The Pains of Labour:
How the Commodification of Nursing is Costing the Lives of Mothers in the Philippines

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ABSTRACT

The Philippines, as the largest exporter of nurses, faces challenges in its own maternal health needs. The Philippines has enormous capacity to train nurses, yet few ever care for maternal health needs in domestic communities where they are critically needed. This thesis asks how can the "Right to Development" be applied to the capacity building and retention of Filipino nurses? Could this approach morally justify the reorientation of health sector priorities to improve maternal health outcomes in the Philippines? Export-oriented nurse training leaves pressing maternal health needs unattended and weakens capacity. By applying the framework of the "Right to Development", this thesis demonstrates how exporting nurses negatively impacts the quality of health care in the Philippines. This thesis argues that the political choice to export nurses without ensuring safe conditions for compatriots is structural violence against poor women in the Philippines by favoring economic development over the right to development.

LIST OF ABBREVIATIONS USED

ARMM: Autonomous Region of Muslim Mindanao

BEmONC: Basic Emergency Obstetric and Newborn Care

BHU: Barangay Health Units

BScMW: Bachelor of Science in Midwifery

CEDAW: Convention on the Elimination of All Forms of Discrimination Against Women

CEmONC: Comprehensive Emergency Obstetric and Newborn care

CHCs: Community Health Centres

CHDs: Centres for Health and Development

CHED: Commission on Higher Education

CPD: Continuing Professional Development

DOH: Department of Health

FGDs: Focus Group Discussions

GDP: Gross Domestic Product

GNI: Gross National Income

HCP(s): Health Care Practitioner(s)

HRH: Human Resources for Health

ICECSR: International Covenant on Economic, Social and Cultural Rights

ICN: International Council of Nurses

LGUs: Local Government Unit

MDR(s): Maternal Death Review(s)

MMR: Maternal Mortality Ratio

NCR: National Capital Region

NCLEX: National Council Licensing Exam

NNA: National Nursing Associations

OFW: Overseas Filipino Workers

OOP: Out-Of-Pocket

PRC: Professional Regulation Commission

PSA: Philippine Statistic Authority

RHUs: Rural Health Units

RTD: Right to Development

SRH: Sexual and Reproductive Health

THE: Total Health Expenditure

UN: United Nations

WHO: World Health Organization

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CHAPTER 1: INTRODUCTION

1.1 The Context of Maternal Death in the Philippines

Worldwide, the birth of a child is a celebrated and commemorated event. The United Nations declares that every child is born with the fundamental freedoms and the inalienable rights of life, liberty, and dignity without distinction or discrimination (United Nations General Assembly, 1948). While we are all "born free and equal in dignity and rights", there is no dignity in the death of a mother during pregnancy or childbirth as a result of discrimination or negligence (United Nations General Assembly, 1948, art. 1). So too is maternal death abhorred when it comes at the hands of a negligent government or the unavailability of access to health care practitioners (HCPs).

Although the experience of pregnancy and childbirth is universal, the opportunity to survive pregnancy and childbirth is not. Safe childbirth for both mother and child is determined by accessibility to quality health care for women. Such quality depends on appropriate social policies for access to needed health care that allows for healthy, and safe pregnancies and childbirth. Maternal death should not be an expected feature of specific marginalized populations of women based on their economic, political, or social status. Considering the current global levels of wealth, knowledge, and human resources for health, continuously high rates of maternal mortality is serious development challenge. In the Philippines an average of 7- 11 maternal deaths occur every 24 hours (Huntington, Banzon, & Recidoro, 2012). The country loses 3,000 women per year due to preventable pregnancy and childbirth related complications (Huntington et al., 2012). Despite the high priority of maternal health on the global health agenda, the Filipino

maternal mortality ratio (MMR) has remained consistently, and unacceptably, higher than the globally projected targets. Even with the launch of "162 to 52", an inter-sectoral program to drastically reduce maternal mortality in the Philippines, the national MMR remains shockingly high for a country of its economic standing, and with its capacity to train health workers (Dayrit, 2015). In as much as the Philippines has capacity to train health workers to meet domestic health needs such as maternal health, this area of health care remains seemingly neglected (World Health Organization, 2012a). Why?

The Philippines is identified as a significant provider of internationally competent, English-speaking nurses that are ready to practice in countries seeking foreign-trained nurses, to meet the global demand for human resources for health (HRH) (Gardiner Barber, 2013; Lorenzo et al., 2012). Simply put, government policies in the Philippines favour the exportation of nurses to meet foreign demand, rather than prioritizing resources to meet the needs of compatriots. The migration of Filipino nurses, either temporary or permanent, offers important support for international nursing workforces, does generate revenue for the Philippines and even fulfills cosmopolitan values of Rawls' "equity of opportunity principle," which argues for skilled workers to work where they wish to (Rawls, 1985). However, out-migration of nurses hinders the right to development for women of reproductive age in the Philippines, in that the exodus of skilled workers within the country has strained the health system to a level where health promotion and disease prevention in maternal health cannot be guaranteed for all (Clark, Stewart, & Clark, 2006). What is more, these strains worsen the quality of advanced emergency care for women in the Philippines.

Considering that the Philippines has such impressive capacity to produce HHR, it begs the question as to why it is so difficult for the Philippines to retain nurses for their own needs (Commission on Higher Education, 2018)? Many nations, such as Cuba, Thailand, South Korea and even Ireland, do see out migration of human resources for health, but often measures are taken in order to ensure that domestic health services are maintained (Huish, 2013). The desire for the Filipino government to encourage out-migration of nurses leads to strenuous effects on the national health care system in two ways. First, outmigration puts an increased demand on midwifery services as the frontline of maternal health care provision in the Philippines. Indeed, midwifery serves an important role in quality maternal health care, but the discipline is not a fully functioning health system within itself. This to say that midwives should be valued within health systems, but they should not be expected to take on responsibilities of advanced obstetric specialists. Second, the lack of nurses in rural and marginalized communities deprives women in these communities of choice and quality of care in their access to maternal health services. This inequity and risk can be understood as structural violence against the marginalized, as it is the result of political decisions at the national level to pursue economic development over the collective "right to development" (RTD) (Farmer, 2003; Icamina, & Javier, 2007; Lorenzo, Galvez-Tan; Lorenzo et al., 2012;).

Paul Farmer (2003) argues that structural violence occurs when suffering is intended for a group of people. He suggests that even though resources, knowledge, and technology are physically available, the decision to systemically deny these resources to a population is morally problematic (Farmer, 2003, p. 9). Often, structural violence is witnessed against minority communities and against the marginalized.

This thesis builds on literature suggesting that the out migration of nurses creates dangerous strains within the Filipino public health system. The thesis asks the following research question: Can the values of the Right to Development be applied to capacity building, and retention strategies of Filipino nurses so as to improve gaps in the national health system? To answer this question this thesis explores how nursing education, training, and migration have created barriers to improving health system support for the needs of marginalized women in the Philippines. The research question is approached in two ways. First, to assess capacity-building strategies through analysis of national policies within the Philippines as well as an analysis of the country's commitments to international edicts on the Right to Development. Second, through first-person interviews with health workers, patients, and policy-makers in the Philippines to identify the existing tensions, lived experiences, and personal accounts of maternal health issues in the Philippines. Taken together, this thesis offers an important contribution to the discussions on domestic capacity building and strategies to ensure improved health outcomes that are sought in the Philippines.

In using the RTD, this thesis can situate maternal death within a human development framework to identify the subjects, duty holders and stakeholders, and the obligations of duty holders, in regards to maternal health care provision in the country, and the feasibility to protect, respect and fulfill these obligations. This can better understood using the methods employed: interviews and focus group discussions (FGDs)with all disciplines in the interdisciplinary health care team that provide maternal health services, questionnaires with users of maternal health services in the country (Birth Mothers) and secondary data analysis through national and international policy

assessment. Such an approach can help to identify the gaps in health system capacity, through first person narratives, and the poor health outcomes in the Philippines indicated in existing data. Further, investigating how out-migration as a national development strategy is creating conditions non-conducive to the process of human development articulated in the RTD, that further determines structural violence that results due to a failure to adhere to the RTD and national and international policies, can be better understood to identify capacity building measures at a national and international level.

1.1.1 Thesis Statement

Based on data collected, this thesis argues that the Filipino nursing migration pipeline serves a purpose as an economic development strategy, but compromises the strength, functioning, and even safety of the national health system for maternal health needs. The lack of HRH in key areas results in a persistent public health crisis that leaves rural areas inadequately served, health workers over-stretched in their duties, and the system itself full of "dangerous delays" for maternal health (Godal & Quam, 2012). The strain and risks posed from this health system are the result of a lacking, albeit negligent, commitment to the collective Right to Development, which translates as a form of structural violence to marginalized and vulnerable women who rely on national health services in the Philippines. Currently the moral and political value of outmigration creates a normative expectation that "good nurses" will leave the Philippines. As the findings of this thesis demonstrate, valuing health workers through scholarships and retention programs challenges this normative expectation and could serve as an important means of building capacity to improve care for compatriots. As this thesis demonstrates,

the Right to Development not only challenges the merit of these values but invites discussions on capacity building that meet collective needs within the country.

A system that denies comprehensive, quality obstetrical care that is accessible and technically available is structural violence against women needing medical assistance, based on gender and of childbearing age. This inhibits the rights to dignity, to life, and to enjoy the highest attainable standard of health (United Nations General Assembly, 1979). In as much as the Filipino government has taken steps to address and improve maternal health care needs through the 162 to 52 initiative, the Philippines fails to guarantee essential services by supporting the domestic health system amid a surplus of human resources for health (Dayrit, 2015). Current initiatives in the Philippines remain reactionary, disconnected, and unable to prevent dangerous delays. Failing to provide incentives for nurses and designing strategies obtuse to the Right to Development reflects the lack of prioritization of women's rights. As this thesis suggests, the Philippines' educational and human resource potential could serve to improve health equity and sustain the protection, respect, and fulfillment of the Right to Development within the country.

By using the Right to Development (1986) as an analytical framework for this study, it allows for an important discussion of how the political choice to fulfil imagined economic development goals without meeting real human development needs factor in to capacity building strategies. As a resolution adopted by the General Assembly in 1986, the Declaration on the Right to Development is both a human right itself and a an analytical framework for development, created by a synthesis of international law, charters, and conventions, with the universal objective to ensure that "every human

person and all peoples can participate in economic, social cultural and political development" (United Nations General Assembly, 1986, art. 1). The Declaration (1986) links individual human rights to the process of development and seeks to build upon the capacities of existing states, structures, and of individual and collective agency to provide conditions conducive to the realization of duty and rights fulfillment and to the sharing of the benefits of scientific and technological advancement. The declaration insists signatory states, including the Philippines, "have the right and duty for formulate appropriate national development policies that aim at the constant improvement of the well-being of the entire population and of all individuals" (United Nations General Assembly, 1986, art 2.3).

This thesis analyzes the current capacity building policies in the Philippines in order to answer the question of whether RTD could improve health system performance. The data collected for this thesis, both in the analysis of policy documents and through first person interviews are informed by cosmopolitan theory that implies that development could be improved with better commitments to existing civic obligations, including RTD (Pogge, 2008; Rawls, 2001). Not only does this approach allow for better understanding how the current capacity building and migration policies fit into collective rights frameworks, but also to elicit how actors themselves feel about these values. This is to say whether or not nurses in the Philippines themselves feel obligations to their compatriots that supersede normative values of out migration. Granted, that the Government of the Philippines has taken initiatives to improve tensions in their health care delivery systems, such as the 162 to 152 initiative, a need remains to improve quality of care and choice in access to care for women in marginalized areas of the country. It

raises questions as to whether values of service to compatriots can align with real economic, and moral career choices of nurses themselves, and if this can give access to all for economic, cultural, and social development.

1.1.2 Rationale

A particular knowledge gap exists in understanding how the moral and political emphasis on out-migration strains the quality of health care services in the rural areas of the Philippines. Cooke (1993) suggests that as a discipline nursing lacks the ability to "address [structural] issues such as inequality which have a damaging effect on the delivery of nursing care" (Cooke, 1993, p. 1995). In response to Cooke, Porter and Ryan (1996) state that it is possible for nursing research to give due attention to social structures through critical ethnographies that recognize both structures and individual actors. Building on Porter and Ryan's call, it is possible, and worthwhile, for practicing nurses to have concern with social structures that impact practice and care. What's more, by recognizing that quality of care and the achievement of a rights-based approach to health ultimately comes from understanding the capabilities and limitations of both structures and individuals. Although the issue of out migration of nurses is central to the challenges of domestic health care delivery in the Philippines, it is important for this research to also bring in the voices of other health workers such as physicians, midwives, and hilots. In exploring how the structure of the system and agency of health workers and patients who engage the system result in notions of care, the question then becomes whether or not a deeper moral commitment to RTD could create the space for better health-system improvements in the Philippines. Also, it is important to recognize if the

stated goals of out-migration of nurses in fact bolsters economic growth, and within it the well-being of all Filipinos.

1.1.3 System Stresses on Maternal Health

The World Health Organization (1946) understands "health" as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". Within this broad definition, some specific health calamities can help to understand the quality and functionality of a health system. Maternal mortality, for example, is one of several measures of women's health, but also a calculation of the risk of dying from pregnancy and childbirth based on the capabilities of a health system. The World Health Organization (WHO) defines maternal mortality as:

> the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes (World Health Organization, 2004).

Measuring only maternal death does not assess overall maternal health of a system, nor does it factor in maternal morbidity, a measure that accounts for disabilities related to maternal health. The UN Human Rights Council (2010) assumes that 20 women will suffer from maternal morbidities for each accounted maternal death.

Notably, pregnancy, labour and birth require the prioritization of women's needs is essential for survival of both mother and child. High maternal death rates depict the failure of access to scientific and technological advancement in medicine. While scientific and technological advancements in medicine improved maternal health services and reduced maternal deaths on a global scale, the unequal global distribution of these benefits of 'development' continue to hinder the ability of certain populations of women

to enjoy the highest attainable standard of health. This inequity challenges the Right to Development, as well as the right to enjoy the highest attainable standard of health, that consequently differentiates the health and well-being of specific populations (United Nations High Commissioner for Human Rights, 1966).

Although some maternal health emergencies may be unpredictable, 88% - 98% of maternal deaths can be prevented by the following measures:

- appropriate antenatal care; skilled birth attendance
- access to information and services to make informed decisions regarding SRH
- basic, comprehensive and emergency obstetric and newborn care
- appropriate referral system for comprehensive obstetrical care

(Freedman and Maine, 1993; Physicians for Human Rights, 2007; The Sphere Project, 2011, p.325).

These are all elements that are required for high quality maternal health care. Knowing how these elements factor into rural health in the Philippines will be of importance during the discussion section of this thesis.

The major causes of direct maternal mortality in the Philippines are related to: hemorrhage, preeclampsia, sepsis, obstructed labor, and unsafe abortion (Lucas, 2008; United Nations General Assembly, 2010; World Health Organization, 2013). The pharmaceuticals used to manage complications of childbirth and pregnancy, uterotonics, tocolytics, antibiotics, anti-hypertensives, and those to manage indirect causes, such as antiretrovirals, antimalarials and tuberculosis treatments, are all included on the WHO's essential medicines list and should be attainable by all countries (The Sphere Project, 2011; World Health Organization, 2017). Also, minimum standards for basic and comprehensive reproductive health planning, interventions, and coordination between sectors is also expected for the integration of comprehensive reproductive health services

into primary health care provision (Inter-agency Working Group on Reproductive Health in Crises, 2010). This raises the question to how well RTD fits into planning models.

1.2 Geographies of Maternal Death

Despite the increased global attention to the issue of maternal health through the Millennium Development Goals, maternal mortality persists as a consequence of poor health system planning, and as a social injustice. It remains the number one cause of death among women and girls of reproductive age, as access to, and, the availability of, acceptable quality sexual and reproductive health services is shockingly inequitable on a global scale (United Nations Human Rights Council, 2009). The global target for an acceptable MMR is 70 per 100,000 live births (Cabral, 2016; World Health Organization, 2015). In 2017, records of Filipino MMR were as high as 204 per 100,000 live births. A closer look at the trends of Filipino maternal mortality demonstrates that the country has been unable to reduce the number of maternal deaths in the past 30 years, averaging 114 [87-175] maternal deaths per 100, 000 live births since the 90s (Maternal Mortality Estimation Inter-Agency Group, 2015a). This stands out particularly within the region of Southeast Asia as the region itself had a 63 percent decline of maternal death rates in the past 20 years, with Filipino neighbours, Vietnam, Laos, and Cambodia, boasting 70 percent declines of their national MMR (Rufino, 2012; World Health Organization, 2015). Vietnam has decreased its MMR from 139 in 1990, to 54 in 2015, Cambodia decreased its MMR from 1020 down to 161, Laos, from 905 down to 197 (Maternal Mortality Estimation Inter-Agency Group, 2015a; Maternal Mortality Estimation Inter-Agency Group, 2015b; Maternal Mortality Estimation Inter-Agency Group, 2015c).

In contrast, the World Bank Group (2015) estimates that the MMR in Canada for 2011-2015 is 7 per 100,000 live births; United Kingdom (UK): 9 per 100,000; and the United States (US): 14 per 100,000 live births. All of these countries experience comparatively good maternal health services, and yet they have also benefited from the in-migration of Filipino nurses (Gardiner Barber, 2013). It is morally troubling then for the out-migration pipeline to benefit the needs of affluent countries with nurses from a source such as the Philippines that struggles with pressing health needs, including maternal mortality. What's more, it is also problematic to maintain this migration trend without offering some level of compensation or restitution to communities left marginalized, and to a system left strained (Huish, 2015). These disparities in maternal mortality ratios are just one indicator that demonstrates this gross inequity.

1.3 The Commodification of Nursing in the Philippines

As the largest exporter of HRH, the Philippines has seized the opportunity to capitalize on the global demand for nurses (Castles, 2013). This export-oriented model commodifies nursing as a profession in the Philippines. This 'commodification is enabled by the expansion of the number of nursing schools, increased rates of nursing enrollment and the integration of international nursing curriculum into existing curriculums of higher education institutions (Lorenzo, et al., 2007; Ortiga, 2014). Collectively, this has fostered an identity of the overseas Filipino nurse that Pittman, Aiken, & Buchan (2007) portray as a legitimate exportation of human capital for continuous participation of the Philippines in this global market.

The out-migration of Filipino HCPs initially presented opportunities to relieve high rates of unemployment and poverty within the country, and to seek training and experience abroad with the hopes of returning to the Philippines with the heightened knowledge of clinical practice and technology from advanced health care systems (Castles, 2014; Huish 2015; Lorenzo, Galvez-Tan, Icamina, & Javier, 2007;). This expectation has fallen short. The continuous participation in the nursing pipeline has led to the exportation of roughly 70 percent of its Filipino nursing graduates abroad, leaving an estimated 30 percent contribution of HRH for domestic health service provision (Bach, 2003; Gardiner Barber, 2008; Ortiga, 2014). This small contribution to the domestic workforce leads to a limited number of experienced, but over-stretched nurses within the country, whose duties are also expected to be transferred to other health workers (Ortiga, 2014). The majority of the remaining 30 percent are employed in the private sector, leaving a small domestic workforce to oversee public health service provision for the entire country in government retained hospitals or Local Government Units (Asia Pacific Observatory on Health Systems and Policies, 2011). This resulted in an uneven distribution of health facilities and human resources for health in rural and isolated communities of the Philippines (Lorenzo et al., 2007; Paterno, 2013). Literature further highlights how the small proportion of the remaining nurses, as well as many HCPs domestically, are concentrated in the urban areas (Lorenzo, Galvez-Tan, Icamina, & Javier, 2007; Huish 2015; Castles, 2014). The urban areas, especially the nation's capital region, maintain a larger proportion of both HCPs and health facilities in the country, while remote areas lack these essential elements of health care, showing the inequitable access urban and rural populations of women have to health care (Lorenzo,

Galvez-Tan, Icamina, & Javier, 2007. Yet, between urban and rural areas, the public system remains under-funded and often overwhelmed (Castles, 2014).

