RESEARCH ARTICLE

Incentivizing (and Disincentivizing) Mothers to Utilize Maternal Health Services: A Focus Group Study

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Abstract

Background. In ensuring access to maternal health services, various strategies toward safer health practices and improved health service delivery are important ingredients to eliminate avoidable maternal deaths. A recent household survey showed that access to antenatal care (ANC) (89%) and facility-based delivery (FBD) (82.4%) in the Eastern Visayas region is significantly high, despite the extensive damage to over 500 health facilities caused by Typhoon Haiyan in November 2013. Postpartum care (PPC), however, was relatively low (37.4%). As these findings needed further elaboration, a qualitative study using focus groups was conducted.

Method. The focus groups method was utilized to elicit responses from the mothers, BHWs, and midwives to explain what contributed to the high ANC visits, high FBD, and low PPC. Sixteen focus groups were conducted in the local dialect (Waray and Cebuano), and all discussions were audio recorded. Focus groups data were transcribed and subsequently translated to English text, then reviewed and validated by socio-linguistic academics from the region. Other data sources included debriefing session reports and expanded field notes. Nvivo 10 software was used in the coding process and data management. The data analysis referred to the principles of thematic analysis.

Results. The findings showed that incentives in the form of free maternal services and cash grants drive mothers to go to the health facility for antenatal care and facility-based deliveries. The free services were provided by PhilHealth (the country's social health insurance), while cash grants were awarded through the government's conditional cash transfer program and other community partners. Mothers were provided with some financial risk protection through these financial incentives. The disincentives came in the form of local ordinances, which prohibited home births. Penalties included fines for both mother and birth attendant when the mother was found to deliver outside the health facility. The unintended stigma, shame, and fear that developed in response to these ordinances also deterred home births. The significantly low use of PPC services in the health facility was attributed to the lack of advices given to mothers regarding the need for follow-up care after delivery. It is also noted that there are no incentives for PPC, which may contribute to its low rates. The role of the community health workers and midwives were to inform and educate the mothers on these incentives and disincentives. However, these incentives and disincentives are extrinsic motivators and are deemed insufficient to provide long-term impact.

Conclusion and Recommendations. The implementation of the incentives and disincentives in Eastern Visayas has increased rates of ANC and FBD. The presence of these in the current environment has initially facilitated behavior change, shifting home births to facility births. However, we argue that financial incentives, with a lack of intrinsic motivation, may be insufficient to sustain long-term impact. Disincentives, in the form of local ordinances, forced mothers instead to seek care in facilities. Such an approach may eventually become less effective over time. Incentives and disincentives are both demand-side factors, and to sustain change, concurrent improvements in the supply end need to be implemented. The capacity of facilities to absorb the increased demand should be in place to provide positive experiences for mothers in the health facilities.

Keywords: *antenatal care, facility-based delivery, postpartum care, home-based delivery, access*

Introduction

Facility-based maternal care could reduce the risk of death as mothers have better access to skilled birth attendants, medicines, supplies, and equipment in the event of any pregnancy-related complications (Campbell & Graham, 2006). Worldwide, the utilization of facility-based maternal services has recorded steady increases since the institutionalization of the Millennium Development Goal on decreasing maternal mortality (MDG 5) (Montagu et al., 2011; Shah et al., 2014) and the same

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was observed in the Philippines. Country data shows that access and utilization of ANC, FBD and PPC have been improving in the past decade (NSO, 2004, 2009; PSA, 2014). Despite this, the 2015 goal of decreasing the maternal mortality ratio (MMR) to 52 per 100,000 live births was not met (NEDA & UNDP, 2014).

