EVALUATION OF ACCELERATING THE IMPLEMENTATION OF THE INVESTMENT CASE FOR MATERNAL, NEWBORN AND CHILD HEALTH IN ASIA AND THE PACIFIC PROGRAMME

FINAL COUNTRY REPORT:
PHILIPPINES

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Professor Don Matheson
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ABBREVIATIONS

AHA  Aquino Health Agenda
ANC  Antenatal care
AOP  Annual Operational Plan
AusAID  Australian Agency for International Development
BEmONC  Basic Emergency Obstetric and Newborn Care
BNA  Bottle Neck Analysis
CEmONC  Comprehensive Emergency Obstetric and Newborn Care
CIPH  City wide Investment Plan for Health
CPR  Contraceptive Prevalence Rate
DFAT  Department of Foreign Affairs and Trade (Australia)
DOH  Department of Health
DP  Development Partner
EBaP  Evidence-Based Planning and Budgeting
FHS  Family Health Survey
FP  Family Planning
GAVI  GAVI Alliance
GFATM  Global Fund to Fight AIDS, Tuberculosis and Malaria
HPNSDP  Health Population and Nutrition Sector Development Program
HSRA  Health Sector Reform Agenda
IC  Investment Case (for Maternal, Newborn and Child Health)
IMAM  Integrated Management of Acute Malnutrition
IP  Implementation Partner
LGU  Local Government Unit
MBB  Marginal Budgeting for Bottlenecks
MCH  Maternal and Child Health
MDG  Millennium Development Goal
MOA  Memorandum of Agreement
NCDs  Noncommunicable Diseases
NDHS  National Demographic and Health Survey
NEDA  National Economic and Development Authority
NGO  Non-Governmental Organization
NHIP  National Health Insurance Program
NOH  National Objectives for Health
OPIF  Organisational Performance Indicator Framework
PDP  Philippine Development Plan
PIPH  Province-wide Investment Plan for Health
RMNCH&N  Reproductive, Maternal, Newborn, and Child Health and Nutrition
RH  Reproductive Health
SAM  Severe Acute Malnutrition
SLA  Service Level Agreement
THE  Total Health Expenditure
TOR  Terms of Reference
UNICEF  United Nations Children's Fund
UPNCPAG  University of the Philippines National College of Public Administration and Governance
UQc  The University of Queensland Consortium
WHO  World Health Organization
EXPLANATORY NOTE

The Investment Case (IC) in the Philippines is now referred to as Evidence Based Planning and Budgeting, (EBaP). The structures/administrative organisations (and their quantities) referred to in the report include:

- National: Department of Health
- Regions: 17
- Provinces: 81
- Municipalities: 1,490
- Cities: the cities referred to in this report are highly urbanised, independent cities and not under the jurisdiction of a province. There are 144 in total in the country.
- Districts
- Barangay: the equivalent of a village. There are 42,028 in the country.

INTRODUCTION


The report follows on from the Baseline Report for the Philippines and should be read in conjunction with the Synthesis Report for the four countries: Bangladesh, Indonesia, Nepal, and the Philippines. The Synthesis Report includes a description of the methodology and the overall findings of this evaluation across the four countries.

THE BASELINE REPORT FINDINGS

The Philippines is on track to achieve Millennium Development Goal (MDG) 4, but 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 are maternal mortality and neonatal mortality, with the latest data suggesting that maternal mortality has increased and newborn mortality has remained unchanged. Coverage of relevant programmes (such as family planning and institutional deliveries) is uneven, with poverty, rurality, and 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 in 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 Department of Health (DOH) issued a policy to reduce maternal and neonatal mortality in 2008. Since then there has been a noticeable upsurge in the proportion of pregnant women delivering in health facilities and attended by skilled birth attendants.

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. The disparities in immunisation 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 reduced from 1990 to 2005. However, it went up slightly in 2008.

There is very active engagement and leadership in support of reproductive, maternal, newborn, and child health and nutrition (RMNCH&N) from senior government leaders. National policies for strengthening maternal and child health have been institutionalised with the enactment of several pieces of legislation. It has had focused attention from Congress, the President and the DOH, all of whom have passed numerous Bills, Executive Orders and policies respectively.
There has been a doubling of national government expenditure for health in recent years to PhP1 42.4 billion in 2010 and a 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 per cent of Total Health Expenditure (THE) in 2000 to only 26.5 per cent in 2010, with out-of-pocket expenditure being the main source of financing. The total national budget allocation to Maternal, Newborn, and Child Health and Nutrition (MNCH&N) related programmes has increased, but the absorptive capacity remains a major concern, and it has halved as a proportion of the total national budget allocated to the DOH.

Health financing is fragmented, with overlapping streams of funding that are managed independently of each other. The devolution of health services to local government units (LGUs) in 1991 brought health planning, decision-making, management and implementation of health programmes closer to the constituents. However, it also brought government financing for health services under the control of more than a thousand officials from the DOH, PhilHealth and LGUs (governors and mayors), leading to coordination and harmonisation 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 a major cause of inefficiency. Weak government stewardship of the private sector and lack of capacity for equitable planning and budgeting at the LGU level also impacts on the quality of care provided.