The total health spending of the Gross Domestic Product (GDP) for the Philippines is four percent, of which a third goes to the public sector (The World Bank, 2015). In contrast, the total health spending of Gross Domestic Product (GDP) for Canada is 10.9 percent; the US: 17 percent; the UK: nine percent (The World Bank Group, 2015). Of this total health spending, it is estimated Canada spends 68 percent of health care funding on the public sector, while the UK and the US public health funding is 83.5 and 47 percent, respectively (The World Bank Group, 2015). While these figures are taken from affluent nations, several middle income and even lower-income countries contribute the same percentage as the Philippines but have better maternal mortality rates (see Appendices A & B). The graphs also show a strong relation between income per capita and better maternal mortality rates, but not always with the percentage spend on health. These statistics could demonstrate that the Philippines spends a proportionately low amount of domestic revenue on national health care spending, while at the same time gaining greater GDP through out-migration. The Philippines has experienced annual growth rates between 1.1% and 6.7% in GDP, to what Manila claims to be in part due to out-migration of nurses (Cigaral, 2018; Ortiga, 2018). Failing to strategically increase in spending on national health care services creates a moral conundrum in diverting resources away from the needs of compatriots to that of global demand, and without seeing any real benefit to the national system (Pogge, 2008). It is to say that the health needs of others is prioritized over the health needs of marginalized compatriots, which is

ultimately a form of structural violence that creates needless suffering upon the vulnerable.

The Philippines' lack of human, financial, and structural resources to sustain a domestic health workforce continues to foster push factors that drive Filipino nurses out of the country. Literature suggests that a poorly-funded health care sector, difficult working conditions, limited professional opportunities, and high patient to nurse ratios at 50:1, are all factors contributing to this trend (Brush, 2010). Combined, this leads to high levels of job dissatisfaction, low morale and dangerous working conditions, with little remuneration. (Gardiner Barber, 2013; Lorenzo et al., 2007; Pang, Lansang, & Haines, 2002; World Health Organization, 2010b). Countries seeking health care workers such as Canada, the United States, the United Kingdom, and Saudi Arabia are able to remunerate migrants with wages that vastly exceed wages earned in the Philippines, and can provide stimulating environments for professional growth, and job and livelihood security that contribute to the pull factors of host countries of migrating HCP workers (Brush, 2010; Pang, Lansang, & Haines, 2002). However, in the case of Saudi Arabia, multiple accounts of physical abuse against Filipino nurses have resulted in calls to cease sending nurses to the Kingdom (Lee-Brago, 2018). Not only are nurses migrating, but doctors and other health sector workers have retrained as nurses given the economic and developmental opportunity presented abroad (Gardiner Barber, 2008; Huish, 2015).

1.4 International Dimensions of Nurse Commodification

Seeking international nurses already trained and ready to work is a quick fix to current international HCP shortages. As the investment in the education of health care

practitioners and hospital beds decline in higher income countries, the number of foreign trained health care professionals sought from migratory source countries increases (Robinson & Clark, 2008). Source countries, like the Philippines, that mass produce nurses, must invest public monies into the establishment of high-quality nursing education. This creates a double drain on the source country by investing in capacity building, but without gaining any direct benefit from it. In contrast, many countries seeking Filipino HCPs have significantly higher investments in public health, lower MMR, and provide little bilateral reciprocation to HCP donor countries such as the Philippines (Labonté, Packer, & Klassen, 2006).

The Philippines relies on out migration in many economic sectors for Gross Domestic Product, through the enormous quantities of remittances sent back to the country. Remittances contribute as much as 12-13 percent of the GDP annually under the assumption that remittances would contribute to local economy (Castles, 2013; Gardiner Barber, 2013; Gardiner Barber, 2008; Lorenzo, et al., 2007; The World Bank Group, 2015). Remittance income may well improve the GDP, but the promise of increased national wealth being used to bolster national programs is not fulfilled by Manila (Brush, 2010). However, countries sending HCPs abroad often fail to receive collective benefits of HCP migration, as Huish (2015) notes that much of remittances from HCPs abroad may influence familial lifestyles and spending, but minimally affect national development. Pang, Lansang, & Haines (2002) suggest that policy makers shift from ethical migration management to bilateral relations that return benefits to the educational institutions and hospitals providing the trained global HCP workforce. This is an

important call in that bilateral relations may be a stronger supporting mechanism for RTD, rather than a development plan that relies on the intake of individual remittances.

1.5 Health Care in the Philippines

The Philippine Nursing Act (1991) decentralized the health care system as a management strategy with the intent to bring control of resources and access of health care to local levels of influence to better increase the quality and specificity of services delivered. Health services were devolved to provincial, city, and municipal government units, with the national Department of Health (DOH) as distal the governing body. The DOH provides national policy development, standards and guidelines to be implemented by government units, and also private service providers. They also provide such guidance and governance through Centres for Health and Development (CHDs), under which the government units implement national health programs, with tertiary level and retained hospitals managed by the DOH (WHO, 2011).

While the DOH licenses health facilities, professional regulatory bodies license health care practitioners, and PhilHealth accredits both practitioners and health facilities in order to claim reimbursements from PhilHealth. PhilHealth is a government owned and controlled corporation. It remains the sole National Health Insurance Program in the Philippines, created to instill universal health coverage under the National Health Insurance Act (1995). As part of the 162 to 52 initiative, the NHIP has expanded to cover over 80% of the population (Philippine Council for Health Research and Development, 2018). The mandate of PhilHealth is in line with the visions of the Alma-Ata Declaration that holistically seek to reduce health inequities and ensure health care for all (World

Health Organization, 1978). However, PhilHealth has struggled to provide universal national coverage. The program covers inpatient benefits, low financial protection for members, and a persistently low share in national total health expenditure (Paterno, 2013). PhilHealth does not cover outpatient services and special benefits, which are integral to ensuring coverage of public and primary health care interventions and education, including maternal health. PhilHealth inpatient benefits offer little financial protection, providing financial protection of only 30-50 percent of hospitalization costs, leaving a 50-70 percent gap of fees to be paid by out-of-pocket (OOP) payments for those enrolled in PhilHealth (Paterno, 2013). Of the total national health expenditure, PhilHealth averages a contribution of 8-9 percent, while in contrast, health care users contribute an average of 53 percent through OOP payments due low rates of universal health care coverage (Paterno, 2013). An estimated 38 percent of the Filipino population has PhilHealth coverage, primarily those employed formally or by the private sector, neglecting the destitute poor, the unemployed and the informally employed populations who are not paying into PhilHealth through employment taxation, and must pay 100 percent through OOP payments (Paterno, 2013). Since the national health insurance provider functions only through individual contributions, rather than through collective financial support, it challenges the values of RTD in both universal access, and quality of insurance.

1.6 Education of Nurses and Midwives

The scopes of practice for of nursing and midwifery are important to explore. Each discipline of care works best with proper support and adequate capacity building, and both areas can be essential for ensuring safe maternal health care within a system.

On the other hand, if the scope of practice is strained by lacking resources, or challenges in the system, harmful consequences can occur ranging from poor patient support to "deadly delays" (Friedman & Maine, 1993). Nurses do have capacity to intervene in health emergencies and policy planning, than do midwives. Nursing's scope of practice facilitates the capacity to intervene to the highest level of acuity in serious health complications, while midwives are granted this capacity only with extracurricular training and supervision.

The Philippine Nursing Act (1991), and the Philippine Midwifery Act (1992), define the scopes of practice, education, examination(s), standardization and regulation of the two professions in the country (The Philippine Nursing act of 1991, 1991; The Philippine Midwifery Act of 1992, 1992). These acts task duty holders with subsequent duties and functions to perform and further identifies key stakeholders relevant to both the midwifery and nursing professions.

According to The Philippine Nursing Act (1991), and the Philippine Midwifery Act (1992), the State assumes the:

> responsibility for the protection and improvement of the nursing profession by instituting measures that will result in relevant nursing education, humane working conditions, better career prospects and a dignified existence for our nurses (The Philippine Nursing act of 1991, 1991, art. 2, sec. 2).

and

> the responsibility for the protection and improvement of the midwifery profession by instituting measures that will result in relevant midwifery education, humane working conditions, better career prospects and dignified existence of midwives, while guaranteeing "the delivery of quality basic health services through an adequate nursing personnel system throughout the country" and "the prioritization for the needs of women and the delivery of quality health services through an adequate midwifery personnel all over the country" (The Philippine Midwifery Act of 1992, 1992, art. 2, sec. 2).

The Professional Regulatory Boards of Nursing and Midwifery regulate registration, conduct licensure examinations, issue practice licenses, and determine the Code of Ethics, while monitoring and ensuring quality standards of education for both professions. The CHED prescribes the education curriculum and training standards and policies for both professions and accredits institutions of midwifery and nursing education (Philippine Nursing act of 1991, 1991; The Philippine Midwifery Act of 1992, 1992).

The scope of nursing is defined as:

> A person shall be deemed to be practicing nursing within the meaning of this act when he/she singly or in collaboration with another, initiates and performs nursing services to individuals, families and communities in any health care setting. It includes, but not limited to, nursing care during conception, labor, delivery, infancy, childhood, toddler, preschool, school age, adolescence, adulthood, and old age. As independent practitioners, nurses are primarily responsible for the promotion of health and prevention of illness. [As] members of the health team, nurses shall collaborate with other health care providers for the curative, preventive, and rehabilitative aspects of care, restoration of health, alleviating of suffering, and when recovery is not possible, towards a peaceful death (Philippine Nursing act of 1991, 1991, art 6, sec, 28).

This scope of practice allows nurses the ability to provide:

> ...essential primary health care, comfort measures, health teachings, and administration of prescription for treatment, therapies, oral, topical and parenteral medications, internal examination during labor in the absence of antenatal bleeding and delivery (Philippine Nursing act of 1991, 1991, art. 6, sec. 28).

The nursing degree in the Philippines is four years, and as described above, has a wide scope of practice and matching curriculum. The scope of the Midwifery Practice in the Philippines is defined in Section 23 of The Philippine Midwifery Act (1992) as:

> "...Performing or rendering, or offering to perform or render, for a fee, salary, or other reward or compensation, services requiring an understanding of the principles and application of procedures and techniques in the supervision and care of women during pregnancy, labor and puerperium, management of normal deliveries, including the performance of internal examination during labor except when patient is with antenatal bleeding; health education of the patient, family and community...prevention of complications, breastfeeding, nutrition, exercise...preparation for delivery, postpartum check-up, prevention of illness, immunization, relevance of newborn screening...primary health care services in the community including nutrition, reproductive health education, prevention and control of communicable and non-communicable diseases, newborn care and care of the family and community, basic life saving skills, obstetrics and basic gynecology, and family planning;....antenatal, intra-natal and post-natal care of the normal pregnant mother... including oral and parenteral dispensing of oxytocic drug after delivery of placenta, suturing parietal lacerations to control bleeding, to give intravenous fluid during obstetrical emergencies, administer life-saving drugs such as Magnesium Sulphate, oxytocin, steroids, and oral antibiotics when no physician is available, provided they [have been] are appropriately trained for that purpose [:] and certified proficient to perform the necessary care and services to prevent maternal deaths…" (The Philippine Midwifery Act of 1992, art. 6, sec. 2).

There exists two levels of midwifery education: the first is a Diploma in Midwifery (a two-year programme), and the second is a Bachelor of Science in Midwifery (a four-year programme). The difference between the two levels of education is the heavy focus of obstetrics as the foundation of midwifery in the Bachelors of Midwifery program, including pharmacology, that is not included in the two-year diploma. It will be important to note that The Philippine Midwifery Act (1992) expands the original scope of practice integrating the following key amendments in 2002:

- "allow midwives to administer life-saving drugs when no physician is available, provided that they are appropriately trained for such purpose.
- require midwives to be certified proficient to perform the necessary care and services to prevent maternal deaths and allow them to administer essential born care.
- require practicing midwives who intend to perform Emergency Obstetric and Neonatal Care (EmONC) to apply for and acquire accreditation from the Department of Health (DoH).

- require registered midwives to maintain competence by continual learning through Continuing Professional Development (CPD) to be provided by the accredited professional organization or any recognized professional midwifery organization.

- provide for a mandated comprehensive midwifery program which includes a valid assessment of career performance and potential of midwives...” (The Philippine Midwifery Act, 1992).

This demonstrates, quite clearly that the act is meant to cope with strain on nurses, so that additional duties fall to midwives.

In 2008, the Filipino government created the DOH scholarship and retention programme, ‘Midwifery Scholarship Program of the Philippines (MSPP)’ to produce “graduate midwives to be deployed as Rural Health Midwives (RHMs) in priority areas identified by the Department of Health (DOH) in the country.

> In support to the achievement of the Millenium Development Goals to decrease maternal and neonatal morbidity and mortality rate by producing and ensuring a constant supply of consistent competent midwives fit to serve the identified priority areas of the country” (DOH, 2008).

This educational contract provides free education for qualifying students to expand maternal health service provision in the country. Upon completion of the Bachelor of Science in Midwifery and

> upon receiving the Professional Regulation Commission (PRC) Midwives License, midwives shall render service to the government on the ratio of two (2) years of service for every year of study or scholarship. Return service shall be in a form of an area assignment to the chosen identified priority areas in the country” (DOH, 2008).

This program is one of several efforts by Manila to help offset the strains on the system, however no such scholarship program exists for nursing programmes in the Philippines, and it is unclear as to whether or not this program leads to better outcomes.

In sum, this chapter has outlined the main research question of how the Right to Development could be applied to the Filipino health system, especially to alleviate strains caused by an overwhelming out migration of health professionals. The contextual information about the nature of health services, and health worker training in the Philippines already demonstrates clear strains and tensions in achieving universal access to care, which is a foundation of the Right to Development. In order to address the research question, this thesis will discussion what the Right to Development is in Chapter 2. The methods used to collect and analyze data are described in Chapter 3. Chapter 4 reviews the data collected from fieldwork conducted in the Philippines. Chapter 5 discusses the results in eliciting voices of health workers and patients to understanding how and RTD approach to capacity building would be received. Chapter 6 offers conclusions drawn from this research.

CHAPTER 2: ANALYTICAL FRAMEWORK
THE RIGHT TO DEVELOPMENT: DEVELOPMENT AS A HUMAN RIGHT

2.1.1 Introduction

This thesis applies the analytical framework of the Right to Development (RTD) to understand how health system strengthening through capacity building and retention could be improved in the Philippines. The Right to Development is a comprehensively inclusive collective right: it focuses not on the realization of an(y) individual human right, but on the realization of collective rights, such that all human rights are "indivisible and interdependent", and are synergistic and symbiotic in the realization of all other rights whilst not violating or diminishing any other right (United Nations General Assembly, 1986, art 41, res 128). It is important to understand how objectives of current economic and social development policies are shaped in order to achieve particular outcomes of development is explored in this thesis, along with what the objectives and outcomes of development 'ought' to be. A collective human rights lens identifies how the subjects, beneficiaries, participants, and obligated duty holders fit into intended development processes. Understanding these elements of human rights and development is pertinent to answering the research question: Can the values of the Right to Development be applied to capacity building, and retention strategies of Filipino nurses so as to improve gaps in the national health system?

With the application of this framework, how the specific rights of health and development become intrinsic, or instrumental, to the process of development can become apparent. Intrinsic rights are valued as inalienable from the human experience,

and to deny them is seen as a serious offence (Pogge, 2008). Instrumental rights can be compartmentalized, measured, and distributed through services or arrangements (Pogge, 2008). Often health is quietly valued as an intrinsic right, but rarely guaranteed for all, which in practice makes it an instrumental right. The RTD framework values health as part of the collective right to development, making it an intrinsic value (United Nations General Assembly, 1986). Considering this, health systems can be scrutinized in their ability to guarantee access, and to ensure quality, to health care services that lead to good health. It views health as a product of the obligations of identified duty holders, rather than an accidental product of economic development. As such, it is possible to examine the current capacity of the Filipino health system in protecting, respecting and fulfilling articulated duties in regard to maternal health. Finally, applying RTD to the capacity and retention of nurses in the Philippines can provide suggestions on how to integrate human rights into policy frameworks at national and international capacities.

2.1.2 What is Development as a Right?

The UN General Assembly (1986), in the Annex of the Declaration on the Right to Development, recognizes that development:

> "is a comprehensive economic, social, cultural and political process, which aims at the constant improvement of the well-being of the entire population and of all individuals on the basis of their active, free, and meaningful participation in development and in the fair distribution of benefits resulting there from".

As such, development is defined as a process. It is one that includes economic, social, cultural, and political dimensions that cannot be isolated from each other. The right to development is an inalienable collective human right based on fundamental freedoms of of participation in the enjoyment of the economic, social, cultural and political

development process (United Nations General Assembly, 1986; United Nations High Commissioner for Human Rights, 1966; United Nations General Assembly, 1948; United Nations General Assembly, 1966). As a collective right, it is principally concerned with inequities in this experience. It is concerned with "improvement of the well-being of the entire population and of all individuals" (United Nations General Assembly, 1986, art. 14, res. 128). This "concept of the Right to Development could and should serve as a basis for the adoption of laws and procedures intended to eliminate conditions of underdevelopment or, at the very least, to help overcome the obstacles of development" (United Nations High Commissioner for Human Rights, 2013, p. 56).

This articulated 'process of development' places all individuals as the subjects, participants and beneficiaries of the development process, and the well-being of all individuals as the objective of (the process of) development. As the objective of the right to development is the constant improvement of the well-being of all, development processes should aim to produce legislature and provide services that do not further inequality, discrimination, or social injustice, (United Nations General Assembly, 1986). These obligations are to respect, protect and fulfill claims of rights bearers, by means of social or economic policies for the purpose of "eradicating all social injustices", but done in a way in which the realization that one right will not inhibit, deter, or reduce, the enjoyment of any other right (Sengupta, 2013, p. 70).

For some, this is a lofty claim, as the economic, social, and even human security capabilities in many lower to middle income countries are lacking too much. Jha (2012) argues that RTD is controversial in that several wealthier nations object to it on the very institutionalization of the term "development". Others argue that economic liberties, and

commerce would be severely limited if RTD were universally respected (Jha, 2012). As Jha (2012) notes, the idea that policy makers could craft legislature free of confusion as to the conceptual underpinning of "economic, social, and cultural rights" is limited, if not laughable (Jha, 2012, p. 17). In as much as RTD itself can be rightly critiqued for its practicality, and perhaps its moral positioning to free-market values, RTD itself can be used as a powerful critique against development policy, including health system strengthening. Being that collective values of development are concerned with inequities, a RTD critique exposes two important factors. First, who may be excluded from processes of development, and second if development stakeholders themselves feel a sense of inequity within processes of development.

The collective improvement of the well-being of all individuals as the central objective of the development process makes each individual the beneficiary (UN General Assembly, 1986). This well-being enables the means to exercise fundamental freedoms to enjoy health, education, and participation in the workforce. To this extent the Philippines has made efforts to expand collective rights of health, notably maternal health, through the expansion of universal health coverage, the increase in facility-based deliveries, and in expanding emergency response systems for maternal health (Dayrit, 2015). These programs can be considered important moves towards collective rights, however, they all suffer from structural shortcomings. The health insurance program only covers 80 percent of the population, although this is an improvement what was only 60 percent coverage in 2012 (Dayrit, 2015). Maternal health facilities and emergency care both lack material and human resources, which can increase risk for patients who rely on them. In this sense, the intention of Manila falls short in achieving RTD. For Jha

(2013, p. 21), this is not surprising, as he argues that a lack of resources is often what inhibits collective rights from achieving success. Hence, calls for economic development first tend to gain favour in low- and middle-income countries when collective rights approaches do not meet their targets.

When economic development is placed as the objective of national development policies, the means of achieving these economic objectives may alter how the outcomes of human development are realized. This is to say that policies aimed only at increasing GDP, or other economic indicators, may succeed in achieving a numerical goal, but they may also exacerbate inequity. In placing national economic growth as the primary objective in place of collective development policies, the fundamental freedoms and ability of people to exercise their economic, social, cultural, and political is not guaranteed. It then leaves a tense debate in play as to whether RTD requires economic growth first, or if economic growth ultimately thwarts RTD by increasing inequities within the development process.