Previous international studies have identified various factors that influence access and utilization of ANC, FBD, and PPC. Among the most common factors include *education of mothers* (Dahiru & Oche, 2015; Fotso et al., 2009; Khanal et al., 2015; Hagos et al., 2014; Ononokpono & Odimegwu, 2014; Sinha et al., 2013; Tsegay et al., 2013; Vora et al., 2015; Wilunda et al., 2015; Worku et al., 2013), *antenatal care as predictor of facility-based delivery* (Fotso et al., 2009; Chama-Chiliba & Koch, 2015; Mpembeni et al., 2007; Ononokpono & Odimegwu, 2014), *parity (Chama-Chiliba & Koch, 2015; Dahiru & Oche, 2015;* Fotso et al., 2009; Sinha et al., 2013; Tsegay et al., 2013), *quality of care* (Exavery et al., 2014; Sule & Baba, 2012; Wilunda et al., 2015), *economic status* (Khanal et al., 2015; Fotso et al., 2009; Hagos et al., 2014; Exavery et al., 2014; Wilunda et al., 2015), and *distance or location of residence* (Fekadu & Regassa, 2014; Dahiru & Oche, 2015; Hagos et al., 2014; Mpembeni et al., 2007).

This focus group study was done to explain the initial findings generated by a recently conducted household survey (Ramirez et al., 2015) that aimed to assess the utilization of maternal services in the Eastern Visayas, the second poorest region in the Philippines. The household survey revealed high utilization of ANC services (89% have at least four visits) and FBD (82.4%) despite the devastating effect of Typhoon Haiyan, locally known as Typhoon Yolanda, in 2013. Utilization of postpartum services, however, was very low (37.4%). Hence, the survey findings warrant further investigation of factors that explain the inconsistent utilization of maternal services, which were surprisingly high despite the post-disaster setting.

Methodology

Data Collection. Data collectors were grouped into four teams each headed by an area supervisor. Each team covered 1-2 of the 6 provinces in Eastern Visayas region to gather data using the focus group discussion (FGD) method. Barangays (villages) were selected from the previously conducted household survey (Ramirez et al., 2015). In each barangay, mothers were selected from those who were interviewed in the said survey study. Midwives and BHWs with at least five years of work experience were recommended by local health officials. All participants were at least 18 years of age and provided consent for participation. Each FGD had 6 to 12 participants and was conducted in the local dialect in a venue most appropriately suited for free and uninhibited discussion. Each FG comprised a homogenous participant profile, eight (8) of which were with mothers, four (4) with village or barangay health workers (BHWs) and another four (4) with midwives. Mothers' groups were further subdivided into defined socio-economic profiles according to their membership to the government-run conditional cash transfer (CCT) program and sponsorship as indigent members of the national social health insurance program called PhilHealth.

The research teams used a pre-tested focus groups guide and a field notes tool that articulated specific research questions. Other necessary data about non-verbal observations and context that may influence interaction among participants were also collected by the researchers. Aside from asking questions, teams also made use of pictures, numbering, and storytelling to facilitate the prompting of responses from participants (Colucci, 2007).

In every team, a debriefing session was conducted immediately (within the succeeding 24 hours) after each FGD to identify initial findings, provide clarification of ideas, troubleshooting of other concerns, and planning for the next FGD. Results were electronically shared with the other teams to determine data trends and improve the conduct of succeeding FGDs. Field notes were also written and shared among the data collector teams during the data collection period to determine recurrence of identified key ideas. Saturation was achieved after completing a total of sixteen (16) FGDs.

Data Analysis. All FGD recordings were transcribed in the local dialects of Waray or Cebuano and translated into English by members of the same team. Local socio-linguistic academicians were hired as third-party reviewers to validate the accuracy of the translated text. The area supervisors then conducted initial review and pre-coding of all the translated FG transcripts. Data were then coded using Nvivo 10 software and condensed into themes using digest matrices. Data derived from the field notes and debriefing sessions were added to the digest matrices. Principles of thematic analysis (Braun & Clarke, 2006) were used to summarize the key findings.

Ethical Considerations. All participants were invited to participate several days before the actual FGD and signed a written consent to participate in the study. Ethics clearance was granted by the Ateneo School of Medicine and Public Health (ASMPH) Ethics Review Board.

Findings

Analysis of the results generated two major interrelated themes that explain the factors that influenced the utilization of ANC, FBD, and PPC services in the Eastern Visayas region following Typhoon Haiyan. These are 'financial incentives to support facility-based care' and 'disincentives against home delivery'. Midwives and BHWs play a key role in communicating these policies to mothers, acting as mediators between the mothers

and the health system. Another important finding was the role of 'quality of care' in the experience of facility-based maternal services, but this will be discussed in a separate article to provide more in-depth analysis.

