Support from the Government of Australia for an Evidence-Based Approach to Planning for Maternal, Newborn and Child Health in the Philippines
Progress in maternal, newborn and child health (MNCH) in the Philippines has been variable. Overall, achievement in child health has been good; the nation is likely to reach the Millennium Development Goal (MDG) targets for under-five and infant mortality. However, despite considerable efforts within the country and support from development and academic partners over recent decades, major constraints (“bottlenecks”) and wide disparities persist. These challenges include low prioritization of MNCH; complex and unreliable funding arrangements; weak accountability and technical capacity at district level; inadequate collection and use of data; a lack of human resources and sufficient supervision of those in place; low health literacy and related behaviour, and poor quality of care. Based on lessons learned in an earlier pilot of the Investment Case (IC) approach, UNICEF and the University of Queensland Consortium (UQc), in collaboration with central and district government partners, developed a new set of activities at national and sub-national levels. The new “evidence-based planning” (EBP) approach again focuses on supporting prioritization, planning and budgeting of MNCH activities at district and sub-district levels, but also includes national and regional advocacy, management strengthening, training and technical support for child health. Bottleneck analysis, use of local data and engagement of both health and non-health authorities remain key elements of the process, which is being supported in three local government units (LGUs), all cities, over 2012-2014. Progress has been very encouraging, with enthusiastic uptake in each LGU, identification and implementation of locally prioritized interventions, the establishment of multi-sectoral technical support teams and buy-in from related national authorities. Moreover, additional requests for capacity building and technical input from the Department of Health (DoH) and the national insurer signify close engagement with government authorities at national level. However, significant delays in implementation of activities have occurred since the Philippines Government cancelled all development assistance to areas not affected by typhoon Haiyan for three months, beginning mid-November 2013. Independent, formal evaluation of the programme will be completed by mid-2014.

1 UQ Consortium (UQc) is led by the University of Queensland, and involves the Nossal Institute for Global Health, and local academic partners within the Philippines.
What is the problem?

Over the last decade, despite reasonably consistent economic growth, progress on MNCH in the Philippines has been variable. As a nation, although it should reach the MDG 4 targets on infant and under-five mortality, it is unlikely to reach the MDG 5 target on maternal mortality. Within those areas, there has been good progress on communicable disease control through vaccination and access to safe water and sanitation (Figure 1), but uptake of improved maternal and newborn health services remains poor for some groups.

Government attention to health has improved, with numerous new Acts, Bills and Orders introduced, and substantive increases in health funding, including for MNCH. However, these increases have not raised the government’s contribution to total health expenditure (THE), which declined from 47.6% in 2000 to only 33.3% in 2011 (www.databank.worldbank.org); the contribution of social health insurance to THE has remained at around 10% and funding for MNCH as a proportion of the national DoH budget has declined; absorptive capacity for government funding is limited. Bottlenecks related to policy, governance, financing and staffing impact access to and the quality of healthcare. The mix of these factors varies widely across this diverse country. Significant disparities along geographic, demographic and socio-economic lines, and also according to women’s education, indicate inequity in healthcare access, uptake, supply and quality (Figure 2).

Although these bottlenecks and inequities have been acknowledged by both government and development partners for years, progress on closing these gaps is slow, despite several major health reform packages since 1991. Most recently, the DoH has launched the Aquino Health Agenda framework for universal health coverage (UHC), which includes an improved social health insurance package, administered by the national insurer, PhilHealth. The DoH with support from international agencies and

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**Figure 1: Improved drinking water and sanitation coverage**

**Improved drinking water coverage**
- Piped on premises
- Other improved
- Unimproved
- Surface water

**Improved sanitation coverage**
- Improved facilities
- Shared facilities
- Open defecation

Source: WHO/UNICEF JMP 2012

Source: www.countdownmnch2015.org
**Figure 2: Profile on equity in MCH indicators, Philippines, 2012**

**Socioeconomic inequities in coverage**

Household wealth quintile: ● Poorest 20% ○ Richest 20%

- Demand for family planning satisfied
- Antenatal care 1+ visit
- Antenatal care 4+ visits
- Early initiation of breastfeeding
- ITN use among children <5 yrs
- DTP3
- Measles
- Vitamin A (past 6 months)
- ORT & continued feeding
- Careseeking for pneumonia

DHS 2007

Coverage levels are shown for the poorest 20% (red circles) and the richest 20% (orange circles). The longer the line between the two groups, the greater the inequality. These estimates may differ from other charts due to differences in data sources.