As the right to development is an integrated process, economic growth could be a development objective that may be instrumental to the fulfillment of other development objectives and human rights (Sengupta, 2013). Development policies with objectives regarding economic growth are often shaped as a response to national and international market forces. While market forces can be used for economic development policies to "improve the well-being" of the population, they should not be constructed in a way that "creates conditions" that "have an adverse effect" on vulnerable populations (Sengupta, 2013, p. 85). Appropriate national development policies can be devised through the harnessing of "opportunities provided by the global economy" but should suggest

"sustainable economic growth, appropriate resource allocation" (Sengupta, 2013, p. 80). National development policies that are dedicated to the Right to Development should seek to share the benefits of development, but may actually hinder respect for human rights, and further hinder the realization of the Right to Development through conditions that may have an adverse effect. A RTD approach would not devalue individuals as mere human capital to be exploited in the pursuit of national economic development objectives within policies that place economic growth as the subject of development policies that creates adverse effects on vulnerable populations. Understanding this process of development is important in approaching the commodification of Filipino nurse migration as a reflection of national and international policy priorities, above that as a commitment to the Right to Development. This is to say that with such a strong push towards sending nurses out of country with the expectation of sending remittances back converts nursing capacity building into an economic driver, rather than a broader development experience.

2.1.3 The Concept of The Human Right

Sengupta (2013, p. 67) explores the concept of collective human rights: "To have a right means to have a claim to something of value on other people, institutions, state or international community, which in turn have the obligation to provide or help to provide that something of value". However, the feasibility of the realization of right(s) requires identifying the agents who have the duty "to fulfill or enable the fulfilment of the right", who further bear the responsibility to provide conditions that lead to the realization of said right (Sengupta, 2013, p. 67). Identified duty holders should then have identified means to carry out their obligations to provide and enable the fulfillment of the right

either within existing institutions, or even changing institutions if necessary. (Sengupta, 2013). It requires utilizing programmes of action or procedures, and a binding agreement amongst duty holders, whether it be bound amongst parties "legally, morally, or by social convention on all the parties", creating an obligation, norm of behaviour and action, and therefore a human right in and amongst peoples, institutions, states and the international community (Sengupta, 2013, p. 68).

While many states, including the Philippines, support RTD, it has not done well, according to Marks (2004), to enter the practical realm of development planning and implementation. Many states express rhetorical support for this right but neglect its basic precepts in development practice. Various U.N. working groups have politicized RTD in four broad groups. The United States opposed, and continues to oppose, amendments in support of RTD. A second group of middle-income countries, as well as the European Union favour some implementations of RTD in order to improve dialogue between the global North and the global South (Marks, 2004). A third group of countries in the global South feel that RTD should be embraced, but not to the point of offending the interests of current development donors. Meanwhile a third group of nations, referred to as the "Like Minded Nations" including the Philippines hold the belief that RTD should "reduce inequities of international trade, the negative impacts of globalization, differential access to technology, the crushing debt burden" and other factors including "health" to improve the human condition (Marks, 2004, p. 141). The Philippines has been a strong supporter of RTD, but the new populist government of Rodrigo Duterte has shown little commitment to the RTD working group. Instead Mr. Duterte's government has been

accused of thwarting human rights altogether with extra-judiciary killings (Thompson, 2016).

The "Like Minded Nations" approach the RTD as a means to reduce inequalities against the tide of globalization and unfair trade agreements. It is an outward critique against the global economic order and speaks less to internal policies and practices that also promote suffering and hardship. For Sengupta (2002, p. 838), "it is important to appreciate the full significance of the point that the right to development implies a process with equity and justice". In this sense a human rights approach to development must be based on a system of justice that creates dignity from a "social contract" (Sengupta, 2002). This approach does not excuse nations from dismissing internal challenges to the global economy, and instead invite critique against domestic policies that do not provide equal opportunities. Empowerment towards equity also encompasses better conditions of both social services, and of work.

Fox & Meier (2009) suggest that drastic imbalances in power within the global economic order prevent many countries in the global South from realizing public goods for health. For countries like the Philippines, these inequities are so profound that the country has taken to feeding the global imbalance of power by sending out its own trained health workers without ensuring comprehensive primary care services for its own citizens (Brush, 2010). It challenges, what Pogge (2008) calls, a tendency for nations to ensure the well-being of fellow compatriots before that of foreigners. Fox and Meier (2009, p. 113) suggest that "the right to development, working through a vector of rights, can address the social determinants of health", including health care capacity building. RTD can serve as a framework to insist that states to guarantee public health

commitments alongside reducing inequities stemming from poverty. RTD, taken in this way, is more than an analytical framework for assessing the quality of development initiatives through identifying inequities, collective rights, and responsibility to compatriots. It is a rally call to reform development processes themselves, and in doing so address the underlying determinants of health.

When states, like the Philippines, place greater financial responsibility of health to that of the individual, it leads to a spiraling deterioration in the public good for health. This occurs in two ways. First, personal resources are often spent, at greater expense, in private health systems, which encourages an internal migration of workers towards those places of practice. Second, political support for bolstering an over-stretched public system wanes, as individuals are encouraged to seek treatment options privately. Taken together, the strained system is pushed even further as resources fail to appear and human resources begin to flee (Kingma, 2018). For the Philippines, Manila encourages this is sort of individualism in both the receipt of health, and in the practice of health care (Kingman, 2018). Health workers are pressed to secure their own financial interest over that of the public good, while patients will seek opportunities and short cuts to navigate around the blockages to good care in the public health system (Kingma, 2018).

To build health system capacity, is to ultimately alleviate pressing social determinants of health, by assuring the provision of public goods (Fox & Meier, 2009). Since the practice of maternal health care in the Philippines is not approached, managed, or consumed as a collective good, there are few shared outcomes from this experience. Instead, there are numerous competing narratives of individualized experiences navigating health and health care (Asia Pacific Observatory on Health Systems and

Policies, 2011). The data collected from my interviews with health care workers, which is presented in chapter 4, reflects this as well. With each one, comes stories of disconnected and fractured experiences that only reinforce the fractured nature of health services, and ultimately reinforcing the values of individualism.

Ultimately the challenges of bolstering the public good for health in the Philippines extended from the harm done by severe austerity measures that have now led into a mix of populism and authoritarianism (Thompson, 2016). The connection between health and human rights through the RTD is still under-explored in both health care and international development studies literature. Meier & Fox (2008) argue that the RTD as a collective right, should supersede that of individual rights for the design of policies, such as health care capacity building. As mentioned earlier, collective rights strive towards universalism of an experience, and help to identify how inequities emerge within societies Collective rights are about shared experiences of a system that could respond to people's needs, rather than continuing in a fractured system with radically different outcomes among individuals. Collective rights can work to ensure best practices within a system, as the system design would require collective accountability, and hence improve outcomes within the system. However, collective rights are only successful if valued by the people in which they are meant to protect. This is to say that if health workers and patients would not value an RTD approach to capacity building or retention, it could not be deemed as a success.

A collective rights approach could address national concerns related to deep inequity and the underlying determinants of health (Meier & Fox, 2008). Many nations have struggled with issues of retention and capacity building (Labonté, Packer, &

Klassen, 2006). Some approaches have been to restrict the movement of health workers, others have tried to offer incentive structures through scholarships or by forgiveness of tuition costs associated with training. In this sense RTD would not apply to a policy that actively restricted the movement of individuals, as it would conflict with principles related to the equality of opportunity (Rawls, 2001). While some hold the belief that RTD can be a legally binding agreement to ensure such values, it is, in the meantime, an important analytical framework to assess the efficacy of health systems, not just in terms of function, but also in terms of moral commitment.

2.1.4 International and National Duty

As all individuals are active subjects, participants and beneficiaries of the development process, everyone has the individual and collective responsibility to respect all human rights and fundamental freedoms to which all individuals are entitled and to fulfill duties to the community by promoting and protecting an environment conducive for economic, social, cultural and political development (United Nations General Assembly, 1986, art. 2, sub-cls. 1-2). Individuals are ultimately responsible for their own welfare but can only do so under the structural conditions that allow for it. States follow up this responsibility by providing freedom and protection of individuals to take their own action by providing "assistance for individuals and groups to ensure the equal opportunity and provision of resources, required to take individual action for his/her own welfare" (Sengupta, 2013, p. 55; United Nations General Assembly, 1986).

The international community, in efforts of solidarity, should foster the ability of states attempting to harness such opportunities of the global economy by providing cooperation through aid to promote: national and international development via the

through human rights, and a "new international economic order based on sovereign equality, interdependence, mutual interest and cooperation" (UN General Assembly, 1986, art. 3, sub-cl. 3). This "implementation of the right to development has to be global in its reach… to provide an environment that is transparent and non-discriminatory and promotes universal access and equity in the distribution of the benefits from the development process" (Sengupta, 2013, p. 82). This includes immediate action, such as national policy and development plans, "strengthening democracy" by enabling participation of individuals, peoples, states, and international community, as well as national corporations and legal aid that work to enhance, rather than hinder, the flourishing of respect for human rights (Sengupta, 2013, p. 63). The international community has the ethical, moral and legal obligation to assist developing countries in the realization of social and economic development, pertaining to the international participation in the realization of the RTD.

The ethical aspects of the RTD acknowledge the global interdependence of countries within the development process. The international movement of human capital, technology, information, and further the international migration of human capital, that is responsive to the global market and economy has established continued "patterns of domination and dependency, unequal trade relations and restrictions from external sources on the right of every nation to exercise full sovereignty over its national wealth" (United Nations General Assembly, 2013, p. 9). The United Nations further notes the "moral duty of reparation", stating that: "...industrialized countries, former colonial powers and some others have a moral duty of reparation to make up for past

exploitation" (United Nations General Assembly, 2013, p. 10). This is an important edict in that many countries have greatly benefited from the outmigration of Filipino nurses.

This duty to respond, in the form of international solidarity, is articulated in several human rights instruments listed above. Farmer discusses 'pragmatic solidarity' as a key recommendation on integrating human rights into the global agenda, described as: "...the rapid deployment of our tools and resources to improve the health and well-being of those who suffer this violence" (Farmer, 2003, p. 220). Contextually, this means support should be implemented by members of the international community through just and equitable sharing of the benefits of development, including human resources for health, public health infrastructure, and up-to-date information and technology. The requirement of nations to fulfill their duties of international solidarity, including establishing and maintaining an environment conducive to the realization of all human rights, is backed by the binding legal obligations put forth in several human rights instruments reviewed above and clearly articulated in the Right to Development.

The ability to provide a conducive environment for the fulfillment of human rights is non-existent if the state is unable to provide access to and services that fulfill basic needs, is without resources, or holds an insufficient legal system itself. The role of the international community, then, is not to interfere with the self-determination of states and peoples, unless the state or peoples are unable to do so independently (United Nations High Commissioner for Human Rights, 2013, p. 51). When a state does not have the ability to provide resources, the international community has the responsibility to provide appropriate means to foster development, as stated in the RTD:

> "universal respect for and observance of all human rights and fundamental freedoms without distinction... and implementation, promotion and protection of civil, political, economic, social and cultural rights…to eliminate obstacles to development resulting from failure to observe civil, political, economic, social and cultural rights" (United Nations General Assembly, 1986, art. 4, sub-cl. 2; art. 6, sub-cls. 1-3).

Further, individual countries have the right to engage with the international community to seek assistance and cooperation in meeting development goals and universal realization of human rights. States should then instill development programmes and policies, and conditions conducive to minimizing inequalities and the breach of rights domestically, and internationally for those unable to do so independently (Sengupta, 2013). Therefore, all states will need to participate in the development process to create the environment and feasible means conducive to the equal realization of all rights for all individuals in each state. The duty of states to cooperate (with each other) to progressively realize the right to development, including international peace and security, and international economic stability that is free from discrimination, is articulated in international law in both the Charter of the United Nations and the International Bill of Human Right (United Nations, 1945; United Nations General Assembly, 1948). Within the RTD framework, this 'duty' further extends to "transnational corporations, producer's associations, trade unions...financial institutions, public and private institutions...in all development related activities…" (United Nations, 2013, p.12-15). As such, RTD contributes to a thorough analysis regarding the research question by identifying rights and duties to be fulfilled by current health care services in the Philippines. To understand the nation's moral commitment to protect, respect and fulfill duties regarding maternal health care in the Philippines, RTD provides a fitting lens to question how well collective rights are protected by the current system.

2.2 Situating Maternal Health within Human Rights.

The WHO indicates that sexual and reproductive health is an essential health service to be provided in any health system, including access to information and services to make informed decisions regarding SRH (The Sphere Project, 2011, p. 325). The right to have such essential services have been laid out in international law, covenants, conventions and treaties. Under these human rights instruments, states that have ratified are obligated to respect, protect and fulfill human rights in regard to sexual and reproductive health for the means of surviving pregnancy and childbirth. These rights include the right to life, the right to be equal in dignity, the right to enjoy the benefits of scientific progress, right to freedom from discrimination and to enjoy the highest attainable standard of physical and mental health, including sexual and reproductive health (United Nations, 2012). In this light, the denial of such rights, either by force or by accident is a failure of a collective duty.

Health is often understood "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (World Health Organization, 1946). As such, SRH, defined as "complete well-being related to sexual activity and reproduction", becomes integral to the "enjoyment of the highest attainable standard of physical and mental health" (World Health Organization, 1946; United Nations General Assembly, 1966). SRH is comprehensively inclusive of men, women and children, however, women disproportionately face the majority of the biological, social and legal consequences of ill sexual and reproductive health and biological reproduction and face a significant amount of risk to their physical, mental, and social health, in addition to their economic status. Indicators used to measure SRH are disproportionately applicable to

only women and reiterates the need for maternal health care that benefits family and community development (World Health Organization, 2006). As such, maternal health becomes a vital element of SRH. Violating the right to health, including SRH, impedes the fulfillment of other human rights, as the ability to live a productive life with equal opportunity to participate in social and economic development through health, education and employment is compromised. Therefore, sexual and reproductive health is a right in and of itself, but also consists of its own human rights, including "the right to exercise control over and make decisions about one's sexuality, including sexual and reproductive health, free of coercion, discrimination and violence" (UN Women, 1995). These rights are not unique to sexual and reproductive health, but are part of collective rights, regardless of the gender division.

2.2.1 International Duties

The protection of these rights is well documented within human rights instruments. Article 10 of the *International Covenant on Economic, Social and Cultural Rights* (ICECSR) states that "special protection should be accorded to mothers during a reasonable period before and after childbirth" (United Nations High Commissioner for Human Rights, 1966). According to the *Convention on the Elimination of All Forms of Discrimination Against Women* (CEDAW): "States parties shall ensure to women appropriate services in connection with pregnancy, confinement, postnatal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation" (United Nations General Assembly, 1979, art. 12, para. 2). Ensuring women's access to health care services required to survive pregnancy and childbirth are enforced by a nation's commitment to protect, respect and fulfill these duties, regardless

of geographical location, age, sex, education or financial status. This is accomplished by taking all measures required to prevent maternal deaths during pregnancy and childbirth and provoking political will in forms of "legislative, administrative and judicial" action, including the investment of full resources to address preventable maternal death (UN, 2012, p. 7). These obligations are of immediate and ongoing effect and should be prioritized. The ICESCR blocks any negations by States regarding these human rights, as countries "cannot justify non-compliance of obligations" (United Nations High Commissioner for Human Rights, 1966, p.8). Denying comprehensive, quality obstetrical care that is accessible, available, and acceptable is a form of discrimination against women needing medical assistance, based on gender and of childbearing age, and inhibits the rights of dignity, to life, and to enjoy the highest attainable standard of health (United Nations General Assembly, 1979).

2.2.3 National Duties

The Responsible Parenthood and Reproductive Health Act (2012) was established by the Filipino government only six years ago and acknowledges that:

> "it is the duty of the State to protect and strengthen the family as a basic autonomous social institution and equally protect the life of the mother and the life of the unborn from conception. The state shall protect and promote the right to health of women especially mothers...and guarantees the promotion and equal protection of the welfare and rights of children, the youth, and the unborn" (The Responsible Parenthood and Reproductive Health Act of 2012, 2012, sec. 2).

The Act further summarizes definitions, duties and responsibilities of the government and HCPs, while identifying the elements of reproductive health to be provided.

As per the Responsible Parenthood and Reproductive Health Act (2012), both basic and comprehensive emergency obstetric and newborn care (CEmONC) are to be

provided. Basic emergency obstetric and newborn care (BEmONC) consists of, at minimum: “administration of parenteral oxytocic drugs, administration of dose of parenteral anticonvulsants, administration of parenteral antibiotics, administration of maternal steroids for preterm labor, performance of assisted vaginal deliveries, removal of retained placental products, and manual removal of retained placenta... newborn resuscitation, provision of warmth, and referral, blood transfusion where possible” (The Responsible Parenthood and Reproductive Health Act of 2012, 2012). In the act, Comprehensive Emergency Obstetric and Newborn Care (CEmONC), are listed as lifesaving services, as well as plus the provision of surgical delivery, blood bank services and other highly specialized obstetric interventions (The Responsible Parenthood and Reproductive Health Act of 2012, 2012).

Section 5 explores the “hiring of skilled health professionals for maternal health care and skilled birth attendance” stating that “people in geographically isolated or high populated and depressed areas shall be provided the same level of access to health care” (The Responsible Parenthood and Reproductive Health Act of 2012, 2012). Section 6 addresses health care facilities, stating that those living in rural and poorly accessible communities “shall not be neglected by providing other means such as home visits or mobile health care clinics as needed” (The Responsible Parenthood and Reproductive Health Act of 2012, 2012). This act also states that these health care facilities are to have “adequate and qualified personnel, equipment and supplies to be able to provide emergency obstetric and newborn care” (The Responsible Parenthood and Reproductive Health Act of 2012, 2012). The Act also includes sexual health education, which can be taken as a commitment to the collective rights mention above, and as an element of SRH.

In summary, the provision of maternal health services and the measures taken to reduce maternal mortality are can be made possible with strong national commitments, and within an international system that respects those commitments. The acts listed above identify and describe methods of prevention, intervention and protection of maternal health as a human right. The scopes of practice of frontline service providers explored in Chapter 1, and the definition of services to be provided, as explored in this chapter, through Filipino policies helped to situate maternal health in a collective rights framework while identifying key stakeholders, as well their obligations to fulfill in regards to SRH, at a national and international level. This summary, in addition to the data collected as discussed in Chapter 4, gives a sense of how a commitment to RTD could assist the Philippines in achieving these rights, and if stakeholders value such an approach.

CHAPTER 3: METHODOLOGY

3.1 Introduction

This chapter discusses the methods used for this thesis, including the rationale of the study design, logistics of data collection, as well as the scope and limitations of this study. The chapter justifies how the data collected in the Philippines relates to the analytical framework used, as well as the positionality of the writer as the lead researcher within this study. In order to understand if an RTD approach could lessen strain on the health care system in the Philippines from out migration of nurses, two subsets of data must be used. First, discussion of policies governing nurse education and practice must be discussed in order to understand how current policies fare against the RTD approach. Second, if RTD were proposed as a means of policy for increasing the retention of nurses, the voices of health care workers themselves must be heard to understand if such an approach would be accepted. This study took place from January to April, 2017 in six areas of the Philippines and was done with the help of my research assistant, Sherwin Magsombol, and translating services of both Sherwin and Ana Marie Dizon. Upon completion, data collected consisted of a total of 30 HCP interviews including 5 nursing students, 9 midwifery students, 2 nurse educators, 1 midwife educator, 4 nurses, 4 midwives, 2 physicians, and 3 *hilots* (traditional birth attendants). 4 questionnaires were received from 'birth mothers'.

This research uses qualitative methods of in-depth semi-structured interviews and Focus Group Discussions (FGDs) with health care professionals (HCPs). Questionnaires with previous obstetrical patients ('birth mothers'), and secondary source data analysis

are also included. The data collected for this study was analyzed using qualitative thematic content analysis, explored later in this chapter, and more in-depth in Chapter 4.

I pursued this data with the intention of connecting out migration to be a direct driver in high maternal mortality. Seeing that this argument is not achievable based on the findings at hand, I returned to review the data to focus more closely on how health workers and patients engaged with the Filipino health system for maternal health needs. In this process, it became clear that the questions asked (see Appendices G, H, I, J, K, & L) elicited important narratives as to how health workers valued their current work and whether they also valued out migration. The responses from health workers, as discussed in Chapter 4, combined with an analysis of current Filipino policies governing maternal health care and education provide important insight into how RTD could be valued as a development policy for improved retention of human resources for health in the Philippines.