The country is undergoing a major reform in expanding social health insurance. 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 in both the public and private sectors, and people’s health seeking behaviour. However, the country is caught in a bind, as insurance coverage in poor areas will not necessarily improve access and utilisation because of major capacity gaps in service delivery infrastructure and human resources for health.

The government has well developed planning and investment processes at the national and sub-national 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 mobilising 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, and correcting variation in health performance levels.

Views differ on the value of the past IC activity in the Philippines (prior to the current programme being evaluated). Groups involved in the implementation point to a number of successful outcomes from the IC activity. However, national and local officials with experience of the IC work take a more cautious view.

The main problems identified by officials related to the complexity of the tool and strong focus on the tool rather than the process, and its lack of fit with existing planning and decision making processes. A senior DOH planning and policy official interviewed in Phase I viewed the use of the IC tool as too demanding of both time and the limited skills available at both national and local level, and saw its use as a research tool to be applied once every few years.

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1 One Philippine Peso equals approximately USD0.023 as at 02/08/2014. One USD equals approximately PHP43.69.
PROGRAMME LOGIC FOR EVIDENCE-BASED PLANNING AND BUDGETING (EBaP)

During the first phase of the evaluation, the evaluator requested the UNICEF country office to establish the programme logic for their activities. The programme logic for “Evidence-Based Planning and Budgeting” (EBaP) was developed jointly by the Government of the Philippines and the UNICEF national office. The approach had a focus on equity, advocacy and alignment with existing government programmes and planning cycles, and a demographic focus on urban slums. The intention was to integrate the IC process with the current 7th Government of the Philippines - UNICEF country programme and to share the lessons learned with a key Cabinet committee.

The main unpredicted event to occur since the development of the programme logic was the impact of Typhoon Haiyan in November 2013. This typhoon was one of the strongest ever recorded and affected 14 million people, leaving 4 million homeless. Both the government and UNICEF have been focused on typhoon recovery since it occurred. The President instructed government departments to make the recovery efforts their main priority over the period from November 2013 to the time of the evaluation in April 2014. This work understandably took precedence over the EBaP activities. The UNICEF country office team built on its EBaP experience and adapted the approach to meet the needs of disaster recovery, known as Evidence-based Planning and Budgeting for Resilient health systems (rEBaP).

Two major opportunities developed within the government system since the programme logic was developed. The first opportunity, in relation to extending the social insurer PhilHealth, was forecast in the programme logic, however the scale of what was intended has increased significantly. The other opportunity relates to the government’s revision of its sub-national planning process for health, Province-wide Investment Plan for Health (PIPH) and City-wide Investment Plan for Health (CIPH).

In summary, the programme mobilised additional resources, delivered on its outputs and extended the scope of its activities between Phase I and Phase II of the project. It was able to position EBaP in relation to new opportunities that arose in the health sector with PhilHealth and sub-national planning for health. It was less successful at popularising the EBaP approach in relation to Cabinet decisions and DOH budgeting and decision making, with the exception of a one-off investment case analysis of care of the newborn.

Note the EBaP programme logic was developed in Phase I of the evaluation.
LOCATION OF ACTIVITIES

EBaP activities were conducted in three cities; Quezon City, Davao City and Puerto Princesa City.

QUANTITATIVE ANALYSIS FOR THE PHILIPPINES

Government administrative data on health service utilisation was sought for the three cities, as well as information held at the district level.

QUANTITATIVE ANALYSIS FOR THE PHILIPPINES

Thirty-nine people were interviewed in the Philippines over the two phases of the evaluation. Four group meetings were held at clinics in Davao City, Quezon City and Puerto Princesa.

NATIONAL PROGRESS ON RMNCH&N

Figure 1: National RMNCH Indicators, Philippines

Figure 1 shows the national progress being made in RMNCH&N indicators since 2003, based on NDHS survey results. Most indicators are showing improvement, with large gains in SBA attended births and deliveries in institutions over the last 5 years.
RESPONSES TO THE EVALUATION QUESTIONS

Evaluate the impact of the IC on how planning is undertaken, programmes are delivered, policies are crafted and the processes by which budgets are decided

(A) What was the process of planning and budgeting prior to the introduction of the IC?

The Philippines health system is decentralised in nature, following its devolution to LGUs in 1991. This brought health planning, decision-making, management and implementation of health programmes closer to the constituents. However, the financing of health systems is fragmented, under the control of more than a thousand officials from DOH, PhilHealth, and LGUs (governors and mayors) leading to coordination and harmonisation problems. In addition, private sector financing through out-of-pocket payments constitutes the major part of the health system’s financing. This increases the fragmentation of health services and is a 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.

With this disconnect between planning and financing, it is not surprising that the experience of planning processes at the local level has often lacked depth:

“In the past planning consisted of filling in the right form or template. It was just compliance.” (District health manager)

“Previously it was left to the planning officer who would fill in the matrix and send the form, often without thinking.” (National IP)

“Prior to this, planning was left to each department, and budgets did not change year in year out. It missed deep analysis, and activities had little impact on the problem.” (City level planning official)

“Previously we had planned top down.” (City Health Officer)

“The process starts with a budget ceiling determined by the agencies or units. It is based on programmes, or ‘vertical’ in approach, not geographical and not ‘horizontal’…equity and gender considerations are minimal.” (City level health official)

The interplay between ‘technical’ planning processes and ‘political’ decision making was a reality that the City level planners were very familiar with:

“Prioritisation of programmes is generally according to the budget ceiling provided and this part is not political. It then goes through a process of approval which is basically political in nature. There is a need to deepen the awareness and understanding of the political stakeholders in terms of health needs and priorities.” (City health official)

The prioritisation and decision making process at the national level is described in detail in the Baseline Report.

Information and data play a significant role in existing processes, but there is a general view that it is of poor quality and missing key elements:

“Data tends to be weak.” (National IP)

“The main problem we face is missing data elements to do the analysis.” (City Health Officer)

“The basis for decision making is the Field Health Services Information System. It needs to be updated to adapt to emerging health concerns and the changing needs of LGUs.” (City Health Officer)

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

Addressing MCH and inequities is a high political priority in the Philippines. The Aquino Health Agenda (AHA), through Administrative Order Number 2010-0036, 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 Filipinos. Kalusugan Pangkalahatan prioritises 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, health care facilities and services; and

3) Attainment of the health-related MDGs including noncommunicable diseases and their health-related risk factors (DOH 2010).

From an equity perspective the DOH recommends five criteria for prioritising health needs for consideration in health planning, two of which have a very strong equity focus:

- 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; and

- 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).

The challenges and deficiencies primarily relate to the difficulties of implementation, not the expression of intent. The “Case for Investment” has already been made and accepted in the Philippines for some time. The issues relate to the problems of implementation: of fragmented funding, poor data, and weak planning processes as have been discussed above.

(C) How was the IC introduced, process used, aspects of IC used, resources, timing and time taken, organisations and people involved?

The IC had a history in the Philippines prior to the activities that are the subject of this evaluation. This history, which was discussed in the Baseline Report, had led to a negative view held by senior officials in the DOH.

Although the tool had some utility in the preparation of provincial plans (Province-wide Investment Plan for Health, PIPH), its drawback was the requirement for very complex data sets needing to be inputted, processed and analysed. This required a lot of technical skills and capacity building, and was beyond the time available and the capability of national, let alone local, planners. Senior health officials felt its role should be restricted to occasional (six-yearly) medium-term planning. Its lack of proof of utility, its lack of fit with existing processes, and its lack of an official guideline were also seen as barriers to further use.

The process in the Philippines was re-designed in response to these criticisms:

There was a change in branding, so ‘Investment Case’ became ‘Evidence Based Planning and Budgeting for RMNCH&N.’

The use of ‘Tools’ was strongly de-emphasised, and a strong focus brought to the process of engagement instead:

“The ‘investment’ part is not emphasised, instead the process is highlighted. In fact, investment case is never mentioned. What is highlighted is data, its quality, and exploring where the best data that is available is” (National IP)

The activities conducted were also refashioned with the needs of cities given prominence:

“Cost and impact analysis has been dropped off. The process is now very much city led, responding to the cities’ needs. This differentiation is seen in the way the cities are doing things differently.” (International IP)

This change in approach was very evident in the cities visited as part of this evaluation. However it was not well communicated to senior levels of the DOH whose views were still strongly influenced by the previous negative IC experience:

“We are aware of the meeting in 2013 with Undersecretary Herbosa and Undersecretary Valera where it was said that EBaP was potentially confusing, as it was an additional planning system when the government already had a planning system. The Undersecretary asked UNICEF to not introduce a new system but to work with the existing planning system. After this launch there was no follow up with us or with the regions so we don’t know what happened.” (National health planners)

There was one exception where the original Investment Case tool was used. In response to a specific request by a government official, UNICEF with the University of Queensland conducted a modelling and costing exercise to explore options for improving neonatal health. This was very well received by the official concerned, who could see much wider application when it comes to assessing different priorities for intervention.

“It opened my eyes to a bigger picture. It was very helpful to model scenarios, costs and lives saved with different interventions.” (Government health official)
Although well received by the individual concerned, at the time of this evaluation it was unclear whether the findings from the exercise would be accepted by the DOH decision makers, the ‘cluster’ heads. The same official engaged WHO to write a costed plan and strategies, with a WHO tool:

“Both are useful, complementary. The UNICEF tool is better visually, you can clearly see the impact.”

(D) How effective and efficient was the IC process?

In two of the three cities, the approach was seen as very effective and not cumbersome:

“It’s an approach where we learn how to make a realistic plan. It is not a burden. It makes us realize new possibilities of what we can do, even within existing resources.” (City Health Officer)

In one city, its effectiveness was such that it was being considered for wider application outside of the health sector:

“The approach is of interest to other sectors in the city, and we are interested in using it across the city’s social programmes.” (City planning officer)

The perception of the EBaP approach as being cumbersome and time consuming was reflected in only one of the three cities, and here it was accepted that EBaP was more detailed and participatory, but concerns were raised about its fit with existing planning processes:

“There are portions of the EBaP that overlaps or duplicates with existing planning and budgeting guidelines and it requires additional paperwork and a lot of work load for staff.” (City health officer)

The priorities in each city reflected the perceived need. In Quezon City, the priority began with a RMNCH&N focus on a high need district (District 2) and then moved to involve all districts. In Davao, the focus was on malnutrition, a decision that was taken following a stakeholder meeting. In Puerto Princesa, the planning process was conducted but there was uncertainty as to whether the plans would be supported by the city’s leadership. It was also not synchronised well with the city’s planning cycle, with the 2015 budgeting process well advanced before EBaP was completed, reducing its likelihood of having an impact next year.

“The potential for duplication and overlaps with other planning processes required by different agencies at the national level is great if EBaP does not become part of the existing system.” (City planning officer)

(E) What were the “products” produced by the IC process? Who received them, and when?

In Quezon City, EBaP began with a focus on District 2, where there are large numbers of informal settlers. Initially the District 2 health facility managers were trained (these are health personnel and doctors with little prior management orientation). This was followed by a training exercise for all districts and city programme leads, led by the District 2 managers, and supported by the IPs.

In Davao, the focus was on Severe Acute Malnutrition (SAM) city-wide, including at a disaster relief camp for informal settlers following a fire that destroyed their dwellings. The EBaP process involved multiple stakeholders, and the priority was agreed. The subsequent EBaP analysis of the nutrition situation and bottlenecks was discussed with the communities and stakeholders. This was followed by significant inputs from UNICEF in training, equipment, therapies, and treatment protocols. By the time of Phase II of the evaluation, funding responsibility for the initiative was on the city’s programme.

Anxiety was expressed by one City Health team that pilots, even when they are successful, often do not get picked up nationally. They wither, despite having been proven to be effective.

The City Health Officer documented through photographs the experience of nine children with SAM, and presented ‘before’ and ‘after’ images to the mayor and city leaders. This resulted in the city leadership strongly supporting the nutrition activities, with consideration being given to increasing the city’s budget for nutrition from 6m pesos to 16m pesos this financial year; 50 per cent of the increased health allocation for the year. This is an example of the innovative approach to advocacy arising out of the EBaP process.

In Puerto Princesa the EBaP process is still in its initial phase with the planning process involving the representatives of the City Health Office and the City Planning and Development Office. Specific products will take some time as the 2015 budget proposal for health was submitted before the analysis with the EBaP approach was completed.
EBAP activities have also provided an entry point to a number of other programme areas.

The national health insurer, PhilHealth, has set itself a goal of the provision of a comprehensive primary care benefit to all Filipinos by 2016. UNICEF is providing advice to support PhilHealth to develop the package, alongside other development partners such as WHO and the World Bank.

UNICEF and the Davao health authorities also intend for this activity to influence national discussions on the management of acute malnutrition. Integrated Management of Acute Malnutrition (IMAM) guidelines have been stalled at the national level. It is intended that the Davao experience be used to advocate for national level policy endorsement. The EBaP process shows that there is a need for the guidelines and the potential application of those guidelines nation-wide.

The DOH is undertaking a review of its sub-national planning program, CIPH and PIPH. UNICEF is assisting the Bureau of Local Health Development, part of the DOH, in the conduct of this review.

At the national level, the EBaP activities also included working with the DOH, with the support of the Zuellig Foundation, to provide a health governance and leadership programme for mayors and municipal health officers. This will incorporate a three-hour EBaP component, based on the experience of the three cities where Mayors and Muncipal Health Officers will be introduced to evidence-based planning principles during the leadership course. This will be complemented by EBaP workshops during the 6-month coaching period in between the training modules.

In the typhoon-affected areas, the EBaP experience in the three cities has influenced UNICEF’s approach, with the “rEBaP” process being rolled out in Typhoon Haiyan-affected areas (40 LGUs).

Evaluate the impact of the IC on government processes, including the political and subsequent budgetary priority given to Maternal, Newborn, and Child Health and Nutrition

(A) Did the IC impact on governments planning, budgeting and monitoring processes?

The EBaP process impacted on the activity and planning cycle in two cities, while it is too soon to see any impact in the third. It has particularly impacted on the approach to data and information:

“The data we use is our own data, and we are now equipped to use it as evidence.” (City health officer)

“The BNA process made us look more deeply at what we were doing. Previously we had assumed we were treating pneumonia correctly, but when we explored this in the process, we realised many children were not getting treatment through to completion.” (District health officer)

It has impacted on managers’ sense of possibility and empowerment:

“It makes us realise new possibilities of what we can do, even within existing resources.” (City health officer)

“Its main impact has been on empowerment and the increase in managerial skills.” (City health officer)

It has impacted on planners’ tools to examine equity and gender:

“It has great utility in taking into consideration prioritisation and target setting, equity concerns and focus of health services to the more marginalised sectors of the city, gender considerations.” (City Health Planners)

It has also assisted in positioning UNICEF:

• as a key government adviser in the planning of a major health insurance policy;
• to influence the review process for sub-national planning mechanisms;
• to support a mayoral training program; and
• in advocacy for nationwide nutrition guidelines.

The direct connection between the EBaP process and the national activities was clear however there was little awareness of EBAP amongst some of the agencies engaged by UNICEF to work on the national activities.

The EBaP work with the three cities had highlighted the low level of financing of primary health care. This is evident in the different analyses with the three cities and results in inadequate supplies, lack of human resources, no demand generation activities and little attention to quality of care. This was the main motivation to engage PhilHealth in developing an outpatient benefit package for under-5 children. This engagement later evolved to considering a more comprehensive primary health care benefit package. Similarly, the work on the revision of the planning guidelines drew on lessons from EBaP work with the three cities.
The connection was also clear in relation to IMAM advocacy, the Typhoon recovery program, and the training of mayors. On the other hand, from discussions held with the contractors engaged by UNICEF in supporting PhilHealth and the sub-national health planning review, and from discussions with staff of WHO and World Bank engaged in RMNCH&N projects, it appeared that they had little knowledge or awareness of the EBaP process, and had, at the time of the interview, not considered its relevance to the work they were engaged in.

(B) What particular aspects of the IC made the most impact on planning and budgets, and in what circumstances: the bottleneck and equity analysis? The fiscal space analysis? The estimates of coverage and lives saved? The scenarios? The relationships with IPs?

The approach taken in the Philippines under EBaP has changed considerably from the original conception of the IC. Firstly, it focused more on the process of planning at the city level, and did not include fiscal space analysis, estimates of lives saved, and scenarios. The biggest impact appears to be on the use of data and information, as well as the BNA, which provided insights into the health system components that had not been considered previously, especially by clinical managers.

“The EBaP has been very helpful for health centre managers. They are good clinicians but poor administrators. They were not using the monthly reports effectively. They were not able to integrate logistics and services. The EBaP empowered them.” (City health manager)

(C) Has the IC approach helped to frame and better articulate the way RMNCH&N is characterised, and the way decisions are made?

Its impact has been significant at the local level where it has been applied in two of the three city sites. It has positioned UNICEF to have a potential impact in significant policy discussions and training of sub-national leaders.

(D) What has been the impact on RMNCH&N programmes and policies?

There have been no significant impacts on the national RMNCH&N programmes at the time of Phase II of the evaluation. Two processes, in relation to IMAM, and the modelling exercise for newborn care, hold the potential for future direct national impact on specific aspects of national RMNCH&N policy. The engagement in PhilHealth, training and in sub-national planning hold the promise of wider system impacts.

(E) Is there a difference observed between districts involved in IC activities and those that are not?

The cities selected have RMNCH&N performance indicators above the national performance, and were showing established patterns of improved performance prior to the introduction of the EBaP process. Prior to EBAP introduction there have been other much bigger and major policy reforms (MNCHN Policy) and budgetary inputs to LGUs (double to triple budget outlay for health).

Figure 2: Comparison of two MNCH indicators with national average

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Were IC activities targeted to those with highest need? City denominators are unknow!
The two cities, Davao and Puerto Princesa, and the original district in Quezon City, District 2, have higher rates of SBA attendance and institutional deliveries than the national average.

There is considerable uncertainty over the denominator for urban areas, with large movements of people occurring between census surveys and even on a daily basis. Within these large urban areas, there are considerable pockets of poverty in slum areas where coverage is likely to be low.

Although Figure 2 suggests there is greater service provision and that these cities are not among the highest need communities in the country, within these cities there are areas where the needs are very high.

Trend information for the last three years from Puerto Princesa City shows high levels of coverage for most indicators except fourth ANC visits, and sustained rises in deliveries by SBA and facility based deliveries. This pattern of improving service delivery precedes any EBaP impact.

A similar trend is seen for Davao City, with improving performance across most indicators.

District 2 in Quezon City also shows substantial increased performance across all indicators, with greater than 100% coverage in immunisation and first ANC reflecting the temporary movement of people into the area for services.

Once again there was a pattern of improved performance prior to EBaP introduction, including Out Patient Visits.

Quezon City as a whole improved performance across many indicators over this time period.
(F) Has the IC approach influenced the way decisions are made?

The approach has influenced the way decisions are made in two of the three city sites. The focus on SAM has been discussed above. In Quezon City, the impact has been on the ability of district-level medical officers to articulate their needs, and this has been met by a positive response at the city level.

The engagement of a Manila-based IP (UPNCPAG) focused on developing the capacity of local staff. They have not built significant capacity at the national level, and would be unlikely to sustain the activities without further financial support from UNICEF.

There were mixed views about sustainability beyond UNICEF funding for the initiative.

In one city there was little doubt:

"We can sustain this. It will be a line item in the city budget." (City health officer)

There was also confidence from the IPs:

"There has been a depth of training for the teams in each city. This has now penetrated several levels, so if there is weak, or a change in leadership, the approach will persist." (IP)

Others at the city level were not so convinced that it would persist outside of UNICEF’s direct influence:

"There is a history of pilots in Davao that have not led to implementation. An example is a vitamin initiative through UNICEF. It was evaluated, seen to be successful, but not taken up nationally. IMAM is another example. We have a 21 year history of support from UNICEF." (City health worker)

"There is a need for continuous support from UNICEF beyond the current project time frame to make sure that the entire concept is institutionalised at the local level. There is also a need for UNICEF to push for integration in the DOH and Department of Interior and Local Government planning and budgeting process. Without this mandate the process may not be sustained and the staff trained on the EBaP will just revert back to the status quo." (City health officials)

(G) Has the IC approach strengthened the power of key actors engaged in MNCH&N at national or sub-national levels? For example, increasing their visibility, credibility, coordination, collective action, leadership, or available resources?

In two cities there was clear evidence of the EBaP strengthening the power of local actors. In Quezon City, the empowerment of medically trained district managers to understand and communicate their district’s needs was impressive. This was also assisted by a responsive city administration, who were then instructed to act on those needs and move away from the top-down approach to planning they were familiar with.

In Davao City, the approach strengthened the City Health Officer’s ability to make a case at the city level for more resourcing.

In Puerto Princepsa City, with a less sympathetic administration, there was less evidence that the local actors had been empowered by the process.

In terms of implementation partners, UQC provided the bulk of the technical inputs into the planning processes of the three cities as well as supporting national activities around neonatal health. The local implementation partner changed between phase one and phase two, and the new partner, University of Philippines National College of Administration and Governance, was new to the approach but is now developing a level of expertise, and considering its wider application.

The EBaP in the Philippines has been adept at taking advantage of ‘political windows’ that have opened in the course of the project, as can be seen by the range of national initiatives it has become engaged in.

(H) What is the nature and intensity of IC activities at the time of evaluation?

All the activities mentioned in the report were in a very active phase at the time of the evaluation. Activities were occurring in the three cities, as well as in the four areas of national engagement. The disruption caused by the typhoon had led to an extension of the programme for another six months, so the activities reported on in this report are by no means complete.
Do different stakeholders, including DPs, have consistently different views on the usefulness of the IC methodology in promoting improved MNCH?

The DPs interviewed during Phase II of the evaluation had little or no understanding of the EBaP. One commented:

“There goes UNICEF behaving like an NGO again.”

Another was not aware of the programme until immediately prior meeting with the evaluators.

There are a number of planning tools actively used in the Philippines. Examples include UNICEF tools such as rCHITs, and some which are specialised for the urban environment such as Urban HEART (Health Equity Assessment and Response Tool). The complementary use of the One Health tool has been mentioned previously.

There is clearly no consensus between government and DPs on the use of planning and budgeting tools.

The comparison across the four countries is contained in the Final Evaluation Report.
DISCUSSION

This evaluation has identified significant positive effects of the EBaP process in two of the three city sites. In Davao City, it supported a local prioritisation process, then implementation was strongly resourced by UNICEF, and now the city itself is actively considering direct funding of the intervention. In Quezon City, the impact has been on the management relationship between the City Health authorities and the district health leaders. The shift in emphasis taken by UNICEF from a focus on “tools” to a focus on “process” has contributed to this success.

Whereas, prior to the EBaP, planning was ‘top down’ and the system dynamics at the local level were not considered, now at the district level there is increased understanding of the complex requirements for effective programme delivery and improved ability and tools to articulate the unique needs to the city authorities. Importantly, the city health authorities have responded positively to these new and better articulated demands.

At the city level, the EBaP program has demonstrated that it can make significant impacts. It can improve the use and value derived from local data; it can help achieve improvements in service provision; it can improve local purchasing and management practices and (possibly) attract direct investment by the city. Most importantly, it can empower local level staff to advocate for the resource they need and extend their understanding of the dynamics of the health system they are engaged in.

The overall impact on outcomes needs to be considered in the context of a rapidly evolving health system. Considerable system improvement is evident across the Philippines health sector and there are many activities occurring. EBaP activities would be making, at best, a minor contribution to improvements in the key health indicators both at the national and the city levels. The main contributory factor for improvements in MNCH&N/FP/RH indicators would be the growth of the health budget between 2008 and 2013, growing from 10 billion pesos in 2008 to 33 billion in 2010, and eventually 80 billion in 2013. Another critical contributory factor is the push to implement the RMNCH&N policy that started in 2008, specifically shifting deliveries from home-based, traditional birth attendant delivery to skilled birth attendant delivery in health facilities, especially in BEmONC facilities. More recently, the major push for reproductive health and family planning by the current Aquino administration will have a significant impact.

While the necessary support in these cases was apparent at the city level, the approach at the national level is mixed. The EBaP approach is not widely accepted or understood either within government or amongst the development partners. There are multiple local level planning approaches and no shared views amongst development partners on which approaches to support. The EBaP as yet does not have a clear relationship with existing planning approaches and prioritisation. Its scope is also an issue, as at the local level the need is for a comprehensive planning approach, and its relationship with narrower approaches, such as micro planning, and with broader approaches that encompass issues from MCH to NCDs, has not been defined.

Of these, PhilHealth is the most significant, as it involves the design of a support package to increase access to primary health care for the poorest of the poor and the most marginalized sector of Philippine society. This is part of a wider global focus on Universal Health Coverage, and there are important lessons being generated in other countries about how this can be approached. UNICEF is playing a unique role in championing equity and a focus on mothers and children in this system change. Given the short timeframe, and the level of system change required, UNICEF should consider increasing its support for this initiative, including developing ways that the experience in other countries can be made available to the process.

Each of these initiatives has the potential to have far-reaching impacts on RMNCH&N. To realise this potential will require skills and resources of a different configuration, as each of these are specialty areas.
CONCLUSION

EBaP has been successful at invigorating local health administration, and identifying and mobilising accessible resources. It has successfully positioned UNICEF as a key adviser to government on decentralised planning, and brought an important focus to the process of local planning as well as improving the use of evidence.

The broader system initiatives such as PhilHealth that UNICEF is engaged in through its EBaP activities will have a profound impact on the future health service configuration of the Philippines. The skills, expertise and experience required to derive the maximum benefit from engagement with these activities need to be assessed.

To realise the full potential and sustain these activities, long term engagement and further refinement of processes in terms of scope and approach will be required, including building a consensus across development partners. There is a need for greater engagement with national agencies such as the DOH and the Department of the Interior and Local Government in the EBAP to further sustain the harmonization of the planning and budgeting processes and to integrate EBAP into existing nationally mandated planning and budgeting processes.

RECOMMENDATIONS

The achievements of the IC (EBaP) process in the Philippines are significant. The focus on city level planning processes is a key strategic opportunity in the further development of the Philippines health system and continued engagement in support of government in this area is highly recommended, building on the experience gained from the EBaP activities to date.

To fully realise this opportunity further consideration needs to be given to the following areas:

- Improve the alignment of the IC activities with the government’s planning and budgeting processes, (CIPH, PIPH) by strengthening the engagement with national agencies (DOH, DILG and DBM) to sustain the EBAP process and harmonize its tools and processes in the existing planning and budgeting system.

- Establish a broad consensus amongst development partners regarding advice to government on the approach to city level planning in the Philippines.

- Re-consider the scope of the city level planning processes, with regard to the participation of health sector actors such as the private sector and NGOs, and the scope of activities covered beyond RMNCH&N.

- Increase the technical resources available to the PhilHealth initiative, including leveraging global experience of moves towards UHC and their potential impact on equity and RMNCH&N.
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<tr>
<th>Recommendations</th>
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<th>Rationale and risks</th>
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<tr>
<td><strong>Align with government processes</strong></td>
<td>UNICEF, IPs, GoP</td>
<td><strong>Rationale</strong></td>
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<td>Improve the alignment of the IC activities with the government’s planning and budgeting processes (CIPH, PIPH) by strengthening the engagement with national agencies (DOH, DILG and DBM) to sustain the EBAP process and harmonize its tools and processes in the existing planning and budgeting system.</td>
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<td>The DOH has an existing local level planning and budgeting process. The government’s position is that they want support for their existing processes, and not the introduction of new processes. UNICEF is currently engaged in supporting a review of the existing subnational planning and budgeting process, but at the time of the evaluation, UNICEF’s agents conducting the review had minimal awareness of the IC activity.</td>
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<td><strong>Risks</strong></td>
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<td>The IC approach may need to be modified to conform to the government’s requirements.</td>
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<td><strong>DP consensus in approach</strong></td>
<td>UNICEF</td>
<td><strong>Rationale</strong></td>
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<td>Establish a broad consensus amongst development partners on advice to government on city level planning in the Philippines.</td>
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<td>There are differently labelled planning approaches being used at the district level, and other development partners are supporting their own planning approaches as well. The processes have more commonality than differences. Common elements relate to the use of evidence, the importance and use of local information, problem analysis, budgeting and planning, monitoring and review. Where they differ is in their scope and branding. It is desirable to bring these differently labelled approaches into a common framework in support of the government’s processes.</td>
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<td>Some elements of the IC process may need to be compromised.</td>
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| Engagement of the private sector | UNICEF, Government     | **Rationale**<br>The private sector is the main provider of health services in the Philippines, and consideration needs to be given to its engagement in the district and city planning process. The dual role that public sector employees play in both the private and the public sectors will require management within this process. The nature of engagement with the private sector needs to be consistent with the strategic intent of the planning process. The private sector’s participation as a stakeholder should be managed so that it does not compromise any regulatory or contracting relationship. Regulatory approaches to improving quality in private sector birthing centres are being taken in Quezon City, and this experience may have application more widely.  

**Risks**<br>There is a risk that the planning process becomes so broad that it loses focus and becomes ineffective. Engagement of other actors should be prioritised to those with the greatest ability to influence the health outcomes in question. |
| Increased support for PhilHealth PHC initiative | UNICEF Headquarters     | **Rationale**<br>The government’s PhilHealth initiative to extend primary coverage in the high need groups in the community is a time limited, once in a lifetime opportunity to support transformational change. UNICEF has a unique opportunity to support system developments that improve MCH and equity in this process. It is also an opportunity to support learning between countries who are undertaking similar policy shifts. In addition to the current UNICEF involvement, additional resources, as well as technical analysis of cross country developments are required to gain maximum value from this opportunity.  

**Risks**<br>This process has short time frames, limited information and high political expectations elevating the risk of policy failure. |
ACKNOWLEDGEMENTS

Thanks are due for the assistance and insights provided by the local consultant Dr Mario Villaverde, Quezon City officials led by Dr Antonietta Inumerable, Commonwealth Health Centre manager, Dr Kristine Agbayani, Davao City, Dr Josephine Villafuerte and her nutrition team and Puerto Princesa City officials led by Dr Juancho Monaserate.

The UNICEF country office in Makati provided the team with excellent access to their activities, and thanks also to Rossann Lovendino for her office assistance.

Finally, I wish to acknowledge the leadership and innovation shown by UNICEF regionally and globally, DFAT for their foresight and confidence in exploring this important area of health development, and UQc for their technical support.

INTERVIEWEES

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<tr>
<th>Name</th>
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<tr>
<td>Hammad Masood</td>
<td>Planning, Monitoring and Evaluation Specialist, UNICEF Philippines</td>
</tr>
<tr>
<td>Patrocinio Jude H. Esguerra III</td>
<td>Undersecretary of National Anti-Poverty Commission, Government of Philippines</td>
</tr>
<tr>
<td>Dr Lilibeth David</td>
<td>Director of Policy and Planning, Department of Health, Manila</td>
</tr>
<tr>
<td>Willibrand Zeck</td>
<td>Chief of Health, UNICEF Country Office, Manila, Philippines</td>
</tr>
<tr>
<td>Raoul Bermejo</td>
<td>Health Specialist, UNICEF Country Office, Manila, Philippines</td>
</tr>
<tr>
<td>Abbey Byrne</td>
<td>Senior Program Officer, Nossal Institute for Global Health, University of Melbourne</td>
</tr>
<tr>
<td>Erwin Alampay</td>
<td>University of Philippines, National College of Administration and Governance</td>
</tr>
<tr>
<td>Geovhacerela Bayron</td>
<td>Rural Health Midwife, Santa Monica Health Center, Puerto Princesa</td>
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<tr>
<td>Leonora Atienza</td>
<td>Rural Health Midwife, Santa Monica Health Center, Puerto Princesa</td>
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<tr>
<td>Anthony Calibo</td>
<td>Director of Child Health (except EPI), Department of Health, Manila</td>
</tr>
<tr>
<td>Dr Kristine Agbayani</td>
<td>Commonwealth Health Centre, Quezon City, Manila</td>
</tr>
<tr>
<td>Marcelino Escalade Jr</td>
<td>Davao City Planner</td>
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<tr>
<td>Flor Cayon</td>
<td>City Planning Office: Planning Officer</td>
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<tr>
<td>Dr Rosette Vergeire</td>
<td>Health Policy and Development Planning Bureau, Department of Health, Manila</td>
</tr>
<tr>
<td>Raul Alamis</td>
<td>Bureau of Local Health Development, Department of Health, Manila</td>
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<tr>
<td>Dr Josephine Villafuerte</td>
<td>City Health Officer, Davao City</td>
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<tr>
<td>Digna Salmasan</td>
<td>Health Officer, Davao City</td>
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<td>Dr Selna Tejare</td>
<td>Action Contre la Faim (ACF), Program Manager, Davao City</td>
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<td>Jojie Manalo</td>
<td>First Pacific Leadership Academy, Manila</td>
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<tr>
<td>Dr Antonietta Inumerable</td>
<td>City Health Officer, Quezon City</td>
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<td>Dr Antonio Gabigas</td>
<td>Quezon City General Hospital, Officer in Charge, Quezon City</td>
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<td>Dr Leticia Guzman</td>
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<td>Dr Juancho Guzmanate</td>
<td>City Health Officer, Puerto Princesa</td>
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<tr>
<td>Dr Liezel Lagrada</td>
<td>Vice President for Standards, Monitoring, PhilHealth, Shaw Blvd, Pasig City</td>
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<tr>
<td>Dr Rizza Herrera</td>
<td>Primary Care Benefit Package, PhilHealth, Shaw Blvd, Pasig City</td>
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<tr>
<td>Dr Mary Anne Remonte</td>
<td>MCH/FP Package, PhilHealth, Shaw Blvd, Pasig City</td>
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<tr>
<td>Dr Ricardo Panganiban</td>
<td>Asst. City Health Officer, Puerto Princesa City</td>
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<tr>
<td>Nelson Heredero</td>
<td>Population Program Officer, Puerto Princesa City</td>
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<td>Ofelia Aguilar</td>
<td>Project Evaluation Officer, Puerto Princesa City</td>
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<tr>
<td>Dolores Mesicula</td>
<td>Public Health Nurse, Puerto Princesa City</td>
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<td>Jasmin Rocamora</td>
<td>Public Health Nurse, Puerto Princesa City</td>
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<td>Analiza Herrera</td>
<td>Nutrition Officer, Puerto Princesa City</td>
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<td>Dr Eunice Rina Herrera</td>
<td>Medical Officer, Puerto Princesa City</td>
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<td>Engr Jovenee Sagun</td>
<td>City Planning and Development Officer, Puerto Princesa City</td>
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<tr>
<td>Dr Anthony San Juan</td>
<td>Regional Health Officer, National Capital Region, DoH</td>
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<td>Shelter workers and NGOs</td>
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<tr>
<td>Dr John Wong</td>
<td>Alliance for Improved Health Outcomes, Manila</td>
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<tr>
<td>Bukhati Shengelia</td>
<td>Senior Health Specialist, World Bank</td>
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<tr>
<td>Dr Jonathan Go</td>
<td>WHO Country Office (Philippines)</td>
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<td>Dr Roberto Rosadia</td>
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