Project Name	PHILIPPINES-PH-2ND WOMEN'S HEALTH & (@)... SAFE MOTHERHOOD
Region	East Asia and Pacific Region
Sector	Health (100%)
Project ID	P079628
Borrower(s)	REPUBLIC OF THE PHILIPPINES
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Environment Category	C
Date PID Prepared	February 12, 2003
Auth Appr/Negs Date	October 15, 2003
Bank Approval Date	April 29, 2004

1. Country and Sector Background

Women's Health Outcomes. Reviews of health status of Filipinos consistently point to relatively high levels of total fertility, maternal mortality and infant mortality for a country at its income level (US$1,020 in 1999). With a total fertility rate of 3.7 children per woman (1998), infant mortality rate of 49 infant deaths per 1,000 live births (1995) and a maternal mortality rate of 180 maternal deaths per 100,000 live births (1995), the Philippines obviously faces many outstanding challenges in securing improvement in these important indicators of health status. The introduction of the HIV virus into the country in the 1980's and the slow but definite spread of the infection around the archipelago has created an added source of concern about the state of overall reproductive health.

Over the last twenty years, a succession of government administrations have pursued several worthwhile directions in the field of maternal care, family planning and prevention of HIV/AIDS. In maternal care, a combination of (a) delivering improved services to mothers through the extensive network of public and private providers and; (b) deliberate reduction of the most harmful practices in birth attendance among still widespread traditional home-based deliveries, has brought down maternal deaths to comprise less than one percent of total deaths. These deaths, however, still comprise 14% of all deaths among women aged 15 to 49.

A wide range of family planning methods have been made available to most women of reproductive age, raising contraceptive prevalence from 36% in 1988 to 47% in 2000. Women, however, are still having, on average, one more child than they intended. Unmet needs for family planning remains

sizeable as reflected in an estimate for 1998 that places 20% of all women of reproductive age not able to practice family planning despite their stated desire to either limit or space their pregnancies. These outstanding problems also have to be tackled in the context of a demographic scenario where previous periods of high fertility have yielded a still growing population, which in 1995 included 38% of Filipinos 14 years old and below, who are slated to eventually enter the reproductive age groups.

STI and HIV/AIDS. Early recognition of the country's increased risk to an HIV/AIDS epidemic facilitated a relatively early and vigorous response, including passage and initial implementation of an enlightened national law on AIDS prevention. Although current levels of HIV prevalence remain relatively low (<0.01% of population 15-49 years, or around 9,400 people, estimated to be living with HIV/AIDS as of end-2001), risks remain due to a large population involved with commercial sex and practicing risky sexual behavior. Their current exposure to sexually transmitted diseases is driving the prevalence of these diseases, which might be a major factor in a still possible deterioration of the current "low and slow" rate of HIV/AIDS infection.

Access to Services for Disadvantaged Women. Traditionally, Government has ensured access to care for the poor through direct provision of care in publicly-owned facilities. Although initially meant to be provided completely free, these services have gradually become "less free" in that users are oftentimes expected to pay for drugs and diagnostic tests and/or purchase their own drugs and provide their own hospital food and bed linens. Prices in public facilities still remain lower than in private facilities because (i) professional fees are not charged; (ii) prices of drugs and diagnostic tests provided on-site are not increased to accommodate profit margins; and (iii) ward accommodation is available without charge. In general, though, the quality of care is perceived to be poorer in public facilities because of deteriorating physical infrastructure, frequent stock-outs in supplies, and less client-friendly staff.

Increased prices in public facilities has likely led to reduced use of health services by the very poor or serious economic difficulties for poor families that do use these facilities, particularly in emergency cases. Deteriorating quality has also led to bypassing of lower level public facilities to go directly to higher level public facilities where quality is perceived to be relatively better, or to private facilities, again with economic consequences for the poor (World Bank, Filipino Report Card on Pro-Poor Services, 2001).