Financial incentives to support facility care

The study identified key financial incentives that encourage mothers to seek care in facilities, namely, the availability of free delivery services and the provision of cash rewards. Free delivery services, or the elimination of user fees, highly influence access to facility care. Mothers have considerable out-of-pocket expenditures (OOP) for medicines, transportation, food, and lost income for themselves and their companion when accessing facility-based care. Hence, the availability of free maternal services considerably decreases the associated costs. Unique to the Eastern Visayas region is the implementation of PhilHealth circular No. 34, s.2013 (PhilHealth, 2013), which provided antenatal and delivery services to all women in the region after the devastation of Typhoon Haiyan at no charge. Because of this circular, mothers, despite not having previous membership to PhilHealth, were allowed to enroll and access benefits which, prior to the policy, would translate to a large OOP. The statements of mothers below confirm this:

> *"I did not pay anything because we were affected by typhoon Yolanda." (Mother)*
>
> *"For me, just after the Yolanda, I became a member of CCT and PhilHealth as well. I can say that PhilHealth is good because I did not pay anything…" (Mother)*

In addition to free services, government and non-government groups have established cash-based incentive programs to encourage women to seek facility-based care. According to the respondents, agencies that provided cash grants include the Department of Social Welfare and Development (DSWD) through its CCT program, PhilHealth and non-government organization Zuellig Family Foundation (ZFF). Program implementation varies across provinces, but as a rule, specific visits have equivalent monetary values. Completion of the required specifications qualifies them to claim the cash grants, but with every component missed, a corresponding cash deduction was noted. Despite being given at the end of the pregnancy course, cash incentives were effective in pushing mothers to go to facilities, as illustrated by these narratives from a midwife and mother:

> *If you invite them for prenatal, they will just have many reasons. But if you threaten them about their CCT…that they will not be able to received their benefits, they will go. It is a big help because they are afraid that they will be deducted five hundred pesos if they do not go for check-up. [Midwife]*
>
> *…since we have a health grant, we have to go for prenatal check-up, weight monitoring, health check-up. We have to be monitored because of the health grant – especially those who are beneficiaries of the CCT. [Mother]*

A group of midwives supports this sentiment as they discussed their observations on changes in women's access to antenatal care:

> *Respondent 7: …six months after typhoon Haiyan, the pregnant women were given incentives by an NGO.*
>
> *Respondent 6: That is why the number of pregnant mothers coming to the health center increased as they received two hundred and fifty pesos.*
>
> *Interviewer: For the three trimesters, they get two hundred fifty pesos?*
>
> *Respondent 3: No, they have seven hundred fifty pesos, because every trimester they get two hundred fifty pesos.*
>
> *Respondent 1: After giving birth if they delivered through cesarean section, they will receive two thousand five hundred pesos.*
>
> *Respondent 2: That is why the number of pregnant women increased. Many are now going for a prenatal (all agreed) [Midwives]*

It was noted that incentives are only in place for ANC and FBD. None are in place for the completion of postpartum visits and could contribute to the low utilization of PPC services.

Disincentives against home deliveries

In support of the drive to increase facility-based deliveries, some municipalities and provinces have enacted local ordinances that prohibit home births. The benefits of this policy includes safety of both the mother and the child through greater access to emergency response if pregnancy-related complications arise. There are widespread awareness of the ordinances, shifting the norm for delivery practices towards facility-based care. Some respondents narrated:

> *When the lying-in started its operation, very few mothers delivered there. As of now, when there is an ordinance that prohibits home delivery, most women deliver at the birthing center. [BHW]*
>
> *They said that it is prohibited to deliver at home even if it's the midwife or TBA who will attend to our delivery, so I needed to deliver in the rural health unit. [Mother]*

This policy restriction explains the high FBD in the region. Intimately linked with this is the high ANC because in many rural

health units (RHUs), completion of four ANC visits is a prerequisite to facility delivery. This is not explicitly stated in the country's prescribed manual of operations (DOH, 2009) but mothers relay that it is emphasized by midwives and BHWs, and at times, those who do not complete the required package of services are reprimanded. Below are some sentiments that clarify this ANC package, and facility-delivery services:

