 deaths per 100,000 live births in 2015. The MMR in the Philippines has declined from an estimated 209 per 100,000 live births in 1987-93 (NDHS 1993) to 172 in 1998 (NDHS, 1998). The Philippines finds it hard to reduce maternal mortality and lessen the disparities seen across regions. Similarly, perinatal mortality reduction has been minimal. It went down by 11 percent in 10 years from 27.1 to 24 perinatal deaths per thousand live births (NDHS 1993 and 2003).



The PHS 2000 revealed that 25 percent of all maternal deaths are due to hypertension, 20.3 percent to postpartum hemorrhage, and nine percent are due to pregnancy with abortive outcomes.

Critical actions to reduce the number of maternal deaths should address the following: delay in seeking care, delay in making referral and delay in providing appropriate medical management. Other factors that contribute to maternal deaths include closely spaced births, frequent pregnancies, poor detection and management of high-risk pregnancies, poor access to health facilities brought about by geographic distance and cost of transportation, and lack of competence of health staff in handling obstetrical emergencies.

Among the Filipino women incurring the highest health risks during pregnancy are: (1) pregnant women less than 18 years old and those more than 35 years old; (2) women who had received only up to elementary education; (3) women in the 20 percent poorest households; (4) women in areas with armed conflict; (5) women victims of domestic violence; and (6) pregnant women with concurrent chronic illness (iron-deficiency anemia, tuberculosis, cardiovascular disease, diabetes mellitus, etc.).

- Essential Health Care Package for Mothers and their Unborn**
1. Antenatal registration
 2. Tetanus toxoid immunization
 3. Micronutrient supplementation
 4. Treatment of diseases and other conditions
 5. Early detection and management of complications of pregnancy
 6. Clean and safe delivery
 7. Support to breastfeeding
 8. Family planning counseling
 9. STD/HIV/AIDS prevention and management
 10. Oral care

Services that ensure the health and welfare of the mother and the unborn are in place in the health system. Essential prenatal and postnatal services should be easily accessible to the mother and the unborn as these are available at the primary level. Maternal care benefit package in public health facilities includes pre-pregnancy, prenatal and post-natal services. Criteria for health facility accreditation by the DOH and the PhilHealth are heavy on maternal and child care. While PhilHealth is accrediting more basic level services, not all poor families are enrolled in the PhilHealth indigency program. Uncertainty about the cost of care compounded by transport difficulties have kept women from seeking the medical care they need.

Medical and nursing curricula have sufficient coverage while midwifery is almost exclusively for maternal and child care. In addition, service providers, majority of whom are midwives, have been trained on the various aspects of health care for women which include clinical care, health education and counseling, family planning, and nutritional assessment, among others.

Technical assistance is available at the DOH. In the last five years, policies, standards and guidelines pertaining to the mother and the unborn were updated. Among these are safe motherhood policy, family planning policy, essential care practice guidelines on pregnancy, childbirth, post-natal care, newborn care, management of complications of pregnancy and childbirth and management of abortions and its complications. In addition, a policy that mandates health facilities to conduct a maternal death review has been passed. International health agencies like UNICEF, UNFPA and WHO are assisting in the local application of these new initiatives.

Since the poor, uneducated women are most at risk, it is important for rural health units and first level referral hospitals to administer adequate and appropriate emergency obstetric interventions. However, many rural health facilities are unable to provide these because of lack of obstetrical supplies and equipment and lack of local competencies due to the rapid turnover of doctors and shortage of medical staff. Volumes of studies and experience have consistently pointed out that illiteracy, poverty and peace and order problems are the main obstacles to maternal and child health. However, not enough literature, strategies, practical models and funding assistance have effectively filtered down to reach the high risk groups and further improve the delivery of health services for the mother and the unborn.

Goal: The survival, health and well-being of mothers and their unborn are ensured.

National Objectives for 2005 - 2010

Objective	Indicator	Target	Baseline Data and Source
Maternal mortality is reduced	Maternal mortality ratio per 100,000 live births*	90 maternal deaths per 100,000 live births	172 maternal deaths per 100,000 live births <i>NDHS 1998</i>
Perinatal mortality is reduced	Perinatal mortality rate per 1,000 live births	18 perinatal deaths per 1,000 live births	24 perinatal deaths per 1,000 live births <i>NDHS 2003</i>
Low birth weight infants are reduced	Percentage of low birth weight infants out of total live births	10 percent	12 percent <i>NDHS 2003</i>
Risk factors associated with maternal morbidity and mortality are reduced	Prevalence rate of iron deficiency anemia among the pregnant	38 percent	43.9 percent <i>National Nutrition Survey 2003</i>
	Total contraceptive prevalence rate	80 percent	48.9 percent <i>NDHS 2003</i>
	Modern natural and artificial contraceptive prevalence rate	60 percent	33.4 percent <i>NDHS 2003</i>
	Percentage of deliveries assisted by skilled birth attendants and in a health facility*	70 percent	53.9 percent <i>NDHS 2003</i>
	Percentage of post-partum first visit within the first week of delivery	80 percent	51 percent <i>NDHS 2003</i>

* Millennium Development Goal Indicator

Strategic Thrusts for 2005-2010

- Launch and **implement the Basic Emergency Obstetric Care or BEMOC strategy** in coordination with the DOH. The BEMOC strategy entails the establishment of facilities that provide emergency obstetric care for every 125,000 population and which are located strategically. The strategy calls for families and communities to plan for childbirth and the **upgrading of technical capabilities of local health providers**.
- **Improve the quality of prenatal and postnatal care.** Pregnant women should have at least four prenatal visits with time for adequate evaluation and management of diseases and conditions that may put the pregnancy at risk. Post-partum care should extend to more women after childbirth, after a miscarriage or after an unsafe abortion.
- Reduce women's exposure to health risks through the **institutionalization of responsible parenthood and provision of appropriate health care package to all women of reproductive age** especially those who are less than 18 years old and over 35 years of age, women with low educational and financial resources, women with unmanaged chronic illness and women who had just given birth in the last 18 months.
- Advocate for **resource generation and allocation for health services provided for the mother and the unborn**, particularly with LGUs, NGOs, and partner agencies and the private sector.