Evaluation of the “Accelerating the Implementation of the Investment Case for Maternal, Newborn and Child Health in Asia and the Pacific” Programme

Background findings: PHILIPPINES

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<tr>
<td>AusAID</td>
<td>Australian Agency for International Development</td>
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<td>AHA</td>
<td>Aquino Health Agenda</td>
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<td>ARMM</td>
<td>Autonomous Region in Muslim Mindanao</td>
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<td>AOP</td>
<td>Annual Operational Plans</td>
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<td>BEmONC</td>
<td>Basic Emergency Obstetric and Newborn Care</td>
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<td>BFHI</td>
<td>Baby Friendly Hospital Initiative</td>
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<td>BHS</td>
<td>Barangay Health Stations</td>
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<td>CEmONC</td>
<td>Comprehensive Emergency Obstetric and Newborn Care</td>
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<td>CHD</td>
<td>Centres for Health Development</td>
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<td>CIPH</td>
<td>City wide Investment Plan for Health</td>
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<td>CPR</td>
<td>Contraceptive Prevalence Rate</td>
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<td>DBM</td>
<td>Department of Budget Management</td>
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<td>DOH</td>
<td>Department of Health</td>
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<td>DP</td>
<td>Development Partner</td>
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<td>FCTC</td>
<td>Framework Convention for Tobacco Control</td>
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<td>FHS</td>
<td>Family Health Survey</td>
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<td>GAVI</td>
<td>Global Alliance for Vaccinations and Immunization</td>
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<td>GF</td>
<td>Global Fund to Fight AIDS, Tuberculosis and Malaria</td>
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<td>HSRA</td>
<td>Health Sector Reform Agenda</td>
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<tr>
<td>HPNSDP</td>
<td>Health Population and Nutrition Sector Development Program</td>
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<td>IC</td>
<td>Investment Case (for Maternal, Newborn and Child Health)</td>
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<td>IP</td>
<td>Implementation partners</td>
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<td>IRA</td>
<td>Internal Revenue Allotment</td>
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<td>IYCF</td>
<td>Infant and Young Child Feeding</td>
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<td>LGU</td>
<td>Local Government Unit</td>
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<td>MBB</td>
<td>Marginal Budgeting for Bottlenecks</td>
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<td>MDG</td>
<td>Millennium Development Goal</td>
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<td>MOHFW</td>
<td>Ministry of Health and Family Welfare</td>
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<td>MOA</td>
<td>Memorandum of Agreement</td>
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<td>MTEF</td>
<td>Midterm Expenditure Framework</td>
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<td>MTPIP</td>
<td>Medium Term Public Investment Program</td>
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<td>RMNCH&amp;N</td>
<td>Reproductive Maternal, Newborn, and Child Health and Nutrition</td>
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<td>NDS</td>
<td>National Demographic Survey</td>
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<td>NEDA</td>
<td>National Economic and Development Authority</td>
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<td>NGO</td>
<td>Non-governmental organization</td>
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<tr>
<th>Acronym</th>
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<tr>
<td>NHIP</td>
<td>National Health Insurance Program</td>
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<td>NOH</td>
<td>National Objectives for Health</td>
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<td>ODA</td>
<td>Official Development Assistance</td>
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<td>OPIF</td>
<td>Organisational Performance Indicator Framework</td>
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<td>PDP</td>
<td>Philippine Development Plan</td>
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<td>PIPH</td>
<td>Province wide Investment Plan for Health</td>
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<td>RHU</td>
<td>Rural Health Units</td>
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<td>SDAH</td>
<td>Sector Development Approach to Health</td>
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<td>SLA</td>
<td>Service level Agreement</td>
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<td>THE</td>
<td>Total Health Expenditure</td>
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<td>TOR</td>
<td>Terms of reference</td>
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<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<td>UQc</td>
<td>The University of Queensland consortium</td>
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<td>WHO</td>
<td>World Health Organization</td>
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The Philippines is on track to achieve MDG 4, and will struggle to achieve MDG 5.

The country is doing well in reducing under-5 and infant mortality rates, reducing morbidity and mortality rates from malaria and tuberculosis, and increasing coverage of households with access to safe water and sanitation facilities. The exception in the under-5 group is for newborn, where mortality has not declined. The country needs to strengthen and improve its approach in three major areas: attaining universal primary education, improving maternal health and reducing maternal mortality, and eradicating extreme poverty which is crucial to the attainment of goals related to hunger and childhood malnutrition.

Of particular concern is maternal mortality and neonatal mortality, with the latest data suggesting maternal mortality has increased and newborn mortality has remained unchanged. Coverage of relevant programs (such as family planning and institutional deliveries) are uneven, with poverty, rurality, low education levels being closely linked to lower levels of coverage. Most maternal and neonatal deaths in the Philippines occur during the delivery phase and the first two days after delivery, pointing to weaknesses in the delivery of maternal and neonatal health services and the continuum of care over this time period.

In response, the DOH issued a policy to reduce maternal and neonatal mortality in 2008 and since then there has been a noticeable upsurge in the proportion of pregnant women delivering in health facilities and attended by skilled birth attendants, and the gap based on income status seems to have narrowed, however wide disparity is still observed based on education level.

Substantive progress is seen with Immunisation. National coverage levels of 91 per cent are close to achieving universal coverage, and in terms of equity measures, the disparities in immunization coverage between higher income groups and lower income groups, between those living in urban areas and rural areas, and between those whose mothers have higher education and those with no education have narrowed. Nutrition has a more mixed picture. The proportion of malnourished children had been reduced from 1990 to 2005. However, it went up to slightly in 2008.

There is very active engagement and leadership in support of RMNCH&N from senior government leadership and national policies for strengthening maternal and child health have been institutionalized with the enactment of several pieces of legislation. It has had focused attention from Congress, the President, and the Department of Health, all of whom have passed numerous Bills, Executive Orders, and policies respectively.

There has been a doubling of national government expenditures for health in recent years to Php 42.4 billion in 2010 and the continuous increase in local government spending for health to Php 58.0 billion in 2010. However as a percentage of total health expenditure, the government share has actually declined from 40.6 percent of Total Health Expenditure in 2000 to only 26.5 in 2010, with out of pocket expenditure being the main source of financing. The total national budget allocation to MNCHN-related programmes amounted to almost Php 32 billion and has increased, but the
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Absorptive capacity remains a major concern, and it has halved as a proportion to the total national budget allocated to DOH. Health financing is fragmented with overlapping streams of funding that are managed independently of each other. While the devolution of health services to LGUs in 1991 brought health planning, decision-making, management and implementation of health programmes closer to the constituents, it also brought government financing for health services under the control of more than a thousand officials from DOH, PhilHealth, and LGUs (governors and mayors) leading to coordination and harmonization problems. In addition, private sector financing through out of pocket payments, which constitutes the other half of the health system, increases the fragmentation of health services and is major cause of inefficiency. Weak government stewardship of the private sector and lack of capacity for equitable planning and budgeting on LGU level also impacts on the quality of care provided.

The country is a undergoing a major reform in expanding social health insurance and its emergence as a potential major source of health financing is expected to have a positive impact on the health system in terms of changing health provider practices by both the public and private sectors, and in terms of people’s health seeking behaviour. However, the country is caught in a bind, as coverage in poor areas will not improve access and utilization because of major capacity gaps in service delivery infrastructures and human resources for health.

The government has well developed planning and investment processes at the national and subnational levels. Provincial and city investment plans for health translate national health goals into specific concrete actions at the local level. They become the basis for mobilizing and allotting resources from the national government and development partners to the LGUs. As an investment planning tool for local health development, a step-by-step Guide has been developed to provide pointers, tools, materials and references that can be used during the process of sub national planning and budgeting. The DOH also has a prioritisation process for allocating resources, based on issues such as; health impact, equity, political commitments, correcting variation in health performance levels.

Views differ on the value of the past IC activity in the Philippines. Groups involved in their implementation point to a number of successful outcomes of the IC activity. However, Philippine national and local officials with experience of the IC work take a more cautious view.

The main problems relate to the complexity of the tool and strong focus on the tool rather the process and its lack of fit with existing planning and decision making processes. The key DOH official views the use of the IC tool as too demanding of both time and the limited skills available at both national and local level, and sees its use as a research tool applied once every few years.

The Program logic for “Evidence Based Planning” developed jointly by 7th Government of the Philippines and the UNICEF national office intends to tackle these issues. There is a focus on equity, advocacy and alignment with existing government programs and planning cycles and a focus on urban slums. This is an opportunity to integrate the IC process with the current 7th Government of the Philippines - UNICEF country program and to share the lessons learned with a key cabinet committee.
INTRODUCTION

As the countdown for the achievement of the Millennium Development Goals (MDGs) proceeds, donors and implementation partners are asking if their efforts to accelerate improvements in maternal and child health are effective.

The Investment Case for Maternal, Newborn and Child Health (IC) in Asia and the Pacific has an ultimate goal of improving equitable progress towards achieving MDGs 4 & 5.

“Equitable progress” towards addressing the MDGs calls for closer attention to the progress being made by disadvantaged and marginalized groups in the country, even when their population numbers do not strongly influence the national statistics. Many countries are “on track” to achieve the MDGs while significant groups and populations within the country are being left behind. IC activities have a particular focus not only on the achievement of the MDGs, but on ensuring improved maternal and child health is enjoyed by all.

In developing the IC work as with any efforts in the health sector in Philippines, a stronger equity analysis is required to determine progress and “success”. The particular populations of interest from an equity perspective differ in each country. Common groups that are described from an equity perspective include urban/rural, high/low socioeconomic status, ethnicity and caste.

Investment Case Evaluation

The IC aims to provide policy-makers and development partners with the best available evidence for an equitable scaling-up of priority interventions that address the burden of Maternal, Newborn and Child mortality. It is a dynamic process that assesses the extent to which Reproductive, Maternal, New Born, Child Health and Nutrition (RMNCH&N) variables are equitably distributed, identifies key issues and influences impacts upon maternal and child health within a country. It involves results-based analysis to inform RMNCH&N planning, budgeting and policies, and spells out the costs and benefits of scaling-up packages of high impact interventions. The IC focuses on addressing the main health and nutrition problems of the most deprived children and families; identifying bottlenecks and barriers that contribute to this deprivation using the Tanahashi model (Tanahashi 1978; Tanahashi 1978); and identifying specific strategies to overcome the barriers that have created disparities.

This paper provides the baseline findings of an evaluation of an acceleration of the IC programme in the Philippines. UNICEF has been supporting these countries with tools for developing the IC since before 2011, and is coordinating the planned IC work in partnership with national and sub-national governments. This work is carried out in partnership with local research institutes, and the University of Queensland consortium (UQc) has been providing additional technical assistance in Nepal, the Philippines and Indonesia. However, given the different country contexts, processes and capacities, and variations in ways in which countries have adopted an inherently
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complex IC approach, there are differences in subsequent approaches and anticipated impacts and outcomes.

These four countries have been chosen because they are “early adopters” of the IC approach, and because each country has adopted the IC approach in different ways and at different levels. Within countries the focus is on specific districts or cities with the expectation that a wider system impact will result. The IC approach is designed to have an impact at both the national and sub-national level, such that activities may focus at the district or city level, but are expected to have an influence at the national level as well, and also impact on international partners. This baseline findings paper specifically addresses the IC programme in the Philippines.

This is an independent evaluation commissioned by UNICEF and funded by AusAID. The evaluation design is described in the report titled “Inception report of the independent evaluation” October 2012 (Matheson 2012).

Objectives of the Evaluation

The purpose of the overall evaluation is to assess the impact the IC approach has on MNCH and health equity, and to understand how this occurs. It focuses on evidence-based planning for RMNCH&N.

Specifically, in each of the four countries, the evaluation will:

1. Describe and assess how planning is undertaken, programmes are delivered, policies are crafted, and what processes are used to decide budgets;
2. Determine the political and subsequent budgetary priority given to MNCH&N in four countries;
3. Document the current use being made of the IC; and
4. Compare the IC process between the countries, and put forward lessons learned and recommendations.

This baseline report focuses on the first of the evaluation objectives and poses the following questions:

(A) What was the process of planning and budgeting before the introduction of the IC?
  - What organizations and people were involved?

1 “Analysis occurs first at the district level, with potential benefits arising both through the process of improving the quality and capacity for decision-making, and through reorienting the delivery of services. By synthesizing several district analyses, there are also potential beneficial impacts upon policy and programme design at national level. These analyses are also expected to guide the allocation of budgets and priorities of national and international partners, and to eventually be reflected in actual implementation (e.g. increased expenditure and actions for prioritized populations, interventions and strategies).” IC TOR
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- Do political decisions on budget allocations take into account technical advice from agencies such as health or DPs such as UNICEF?
- How are priorities arrived at, both in the health bureaucracy and within the political arm of government?
- At what level of government are these decisions being made?
- How was evidence used in this process?
- How was data used in this process?
- How was equity/inequity addressed?
- How were gender issues addressed?
- What focus was there on MNCH&N?

(B) What was the understanding of the key challenges/deficiencies of existing plans and budgets, especially in terms of addressing the needs of MCH and of the most deprived?

Evaluation process

This baseline findings paper forms a baseline report; it follows document reviews and introductory country visits, and an inception report describing the evaluation design. A final country case study report that assesses the outcomes of the IC work will be produced in 12 months’ time.
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BRIEF DESCRIPTION OF THE PHILIPPINE HEALTH SYSTEM

Organization of the health system

The Philippine health system comprises the public sector and the private sector (DOH 2005). Under this health system, the public sector consists of the Department of Health (DOH), other national government agencies, and more than 1,500 local government units (LGUs) providing health services. The DOH is mandated as the national lead agency in health. It provides national policy direction and strategic plans, regulatory services, technical assistance and capacity building, and national standards and guidelines for health. It has 16 regional field offices called Centers for Health Development (CHD); that is, one regional field office in each administrative region of the country. It also maintains several national specialty hospitals, regional hospitals and medical centres that provide tertiary specialized health services and specialty training of health professionals. Other national government agencies, such as the Department of National Defence, Philippine National Police, Department of Education, and Department of Labor and Employment, among others, also provide direct health services to specific sectors such as the military and the police, students and teachers, and the workforce within their respective mandates.

Under the Local Government Code of 1991, the LGUs are mandated to provide primary and secondary level health services, although most middle and high-income and large provinces provide tertiary levels of care. Under this set-up, the provincial government, headed by the provincial governor, manages the provincial and district hospitals while the municipal government, headed by the mayor, manages the Rural Health Units (RHUs) and Barangay Health Stations (BHSs). Highly urbanized and independent cities maintain and manage hospital services, health centres and barangay health stations. Every province, city or municipality has a local health board chaired by the local chief executive. Its function is to serve as an advisory body to the local executive and the sanggunian (local legislative council) on health-related matters. The DOH maintains representation on all local health boards.

As a distinct sub-national entity, the Autonomous Region in Muslim Mindanao (ARMM), consisting of five provinces, has a regional Department of Health headed by a regional Secretary of Health directly responsible to the Regional Governor. It directly administers the provincial, city and municipal health offices and the provincial and district hospitals within the autonomous region.
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The private sector, on the other hand, is generally a more disjointed health system consisting of thousands of for-profit and non-profit providers. Their involvement in maintaining the people’s health is enormous and their capacity augments the inadequacy of the public sector. The private sector includes, among others, individual and group practice clinics, laboratories, hospitals, drugstores, health insurance companies, pharmaceutical and medical supply manufacturers and distributors, research and development institutions, academic and training institutions, and other related health services including traditional healers and birth attendants. For-profit entities are largely run by self-employed health professionals, family-owned businesses or corporate entities. Non-profit entities, on the other hand, are commonly run by charitable institutions, faith-based organizations, civil society organizations and community-based volunteer groups.

Health financing system

The duality of the health system organization becomes more obvious in the context of the existing health financing system in the Philippines. The existing set-up is characterized by four critical factors related to the way funds for health are sourced and utilized (DOH 2010).

First, health financing remains fragmented with overlapping streams of funding source that are managed independently of each other (WB 2011) (DOH, 2010). While the devolution of health services to LGUs under the Local Government Code of 1991 brought health planning, decision-making, management and implementation of health programmes closer to the constituents, it also brought government financing for health services under the control of more than a thousand officials from DOH, PhilHealth,(see page 34) and LGUs (governors and mayors) leading to coordination and harmonization problems. Taking into account the private sector, which constitutes the other half of the health system, the fragmentation of health services and financing has become enormous and a major cause of inefficiency.
Second, total health expenditures (THE) remain on the low side compared with other middle income countries within the region, increasing only slightly as a percentage of GDP from 3.4 in 2000 to 4.2 in 2010 (NSCB 2012). Absolute amount of public spending on health increased, mainly because of the doubling of national government expenditures for health in recent years (from Php 24.4 billion in 2000 to Php 42.4 billion in 2010) and the continuous increase in local government spending for health (from Php 22.2 billion in 2000 to Php 58.0 billion in 2010). PhilHealth’s expenditure through the national health insurance programme also increased in absolute amount (from Php 8.0 billion in 2000 to Php 33.8 billion in 2010). In real terms, however, total government (national and local) expenditures for health and social health insurance only slightly increased through the years. As a percentage of total health expenditure, the government share has actually declined from 40.6 percent of THE in 2000 to only 26.5 in 2010 while PhilHealth’s share has remained less than 10 per cent of THE.

Third, out-of-pocket expenditure has accounted for over half of the total health expenditure and its share has increased through the years from 40.5 per cent of THE in 2000 to 52.7 percent in 2010 (NSCB, 2012). In effect, the health financing system does not provide individuals and families an adequate safety net from the financial consequences of illness. This situation points to a serious inequity in health where families, specifically the poorer sector of society, are forced to pay for health care at the time of need when they are most vulnerable.

Fourth, provider payment and incentive mechanisms play a key role in the behaviour of both the supply side and the demand side of the health system, and current DOH efforts have a stronger supply side focus with activities such as refurbishing buildings dominating. The public sector is largely financed through a tax-based budgeting system at national and local levels, which does not provide the right incentives for better performance in terms of quantity and quality. Historical-based budgeting is the main method used for allocating government budget and there is no clear relationship between the amount received by public hospitals and public health units and their performance. In contrast, the private sector is largely market-oriented and health services are generally paid through direct user charges at the point of service or, in some cases, through some form of social and/or private health insurance scheme. This set-up leads private health providers to where demand and capacity to pay are highest, mainly in urban centres. This poses a big challenge for the national and local government and PhilHealth in terms of harmonizing the current provider payment and incentive schemes.
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Health service capacity and delivery
There is a big capacity gap in health service delivery in both primary health care facilities and hospital services. Health infrastructure development, although given a large budgetary allocation in the last four years, has not kept up with the considerable growth of the Philippine population in the last three decades.

Capacity gaps are most prevalent in rural and hard to reach areas and in densely populated urban barangays – largely in informal settlements. In 2005, there were 2,374 Rural Health Units and 15,436 barangay Health Stations (DOH 2012). At the current Philippine standard of one Rural Health Unit per 20,000 population, there should be 4,750 RHUs; and at the current standard of one village health station per 5,000 population, there should be 19,000 village health stations. With these constraints, public health facilities at the primary level cannot cope up with the demands of a growing population.

Hospital bed capacity in the Philippines is also below the average compared to other countries in the region. Few new hospitals and hospital beds are being added. Private hospitals, which provide almost 50 per cent of hospital services in the country, are generally located in cities and large towns, but not covering informal settlers and urban slums – as expected, since they have to recover their investment. However, government hospitals, while expected to complement these services in underserved areas, are also located in large towns and cities, further exacerbating capacity gaps in the rural, semi-urban and slum areas. There is little emphasis on policies to influence the demand side.

In terms of human resources for health, the Philippines has more health workers per capita than other countries in the region. In fact, the Philippines is the leading exporter of nurses and the second leading exporter of physicians in the world. Off-shore workers are a major source of the country’s revenue. The country, however, is in a paradoxical situation where, as a major producer of health professionals, it has a dearth of the same resources on its shores, specifically in rural areas and urban poor communities, because of severe maldistribution of its health professionals.

The country, therefore, is caught in a bind, where a major reform in expanding social health insurance coverage in poor areas will not improve access and utilization because of major capacity gaps in service delivery infrastructures and human resources for health.

Health reforms in the Philippines (1991-2012)
The Philippines has implemented several reforms in the health sector in the last two decades, the most recent achievements being the passing in the last year of the reproductive health bill and the milk code. In 1991, a landmark legislation, known as the Local Government Code, transferred the management of government health services and facilities from the national government to LGUs, which resulted in the decentralization of health service delivery, the localization of decision-making in health, and fragmentation of the highly centralized public health system in the country. This was followed in 1995 with the enactment of the National Health Insurance Law, which established the government-owned Philippine Health Insurance Corporation (PhilHealth), and mandated the expansion of the then existing Medicare, which caters to the formal sector, into a bigger programme with the objective of providing universal social health insurance coverage, specifically among the informal and indigent sectors.

In response to these two major legislations, the Health Sector Reform Agenda (HSRA) was formulated in 1999 as the policy framework for the major sectoral and organizational reform strategies, policy changes and public investments needed to improve the way health care is delivered, regulated and financed. This framework served as the medium-term strategic plan for the health sector from 1999 to 2004. Building on the policy concepts and accomplishments of the Health Sector Reform Agenda, the government launched the “Formula One for Health” in 2005 as the strategic and operational framework for 2005-2010 to accelerate the implementation of health reforms along four areas: health financing, health regulation, health service delivery and good governance in health.

Most recently, the DOH launched the medium-term strategic framework (2011-2016) for Universal Health Care or Kalusugan Pangkalahatan, which further focused health reforms on three critical implementation challenges encountered in the previous decades: financial risk protection anchored on the expansion of enrolment and the benefit package of the national health insurance programme; enhancement of hospital and health facilities to improve access, utilization and quality of health services; and the attainment of the Millennium Development Goals, (MDGs) including goals for non-communicable diseases. The expansion of social health insurance in recent years and its emergence as a potential major source of health financing is expected to have a positive impact on the health system in terms of changing health provider practices by both the public and private sectors, and in terms of people’s health seeking behaviour.
Progress in attaining MDG 4 and MDG 5

With barely three years left for attaining its commitment to the MDGs for 2015, the Philippines is still faced with a number of challenges. Overall, the country is doing well in reducing under-5 and infant mortality rates, reducing morbidity and mortality rates from malaria and tuberculosis, and increasing coverage of households with access to safe water and sanitation facilities. However, the country needs to strengthen and improve its approach in three major areas: attaining universal primary education, improving maternal health and reducing maternal mortality, and eradicating extreme poverty which is crucial to the attainment of goals related to hunger and childhood malnutrition.

Based on the Philippine Progress Report on the Millennium Development Goals (NEDA 2010), there is a high probability of attaining goals and targets for child mortality reduction with the faster pace of improvements in under-5 and infant mortality rates. The neonatal mortality component, however, has barely improved in the last decade and much is needed to expand the coverage for neonatal care, particularly in the first two days of life. However, the probability of attaining goals and targets for improving maternal health is low, with slower progress in reducing maternal mortality and increasing universal access to reproductive health. Latest data (NSO 2012) revealed that maternal mortality has even increased from 162 to 221 for every 100,000 live births between 2006 and 2010. These national averages tend to hide disparities of performance in terms of income groups, geographic location, and educational attainment, among other parameters.

As the agency that is nationally mandated to take leadership for the attainment of the goals related to MDG 4 (Child Health) and MDG 5 (Maternal Health), the DOH with the collaboration of the LGUs has appropriately introduced a set of effective and well-defined policies and programmes in the last decade using the life cycle approach. The package of health services offers a wide range of health-related interventions from comprehensive maternal health care (pre-pregnancy, pregnancy, delivery and post-partum stages) to integrated child health services (neonatal, infant, early childhood, adolescent and youth stages).

The national policies for strengthening maternal and child health have been institutionalized with the enactment of several pieces of legislation, among which are Executive Order 51 “Milk Code of 1986”; R.A. 7600 “Rooming-in and Breastfeeding Act of 1992”; R.A. 8980 “Early Childhood Development Act of 2000”; R.A. 9288 “Newborn Screening Act of 2004”; and most recently, R.A. 10354 “Responsible Parenthood and Reproductive Health Act of 2012”. This legislation has been supplemented with the issuance of several administrative orders and guidelines that further strengthen the life cycle approach and the corresponding package of health
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services directed at each stage of the life cycle, such as A.O. 2008-0029 “Implementing health reforms for rapid reduction of maternal and neonatal mortality” (i.e., the MNCHN Policy); A.O 2009-0025 “Adopting new policies and protocol on essential newborn care”; A.O. 2010-0010 “Revised policy on micronutrient supplementation to support achievement of 2015 MDG targets to reduce under five and maternal deaths; and A.O. 2012-0009 “National strategy towards reducing unmet need for modern family planning”, to name a few. Also, the Integrated Management of Childhood Illnesses and the Expanded Program on Immunization, among others, have been strengthened and expanded at the community level in the past decade.

Key indicators related to the attainment of MDG 4 and MDG 5 have been institutionalized and tracked through the years. The key indicators described below are representative of health care performance at different stages of the life cycle approach.

Maternal care

Pre-pregnancy phase

The level of current use of contraceptive methods is the main indicator representative of the package of health services for women and mothers in the pre-pregnancy phase. It is the indicator most frequently used to assess the success of family planning programmes and the attainment of the overarching goal at this stage of the maternal cycle: that every pregnancy is wanted, planned and supported. With the country’s contraceptive prevalence rate target for 2015 of 80 per cent, there was only a very slight increase in Contraceptive Prevalence Rate (any method) from 40 per cent in 1993 (NSO 1994) to 49 per cent in 2011 (NSO 2012). With modern methods of family planning, however, CPR showed a moderate improvement from 25 per cent in 1993 to 37 per cent in 2011. Modern CPR is higher among the highest income group than the lowest income group. However, there is not much difference when comparing modern CPR between women in urban areas and women in rural areas. In the latest Family Health Survey (2011) the biggest disparity in performance is observed between those with higher education (37 per cent) and those with no education (13.4 per cent).

Data presented in this Baseline have been drawn with line graphs to show the relationship over time. The source for each of the data points is identified in each graph. Given that for some data points come from different survey methods, the graphs demonstrate general trends only. More specific inquiry as to the survey method is required to differentiate the differences between any two data points presented.
Comparison of CPR across countries in the region showed that the Philippines lags behind in contraceptive use (NEDA, 2010). This is a result of the lack of government policy and programmes to promote contraceptives in the past, although in December 2012 President Benigno S. Aquino III signed into law the "Responsible Parenthood and Reproductive Health Act of 2012". This finally settled a contentious debate between those who are in favour of a definitive reproductive health policy and promotion of artificial contraceptive methods and those who oppose it: the Philippines being a predominantly catholic country with a degree of social conservatism.

Pregnancy phase

The DOH recommends that pregnant women receive at least four antenatal care visits during the entire phase of pregnancy, with at least one visit at each trimester. Antenatal care services aim to monitor the health of the mother and the unborn child, to detect any pregnancy-related problems at an early stage, and to provide health services such as tetanus immunization and micronutrient supplementation to the expectant mother during these visits. Philippines is still not tetanus free and UNICEF is supporting DOH in an elimination campaign which includes pregnant women. Antenatal care visits ensure that every pregnancy is adequately managed throughout its course, which is the overarching goal at this stage of the maternal cycle.
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Data on antenatal care reveal that coverage for pregnant women with at least four antenatal visits have improved through the years from 52 per cent in 1993 to 78 per cent in 2011. The overwhelming majority of pregnant women received their antenatal care from a skilled health provider with 55 per cent receiving care from a midwife, 37 per cent from a doctor and 2 per cent from a nurse. A small proportion received antenatal care from a traditional birth attendant (2.3 per cent). Antenatal care coverage for pregnant women in urban areas is higher at 84 per cent compared with those from rural areas at 73 per cent (NSO 2012).

The latest data from FHS 2011 also revealed that antenatal care is higher among pregnant women with higher education (98 per cent) and with higher income (97 per cent) than among pregnant women with no education (56 per cent) and with lower income (89 per cent). Trends for variation in antenatal care performance based on income and education status of pregnant women cannot be established as the data were not gathered in previous national surveys.

Delivery phase

Evidence gathered by the DOH showed that most maternal and neonatal deaths in the Philippines occur during the delivery phase and the first two days after delivery. In an effort to reduce health risks to mothers and their neonates the DOH issued A.O. 2008-0029 “Implementing health reforms for rapid reduction of maternal and neonatal mortality” (i.e., the MNCHN Policy). It mandated capacity building for the provision of basic emergency obstetrics and neonatal care (BEmONC) at the primary level of care as well as the provision of comprehensive emergency obstetrics and neonatal care (CEmONC) in strategically located referral hospitals. It created MNCHN service delivery networks of facilities and providers within the local health system (consisting of inter-local health zones, province-wide health system or city-wide health system). The policy also prescribed a shift from home-based to facility-based delivery attended by trained health professionals. It discouraged traditional birth attendants from attending births and shifted their role to one of auxiliaries assisting the health professional team. The primary operational goal at this stage of the maternal cycle is to have every delivery attended in a health facility and managed by skilled health professionals who are trained to provide emergency care in case of need.

Since the implementation of the policy in 2008, there has been a noticeable upsurge in the proportion of pregnant women delivering in health facilities and attended by skilled birth attendants. Latest reports show that births assisted by skilled birth attendants increased from 53 per cent in 1993 (NDS) to 72 per cent in 2011 (FHS).
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while facility-based deliveries increased from 28 per cent in 1993 (NDS) to 55 per cent in 2011 (FHS).

Variations in performance for facility-based delivery and those attended by skilled birth attendants have been noted with pregnant women who have higher income, live in urban areas, and who have higher education having better coverage than those who have lower income, live in rural areas and have no education. However, recent data showed that the gap based on income status seems to have narrowed. On the other hand, the widest disparity is observed based on education level.
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Birth by skilled birth attendants, by income
Philippines, 2003-2011

Facility-based deliveries, by income
Philippines, 2003-2011

Birth by skilled birth attendants, by education
Philippines, 1993-2011

by education
Philippines, 1993-2011
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Post-partum phase

Post-partum care is recommended within the first two days after delivery and within one week of delivery up to 41 days to assess and prevent complications and deaths due to maternal causes. The primary operational goal at this stage of the maternal cycle is to have every mother secure proper postpartum care with a health professional and eventually have a smooth transition to the women’s health care package. It has been noted that more women who deliver in health facilities generally seek post-partum check-ups than those who deliver at home (FHS, 2011).

The coverage of women with at least one post-partum visit within one week of delivery up to 41 days has improved from 43 per cent in 1998 (NSO 1999) to 84 per cent in 2011 (FHS). There seem to be minimal variations in performance between groups of women in terms of income level, geographic location and educational attainment. But again, disparity between these groups of women seems more pronounced based on education status.

Maternal mortality

Most maternal deaths in the Philippines occur during delivery and the first two days immediately after. Major causes are post-partum haemorrhage, hypertensive diseases and toxaemias of pregnancy, and infection (such as pelvic infection and post-abortion complication). The underlying causes of these maternal deaths have been categorized according to the “three delays”: (1) delay in deciding to seek
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medical care; (2) delay in reaching appropriate care; and (3) delay in receiving care at health facilities. To address this situation, the DOH issued A.O. 2008-0029 “Implementing health reforms for rapid reduction of maternal and neonatal mortality” (i.e., the MNCHN Policy) which mandated a shift from the risk approach that focuses on identifying pregnant women at risk to one that considers all pregnant women at risk. This was mainly in response to the findings that even good antenatal care cannot accurately predict the onset of complications during childbirth.

While the maternal mortality ratio has been declining in the past two decades, from 209 per 100,000 live births in 1990 (NDS) to 162 per 100,000 live births in 2006 (FPS), the rate of decline is relatively slow. The Family Health Survey of 2011 even showed an increase to 221 maternal deaths per 100,000 live births. Although the point estimates from the 2006 FPS survey and the 2011 FHS survey imply an upward trend, the apparent increase cannot be considered statistically significant because the 95 per cent confidence intervals from the two surveys encompass the point estimates from other surveys (NSO 2012). Based on this trend, however, it seems that the MDG 2015 target of reducing maternal deaths to 52 per 100,000 live births is still relatively far from being attained.

Because of the limitation of sample sizes, surveys on maternal mortality ratio do not allow for the disaggregation of data relative to measures of equity. It is assumed, however, that women in lower income brackets, those in rural areas, and those with lower educational attainment have higher mortality rates than other groups of women.

Although a number of maternal health initiatives have been undertaken in the past decade, it is critical that the MNCHN policy and strategy be integrated in the package of health services and in the investment plans of LGUs. Efforts should be exerted to upgrade managerial and technical capabilities of health workers in the primary, secondary and tertiary referral levels. Furthermore, facilities and equipment at all levels of health care need to be upgraded to be able to handle the package of maternal health services, and specifically to handle emergency obstetrics care for pregnant women. Support services also need to be improved such as supply chain management for critical logistics, database and information systems, monitoring and evaluation, and advocacy among stakeholders. There is also a need to continuously advocate for budgetary support to implement the newly enacted Reproductive Health Act 2012 and to strengthen networking with the private sector and civil society organizations to facilitate delivery of services for pregnant women and mothers.

Child Health and Nutrition

Early neonatal phase

Analysis of neonatal deaths in the country showed that half of these deaths occur during the first two days of life. Birth asphyxia, complications of prematurity and severe infection account for the majority of newborn deaths. The peak of neonatal
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deaths coincides with the time when most maternal deaths also occur; that is, within the first two days after delivery. This situation points to certain weaknesses in the delivery of maternal and neonatal health services within that time frame. An observational study of deliveries documenting minute-by-minute newborn care done in the first hour of life was undertaken in several hospitals in the country in 2008 (DOH, 2009). The study found that practices in hospitals prevented newborns from benefitting from their mothers’ natural protection in the first hour of life and that the timing of essential interventions were below WHO standards for newborn care. Within this context, the DOH issued A.O. 2009-0025 “Adopting new policies and protocol on essential newborn care” supplementing the policy on MNCHN issued a year earlier.

Improvement in early neonatal care is critical in at least four areas: (1) prevention of hypothermia by drying and providing warmth to the newborn, (2) facilitating immediate skin-to-skin contact between the mother and the newborn to facilitate bonding, (3) delaying cord clamping to reduce the incidence of anaemia, and (4) facilitating the newborn’s early initiation to breastfeeding and transfer of colostrum, followed by proper eye care to prevent ophthalmia neonatorum. These steps, therefore, should be monitored to determine the quality of newborn care. Existing information systems (reports and surveys), however, do not regularly collect these data except on breastfeeding.

It was observed that breastfeeding within one hour after delivery has improved from 36 per cent in 1993 (NSO 1994) to 54 per cent in 2008 (NSO 2009). Variations in performance on breastfeeding have been observed in terms of income level and educational attainment of the mother. NDHS (NSO 2009) showed that breastfeeding is higher among the lowest income group (59 per cent) than among the highest income group (50 per cent) and the disparity seems to be widening. In terms of educational attainment, breastfeeding is higher among those with no education (74 per cent) compared to those with higher education (48 per cent). There is only minimal difference of breastfeeding between those from urban and rural areas.
The most recent Family Health Survey (2011) showed that 92 percent of children 6 to 35 months had ever been breastfed but only 27 per cent had been exclusively breastfed. Children of better-educated mothers are less likely to be exclusively breastfed than children of mothers who are less educated. Also, children from higher income families are less likely to be exclusively breastfed than children from poorer households.

**Infancy phase**

The DOH has prescribed an essential health care package for the first year of life. Among these services are breastfeeding exclusively in the first six months, introduction of complementary feeding at age 6 months, growth monitoring, full immunization, micronutrient supplementation and use of fortified food, oral care, psychosocial stimulation, and integrated management of childhood illnesses, among many others. The most accessible and the most widely covered of these health programmes is the provision of immunization. In all rural health units, health centres, barangay health stations and public hospital facilities BCG, DPT, OPV, anti-measles and Hepatitis B vaccines are essentially given free to all infants. Immunization indicators, therefore, are reflective of health system performance for infants.

Latest data showed that the coverage for immunization has improved through the years from 72 per cent of infants in 1993 (NSO 1994) to 91 per cent of infants in 2011 (NSO 2012) with full immunization. In terms of equity measures, the disparities in immunization coverage between higher income groups and lower income groups, between those living in urban areas and rural areas, and between those whose mothers have higher education and those with no education have narrowed. It must be noted, however, that although 91 per cent of children were fully immunized before they reached their second birthday, a lower percentage (81 per cent) of children were immunized with measles vaccine before their first birthday, indicating that some children were late in receiving their measles vaccine (NSO 2012). Although much needs to be done to further strengthen the expanded programme on immunization (EPI), the data suggest that the immunization service is almost at the threshold of reaching universal coverage level.
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**Early childhood**

Children make up one fourth of the country’s total population and their quality of life and health depends largely on good care practices. Various diseases affect the survival of children. The impact of health care or the lack of it during the earlier stages of the child’s life cycle and during the stages of maternal care while the child is still unborn would be most obvious during the early childhood phase. This will usually be manifested by stunting and wasting, aggravated by parasitism and other childhood illnesses such as diarrhoea and pneumonia. The DOH, has prescribed a distinct set of essential health care package for this age group, such as micronutrient supplementation and use of fortified food, growth monitoring, deworming, oral care, use of safe toys and injury prevention, and integrated management of common childhood illnesses.

Monitoring of the underweight prevalence rate among under-5 children becomes important at this stage and is reflective of health care performance for this age group. Data on nutrition is also tied up with income poverty data, both critical indicators for tracking progress toward the attainment of MDG 1 on eradicating extreme poverty and hunger.
Most recent data showed that the proportion of malnourished children had been going down from 34.5 per cent in 1990 to 30.6 per cent in 2001 and 24.6 per cent in 2005. However, it went up to 26.2 per cent in 2008 (FNRI-DOST 2008). The proportion of households with per capita intake below 100 per cent dietary energy requirement also declined from 69.4 per cent in 1993 to 56.9 per cent in 2003. This amounts to 12.5 per cent improvement within the 10-year period. This is considered a small improvement since almost double this (22.2 per cent) is still required to be able to meet the target of 34.7 per cent by 2015 (NEDA, 2010). Therefore, halving the proportion of underweight children 0 to 5 years old and the proportion of households with per capita intake below 100 per cent dietary energy requirement by 2015 has been rated as medium probability.

For this reason, the government launched the Accelerated Hunger Mitigation Program (AHMP) in 2007 as a strategy to address the primary causes of hunger. The programme was conceptualized to tackle both supply-side and demand-side interventions. Supply-side strategies include increasing food production and enhancing the efficiency of logistics and food delivery interventions, technical assistance to farmers, and rehabilitation of irrigation facilities, among others. Demand-side strategies include increasing poor people’s income through livelihood skills training, microfinance, upland distribution for cultivation of cash crops, and the promotion of good nutrition education and population management (NEDA, 2010).

The Philippines is performing well in reducing child mortality over the past two decades. The under-5 mortality rate has decreased from 80 deaths per 1,000 live births in 1990 (NDS) to 30 deaths in 2011 (FHS). The infant mortality rate has also gone down from 57 deaths per 1,000 live births in 1990 (NDS) to 22 deaths in 2011 (FHS). On the other hand, neonatal mortality rate barely improved from 17.7 deaths per 1,000 live births in 1993 (NDS) to 14 deaths in 2011 (FHS). Major causes of child deaths occur during the neonatal period, including prematurity, sepsis and asphyxia, followed by causes occurring during the early infancy period such as cardiovascular problems, respiratory problems, congenital causes and infections.
Variations in child mortality rates have been observed based on income level, geographic area, and educational attainment of mothers. Disparities in child mortality rates seem to be narrowing in terms of geographic location and level of education, but the gap has remained wide between income groups, with child mortality rates higher in the low income than in the higher income groups.

Overall, however, the rate of decline in child mortality rates indicates a high probability of attaining the MDG goals of 19 infant deaths per 1,000 live births and 26.7 under-5 deaths per 1,000 live births by 2015. The major factor that contributed
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to this remarkable achievement is the package of child health programmes carried out by the DOH, in collaboration with the LGUs. The package offers a range of interventions that are appropriate at each stage of the life cycle during childhood. These interventions include, among others, the expanded programme on immunization (EPI), micronutrient supplementation and food fortification, and the Infant and Young Child Feeding (IYCF) strategy. Despite remarkable progress in reducing child mortality, drastic actions need to be undertaken to further reduce neonatal deaths, such as scaling up and expanding the implementation of the MNCHN strategy and the essential newborn care strategy.

**POLICY AND DECISION MAKING FOR RMCH&N IN THE PHILIPPINES**

Health policy development process

The health policy development process occurs from national level down to local government unit (LGU) level, and in specific health agencies or institutions of government.

At the national level, there are at least three streams of health policy development. First, the Congress of the Philippines, which consists of two chambers (the House of Representatives and the Senate), exemplifies how a proposed bill introduced by its member/s becomes a law through the legislative process. Generally, bills emanate from either the Senate or the House of Representatives. On First Reading, the title and number of the bill is read and then referred to the appropriate congressional Committee. After public hearings, the Committee comes up with a Committee Report that may include modifications to the original bill, consolidation of several bills filed on the same subject matter, or a proposal for a substitute bill. It goes into Second Reading where the periods of debate and amendments take place. The amendments, if any, are incorporated and copies of the amended bill are reproduced and distributed to all members. At Third Reading, a roll called and members vote for the approval or rejection of the bill. Once approved, the bill is transmitted to the other chamber of Congress for concurrence. A Bicameral Conference is called to thresh out differing versions of the bill. After the differences are resolved, the bill is sent to the President. Once the President signs the bill, it becomes a law. (DOH-DAP 2009) Examples of health policies enacted through this process include the Republic Act 10354 “Responsible Parenthood and Reproductive Health Act of 2012”; Republic Act 10152 “An Act Providing for Mandatory Basic
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Immunization Services for Infants and Children”; Republic Act 10028 “An Act Expanding the Promotion of Breastfeeding”; Republic Act 8980 “Early Childhood Development Act”; and Republic Act 9288 “Newborn Screening Act.”

Second, the President of the Philippines, as head of the executive branch of government, translates public policies, including health policies, into executive orders, administrative orders or presidential proclamations. In general, such policy is issued in response to policy or operational concerns that cut across several policy areas, or affect wide sectors of the population, or involve implementation by several government agencies. The issuance is usually drafted by a specific line agency concerned with the policy issue. The draft is then forwarded to the Office of the Executive Secretary for review. Comments and recommendations from other government agencies with related concerns or interests in the draft policy are sought before it is finalized. Once approved by the President, the policy takes effect and becomes the basis for implementing programmes, projects or activities by concerned government agencies (DOH-DAP 2009). Examples of such policies are Executive Order 51 (s. 1986) “Adopting a National Code of Marketing of Breastmilk Substitutes, Breastmilk Supplements and Related Products” (Milk Code); Executive Order 102 (s. 1999) “Redirecting the Functions and Operations of the Department of Health”; Executive Order 286 (s. 2004) “Bright Child Program”; and Executive Order 472 (s. 2005) “Transferring the National Nutrition Council from the Department of Agriculture to the Department of Health.”

Third, the policy development process also occurs at agency level and, in the health sector, is exemplified by the DOH’s procedures for issuing administrative orders. In the DOH, policies emanate from the different offices or bureaux of the Central Office and go through the policy development process with the Health Policy Development and Planning Bureau as the lead policy reviewer. Once the draft policy issuance is finalized, the relevant Undersecretary or Assistant Secretary gives it clearance. If input is needed from other members of the DOH Executive Committee (Execom), the draft policy issuance is presented during the Execom meeting before it is finalized and approved by the Secretary of Health. Whether health policies are applied within the confines of the DOH offices or employed sector-wide at national or local levels, a wide range of discussions among stakeholders takes place before it is approved. In general, DOH administrative issuances whose application is limited to the confines of DOH
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offices are issued as Department Orders, while those affecting stakeholders in the wider health sector are issued as Administrative Orders (DOH-DAP 2009). Examples of health policies issued through this process are A.O. 2008-0029 “Implementing health reforms for rapid reduction of maternal and neonatal mortality” (i.e., the MNCHN Policy); A.O 2009-0025 “Adopting new policies and protocol on essential newborn care”; A.O. 2010-0010 “Revised policy on micronutrient supplementation to support achievement of 2015 MDG targets to reduce under-5 and maternal deaths; and A.O. 2012-0009 “National strategy towards reducing unmet need for modern family planning.”

At the local level, the 1987 Constitution and the Local Government Code of 1991 mandated local government autonomy. The formulation of policy measures and programmes that cater to local issues and concerns, including those concerning health, is the result of interactions among the local legislative council, the local chief executive, local constituents, civil society and the private sector (DOH-DAP 2009). Under this set-up, there are at least two streams of health policy development at the local level. First, executive power at the provincial level is vested with the governor, at the municipal and city levels with the mayor, and at the barangay level with the barangay chairperson. In this context, policies may be issued by the local chief executive in the form of executive orders or administrative orders. Second, legislative power is vested in the sanggunian or local legislative council chaired by the vice governor at the provincial level and by the vice mayor at the city and municipal levels. As such, policies are enacted by the local legislative council in the form of local ordinances and resolutions. Application of policies issued through these two streams is local in nature and limited to the political and territorial jurisdiction of the LGU.

Health planning process

The health planning process is often described as a cycle. It is iterative in nature, with successive planning processes building on the previous plan’s gains and lessons. The DOH generally follows several major steps in the health planning process: (1) situational analysis, which is the process of identifying problems, their causes and extent, and previous efforts to address them; (2) goal setting, which involves priority setting and appraisal of options and strategies to achieve the set goals and targets; (3) programming and budgeting, which is simply translating the priorities and strategies into workable programmes of activity that become the basis of the plan and its corresponding budget; (4) implementation, and (5) monitoring and evaluation, findings from which become the basis for the next planning cycle (DOH-DAP 2009). This same process is also prescribed by the DOH for local health planning.

The process described above is the general basis for developing all plans in the health sector from the national medium-term strategic plan for the health sector, called the National Objectives for Health (NOH), down to the annual work and financial plans of field health operating units. The NOH describes the present health
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Conditions in the country based on data coming from several sources such as the civil registry, national demographic and health surveys, field health service information system, and special surveys and studies commissioned by the national government. It also contains the priority thrusts and strategies in health, the sectoral goals, and key objectives and targets to attain health sector goals at the national level. Key strategies, programmes, goals and targets identified by DOH in the NOH are iteratively discussed with the National Economic and Development Authority (NEDA) for inclusion in the country's medium-term plan, called the Philippine Development Plan (PDP).

The NOH becomes the basis for developing the medium-term investment plan for health, and the annual operational plans of offices and bureaux in the DOH and the health offices and units down to the regional CHD and the LGUs (provinces, cities and municipalities). Investment planning for health involves identifying required resources beyond current resource levels, to implement effective and priority strategies to achieve health goals and objectives. It includes time-specific estimates of financial requirements for implementing programmes, projects or activities and identifying policy actions necessary to improve health outcomes (DOH-DAP 2009).

An example of an investment plan at the national level is the Medium Term Public Investment Program (MTPIP), which includes components of the estimates of investment needed in the health sector. At the local level, the Province-wide Investment Plan for Health (PIPH) and the City-wide Investment Plan for Health (CIPH) are typical examples of investment plans.

The PIPH and CIPH are the key instruments in building the DOH-LGU partnership, in collaboration with international development partners and other local stakeholders, to attain health sector goals. The PIPH/CIPH translates national health goals into specific concrete actions at the local level. It becomes the basis for mobilizing and allotting resources from the national government and development partners to the LGUs. As such, the PIPH/CIPH represents all interests, activities, and investments of stakeholders for health in the local health system (DOH-DAP 2009). As an investment planning tool for local health development, a step-by-step Guide was developed to provide pointers, tools, materials and references that can be used during the process of PIPH/CIPH development.

Eventually, the PIPH/CIPH is translated into Annual Operational Plans (AOP). The Annual Operational Plan is a local policy and planning instrument that allows LGUs to draw up local programmes, projects and activities and their budgetary requirements for a particular year based on strategic and medium-term proposals contained in the PIPH/CIPH. It is therefore the yearly translation of the PIPH/CIPH and other related plans. The AOP contains all the projects and activities the LGU wants to implement within the year, the annual targets, the timeframe for implementation by month or by quarter, the resource requirements, and the sources of funding specifying local and national government sources and other sources such as international development agencies.
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Recently, the concept of bottom-up planning and budgeting was introduced in the government sector (DBM 2011). It was piloted in the Human Development and Poverty Reduction Cluster (which includes the health sector) and the Good Governance and Anti-Corruption Cluster of the Cabinet. The scheme ensures the delivery of national services converges at the local level through inclusion of funding requirements for the development needs of selected pilot LGUs. It improves the planning and budgeting processes of both local and national governments by making them more participatory, involving stakeholders at the grassroots level. The ultimate goal is the attainment of the MDGs, particularly the reduction of poverty.

Health priority setting process

Health system needs must be prioritized because scarce resources do not allow everybody's needs to be addressed. It is important that the more significant health needs are addressed so that resources are optimized to produce maximum results. The DOH recommends five useful criteria for prioritizing health needs for consideration in health planning: (1) significance of health impact, which refers to factors that cause the greatest impact on health outcomes such as disease burden, health risk factors, and health financing risks, which are embodied in the in the Aquino Health Agenda and the National Objectives for Health; (2) equity concerns, which is related to significant health problems suffered by the most vulnerable sectors such as the poor, mothers and children, indigenous population groups, and the elderly; (3) political commitments, which include international commitments like the MDGs, the Framework Convention on Tobacco Control (FCTC), and the Philippine Development Plan which embodies the President's social contract with the people, and such other political commitments at local levels intended to improve health services and health outcomes; (4) health performance levels, such that poor performance on certain health needs must be prioritized over health needs whose current strategies and interventions have been assessed as performing well; and (5) health performance distributions, such that health needs of groups that experience a wide disparity of performance in health are given priority over groups that are already doing well (DOH-DAP 2009).

Prioritizing health needs for medium-term plans is based on the use of the five criteria mentioned above. Once priorities have been set for the medium term, prioritizing health needs for annual plans is based more on yearly performance levels and yearly performance distributions, and any political concerns that may arise. In view of Executive Order 43 (s. 2011), LGUs are encourage to align their programmes, projects and activities to five priority areas: (1) anti-corruption and transparent, accountable and participatory governance; (2) poverty reduction and empowerment of the poor and vulnerable; (3) rapid, inclusive and sustainable economic growth; (4) just and lasting peace and the rule of law; and (5) integrity of the environment and climate change adaptation and mitigation(OPP 2011).

To address the major gaps and challenges in the health sector, the Aquino Health Agenda (AHA), through Administrative Order No. 2010-0036, was launched. It contains the operational strategy called Kalusugan Pangkalahatan (Universal Health Care), which aims to achieve universal health care and ensure equitable access to quality health care by all.
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Filipinos. Kalusugan Pangkalahan prioritizes three strategic thrusts: (1) financial risk protection through expansion of enrolment and benefit delivery of the National Health Insurance Program; (2) improved access to quality hospitals and health care facilities and services; and (3) attainment of the health-related MDGs including non-communicable diseases and their health-related risk factors (DOH 2010).

Particular emphasis is given to prioritize the attainment of MDG goals for mothers and children. Key interventions are anchored to the MNCHN package and the Essential Newborn Care package that include services like the following:

- Community/women’s health team
- Basic and comprehensive emergency obstetric and neonatal care (BEmONC/CEmONC) including facility based deliveries
- Breastfeeding promotion services
- Expanded immunization programme
- Nutrition and hunger mitigation programmes
- Integrated management of childhood illnesses
- Other child health survival package
- Family planning and contraceptive self-reliance.

Implementation of the programmes will harness the strengths of inter-agency and inter-sectoral approaches to health, especially with the Department of Education, Department of Social Welfare and Development, and Department of the Interior and Local Government.

FINANCING FOR MNCH&N IN THE PHILIPPINES

Sources of funding for MNCHN

Several sources of financing are available for the government to mobilize more investments for MNCHN programmes. These sources are classified as budgetary sources (from national and local governments), social health insurance, and a myriad of extra-budgetary and private sources of financing (such as private health insurance, out-of-pocket expenditure, and grants and assistance from international development partners and private and non-government organizations). There is a growing trend for private sources, particularly out-of-pocket expenditure, as the main source of funds for health. Budgetary sources and social health insurance funds come in second and third, respectively, as major sources of funds for health.

First, budgetary sources of funds come from revenues generated through taxes, fees and other charges imposed by the government. Taxes imposed by the national government include income tax, value added tax, excise tax, tariffs and customs duties. Taxes imposed by local governments include property tax, franchise tax, amusement tax, and professional tax. Fees and other charges, on the other hand, are imposed by both national and local governments in the exercise of regulatory powers and the provision of certain services (DOH-DAP 2009). For most LGUs, however, the most important source of funds is the Internal Revenue Allotment (IRA), which is the local government share of taxes collected by the national government, as well as a share of funds from the utilization and development of natural resources within their respective areas (DBM 2012). Authorization for the use of funds generated from these revenue sources goes through the regular budget cycle, that is, through budget appropriation by Congress at the national level or by the local legislative councils (sanggunian) at the local level. Since MDG goals for mothers...
and children are priority thrusts of the government, MNCHN programmes are always given priority in budgetary allocation by both national and local governments.

Second, social health insurance is slowly emerging as a major source of funding for health services. In terms of absolute growth in expenditure, the National Health Insurance Program (NHIP) under PhilHealth is the mechanism with the most potential, although it still lags behind other sources of funds in terms of total expenditure. Since the last decade when the government has prioritized the expansion of social health insurance, progress has been made in expanding social risk pools, particularly among the indigent sector. However, the informal sector, consisting mostly of the self-employed (such as small entrepreneurs, farmers, fisher folks, labourers and professionals), has remained a major challenge in terms of enrolment in the NHIP. PhilHealth has included maternal and child health packages such as antenatal and delivery services, BEmONC/CEmONC services, newborn screening, and immunization, among others, as part of its benefits for members and their dependants. Recently, it also introduced a primary care benefit package that includes preventive and diagnostics services and breastfeeding education as a benefit package for the indigent sector.

Third, funds for health may also come from extra-budgetary sources such as the official development assistance (ODA), which may come in the form of loans, grants, commodities and technical assistance to support various health programmes and projects of the DOH and the LGUs. The use of these resources is governed by the provisions or conditions of the agreement or contract signed by the national government and the international development partner. A substantial amount of these funds are allocated to MNCHN-related programmes, including family planning and reproductive health. In recent years, the largest of these projects is the Women’s Health and Safe Motherhood Project. Also, private and non-government organizations are involved in numerous women’s, maternal and child health programmes and projects. However, resources coming from these groups are generally provided directly to beneficiaries.

Finally, the burden of paying for health care remains dominated by out-of-pocket expenditure. This means that individuals and families rely mainly on their own resources to access health care. Expenditure for drugs and medicines and hospitalization comprise the biggest proportion of this out-of-pocket expenditure. This situation leaves the health status of low income groups the most vulnerable, and thus creates large inequities in health.

### Budget process for health programmes, projects and activities

The budget is the government’s most potent instrument in carrying out its policies. For the health sector, after out-of-pocket sources, the budget becomes the major source of funding for implementing health policies, programmes and services. This is especially true for MNCHN services, particularly at the primary care level. Therefore, mechanisms for ensuring the policy/planning/budget link are essential foundations of the entire budget process. These include coordination mechanisms for policy formulation within the government; consultations with the broader sector of society; adequate means for legislative review of policies, plans and the budget; and regulations to reinforce the policy/planning/budget link.

The budget cycle at the national level generally consists of four stages: budget preparation, budget authorization, budget execution, and budget accountability. The national budget cycle is a continuing annual cycle that starts in January and ends in December. The budget process at the local level generally follows the same stages,
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except that a budget review phase is conducted after the budget authorization process. The primary purpose of budget review is to determine whether the local appropriation ordinance has complied with the budgetary requirements and general limitations set forth in the Local Government Code of 1991 as well as provisions of other applicable laws (DOH-DAP 2009).

In line with the Aquino Administration’s thrust for better transparency and accountability in the budget process, the bottom-up budgeting approach was introduced to ensure complementation between national and LGU programmes and projects, and to assure the technical and financial feasibility of the LGU’s proposals on one hand, and the appropriateness of the national agencies’ service interventions on the other. Also, for more depth, greater substance and refinement of plans and budget, a process for constructive engagement with civil society organizations and consultations with regional and local officials and stakeholders was introduced. As part of the public expenditure management reforms and to maintain a focus on results, the Medium Term Expenditure Framework (MTEF), the Organizational Performance Indicator Framework (OPIF), the Zero-Based Budgeting (ZBB), and output-based budgeting systems and processes are being continued and strengthened. These planning and budgetary reforms are essential components of good governance, sound fiscal discipline, and efficient operational management being espoused by the national government (DBM 2011).

The LGU Plan–Budget Cycle is a good reference point for the DOH and the international development partners when giving support and providing resources to implement the PIPH/CIPH. On a yearly basis, the resource requirements of the provinces/cities are identified in their respective Annual Operational Plans. Within the framework of the Sector Development Approach for Health (SDAH), it is necessary that the province/city and the DOH and development partners discuss the resources that are available from all potential sources. Eventually, support provided to LGU by the DOH and the international development partners to implement the PIPH/CIPH is formalized through a Memorandum of Agreement (MOA). On the other hand, support to implement the Annual Operational Plan, including modes of transfer of resources to the LGU, is formalized through the annual Service Level Agreement (SLA). This process provides the mechanism for national–local planning and budget links.

Budget allocation for MNCHN

The total budget of the DOH and its attached agencies has grown in recent years. From an average budget of Php 10 billion per year in the decade preceding 2008, the budget for DOH and its attached agencies was doubled to Php 21.3 billion in 2008 and almost tripled the following year to Php 29.6 billion in 2009. The approved budget for 2013 has now grown to Php 52 billion (DBM 2013). This has brought a large fiscal space for the DOH to prioritize its three major health thrusts for the attainment of Universal Health Care.

However, the figures show that the budget allocation for MNCHN-related programmes being implemented by DOH (such as maternal and child health, family planning, women’s health and safe motherhood, nutrition and immunization programmes), and by its two attached agencies the National
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Nutrition Council and the Population Commission, has remained almost constant, ranging from PhP 4.6 to 6.6 billion annually from 2008 to 2013. Over the same period, the total national budget allocation to MNCHN-related programmes amounted to almost PhP 32 billion, much of which was allocated to family health programmes (34 per cent), expanded immunization programme (29 per cent), and nutrition and hunger mitigation programmes (28 per cent). Yet in proportion to the total national budget allocated to DOH and its attached agencies, the share of MNCHN-related programmes is actually decreasing from a peak share of 22 per cent in 2010 to a low of 10 per cent in 2013.

The funds that are most critical to attaining MDG 4 and MDG 5 are the budget allocation for the DOH Family Health Programs and the DOH Expanded Programme on Immunization. The bulk of these funds are used for the procurement of commodities for maternal and child care services such as vaccines, micronutrients, family planning supplies, basic emergency drugs, to name a few, as well as for capacity building, training and technical assistance to health providers. The DOH foreign-assisted programme is essentially for women’s health and safe motherhood while the Population Commission programmes are generally for promotion of natural family planning and responsible parenthood. The National Nutrition Council’s budget is directed to childhood nutrition and hunger mitigation programmes, that is, basically towards the attainment of MDG 1 but closely linked to MDG 4.

Almost the entire DOH budget for maternal and child health services is eventually transferred to LGUs in the form of vaccines, drugs, medicines and supplies; and technical assistance, training and capacity building. A small amount is also sub-allotted by the DOH as a performance-based cash grant to high performing LGUs. Therefore, it is crucial that LGUs are eventually able to absorb these cash and non-cash resources. A major concern, however, is the absorptive capacity of the existing DOH system and the recipient LGUs. For example, in 2008 there was a big increase in the budget appropriated to Family Health programmes, amounting to PhP 3.02 billion. Of this amount, only PhP 1.02 billion was eventually released by DBM to DOH, but DOH was only able to expend PhP 325 million during the year. For EPI, Congress appropriated PhP 513.9 million in 2008. Of this amount, DBM released only PhP 483.9 million but DOH was able to spend only PhP 468 million. By 2011, the appropriation for Family Health programmes was PhP 731 million, all of which was released by the DBM to the DOH, but DOH was able to spend only PhP 469.1 million. In the same year, EPI was appropriated a budget of PhP 2.46 billion, all of which was released by DBM, but DOH was only able to spend PhP 1.74 billion.(HPDPB-DOH 2013). It seems that since the time when the budget for
maternal and child health services was increased to fast track the attainment of MDG 4 and MDG 5, absorptive capacity remains a major concern.

### PAST INVESTMENT CASE ACTIVITY IN THE PHILIPPINES

The Investment Case (IC) for financing equitable progress towards the attainment of MDG 4 and MDG 5 is a project funded by AusAID and the Bill and Melinda Gates Foundation. It is implemented by a consortium of the Australian Knowledge Hub, represented by the University of Queensland, and a Philippine counterpart, the UPecon Foundation, Inc., in coordination with UNICEF. The IC is a multi-country research initiative implemented in Indonesia, Nepal, Bangladesh and the Philippines, whose ultimate objective is to provide policy-makers with the best evidence for an equitable scaling-up of priority interventions and investments focused on addressing maternal, neonatal and child mortalities. Results of the IC analysis are expected to influence the content and process of planning and budgeting in-country by identifying health system constraints and bottlenecks in the attainment of MDG 4 and MDG 5.

(Aldaba, LaVincente et al. 2011)

The IC in the Philippines was piloted as a framework to assist in the development of Investment Plans for Health in three LGUs, namely, Pasay City, and the provinces of Eastern Samar and Northern Samar. The IC project identified several barriers in the implementation of MNCHN programmes, as reported by Aldaba et al, and summarized below.

Pasay City is a highly urbanized city located in the National Capital Region (Metro Manila). Key barriers identified for MNCHN services in Pasay are: (1) private health providers dominate the delivery of MNCHN services within the local health system; (2) very few of these private providers are accredited by PhilHealth, creating financial barriers for poorer families; (3) the limited capacity for government regulation raises concerns about quality of care; and (4) lack of communication with the constituents regarding available MNCHN services. While data shows that people of Pasay City have better MNCHN outcomes relative to the national averages, these figures mask significant inequity, specifically for the most disadvantaged residents in informal communities where poor health outcomes are observed.

On the other hand, Eastern Samar and Northern Samar are neighboring provinces in the Eastern Visayas Region. Both are predominantly rural and among the poorest provinces in the Philippines, and experience some of the worst maternal and child health outcomes. Northern Samar is composed of 24 municipalities while Eastern Samar is composed of 22 municipalities and one city. Key barriers identified are: (1) provision of MNCHN services in the two provinces is dominated by the public sector but physical access is limited due to an insufficient number of public health facilities; (2) an inadequate number of trained personnel and supplies to provide basic and comprehensive emergency obstetrics and neonatal care; (3) quality concerns due to having only a few health facilities accredited by PhilHealth; (4) many deliveries still occur at home without skilled birth attendants, and (5) lack of knowledge by the community regarding care during pregnancy and delivery.

Common barriers observed in the three project sites were also noted: (1) the new MNCHN policy and protocol adopted and promoted by the national government are not being followed, such as practices around essential newborn care, infant and young child feeding, and integrated management of childhood illnesses (due mostly to lack of appropriate training specifically among private providers); and (2)
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inadequate supplies for delivering maternal and child health services, as most LGUs have not included them in their budgets, resulting in patients purchasing these supplies themselves, thereby creating financial barriers for the poor.

As a result of conducting the IC study in the Philippines, Aldaba et al reported the following broad outcomes:

1. IC activities were coordinated with local government budgeting cycles and have assisted in the preparation of Investment Plans for Health (PIPH/CIPH) in Pasay City, Eastern Samar and Northern Samar.

2. The IC results initially persuaded policymakers in Pasay City to scale down and postpone their plans to build more facilities in favour of strategies focused on better engagement and regulation of the private sector. (However this decision was reversed a year later, ignoring a major finding of the IC activity (Anderson 2012).

3. In Eastern and Northern Samar, where access to health facilities was a major constraint to receiving quality health care, the government adopted the recommended IC strategies. These included large initial investments in infrastructure.

4. The IC process revealed gaps in local-level data. This finding stimulated local planners to improve routine data collection systems. For example, Pasay City officials plan to recruit a data management specialist to help prevent such gaps arising in future.

5. IC activities provided evidence to support LGUs’ assessments of health system supply and demand issues and enabled them to find solutions that draw on a broad range of practical approaches. The IC also provides local governments with clearly defined indicators by which to monitor progress.

Discussions and interviews conducted with key staff and officers of the DOH Central Office (Director and technical staff of Health Policy Development and Planning Bureau and Director of NCDPC Family Health Office) and with the regional Centers for Health Development for the National Capital Region (the present and former Regional Directors and the DOH Representative to Pasay City) and the Eastern Visayas Region (the present and former Regional Directors) revealed critical insights into the IC as a tool, an approach or a process for evidence-based planning and budgeting for more equitable MNCHN services and health outcomes.

In the context of project implementation in Pasay City:

1) The IC has limited value in the development of the city-wide investment plan for health (CIPH) since it was introduced after they developed the plan; however, it pointed, to some gaps in their CIPH

2) It did not create the expected interest and appreciation of local chief executives and local health personnel because they are at a loss as to what the tool is all about

3) There was no hands-on involvement of local health personnel since the research team were the ones processing and analysing the data and only confirming results with local staff
4) Local health personnel find the tool and the process time-consuming and complex, and too academic, requiring data that are not routinely gathered or reported at the local level.

5) The recommendations from the report were appreciated but have very little value since local decisions are made based on available funds and political priorities;

6) They do not see the IC as sustainable since this is just project-based activity. The local health personnel will always revert back to the prescribed tool and process required for the release of local funds and the release of sub-allotments and assistance from the national government and development partners.

7) The DOH regional CHD was not deeply involved in the process, but only participated in meetings and workshops without a very clear role after the project ended. Sustainability and institutional memory have ended with the change in local political leadership and the change of regional directors.

In the context of project implementation in Northern Samar and Eastern Samar:

1) There is limited participation of local officials, generally limited to health personnel. The local chief executives, the provincial administrators, budget and planning officers and other key officials and staff need to be involved, as most data-bases needed and interventions recommended will require action from sectors outside health.

2) The tool can be used for bottom-up planning and has generated some local interest, but there is a need to reconcile and harmonize it with the PIPH. There is no need to introduce a more complex tool and process. The PIPH has some good features, especially that the PIPH as a tool and process has been integrated with the resources needed to implement it and linked with a simple performance evaluation tool like the LGU Scorecard.

3) At the regional CHD level, there is a need to strongly involve the programme managers since they are knowledgeable with the tracking of indicators, but will also need involvement of the finance and budget officers and the auditor to strengthen IC link with finances and accountability.

4) There is no sustainability because there is no involvement and push from the central office. There are already prescribed processes, tools, matrices and forms for planning and budgeting coming from higher level offices.

5) “The IC is useful in the eyes of health economists, the PIPH is more useful in the eyes of public health managers and programme implementers.” (direct quotation from the former Regional Director of CHD Eastern Visayas). The utility of the tool to those who manage and implement health programmes and those who make decisions is a critical consideration.

From the point of view of DOH Central Office Directors and staff:
1) The IC as a tool can be used as basis for optimizing investment for health, and the DOH Central Office has received feedback that it has some utility in the preparation of the PIPH in the Samar provinces.

2) The main drawback is that the IC is a sophisticated tool with very complex data needing to be inputted, processed and analyzed. As such, it requires a lot of technical skills and capacity building, particularly at the local level. If planning and budget experts and technical specialists in the DOH Central Office find the IC difficult, then the more difficult it becomes at the local level where capacity is limited and demand for staff time is crucial for delivering services to the constituents.

3) It is doubtful that this can be done on a routine basis at the local level without tying it to a regular administrative budget and personnel. The whole IC process needs a team approach and wider participation from other sectors outside of health.

4) The IC tool will probably be helpful if done at the NEDA level during medium-term planning (every six years in the Philippines), but not on a routine annual basis at the DOH or even at the local level. The tool is rather academic and good for researchers but not practical for local level health personnel.

5) There is no actual demonstration or proof of utility for IC, no push from DOH, NEDA, DBM or from the development partners has been seen.

6) It is difficult for LGUs to implement the IC as tool or process for planning and budgeting without clear mandates or guidelines from the Central Office, as tools prescribed by DBM for budgeting purposes and by DOH for planning purposes already exist.

7) Without tying the IC to financial resources, CHDs and LGUs will always revert back to the prescribed planning and budgeting approaches.

8) The IC pilot project was implemented with no significant engagement at the national level (whether DOH, DBM, NEDA), therefore there is no significant institutional memory and no sustainability.

9) The IC may be useful but any effect or impact will just be marginal as what it intends to change has already been included as a national priority and as an international commitment to attain MDG goals, specifically those that relate to MDG 4 and MDG 5.

PROGRAMME LOGIC FOR THE INVESTMENT CASE WORK IN PHILIPPINES

Programme logic is a roadmap that sets out how the acceleration of the implementation of the IC for MNCH project will achieve its desired outcomes. The overall desired outcome is to improve country MDG 4 and MDG 5 indicators. Implementation of IC activities is expected to effectively reduce bottlenecks that impact upon disparities in MNCH, increase level and equity of coverage, and thereby decrease child and maternal mortality and malnutrition. While the logic of the IC...
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The programme logic for the Philippines has been developed following discussion with country office personnel in late 2012. It captures their intentions at that time, and the relationships that they see between their activities and the broader goals of improved MNCH.

Programme logic for the acceleration of the IC for MNCH work in the Philippines, See separate document.

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