> *Yes, we were obliged to go there [health facility] by the midwife [all agreed]. We are not allowed to have just one [prenatal] visit, she required us to complete the four visits. [Mother]*

> *Most of the pregnant women go for prenatal checks because there is already a law that prohibits home delivery. We will not be entertained at the RHU (for childbirth) when we have incomplete prenatal check-up. [BHW]*

> ***…****it was already mandated here that having prenatal is necessary because we will not be accepted for delivery [at the RHU] if we do not have complete prenatal visits [and records] there. Every month, the BHW will visit us to remind us about the law. [Mother]*

Like financial incentives, the ordinances do not have any provisions beyond delivery. Hence, the policy has no direct impact on postpartum care.

Unintended stigma, shame, and fear

One significant finding was the role of stigma, shame and fear borne out of the policy prohibiting home births. The enactment of these local ordinances has seemingly transformed the culture at the barangay level. Today, mothers are flocking to the facilities to access care in compliance with the new policy.

Mothers who are found to deliver at home as well as the traditional birth attendant, and those who assist in the delivery such as husbands and community members, may be penalized. Penalties for noncompliance, vary across provinces. For instance, in one province, the mother and the traditional birth attendant (TBA) are fined with PHP1,000 (USD 21.35) for the first offence and PhP2,000 (USD 42.67) for the second offence. In another province, apart from penalizing the mother and the one who cuts the cord (usually the TBA) with a Php1,500 (USD 32) fine each, accomplices (usually the driver or the husband who assisted the travel of either TBA or mother) are also penalized. In most cases, these penalties are not enforced but rather serve as social pressure to the community members, exemplified in the comment below that involved the participation of the police:

> *… I heard that someone living in the interior village gave birth at home. The police officer went there to find out. They really talked to the TBA. She was told that if ever she would assist again in a home delivery, she would be arrested. [Mother]*

Social pressure, however, is experienced not only by the mothers but also by health workers. The succeeding text is a vignette that narrates the difficult experience of a midwife when she denied care to a mother in compliance with the policy. Because of this, instead of being delivered by a skilled worker, the mother was attended to by a local TBA, placing the mother at greater risk for complications.

> One time, there was a mother in far flung area who delivered at home. Before her delivery, I already told the family to go to the birthing center. However, during her labor they knocked at our house, but I advised them again to go to the health center and I told them I am no longer assisting any home delivery. After a few minutes, the husband went back and knocked at the window of the room where I usually sleep. I pretended that I did not hear him. He went to my house the third time and heard him saying the baby was nearly going out of the mother's womb. Still, I did not respond, and I just kept my mouth shut. The following day, I just heard that the TBA assisted the mother to deliver. Though I understand their condition, I am forced to remind them about the ordinance because I know I will be reprimanded about a case of home delivery in a place where I live. The barangay captain and I showed the husband the ordinance, but he just said, "I don't know how to read". The ordinance was enforced since 2013 and it was an order from our municipal government. When I read it in front of him, the husband of the woman who delivered at home said that he was willing to be imprisoned on behalf of the TBA who assisted his wife in giving birth. [Midwife]

Box 1: *Vignette on the implementation of local ordinance*

The local policies prohibiting home births increased facility-based maternal care but also contributed in increasing social pressure and decision-making based on fear and shame. Many mothers expressed discontent with the inability to choose to deliver at home and instead are forced to go to facilities against their will.

> *Yes, I prefer a TBA than going to the health center, but unfortunately, I can't go to the TBA anymore because they are banned. For this reason, I am forced to go to the health center. [Mother]*

> *… they (mothers) will just go with the flow, obeying the instruction of the midwife. They are just being compliant. [BHWs]*

Some mothers' preferences are based on comfort and familiarity, while others have practical concerns such as finances, difficult geographic access, and other household responsibilities.