Source: www.countdownmnch2015.org

The most recent data on MNCH in the Philippines can be summarised as follows:

- The under-five mortality rate (U5MR) was an estimated 25 deaths per 1,000 live births in 2011, a decline of 56.1% since 1990. The MDG 4 target is 19 or less by 2015 (UNICEF, 2012).
- Both UN and local survey data suggest that progress on reducing child malnutrition and improving household energy intake is inadequate for the MDG 1 nutrition targets to be met.
- Disparities in under-five and infant mortality by income remain high, but are improving by maternal education level.
- Disparities also exist for certain health system performance indicators such as early introduction of breast-feeding, but have almost disappeared for vaccination.
- Local data report that the maternal mortality ratio (MMR) increased from 162 per 100,000 live births in 2006 to 210 in 2010. However, UN statistics report a fall from 170 in 1990 to 99 in 2010; the published MDG 5 target is 43 or lower, by 2015 (www.childinfo.org).
- Although improving, skilled attendance at birth remains low (72% in 2011); 78% of women attended four antenatal visits. Major disparities in maternal health service uptake exist, particularly by education level, and to a lesser degree by income and place of residence.

On the *demand side*, there is disparate uptake of certain critical health-related practices. Disparities are low for some practices, for example any breastfeeding and vaccination coverage, but higher for exclusive breastfeeding, antenatal care, modern contraceptive prevalence, skilled birth attendance, facility-based delivery and adequate energy intake. Similar differences

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2 Preceding MNCH data taken from baseline assessment by independent evaluators, Mario Villaverde and Don Matheson, March 2013.
in the *supply* of interventions known to save lives and improve child development exist, by geography, local average income and particularly in urban areas according to whether the local population is well-established or is newly settled. Disparate *quality of care* also exists between and within districts in the Philippines, which is a major exporter of human health resources but experiences a serious lack of such resources in many parts of the country. Total health expenditure (THE) in the Philippines has increased dramatically, especially due to an explosion in unregulated private health services.

**Figure 3: Sources and flow of funds within the Philippines’ health sector**

[Diagram of health financing flows in the Philippines]

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**MNCH challenges**

The obstacles to reducing inequities in MNCH in the Philippines are not unique, but certain issues are specific to this context. Based on the experience gained in an earlier iteration of the IC work (2009-2011), and since inception of this project, the major challenges are listed in Box 1.

These characteristics have the most significant impact on the poorest households and are not unique to the health sector. Improving MNCH outcomes requires the engagement of multiple health and non-health actors at all levels. DFAT’s programme thus supports a systems approach to the funding and implementation of the Philippines’ decentralized social sector programmes.

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**Box 1: Challenges to reducing MNCH inequities in the Philippines**

1. Substantive national and sub-national policy support, but weaker engagement of non-health authorities with an influence on budget allocation and planning.
2. Substantial government funding, but complex mechanisms for its allocation and disbursement (Figure 3).
3. Decentralization has delegated the prioritization of health programmes and allocation of budgets to over 1,000 sub-national authorities, some of whom have low technical, absorptive and management capacity.
4. In proportion to the total national budget allocated to the DoH, the share allocated to MNCH has decreased from a peak of 22% in 2010 to a low of 10% in 2013.
5. Low physical access to services in poorer rural and urban areas; poor referral systems.
6. Lack of trained personnel, especially specialist services in poorer rural and urban areas; quality of care in some public and many private facilities is so weak, they are unaccredited by PhilHealth.
7. New national MNCH policies are not implemented due to lack of training, especially of private providers.
8. A lack of supplies at public facilities, due to a lack of budget allocation at local level, resulting in patients having to purchase same out of pocket.
10. Weak information systems and use of data for local decision-making/prioritization.
11. Low capacity to plan, implement and monitor MNCH activities; low incentives to improve MNCH outcomes, and weak accountability for the use of available funds.
12. Weak engagement of the most vulnerable communities and poor health literacy; persistent traditional MNCH practices that place women and children at risk.
What is DFAT support providing to EBP?