3.1.1 Areas of Research

The Philippines was selected for this study because of its impressive capacity to train health care workers, notably nurses, but to still struggle with gaps in health care service provision. The Philippines is an important country to investigate because it is a low-income country facing significant environmental and political challenges, both from internal and external factors. The majority of the population (81.04%) identifies as Roman Catholic, with several minority groups identifying as Muslim or indigenous (World Health Organization, 2011). Its location in the Western Pacific subjects the country to natural disasters including typhoons, earthquakes and volcanic eruptions (World Health Organization, 2011, p. 2). It faces armed conflict in the southern regions,

all of which predispose it to subpar health indicators (Casey, Chynoweth, Cornier, Gallagher, & Wheeler, 2015). This geographic and political predisposition leads to the constant need to replenish physical, financial, and human resources for many public sectors. Over 50 percent of the population lives in urban areas, while the rest are dispersed in hard to access and isolated rural areas.

The communities and regions selected for this research were based on data from the Philippine Statistic Authority (2015) report: "Maternal Deaths By Place of Occurrence and By Usual Residence, By Region and Province: 2013", as well as the Philippines Statistics Authority (2016) report: "Registered Maternal Deaths By Type of Attendance, Region, Province and City/Mun: 2013" (Philippines Statistics Authority, 2016). These data demonstrate the unproportionate burdens of maternal death in specific areas of the Philippines, as well as which discipline, if any, of HCP was in attendance of these maternal deaths. Under further investigation, this data could be reflective of the gaps in the health care system that hinder adequate HCP coverage.

Data for this study was collected from six communities, using first-person interviews, questionnaires, and focus groups. The choice to use multiple methods was undertaken as a learning opportunity in engaging various methodologies. Due to safety reasons, the Autonomous Region of Muslim Mindanao (ARMM) was excluded from this research (Philippines Statistics Authority, 2015).

The first area for data collection was in Manila, in the National Capital Region (NCR). The NCR is on the island of Luzon, and has the largest number of maternal death cases, the majority of which were in the Second District (Philippines Statistics Authority, 2015). This was an important starting location to connect with health workers who would

likely have first-hand experience with challenges of maternal health provision. The second area of research was in Region IV-A- Calabarzon, also on the island of Luzon. This is another region, that according to the Philippines Statistics Authority (2015) has the second largest proportion of national maternal death. In this region, interviews took place in three rural communities (Santa Rosa, Santo Domingo, and Calamba). The third area of research was Region VII: Central Visayas, in Cebu, as is it had the third largest proportion of maternal deaths (Philippines Statistics Authority, 2015). Data was collected from one urban and one rural community (Cebu City, Dumaguette). Although other regions had close proportions of national maternal death, each indicated region above had the most prevalence of maternal death (excluding ARMM). Further investigation of the high prevalence of maternal death in these regions demonstrated that minimal to none of the maternal deaths in these communities were attended by a health care professional (Philippines Statistics Authority, 2015).

3.1.2 Rationale of Methodological Design

Based on the multiple-method approach I employed in the Philippines, this study seeks to understand how the Filipino HCP migration pipeline strains the national health system for maternal health issues, and whether or not RTD aimed at capacity building and retention could improve conditions. The nature of this qualitative data elicits common themes on key issues related to the research question. In particular, how maternal health care education is valued, the place of service provision in national economic development strategies, and how service acquisition is valued in light of massive out-migration of HCPs and insufficient public health infrastructure in the Philippines.

3.2 Logistics of Data Collection

Interviewees were recruited using voluntary recruitment and the use of chain referral (snowball) sampling. Letters requesting information were given, either in person or via email, to a range of contacts at nursing institutions, government offices, non-governmental organizations and health facilities. Interviews were arranged with responding participants and health care practitioners. Questionnaires with 'birth mothers' were dropped off and picked up in person. Participants and health facilities have been assigned pseudonyms to assure anonymity and privacy but are identified by their respective discipline of respondents for this research (for example, midwifery students will be: MWS #1, MWS #2, etc.).

3.2.1 In-Depth Semi-Structured Expert Interviews

Due to the interdisciplinary approach of maternal health care provision in the Philippines, semi-structured interviews were done with midwifery students, midwifery educators, registered midwives, nursing students, nursing educators, registered nurses, physicians, and traditional birth attendants (TBAs), known locally as *hilots*. The initial research question of connecting maternal mortality to nursing trends, had difficulty incorporating this data into the research framework. However, the stories and experiences of this wider range of HCPs present important information on both the tensions in the Filipino health system, and also opportunities for ways to encourage retention and capacity building. Written consent (see Appendix D) was obtained and interviews were recorded using a digital voice recorder. Interviews were guided by open questions to foster dialogue around the topic. A general interview guide (see Appendix H) was designed using guiding questions, and separate interview guides were developed

for each designation listed above to capture more specific information based on the designation of the interviewee (see Appendices I, J, K, & L). These interviews took place primarily in unused offices and classrooms at universities and health clinics and at times at the discretion of the interviewee. These interviews were approximately 30 minutes long, however some did carry on for 2 hours (at the discretion of the interviewee). Admittedly, this approach to data collection was exploratory, and not well structured by a rigid analytical framework. From continued analysis and discussions of the findings after the fact, it is clear that the themes of valuing work, service, compatriotism, and out migration are present in the respondents' feedback. Identifying these values gives a strong understanding of how current economic development strategies are viewed, and if an RTD approach would be accepted.

In interviewing students and educators, I explore the curriculum of nursing and midwifery education, including what the curriculum consists of and how it shapes future practice. The interviews sought a better understanding of the scholarship and licensing processes, the motivations of students to enroll in health care education, and how they plan to use their degree. My intention was to understand their perceptions of value of practice within their respective disciplines, and the roles they were expected to play in both hospital and community settings within each discipline's scope of practice.

Similarly, interviewing practicing nurses, midwives, *hilots,* and physicians allowed me to collect and analyze the subjective, practical experiences of maternal health care provision in varying disciplines. The interests and motivations of these practitioners taken against systemic help to identify the tensions and coping mechanisms of health workers in their jobs. Midwives, nurses, *hilots* and physicians provided information on

their scopes of practice and information of the reality and challenges of their practice, and of the multidisciplinary interaction and referral within, and amongst, their respective disciplines. This also demonstrates cases when health workers were expected to perform duties outside of their disciplinary lens, which can be understood as a coping mechanism against structural deficiencies within the system.

3.2.2 Focus Group Discussions

The use of FGDs as a qualitative method is advocated in nursing and International Development Studies related research, and can be catalytic in eliciting ideas and fostering conversation amongst a homogenous group (Kingrey, Tiedje, & Freedman, 1990). This was a good learning opportunity to explore this method. FGDs were done with HCPs in settings where doing several individual interviews was not a feasible option, so as not to waste the time and productivity of HCPs being interviewed. The use of FGDs stimulated group discussion, and simultaneously provided multiple answers from various practitioners (present) at the time of the interview, while accommodating to the availability of interviewees. These FGDs used the same interview guide for discussion as used for individual interviews (see Appendix H & K). Individual consent was obtained (see Appendix D). These FGDs took approximately 30-50 minutes and were recorded using an audio recorder. A total of two FGDs were done in this research: the first FGD was done with multidisciplinary HCPs at a clinic in a rural community, and the second FGD involved 5 nursing students at the same university in Manila, (Jose Rizal).

3.2.3 Questionnaires with Birth Mothers

Questionnaire surveys were done with birth mothers in the Philippines, as patient experiences provide important insight into the relationship between the structures of the health care system and the agency of health care practitioners and can describe what resources patients have access to. The population for these surveys consisted of 4 women who identified as having needed, or used, obstetrical services at facilities within the areas of research within the past five to ten years. Questionnaires were completed by these women to understand their interactions, experiences, and relationships with the varying levels of HCPs who offer maternal health provision in varying capacities. Although interviews with birth mothers would have been ideal, due to the lack of interest in setting up a formal interview, birth mothers chose to respond to questionnaires (see Appendix G). These birth mothers were recruited by the use of chain referral (snowball) sampling, as HCP interviewees referred friends and colleagues in the community. These mothers responded to the invitation to participate in this research and questionnaires were distributed to and collected from responding participants in person. In doing so, the opportunity for informed consent was obtained (see Appendix F), and questions from respondents answered by the lead researcher and research assistant. I analyzed questionnaires individually, with each participant given an alias to maintain confidentiality (i.e., Birth Mother #1), and then analyzed collectively to depict the subjective understanding of obstetrical care from patients in both rural and urban communities. Consent forms were stored separately from collected data to ensure confidentiality.

Questionnaires with birth mothers allowed for the collection of data regarding how, where, and when Filipino women seek and access maternal health care. It also

sought their knowledge of available maternal health care services, and the level of satisfaction they had with maternal health care services. It concluded with asking participants to identify any challenges in regard to accessing maternal health care services. This information was collected to contribute to the understanding of how maternal health care is perceived and accessed by its primary users. These questionnaires also sought data regarding potential barriers that may exist when seeking maternal health care, such as financing, transportation, and knowledge of available maternal health services. Questionnaires were translated into Tagalog by local Filipino Ana Marie Dizon, verified by Sherwin, and were analyzed independent of other interviews, using thematic content analysis.

3.3 Limitations and Challenges

There were few major limitations to this study. The most significant of the limitations that arose was the heavily misperceived understanding of my visitations to health care facilities, particularly when seeking permission to access information for potential interviewees. I was perceived as someone who was sent to investigate performance, documentation or skills of practitioners and health facilities. These misunderstandings did not allow me to pursue research in these areas despite thorough explanations in both English and Tagalog.

Other primary challenges of this study included long travel times and geographical distances to the health facilities sought for this study, the frequent changes in schedules due to the(in)availability of HCPs with whom I sought interviews and long waiting times for responses to interview requests.

The final challenge in this study was the language barrier. The Tagalog translating services of Sherwin were used frequently. The majority of health care professionals demonstrated a higher ability to participate using English, while local 'birth mothers' required translated questionnaires and language assistance from my translator, as English was often their third and least used language. Also, the total sample size of interviewees of students and HCPs is relatively small. However, synthesis of themes emerged throughout their responses and as such, the findings can be taken as useful in satisfying the research question.

3.4 Positionality

As the lead researcher, I have many qualifications that allow me to facilitate research of this nature. I am a licensed and practicing obstetrical registered nurse, and thus, have done the nursing education, and have had much training and experience in obstetrical and newborn care. My clinical experiences have provided me with the knowledge and understanding of normal and atypical processes of childbirth and transition to motherhood, adverse obstetrical outcomes, and an understanding of what is needed to provide basic and emergency obstetrical and newborn care in a variety of settings. Further, they have provided me with an understanding of both the limitations and challenges of providing obstetrical health care as a nurse. My clinical experience and education in a variety of local and international capacities has enabled me to facilitate this research in a culturally and ethically appropriate manner.

3.5 Ethics

This research project has been reviewed by the Office of Research Ethics Administration at Dalhousie University, Nova Scotia, Canada. Ethical approval for this research was granted from Dalhousie University's Social Sciences and Humanities Research Ethics Board. This research follows University and Tri-Council policies. This is study is independent of all health facilities, authorities and government, and is not in affiliation with any Filipino university or organization. Personal details of each participant were not shared with other participants. Participants will not be personally identified by geographical location or professional details. Instead, each participant has been given an alias (For example: Nurse #1). Only aliases are used in final research findings. Personal information is stored separately from collected data for confidentiality.

To maintain confidentiality, data was not be shared with foreign servers or third parties. Data from interviews will be saved on the password protected hard-drive and will only be available to the lead researcher. Data will not be shared with anyone other than research assistants and the research supervisor. I will continue to take all reasonable precautions to protect data and maintain confidentiality.

3.6 Post-Research Analysis

The analysis of this research took place in two very distinct periods. The first, leading up to the thesis defence attempted to strongly connect the research findings with maternal health outcomes. The data and analysis did not make this connection. However, the data when reviewed through the RTD framework elicits a strong sense of morals and values of the health workers and patients. In this sense the focus on mortality as the key issue in Filipino maternal health policy is lessened. Instead, the focus then turns to the connection of how export-oriented migration creates strains in the current

system, and if RTD would be welcomed as a potential approach by increasing capacity building and retention of nurses within the system.

CHAPTER 4: DATA AND DISCUSSION

4.1 Introduction

This chapter reviews data collected from both the literature and from my fieldwork in the Philippines. The chapter explores how the experience of health workers can inform the research question of whether the Right to Development could help to improve the health system performance for maternal health in the Philippines. The data explores the challenges health workers face in their jobs, exposes the disconnects in the system, and also explores health workers' commitment to service to their compatriots, rather than to service abroad. If an RTD approach to health system improvement allowed for more opportunities and choices for health workers to stay and practice in the Philippines, would they do so? Or are the values of the current normative approach to encouraging out migration favored, and by whom?

Interviews also took place with birth mothers to expose the quality of care they receive, as well as the limits and potentials of the national health insurance program. I used a multiple data collection methods for this research including, interviews, surveys and FGDs. I discuss the findings from the data collected within the RTD framework and broader implications of this research. Interviews and FGDs were initially segregated by discipline to elicit pertinent themes and information provided by each. Interviews and FGDs were then collectively analyzed to assess how these experiences relate to the goals of RTD. Questionnaires were analyzed separately and integrated into the overall discussion.

4.2 Interviewees

All students interviewed, both in midwifery and in nursing, were studying in a Baccalaureate program at their respective universities. Both groups of students were interviewed using similar interview guides focused on the specific practice of each (see Appendix K & L). All interviewees were selected by the university contacts who both granted permission to interview students for this research and facilitated meeting times and places to do so at their facilities. Students were interviewed individually after informed consent was obtained (see Appendix D). Five nursing students collectively participated in a FGD using the same interview guide to foster discussion, after individual informed consent was obtained. Student participants were chosen by professors at respective universities after the project was formally explained to program directors and Deans within respective disciplines. Students were selected based on the availability of students' academic schedules. Each participant has been given an alias (For example: Midwifery Student #1). Only aliases are used in final research findings. Personal information is stored separately from collected data.

4.2.1 Midwifery Students

A total of 9 midwifery students were interviewed using Appendix L. All of these students stated that the BScMW they were participating in was not their first degree. Every midwifery student interviewed stated that she had previously taken the Diploma of Midwifery course and had practiced as a midwife prior to entering the BScMW programme. Some of these students further identified having taken studies outside of midwifery, including nursing, pre-dentistry, and education. Midwifery Student #3 stated: "I wanted to become a dentist...Fortunately I qualified for the DOH scholarship to become a Bachelor midwife…". Interestingly, these students expressed eagerness to

pursue the educational and professional opportunity of secondary education within midwifery for specific motivations not related to their initial career choice.

When asked why they chose to take the BScMW course, several students identified the following themes: educational opportunity, financial opportunity, a desire to increase personal skillset, and the opportunity to fulfill a duty to their communities. Midwifery Student #5 indicated that she "would not be here today without scholarship", while Midwifery Student #7 specifically indicated that she pursued the BScMW course "to expand [her] knowledge in order to help [her] community people". These midwifery students were also asked why they previously chose to take the Diploma of Midwifery course, and why they further chose to participate in the BScMW course after already working as midwives. Most students chose to take the two-year diploma programme initially, rather than a 4-year Bachelor programme in midwifery, nursing or other professions, because of the shorter time of programme completion, and the reduced financial expense to pursue a viable career within a 2-year timeline. Exemplifying this, Midwifery Student #6 shared:

> "My first course was nursing, for two years, but then I got pregnant. After…I had to go back to school. I told my mom that...I need to...get another course because the nursing bachelor's degree is all curriculum and there is new curriculum. When I go back to nursing school, I will go back to first year. So, my two years will become a waste of my time. ...other subjects that I already finished during first and second year [of nursing] were credited. That's why I chose midwifery".

Important to note is the fact that all of these interviewees were recipients of the DOH retention scholarship, which is a prestigious award aimed at encouraging students to work in marginalized areas. These students were offered the retention scholarship to upgrade their Diploma to the Bachelor of midwifery by providing scholarships of two years, that would transition Diploma midwives to Bachelor educated midwives (instead

of completing the 4 programme anew). The goal is to allocate these midwives to communities in need of these first-line maternal health care providers. These students seized the opportunity, and many described it as a privilege and "a blessing in disguise" (Midwifery Student #2). Midwifery Student #9 stated:

> "I studied nursing at University X. Unfortunately, I had to stop in the middle of second year because of finances...I really want to pursue my education, since it is very hard for me to finance my studies...when I renewed my contract [as rural health midwife under the DOH], they offered me this scholarship. I gladly grabbed it because I don't have money..."

Midwifery Student #8 stated: "…my first course is nursing. One and a half years. My mother told me to switch to midwifery. The diploma is only two years, nursing is more extensive...I want to finish nursing but can't because of money and finances". In both cases the students demonstrated how pressing financial challenges would have deprived them of the opportunity to continue studying. In this case, the scholarship mattered enormously in allowing students to persue capacity building aimed at the serice of compatriots, even though it was not their primary career goal.

This provision of educational and occupational opportunity for these students is reflective of the process of collective rights and human development articulated in the RTD. This process enables participants of this strategy (midwifery students) to pursue both a feasible and viable education and occupation within their own country. What's more, there is no actual restriction of movement, or government edict demanding service of the students. It is a program based on positive affirmation, in enabling opportunity, and not restricting the limits, of a person's capabilities. These values of building capacity for collective benefit speaks to the RTD approach. What's more, capacity building through the scholarship programs enhance individual rights, and collective rights through

increased education capacity and decreased unemployment in the country. Ultimately, the value of the scholarship program encourages moral obligations to compatriots, while furthering access to health services in the pursuit of the Right to Development.

When it comes to valuing out migration, these students noted that the BScMW programmes upgraded domestic midwifery education to match international education and practice standards., Midwifery Student # 2 stated "…that's why they changed the Diploma program to a BScMw because in the rest of the world, some countries offer 3-5 year programs". However, the students were not particularly interested in the opportunity of out migration. Most stated that they wanted to work in their communities where the duty is needed: "my heart belongs to the community… because people in the community are looking for support. If the DOH gives me a chance to choose, I'll choose my own town to serve" (Midwifery Student #6). Midwifery Student #3 further stated: "I want to render my service here with Filipinos in our community". These students expressed interest in continuing to expand their education by returning to university to continue their secondary education in programs such as nursing, medicine, and education. Midwifery Student #6 indicated: "if God will permit me, I will pursue my dream to become a physician someday...if not in medicine, I will go get units for teaching here". They also expressed interest in expanding the professional and financial goal of operating a private lying-in (a typical name for a birth clinic in the Philippines). Midwifery Student #9 told me: "my plan was to continue my studies if I can...I want to pursue medicine but not sure I can right now. My goal was to set up my own birthing clinic…".

Taken together, the experience of midwifery students shows a strong commitment to community and country. Even if their long-term career advancement goals are not

achieved, many indicate that they want to pursue some sort of health service for their compatriots.

4.2.2 Nursing Students.

A total of five nursing students participated in a FGD (see Appendix K) and signing individually informed consent (Appendix D). Of these nursing students, only one had chosen to participate in the nursing programme as second degree. The remaining four students were participating in their first degree as nursing students. Four out of five nursing students stated that they had pursued the opportunity of nursing specifically because of "the opportunity to work abroad". These students noted that higher salaries and the opportunities that exist abroad are the main factors for considering migrating as a nurse. Some had previously worked abroad and had plans of going abroad after graduation, specifically to Canada and the United States. Interestingly, these students who planned to go abroad shared that value and duty to the economic well-being of their families was a key determinant in deciding to pursue nursing as an occupation. Nursing Student #4 indicated that she originally had wanted to study ophthalmology but admitted that her family had influenced her to go abroad for "a better life", and that the "best way to go abroad is to take nursing". In this sense, out migration is the goal of these students. This value is also reinforced by the family, if not community investment, in tuition and costs for the student to attend a nursing program. These students all stated that finances for education came primarily through family funding. The expectation is that the upfront investment in the nurse will be returned through remittance, over time and bring about a better life to herself and to those at home. This process speaks less to the goals of RTD, and more to individualistic values of neoliberal economic development.

Further, all five nursing students stated that they intended to write the National Council Licensing Exam (NCLEX), the licensing exam in for Canadian and American nurses, after graduation to improve their chance to go abroad. The four nursing students who stated intentions of migrating as a nurse abroad agreed that they wanted to work in an advanced private health facility to develop the capacity of their scope of practice domestically for a short period, with further intentions to go abroad. One factor in choosing a private facility for employment was the notable lack of available resources in public health facilities. Nursing students all expressed how important financial betterment was as the driving force in pursuing their career paths. This is a drastic departure from the more community-based values that were expressed by the midwifery students. A key difference is that these nursing students were all "self-funded", which places commitment to personal financial matters as a primary goal.