A second major obstacle to access for the poor is physical accessibility of providers -- health facilities are often located in areas that are not easily accessible to the poorest families, who tend to live in more remote, less accessible areas. Concentration in areas of easy access is particularly true of private facilities (as well as private outlets for drugs and supplies), but to a large extent also applies to public ones. Even when public facilities are present, staff in these remote facilities tend to be more poorly qualified and the facilities more poorly stocked with supplies and more poorly maintained.

For WHSM services as with other health services, financial and physical access are major obstacles to care. This is particularly true with respect to the lack of access to hospitals that can offer safer deliveries and the poor transport conditions in the event of an obstetrical emergency when deliveries take place outside hospitals. For family planning, although FP commodities have largely been offered free or at highly subsidized prices, this situation will change soon with the expected reductions in contraceptive provision by USAID (see below).

Access to WHSM services is also limited by a lack of appropriately skilled personnel who could offer advice or services for the full menu of options for FP, treat STIs using the lower-cost syndromic approach (applicable where lab testing is unavailable), or offer counseling and testing for HIV infection. For adolescents specifically, there are few channels for offering advice on sexuality and high-risk behavior. Cultural and religious beliefs also play an important role, especially for FP.

Government's response to the above obstacles has mainly focused on continuing investment in public providers of WHSM services. Over time, this has proven insufficient because of the high cost of maintaining the physical and human capital infrastructure and because of limitations on public budgets. Devolution of health care to LGUs in the early 1990s was expected to improve the targeting of publicly-provided services to the most needy, although this has not really happened because of the lack of understanding at the local level of basic principles of efficient health financing and provision and because of the worsening budget situation. Deteriorating conditions in public facilities, combined with the growing need (because of the rapidly increasing population) has left many women in disadvantaged positions without access to publicly provided care.

The introduction of national health insurance in the mid-1990s was meant to ensure universal access by bridging the financing gap, with benefits accessible through accredited providers, whether public or private. In particular, the Indigent Program of the National Health Insurance Program (NHIP), which provides for public financing of membership premia for indigents, would allow the poorest families to participate in the program. However, the Indigent Program did not take off until 2001, and even then indigent members have been largely unable to use benefits because of the co-pay required by providers, making care still unaffordable to the poor. Because of their poorer standards, many public hospitals were unable to gain PHIC accreditation. In addition, the NHIP benefit package included only in-patient services and a limited number of specialty outpatient services, and it was only in 2001 that capitation payments to Rural Health Units were started as part of the Indigent Program package (as an incentive to LGUs to pay their share of the premium for indigents). Given that a large part of WHSM services are outpatient services, the NHIP has done little, so far, to help disadvantaged women get better access. Philippine Health Insurance Corporation (PHIC) is currently reviewing its benefit package for ways to render it more pro-poor. It is preparing to introduce a zero-co-pay package of basic services, including priority in- and outpatient services such as prenatal care, and is expanding the list of out-patient services in its standard benefit package. Through the Health Sector Reform Agenda (see below) the DOH is also promoting wider PHIC accreditation for public facilities through an upgrading program.

Contraceptive Supplies. Current levels of contraceptive use has remained stagnant at relatively low rates in the past 5 years (47% of married women of reproductive age use a family planning method; 32% use a contraceptive-based FP method). Most current users of FP depend on public sector providers (73% of pill users; 81% of IUD users; 94% of injectable users; 50% of condom users obtain their supply from public sources). In the last twelve years, contraceptive donations provided by USAID have accounted for 80% of the country's total supplies. These donated contraceptives (pills, IUDs, injectables and condoms) flow almost exclusively through the public sector and are provided free to clients. In the last few years, USAID has been promoting a "Contraceptive Independence Initiative" that would wean the country of its heavy dependence on donated contraceptives. This strategy would have two key features: (i) increased responsibility by the government to provide free or highly-subsidized contraceptives to poor households; and (ii) reduced support for contraceptives for households that are able to pay for these. USAID's current plans are to completely stop its condom deliveries and to start to reduce supplies of pills in 2003 and 2004 to levels sufficient to cover only the poorest users. On the other hand, the current administration has taken the position that no DOH funds will be used for purchasing contraceptives. There is, therefore, an imminent threat of serious shortages in contraceptive supplies in the country in the coming years.