I will buy things and food in the hospital, which are expensive. And then I will let my husband go home to check on our other children…of course the fare is expensive and the food as well. So, do you think I will choose to deliver in a facility? [Mother]

Key roles of midwives and village health workers

Midwives and village health workers are the main providers of information and the key mediators of knowledge about maternal and overall health care in the community. These health workers play a crucial role in informing, reminding, encouraging, and at times even cajoling and threatening the mothers using these incentives and disincentives as tools to increase utilization of maternal services.

They are the ones who inform mothers about the local ordinance as well as the benefits and added value of visiting facilities for maternal care. Midwives are assigned a catchment area of several barangays of varying size and geography. At times, these catchment areas include interior villages and islands that are difficult to access. BHWs, despite limited training, provide much needed support by monitoring pregnant and postpartum women within their village and reporting their condition to the midwives. A BHW describes an aspect of their work for maternal care:

Yes, because we really focus on the pregnant women here….When the fetus is just developing inside the womb of the mother, if we notice that the abdomen is starting to get big, we ask them if they are pregnant. Some will not admit, but we insist that they go for a check-up. Each one of us has a list of pregnant women in our catchment barangay. [BHW]

They also conduct home visits and are able to maintain closer relationships with the mothers. Their collaboration is the key to ensuring the mothers get to seek proper care.

They really go to our zone even if it is far from here just to inform us that there are check-up, immunization, and tetanus toxoid [TT] vaccination and prenatal at the health center. [Mother]

Midwives and village health workers play significant roles in addressing the need of mothers through education and close monitoring. They are effective in providing advice and other information to improve mindset, perception, and behavior because of the close contact they have with the mothers.

Respondent 8: Yes. We were obliged to go there [health facility] by the midwife [all agreed]. We are not allowed to have just one [prenatal] visit, she required us to complete the four visits.

Respondent 9: The BHWs were told to inform us. They inform us that we need to go to the health center.

Respondent 7: If the vaccination [tetanus toxoid] is not yet complete, we are being informed to go there to have it completed. [Mothers]

When asked why they did not access postpartum care, mothers stated that it was because they were simply not advised to do so. The lack of counseling and instruction regarding preventive postpartum care highlights even more the key role of midwives and BHWs in educating mothers.

Discussion

Community-level incentives and disincentives are successful interventions in increasing the utilization of maternal care services in the Eastern Visayas Region. The provisions of free services and cash grants as well as prohibition of home deliveries have been effective demand-side policy instruments in shifting health-seeking behavior and driving facility-based care. The low rates of PPC utilization can be attributed to the lack of the incentives and/or disincentives in the period following the mother's delivery, as well as the lack of advice for follow-up care. Extending the policies and interventions until the postpartum period may improve service utilization and may also decrease maternal deaths, as data reveals most cases of obstetric hemorrhage occur in the postpartum period (Say et al., 2014).

Impact of financial incentives

Eliminating user fees and providing supplementary cash grants can increase utilization of health services. Out-of-pocket expenditures (OOP) remain to be a leading barrier for facility-based care in low- to middle-income countries (Liu et al., 2012). In the Philippines, OOP comprises 56.3% of total health expenditures from purchase of medicines and drugs (PSA, 2015). The findings of this study are consistent with experiences in other countries where they increased service utilization with the elimination of user fees (Aboagye & Agyemang, 2013; Dzakpasu et al., 2012). The same is evident for conditional cash transfers, where cash incentives increased utilization (Glassman et al., 2013; Orbeta et al., 2014) through improved purchasing power and guaranteed access to services.

However, despite this trend, evidence of sustained utilization following user fee removal is weak and the association with improved health outcomes is still sparse (Glassman et al., 2013; Randive et al., 2013). In addition, despite these financial incentives, OOP expenditures remain high and may not protect the poor from catastrophic expenditures (Liu et al., 2012). While cash grants augment direct medical costs, they may not be enough to cover the associated indirect costs for transportation, food, and lost opportunity cost for both mother and companion.

In addition, while health workers recognize increased utilization as positive, many interpreted this new behavior simply as

compliance to receive the cash grants. Mothers relayed that without the restrictions, they would deliver at home. Questions then arise as to the long-term sustainability of this desired behavior, as driven by external factors.

Impact of home birth restriction

More than financial incentives, the policy restricting home births had a greater influence on increasing facility deliveries. This policy had several observed effects. First, it encouraged women and families to develop confidence in the health system. The message of safety was emphasized, and many mothers felt more secure giving birth in facilities equipped with formally trained personnel and life-saving equipment necessary to respond to complications. Midwives and village health workers are the main mediators for communicating this policy and its benefits to mothers. They are the key to informing, reminding, encouraging, and at times even threatening the mothers through their close monitoring, home visits, and education sessions. They are effective in providing advices and other information to change mindsets, perceptions, and behavior because of the close contact they have with the mothers. How they communicate these incentives and disincentives can drive internal motivation and improve access to health services.

Second, the policy imposed negative constraints on women who preferred home deliveries. Some favored the quality of care offered by TBAs for the perceived higher quality of care received at home. In addition, home deliveries cost less than facility-based, where direct and indirect costs can potentially lead to catastrophic expenses. Requiring facility-based care imposes that women overcome cost barriers and other practical concerns, such as travel to facilities, distance and terrain, opportunity costs of companions, and domestic responsibilities. With the lack of safety nets for addressing persistent barriers, some mothers feel forced to carry the burden of these difficulties only to comply with the ordinance. After delivery, these practical considerations are intensified by the addition of a new family member and greater household duties. Hence, this provides additional insight into the low rates of PPC.

Third, this policy seems to have created social pressure and stigma among mothers, their families and health care workers. Many mothers expressed discontent with the inability to choose to deliver at home. Negative sentiments such as being “forced” or “banned” and simply “obeying instructions” are expressions of the policy's limitations and ought to be considered in its implementation. The same observation has been noted in Burkina Faso, where a similar policy was implemented, imposing fines on husbands if their wives gave birth at home. However, the policy was eventually considered illegal and discontinued by the national authorities (Belaid & Ridde, 2014). One women's advocacy group in the Philippines has also been lobbying against this policy as a violation of women's right to free choice (Ilagan & de Jesus, 2014). Aside from the mothers, midwives are also placed in a dilemma. The example of the vignette in Box 1 above should also alert policy implementers of the ordinances' impact on withholding skilled care because of fear of penalties, reprimand, and criticism, at the expense of placing mothers at greater risk for complications. Evaluating the impact of these policies to overall service delivery and health outcomes is of utmost importance.

Developing sustained behavior change

External incentives, disincentives, and restrictions have been shown to have a limited effect on sustaining behavior change (Gneezy et al., 2011). Although there is positive evidence of increased utilization of maternal health services, there is uncertainty as to its long-term impact. While these external factors can foster good habits by jump starting the desired behavior, its effects “depend on how they are designed, the form in which they are given, how they interact with intrinsic motivations and social motivations, and what happens after they are withdrawn” (Ashraf, 2013).

Efforts ought to be made to develop factors associated with securing mothers' intrinsic motivation. Education about the risks and benefits of pregnancy, as well as the manner of securing access to care is important. In addition, providing safety nets to help address external constraints such as distance, transportation, finances, and household responsibilities are also critical. Without adequate support, it will be difficult for many mothers to bear the burden of these practical considerations.

Consequently, the health system ought to be prepared to respond to increased demand for maternal services. Facilities should ensure the provision of appropriate infrastructure and manpower to provide quality health care. It is an accepted fact that increasing availability of skilled health workers is directly linked to improved maternal health outcomes (Gupta et al., 2011). The midwives and BHWs of Eastern Visayas are an integral part of access to maternal health care because of their access and acceptability to local women (Hafeez et al., 2011) and leaders from among this cadre of health workers have been known to use creative strategies to promote higher utilization of health services.

Intimately linked with this is addressing the associated stigma and fear of mothers and health workers. Ensuring respectful and compassionate care, as well as addressing the practice of victim blaming cannot be overemphasized. Technical and administrative support for health workers with direct contact with the mothers is directly associated with quality of care that they can deliver

Conclusion and Recommendations

This study provides insights to the reasons why facility-based ANC and FBD increased in the Eastern Visayas region following Typhoon Haiyan. Financial incentives (cash grants and free maternal services), as well as disincentives (implementation of ordinances that prohibit home deliveries, unintended consequences of stigma, fear, and shame), are the key factors that led to this increase. The absence of incentives and disincentives in support to postpartum care may explain the low rates of PPC in the region.

Increased access and utilization of services is commendable, revealing the effectiveness of policies in driving behavior change. Midwives and BHWs are the primary source of information and education for mothers, influencing decisions and behavior through close monitoring, home visits, and regular education sessions.

However, the provision of incentives and disincentives is insufficient in achieving long-term impact. Efforts should be given to improve intrinsic motivation to sustain behavior change. For this to occur, the provision of safety nets to attend to other practical needs such as addressing out-of-pocket expenditures, transportation, and household responsibilities will benefit mothers and their families and support their decision to seek care in facilities. Eliminating the associated stigma and fear should also be a primary concern for both mothers and health workers to allow positive reinforcement of experiences in health facilities. A culture of penalizing and shaming will contradict any sustained change in the health system.

The health system ought to provide quality care, with assurance of safety, security, and delivery of respectful and compassionate care by skilled providers. Putting in place appropriate infrastructure is critical to responding to the increased demand and investing in capacity building of midwives and village health workers will be most effective in reaching and educating mothers.

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POSTSCRIPT

Though this paper was originally written few years ago, its main idea of access to maternal healthcare services is extremely relevant to the present health situation in the country and elsewhere. The recently promulgated Universal Health Care (UHC) Act (RA 11223) promises access to maternal health services in the Philippines. One of its main principles is the provision of "access to a comprehensive set of quality and cost-effective, promotive, preventive, curative, rehabilitative and palliative health services" to all Filipinos. This can help ease financial burden on them and at the same time will regulate prioritization of needs for those who cannot afford such services.

In the ideal set-up, the UHC law has the potential of strengthening primary care; hence, services should be made available at all Rural Health Units in all local government units. Some relevant provisions may include: the automatic inclusion of all Filipino citizens to the National Health Insurance Program, the creation of positions for Primary Care Providers who will serve as initial point of contact of several households, and the establishment of Service Delivery Network that may streamline delivery of some health services. These are potential sources of incentives and motivation for mothers to access maternal health care services. However, up to this date, this law is yet to be fully implemented. Its Implementing Rules and Regulation was just developed in the late 2019. Only few provinces and cities are on the stage of piloting its implementation. No substantial experiences are available to guide a full-scale implementation of this law.

There are also some questions that need to be answered in addressing problems on inaccessibility of maternal health services within the context of COVID-19 pandemic. To what extent does the current pandemic affect the implementation of this law? How will the number of prenatal check-ups, maternal delivery, and postpartum care be affected? Can home visiting and home-based delivery be again considered as necessary and safe strategies to maternal care?

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Acknowledgment

The authors would like to thank Dr. Wendell Asuncion for his significant contributions as the area supervisor for Western and Eastern Visayas provinces. The authors are also grateful for the contributions of Dr. Manuel Dayrit, Executive Director of the Ateneo Center of Health Evidence, Action and Leadership (A-HEALS), who suggested that this focus group study be implemented. Special thanks to the eleven young nurses from the Eastern Visayas region, who patiently prepared, facilitated, and recorded the FG discussions, transcribed, and translated the FG documents.

The training and guidance of Dr. Erlinda Palaganas and Ms. Marian Sanchez of the Institute of Management of the University of the Philippines Baguio in conducting focus group data collection, and qualitative data analysis and management were irreplaceable. The political and health officials of all the villages, municipalities, and provinces of the Eastern Visayas region who facilitated the fieldwork of the data collection teams helped the authors so much as well as the socio-linguistic professionals from the region who contributed in validating the translations of the transcripts.

The medical students and alumni of the Ateneo School of Medicine and Public Health (ASMPH) also contributed to the finalization and review of the FG transcripts, debriefing reports, and expanded field notes. For all the respondents from the different communities of the Eastern Visayas region who willingly shared their experiences and perspectives regarding access to maternal health services, the authors are extremely grateful.