4.2.3 Instructors

Interviews with nursing and midwifery instructors, using appendices I and J, explored the curriculum and competencies expected in their respective disciplines. Two nursing instructors and one midwifery instructor were interviewed for a total of 3 instructor interviews. These instructors provided information on why they pursued education roles in their disciplines, including themes of better financial opportunity, enjoyment of the teaching role by continuing nursing competence and training within the country.

Tested core competencies in the nursing curriculum of maternal and child health nursing, include prenatal, intrapartum, and postpartum theoretical foundations. Also, it

included practical skills, and in-depth pharmacology, bioethics, implemented in the delivery room, and obstetrical ward clinical rotations in both urban and rural health centres (NI #1 and NI #2). Competencies of midwifery included, similarly, pharmacology, health ethics, family planning and obstetrical foundations, methods of delivery, risks of prenatal and obstetrical outcomes, and emergency procedures. The midwifery instructor interviewed, however, noted that maternal death is not yet discussed in-depth in the classroom (MI #1). The major difference in maternal health education within the two disciplines is that the foundations of midwifery extend beyond a semester of maternal health service provision in nursing school and form in-depth knowledge on the understanding of prenatal development and obstetrical emergencies. These become specialties in nursing practice. Yet, the physiological and pharmaceutical foundations of nursing, in addition to practical skills, enable nurses to perform maternal health care in various settings. While instructors of both disciplines acknowledged the integration of ethics as well as foundations of maternal health service provision, they denied needing amendments to existing curriculum to address the issue of high maternal mortality in the country, and further denied any curriculum encouragement of nursing graduates to go abroad.

In contrast, Midwifery Student #2 stated that the "…midwifery curriculum is not as wide as nursing… I really want the government or CHED to make our curriculum more specific and I want to make it wide or broad like nursing because we are at a bachelor level. I think we are at the same level" to provide life saving interventions, but "our midwifery law does not support the latest right now. Our midwifery law is just focused on administering oxytocin after delivery of the placenta, vitamin K injections…"

(Midwifery Student #2). This student articulates the equal quality in knowledge acquisition to provide maternal health care but the inability of midwives to perform, despite equal credentials, the skills needed to prevent maternal mortality, due to the policies and legislation that both shape and hinder their scope of practice.

One nursing instructor shared the details of her role, that included: the implementation of curriculum development program, collaboration with different health care services and institutions for clinical affiliations, and the evaluation of the performance result of the nursing program, both for students and clinical instructors. This is important data, as nursing educators, and educational institutions, become stakeholders in building national nursing capacity by instilling moral values of nursing care within the curriculum, that creates a norm of maternal health care. They further become a means of valuing social justice, as well as development processes articulated in the RTD framework into the curriculum. The educational environment and leadership of nursing educators can become a means of articulating national and international population health needs and a means of advocating for the reflection of these identified needs in policy, curriculum and practice. Further, the assumption that 'duty' extends to meeting the needs of foreigners, in exchange for better earnings, is incongruent to values articulated in the RTD framework (United Nations, 2013, p.12-15).

The information provided by these instructors, in addition to student interviews, shapes an understanding of how the education of maternal health care providers, as nurses and midwives, is obtained. It also illuminates the roles of educators within the education system. These instructors can provide input and evaluate clinical education and settings, but also partner with the universities and other key duty holders that are

involved with the structuring of HCP education and regulation, to adhere to moral values of development.

4.2.4 Midwives

Four practicing midwives were interviewed during the data collection process using Appendix H. These midwives worked in public health centres, two in a rural community and two in an urban community. These midwives started working after their completion of the Diploma of Midwifery and then upgraded to the BScMW. These midwives indicated that much financial support was given by family (aunts, uncles, brothers) to fund their education. Midwife #1 said that her parents encouraged her to pursue school and helped to fund her education in midwifery. There was an assumed overabundance of nursing students in the country and the diploma course offered a shorter study commitment. Interestingly, these midwives were not encouraged by their families to go abroad, but instead, were encouraged to pursue a viable and needed career within a short study period. Unlike the nursing students, who suggested that the expense of nursing school was justified by the hope of repayment through remittance, the midwives continued to express service to compatriots as being the primary moral driver.

These midwives all stated that the scope of practice within their health clinics included: performing only normal deliveries, prenatal care, reproductive and family planning services and information, and well baby programmes. This scope of practice within health clinics, and multidisciplinary teams, is not unique, as some duties of midwives overlap with the duties of nurses. While both scopes include a similar provision of care, it neither fosters a scope of practice for midwives as the primary maternal health

service providers, nor does it allow for adequate allocation of nurses to address the pressing shortages in rural areas.

Patients requiring care outside of the practices indicated above are referred to either a private or public facility within these communities depending on the finances of the patient. Midwife # 4 stated: "…we refer out to public and private facilities, depending on finances of the patient. If they can afford it, we send them to a tertiary level private hospital, but if not, we send them to a public hospital". Interestingly, these midwives denied the frequent occurrence of maternal mortality within their own facilities, as they indicated most maternal deaths occurred during transportation or at a referral facilities. Taken together, the midwives demonstrate a commitment to national service, while recognizing serious deficiencies in the services provided.

4.2.5 Nurses

Six nurses were interviewed during the collection of this data using Appendix H. Five out of 6 nurses interviewed were employed in a rural health community by the DOH. The remaining nurse was employed as a public health nurse in an urban community health centre. These nurses all indicated that their nursing education was paid for by their parents, all volunteered as nurses within the first year of becoming a nurse before obtaining paid positions and all were denied the availability of nursing scholarships and retention programmes. These nurses indicated that despite the need for nurses in the country, there is a "lack of available jobs, especially in the public sector", and that most nursing graduates volunteer in unpaid positions to "gain experience" while seeking better paid employment (Nurse #3).

The scope of practice as nurses in maternal health included the provision of primary care services, which included immunizations, prenatal care, drug administration, health teaching, family planning, as well as health surveillance and other health programmes. The main challenge in providing care at these clinics, as indicated by these nurses, is the affordability of health care for its lower income patient population. Nurse #2 stated that "patients that cannot always pay for services have difficulty accessing care…because public health services are cheaper…but are not as well equipped". However, the nurses are aware of this and try to facilitate patient referrals to centres that can "…accommodate the finances of a patient" (Nurse #3). The lack of, or inconsistent replenishing of, supplies was further noted as a challenge by nurses. One nurse stated that sometimes "there are not enough vaccines or medicines. Patients need to buy their own at the pharmacy for nurses to provide the services" (Nurse #1).

These nurses noted that no immediate management of obstetrical complications can be done at these primary care health clinics, including the administration of Magnesium Sulphate, as these cases are referred to an obstetrician for further assessment and management. It was further noted that the clinics were operating on a 24/7 basis, with its own ambulance, but not always with adequate HCP coverage. These nurses acknowledged the lack of HCP coverage but were unphased, as it was indicated that the norm of working in settings without adequate drug supplies and HCP runs throughout the public health system (Nurse #1).

These DOH nurses did not openly admit to entering their nursing careers for the opportunity of migration. The nurses indicated the desire to work in public hospitals, psychiatry units, and in public health but initially pursued nursing because of the

overwhelming need for HCPs in these settings, with the hope of assumed long-term remuneration returns.

4.2.6 Hilots

Three hilots were interviewed at one rural health clinic using guiding questions from Appendix H. The role of these hilots changed in 2005 under a government ordinance from the role of management of natural labours in the community to a support role in primary health care provision. Within this role, these hilots are compensated by the health centre for emergency deliveries if needed. They were also tasked with postpartum mother and baby care, education and breastfeeding support, traditional massage, communications and transportation between birth centres and referral centres, and educating pregnant women on when and where to receive maternal health services. One hilot stated that "...since they stopped delivering babies in the house, there have been zero fetal deaths at home… the system in (Community X) is now working…" (Hilot #2). Adjusting to the shift in their role in maternal health care provision, these hilots have become part of the multidisciplinary team, and a huge link to the community. As put by one hilot, they "are trusted by their community. They are known as very good at delivering babies…sometimes still deliver babies there, even though there is a little bit of danger, they do it because they are so far away" (Hilot #3). While trained in the community from previous generations of hilots, the integration of hilots into the multidisciplinary health care team provides training on emergency deliveries and community education and support from the DOH. As these hilots have accepted the ordonnance to refrain from practicing home deliveries in the community, they have sustained a good working relationship within health clinics. Programs continue to

integrate hilots into the multidisciplinary team settings. While all hilots indicated that they missed doing deliveries, they stated that they enjoyed their new role, as Hilot #3 indicated: “we are part of the team at this clinic”.

4.2.7 Physicians

Two physicians were interviewed using Appendix H. Physician #1 practiced pediatric medicine privately for fifteen years. At the time of the interview, she was newly employed as a medical officer at at public health centre in an urban community. Physician #2 was a general practitioner in a private 25 bed rural hospital 100km from the nearest city centre with anesthetic and surgical capabilities. Both of these physicians worked previously overseas but returned to the Philippines to practice medicine for personal reasons, as both felt they could have a greater impact in their home country.

Both of these physicians noted the difficulty of practicing within a wide scope of general medicine at both of these facilities, particularly in providing specialty obstetrical case management without obstetrical specialization. Both stated that they can only perform normal deliveries and are unable to provide cesarean section if needed. Interestingly, Physician #2 noted that while anesthetic and surgical capacities at his facility of employment exist, the lack of consistently employed physicians who are trained either in anesthesia or obstetrics, as well as the unavailability and inconsistency of nurses and equipment, hinders the ability to provide 24 hour accessibility to emergency obstetrical health care provision. Physician #1 also revealed challenges at their health centre, stating that the facility had recently been approved to operate 24/7, however, there were insufficient staff to provide 24/7 coverage of either nursing or midwifery services. Community health workers, known locally as barangay health workers, who disseminate

information in the community (house-to-house) are not available on a regular basis and are not always paid for their services.

The processes of referral were explored with both physicians. Physician #1 stated that patients are referred to the city hospital located nearby that also is responsive to all economic classes. Physician #2, on the other hand, described the challenges of an ineffective chain of referral that exists in rural communities. These challenges presented in the form of logistics and accessibility. He noted the lack of efficient and reliable modes of transportation for emergency contexts, as ambulances are not necessarily regulated and are paid for out-of-pocket by patients, and roads are inaccessible due to traffic, damage, or are of long distances to tertiary facilities. He further stated that hospitals along the way are not well equipped to manage complicated cases and further lack skilled HCPs to provide necessary emergency services. Finally, he revealed that even when a tertiary facility is reached, a pregnant woman requiring a cesarean section may still have to face long wait times due to the preexisting line of patients requiring medical emergency services.

When questioned on the core issues of unavailability and inaccessibility of both HCPs and facilities to accommodate womens' health needs, both physicians noted the challenges of providing health care in the decentralized health system, such as: difficulty in retaining staff, poor urban planning, and the lack of paid positions in rural and public health settings. These challenges ultimately determine the care patients are able to receive in both rural and urban settings.

4.3 Questionnaires with Birth Mothers

Questionnaires were focused on exploring the perceptions of respondents regarding the promotion of, existence of, and access to health services for their pregnancies, labours and deliveries. Questions were translated by a local researcher, Ana Marie Dizon, for birth mothers who preferred to participate with the questions in Tagalog. The findings from the questionnaires with 'birth mothers' are categorized by urban or rural communities in which they live. In doing so, how access to, and what services exist, for labor and pregnancy in differing settings is better understood from the questionnaires.

4.3.1 Urban Mother Respondents

The respondents from urban communities all indicated that the services available to them are within 1-4 kilometers from where they live: approximately "30 minutes, or 1 ride of a jeepney and one ride of a tricycle" (BM #1), or within walking distance (BM#2). All respondents stated they had no difficulty in accessing a HCP (RN, RM, or physician). Respondents stated both private and public services were available to them, including a private hospital and health center. Services available to these women included the delivery package, prenatal check-ups, ultrasound, and prenatal vitamins. All respondents agreed that maternal health services were advertised in their communities but had mixed thoughts on whether women's health was promoted enough, with only one respondent out of 4 feeling it was. 100 percent of urban birth mothers delivered their babies in a hospital,with 2 out of 3 of these women delivering in a private hospital because of the ensured safety and cleanliness. The remaining urban respondent delivered in a 'lying-in' birth centre because of financial concerns, despite having a preference to

access services in a private hospital (BM #1). All respondents in this category received services from an obstetrician.

Only half of all of the women who responded had ever been offered family planning services regarding pregnancy. One respondent shared that while affordability of and access to all equipment is needed for pregnancy safe delivery, it is not always guaranteed: "Private lying-ins are cheaper than private hospitals here, but in a private hospital they have complete equipment needed" (BM #1). The payment options of maternal health services for Filipino mothers are exemplified by the examples provided by three mothers below:

> BM#1: Was not a PhilHealth member, but received the delivery package discount as she was a beneficiary of her husband's Philhealth membership. Despite this package, she still had to pay out of pocket for both medications and services, and was not reimbursed.
>
> BM#2: Was a PhilHealth member, did not have to pay out of pocket for services, did pay for prenatal supplements, but was not reimbursed.
>
> BM#3 : Was a PhilHealth member, did have to pay out of pocket for medications and services, and was not reimbursed for services.

These responses indicate various tensions within the health system, notably transportation and out-of-pocket costs. Even though Philhealth is meant to provide coverage for such services, the lack of HCPs, particularly nurses, redirects care towards the private sector, and with it increased travel, costs and risks to mothers.

4.3.2 Rural Mother Respondents

One rural respondent agreed that maternal health services were advertised in her community. However, as BM#4 noted, "they promote enough to control their program in

the government". This rural respondent denied difficulty accessing health care. She was cared for by a team of HCPs (a physician, nurse and midwives) at a facility within walking distance from home and via "some health officer doing house to house routines and saying to me health clinics are always available" (BM #4). This mother chose to deliver at a laying-in because of financial concerns, but only public health care facilities are available in this community (BM#4). BM # 4 was not a PhilHealth member but did not have to pay out of pocket for medication or services, in her case. Services were covered by the Barangay Health office, and included "prenatal check-up, well-booklet, and being checked by a health officer such [as] nurses and midwives…free medicines, free ambulance if a possible childbirth occurs, and free vaccination"(BM#4). This indicates a sort an obvious level of coping against a strained system. What's more, these birth mothers were all referred to by health workers who had cared for them. This sample does not include the experience of mothers who failed to get access to quality care.

4.4 Policies on Maternal Health

This discussion will summarize the important contributions of the data collected for this research. To start, it is important to note that the Philippines has undertaken efforts to reduce maternal mortality. It has ratified many conventions promoting the health of women and women's rights, and those of reproductive health including:

> The International Covenant on Economic, Social and Cultural Rights in 1976;
> The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) in 1979;
> The Convention on the Rights of the Child (CRC) in 1989,;
> The International Conference on Population and Development (ICPD) in 1994;
> The Beijing Declaration and Platform of Action during the Fourth World Conference on Women (WCW) in 1995;
> The Millennium Development Goals in 2000 (UNFPA, n.d.).

In 2012, the Philippines signed the "162 to 52 Coalition", which aims to accelerate "maternal health development through local health system development" (UNFPA, n.d.). Further, it has created the "The Responsible Parenthood and Reproductive Health Act of 2012" (2012).

4.4.1 Scopes of Practice

It is important to discuss the scopes of practice of the midwifery and nursing professions and how these scopes affect the provision of maternal health service in the country. Both Bachelor programs take 4 years to complete. Yet, the nursing profession allows for a wider scope of practice in a variety of clinical settings, including tertiary level facilities that provide emergency and operating room services, in both rural and urban and public and private facilities. This degree of autonomy and mobility of the nursing profession is not shared with the midwifery profession. While the midwifery program is also 4 years and midwives can establish and run their own private birth clinics, they only have the ability to manage 'normal deliveries' (World Health Organization & Unicef, 2015). The key amendments put forth by the Congress in the Philippine Midwifery Act (1992) in 2002 expanded the scope of midwives to reduce "maternal and pre-natal morbidity and mortality" to include:

> -allow midwives to administer life-saving drugs when no physician is available, provided that they are appropriately trained for such purpose;
> -require midwives to be certified proficient to perform the necessary care and services to prevent maternal deaths and allow them to administer essential born care;
> -require practicing midwives who intend to perform Emergency Obstetric and Neonatal Care (EmONC) to apply for and acquire accreditation from the Department of Health (DoH)

It could be assumed that an accredited four-year program, specialized in women and infant health, would enable its graduates to manage complex maternal health needs in the Philippines as midwives are the frontline care providers for women and children's health in the country. The scope of practice dictates that midwives use the "application of procedures and techniques in the supervision and care of women during pregnancy, labor and puerperium" for the "management of normal deliveries" (The Philippine Midwifery Act of 1992, 1992). As obstetrical complications and emergencies arise, basic, comprehensive and emergency obstetric and newborn care (BEmONC; CEmONC) or an appropriate referral system for comprehensive obstetrical care is needed to manage the acuity of complications and emergencies.

While midwives are allowed to administer life-saving drugs under emergency conditions and when there are no physicians available, the provision indicates that they must be "appropriately trained for that purpose, and certified proficient to perform the necessary care and services to prevent maternal deaths" (The Philippine Midwifery Act of 1992, 1992: art. 3, sec. 23). Yet, the same document amends that midwives who intend to perform Emergency Obstetric and Neonatal Care (EmONC) are required to "apply for, and acquire, accreditation from the Department of Health". This fails to integrate the highest level of care to be provided in obstetrical emergencies by those primarily responsible for the care of women during labour and delivery. It also fosters more resource constraints to continue to expand a competence that should be assumed within the existing scope of practice. The Philippine Midwifery Act (1992) does not distinguish to what level registered midwives can apply either BEmONC or CEmONC in practice. Data collected in the field indicated that facilities had not, or are only beginning to

integrate CEmONC into the education and practice of midwives at their respective facilities. The practice of midwives therefore is shaped by the policies enacted by the government but are additionally shaped by the lack of health infrastructure in the Philippines. These policies shape the kind of care women and families have access to in the country, and it also influences how midwives, or other HCPs, are expected to practice beyond the scope of their training.

4.4.2 Health Service Provision

The Responsible Parenthood and Reproductive Health Act (2012) outlines the services that women and families have the rights to, as well as the duties of the State and of HCPs to provide services for women and families. Of importance are key 'Guiding Principles for Implementation' of the Act:

> (c) "Since human resource is among the principal assets of the country, effective and quality reproductive health care services must be given primacy to ensure maternal and child health, the health of the unborn, safe delivery and birth of healthy children, and sound replacement rate, in line with the State's duty to promote the right to health, responsible parenthood, social justice and full human development.
>
> (d) The provision of ethical and medically safe, legal, accessible, affordable, non-abortifacient, effective and quality reproductive health care services and supplies is essential in the promotion of people's right to health, especially those of women, the poor, and the marginalized, and shall be incorporated as a component of basic health care.
>
> (e) The State shall promote and provide information and access, without bias, to all methods of family planning, including effective natural and modern methods which have been proven medically safe, legal, non-abortifacient, and effective in accordance with scientific and evidence-based medical research standards" (The National Health Insurance Act of 1995, 2012, sec. 23).

As described earlier, BEmONC and CEmONC are crucial elements of practice that ensure safe delivery of newborns, and the survival of women during pregnancy and childbirth. In addition to the lack of comprehensive emergency obstetric and newborn care in the education, training, and practice of midwives, many practitioners denied the reality of existing or consistent access to blood banks and effective referral systems. Most of the referral facilities capable of providing CEmONC were greater than an hour away. In conjunction with the lack of efficient transportation options and jammed city traffic in the Philippines, rapid and acutely life threatening obstetrical emergencies cannot be feasibly managed in such conditions.

While including reproductive health education in the Republic Act No, 10354: The Responsible Parenthood and Reproductive Health Act (2012), the provisions associated with SRH education include:

> "That flexibility in the formulation and adoption of appropriate course content, scope and methodology in each educational level...allowed only after consultations with parents-teachers-community associations, school officials, and other interest groups"; and "that minors will not be allowed access to modern methods of family planning without written consent from their parents or guardians except when the minor is already a parent or has had a miscarriage" (The National Health Insurance Act of 1995, 2012, sec. 7, para 2).