DFAT funding for EBP evolved from earlier support for an IC approach for MNCH in South and East Asia. The current DFAT grant commenced in June 2011 and also supports work in Nepal, Indonesia, Bangladesh and India. Funds are channelled through UNICEF, supported by its regional offices and global headquarters, and through UQc working with domestic research and development centres. Funding is scheduled to end in June 2014.

The IC and EBP approaches arose from global recognition that technical, service-focused health interventions have had limited long-term impact. The first iteration of the IC was co-funded by the Gates Foundation. EBP targets MNCH policy, planning, prioritization, budgeting, implementation, monitoring and evaluation, at national and sub-national levels. The focus on MNCH has high-level support from the Philippine’s government. The objective is to provide a compelling foundation for a new and sustained approach to MNCH, based on locally generated data and evidence, and driven by local stakeholders. It is also hoped to influence national MNCH policy, prioritization and allocation of funds, and ultimately related MNCH indicators. This is particularly relevant in the context of the Philippine’s move towards UHC.

Experience with the IC in Northern Samar and Eastern Samar provinces and Pasay City in 2009-2011 informed the current EBP initiative. Challenges noted in these earlier pilots involved both national and sub-national bottlenecks. While the IC approach was seen as a useful addition to well-regarded existing national approaches to health planning and budgeting, it did not adequately engage local non-health authorities or the private sector, diluting ownership and sustained uptake. Bottleneck analysis was very much appreciated, but the costing simulations and matrix used were too complex. Numerous implementation constraints were identified, including fragmentation of responsibilities and weak coordination among national and local agencies involved in MNCH; uncertain or delayed funding from multiple different channels, and lack of local discretion on funding for health; lack of local government buy-in; inadequate supply of commodities, and low demand. These problems called for a refining of the approach, stronger alignment with existing planning approaches (including the Aquino Health Agenda for UHC and the National Objectives for Health, Province and City-wide Investment Plans for Health and Annual Operations Plans (PIPH, CIPH, AOPs), a stronger focus on local data gathering and ownership, a reduced focus on simulation and costing, and more intensive advocacy at all levels. UNICEF and UQc learned from these pilots and incorporated those lessons in the design of the current, DFAT-supported initiative.
A second iteration of the IC/EBP is now being implemented, with support from local government and academia in three urban LGUs – Davao City, Quezon City and Puerta Princesa. The focus on cities acknowledges an emerging problem for MNCH in the Philippines – the supply of services for newly arrived rural-urban migrants. The initiative involves collaboration with health and non-health authorities at each level of the health service, and uses a simplified approach to prioritizing, planning and budgeting MNCH activities at district level. Bottleneck analysis remains a major component, but there is less focus on detailed costing. Moreover, the approach taken has more explicitly involved DoH-level authorities and is also supporting activities at higher levels, on health planning, approaches to child health insurance, governance and leadership training, introduction of blended learning in certain technical areas and refining the DoH’s urban health strategy (in partnership with WHO). UQc’s support includes deliberative engagement with LGU health and non-health authorities, detailed support for health planning, monitoring and evaluation using the bottleneck approach, and the development of resilience.

What has been undertaken so far?

UNICEF and UQc personnel are providing support on a wide variety of policy, advocacy, technical and research activities at several levels in the Philippines. As the only UN agency with access to both high echelons of government and a field programme at community level, UNICEF is uniquely able to support and advocate for an initiative such as EBP. UQc is providing quality technical support for training, implementation and replication of the EBP approach.

The following activities have been undertaken at national level and in three urban LGUs since 2012.