Governmment Policies on Women's Health and Safe Motherhood. In general, the government's basic policies on these matters are sound. Public support is strong for extending high quality maternal care to all in both public and private sectors. Despite the policy not to use national budget funds to purchase contraceptives, the government remains committed to a policy of making a wide range of legally allowable family planning methods available to all on the basis of respect for the free and informed choices of women and couples. The Philippine AIDS Prevention and Control Act of 1998 provides a robust legal framework for the national response to HIV/AIDS, which is consistent with international best practice.

The real challenge is in making these policies bear down on the actual technical content, quality, cost, effectiveness and accessibility of services delivered to women at all localities and increasing appropriate use of these services by local populations, particularly by those segments whose current reproductive health status are well below the national average. Meeting this implementation challenge in the next five to ten years will need to account for at least the following key sector-wide conditions: (a) Public provisions of health services are now the financing and management responsibility of local governments. Sustainable success in securing better reproductive health outcomes for all will therefore depend largely on the readiness, capacity and response of local governments in assuming their legal mandate and performance accountability under the law. (b) Opportunities for mobilizing private providers have expanded considerably through the reform and expansion of the National Health Insurance Program (NHIP). Of special interest is the Indigent Program which provides for fully subsidized membership in the NHIP for indigent families, jointly financed by the National Government (NG) and the LGU. (c) National policies and programs initiated by the NG will need to move beyond mandates and target setting to support for more systemic issues of financing, logistics, quality assurance, information, and other

organizational functions.

The Government's Health Sector Reform Agenda (HSRA). The HSRA, adopted in 1999, presents a broad set of strategies and policies that comprise a potentially sustainable response to this challenge. Five major areas of reform are proposed: (i) provide fiscal autonomy to government hospitals, to reduce their dependence on direct subsidies from government; (ii) secure funding for priority public health programs, using multi-year budgeting to guarantee the needed continuity in resource availability; (iii) promote the development of local health systems and ensure their effective performance by engaging local government units in cooperative and cost sharing arrangements to improve local health services and providing them with the necessary technical assistance to enhance capacity for governance of health systems; (iv) strengthen the capacities of health regulatory agencies with special emphasis on the Bureau of Food and Drugs; and (v) expand the coverage of the National Health Insurance Program especially for the poor. These five reform areas are highly interdependent, complementary and therefore expected to be implemented as a package. Because responsibility for local health services is devolved to Local Government Units (LGUs), HSRA implementation will require full participation of LGUs with the DOH providing leadership, technical advice, regulation and selective financing as needed.

2. Objectives

ñ To assist disadvantaged women of reproductive age to gain sustainable access to high quality and cost-effective reproductive health (RH) services and to enable them to safely attain their desired spacing and number of children

ñ To assist in the development and implementation of systems within the framework of the Health Sector Reform Agenda (HSRA) that are critical for financing and delivery of reproductive health services.

3. Rationale for Bank's Involvement

The Bank was one of the first donors to express readiness to support the DOH's population policy, enunciated during the first months of the current Secretary's term (in June 2001) That policy statement, though issued under the cloud of the President's commitment to not use NG funds for purchasing contraceptives, nevertheless contained all the elements of a comprehensive and well-balanced program, including commitment to the full menu of methods and respecting clients' choice. The Bank's decision to finance other interventions where NG/loan support could be used productively for FP (training of staff, advocacy/information, rationalizing the delivery system for WHSM services in general) and to tap alternative funding sources for contraceptives (LGUs, NHIP, social marketing) - rather than to withhold support until the policy environment improved - has revived interest among other donors as well (e.g., ADB, recently decided to focus on FP and TB in its proposed Health Sector Reform Project). The project has also provided a vehicle for pursuing new alternatives for achieving contraceptive independence as USAID phases out its donations.

Besides the financial support for the three key components of the WHSM-SP, the Bank will also bring technical assistance to help the DOH and LGUs take a step back from the traditional ways of doing business to develop a more cost-effective package of services, and to ensure that financing issues in particular, and systemic reforms in general, figure as

prominently as the more usual technical issues in these new approaches and models.

4. Description
Component A: Support to Local Delivery of the WHSM Service Package

At selected project sites, this component would support local governments in mobilizing networks of public and private providers as well as other community groups in the locality to undertake activities and deliver services included in the Women's Health and Safe Motherhood service package (WHSM-SP), with focus on maternal care, family planning and STI/HIV control services. While local networks are intended to serve everyone in respective communities, the Project activities and inputs would give priority attention to assuring that disadvantaged women obtain their fair share in access to and use of the WHSM-SP. The component would include the following as appropriate for each project site:

A.1. Critical Capacities to Provide Quality WHSM Services. This subcomponent would ensure that critical organizational, facility, and human resource capacities essential to delivery of currently unavailable elements in the WHSM-SP are installed and maintained at the appropriate levels of the local health care delivery network of the project site.

A.2 Accessible and Affordable WHSM Commodities. This subcomponent would ensure an accessible and affordable supply of commodities necessary to deliver the WHSM-SP by: (i) establishing efficient procurement, logistics and management systems to enable coordinated support to local networks of public and private outlets in terms of mission-essential drugs and commodities; (ii) supporting the expansion of existing commercial and non-governmental initiatives providing affordable contraceptives to public and private outlets and other re-supply points at the community level; and (iii) developing a model blood services system meeting WHO standards for ensuring safe blood supplies to local networks of health outlets that perform transfusions.

A.3 Advocacy and Promotion of WHSM. This subcomponent would support mass media and other communications programs at the local level that: (i) promote knowledge, attitudes and behavior consistent with attaining desired WHSM outcomes, including demand and use of appropriate services; (ii) increase popular understanding of the barriers and risks to better women's health and safer motherhood, including greater appreciation of the nature of sexual risks to HIV/AIDS infection; (iii) create broad constituencies for vigorous, enlightened and forward looking local government responses to delivering WHSM services, including public support to assuring availability to all of the full menu of family planning methods.

A.4 Integrated Local Financing and Management of WHSM Services. This subcomponent would develop and field test potentially replicable systems for local financing and management of WHSM services delivered by the local networks of providers assisted and supported by sub-components A.1, A.2 and A.3. Models for management systems of local networks would be based on LGUs serving both as administrators of LGU-owned and managed service outlets, and as facilitators of private providers that are sub-contracted, coordinated or linked up with the public system. Models for financing

would establish local arrangements for mixing and matching different sources and uses of funds for WHSM services. National government financing would be linked with LGU financing at provincial, city, municipal and/or barangay levels, and this combined government financing would be matched and mixed with social insurance payments and individual payments. The management and financing systems would be linked to the service delivery systems.

Component B: National Capacity to Sustain WHSM Services

This component would develop national-scale institutional capacities, policy frameworks and knowledge management mechanisms that would create an operating environment conducive to LGUs managing and sustaining local delivery of the WHSM-SP at levels necessary to improve outcomes. The component would support four key channels through which the national government continues to influence the cost, quality, reach and equity of already locally devolved service delivery. These channels are: (a) promulgation of technical guidance and regulatory standards with which local providers are obliged to comply; (b) provision of staff competencies which are regarded as valuable or attractive by local workers and managers; (c) extension of funding support for goods and services through national government resource transfers or through PHIC payments to local providers; (d) dissemination of monitoring, evaluation or research findings which local providers have to confront or consider. While these channels operate to serve a wide range of health objectives important to the national government, the focus of the Project is to assist in those aspects of navigating these channels that are important to the delivery of the WHSM-SP to all women in general and to disadvantaged women in particular.

B.1 Operational and Regulatory Guidelines for Provision and Use of WHSM Services. This subcomponent will support the research-based formulation, transparent official adoption, and thorough field dissemination and installation of two types of technical guidelines, namely, best-practice advisory operational guidelines which providers need to consider for improved services, and mandatory regulatory standards which providers are obliged to meet. The guidelines themselves may be in various forms such as service delivery standards, clinical practice guidelines, referral protocols, IEC and counseling guidelines, technical specifications of goods and equipment, checklists and procedural manuals, etc. necessary for the provision and use of WHSM services.

B.2 HRD Systems for Competencies in WHSM. This subcomponent will provide support for local providers and managers to obtain competencies and capabilities essential to providing the WHSM-SP according to the needs and specifications of Component A. Two key systems would be supported, namely, the health worker training system which extends a range of training opportunities for health workers to acquire critical knowledge and skills; and the public sector health worker appointment, deployment and supervision system which administratively directs the broad function and behavior of civil servants in health.

B.3 National Instruments for Financing Local Delivery of WHSM Services. This subcomponent would support Component A through the strengthening of

two specific national instruments in terms of their sensitivity to WHSM concerns. One instrument is the DOH annual budget, which can provide the important resource transfers from the national government to local governments on cost items for delivering WHSM services. The DOH budget could provide critical subsidies for some commodities, training, and other goods and services that are of value to integrated local service delivery. This subcomponent would provide support for the development of new WHSM-friendly budgetary provisions and budget execution mechanisms that would be linked to LGU's budget formulation and allocation processes.

The other key national instrument is the NHIP policies concerning enrollment coverage, benefit package specification, provider accreditation and provider payment. The subcomponent would support the development of new NHIP policies in these areas, including policies concerning new beneficiary services to be extended by PHIC through Local Health Insurance Offices, which may offer opportunities for more effective support to local WHSM services.

B.4 Monitoring, Evaluation, Research (MER) and Dissemination. This sub-component would (a) track progress in implementation of the WHSM service package using pre-identified intermediate indicators and performance benchmarks; (b) carry out baseline and evaluation studies in project sites; (c) support policy and operations research on WHSM; and (d) disseminate MER results to relevant stakeholders.

5. Financing
Total (US$m)
BORROWER $10.00
IBRD $30.00
IDA
Total Project Cost $40.00

6. Implementation
The Project will be implemented over six (6) years. Implementation of WHSMP 2 will involve DOH at both central and regional levels, as well as Chief Executives and Provincial/Municipal Health Officers in the project sites. Civil society organizations will be involved in project activities at the community level.

Within DOH, the main responsibility for project management and administration will lie with the Unified Project Management Division (UPMD). Overall technical responsibility will be with the respective program units concerned, with the National Center for Disease Prevention and Control (NCDPC) acting as lead coordinator. Coordination of field activities with LGUs will be the responsibility of the DOH's Regional Centers for Health Development (CHDs).

Although the National Government (NG) is the Borrower for the project and responsibility for project management and implementation lies principally with NG agencies, all activities under the first component of the project (Support to Local Delivery of the WHSM Service Package) can occur only with full participation of the provincial and municipal governments involved, and their respective health teams under the leadership of the Provincial and Municipal Health Officers. Each ILHZ is managed by an Inter-Local Health Board (ILHZ Board) which is the policy and governing

body that provides complementary advice to the legally constituted health boards at provincial and municipal areas, with membership consisting of representatives (usually LCEs of the concerned province and municipalities). Its main purpose is to facilitate inter-LGU cooperation and coordination (DOH, A Handbook on Inter-Local Health Zones: District Health System in a Devolved Setting, 2002).

Civil society organizations, to be modeled after the community-based Women's Health Groups organized under the Partnerships Component of the First Women's Health and Safe Motherhood Project, will be involved in design, implementation and monitoring of project activities and outcomes at the field level.

7. Sustainability

Severe budget constraints in a time of budget deficit are by themselves serious obstacles to long-term sustainability. Add to that the complications that stem from political sensitivities surrounding family planning, and it becomes even more difficult to guarantee that project outputs and outcomes will continue after the project ends. The project will nevertheless attempt to work around these fiscal and political constraints to generate a system for effective WHSM service delivery.

Political. The political volatility of the FP program presents the greatest risk to project sustainability. Assuming that the permanence of uncertainty at the top would continue, the best strategy would be to build a growing constituency at the grassroots level that will demand FP services even when local or national politicians or strong personalities oppose it, and that will eventually carry sufficient weight to bring greater stability to the program.

A second key element of the strategy would be to maintain strong support for the full menu of (legal) FP methods (including NFP), and to ensure that information on all methods is always impartially provided, and that the client's choice is always respected

Institutional. There is a substantial institution-building component in the project. At the national level, the project would help DOH develop the policy framework and mechanisms for knowledge and skills transfer to the LGUs. It would also help PHIC establish a benefit package and payment mechanisms that contribute to achieving universal access to the core WHSM-SP. At the local level, LGUs will acquire the systems and skills to manage, finance, provide and sustain local delivery of the WHSM-SP and will learn to organize themselves into efficient-sized groupings that correspond to the scale economies of a health care delivery system (ILHZs). At the community level, health and non-health public institutions, private facilities and community groups will build a politically influential constituency for WHSM.

Financial. The project would help develop and establish WHSM-SP financing systems that are less susceptible to the vagaries of politics, and yet are prepared to mobilize opportunistically should political conditions turn favorable. Of critical importance is the goal of contraceptive independence, built around a market for contraceptives with fewer price distortions, and which reserves public subsidies, whenever available, for those who truly cannot afford to pay.

8. Lessons learned from past operations in the country/sector
Overall, the most important lesson from recent and ongoing projects in the human development portfolio in the Philippines is that the implementation of Bank-funded projects can be seriously impeded by the inadequate implementation capacity and management oversight in the implementing agency. In particular, the ICR of the recently closed Bank-loan for the Urban Health and Nutrition Project and preliminary findings of the First WHSMP ICR emphasize the following lessons:
the need to recognize that, under devolution, the LGU plays the major role in health care delivery and DOH can act only in conjunction with the LGUs; as a corollary, the need to involve LGUs as active partners in project preparation, implementation and monitoring
the need for a professional project management office in the implementing agency while involving technical services in all aspects of project implementation;
the need to resolve cross-cutting fundamental management problems upfront (e.g., weak financial management, procurement and civil service).

The DOH has been taking action to address these issues over the last few years, through:
adoption of the HSRA, which defines the respective roles of the DOH and LGUs in health sector development consistent with the realities of devolution - viz., technical assistance and regulation as the main responsibilities of the DOH and its regional offices and implementation and financing as the main responsibilities of the LGUs;
establishment of a Unified Project Management Division (UPMD) with TORs that require the unit to work with technical services in DOH on technical aspects of projects;
capacity building efforts being implemented under the Second Social Expenditure Management Project (SEMP2) for the FM, procurement and IT units within the DOH central and regional offices.

9. Environment Aspects (including any public consultation)
Issues : The issue of medical waste management will require close attention in the project, in particular because incineration is not legal in the Philippines. The Safeguards review of the proposed Philippine Health Sector Reform Project (minutes dated July 16, 2002) recommended that the project review the country's solid waste legislation, its overall strategy for medical waste, its readiness to respond to the new law, and how the project can contribute to that readiness. It was also suggested that the HSRP could consider piloting alternative technology for the disposal of medical waste. A strategy for medical waste management will be worked out as part of the preparation of the HSRP (also a FY04 operation) with PHRD funds now set aside for this purpose. Recommendations from that study will be applied in this project (WHSMP2), to the extent appropriate.

The HSRP Safeguards review also recommended that, "if new construction is planned, then an Environmental Assessment could be needed, depending on the nature and scale of the works. However, if limited construction or rehabilitation is planned, no EA is needed, but construction contracts and bidding documents should included good construction practices. It was recommended that all medical facilities be asked to prepare a medical waste management plan. The Safeguards team recommended that if the exact project locations are not known by appraisal, then a screening process

would have to be developed and used to identify potential environmental concerns. However, if project locations are known prior to appraisal, then the task team should notify the safeguards team on the nature and scale of construction so that the most appropriate environmental and social safeguards measures can be determined."

For this project (WHSMP2), it is likely that there will be some rehabilitation and small new construction, and that not all locations will be known prior to approval. The task team should be able to inform the safeguards team of the nature and scale of construction by the time of appraisal, as advised for the HSRP.

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Note: This is information on an evolving project. Certain components may not be necessarily included in the final project.

This PID was processed by the InfoShop during the week ending February 21, 2003.