It is important to note that the age of legal sexual consent is twelve. The age of minority only expires at eighteen, and the age to consent to contractual marriage is twenty-one (The Anti-Rape Law of 1997, 1997). The provisions of this act become restrictions by requiring third party consent for access to vital information and services that are further shaped and influenced by parents and community associations, particularly the Catholic church, unless the minor has previously had a child or miscarriage. These provisions hinder the ability to exercise the individual's rights "to be equal in dignity, to education,

to enjoy the benefits of scientific progress, and to enjoy the highest attainable standard of physical and mental health, including sexual and reproductive health" (UN, 2009). It falls short in the ability of adolescents to actively participate in health-seeking behavior by withholding information that is particularly essential for women of reproductive age (15-45). What's more, in a country that has high rates of child sex trafficking, abuse and exploitation, the question remains why and how can a 12 year-old girl be able to legally consent to sexual interactions but cannot obtain the vital information to inform and protect her health until she reaches the age of majority (18), or with parental consent, and only if the community agrees to provide a reproductive health curriculum for youth? In this way, a deeper commitment on behalf of Manila to community-based health education, of which nurses are well qualified to administer, is needed.

4.5.3 The Three Delays

In addition to understanding the causes of, and services required to reduce maternal mortality, it can be further prevented by understanding and addressing 'the three delays'. They are the delay in the decision to seek care, the delay in arriving at care, and the delay in receiving appropriate care (Barnes-Josiah, Myntti, & Augustin, 1998). These delays quite often stem from a lack of information, restricted movement and access, and challenges for patients, both reaching and receiving life-saving services that are shaped by broader societal factors. The three delays applied to the context of maternal health care in the Philippines reveals the constraints of the system that is impacted by the out-flow of nurses.

The first delay, when deciding to seek care, begins with the patient's first step in reaching health care services during pregnancy and labor. The level of education provided to pregnant women regarding when to seek the help of a health worker, or to seek emergency care, depends on the quality and quantity of health care professionals and barangay workers who can disseminate information. This is an important starting point for community health workers to provide primary level public health education. As it can save several hours and preventable intrapartum and postpartum complications that could be fatal. Reducing this delay further depends on if these workers are available, and accessible, as there are not always 24/7 services for obstetrics in rural communities, while secondary and tertiary facilities capable of comprehensive emergency services are usually hours away.

The second delay, the delay in arriving at care, stems from the distance a patient may be required to commute in order to access appropriate services that provide SBA. Women who may live in rural areas, provinces, mountains, and far flung villages may need transportation- short or long- to arrive at a health facility. Rural communities may have roads that are run down, overcrowded and heavily trafficked, or unable to be used due to construction, weather destruction, or may not have continuous access to transportation at all times. Little maintenance is done on ambulances provided by long term development and humanitarian partners. When a patient is given ambulatory care to

reach a health facility, they must choose the public or private facility from which to seek medical assistance. This decision is based not only on physical accessibility but quite often on the ability to pay out-of-pocket.

Many women in rural communities do not have PhilHealth memberships and do not have upfront cash for surgery, anesthetic, user fees or medications, or even units of blood. These are life-saving essentials, and one would not arrive in an obstetrical emergency and not require some, if not all, of the services. Roads, as well as a transportation system must be maintained by local government units (LGUs in the decentralized health system) so that consistent access to available facilities can be insured, and routes to public and private facilities known. It is important to further note that meanwhile, during transportation, the patient may continue to worsen, if emergencies arise. With very few resources available during transport the risk increases which makes essential interventions time sensitive.

The final delay is in receiving appropriate care. The nearest facility may be private and therefore the patient may have to pay out of pocket. This can be quite costly for low income families. The next closest facility may be public, however, if the patient does not have PhilHealth, she may also have to face out-of-pocket payments and long wait times. These facilities tend to be overcrowded, of poor quality due to decreased public health funding, and understaffed due to competitive and unsatisfactory work

environments. What's more, the public facilities are fraught with questionably functional equipment, and inconsistent drugs stocks that require a skilled professional to administer. Depending on where, when, and in what condition the patient may arrive in, the facility reached may not be able to provide emergency obstetric care, considering what levels of services are provided at such a facility and if HCPs are present, trained, or available.

In sum, there must be enough available accessible, acceptable, and quality health care services in order to facilitate maternal health services as a process of RTD. This includes the availability of essential drugs to provide comprehensive obstetrical care, trained HCPs, functioning health care facilities, and information regarding SRH. Not only should these services be available, they should also be accessible. This accessibility includes adequate physical access to services, including transportation within a reasonable distance to a facility that can accommodate the acuity of care needed, but also, most importantly, be financially accessible. Finally, care must also be scientifically sound and medically appropriate to match international standards of care.

Taken together, the policies towards maternal health in the Philippines do attempt to secure both individual and collective rights to health. The interviews with health workers also tend to confirm this value. However, as demonstrated through the structural deficiencies in the system, questionnaires with birth mothers and interviews with physicians, it is clear that a disconnect exists between the desire to achieve collective

rights to health, and the actual state of service in the country. Challenging the health system even further is the out migration of nurses. It is praised as a development driver, and, as demonstrated through my interviews, also valued by nurses themselves. The three delays are important in the case of the Philippines, as they clearly show three areas where the risk to maternal health is increased. All of these areas could be improved through better capacity building and retention of nurses. Chapter 5 discusses these thoughts further.

CHAPTER 5: ANALYSIS

5.1 Analysis & Discussion

Based on the findings from the previous chapter, nursing education, training, and migration have created barriers to achieving good maternal health initiatives in the Philippines by favoring national economic development that reduces health equity and neglects RTD becomes apparent.

As a response to global market forces, the Filipino nursing migration pipeline has become a national development strategy to create conditions that "have an adverse effect" on specific populations of women in the Philippines. This export-oriented approach inhibits "sustainable economic growth", "appropriate resource allocation", and the equitable sharing of the benefits resulting from (national) development (Sengupta, 2013, p. 80). Nursing students admitted that personal financial gain, achieved through out-migration, was a driving force for them to enter nursing programs. This too shapes their moral values of care. Urban birth mothers fared well in gaining access to maternal health services, but their rural counter-parts suffered. Both paid for services out of pocket. With such dedicated attention to nurse training for out-migration, the lack of quality care in the rural areas of the Philippines is apparent in that some of the tensions in maternal health provision could be remedied through better capacity building and retention of nurses.

The nursing students eluded to the institutionalization of nurse migration. It has become a development strategy that ultimately breaches collective human rights of access to quality care by intentionally failing to meet the needs of compatriots. Ultimately, it systematically puts vulnerable women at needless risk. This structural violence ultimately

limits universal access Filipino women have to maternal health services by compromising the presence and functioning of sustainable service delivery, lacking a well-trained health workforce, and faltering health financing and political leadership (World Health Organization, 2007; UN, 2013, p. 55). Not only does this hinder the "equal opportunity and provision of resources" individuals are required to manage their own health, which is easier done for women with better access to resources. More telling is that patients, nurses, and even physicians felt enormous strain from the fractured system. The responses from both urban and rural women indicated that little was done for effective maternal health promotion, even though this survey sample did receive access to care. Physicians also indicate how overwhelmed they were in their duties, and that no capacity existed for the system to deal with upstream determinants. The focus is on emergency and reactive care.

The feasibility, protection, and obligation to fulfill rights and duties of SRH to encompass maternal health care in health service provision exists, but the ability to transform rights into functioning reality is determined by the structure of state and international policies that overlook such human needs. This is not merely high-level matters of global political economy. It impacts the moral values of the nursing profession in the Philippines itself. This is to say that with such a strong emphasis of nurses using the profession for out-ward mobility, it is unlikely that political change will come from within the profession itself to transform practice more towards ensuring collective rights.

These policies however, shape both health and development, and determine the access women have to receive essential health care for healthy and safe pregnancies and childbirth with the attendance of a skilled birth attendant (HCP, nurse, midwife).

International standards and human rights instruments in the Philippines are meant to protect the collective rights of women in maternal health, but the structural inequities of the health system lead to a failure of RTD. These challenges stem from broader moral values of favoring economic growth through migration as opposed to public health strengthening and the promotion and encouragement of RTD.

The question then is whether or not an RTD approach to improve collective rights to health through capacity building and retention could benefit the Philippines? Manila actively encourages, and praises, outmigration of nurses, and this value seems to be strongly felt among nurses in the Philippines. Nursing students strongly valued the opportunity for out migration, and practicing nurses admitted to the importance of financial security and remuneration as being a leading moral value. Taken together, the value of out migration runs high in both the profession, and the government. A prohibition on out migration would likely not be accepted as a solution to improving the quality of care in the Philippines.

Nonetheless, a strong structural factor remains among the nursing profession that directly contributes to the emphasis on financial remuneration above community service. In the Philippines nurses finance their own education, which can cost tens of thousands of dollars (U.S.). Communities and families also contribute to this financing. It then leaves nurses in a position to resettle debts even before they begin their studies. This has enormous impact in driving the moral incentive to practice nursing. It also contributes to an institutional ethic, although not overtly admitted in the interviews, of encouraging nurses to meet international standards so as to pursue migration. If the cost, and debt, of nurse training is such a pressing factor in valuing personal remuneration as a top moral

goal in nursing, then it should be considered a factor in approaching health system design.

Based on the interviews with patients and caregivers, it is clear that the Philippines has not embraced collective rights in creating universal access of its health system, nor has Manila fully explored options to improve capacity building or retention of nurses. The collective theme from all interviewees was that even though services officially existed, they did not always function well, and as a result a great deal of improvisation and coping was required. As per ICESCR, the Philippines cannot by any means justify the lack of commitment to protect, respect or fulfill these duties (ICESCR, 1966, p.8). This lack of commitment results in negligence in the prevention of unnecessary and "reasonably foreseeable" harm. This furthers structural violence of discrimination against women - poor women - by denying comprehensive quality obstetrical care of childbearing age that need medical assistance (Farmer, 2003).

The objectives of RTD are to ensure the constant improvement of the well-being of al through the development process. As the Philippines responds to the global market demands for nurses, the objective of an out-migration development strategy is to contribute to the GDP through the remittances sent back to the country. In this view, the State becomes the central subject and beneficiary of the development policy. With remittance income, the Filipino government is able to financially benefit in two ways. First, OFW income abroad is taxed from 5% - 32%, depending on the income level. Second, remittances are often spent at the household level, and funds are often used to pay for community-level development of housing, and even road improvements. The Filipino government proposed an additional 12% remittance tax on money sent home to

family, but this was not carried through. OFWs are given duty-free shopping privileges in the Philippines as well. However, the benefits gained from the nurse migration pipeline, the contribution of as much as 12-13 percent to the GNI are not shared equally with its citizens. Measuring the value of a massive drain of domestic health workers in simply economic development terms like GDP leaves much to be desired for the real human development needs and lacking health services in rural and marginalized communities.

While the Philippines has outstanding capacity to educate nurses, midwives, and physicians in the country, its motivations in using this strength in nurse education are allotted to expanding GNI through commodification for export. This contribution to the GNI is not directly returned in investment in public health care infrastructure or job creation for HCPs in the country. Nor is it used to bolster national health expenditure or put towards maternal health initiatives. This ultimately compromises the well-being of populations of women and to participate in development. It fails to eradicate social injustices, and it creates obstacles to broader processes of development.

The role of nurse migration as a national economic strategy is embedded in power structures of political institutions. An inherent moral problem exists when a state invests in an economic project, notably one based on rather narrow economic returns to the public good, with the promise of societal betterment, but fails to deliver the returns. The Philippines promises that the heavy investment in export-oriented health worker training will lead to national betterment, but it fails to ensure that remittances go towards the public good. This can be taken as a letdown to ensure RTD for compatriots, as the lack of capacity building for domestic service sacrifices best practices in maternal health for vulnerable women. The maternal health experience of rural Filipino women speak to this.

This economic development strategy caters to the demand of global markets before the needs of compatriots. It is morally problematic for a country to use national resources for training health workers for a more affluent market, while failing to protect the health insecurities of its own people.

Poor health infrastructure and health indicators, such as the consistently and unacceptably high maternal mortality rate, maternal morbidity, neonatal death and under five death rates, have resulted from widening social inequity and an overall lack of public health investment in the Philippines. The international community can also be held accountable for encouraging the Philippines to export their HRH to a global market.

As Farmer (2003) argues that structural violence occurs when suffering is intended for a group of people within a society. In the case of the Philippines, the decision to enhance foreign health needs at the cost of basic domestic care is a structural violence aimed at rural, and poor woman in the country. This lack of moral commitment of the government to provide essential services is structural violence in that it is based on the pillars of negligence and discrimination. It is bolstered by government, and the international community, and it leads to the systematic discrimination of Filipino women. Therefore, the objective and subject of the commodification of nursing as a development strategy has become a political tool that ultimately prioritizes foreign needs at the cost of RTD.

In considering this, it is why the interviews with the midwives were valuable for the research question of this thesis. Clearly there are policies in place in the Philippines that value capacity building, retention, quality care, and accessibility of services. Even

though the current emphasis for outmigration exists, it can be argued that official government policies do aim to improve quality of health care services. Retention and capacity building for nurses is a principle challenge. As mention earlier, a moratorium on out migration would not be a wise approach. However, if positive encouragement were to exist, through the relief of tuition for nursing school, or prestigious scholarships, would this increase values of service towards compatriots? The midwifery students interviewed in this thesis, along with some midwives, received scholarships from the DOH. They acknowledged the importance of these scholarships, and with it the value of service to community and to country. The difference in values of service towards compatriots was clear among midwives, and almost mute among nurses. Granted, that midwives are not recruited for outmigration to the extent that nurses are, but even when midwives discussed upgrading their education, they did not emphasize out migration as a goal. Even more interesting is that the system relied on midwives to perform some nursing duties, and often in challenging conditions, to which midwives did not seem odds with.

Could prestigious scholarships for nurse training help to build capacity in the Philippines by improving retention? If the moral values of the midwives are any indicator, it would. What's more, even the hilots, who the government redirected work duties, expressed enthusiasm to participate in a more integrated setting. Taken together, the value of service to community and to compatriots should not be undervalued. If HCPs are able to be free of pressing financial obligations, or pre-determined expectations of out migration, then these values may be able to have a greater role at the community level and within health-system planning itself. Many of the tensions in maternal health care in the Philippines are caused by inefficiencies that could be overcome better nursing

retention methods. Is it likely that global pressures would continue to demand skilled nurses from the Philippines to go abroad? It is quite likely. But would prestigious scholarships help to offer nurses the choice to stay in country to further RTD? This is quite likely as well. As such, it would be worth exploring how such scholarships could play a role in improving capacity building and retention of nurses in the Philippines.

CHAPTER 6: CONCLUSION AND RECOMMENDATIONS

6.1 Conclusions

Using the data collected and assembled in the discussion, this chapter will conclude this research by answering the research question if can the values of the Right to Development be applied to capacity building, and retention strategies of Filipino nurses so as to improve gaps in the national health system? Based on interviews of HCPs, analysis of Filipino health policy, and exploration of RTD, this thesis argues that the Right to Development can be an important framework in building capacity, and improving retention, of HCPs through positive measures such as offering prestigious scholarships for service to compatriots. Although such measures will likely raise new challenges, it would be an important step to consider in improving health system strengthening in the Philippines.

The institutionalization of nurse migration is a development strategy that challenges RTD, by encouraging strenuous effects on the national health care system. Manila's ability to provide, and Filipinos' ability to receive, maternal health care services has been shaped by policies that facilitate the easy movement of nurses across international borders. While nation states have the right to determine how to use and develop their national resources, the international community also has the responsibility to intervene when there exists a threat to development, including "the absence of access to health services and education" (United Nations General Assembly, 1986: art. 5; United Nations, 2013, p. 51). Typically, this occurs through the receipt of foreign and aid and assistance. But as Orbinski (2008) argues, charity cannot possibly the replace the value, quality, and benefit of resplendent universal health care systems. As the international

community benefits from the massive out-migration of Filipino nurses seeking a better life, it should be noted that it has the responsibility to provide "these countries with appropriate means and facilities to foster their comprehensive development" (United Nations General Assembly, 1986: art. 4, sub-cl. 2).

The International Council of Nurses can also become an active body in an RTD approach to building capacity. The ICN can further explore the right to development to demonstrate how human rights can be integrated into the Filipino maternal health agenda (and its motivations) via the strengthened capacity of the (international) nursing workforce. Representing the "largest health profession worldwide", the ICN is an international federation that consists of 130 national nursing associations (NNA) and is operated by nurses, to represent, advance and influence national and international nursing and health policy (ICN, 2001). The ICN provides a medium of international education, advocacy, and whistleblowing of international nursing matters such as the global shortage of HRH, particularly nurses. The ICN promotes the same principles of RTD, notably equity, non-discrimination, social justice, and solidarity. As such, the ICN could be an ideal medium to support prestigious scholarships for capacity and retention of Filipino nurses to address and reduce maternal deaths in the Philippines.

The ICN, firstly, can be used as a platform for advocacy in raising awareness of how out migration is detrimental to the Philippine health system. As the Philippines is the largest exporter of human resources for health, and has institutionalized nurse commodification, the research regarding the relationship between the participation of foreign nurses in the pipeline and resulting effects on source country health infrastructure demonstrates a precedent to which those source countries should consider how their gain

from Filipino nurses factors into the RTD. Host countries of Filipino migrant nurses should also consider the ethical responsibility of actively seeking thousands of migratory nurses and the resulting effects on source countries.

Secondly, the ICN can be used as a platform for solidarity to advocate for not only ethical recruitment and retention of nurses in international contexts, but to also advocate for those whose rights have been breached. The definition of solidarity, as per the ICN, is congruent to that of the RTD, in working to place nurses as key contributors and essential partners in formulating and implementing public policy" (ICN, 2001). Countries seeking thousands of internationally recruited nurses to supply their national shortfalls for nurses have created and sustained the international market for HCPs, and it further leads to the institutionalization of nursing commodification in the Philippines and other countries. This 'institutionalization' demonstrates government capacity, to expand the number of nursing schools, increased rates of nursing enrollment and the integration of international nursing curriculum into existing curriculums of higher education institutions (Lorenzo, et al., 2007; Ortiga, 2014). Yet, as the Philippines is a low-income country, the "developed" countries seeking Filipino nurses have not been able to establish this same concept of domestic institutionalization to foster their own response to their own national nursing shortages. They continue to rely on the easier, cheaper, method of importing Filipino nurses.

If countries seeking migratory nurses are to take the institutional approach, they will need to rapidly expand their own educational capacity of the nursing and allied healthcare professions to supplement the demand without expropriating HCPs from countries who participate in the global migration pipeline. In response, the Philippines

will need to adapt to the shifting supply and demand of the international migration of nurses by providing equal opportunity for the education and practice of nurses, and other HCPs. This will require immediate action, such as national policy and development plans, through scholarships and funding that enables participation of individuals the "choice to stay" in country (Sengupta, 2013, p. 63). "The adoption of laws and procedures intended to eliminate conditions of underdevelopment or, at the very least, to help overcome the obstacles to development" ought to account for structural violence that results from the institutionalization of export-oriented nursing (Sengupta, 2013, p. 63). Also, the specific economic, social, political and cultural rights at risk and the barriers to rights that are present within the country, in addition to not only ethical, but practical recruitment and retention must be incorporated into policy development.

Within the Preamble of the ICN Code of Ethics for Nurses (2001), the ICN dictates that nurses have four fundamental responsibilities: "to promote health, prevent illness, to restore health and to alleviate suffering". Within this same document, the elements of the code states that the nurse:

> ... promotes an environment in which the human rights, values, customs and spiritual beliefs of the individual, family and community are respected;...shares with society the responsibility for initiating and supporting action to meet the health and social needs of the public, in particular those of vulnerable populations;...assumes the major role in determining and implementing acceptable standards of clinical and nursing practice, management, research and education;… acting through the professional organization, participates in creating and maintaining equitable social and economic working conditions in nursing;...takes appropriate action to safeguard individuals when their care is endangered by a co-worker or any other person (ICN, 2001, p. 377).

The ICN further provides examples on how to integrate these elements, by practitioners and managers, educators and researchers, and NNAs into education and advocacy to build capacity within the workforce.