1. **A detailed analysis of the MNCH situation and related policy, financing, planning and budgeting in the Philippines**, undertaken in 2012 by international and local experts (Professor Don Matheson and Dr Mario Villaverde). This succeeded an independent analysis of the phase one pilots by Ian Anderson in 2012. Both of these provided a solid foundation for the current approach, and for more detailed follow-up reviews to be undertaken in 2014.

2. **EBP exercises** in the three cities in 2013, informing their AOPs and budget proposals for 2014. (The AOP assists national government to provide additional resources to LGUs within the Philippines decentralized health system framework.) Based on lessons learned from the earlier IC pilot, extensive revision of the prioritization, planning and budgeting process was undertaken. UNICEF and UQc have assisted the EBP process and local advocacy efforts; embedding these processes into PIPH, CIPH and AOP activities, and selection of specific examples to better elucidate implementation constraints, in the three cities. Examples of priority focus areas for the Philippines are provided in Figure 4. BP has thus focused on community-level identification and management of acute malnutrition in Davao City (so far screening 25% of all under-5 children in the city and managing 144 children with severe acute malnutrition); training of basic health-workers, data gathering and community engagement in Puerta Princesa, and a variety of quality
improvement and human resource strengthening in Quezon. Project counterparts in all three cities perceive that the approach has increased local ownership and participation of non-health authorities. Regular meetings and advocacy have, for example:

a. Engaged with barangay councils on community nutrition improvement and yielded a statement of support from the Mayor’s Office representative in Davao; elicited increased engagement of grassroots-level medical officers and local politicians in Quezon, and aligned well with a re-integration of the City Health Department with local government in Puerta Princesa.

b. Not neglected the difficult job of improving demand and service uptake. In each of the cities the bottleneck analysis has recommended a focus on community engagement and knowledge-building (again,
with local leaders as well as the population) and improving confidence in local MNCH services. This has, of course, necessitated improvement of the quality and reliability of services, usually through supply and human resource improvements, which are in development.

Ongoing work to enhance capacity for independent EBP is being undertaken in 2014. Regular visits to train and follow up on EBP activities have been conducted in the three cities over 2013 and 2014. Moreover, to ensure sustainability, a core group of at least five LGU staff from the health, planning, and budget offices of each city have been trained as EBP facilitators, and will apply their skills in facilitating EBP for the 2015 AOP.

In addition, engagement with higher levels of government has increased the likelihood of this DFAT-supported project having a lasting and broader impact in the Philippines. Focus areas include:

1. **Revision of the national PIPH/CIPH guidelines**, led by the DoH-Bureau of Local Health Development, supported by UNICEF and a national institution. The guidelines will incorporate lessons learned from the three EBP pilots, particularly on bottleneck analysis and related issues, and the support that LGUs receive from DoH.

2. **Estimating the cost and impact of scaling-up essential early newborn care (EENC) interventions**: in the context of static newborn mortality rates and a national focus on essential early newborn care (EENC), UNICEF supported a two-day simulation exercise on the cost and impact of scaling up EENC interventions. The DoH focal point (Dr. Anthony Calibo) learned about the simulation methodology, a costing tool developed for the earlier IC work, and also various scenarios/results from UQc staff. He will use the results to advocate for EENC scale-up to the DOH and the broader RMNCH community, and to develop a monitoring and evaluation plan for EENC.

3. **PhilHealth benefit packages for under-five and school-age children**: the national insurer plans to launch new benefit packages for children in 2014. UNICEF will shortly contract a national research institution to support this work. The benefit packages will be informed by the EBP pilots, in particular aiming to address financial bottlenecks for MCH services.

4. **Mainstreaming EBP into the Health Governance and Leadership Program (HGLP)** of the Zuellig Family Foundation (ZFF) and DoH will be attended by the mayors and health officers of 609 LGUs in coming years. ZFF will introduce EBP to strengthen the planning domain within their course, providing an opportunity to mainstream key elements of the process and lessons from the pilots among very influential authorities. UNICEF is currently transferring the EBP methodology and lessons to ZFF staff and coaches.

5. **Refining the Urban Health Strategy of the DoH**: UNICEF is currently researching population dynamics in cities and the implications for health planning, budgeting and service delivery. This will be a starting point for discussions with the DoH on its Urban Health Strategy, and is also relevant to revision of the planning guidelines described above.

6. **A revised approach to training on IMCI**: There is recognition from both the DoH and LGUs that the traditional 11-day training for IMCI is not feasible for scale-up. UNICEF may support a blended-learning approach for this work, pending a go-ahead from the DOH.
7. Active promotion of EBP in the context of other health development activities, including in the aftermath of Typhoon Haiyan:

a. UNICEF liaised with WHO which previously supported piloting of the global Urban Health Equity Assessment and Response Tool (Urban HEART) initiative in Davao, and in Tacloban, the city hardest hit by Typhoon Haiyan. Urban HEART both assessed health inequities and aimed to facilitate decisions on viable and effective strategies and interventions to reduce them. A 2012 evaluation identified the need for support from local authorities, a multi-sectoral and user-friendly approach, local financing and linking the tool with local planning processes, echoing the evaluation of the 2009-2011 IC work, and was useful for developing the current EBP pilots.

b. UNICEF and UQc are currently discussing the introduction of the EBP approach and resilience activities in Tacloban and other areas affected by the typhoon, and possibly elsewhere in the Philippines.

8. Launching of “A Promise Renewed” in the Philippines: It is increasingly difficult to attract international support for MNCH in the Philippines because of the nation’s success in reducing the U5MR. However, static newborn and possibly maternal mortality indicate persistent, linked challenges. The EBP pilots have drawn attention to these at high level, and such a launch will draw attention to outstanding issues and what these mean for maternal and young child survival, growth and development and the national economy.

Local funding is not the main issue; rather, support is needed for systems strengthening, particularly in the areas of leadership, governance, health information systems, quality of care and demand-side service strengthening. The ground is currently fertile for national government action in these areas.
Challenges to the sustained expansion of EBP

UNICEF and UQc fully acknowledge the difficult environment for an initiative that focuses on upstream concepts like EBP, budgeting and advocacy. Human resources (numbers and capacity, turnover, and the temptation to move to the private sector or go abroad), lack of data, the local political environment and systemic financial complexities in a decentralized context all create major challenges. Evaluating and sustaining a new process that prioritizes activities previously considered routine (planning and budgeting) is difficult. Intensive advocacy at all levels and the engagement of relevant authorities beyond technical experts at the DoH and in the Finance and Planning Ministries are required, and related data collection must be institutionalized. It is inadequate to rely on second- or third-tier officials to promote the issues being targeted by this programme; fortunately successive health reform initiatives including the 2010 Aquino Health Agenda acknowledge the importance of equity and the need for multi-stakeholder health planning and appropriate budgeting at local level. A final challenge will be to ensure that funds are allocated by local authorities for EBP itself, and that it remains embedded in the PIPH/CIPH/AOP processes. It is imperative that planning itself is prioritized by local government.
Where to from here?

UNICEF, UQc, academic and government partners at national and local levels have established excellent working relationships in the Philippines. Typhoon Haiyan’s clouds may have a silver lining in enabling this relationship to continue beyond the three LGUs where activities are progressing. While activities in this phase have focused on urban districts, there is every reason to believe that efforts to simplify the approach and embed it in existing planning processes make it highly appropriate for poor rural areas too.

Objectives have been agreed with counterparts at all administrative levels, and include:

- Improved (timely) flow of national funds earmarked for health and MNCH to district level, and a proportional increase in the volume of such funds;
- Increased engagement and capacity of local health and government authorities in health sector planning and oversight;
- Improved collection and use of data to influence allocation of funds for MNCH at all levels, and for communication of planning priorities (i.e. EBP);
- An increase in the evidence base for MNCH-related activities in health and other sectors.

Ultimately EBP is one of several levers to encourage relevant authorities in the Philippines to overcome key challenges to MNCH and potentially other social sector programmes. Other options might include major reforms to their financing, the introduction of performance-based assessment of government departments and personnel, and sustained improvement of human resource capacity and other systems elements. These are all potential areas for future DFAT support in this country.