6.2 Recommendations

The ICN makes the following recommendations for practitioners and managers it is essential to:

- "provide care that respects human rights and is sensitive to the values, customs and beliefs of people".
- "set standards for nursing practice, research, education and management".
- "promote participation in national nurses associations so as to create favorable socio-economic conditions for nurses" (ICN, 2001).

Educators and Researchers must:

- "in curriculum include references to human rights, equity, justice, solidarity as the basis for access to care".
- "provide learning opportunities in setting standards for nursing practice, research, education and management" (ICN,2001).

National Nurses' Associations should:

- "lobby to ensure continuing education opportunities and quality care standards".
- "lobby for fair social and economic working conditions in nursing. Develop position statements and guidelines in workplace issues" (ICN, 2001).

Building nursing capacity within RTD framework identifies how by returning to these values through the adoption of scholarships and retention strategies could have positive impacts on the functioning of the health system. Within these recommendations should be attention towards capacity building through scholarship and through the relief of debt. These are the causal effects of social structures that inhibit nursing in the Philippines, notably in the ability for the system to have adequate human resources to provide appropriate care and equitable access for vulnerable populations.

As this thesis demonstrated, nurses themselves share the values of out migration from the Philippines. Indeed, this is a product of the current political and economic climate, but through the ICN, nurses can participate in exercising solidarity by:

- invoking political will to address women's sexual and reproductive health.
- advocating for the provision of essential services and the implementation of international obligations of the global health agenda in regards to maternal health.
- advocating for the prioritization of women's rights, the right to health and the Right to Development.
- advocate for educational and human resource potential of nurses domestically and internationally.
- advocating for, and contributing to, research that supports social, political and environmental policies that are conducive not only to the protection, respect and fulfillment of human rights, but to the conditions that enable the feasibility of these policies to be implemented into practice.
- advocating for not only ethical migration management, but also bilateral partnerships that return benefits (financial, human, technological) to the educational institutions and hospitals providing the trained global HCP workforce.

6.3 Summary

This research contributes to literatures concerned with human resources for health planning, and to work on the right to development to suggest that RTD can play an important role in capacity building and retention through scholarship and debt relief in the Philippines. The nurse migration pipeline leads to poor health infrastructure and health outcomes in the Philippines, based on the desire to fulfil foreign demand for health workers, before that of the need of compatriots. This policy creates a structural violence that leaves rural and marginalized women in a position to be systematically at risk of high maternal morbidity and mortality (Lorenzo, Galvez-Tan, Icamina, & Javier, 2007; Huish, 2015; Castles, 2014).

Data collected provided evidence of how out migration and RTD policies are received and perceived by Filipino legislature, and by health workers themselves. The Philippines formulated out migration policies that respond to global demands over that of local needs, even though several acts encourage an RTD approach to health system strengthening. In place of massive outmigration of nurses, Manila attempts to upscale maternal health services via education and retention of midwives. While these health workers value their role, they are asked to perform beyond their capabilities, and at times with minimal support. The commodification of nursing schools is reflective of the Filipino government's political motivation to seek economic growth by feeding the migration pipeline but failing to care for compatriots. This pipeline is further influenced by lacking physical resources, private educational institutions, poor job security, and quality of life in the Philippines.

Applying the RTD to both the practical and research problem of this thesis identified unfulfilled obligations of identified duty holders. Further, it has provided examples, from the recommendations of the RTD and the ICN, at the national and international level, on how to harness the capacity of the nursing profession to reduce health inequities.

In summary, the RTD can be used as a framework at an international and national level, to assess the impact of development policies on health systems and outcomes, and to identify structural inhibitors to the full realization of development and the fair sharing of the benefits resulting therefrom (United Nations, 2013). Finally, it can help to enable and build upon the capacities of states, structures, and of individual and collective agency to provide conditions conducive to sharing of the benefits of scientific and technological

advancement whilst not denying anyone the right to care, and the need to be cared for (United Nations General Assembly, 1986: art. 9, sub-cl.1-2).

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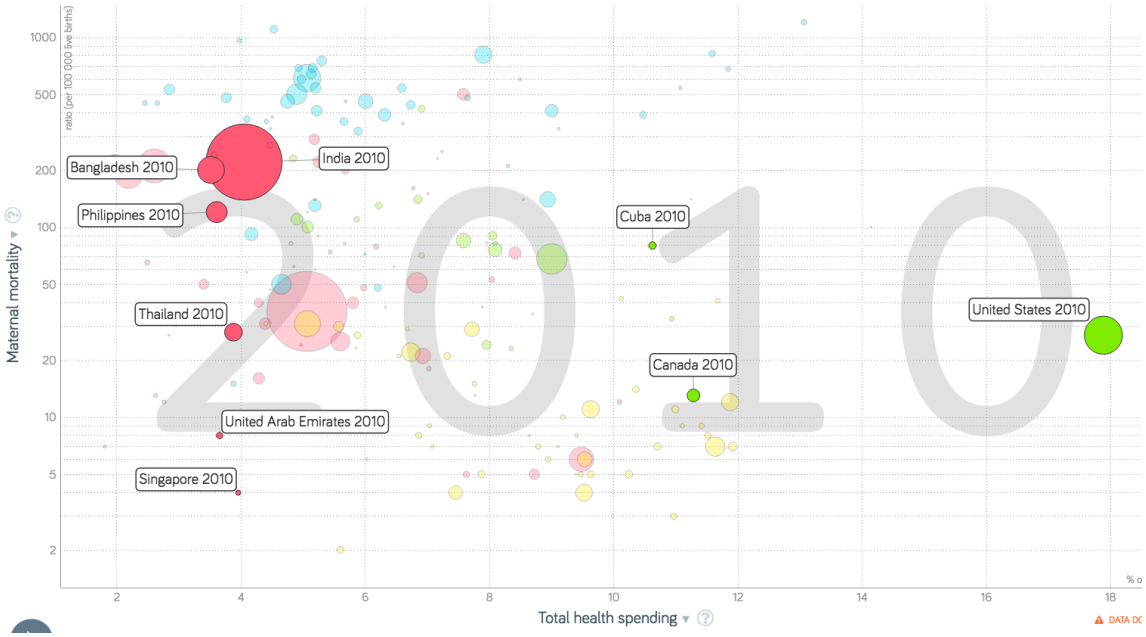
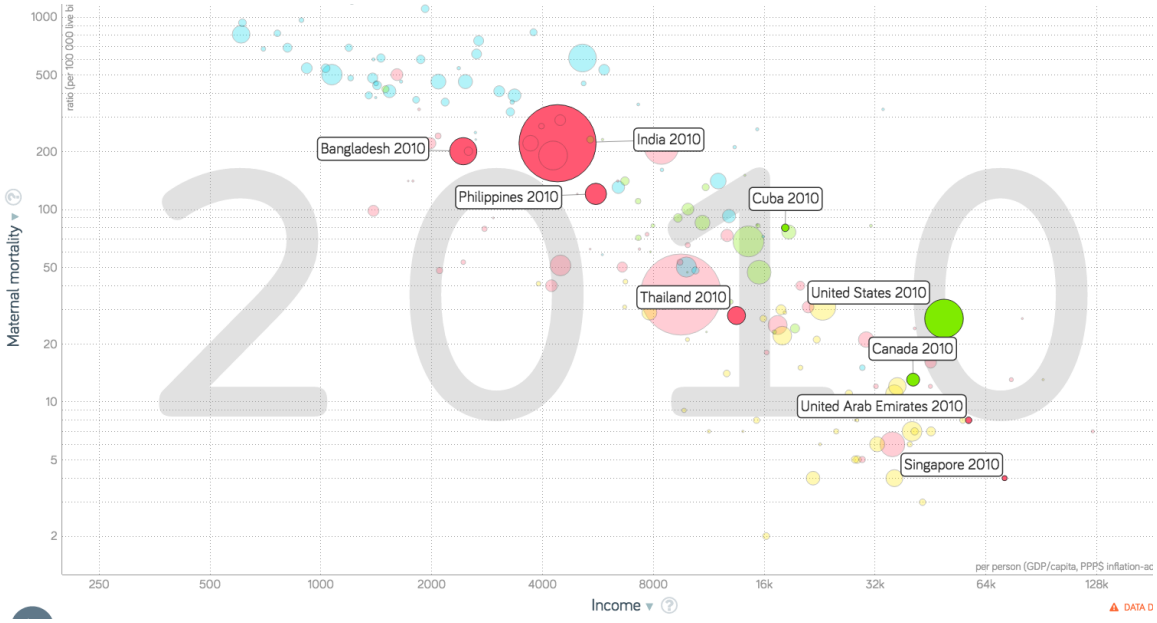
Appendix A

Maternal Mortality vs. Total Health Spending (Gampminder.org).



Appendix B

Maternal Mortality vs. Income per Capita (Gapminder.org).



Appendix C: Interview Information Sheet

Project Title: The Pains of Labour: How the Export of Nurses Increases Risk to Maternal Health in the Philippines.

Lead Researcher: Krisanne Thibodeau (Graduate Student), Masters' of Arts: International Development Studies at Dalhousie University

Local Phone number: (#####) (to be obtained in the Philippines)

Email: kr871108@dal.ca

Other researchers

Research Assistant [Name to be inserted], affiliations

Email: to be obtained from research assistant

Research Supervisor:

Dr. Robert Huish

Dept. of International Development Studies, Dalhousie University

6135 University Avenue, Halifax, Nova Scotia, Canada, B3H 4R2

Email: huish@dal.ca

This Research is Not Funded

Introduction

I invite you to voluntarily participate in this research project that has intentions of advocating for women who face challenges in accessing appropriate and quality maternal and reproductive health that is essential in reducing and preventing excess maternal deaths, and in protecting access to sexual and reproductive health that is a fundamental human right (UNDHR, 1948).

This research study will be led by me, Krisanne Thibodeau, a graduate student at Dalhousie University as part of my MA International Development Studies. My research assistant will be [insert name of research assistant], whose background is [to be determined]. The role of [name of research assistant] will be to assist in recording and transcribing interviews. Research assistants will be also responsible for signing a confidentiality agreement for the research process. The research assistant will not have access to saved data.

To ensure the voluntary nature of this invitation is understood, you have the choice to partake in this research or not. Any participant has the right to withdraw from this project, in any form of participation, at any time, without any repercussion.

The following information will indicate what is involved in the research, what you will be asked to do and about any benefits, risks, inconvenience or discomforts that you might experience.

You can discuss any questions you have about this study with me now or can contact other research team members with attached contact information sheet.

Purpose and Outline of the Research Study

The primary research question is: Can the values of the Right to Development be applied to capacity building, and retention strategies of Filipino nurses so as to improve gaps in the national health system? The purpose of this research is to determine if, and how, nurse migration patterns, under an economic and political rubric for domestic benefit from remuneration and remittances, are circuitously accountable for the stagnantly high and unacceptable Filipino MMR.

The purpose of analyzing this research is to then understand the barriers to the prevention of excess maternal death and in reducing complications of pregnancy by looking at the challenges or the modifiable factors that hinder access and quality care for pregnant women. Having used these services or can provide information or insight on health care layout, you can articulate the current snap shot of women's health in the Philippines, as you've experienced it.

Who Can Partake in this Research Study

This study seeks to interview health care practitioners with varying levels of education and experience with maternal health services, both practicing or non-practicing, but who are or have practiced or studied in the Philippines and can attest to experience in said discipline within the last two years. This includes: physicians, nurses, midwives, nursing and midwifery students, traditional birth attendants, community health workers, public health workers; nursing and midwifery educators, and local birth mothers.

What Will You Be Asked to Do

You will be asked to give consent to participate in this research project. In signing this consent, you will be asked to answer questions regarding your health care background, education, aspirations and employment; perceptions or factual positions on nurse training, education, regulation, job security and acquirement; and perception of challenges that hinder health service delivery. Interviews will be recorded using a digital voice recorder. This is indicated on the consent form. The interview will be comprised of 5-10 minutes to ascertain informed consent, and a 35-50 minute interview, for a total of 60 minutes. You can provide oral or written consent. You will not be compensated for your participation,

but you will be reimbursed (for example: travel expenses), when signing consent. Participation in this study is absolutely voluntary, and you may withdraw without repercussions. You may decline to answer any question if you wish. You may leave the interview at any time if uncomfortable, uninterested or if other priority commitments arise.

Possible Benefits, Risks, and Discomforts

There are no direct benefits of participation to you. The hopes of this research are to add to the knowledge surrounding maternal mortality and identify modifiable barriers to preventing excess maternal death and in reducing complications of pregnancy in the Philippines. An indirect benefit of the study is to provide results that may encourage the strengthening of the capacity of human health resources, for the overarching goal of decreasing maternal mortality in the Philippines.

The level of risk associated with this research is minimal, the harms or discomforts are no greater than those that are related to common experiences of everyday life. This is study is independent of all health facilities, authorities and government, and is not in affiliation with any Filipino university or organization.

Details of each interview will not be shared with other interviewees. Interviewees will not be personally identified by geographical location or professional details unless wishing to do so, as will be reviewed on the consent Form. Instead, each interviewee will be given an alias (For example: Nurse A; Student X). This research will not individually identify you. If you do not consent to use quotations, quotations from you will not be used. If given consent to use quotes, only an alias will be used in final research findings. This

study is not an audit or an evaluation of clinical or educational competence. Employers will not be notified of an individual's participation in this study. There are no other known risks for participating in this research beyond being bored or fatigued; however, you will be offered breaks between activities to reduce these risks.

How your information will be protected

Privacy: This research project has been reviewed by the Office of Research Ethics Administration at Dalhousie University, Nova Scotia, Canada. This is study is independent of all health facilities, authorities and government, and is not in affiliation with any Filipino university or organization. Employers will not be notified of an individual's participation in this research.

The lead researcher will be the only individual with saved data pertaining to this research. Data will not be shared with anyone other than research assistants and the research supervisor. Research assistants will not have access to saved data. Data will not be shared with foreign servers or third parties. The aliases of participants will be saved on the encrypted USB key only accessible to the lead researcher. Data from interviews will be saved on the password protected hard-drive and will only be available to the lead researcher. Details of interviews will not be shared with sectors of this research

Anonymity: You will not be personally identified by personal details unless wishing to do so, as will be reviewed on the consent form. Instead, you will be given an alias as per above, unless you wish to choose one for yourself. This alias will be used in any research findings. No personal details will be attached this alias. Only the lead research will know

the corresponding names and aliases. The document with saved aliases will be stored separately from analysed data.

Confidentiality: Data will not be shared with anyone other than research assistants and the research supervisor. Once in Canada, all information will remain in the country and will be shared only with the research supervisor (Dr. Robert Huish). This data will be stored for five years after this project and will then be permanently deleted. I will take all reasonable precautions to protect data and maintain confidentiality and will act in accordance with the Philippines Republic Act No. 10173*: "Data Privacy Act*". Should the disclosure of personal information by authorities or organizations, said bodies will be referred to the University Legal Counsel Office, as per the Dalhousie University *Policy for the Protection of Personal Information from Access Outside Canada*,

Limits to Confidentiality

It is not anticipated that this research will unintentionally present limits on confidentiality.

I will be responsible for acting in accordance with the duty to disclose information should any abuse or breach of human rights of adults or children be disclosed during your participation in this study.

This will be done with the appropriate legal and protective authorities; and will be done so in good faith and in the utmost confidential manner possible.

If You Decide to Stop Participating

You will be given contact information, including local phone number and email of the lead researcher, the research Supervisor, research assistants and the contact information of Dalhousie University's Research Ethics Board should any questions or concerns arise. The participant can withdraw participation or retract statements at any point during the research collection process by contacting any aforementioned members of research team. You are free to leave the study at any time. If you decide to stop participating at any point in the study, you can also decide whether you want any of the information that you have contributed up to that point to be removed or if you will allow us to use that information. The only limitation on your opportunity to withdraw from participation or the retraction of data will be the need to withdraw or retract statements before the articulated end date of June 30, 2017, after which the ability to withdraw will no longer be possible. After that time, it will become impossible to remove it because it will already be analyzed and anonymized. It is essential that you know that no repercussions will occur should you choose to withdraw or retract statements or information pertaining to this research project.

How To Obtain Results

You will be asked if you wish to receive a copy of the research results and a copy of thesis. No field notes from research findings and or individual information will be included in shared research findings. If you wish to be quoted, you can consent to the use of a quotation. You may also request the notification of the use of your quotation, to assure your consent on the use of such quotation in research findings. These options will be on the signature consent form. You can share your desired contact medium- email, mail, or other preferred contact method on the consent form. Should you wish to obtain

an audio recording of summarized research findings instead, a copy will be sent to you by offered contact information.

Questions

I and the research team are happy to answer any questions you may have presently. You will be given contact information of the research team: lead researcher, research assistants, research supervisor.

Dalhousie University's Research Ethics Board can be contacted at any time at (902) 494-1462, or email: ethics@dal.ca (and reference REB file # 2016-4003), should they have questions about the research process and result sharing, or have questions or concerns that should be articulated to Dalhousie University's Research Ethics Board.

Appendix D: Interview Consent Form

Signature Form

I ,_____, have been read to, or have read myself, the information sheet explaining the research, and about my participation as an interviewee for this project. I have been given the opportunity to discuss my questions and have my concerns clarified. I understand that this interview will be audio recorded unless I state otherwise. I understand that my identity will not be disclosed in this research's findings. I have been informed of the opportunity to withdraw from any research participation, at any time, through any contact media, before June 30, 2017. I consent to participate in this project, with the full understanding of my right to participate and withdraw from this project at any time. I have also been informed that no repercussions will occur should I choose to withdraw or retract statements or information pertaining to this research project. I understand the lead researcher's responsibility to act in accordance to the duty to disclose information should abuse or breach of human rights of adults or children be disclosed during my participation.

This consent clarifies that I have been provided with sufficient information on this project to make an informed decision.

_____ -

_____ _____

Name Signature Date

I give permission to use direct quotations: Yes □ No □

I would like a notification if my quote will be used: Yes □ No □

I wish to use my real identity in this research: Yes □ No □

I would like to NOT be recorded: □

Participant Contact Information (optional)

Phone Number:

Email Address:

Mailing address:

Other:

Appendix E: Focus Group Discussion Information Sheet

Project Title: The Pains of Labour: How the Export of Nurses Increases Risk to Maternal Health in the Philippines.

Lead Researcher: Krisanne Thibodeau (Graduate Student), Masters' of Arts: International Development Studies at Dalhousie University

Email: kr871108@dal.ca

Other researchers

Research Assistant [Name to be inserted], affiliations

Local Phone Number: (#####)(to be obtained in the Philippines)

Email: to be obtained from research assistant

Research Supervisor:

Dr. Robert Huish

Dept. of International Development Studies, Dalhousie University

6135 University Avenue, Halifax,Nova Scotia, Canada, B3H 4R2

Email: huish@dal.ca

Problems and Concerns:

Dalhousie Research Ethics Board

Catherine Connors Dalhousie Research Services,

Dalhousie University Henry Hicks Building, Suite 231 Dalhousie University PO Box 15000 Halifax, NS B3H 4R2 Canada

Dalhousie University's Research Ethics Board can be contacted at any time at (902) 494-1462, or email: ethics@dal.ca (and reference REB file # 2016-4003)

This Research is Not Funded

Introduction

I invite you to voluntarily participate in this research project that has intentions of advocating for women who face challenges in accessing appropriate and quality maternal and reproductive health that is essential in reducing and preventing excess maternal deaths, and in protecting access to sexual and reproductive health that is a fundamental human right (UNDHR, 1948).

This research study will be led by me, Krisanne Thibodeau, a graduate student at Dalhousie University as part of my MA International Development Studies. My research assistant will be [insert name of research assistant], whose background is [to be determined]. The role of [name of research assistant] will be to assist in collecting, recording, and transcribing data. Research assistants will be also responsible for signing an obligatory confidentiality agreement for the research process. The research assistant will not have access to saved data.

To ensure the voluntary nature of this invitation is understood, you have the choice to partake in this research or not. Any participant has the right to withdraw from this project, in any form of participation, at any time, without any repercussion.

The following information will indicate what is involved in the research, what you will be asked to do and about any benefits, risks, inconvenience or discomforts that you might experience.

You can discuss any questions you have about this study with me now or can contact other research team members with attached contact information sheet.

Purpose and Outline of the Research Study

The primary research question is: Can the values of the Right to Development be applied to capacity building, and retention strategies of Filipino nurses so as to improve gaps in the national health system? The purpose of this research is to determine if, and how, nurse migration patterns, under an economic and political rubric for domestic benefit from remuneration and remittances, are circuitously accountable for the stagnantly high and unacceptable Filipino MMR.

The purpose of analyzing this research is to then understand the barriers to the prevention of excess maternal death and in reducing complications of pregnancy by looking at the challenges or the modifiable factors that hinder access and quality care for pregnant women. Having used these services, or can provide information or insight on health care layout, you can articulate the current snap shot of women's health in the Philippines, as you've experienced it.

Who Can Partake in the Research Study

This study seeks to interview health care practitioners with varying levels of education and experience with maternal health services, both practicing or non-practicing, but who are or have practiced or studied in the Philippines and can attest to experience in said

discipline within the last two years. This includes: physicians, nurses, midwives, nursing and midwifery students, traditional birth attendants, community health workers, public health workers; nursing and midwifery educators, and local birth mothers.

What Will You Be Asked To Do

You will be asked to give consent to participate in FGD with other health care practitioners for this research project. In signing this consent, you will be asked to participate in a discussion regarding your health care background, education, aspirations and employment; perceptions or factual positions on nurse training, education, regulation, job security and acquirement; and perception of challenges that hinder health service delivery. Questions and discussion will be fostered by me, the lead researcher. I will ask the group various questions to foster discussion, on which you can comment or share your narratives. FGDs will be recorded using a digital voice recorder. This is indicated on the consent form. The FGD will be comprised of 5-10 minutes to ascertain informed consent, and a 35-50 minute group discussion, for a total of 60 minutes. You can provide oral or written consent. You will not be compensated for your participation, but you will be reimbursed (for example: travel expenses), when signing consent. Participation in this study is absolutely voluntary, and you may withdraw without repercussions. You may decline to answer any question if you wish. You may leave the FGD at any time if uncomfortable, uninterested or if other priority commitments arise.

Possible Benefits, Risks, and Discomforts

There are no direct benefits of participation to you. The hopes of this research is to add to the knowledge surrounding maternal mortality, and identify modifiable barriers to

preventing excess maternal death and in reducing complications of pregnancy in the Philippines. An indirect benefit of the study is to provide results that may encourage the strengthening of the capacity of human health resources, for the overarching goal of decreasing maternal mortality in the Philippines.

The level of risk associated with this research is minimal, the harms or discomforts are no greater than those that are related to common experiences of everyday life. This is study is independent of all health facilities, authorities and government, and is not in affiliation with any Filipino university or organization. You will be given a pseudonym to assure confidentiality. Information from this FGD will not be shared with participants in other elements of this research.

This research will not individually identify you. If you do not consent to use quotations, quotations from you will not used. If given consent to use quotes, only pseudonyms will be used in final research findings. There are no other known risks for participating in this research beyond being bored or fatigued; however, you will be offered breaks between activities to reduce these risks.

Compensation & Reimbursement

You will not receive compensation to participate; however, the expenses you need in order to participate (e.g., travel, phone calls) will be covered to minimize the costs to you. You will be reimbursed in the local currency for the cost of transportation needed to meet in order to participate in the research project (e.g., cost of public transport). Phone calls used to contact the lead researcher will be collect calls charged to the lead researcher. You will be given reimbursement during the informed consent process, and can therefore can participate or withdraw from the study at any point should you feel inclined to do so.

How your information will be protected:

Privacy: This research project has been reviewed by the Office of Research Ethics Administration at Dalhousie University, Nova Scotia, Canada. This is study is independent of all health facilities, authorities and government, and is not in affiliation with any Filipino university or organization. Employers will not be notified of an individual's participation in this research.

The lead researcher will be the only individual with saved data pertaining to this research. Data will not be shared with anyone other than research assistants and the research supervisor. Research assistants will not have access to saved data. Data will not be shared with foreign servers or third parties. The pseudonyms of participants will be saved on the encrypted USB key only accessible to the lead researcher. Data from FGDs will be saved on the password protected hard-drive and will only be available to the lead researcher. Details of FGDs will not be shared with sectors of this research

Anonymity: Participants will not be personally identified by personal details unless wishing to do so, as will be reviewed on the consent form. Instead, participants will be given a pseudonym (FGD# 1:Particpant 1), unless wish to choose one themselves. This pseudonym will be used in any research findings. No personal details will be attached this pseudonym,. Only the lead research will know the corresponding names and pseudonyms. The document with saved pseudonyms will be stored on a separate device than contact information, should you wish to provide contact information.

Confidentiality: Data will not be shared with anyone other than research assistants and the research supervisor. Once in Canada, all information will remain in the country and will be shared only with the research supervisor (Dr. Robert Huish). This data will be stored for five years after this project and will then be permanently deleted. I will take all reasonable precautions to protect data and maintain confidentiality and will act in accordance with the Philippines Republic Act No. 10173*: "Data Privacy Act*". Should the disclosure of personal information by authorities or organizations, said bodies will be referred to the University Legal Counsel Office, as per the Dalhousie University *Policy for the Protection of Personal Information from Access Outside Canada*,

Limits to Confidentiality

It is not anticipated that this research will unintentionally present limits on confidentiality.

I will be responsible for acting in accordance with the duty to disclose information should any abuse or breach of human rights of adults or children be disclosed during your participation in this study. I will also be responsible for acting in accordance with the Republic of the Philippines Republic Act No. 9262: "*Anti-Violence Against Women and their Children Act of 2004*".

This will be done with the appropriate legal and protective authorities; and will be done so in good faith and in the utmost confidential manner possible.

If You Decide to Stop Participating

You will be given contact information, including local phone number and email of the lead researcher the research Supervisor, research assistants, and the contact information of Dalhousie University's Research Ethics Board, should any questions or concerns arise. The participant can withdraw participation or retract statements at any point during the research collection process by contacting any aforementioned members of research team. You are free to leave the study at any time. If you decide to stop participating at any point in the study, you can also decide whether you want any of the information that you have contributed up to that point to be removed or if you will allow us to use that information. The only limitation on your opportunity to withdraw from participation or the retraction of data will be the need to withdraw or retract statements before the articulated end date of June 30, 2017, after which the ability to withdraw will no longer be possible. After that time, it will become impossible for us to remove it because it will already be analyzed and anonymized. It is essential that you know that no repercussions will occur should you choose to withdraw or retract statements or information pertaining to this research project.

How To Obtain Results

You will be asked if you wish to receive a copy of the research results and a copy of thesis. No field notes from research findings and or individual information from FDGs will be included in shared research findings. If you wish to be quoted, you can consent to the use of a quotation. You may also request the notification of the use of your quotation, to assure your consent on the use of such quotation in research findings. These options will be on the signature consent form. You can share your desired contact medium-email, mail, or other preferred contact method on the consent form. Should you wish to

obtain an audio recording of summarized research findings instead, a copy will be sent to you if you offer contact information.

Questions

I and the research team are happy to answer any questions you may have presently. Participants will be given contact information of the research team: lead researcher, research assistants, research supervisor. Dalhousie University's Research Ethics Board can be contacted at any time at (902) 494-1462, or email: ethics@dal.ca (and reference REB file # 2016-4003), should they have questions about the research process and result sharing, or have questions or concerns that should be articulated to Dalhousie University's Research Ethics Board.

Appendix F: Consent Form for Interviews with Mothers

Signature Form

I ,_____, have been read to, or have read myself, the information sheet explaining the research, and about my participation in this project. I have been given the opportunity to discuss my questions and have my concerns clarified. I understand that my identity will not be disclosed in this research's findings. I have been informed of the opportunity to withdraw from any research participation, at any time, through any contact media, before July 31, 2017. I consent to participate in this project, with the full understanding of my right to participate and withdraw from this project at any time. I have been informed that no repercussions will occur should I choose to withdraw or retract statements or information pertaining to this research project. I understand the lead researcher's responsibility to act in accordance to the duty to disclose information should abuse or breach of human rights of adults or children be disclosed during my participation. In signing this consent form I understand that I consent to be confidentially interviewed.

This consent clarifies that I have been provided with sufficient information on this project to make an informed decision.

_____ -

_____ _____

Name Signature Date

I give permission to use direct quotations: Yes □ No □

I would like a notification if my quote will be used: Yes □ No □

I wish to use my real identity in this research: Yes □ No □

I wish to receive a final copy of findings or thesis: Yes □ No □

Participant Contact Information (optional)

Phone Number:

Email Address:

Mailing address:

Other:

Appendix G: Health Care Practitioner Interview Guide

Date:

Interview #:

Community/Barangay:

Pseudonym:

Demographics:

Age:

Profession:

Religion:

Marital status:

Semi-structured Questions

What is your profession? How long have you been in this profession?

How did you choose this profession?

Would you say the opportunity of migration led you into this profession?

Have you worked in the field you trained in? Why or why not?

Is it difficult to secure a job in this profession? Were have you been recruited?

If yes, what barriers existed?

Where are some of the areas you have worked? Have some been more difficult than others?

How did you fund your education?

Were scholarships available? Family support?

What are the different criteria for selection and acceptance of students into the institution of your discipline?

Can you tell me about the licensing process?

Would you say the curriculum is based primarily for the purpose of nurse migration

What would you suggest to change when it comes to the planning of the nursing curriculum or recruitment?

How would you describe working in your health sector environment?

Can you tell me about your working environment in the Philippines?

What are the nurse to patient ratios?

Can you tell me about how your work environment is staffed? Do you think this is sufficient?

Can you tell me about patient tohealth care ratios? Do you think this is sufficient?

Do you think there is an overflow of patient cases in government hospitals that burden the access for poorer families?

Is there a referral system between RHUs, BHUs and primary, secondary, tertiary, private or public hospitals? Any suggestions?

What are some of the challenges you have faced in this line of work?

How do these challenges impact your work, or ability to work?

How would you mitigate these challenges?

Do you find lack of health staff, supplies, financing or management to be the most influential barrier to doing your job? Are these encouraging factors for working abroad?

Have areas you've worked received much guidance from the DOH or CHDs?

What are your thoughts on the Filipino nurse migration patterns?

Are you aware of places abroad to work? Have you considered migrating to do your work?

Are you aware of funding or payment for your job in other countries? Are you familiar of the process of going abroad?

Would you say that nursing migration has directly or indirectly affected your line of work?

Have you ever had a job threatened due to a shortage of health care workers, mainly nurses?

Do you think nurse migration, or HCP migration, is a serious issue here?

What do you think is the biggest challenge facing the global, and Filipino nursing shortage?

What do you think can be done?

What suggestions do you have to create a safe and productive work place?

Have you, or anyone you have known lost a job in this field due to facility closure?

Can you list any RHUs or BHUs in your community or barangay? Hospitals?

What about facilities that have closed?

Do you, or have you, worked directly with pregnant women or in labour and delivery?

What is, or would be, your role in maternal health care service provision?

Approximately how many babies are delivered (in your facility) daily, monthly, or annually?

Are you aware of sexual and reproductive health services in your community?

Can you tell me about family planning or prenatal care facilities or clinics in your area?

Are maternal health services advertised in your community?

Do you think patients are aware of the special maternal care packages available through Phil health? maternal health care facilities and services available to them?

Can you tell me about drugs most commonly used for maternal health services?

Can you tell me about special packages for pregnancy and delivery offered by Phil Health?

Should pregnant women be enrolled in Phil Health when pregnant regardless of ability to pay?

Would you consider the effects of nurse migration, or HCP migration to be a contributing factor to the MMR in the Philippines?

What kind of health facility would you prefer to work in?

If you yourself were seeking care, what kind of facility would you seek for your treatment?

Appendix H: Questionnaire with Birth Mothers

Date:

Interview #:

Community/Barangay:

Pseudonym:

Demographics:

Age:

Religion:

Marital status:

As young female, how would you describe the current status of women in your country, or from the region you come from?

Do you think women's health is promoted enough?

Are maternal health services advertised in your community?

Where did you go to for maternal health care- pregnancy, labor and birth, and postpartum (after birth) needs? Who provided you with care during these times?

Were you able to see a nurse, physician, midwife or hilot? Who would you prefer to see?

Where would you prefer to deliver: at home, midwifery clinic, public hospital or private hospital? Can you explain why?

What are some your experiences with maternal health care like?

What kinds of services in your community are available to you during pregnancy and childbirth?

Can you tell me where these services are available?

Are there public or private health care facilities?

How far are these services from where you live?

Do you receive better care at different places? Can you tell me why you think this?

Are you easily able to find important information regarding pregnancy in your community?

How many facilities in your community are accessible to you? How far?

Do you feel these health facilities provide appropriate care?

How do you get to your health clinics or hospitals?

How do you feel about the quality of the care you received?

Is it difficult to find a doctor, midwife, nurse or hilot to be present during your child's birth? How do you find one?

Have you ever been offered family planning services or services available to you during your pregnancy?

Were you provided iron, or prenatal supplements? Did you have to pay?

Are you a Phil Health member?

What services do you have access to?

Did you have to pay out of pocket payments for your care?

Were you reimbursed for services used at health facilities?

Has anything ever prevented you from having the services and health interventions that you needed? If so, what?

What would you, as users of the health care services, suggest changing when it comes to planning programs or access to health facilities for your maternal health needs?

Appendix I: Interview Guide with Midwife Instructors

Date:

Interview #:

Community/Barangay:

Pseudonym:

Demographics:

Age:

Profession:

Religion:

Marital status:

How long have you been a midwife?

Did you enjoy your role as a midwife?

Can you tell me about your scope of practice?

Where did you practice before becoming a midwife instructor? Are you still practicing?

Did you have any challenges in your profession as a midwife? If yes, can you describe?

What made you pursue the opportunity of becoming a midwifery instructor?

Why did you chose a line of midwifery education?

Do you enjoy this role?

What are the duties of a midwifery educator?

Can you tell me about the curriculum or major topics involved in midwifery education?

Is pharmacology included in this curriculum? Why or why not?

Do you think this curriculum should include anything that it doesn't already include?

Can you tell me about how ethics is integrated in the curriculum?

What are the priorities that are emphasized in midwifery clinical rotations?

What is the role of the student midwife in clinical practice?

Where do students normally perform their clinical or practical education?

Are students usually comfortable with the clinical guidelines used in midwifery care?

Are briefings or debriefings included in midwifery education, or during clinical experiences?

Is there competition or conflict between midwives or nurses in the delivery room setting?

Can you tell me about the interdisciplinary interactions between midwives, nurses and physicians in practice?

Appendix J: Interviews with Nursing Instructors

What is your background (nursing/medicine)?

Did you enjoy your role?

Can you tell me about your scope of practice?

Where did you practice before becoming a nursing instructor? Are you still practicing?

Did you have any challenges in your profession? If yes, can you describe?

What made you pursue the opportunity of becoming a nursing instructor?

Why did you choose a line of nursing education, as opposed to medicine or midwifery?

Do you enjoy this role?

What are the duties of a maternity nursing educator?

Can you tell me about the curriculum or major topics involved in maternal nursing education?

Is an in-depth pharmacology course included in this curriculum? Why or why not?

Do you think this curriculum should include anything that it doesn't already include?

Can you tell me about how ethics is integrated in the curriculum?

What are the priorities that are emphasized in maternal clinical rotations?

To what extent do student nurses perform clinically during these rotations?

What is the role of the student nurse in delivery room/maternal nursing clinical practice?

Where do students normally perform their clinical or practical education?

Are students usually comfortable with the clinical guidelines used in maternal health or delivery care?

Are briefings or debriefings included in maternal nursing education, or during clinical experiences?

Is there competition or conflict between midwives or nurses in the delivery room setting?

Can you tell me about the interdisciplinary interactions between midwives, nurses and physicians in practice?

Appendix K: Interviews with Nursing Students

Where are you from?

What year are you in?

Is this your first degree?

Why did you enter this program?

Have you enjoyed nursing school so far?

What are your favourite placements?

Do you have a job outside of nursing school? If yes, doing what?

Did you have any challenges in this professional degree? If yes, can you describe?

What made you pursue the opportunity of becoming a nurse?

Why did you chose a line of nursing education, as opposed to medicine or midwifery?**

Do you enjoy this role?

What were your thoughts when you first studied maternal health or delivery room nursing?

Can you tell me about the curriculum or major topics involved in maternal nursing education?

Is an in-depth pharmacology course included in this curriculum? Why or why not?

Do you think this curriculum should include anything that it doesn't already include?

Can you tell me about how ethics is integrated in the curriculum?

Can you tell me about the curriculum or major topics involved in maternal nursing education?

Is an in-depth pharmacology course included in this curriculum? Why or why not?

Do you think this curriculum should include anything that it doesn't already include?

Can you tell me about how ethics is integrated in the curriculum?

What are the duties of a maternity nursing student?

Are you interested in maternity nursing? Why or why not?

Have you considered, or do you want to become an delivery room nurse? Why or why not?

Can you tell me about your scope of practice as a maternal health or delivery room nurse?

What are the priorities that are emphasized in maternal clinical rotations?

What is the role of the student nurse in delivery room or maternal nursing clinical practice?

What skills do you get to perform clinically during these rotations?

Where do students normally perform their clinical or practical education?

Are you comfortable with the clinical guidelines used in maternal health or delivery care?

Do you feel prepared when doing rotations in these settings?

Are briefings or debriefings included in maternal nursing education, or during clinical experiences?

Have you ever worried about your own safety or safety of mothers during these clinical experiences?

Is there competition or conflict between midwives or nurses in the delivery room setting?

Can you tell me about the interdisciplinary interactions between midwives, nurses and physicians in practice?

Would you say the opportunity of migrating as a nurse led you into this profession?

Are you aware of places abroad where you can work as a nurse?

Would you say the curriculum is based on the goal of nurse migration? Are you encouraged to migrate or work in country?

How are you funding your education? Are scholarships available to you?

Are you planning on taking the NCLEX exam?

Where would you like to work when you graduate? What kind of facility?

Is there anything else you want to share with me about maternal health or delivery room nursing experiences?

Appendix L: Interviews with Midwifery Students

Where are you from?

What year are you in?

Is this your first degree?

Why did you enter this program?

Have you enjoyed midwifery school so far?

What are your favourite placements?

Do you have a job outside of university? If yes, doing what?

Did you have any challenges in this professional degree? If yes, can you describe?

What made you pursue the opportunity of becoming a midwife?

Why did you chose a line of midwifery, as opposed to medicine or nursing?**

Do you enjoy this role?

What were your thoughts when you first studied maternal health/ delivery room skills?

Can you tell me about the curriculum or major topics involved in midwifery education?

Is an in-depth pharmacology course included in this curriculum? Why or why not?

Do you think this curriculum should include anything that it doesn't already include?

Can you tell me about how ethics is integrated in the curriculum?

Can you tell me about your scope of practice as a midwife (student midwife)?

What are the priorities that are emphasized in maternal clinical rotations?

What is the role of the student midwife in delivery room or maternal nursing clinical practice?

What do your duties include as a midwifery student?

What skills do you get to perform clinically during these rotations?

Where do students normally perform their clinical or practical education?

Are you comfortable with the clinical guidelines used in maternal health or delivery care?

Do you feel prepared when doing rotations in these settings?

Are briefings or debriefings included during clinical experiences?

Have you ever worried about your own safety or safety of mothers during these clinical experiences?

Is there competition or conflict between midwives or nurses in the delivery room setting?

Can you tell me about the interdisciplinary interactions between midwives, nurses and physicians in practice?

Would you say the opportunity of migrating led you into this profession?

Are you aware of places abroad where you can work?

Are you encouraged to migrate or work in country?

How are you funding your education? Are scholarships available to you?

Where would you like to work when you graduate? What kind of facility?

Is there anything else you want to share with me about your midwifery experiences?

Appendix M: Confidentiality Agreement for Research Assistants

In signing this document, I understand that my role in this research project is to help compile and transcribe data pertaining to the sensitive nature of maternal death and subjective experiences and opinions expressed by participants. I understand that it is of the utmost importance to protect the privacy of all participants involved. I have been given the opportunity to ask questions, and to have these questions answered adequately. In signing this consent form, I agree that I will not disclose any findings or personal or identifying information collected, or that is related to this study, to anyone other than the lead researcher, Krisanne Thibodeau.

I, _____, agree to maintain confidentiality regarding this research project by all reasonable measures possible.

Signed:

Date: