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PROJECT PERFORMANCE ASSESSMENT REPORT

THE PHILIPPINES

Improving Basic Health: The World Bank's Experience in the Philippines

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Report No.: 114021

PROJECT PERFORMANCE ASSESSMENT REPORT

THE PHILIPPINES

NATIONAL SECTOR SUPPORT FOR HEALTH REFORM (IBRD LOAN NO 73950)

SECOND WOMEN'S HEALTH AND SAFE MOTHERHOOD PROJECT (IBRD LOAN NO 72900)

September 20, 2017

Human Development and Economic Management
Independent Evaluation Group

Currency Equivalents (annual averages)

Currency Unit = Philippine pesos (₱)

2006	US$1.00	₱49.2
2007	US$1.00	₱46.1
2008	US$1.00	₱44.3
2009	US$1.00	₱47.7
2010	US$1.00	₱45.1
2011	US$1.00	₱43.3
2012	US$1.00	₱42.2
2013	US$1.00	₱42.4

All dollar amounts are U.S. dollars unless otherwise indicated.

Abbreviations

AIDS	acquired immune deficiency syndrome
BCG	Bacillus Calmette–Guérin
DHS	Demographic and Health Surveys
HIV	human immunodeficiency virus
ICR	Implementation Completion and Results Report
IEG	Independent Evaluation Group
LGU	local government units
NSSHR	National Sector Support for Health Reform
PAD	project appraisal document
PDO	project development objective
PhilHealth	Philippine Health Insurance Corporation
PPAR	Project Performance Assessment Report
TB	tuberculosis
UNICEF	United Nations Children's Fund
WHO	World Health Organization

Fiscal Year

Government: January 1 – December 31

Director-General, Independent Evaluation:	Ms. Caroline Heider
Director, Human Development and Economic Management:	Mr. Auguste Tano Kouame
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This report was prepared by Erik Bloom who assessed the projects in February 2017. The report was peer reviewed by Antonio Giuffrida and panel reviewed by Susan Caceres. Aline Dukuze provided administrative support.

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Principal Ratings

National Sector Support for Health Reform

	ICR*	ICR Review*	PPAR
Outcome	Moderately Unsatisfactory	Unsatisfactory	Moderately Unsatisfactory
Risk to Development Outcome	Moderate	Moderate	Negligible
World Bank Performance	Moderately Unsatisfactory	Moderately Unsatisfactory	Moderately Unsatisfactory
Borrower Performance	Moderately Unsatisfactory	Moderately Unsatisfactory	Moderately Unsatisfactory

* The Implementation Completion and Results (ICR) report is a self-evaluation by the responsible global practice. The ICR Review is an intermediate IEG product that seeks to independently validate the findings of the ICR.

Second Women's Health and Safe Motherhood Project

	ICR	ICR Review	PPAR
Outcome	Moderately Unsatisfactory	Moderately Unsatisfactory	Moderately Satisfactory
Risk to Development Outcome	Low to Negligible	Negligible to Low	Negligible
World Bank Performance	Moderately Unsatisfactory	Moderately Unsatisfactory	Moderately Unsatisfactory
Borrower Performance	Moderately Unsatisfactory	Moderately Unsatisfactory	Moderately Satisfactory

Key Staff Responsible

National Sector Support for Health Reform

Project	Task Manager/Leader	Sector Manager	Country Director
Appraisal	Loraine Hawkins	Fadia M. Saadah	Joachim von Amsberg
Completion	Roberto Antonio F. Rosadia	Toomas Palu	Motoo Konishi

Second Women's Health and Safe Motherhood Project

Project	Task Manager/Leader	Sector Manager	Country Director
Appraisal	Teresa Ho	Fadia M. Saadah	Joachim von Amsberg
Completion	Roberto Antonio F. Rosadia	Toomas Palu	Motoo Konishi

IEG Mission: Improving World Bank Group development results through excellence in independent evaluation.

About this Report

The Independent Evaluation Group (IEG) assesses the programs and activities of the World Bank for two purposes: first, to ensure the integrity of the World Bank's self-evaluation process and to verify that the World Bank's work is producing the expected results, and second, to help develop improved directions, policies, and procedures through the dissemination of lessons drawn from experience. As part of this work, IEG annually assesses 20–25 percent of the World Bank's lending operations through fieldwork. In selecting operations for assessment, preference is given to those that are innovative, large, or complex; those that are relevant to upcoming studies or country evaluations; those for which Executive Directors or World Bank management have requested assessments; and those that are likely to generate important lessons.

To prepare a Project Performance Assessment Report (PPAR), IEG staff examine project files and other documents, visit the borrowing country to discuss the operation with the government and other in-country stakeholders, interview World Bank staff and other donor agency staff both at headquarters and in local offices as appropriate, and apply other evaluative methods as needed.

Each PPAR is subject to technical peer review, internal IEG panel review, and management approval. Once cleared internally, the PPAR is commented on by the responsible World Bank country management unit. The PPAR is also sent to the borrower for review. IEG incorporates both World Bank and borrower comments as appropriate, and the borrowers' comments are attached to the document sent to the World Bank's Board of Executive Directors. After an assessment report has been sent to the Board, it is disclosed to the public.

About the IEG Rating System for Public Sector Evaluations

IEG's use of multiple evaluation methods offers both rigor and a necessary level of flexibility to adapt to lending instrument, project design, or sectoral approach. IEG evaluators all apply the same basic method to arrive at their project ratings. Following is the definition and rating scale used for each evaluation criterion (additional information is available on the IEG website: http://ieg.worldbankgroup.org).

Outcome: The extent to which the operation's major relevant objectives were achieved, or are expected to be achieved, efficiently. The rating has three dimensions: relevance, efficacy, and efficiency. *Relevance* includes relevance of objectives and relevance of design. Relevance of objectives is the extent to which the project's objectives are consistent with the country's current development priorities and with current World Bank country and sectoral assistance strategies and corporate goals (expressed in poverty reduction strategy papers, country assistance strategies, sector strategy papers, and operational policies). Relevance of design is the extent to which the project's design is consistent with the stated objectives. *Efficacy* is the extent to which the project's objectives were achieved, or are expected to be achieved, taking into account their relative importance. *Efficiency* is the extent to which the project achieved, or is expected to achieve, a return higher than the opportunity cost of capital and benefits at least cost compared with alternatives. The efficiency dimension is not applied to development policy operations, which provide general budget support. *Possible ratings for Outcome:* highly satisfactory, satisfactory, moderately satisfactory, moderately unsatisfactory, unsatisfactory, highly unsatisfactory.

Risk to Development Outcome: The risk, at the time of evaluation, that development outcomes (or expected outcomes) will not be maintained (or realized). *Possible ratings for Risk to Development Outcome:* high, significant, moderate, negligible to low, not evaluable.

World Bank Performance: The extent to which services provided by the World Bank ensured quality at entry of the operation and supported effective implementation through appropriate supervision (including ensuring adequate transition arrangements for regular operation of supported activities after loan/credit closing, toward the achievement of development outcomes). The rating has two dimensions: quality at entry and quality of supervision. *Possible ratings for World Bank Performance:* highly satisfactory, satisfactory, moderately satisfactory, moderately unsatisfactory, unsatisfactory, highly unsatisfactory.

Borrower Performance: The extent to which the borrower (including the government and implementing agency or agencies) ensured quality of preparation and implementation, and complied with covenants and agreements, toward the achievement of development outcomes. The rating has two dimensions: government performance and implementing agency(ies) performance. *Possible ratings for Borrower Performance:* highly satisfactory, satisfactory, moderately satisfactory, moderately unsatisfactory, unsatisfactory, highly unsatisfactory.

Preface

This Project Performance Assessment Report (PPAR) assesses two World Bank health projects in the Philippines: the National Sector Support for Health Reform Project and the Second Women's Health and Safe Motherhood Project.

The National Sector Support Project was approved in June 2006 and closed in March 2012, nine months after the original date of June 2011. The Second Women's Health Project was approved in April 2005 and closed in June 2013, 12 months after the original date of June 2012. For both projects, the extensions were to permit the projects additional time to finish their activities.

These projects were selected for a field-based assessment for several reasons. First, both projects represented major efforts to reform the health sector in the Philippines. Second, the Independent Evaluation Group (IEG) had previously recommended both projects for further evaluation during the Implementation Completion and Results Report (ICR) review process to validate ratings. Third, the PPAR will contribute to IEG's ongoing evaluation on the World Bank's Support for Basic Health Services.

This report was prepared by Erik Bloom, Senior Economist, IEG. Its findings are based on a review of the project appraisal document, ICRs, ICR reviews, aide-mémoire, World Bank reports, and other relevant materials. It also takes advantage of recent administrative data and household surveys. An IEG mission visited the Philippines in February 2017. This mission included a field visit to two municipalities in the National Capital Region and two in the Bicol Region. The mission interviewed staff involved in the project's implementation as well as policy experts in the Department of Health, the Philippine Health Insurance Corporation, and the National Economic Development Agency. The mission also met with staff at the provincial and municipal levels and visited several hospitals, health centers, and birthing facilities. Appendix C provides a list of persons interviewed. The mission would like to express its thanks to Maylene Beltran and staff at the Department of Health as well as staff in different government agencies and at the local level.

Following standard IEG procedures, a copy of the draft report was sent to the relevant government officials and agencies for their review and feedback. No comments were received.

Summary

The Philippines is classified as a lower middle-income country, with a gross national income of $3,550 per capita and an estimated population of 101.6 million in 2015. In recent years, economic growth has increased substantially between 2012 and 2016, the longest period of sustained economic growth in recent history. However, poverty and inequality remain high and persistent.

At the time of both projects' appraisal, the Philippines had seen low increases of health outcomes that were among the slowest in the region. The Philippines has a double *burden of disease*—both from traditional public health issues and emerging noncommunicable diseases. Health equity was a major challenge, in terms of access and health outcomes, and the high cost of healthcare contributed to impoverishment. The Philippines has long pursued health reform, built around improving equity with demand-based finance through a combination of public and private health services.

National Sector Support for Health Reform

The project's objective was "to assist the Borrower in: (i) improving priority public health outcomes and increasing the utilization of health services by the poor in areas and for conditions or diseases subject to intervention under the Project; and (ii) increasing financial protection of indigents from health care costs." The relevance of the objective was **high** because the project was closely aligned with the World Bank Group's previous and current country strategies and with the government's health care and development strategies. The relevance of the design is rated **substantial.** The project included both supply-side and demand-side interventions, including financing for the government's public health insurance program and the procurement of drugs and vaccines. The project also supported complementary reforms.

The project had a mixed impact on improving public health outcomes. The project contributed to a decline in the tuberculosis incidence rate, from 473 per 100,000 to 412 per 100,000 between 2006 and 2013. During the same period, the case detection rate increased from 36 percent to 57 percent. Despite the project's support for vaccination, it is not clear that there was improvement in the childhood immunization rate.

The project's support led to an increase in the coverage of Philippine Health Insurance Corporation (PhilHealth), from 13.6 million poor receiving subsidized coverage in 2007 to 31.4 million in 2013. This, in turn, contributed to the increased use of health services by the poor, with utilization rates of the first and second quintiles often reaching the rates of the other three quintiles. However, it appears that healthcare continues to consume a significant portion of the poor's income and still plays a major role in impoverishing many households.

The project's outcome is rated **moderately unsatisfactory** based on a **high** relevance of objective and a **substantial** relevance of design, **substantial** improvement in one objective (increase the utilization of health services by the poor) and **modest** achievement in two objectives (improve public health outcomes and increase the financial protection for the

extreme poor). Efficiency is rated **modest;** though the project made several long-term contributions, the same results could have been achieved for a lower cost or a smaller project.

Since the project closed, the fiscal situation of the Philippines has improved significantly, which has led to a major decline in "stock-outs" and increase in support for PhilHealth. Thus, the risk to development outcome is **negligible.** Although there were shortcomings, the World Bank showed flexibility in preparation, close coordination with other partners, and alignment with government strategy. The World Bank could have been more proactive in restructuring and in administrative procedures. World Bank performance is rated **moderately unsatisfactory.** The government had ownership of the project's objective and provided the necessary support. However, there were important shortcomings, which led to slow implementation, delayed delivery of key reports, and limited support to local government units. Borrower performance is rated **moderately unsatisfactory.**

The objective-level indicators were well-chosen with baselines and targets, but the intermediate indicators did not have baseline values at the time of approval. The World Bank did not collect data on many indicators. Though there is no evidence that the project used data, it did make important contributions to the country's monitoring and evaluation capacity at the national and local levels. Monitoring and evaluation is rated **modest.**

Women's Health and Safe Motherhood Project

The project's objective was "to assist the Borrower in improving women's health by: (i) demonstrating in selected sites a sustainable model of delivering cost-effective reproductive health services to disadvantaged women; and (ii) establishing support systems to facilitate countrywide replication of lessons learned within the framework of its Health Sector Reform Agenda." The relevance of objective is rated **high.** The project was well aligned with the World Bank Group's country strategy at approval; the current strategy identifies the possibility of continued support. The country's development strategy continues to support the project's interventions. The relevance of design is rated **modest.** Though the objective had a relatively broad definition of reproductive health, the project design was largely aimed at the safe motherhood aspect. The design did not fully take the low capacity of many of the local governments into account.

The project's support led to a large increase in the number of facility-based deliveries, with percentage of births increasing from 30 percent to 50 percent to above 80 percent in four of the five provinces. The government adopted the project's safe motherhood interventions nationally, which also led to a major increase in facility-based deliveries throughout the country. The project had limited impact on the use of family planning or other women's health outcomes. Overall efficacy for the project's sole objective (improving women's health) was rated **substantial.**

The project's outcome is rated **moderately satisfactory** based on a **high** relevance of objective, a **modest** relevance of design, a **substantial** achievement of outcomes, and **modest** efficiency. The project closed 12 months late. In the first five years of the project, only 18 percent of funds were disbursed, and when the project closed 35 percent were

canceled. An important amount of the World Bank's capital was never utilization. The same outcomes could have been achieved by a smaller project.

The project's approach to safe motherhood is well established in policy and procedure across the country. The risk to development outcome is rated **low to negligible.** Though the World Bank worked closely with the Department of Health to develop a new approach to safe motherhood, there were many shortcomings in how it approached the government's capacity at all levels. The World Bank missed several opportunities to restructure the project and improve its performance. World Bank performance is rated **moderately unsatisfactory.** The national and local governments showed a high degree of ownership of the project and its objectives. This led to the adoption of its interventions nationwide. There were several shortcomings with the project's implementation. At the central level, the implementing agency did not have sufficient staff, which led to delays in a range of activities, including delays in contracting and monitoring project data. The municipalities often lacked the capacity to meet administrative requirements. Borrower performance is rated **moderately satisfactory.**

The project had a well-developed results framework and results monitoring framework, which largely focused on safe motherhood outcomes. Most of the objective-level indicators had baselines and (ambitious) target values, but this was not the case for the intermediate indicators, for which the baseline survey was conducted two years late. Local governments used data for decision making and fine-tuning their activities, but the extent to which the project used them is not clear. Monitoring and evaluation is rated **modest.**

Lessons

Based on the experience from both projects, there are several lessons:

- **When designing results frameworks and identifying the associated data sources, especially for outcome-level data, project teams should take into consideration data sources beyond those collected at the project level.** Much of the data that this evaluation relied on to measure outcomes were captured outside of the project, such as the Demographic and Health Survey and commonly-available health and epidemiological data. Although these data were available at the time of project preparation, they were not fully incorporated in the results framework. There was a further missed opportunity at the Implementation Completion and Results Report (ICR) stage; these additional sources were available when the ICRs were prepared but they were not included because the ICRs restricted themselves to what had been captured by the projects' monitoring and evaluation systems.

- **There are many possibilities in working across projects and sector silos.** Both projects achieved their objectives in large part owing to their collaboration with other interventions. PhilHealth played a major role in achieving the ambitious targets in the Second Women's Health and Safe Motherhood Project because its financing permitted the expansion of both public and private birthing facilities. The World Bank's support for creating the National Household Targeting System played a major role in strengthening PhilHealth. Likewise, the World Bank's support for introducing

sin taxes contributed significantly to PhilHealth's growth. Much of this synergy was planned, but some of it arose during implementation, demonstrating the importance of the flexibility that allows projects to take advantage of opportunities as they present themselves.

- **The consequences of not considering legal structures can lead to delays or reduced effectiveness.** Both projects knew about the World Bank's experience in the Philippines and the challenges associated with working with local government units. Nevertheless, many of the shortcomings were associated with difficulties at the local government unit level. Though much of the focus was on the capacity of these units, the projects did not fully consider national rules on financial management, procurement, and their conduct. These rules proved to be strict and changing. For example, it proved to be quite challenging for local government units to open bank accounts as required in the Second Women's Health and Safe Motherhood loan agreement. Likewise, the government never established a national account for the project to facilitate disbursements.

- **Small interventions and pilots can have transformational impact.** The FOURmula One health sector reform was built on implementing many new initiatives to improve the efficiency and effectiveness of health care in the Philippines. Both projects were designed to pilot certain elements of the reform while also supporting specific elements of the reform. Both project included several interventions that drove much of the reform's positive impacts. The National Sector Support for Health Reform project introduced a targeting system, which was a relatively small intervention and played a major contribution to the rapid increase in PhilHealth. Likewise, the increase in the facility-based delivery? was driven by the growth in PhilHealth and the Second Women's Health and Safe Motherhood Project's support for Women's Health Teams. This proved to be more impactful than capital expenditures.

Auguste Tano Kouame
Director
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1. Background and Context

1.1 The Philippines is a lower-middle-income country, with a gross national income of $3,550 per capita and an estimated population of 101.6 million in 2015. In recent years, economic growth has increased substantially with rates between 5.9 percent and 7.1 percent between 2012 and 2016. This is the longest period of sustained economic growth in recent history for a country that has had a volatile economy. Despite recent economic growth, poverty and inequality remain high and persistent. From 2003 to 2012, the poverty rate hovered around 25 percent; in 2015 it dropped to 20.6 percent, its first statistically significant reduction. From 1990 to 2012, the Gini index was within the range of 43 to 46. Table B.1 provides detailed data on key economic indicators.

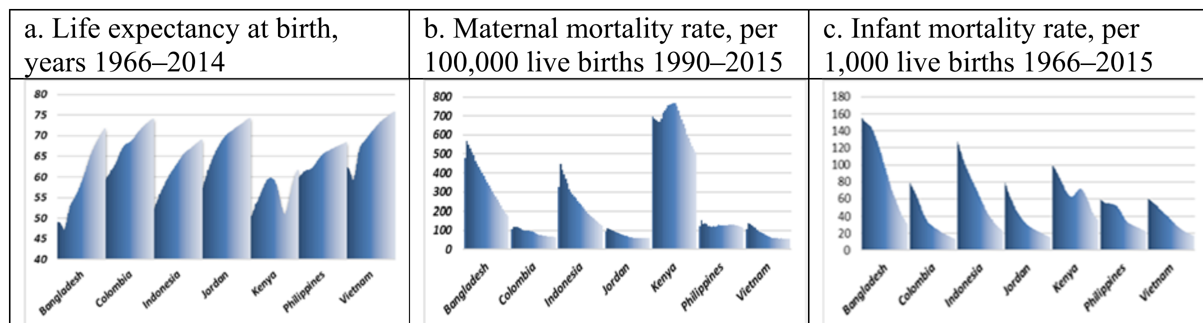
1.2 During the late 1990s and the first decade of the 2000s, the Philippines faced a serious fiscal crisis. The government had a large fiscal deficit and the debt level was expanding rapidly. This led to a series of fiscal adjustments, reduced government spending and higher taxes (World Bank 2005c). By about 2010, economic growth, combined with greater government transparency and improved tax collection, made substantially more resources available to the public sector. The health sector has benefited from the introduction of “sin taxes” in 2012, covering alcohol and tobacco with revenues targeted for the health sector.

Demography and Health

1.3 After World War II, the Philippines had among the best health results in the East Asian and Pacific Region. However, the Philippines has fallen behind other countries in the region. Figure 1.1 presents comparative data on life expectancy, maternal mortality, and infant mortality in seven countries. The Philippines started out in a relatively privileged position but saw less progress than other countries. For example, it had a 25 percent reduction in maternal mortality compared with 45 percent in Colombia and Jordan.

Figure 1.1. Selected Health Indicators

a. Life expectancy at birth, years 1966–2014	b. Maternal mortality rate, per 100,000 live births 1990–2015	c. Infant mortality rate, per 1,000 live births 1966–2015



Source: World Bank data.

1.4 The Philippines is considered to have a double burden of disease: It is affected by traditional public health issues—communicable diseases and poor nutrition—while facing a growing number of noncommunicable health issues such as cancer, diabetes, and cardiovascular disease. Table 1.1 presents the evolution of the burden of disease of the Philippines from 1990 to 2015, expressed in disability-adjusted life years lost. This

methodology calculates the total number of years of life that are lost to early mortality and disability. Appendix table B.2 provides more detailed data.

Table 1.1. Burden of Disease in the Philippines, 1990–2015

Cause	1990	2000	2005	2010	2015	Annual Growth Rate
Communicable, maternal, neonatal, and nutritional diseases *(percent)*	52	40	35	31	26	−2.1
Noncommunicable diseases *(percent)*	39	50	55	60	65	2.7
Injuries *(percent)*	9	10	10	9	9	0.9
Total DALYs lost *(number, unless otherwise indicated)*	24,497,011	25,039,390	26,814,940	28,146,770	28,905,992	0.7%

Source: The *Lancet*.
Note: DALYs = disability-adjusted life years. Percentages refer to the percent of total DALYs lost. Values within categories may not sum due to eliminated rows. The annual population growth rate during this period was 2.2 percent.

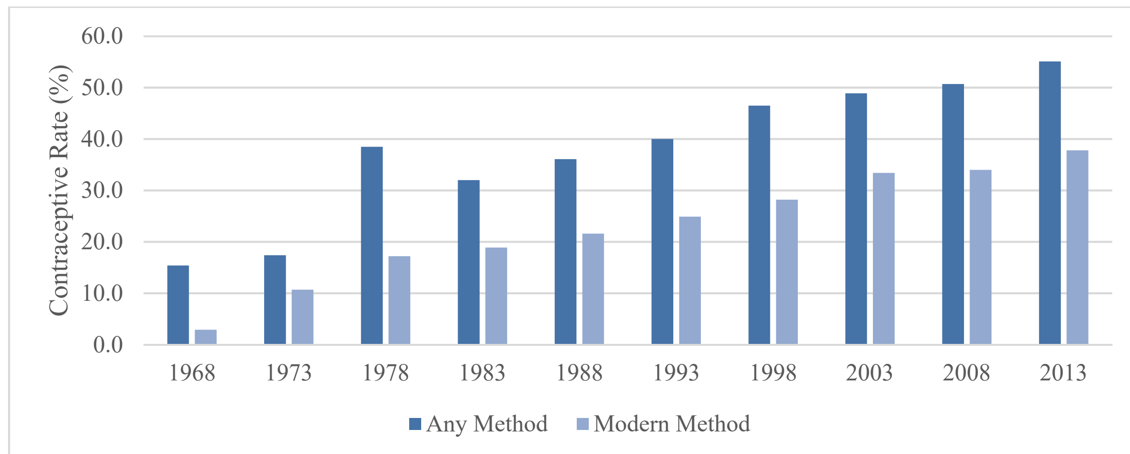
1.5 Since 1990, there has been a clear trend in the burden of disease, with a substantial reduction of communicable and related diseases. This was matched by an increase in noncommunicable diseases, particularly neoplasms (strokes) and cardiovascular problems. Overall, the total burden of disease increased by 0.7 percent annually, below the population growth rate of 2.2 percent.

1.6 Despite improvements, the overall burden of disease remains high. Health equity is a major concern, with poorer areas and low-income groups facing a higher proportion of diseases and lower life expectancies (Bredenkamp and Buisman 2015). In the 1990s, 45 percent of health expenditures were out of pocket, often in private facilities. The high cost of healthcare is a barrier to access for the poor and a major cause of impoverishment.

1.7 The Philippines has had a slow demographic transition driven by a high fertility rate. In 1970, the total fertility rate was 6.0. By 1991, it had declined to 4.1 and to 3.0 in 2013. These average rates hide differences among socioeconomic groups; the total fertility rate in the poorest quintile was 5.2 compared with 1.7 in the wealthiest.[1] Youth pregnancy is high; in 2013, 10 percent of women aged 15 to 19 and 46 percent of those aged 20 to 24 had started childbearing (PSA and ICF International 2014).

1.8 The high fertility rate reflects the relatively low rate of contraceptive use, as seen in Figure 1-2. Although the use of modern contraception rate has increased from 3 percent in 1968 to 38 percent in 2013, it is still low by international standards. Because knowledge of modern contraceptive methods is nearly universal and access is high, this mainly reflects cultural values.

Figure 1.2. Contraception Use by Married Women between Ages 15 and 45



Source: PSA and ICF International 2014.

Health Sector Reform and the World Bank's Support

1.9 The Philippines has long pursued health reform, built around improving equity through insurance. In 1969, it introduced public health insurance schemes for formal sector workers. In 1995, the government established the Philippine Health Insurance Corporation (PhilHealth) as a single insurance scheme that included formal and informal workers as well as the poor. To serve the poor, National Contribution Subsidy paid PhilHealth premiums for indigent households. Local government units (LGUs) had the responsibility to identify and enroll indigents.[2]

Box 1.1. PhilHealth

PhilHealth was created by consolidating several public insurance schemes and expanding coverage to the self-employed and the poor. The *employed* pay a premium of 2.5 percent of wages, shared with their employer. Pensioners and senior citizens are enrolled as lifetime members. Self-employed and Overseas Filipino Workers pay a fixed amount. Various levels of government pay the premiums for sponsored members (uninsured poor households). For all groups, coverage includes spouses, children, and, in some cases, parents.

Benefits in PhilHealth are limited. PhilHealh uses fixed reimbursements ("case rates"). Inpatient rates are based on the level of the provider (primary, secondary, and tertiary levels) and the category of disease. In most cases, rates are less than the private sector fee with the patient paying the difference. PhilHealth is often perceived as a discount for private services. Outpatient benefits for the general population are largely limited to hospital-based services (for example, ambulatory operations) or chronic diseases (for example, dialysis). Sponsored members also receive coverage for preventative services and certain drugs. PhilHealth provides a maternity care package that includes the cost of prenatal care, institutionalized delivery, and vaccination for newborns.

1.10 On the supply side, the Philippines has a mixed public-private system. In 1991, public health providers were decentralized; municipalities were given the responsibility for primary healthcare and provinces the responsibility for secondary health care. Independent cities were given both primary and secondary healthcare. Tertiary healthcare remained under the Department of Health. In 2011, the private sector employed about

70 percent of health personnel, while out-of-pocket expenditures and private insurance accounted for about 60 percent of total expenditures (National Statistical Coordination Board 2013; WHO 2011).

1.11 Bringing together both demand and supply initiatives, the government launched the Health Sector Reform Agenda in 1998, which aimed to improve the decentralization of the health sector and the slow incorporation of the poor into PhilHealth. The reform included an increased benefit package, upgrading of infrastructure, and better regulation. The implementation of the health sector reform was slower than expected, in part because of a poor fiscal situation and coordination issues across different levels of government.

1.12 In 2005, the government introduced the FOURmula One for Health, a reform program that aimed to align health sector reform with the broader public expenditure and governance reforms. It had four strategic areas: (i) health system delivery; (ii) Health regulation; (iii) health finance; and (iv) good management. The package was intended to address concerns that public health gains were stalled or even reversed.

1.13 The World Bank's initial entry into the health sector in the 1990s focused on basic public health issues, such as maternal health, nutrition, and early childhood development. The health sector projects in the Philippines have typically closed with a low rating, as can be seen in appendix table B-3. As the fiscal situation of the Philippines worsened in the early 2000s, the World Bank and the government focused more on larger-scale projects (known as "Sector Support Projects") that supported large government programs as a form of budget support in different sectors. In the health sector, this effort took the form of the National Sector Support for Health Reform (NSSHR) and the Second Women's Health and Safe Motherhood projects, which were both carried out within the FOURmula One framework.

2. National Sector Support for Health Reform

Objectives, Design, and Relevance

PROJECT DEVELOPMENT OBJECTIVE

2.1 The legal agreement between the World Bank and the government states that the project development objective (PDO) is

> to assist the Borrower in: (i) improving priority public health outcomes and increasing the utilization of health services by the poor in areas and for conditions or diseases subject to intervention under the Project; and (ii) increasing financial protection of Indigents from health care costs.

2.2 The objectives are the same in the project appraisal document (PAD) and did not change during the project's implementation period. Based on the project objectives, this evaluation has identified three subobjectives that will be the subject of the Project Performance Assessment Report (PPAR).

- Improve public health outcomes;

- Increase the utilization of health services by the poor; and
- Increase financial protection for the extreme poor.

RELEVANCE OF OBJECTIVE

2.3 The relevance of objective is rated **high.**

2.4 The project was very relevant to the World Bank Group's country strategy at the time of approval (World Bank 2005c). The strategy's overarching objective was to "[help] to build public institutions that serve the common good." The project supported the strategy's focus on social inclusion, specifically "improved performance of national institutions and increased access for the poor and disadvantaged groups to basic service." Regarding regional inequality, the strategy focused on "[providing] greater voice and improved access for the poor and disadvantaged in the planning and delivery of education, health, and other basic services at the local level."

2.5 The project was also well aligned with the World Bank Group's current country partnership strategy, which covers the period 2015 to 2018. The broad theme of the strategy is to ensure that the poor receive the benefits of recent growth in the Philippines. The project addresses this through its pro-poor targeting, its emphasis on public health issues, and efforts to reduce the financial vulnerability of the poor. The project responds to the strategy's second engagement area, empowerment of the poor and vulnerable: "…improve health…and strengthen social safety nets." The project is in line with objective 2.1, which focuses on improving access to basic services, particularly increasing health insurance coverage and supporting the government's universal health care objective (World Bank, 2014).

2.6 The project was also closely aligned with the government's health care strategy. The *National Health Objectives* for 2005 to 2010 and for 2011 to 2016 identify the importance of reducing out-of-pocket expenditures and increasing the coverage of social health insurance (Philippines, Department of Health 2005; Philippines, Department of Health 2011). The government's most recent development strategy, the *Philippine Development Plan, 2017–2022*, builds on the same sector themes. The development plan confirms progress in child health and controlling communicable diseases, and identifies the need to continue improving reproductive health and fighting communicable diseases. The plan calls for additional investment in health services, and continued growth in the coverage in public health insurance (Philippines 2017). This remains highly aligned with the project's objectives.

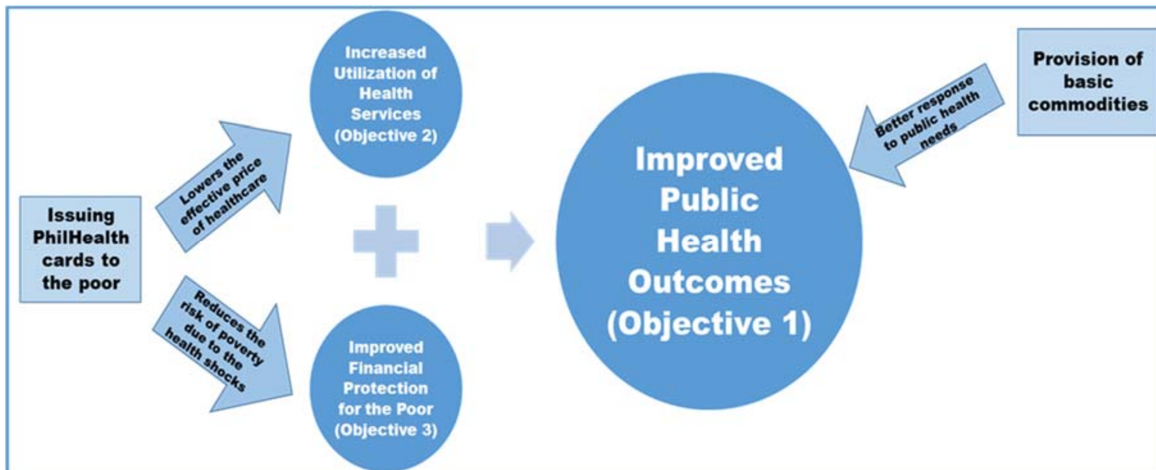
PROJECT DESIGN

2.7 The project was designed as a traditional investment, with standard procurement and financial management rules. The project had some elements of a budget support operation. When the project was approved, in 2006, the Philippines faced serious fiscal constraints. Therefore, the World Bank adopted a "sector support" approach for most of its new investment projects. In this model, the World Bank financed traditional investment projects that were fully incorporated into the budget. Under the same arrangement, the Department of Budget and Management would deduct the value of the

project from its allocation of resources to the department in question, reducing the short-term domestic burden (World Bank 2005c).

2.8 The project was also designed to include some elements of a sectorwide approach, which was called a "Sector Development Approach to Health." It was intended as part of a move toward a "full-fledged [sectorwide approach]" and in line with the World Bank Group's country assistance strategy 2006–08 (European Commission 2006; World Bank 2005c). The project included support for a government health strategy, the use of government systems, and a mechanism for coordination among development partners. The Asian Development Bank, the European Commission, the German government, and the World Bank identified specific areas for each financier. It was also expected that there would be some joint supervision missions. The project was designed to meet the financing needs outlined in the Health Sector Expenditure Framework, 2007–09. Based on project documents and interviews, the PPAR developed the theory of change outlined in figure 2.1.

Figure 2.1. Theory of Change



Note: This visualization of the theory of change by the Independent Evaluation Group is based on the project appraisal document.

2.9 As originally designed, the project had four components focusing on different aspects of the health sector. The project had unallocated financing of $20 million to be reallocated during the midterm review. Appendix B, table B.4, shows the planned versus actual expenditures by component.

2.10 **Component A: Health Financing** (appraisal $40.0 million; actual: $44.0 million). This component aimed to provide health insurance for indigents by financing the central government's payments to PhilHealth. The component supported efforts to improve the quality of means testing at the LGU level, through community-based poverty mapping. Although this component used national systems, it had substantial administrative requirements. The list of indigent beneficiaries would be subject of World Bank "No Objection" quarterly. Loan funds would be disbursed after PhilHealth received endorsement from the Department of Budget and Management with a validated list of indigents and a Certificate of Availability of Funds from the LGU to pay its share of the premium. The World Bank's financial management assessment found

that PhilHealth was solvent and had sufficient administrative controls. The project would finance a selected number of LGUs based on criteria, including readiness and need.

2.11 **Component B: Health Service Delivery: Public Health** (appraisal $48.5 million; actual $32.4 million). This component focused on public health programs (subcomponent B.1; $48 million). The project targeted a broad range of interventions, including: (i) the Extended Program of Immunization vaccines; (ii) the distribution of tuberculosis (TB), acquired immune deficiency syndrome (AIDS), and human immunodeficiency virus (HIV), micronutrients, and other drugs; (iii) efforts to increase health commodities and supplies for laboratories, information campaign on communicable diseases; and (iv) financing drugs and supplies to respond to pandemics. The component also included a pilot of performance-based agreements between LGUs and the Department of Health. This component would use a combination of national procurement and direct procurement through United Nations agencies.

2.12 **Component C: Regulation of Pharmaceuticals** (appraisal $0.5 million; actual $0.0 million). The component was intended to support implementation of a master plan to upgrade the services of the Bureau of Food and Drugs. This was to be achieved through support for the operating costs associated with new business processes, including greater fiscal autonomy; improved services at its drug quality control laboratories; and implementing a new program of "quality seals" to certify pharmacies.

2.13 **Component D: Health System Governance** (appraisal $10.7 million; actual $10.2 million). This component focused on improving governance and capacity in the health sector. It included support for Improving Health Human Resources ($0.5 million at appraisal) to support the preparation of the new Human Resources in Health Master Plan of strategic national initiatives. In addition, the component supported Sector Management and Coordination of Local Health Systems Reform ($10.2 million at appraisal). This was intended to support the Department's contribution to an EU-financed program of performance-linked local health system reform grants for 16 provinces, to support local monitoring and evaluation systems.

RELEVANCE OF DESIGN

2.14 The relevance of design is rated **substantial.**

2.15 The project design was well aligned the project's, the World Bank's, and the government's objectives. It supported interventions that were targeted to meet its objectives in a format that worked within the context of the World Bank's country strategies. The project balanced supply-side and demand-side needs while taking into account the contributions of other development partners and the government.

2.16 On the demand-side, component A, with its focus on PhilHealth, was designed to increase financial protection by providing subsidized insurance to the poor. The government's approach to social insurance was well designed and required additional financing during the fiscal crisis. The component also included technical support to improve the targeting system. At the time of approval, there were concerns about how LGUs identified the poor. This was widely seen as a major challenge for the successful

implementation of the health sector reform. PhilHealth was expected to play a role in all three of the project's objectives; it would raise utilization and encourage the poor to address basic health issues early and so avoid catastrophic costs. The World Bank was the primary external supporter of PhilHealth reform, in collaboration with the European Commission and the German government.

2.17 Components B and C focused on the supply side, with its support for disease prevention and control, primarily through the provision of drugs, micronutrients, and vaccinations (commodities). These components also included support for procurement reform as well as the provision of finance for the appropriate budget lines. In addition, the project included pilots that allocated cash grants and commodities based on performance. These two components addressed widespread concern about commodity stock-outs at the local level.

2.18 With limited resources, the project focused on a few national priorities, including childhood vaccines and combating TB. This focus was strategic. While the Philippines generally had good vaccination coverage, there was room for improvement. Likewise, TB has long been identified as a national priority. It has typically been the first or second most important communicable disease in both morbidity and mortality.[3] The health sector plays a major role in preventing, detecting, and curing the disease. Improving procurement and financing for equipment were likely to contribute to both efforts. Additional support was provided for other priorities, such as HIV, AIDS, and micronutrients, but these were not the focus of the project.

2.19 These activities were coordinated with the government and development partners to finance additional supply-side interventions; health partners included European Commission and the Asian Development Bank and from the American, Dutch, and German governments. Support from other development partners focused on select ("convergence") provinces.

2.20 The project also included support for the Department of Health through component D. This component supported the introduction of performance-based grants to a group of poor provinces, in cooperation with the European Commission and other development partners.

Project Experience

Preparation

2.21 The project was the World Bank's first major health project in the Philippines. Formal project preparation began in 2002 when the concept note was reviewed. At the time, the target date for approval was in December 2003. Initially, the World Bank planned a smaller project that focused on health sector reform in four provinces as well as supporting capacity building for the Department and PhilHealth. As originally planned, the project would invest in strengthening health insurance for the poor, improve quality assurance in health supply, and improve access to affordable drugs.

2.22 During preparation, the approach changed substantially. This reflected a strategic decision to develop projects that were closely aligned to government strategy, effectively a combination of an investment loan and budget support. In early 2005, there was broad agreement that the project's scope should be expanded to support the reform at the national level. The European Commission and the World Bank jointly appraised their projects in March 2006. Throughout preparation, the World Bank worked closely with the Asian Development Bank and the governments of Germany, Japan, and the United States throughout preparation to identify complementary interventions. Appendix table B-4 presents the timeline of major events in the health sector.

IMPLEMENTATION

2.23 The project was approved in June 2006, two and half years after the originally scheduled approval date. The project became effective in March, 2007. Throughout the life of the project, disbursements were behind schedule; typically, by one to two quarters. Initially, the best-performing activity was component B (the procurement of commodities for public health). As noted in the Implementation Completion and Results Report (ICR) and interviews, this good performance reflected the role of United Nations Children's Fund (UNICEF) in procuring vaccinations and the World Bank's support in improving public procurement.[4]

2.24 Component A was the slowest to disburse. Much of this delay was the effect of policy changes. The Department of Social Welfare and Development introduced a new household targeting method (a proxy means test) known as the National Household Targeting System, developed with World Bank technical assistance and implemented nationally between 2009 and 2010 (Fernandez 2012).[5] [Whoever] made the strategic decision to stop developing its own targeting system and to adopt the National Household Targeting System. In 2008, PhilHealth agreed to use the targeting system and, by 2010, had consolidated its database with the targeting system. In 2011, PhilHealth began to use the targeting system for new beneficiaries. Interviews suggest that this targeting system was well received and quickly accepted at national and local levels.

2.25 At the same time, the government revised the cost-sharing model behind enrollment in PhilHealth. Under the original policy, the membership for the poor would largely be financed by LGUs. The national government took on the responsibility of financing PhilHealth through direct transfers. The project shifted its financing to support this effort in 2011. The government introduced "sin taxes" in 2012 and used much of the additional revenue to finance the enrollment of the poor in PhilHealth. The World Bank provided technical assistance to the development of the sin tax legislation. Table 2-1 shows the public expenditures for the Department of Health, including on-budget financing from the project.

Table 2.1. Health Sector Financing, 2006–14

	Year								
	2006	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
Project financing *($, millions)*	n.a.	6.7	11.6	19.7	19.4	12.8	34.5	n.a.	n.a.
DOH budget *($, millions)*	190.7	247.0	425.2	496.8	546.4	734.8	998.3	n.d.	n.d.
Project share *(%)*	n.a.	2.7	2.7	4.0	3.6	1.7	3.5	n.a.	n.a.

Note: DOH = Department of Health; n.a.= not applicable. n.d.=data not yet available.

2.26 The project held its midterm review in February 2010, 18 months later than expected, reflecting the slow initial pace of disbursements. The project was restructured twice. The first restructuring, in August 2010, largely reallocated funds to component B to support the procurement of commodities, and included smaller transfers of funds from components C and D to component B. This restructuring was developed during the midterm review. The second, in May 2011, extended the project from June 2011 to March 2012, to allow additional time to disburse resources from components A and B.

Epilogue

2.27 The project closed in March 2012, nine months after the original closing date. When it closed, nearly $10.4 million were canceled from component B, representing 16 percent of the committed amount. In contrast, component A spent $4.0 million (10 percent) more than expected.

2.28 As the project was closing, the World Bank developed a concept note for a follow-up project that focused on increasing PhilHealth's coverage. This proposed project was appraised in 2012 but was eventually dropped. The World Bank is currently working with PhilHealth to provide technical assistance to improve its capacity.

Fiduciary

2.29 The project faced several delays and challenges. It received several qualified audit opinions, though none of the audits identified any accountability issues. It appears that the department addressed these audit concerns. One of the audit reports was submitted one to three months late. In addition, the project was often late with its financial reports. Much of those issues were associated with limited staff in the department. None of these issues seemed to affect the project's implementation materially.

2.30 Procurement was often delayed, reflecting the complications of procurement with United Nations agencies. With the World Bank's "no objection," the government negotiated a single-source arrangement with the World Health Organization (WHO) and UNICEF. In the end, the government and WHO could not reach agreement. The project used single-source procurement with WHO on a case-by-case basis.

Safeguards

2.31 The project triggered the Indigenous Peoples' Safeguard (OP 4.10 at time of approval). The PAD identified the potential benefits that indigenous people were likely to receive from the project and indicated steps to ensure that members of these groups could take advantage of these benefits. The ICR confirms that the department did implement

the Indigenous People's Framework, though results were mixed because some provinces implemented the framework more effectively than others.

Achievement of the Objectives

2.32 The government and the World Bank designed the project to meet the financial needs of the Department of Health's budget and to support the government's health strategy. The PPAR will focus on the project's contribution to achieving the objectives, considering the role of other actors, and on the interdependency between the objectives.

OBJECTIVE 1. IMPROVE PUBLIC HEALTH OUTCOMES

2.33 As designed, the project provided inputs that would directly support the objective, primarily through its procurement of commodities (component B). Increasing the utilization of health services was also expected to make an important contribution to this outcome. The evaluation focuses on two interventions: immunization and TB, because they were the focus of the project and received the bulk of finance.

Inputs and Outputs

2.34 **Immunization.** Vaccinating against common diseases is one of the most cost-effective ways to improve public health. By the time the project was approved, there was evidence that the Philippines had fallen behind other countries and that many children were not receiving the full, recommended course of immunization. There were also concerns that the immunization rate had decreased.

2.35 The project procured almost all its vaccinations through several sole-source contracts with UNICEF.[6] This was done through a series of advances that were liquidated by UNICEF throughout the life of the project. The project advanced a total of $44.8 million to UNICEF to procure vaccinations. This represented 37 percent of the project's total financing and 90 percent of component B. The project procured $38.5 million worth of vaccines; UNICEF refunded the remaining $6.3 million balance. Procurement documents show that the project procured eight different childhood vaccines, including introducing the Hepatitis B vaccination. Though there are no available data on the Philippines' total expenditure on vaccinations during this period, this represented a significant portion of the country's total expenditure on immunization. In addition to childhood vaccines, the project also purchased rabies vaccines directly from WHO.

2.36 Field interviews indicated that the project simplified the procurement of vaccines and that this approach is still being used. Stakeholders generally identified this as one of the project's contributions to the health system and claimed that it improved the availability of vaccines.

Table 2.2. Coverage Rate and Total Doses Administered of Selected Vaccines

	BCG		Measles		OPV (first dose)	
Year	Doses	Rate	Doses	Rate	Doses	Rate
2006	2,102,828	81.7	2,142,627	83.2	2,104,977	81.8
2007	2,097,171	79.5	2,153,856	81.7	2,119,163	80.2
2008	2,158,555	79.6	2,148,039	79.2	2,217,072	81.7
2009	2,180,030	88.7	2,222,945	90.6	2,254,348	91.7
2010	2,209,052	88.6	2,179,774	87.4	2,219,271	89.0
2011	2,038,563	78.8	1,986,351	76.8	2,123,869	82.1
2012	1,969,390	75.8	2,076,789	80.0	2,150,629	82.8
2013	2,073,356	78.3	2,030,472	76.7	2,074,718	78.4
2014	1,982,867	73.5	2,009,025[a]	74.5	2,090,381	77.5
2015	1,991,807	72.5	2.164,640[a]	78.8	2,071,355	75.6

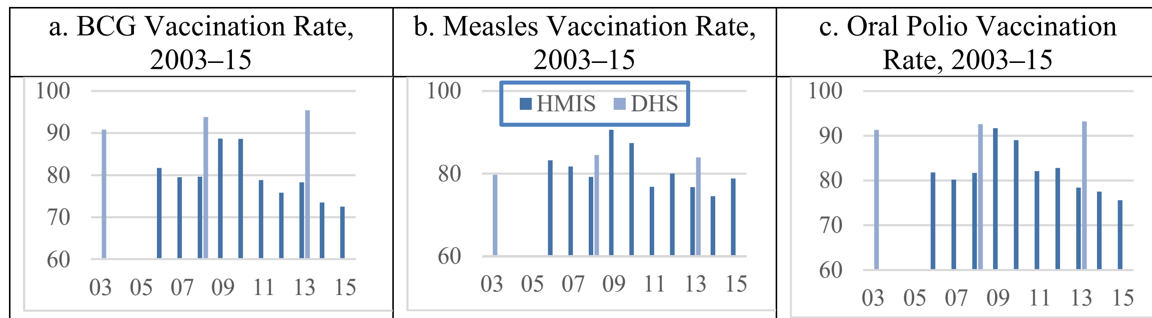
Source: Philippines Health Data.
Note: BCG = Bacillus Calmette–Guérin (for tuberculosis); OPV = oral polio vaccine.
a. First dose of combined vaccine.

2.37 The number of fully immunized children is a commonly used measure of vaccination coverage, but this indicator does not capture the project's contribution, because the vaccination package has changed over time as the country added new vaccines. Likewise, the immunization rates are sensitive to changes in denominator, which has been subject to change. To control for this, table 2.2 shows the coverage of three important childhood vaccinations—Bacillus Calmette–Guérin (BCG; for TB), measles, and polio. It presents both the number of doses provided and an estimate of the coverage rate, using population estimates.[7] The dosage and timing of these immunizations has been relatively stable, allowing a comparison across time. Appendix B, table B.5, presents more detailed data on the BCG vaccination in selected regions.

2.38 The data show that there was an upswing in coverage in 2009 and 2010, followed by a reduction. This might have been driven by project financing, because the project was most active in financing vaccinations from 2008 to 2010. It is possible that more newborns are receiving vaccination from private providers. However, the number of births in public health facilities increased substantially during this period. Likewise, evidence shows that while the total number of doses increased in the National Capital Region, it decreased in the poorer Ilocos Region and Bicol Region. The National Capital Region is the wealthiest in the country and thus is the most likely to see an increase in births in private facilities.

2.39 The data from the Demographic and Health Surveys (DHS) tell a different story on vaccination coverage. Figure 2.2 compares the vaccination rates from the DHS to information from the health information system. The DHS data show a higher level of coverage with consistent increases in coverage from 2003 to 2013, except for measles. Unlike the official health information system, the DHS data include coverage provided by private providers; it also provides a more accurate denominator.

Figure 2.2. Bacillus Calmette–Guérin, Measles, and Oral Polio Vaccination Rates, 2003–15



Source: Philippines Health Data, Demographic and Health Surveys.
Note: BCG = Bacillus Calmette–Guérin.

2.40 **Other public health priorities.** In addition to vaccinations, the project also procured drugs and supplies for basic public health needs. This included drugs for TB, HIV, AIDs, and parasitic infections. This was done through a combination of direct purchases with WHO and the regular bidding process.

2.41 The treatment of TB requires a course of drugs taken over six to nine months. To be effective, it is important to have a functioning laboratory system to detect TB at the local level (WHO 2006). The project supported TB control through its provision of drugs as well as increasing their utilization (see objective 2). The expansion of PhilHealth also increased the access of the poor to TB treatment. The project supported the purchase of TB drugs, which supplemented other sources, such as donations and government purchases. The project also financed equipment and supplies for laboratory testing of TB.

2.42 The Philippines suffers from a high rate of helminthiasis ("worm infections") that can have serious nutritional consequences for children. The project financed the purchase of drugs for the prevention and control of infections. This was done through direct purchase from WHO, the lowest-cost bidder. It appears that during several years, the project was the biggest financing source of these drugs. The project also financed the purchase of the rabies vaccine for several years and was probably the main financier. The project also purchased antiretroviral drugs for HIV/AIDS patients; it appears that the project was the largest procurer of drugs in certain years.

Outcomes

2.43 Measuring public health outcomes can be complicated, particularly within the context of a six-year project. There are several reasons for this. First, many health outcomes can only be observed many years after the intervention. For example, though measles vaccines are administered to young children, the effect on the measles rate would probably only be seen years later. This is even more true for the BCG vaccination, which offers partial lifetime protection from TB. Second, increasing access may lead to measured decline in the health status in administrative data. For example, a population with limited access to health care could see an increase in the reported cases of diarrhea when the health system is expanded and "marginal" cases are brought to clinics.

2.44 The Philippines is among the top 30 countries with a high burden of TB, which has long been one of the leading causes of mortality and morbidity (STBPS 2017). Table

2.3 presents estimated data on TB. The Philippines, like most middle- and low-income countries, relies on a combination of epidemiological data and expert estimates. The table presents the high (the conservative or pessimistic) estimates for the incidence and mortality rates of TB per 100,000 inhabitants. It also includes the case detection rate, which is an estimate of what percentages of actual TB cases the health system detects, using the most conservative estimates.

Table 2.3. Tuberculosis in the Philippines, 2000–15

Year	TB Incidence Rate per 100,000[a]	TB Mortality Rate per 100,000[a]	Case Detection Rate[b]
2000	526	43	29
2001	517	42	26
2002	508	43	29
2003	499	41	32
2004	490	38	32
2005	481	35	33
2006	473	32	36
2007	464	29	34
2008	459	34	34
2009	456	29	35
2010	454	28	39
2011	451	27	46
2012	449	33	50
2013	412	30	57
2014	402	28	61
2015	370	20	74

Source: World Health Organization.
Note: TB = tuberculosis.
a. The data for the incidence and mortality rates are based on the high estimates.
b. The data for case detection rate are based on the low estimates.

2.45 The results show a clear trend in the reduction of TB over time. There has been a substantial improvement in the case detection rate over the years; less conservative estimates show an even larger increase. Other analysis confirms these general trends; a WHO surveillance report covering 2003 to 2011 emphasizes the same trends—namely a reduction in the burden of TB with an increase in the case detection rate (Vianzon et al. 2013).

2.46 **Did the health system drive the reduction in TB?** The answer is almost certainly "yes." Without more effective intervention, TB would tend to increase because of the high level of dense urbanization and the constant migration to urban areas.[8] The reduction of mortality is the consequence of medical intervention, because TB remains active without treatment. Likewise, the improvement in case detection rate is the result of

an increase in visits to formal health centers and an improvement in the coverage of laboratories.

2.47 The project's financing replaced expenditures in the department's budget. During its early years, it prevented budget cuts and thus allowed the government to continue to increase its support for TB prevention and control. The project directly financed a significant portion of the laboratory equipment which contributed to the increased case detection rate. The government's and the project's contribution to improving the vaccination rate is less clear. The project may have contributed to an increase in coverage for several years but these gains appeared temporary.

2.48 The achievement of objective 1 is rated **modest.**

Objective 2. Increase the Utilization of Health Services by the Poor

2.49 This objective focused on increasing the utilization of health services in areas that are related to public health outcomes. This includes the prevention and control of communicable diseases, accidents, and the use of health services for safe delivery as well as pre- and postnatal examinations. The objective was built on enrolling the poor into PhilHealth.

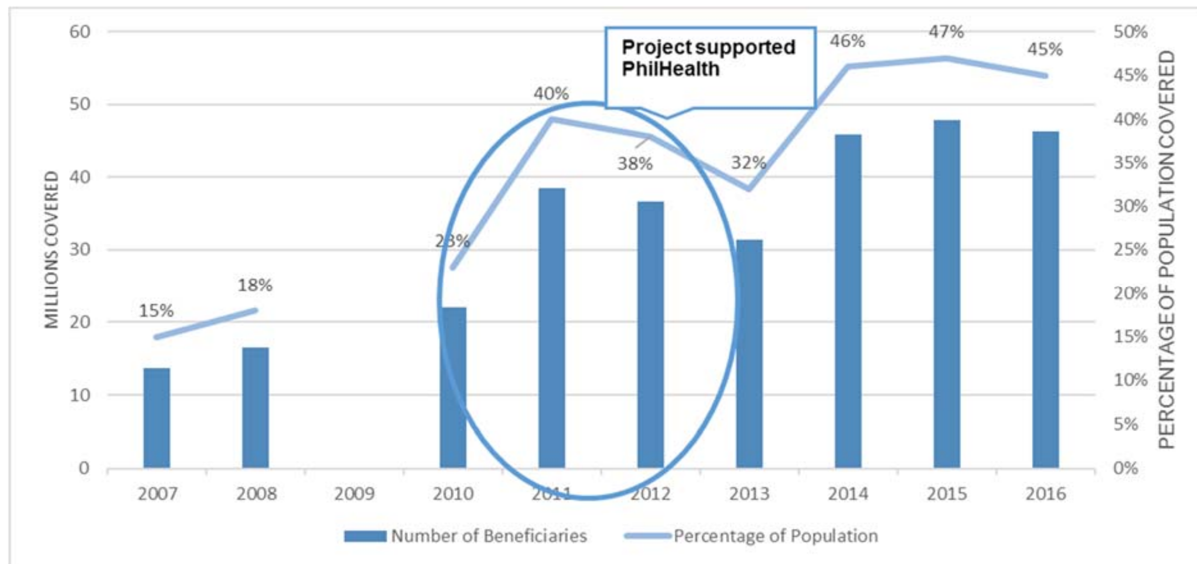
Support for PhilHealth

2.50 **Financing sponsored PhilHealth membership for the poor.** Although the support for PhilHealth contributions came later than expected, it constituted a large portion of the project's financing. The project provided $44.0 million in financing for component A, which accounted for 42 percent of total financing from 2010 to 2012. Figure 2-3 shows the coverage of PhilHealth for the poor population. In 2011, when it made the largest contribution, it financed approximately 10 percent of the sponsored population. It is not clear why the coverage of PhilHealth dropped in 2013. This large and temporary change may be the result of data issues rather than related to the project's closing. Appendix B, table B.6, provides data on PhilHealth coverage for the total population and for the poor.

2.51 The World Bank put specific emphasis on improving PhilHealth's targeting scheme. The original plan was for the Department of Health to design its own system for LGUs to identify the poor. However, the government and the World Bank proposed that PhilHealth use the National Household Targeting System. In addition to the World Bank's support in developing the targeting system, the World Bank also provided support in adapting the targeting system to PhilHealth. It is likely that the introduction of the targeting system would have been further delayed or never introduced without support from the project.

2.52 The national government also changed the financing scheme for PhilHealth. The government incorporated the payment of the premium of sponsored beneficiaries in the national budget, relieving LGUs of the need to enroll the poor with their own resources. Because the LGUs had become a bottleneck in both identifying the poor and financing premiums, national direct financing led to greater and more efficient coverage.

Figure 2.3. PhilHealth Coverage of the Poor Population



Source: PhilHealth Annual Reports.
Note: Data from 2009 are missing.

2.53 **Did the project contribute to the increase in PhilHealth coverage?** In addition to supporting the enrollment of around 10 million poor in PhilHealth, the project's support played a major role in reforming PhilHealth. This included critical support to develop the targeting system and the shift from local to national financing of PhilHealth premium. These reforms led directly to improved targeting and broader coverage.

Changes in Utilization

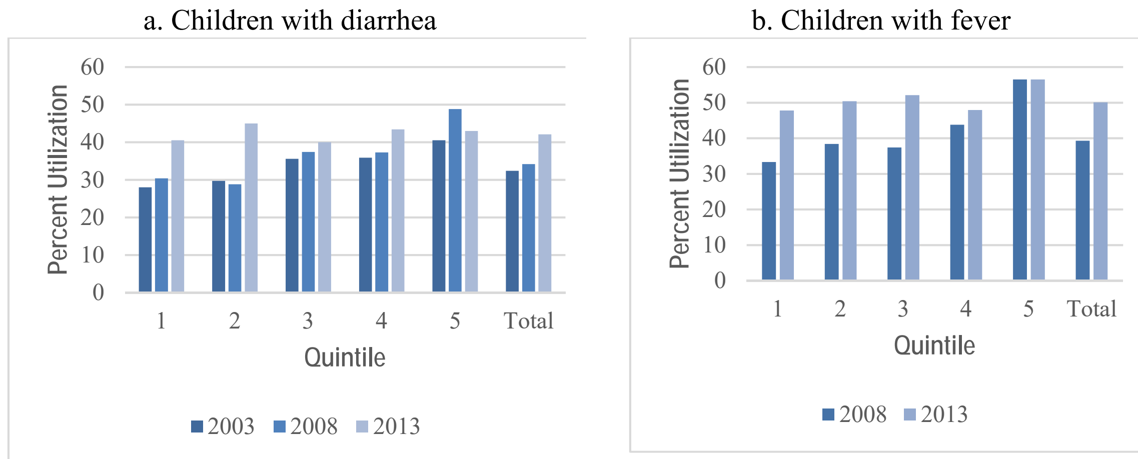
2.54 Administrative data provide information on utilization, but there are several limitations to their use. Given the decentralization of the health system, the quality of national-level data are unreliable. Likewise, there is little data on the user or the motive for the visit, which makes it difficult to measure achievement of the objective of "utilization by the poor for public health priorities." The evaluation uses data from 2003, 2008, and 2013 DHSs to analyze changes in utilization (see appendix table B-8 for more detailed data).

2.55 **Curative services.** Diarrhea is one of the most common childhood diseases. If left untreated, it can have serious consequences possibly leading to death. The DHS show that the prevalence of diarrhea among children five years and younger was about 11 percent in 2003 and dropped to 8 percent in 2013. From figure 2.4, panel a, there is little change in the utilization between 2003 and 2008 for the two poorest quintiles. In addition to having a relatively stable utilization rate of 30 percent, the rates are notably lower than in the other three quintiles. However, by 2013, the utilization rates for all five quintiles were all about 40 percent.

2.56 Figure 2.4, panel b, reports the percentage of children who received formal healthcare to treat fevers. Fevers have varied causes and the way that households self-report fevers likewise varies. DHS has data on utilization from 2008 and 2013, which show a similar pattern to the data patterns for diarrhea. In 2008, households in the first

quintile had a lower rate of utilization than the other four quintiles. By 2013, the utilization rate was about 50 percent for all quintiles, which represented an increase.

Figure 2.4. Utilization of Primary Health Services for Children



Source: Demographic and Health Surveys
Note: The utilization rate is for children aged 5 and younger who reported the specific disease in the previous two weeks.

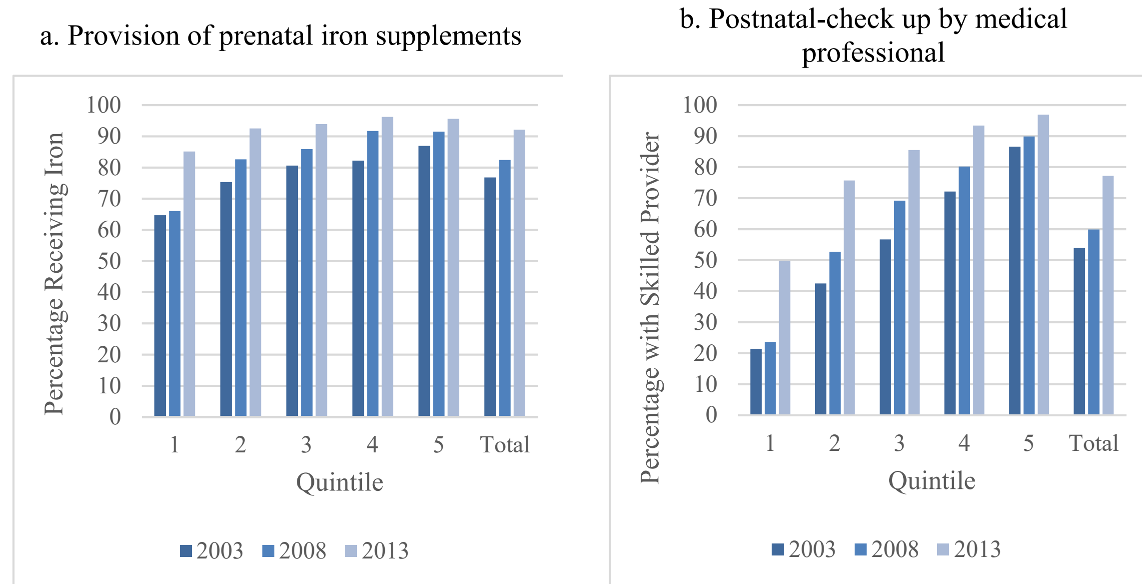
2.57 For these two measures of child health, there has been clear increase in the utilization of primary health care by the poor for basic conditions that are likely to be representative. The project was implemented during a period of slow to moderate income growth, so it is not likely that the increase in income accounts for the significant increase in health care expenditure; nor does there appear to be an important change in the construction of new public health clinics. The expansion of PhilHealth almost certainly played a role in improving the utilization of primary health services; sponsored (poor) beneficiaries receive coverage for outpatient services. It is also possible that the project contributed to the availability of drugs, which would have raised public service quality.

2.58 **Maternal health.** Improving access to maternal health services plays an important role in promoting public health outcomes. This PPAR's evaluates the contribution of the Women's Health and Safe Motherhood Project to maternal health, which is also relevant for the NSSHR project.

2.59 Providing an iron supplement to pregnant women is important to promote the well-being of infants, particularly in countries, such as the Philippines, that have a high burden of anemia. As can be seen in figure 2.5, panel a, between 2003 and 2013, there has been an increase in the percentage of women receiving prenatal supplements across all quintiles. By the far the largest increase is for women in the first and second quintiles; by 2013, the level of iron supplementation was similar across all expenditure quintiles. Additional data are presented in appendix B, table B.9.

2.60 Figure 2.5, panel b, shows the percentage of women who received postnatal care from a skilled provider. By far the largest gains were seen by women in the first and second quintiles, particularly from 2008 to 2013. While the rate for women in the first quintile more than doubled, this group still had rates well below the national. However, by 2013, the other four quintiles had similar rates of access to medical professionals.

Figure 2.5. Provision of Prenatal and Postnatal Care



Source: Demographic and Health Surveys.

2.61 These two indicators both capture the quality of maternal health services. For the poorest population, these increases are likely to be the result of government policy because the poor rely largely on subsidies when accessing modern maternal healthcare, either in a public facility or with a private provider. The results here are likely to be the result of PhilHealth's coverage of maternity care and the better-integrated maternity health package piloted by the Women's Health and Safe Motherhood Project.

Did the Project Contribute to the Objective?

2.62 The evaluation selected a few key public health results to provide a broad view of the project's contribution to primary healthcare outcomes. The evidence suggests that the project contributed to an increase in the utilization of basic curative services and maternal services. This was primarily the result of the expansion of PhilHealth combined with other initiatives to improve the delivery of health services and possibly to improve the availability of drugs and other supplies.

2.63 The achievement of objective 2 is rated **substantial.**

Objective 3. Increase Financial Protection for the Extreme Poor

2.64 Health shocks play a major role in driving families into poverty. Health shocks are unpredictable, and the cost of healthcare can be quite high. In addition to losing income because of illness, families often need to draw heavily on savings or sell assets to pay health bills. Insurance provides families with the means to smooth out health expenditures. Social health insurance, like PhilHealth, makes this available to the poorest households who would not normally be able to buy basic health insurance.

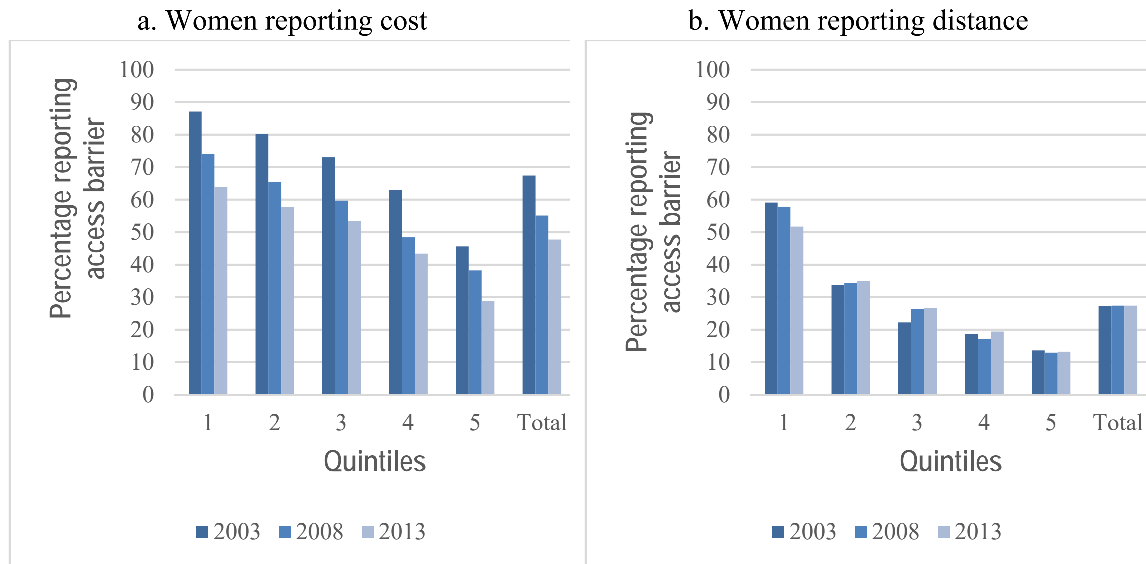
2.65 The evaluation established that the project did make an important contribution in expanding PhilHealth's coverage of the poor. The evaluation has also shown that this insurance has led to changes in the services that the poor use; for example, there has been a substantial increase in facility-based deliveries. Clearly the expansion of PhilHealth has lowered the average cost of institutional deliveries for the poor. However, it may not have led to lower or more predictable health costs for the poor because PhilHealth does not cover all services; nor does it cover the entire cost of services with private providers.

2.66 The DHS asked women about the primary barriers that they face in accessing healthcare for any reason. Figure 2.6, panel a, shows the percentage that report cost as a major barrier to healthcare. In 2003, cost was a significant barrier for more than 80 percent of women in quintiles 1 and 2. While cost remained a significant barrier in 2013, it was less of a concern. PhilHealth may have contributed to this change in perception, but it is important to note that much of the change happened between 2003 and 2008, before PhilHealth had its full expansion, and that it affected the top quintile as well, which already had PhilHealth and private health insurance. This increased perception of access is also related to changes in income, knowledge, and the price of services.

2.67 Figure 2.6, panel b, shows the perception about distance as a barrier to access, which is often cited as a significant barrier to access. Measuring changes in perception can help understand better if supply changes are driving the increase in utilization. There is an expected gradient, with poorer households identifying distance as a greater concern than other households. It is important to note that there is virtually no change between 2003 to 2013, which reflects the government's focus on system reform rather than construction.

2.68 Ultimately, increasing financial protection requires reducing the catastrophic health payments that often drive households into poverty. A review of household surveys between 2000 to 2013 show that contrary to expectations, healthcare costs have increased for the poor as has the percentage of households that have fallen into poverty because of healthcare costs. Between 2000 and 2012, it appears that household out-of-pocket expenditures on health have increased by 150 percent in real terms. This increase was largely driven by the cost of medicines. In 2000, 2.5 percent of households spent more than 10 percent of their consumption on health care; by 2012, this affected 7.7 percent of households. The data show that though wealthier households are more likely to have catastrophic health expenses, the proportion has increased for all income groups. Based on this analysis, out-of-pocket expenditures on health added 1.5 percentage points to the poverty rate (Bredenkamp and Buisman, 2015).

Figure 2.6. Barriers to Healthcare for Women



Source: Demographic and Health Surveys.

2.69 PhilHealth appears to have opened new access for the poor to different types of health care. However, it did not appear to have directly reduced the impact of high health costs on poverty.

2.70 The achievement of objective 3 is rated **modest.**

Efficiency

2.71 As a national project that provides budget support, the project is not amenable to traditional measures of value for money such as a formal cost-benefit analysis or cost-effectiveness analysis.

2.72 The project largely disbursed its resources but there were major delays with component A. These effectively led to a two-year delay in the support for incorporating the poor in PhilHealth, which was central to two out of three of the project's objectives. Thus, the project provided its critical budget support after the worst period of the fiscal crisis, 2008 and 2009. Though financing from component A undoubtedly played an important role in expanding PhilHealth, it could have had more impact if it had been provided earlier. Although the delay led to greater value added in the long term, it represented an inefficient use of resources.

2.73 The project's support for component B probably led to reduced drug and vaccination costs by introducing more efficient procurement methods. Anecdotal evidence from several sources suggest this remains relevant for the Department of Health. Despite the improvement in the procurement process, UNICEF refunded part of its advanced payment (about $10.4 million) because the department was not able to finalize all the procurement before the project closed.

2.74 Overall, the project appears to have a made a longer-term contribution to improving efficiency in the health sector. However, it is likely that the same results could have been accomplished for a lower cost or with a smaller project.

2.75 The efficiency is rated **modest.**

Ratings

OUTCOME

2.76 The relevance of objectives and the relevance of design received ratings of high and substantial respectively, reflecting the close alignment of the project with the government's and the World Bank's development objectives. The first objective, improving public health outcomes, received a rating of modest, reflecting the project's contribution to reducing TB and lack of evidence on the provision of vaccinations. The second objective, increasing utilization of healthcare services by the poor, was rated substantial. This reflected the increase in the use of health services for basic health needs. The third objective, increasing financial protection for the extreme poor, was rated modest because of the limited evidence that the project had reduced catastrophic health expenditures. Finally, efficiency was rated modest because of the significant delays in implementing the project. These ratings are compared with the ICR and ICR Review's ratings in appendix B, table B.9.

2.77 The outcome is rated **moderately unsatisfactory.**

RISK TO DEVELOPMENT OUTCOME

2.78 **Improving public health.** The project's focus in supporting public health was built around improving the procurement of commodities to complement demand-side interventions. Since the project closed, the fiscal situation of the Philippines has improved significantly. This has ensured that financing is not an issue, and has led to a major decline in "stock-outs." Though there is broad agreement that the project introduced new and more efficient procurement procedures, there is little evidence that these have been maintained in areas where they were introduced (primarily childhood vaccinations) or have expanded to other areas of procurement. The expansion of PhilHealth has helped support improvement on the supply side, providing more access for TB and childhood vaccinations.

2.79 **PhilHealth.** The project made several significant contributions to how PhilHealth covers the poor. These included changing the rules of intergovernmental transfers to pay for premiums for the poor as well as introducing a new targeting system. Both reforms were directly supported by the project and both led to improvements in PhilHealth coverage. These policies continue to be cornerstone of the government's policy, and government's financial support for PhilHealth has continued to grow. The newly elected government has the same commitment to expanding the coverage and quality of PhilHealth. There is little or no risk that the project's contributions will be reversed. This support plays an important role in all three of the project's objectives.

2.80 The risk to development outcome is rated **negligible.**

WORLD BANK PERFORMANCE

2.81 **Quality at entry.** The project preparation period was quite long, primarily because of changes in government and World Bank policies to respond to the country's fiscal challenges. The initial design for a modest project, focusing on four provinces and the Department of Health; was relevant from 2002 to 2004. Responding to the need to redesign the project, the preparation team was quite responsive. During the period from 2002 to 2006, there were two task team leaders. Both were based in the Philippines, which facilitated interaction with the government and other stakeholders. The World Bank financed analytical work. The team ensured that the project's design was well aligned with the government's health strategy.

2.82 The World Bank team overestimated the capacity in the Department of Health and at the local level. Though the project was designed to operate with government procedures, it still required compliance with many World Bank procedures. The World Bank team identified support from other projects at the national and local level to mitigate many of these weaknesses. This support was important, but it did not address the small staff available in the Department of Health to manage the project.

2.83 The World Bank worked closely with other development partners to coordinate operations. To facilitate preparation, interested development partners agreed to design and implement their respective projects on an informal basis. The World Bank conducted most of its design missions with the European Commission and stayed in close contact with the Asian Development Bank.

2.84 Internal comments led the project team to develop a more focused and more realistic development objective. It also led to a reduction in disbursement conditions to allow the project to start operating faster after approval. Despite the long preparation period, many implementation issues were not resolved prior to project approval—in particular, the operations manual and the fund flow arrangements.

2.85 Despite many limitations with the World Bank's quality at entry, it is rated **moderately satisfactory,** reflecting the World Bank's flexibility in its preparation, its close coordination with other partners, and its alignment with the government strategy.

2.86 **Quality of supervision.** During its six years of implementation, the project had four team leaders. Three of these were based in the Philippines; the other was in the East Asia and Pacific Region. This facilitated a relatively high level of interaction between the government and the World Bank. The World Bank also coordinated closely with donor partners and carried out joint supervision missions with the European Commission.

2.87 Given the many delays, the World Bank team had to be flexible and exerted much effort to improve the project's performance. At times, the focus on disbursement often led to a loss of focus on technical issues, particularly before the midterm review. This included two level II restructurings (in 2010 and 2011) that primarily reallocated funds from slower to faster moving components. While it appears that the World Bank did consider more ambitious restructurings, these did not come to fruition.

2.88 The project team filed only seven supervision reports, which is about half of the expected number, in part because the supervision team was usually based in the Philippines and had a strong, informal relationship with the government. Supervision missions were difficult to organize because of Department of Finance regulations, although it is worth mentioning that the Second Women's Health and Safe Motherhood Project carried out the expected number of supervision missions.

2.89 Despite slow progress at times, the supervision team consistently rated the project's development outcome and implementation progress as satisfactory or moderately satisfactory. It also appeared that not all the indicators were consistently monitored. The World Bank could have also been more proactive in requesting annual reports from the departments when these were not forthcoming. Finally, the World Bank delayed its preparation of the ICR, exceeding its own standards. Internal correspondence suggests that there was not a strong justification for this delay.

2.90 Despite these shortcomings, the supervision team provided strong support with technical advice and coordination. It was in constant contact with other development partners and carried out joint supervision missions with the European Commission. It coordinated both internally and externally. This included with the Asian Development Bank's health sector operation and the German government's support to strengthen PhilHealth.

2.91 The team was also quite proactive in coordinating with other World Bank projects, including the Second Women's Health and Safe Motherhood Project and several trust funds focusing on health. The team worked closely with the Social Protection and Labor Global Practice to implement a single targeting mechanism, the National Household Targeting System. Though this effort delayed the support for PhilHealth, it ultimately led to a stronger and more sustainable targeting system than originally planned. The team also worked with the Public Management Sector in supporting the government's introduction of "sin taxes" that currently are a significant source of financing for PhilHealth.

2.92 The World Bank team coordinated with other high-level government agencies, particularly the Department of Finance on the "sin taxes" and with the National Economic Development Agency. In addition, the team worked on a series of development policy operations that included health as one of its policy areas. These required substantial engagement both within the World Bank and with central government policy agencies.[9]

2.93 The quality of supervision is rated **moderately unsatisfactory.** Although the World Bank made a significant contribution with its strategic and technical support to the project, it could have been more proactive in restructuring and in its administrative procedures.

2.94 The overall World Bank performance is rated **moderately unsatisfactory.**

BORROWER PERFORMANCE

2.95 **Government performance.** As the project provided budget support, it had significant interactions with the Department of Budget and Management, the National Economic Development Agency, the Department of Finance, and the broader Department of Health. There was broad ownership and support for the project's objectives. The government provided the Department of Health with its required budget and, with time, increased its support as the fiscal situation improved. The Department of Social Welfare and Development worked with PhilHealth to support the introduction of the targeting system and to merge databases of beneficiaries. The government's decision to finance PhilHealth premiums of the indigent population (largely replacing the LGUs in that role) also made a major contribution to the project's objectives.

2.96 Many of the delays in the project implementation were related to stringent government regulations regarding procurement, financial management, and fiscal transfers. Though these regulations applied to all government departments and LGUs, the government could have addressed some of them in the loan negotiations or in the preparation of the operational manual. The Department of Management and Budget's decision not to approve the project's special account complicated the project's fund flows. Government performance is rated **moderately satisfactory.**

2.97 **Implementing agency performance.** The primary implementing agencies were the Department of Health and PhilHealth. Both agencies carried out major reforms with the project's support, such as the FOURmula One health reform and PhilHealth's expansion. Likewise, the department implemented the project's procurement reforms despite reports of resistance on the part of some stakeholders.

2.98 Notwithstanding these achievements, there were several weaknesses in how the department carried out the project. There were important shortcomings with the availability and use of data throughout the project. The department took about two years to approve the results framework, which delayed monitoring. Likewise, despite the requirement in the loan agreement, the department never submitted annual reports on the project's implementation.

2.99 The department was also not able to provide sufficient support to LGUs as they implemented significant parts of the project. There were many delays associated with complicated government regulations. Likewise, the different attempts to introduce results-based financing had many limitations. More concentrated supervision would have helped the LGUs to better support the project.

2.100 In general, procurement was delayed throughout the project. In the case of vaccinations, this eventually led to a large refund from UNICEF to the World Bank for an advance that the government was not able to liquidate before the project closed. Implementing agencies' performance is rated **moderately unsatisfactory.**

2.101 The overall borrower performance rating is **moderately unsatisfactory.**

Monitoring and Evaluation

2.102 **Design.** The PAD had a results framework. Broader results monitoring included a variety of indicators at the project PDO and intermediate levels. From the results framework, the PDO level had three public health–related indicators (on immunization and TB) and two health systems–related indicators (enrollment of PhilHealth and reduction of out-of-pocket expenditure). These are all closely related to the PDOs and were at the objective level. There was also an additional indicator for the number of LGUs that measure increases in prevention, diagnosis, or cure rates of unspecified diseases. All the indicators had baselines and targets.

2.103 There were 11 intermediate (or output) indicators, mostly organized around subcomponents. These were generally well formulated. They were related to the actions of specific components. The indicators were measurable and had data sources, but some of them lacked baselines or targets; these were listed as "to be completed."

2.104 **Implementation.** There were many shortcomings in the implementation of the monitoring and evaluation framework. Several PDO indicators were never reported in supervision reports. The project did not collect information on the number of subsidized beneficiaries in PhilHealth; nor did it develop an indicator to measure the improvements in the prevention, diagnosis, and cure rates. These data were readily available. Many of the intermediate results were not tracked, including the ratio of doctors to the population (no baseline established) and reduction of drug stock-outs (no indicator developed). There did not seem to be any attempt to adjust the indicators during project implementation. Likewise, it appears that the project did not take advantage of data from other sources, such as the DHS or health information systems.

2.105 The project did contribute to improvements in data collection and analysis at the local level, particularly in areas where the project worked closely with the European Commission. This led to the collection of better data on health outcomes (particularly maternal health) and in monitoring TB. The increased utilization of public facilities has also contributed to LGUs' capacity to collect timely data. The project also made a major contribution in targeting the poor, bringing the National Household Targeting System to the health sector to identify PhilHealth beneficiaries.

2.106 **Utilization.** There is no evidence that the project used the formal results framework, particularly because many of the indicators were not systematically monitored.

2.107 The new household targeting system was used by PhilHealth to identify eligible households and to unify its database with that of other poverty programs. This was instrumental in improving the coverage of PhilHealth while also contributing to improving the accuracy and efficiency of targeting. Despite not reporting it in the results framework, the project was aware of the number of beneficiaries in PhilHealth and used this information for its disbursements to support component A. Likewise, there is evidence that LGUs are using more data in planning and responses to health issues.

2.108 The monitoring and evaluation is rated **modest.**

3. Second Women's Health and Safe Motherhood Project

Objectives, Design, and Relevance

Project Development Objective

3.1 The legal agreement between the World Bank and the government states that the PDO is

> to assist the Borrower in improving women's health by: (i) demonstrating in selected sites a sustainable model of delivering cost-effective reproductive health services to disadvantaged women; and (ii) establishing support systems to facilitate countrywide replication of lessons learned within the framework of its Health Sector Reform Agenda. (World Bank 2005a, 25)

3.2 The PAD had a similar formulation although it outlined in greater detail the means that the project would accomplish these objectives:

> The project will contribute to the national goal of improving women's health by: (i) Demonstrating in selected sites a sustainable, cost-effective model of delivering health services that increases access of disadvantaged women to acceptable and high-quality reproductive health services and enables them to safely attain their desired spacing and number of children; and (ii) Establishing the core knowledge base and support systems that can facilitate countrywide replication of the project experience as part of mainstream approaches to reproductive health care within the framework of the Health Sector Reform Agenda. (World Bank 2005b, viii)

3.3 Based on this, the evaluation will focus on "improving women's health." The formulation in the PAD provides guidance on the details and the underlying project's theory of change. This will focus on the project's pilot provinces, concentrating specifically on the project's pilots and its dissemination. It is also clear from the two objective statements that "women's health" refers to improving reproductive health, including support for family planning, safe births, and controlling sexually transmitted diseases.

Relevance of Objective

3.4 The relevance of objective is rated **high.**

3.5 Although the World Bank Group's country assistance strategy for 2006 to 2008 primarily focused on national-level investment programs, it carved out a specific space for smaller projects with a tight focus on improving public institutions at the local level. The project was well aligned with this part of the strategy, which included improving access to and delivery of health services (World Bank 2005c). The project was well aligned with the government's objectives at the time of approval. The 2005 National Objectives identify access to birth control and the need to increase prenatal care (Philippines, Department of Health 2005).

3.6 The current country partnership framework focuses its support health financing but it does draw special attention to maternal mortality in its objective 2.2 (improved health outcomes). The framework does indicate the possibility of future investment in women's health to reduce maternal mortality (World Bank 2014). The 2011 National Objectives identify increasing the number of facility-based births as a goal, along with increasing prenatal care and access to family planning (Philippines, Department of Health 2011). The government's *Philippine Development Plan, 2017–2022* (Philippines 2017), also mentions specifically the need to continue to improve reproductive health and reduce maternal mortality. The plan supports interventions that were directly derived from project activities. The project, which was designed as a pilot, is currently the centerpiece of the Philippines' maternal health policy.

Box 3.1. Does Facility-Based Delivery Lead to Improved Health Outcomes?

One of the underlying assumptions behind the project is that increasing the number of facility-based deliveries will lead to improved health outcomes for women and infants. At present, evidence is mixed, but there are strong reasons to accept the assumption in the Philippine context. Overall, it appears that there is no strong evidence that either facility-based or home-based deliveries are safer. However, this finding is based on studies in the Netherlands and the United Kingdom, with low-risk births supported by experienced midwives and access to high-quality backup care (Olsen and Clausen 2012). These conditions do not apply to most poor women in the Philippines. A systematic review by the Independent Evaluation Group found mixed evidence on the impact of promoting facility-based births, though the number of studies was likewise small. The results are often confounded by the common use of conditional cash transfers with facility-based deliveries (World Bank 2015).

In low- and middle-income countries, there is evidence explaining why women do not access facility-based deliveries, with reasons varying from access to concerns about quality and respect at facilities (Bohren et al. 2014). However, according to the Demographic and Health Surveys for 2013, these do not appear to be major concerns in the Philippines. For example, few women mind the lack of female providers. They are mainly deterred by distance and cost, which PhilHealth partially overcomes. Given the relatively low quality of traditional birth attendants in many parts of the Philippines and the difficulty of transportation in an emergency, combined with the availability of good-quality clinical staff and difficulties with transportation in an emergency, promoting delivery at facilities where good-quality clinical staff are available appears to be a good investment.

PROJECT DESIGN

3.7 The project was a traditional investment loan that offered additional incremental financing to the borrower. Although this differed from the "sector support reform" model that the World Bank was using for larger projects, it was appropriate for a small pilot project with a limited geographic scope. The project did not have a project management component, since this was integrated in the Department of Health and the LGUs' health offices. Appendix A contains detailed information on proposed and actual spending.

3.8 **Component A: Local Delivery of the Integrated Women Health and Safe Motherhood Service Package** (appraisal $13.4 million; actual $5.2 million). Originally, this component included financing of $19 million from the LGUs and PhilHealth. These figures were indicative; the actual amount depended on the LGUs that participated and the coverage of PhilHealth. This component aimed to help local governments mobilize

public and private providers to undertake activities and deliver services included in the package, with focus on maternal care, family planning, and sexually transmitted disease for the general population. The project aimed to give priority attention to disadvantaged women and included, as a pilot, new approaches to reaching high-risk groups.

3.9 As designed, the project would be implemented in six LGUs. It would start with the provinces of Sorsogon and Surigao del Sur as well as Iloilo City. An additional three LGUs would be selected in the project's third year. In each project site, the project would undertake an interrelated set of interventions, including: (i) the establishment and operation of a network of Women's Health Teams in every barangay, and an appropriate number of Basic and Comprehensive Emergency Obstetric Care teams;[10] and (ii) support by improving drug and contraceptive security, strengthening blood safety, improving dissemination, and developing a better health financing mechanism. In addition to providing services, the team would promote behavior change. These interventions were grouped together in the Women's Health and Safe Motherhood Package.

3.10 **Component B: National Capacity to Sustain Women's Health and Safe Motherhood Services** (appraisal $2.5 million; actual $5.1 million). This component was designed to support capacity in the Department of Health at the central level. This aimed to strengthen the capacity of LGUs as well as training and policy research to bring the pilots to scale. It supported three broad sets of activities: (i) the development of operational and regulatory guidelines; (ii) developing a network of accredited training providers for the integrated service package; and (iii) support for monitoring, evaluation, research, and dissemination.

Relevance of Design

3.11 The project was designed as a pilot program within the context of the national health sector reform, FOURmula One. It included a specific set of interventions to provide an integrated approach to women's health. However, the project design had some important divergences from the project's objective. The project's activities were concentrated on improving safe motherhood and promoting family planning, with little focus on other elements such as HIV/AIDS, other sexually transmitted diseases, and other related issues.

3.12 The project put special emphasis on increasing the number of facility-based births. This represented a new approach to safe motherhood, based on emerging evidence about how facility-based delivery can contribute to reducing maternal mortality (box 3-1). Until the project was approved, the official policy of the government was to promote skilled birth attendants to support home-based deliveries. Likewise, bringing together different aspects of the safe birth into one package was also state of the art and supported by empirical evidence. This approach built on existing models for community health workers. It aimed to provide a different role for many trained traditional birth attendants, allowing them to focus on other aspects of reproductive health. This in turn also served to lessen the resistance of an important and respected group of community members.

3.13 The project included actions to strengthen the role of LGUs and their capacity to provide health services, based on lessons learned from two previous health projects which did not take the LGUs roles into account. Likewise, the design also considered the

likely expansion of PhilHealth and its potential role to support project activities. The project included several different "performance-based grant" schemes to encourage LGUs to support certain initiatives, including providing support for their PhilHealth expansion programs. Given the low capacity of many LGUs in poor regions as well as complicated government financial management procedures, these were not realistic. While the project was generally well-targeted to address safe motherhood and family planning, its design was weak in other aspects of women's health.

3.14 The relevance of design is rated **modest.**

Preparation and Implementation

3.15 The First Women's Health and Safe Motherhood Project closed with an unsatisfactory rating. However, given broad concerns about the high maternal mortality and fertility rates, the government and World Bank agreed to develop a new approach. The Second Women's Health and Safe Motherhood Project was designed to pilot universal facility-based deliveries for all mothers in selected LGUs. As part of its support for the health sector reform, the World Bank felt it was important to tie national programs, such as safe motherhood, to the national health sector reform. The government was quite supportive, as it fit in well both with its sector strategy as well as the development strategy.

3.16 The World Bank coordinated across its operations and the project was designed to work with the ongoing World Bank Local Government Finance and Development Project and with the proposed National Health Sector Reform Project. The project also coordinated with other development partners, such as the Asian Development Bank's health project, which provided LGUs with lending to allow their health system to meet requirements for PhilHealth accreditation. The project developed synergies with other agencies, which allowed it to concentrate on its core activities while others financed civil works and PhilHealth at the local level.

3.17 The project included many covenants requiring actions at the national and local levels, including issuing orders and establishing the project structure. The project did not have a traditional project management unit at either the national or local level. At the national level, the department administered the project through the World Bank Unit in its External Coordination Division. One of the project's requirements was that each LGU open a bank account and make an initial deposit. This requirement led to significant delays in the project because this was done outside of an LGU's treasury account.

3.18 The government received a Population and Human Resource Development grant from Japan. Owing to contracting issues, the department was not able to carry out initial surveys to establish the baseline or to identify the poor. Some elements of the projects were consequently delayed. Other elements started slowly, including hiring key consultants. This reflected the limited staff available to deal with two projects. Implementation was quite slow, and when the midterm review was held (October 2008) with the total amount of disbursement less than 5 percent of the total amount after two and half years. Delays in other World Bank and the Asian Development Bank projects contributed to the delay as well.

3.19 Initially, the project included Iloilo City (an independent city) and the provinces of Surigao del Sur (Caraga Region) and Sorsogon (Bicol Region). For financial reasons, Iloilo City did not join the project. Around the time of the midterm review, the project then added three additional Bicol provinces—Albay, Catanduanes, and Masbate. The four Bicol provinces were attracted to the project because they were receiving support from other development partners that effectively covered their counterpart budget.

3.20 In 2009, the government formally adopted the safe motherhood package and introduced it nationally. This was done based on observations in the initial two provinces. However, because the department had limited capacity, the national roll-out complicated the continued implementation of the project, particularly in the three new provinces. The project never implemented other reproductive health initiatives, such as reaching out to at-risk groups. The project did attempt to increase availability of contraceptives but met political resistance at the national level.

3.21 In September 2010, the project had a level 2 restructuring, which was essentially corrective and did not involve any cancellation of funds. Support for infrastructure was canceled because significant resources were available from other sources. The project reallocated these funds to support the performance-based grants.

3.22 The project's performance-based grants, which were designed to operationalize many activities at the LGU level, never functioned as planned. However, the LGUs were quite active in the project's technical aspects. Most LGUs also organized Women Health Teams, which began to interact with local department offices. LGUs organized training and workshops, and the teams began to operate before funds became available.

3.23 The growth in PhilHealth coverage provided additional resources to the LGUs as the number of births in public facilities increased substantially. Although the grants would have provided resources both to the teams and facilities, by the end of the project, the bulk of resources were transferred to facilities through PhilHealth and contributions from the government and other donors. However, the teams largely operated as expected, albeit with lower incentives.

3.24 The project closed in June, 2013, one year later than originally planned. At the end, approximately $5.5 million (35 percent of total commitments) was canceled. The project's structure continues to operate in the five project provinces and has been extended to the rest of the country. Women's Health Teams remain active in the participating LGUs and have expanded throughout the country. After the project closed participating LGUs continued to solicit reimbursements for expenses incurred during the project. The extreme delays are the result of low capacity in many LGUs as well as changing government rules regarding fiscal transfers and procurement. The national government has honored the requests and has financed them out of its regular budget.

Fiduciary

3.25 The project had several financial management shortcomings. In total, it submitted seven audit reports, conducted by the national Commission of Audits. Of these audits, three were qualified and one was adverse. The project addressed all the audit issues, which mostly involved incorrect reporting. The project submitted the required financial

statements, but these were often delayed. National-level procurement was also delayed. Throughout the project, a lack of qualified procurement and financial management staff was the cause of many of these delays.

Safeguards

3.26 At the time of approval, the project was classified as category B in the environmental assessment (OP/BP/GP 4.01). It also triggered the involuntary resettlement (OP/BP 4.12) and indigenous peoples (OP 4.10) safeguards. Prior to approval, the project developed the required frameworks reflecting the need for flexibility because the choice of provinces was not complete. In practice, the project did not support any civil works so the environmental and resettlement safeguards were not triggered. The indigenous peoples' plan focused on ensuring that indigenous women equally benefited from the project. While the ICR reports the indigenous plan, it has little discussion on its contribution.

Achievement of the Objectives

OBJECTIVE: IMPROVING WOMEN'S HEALTH

3.27 As outlined in the development objectives in both the legal agreement and the PAD, the project focused on a relatively broad definition of reproductive health. The evaluation draws on several sources of data. First is data collected by the project, largely from Department of Health data. This is supplemented by data from the DHS, which corresponds well to the period when resources were being disbursed. However, DHS was not statistically representative for the province. However, four out of the five participating provinces are in the Bicol Region; they represent four out of Bicol's six provinces and 56 percent of the region's population. The Bicol region is relatively homogenous culturally and economically. The fifth province, Surigao del Sur, is in the Caraga region, which has five provinces and one independent city. Surigao del Sur accounts for 22 percent of the region's population and is less homogenous. Thus, data from DHS do not represent the project's contribution in Surigao del Sur.

Outputs

3.28 **Women's health teams.** The project's primary output was the creation of Women's Health Teams in most of the rural barangay in the participating projects. These included the local midwife, traditional birth attendants, and community health volunteers. These teams were designed to serve as liaisons between the municipal or city health offices and the community. Although they performed a variety of functions, their major focus was on encouraging women to have facility-based deliveries and to carry out prenatal health visits.

3.29 Since one of the project's goals was to phase out home deliveries, the teams served as alternative employment for many traditional birth attendants. Under the model, they provided prenatal and postnatal care, and encouraged the use of contraceptives. They played a major role in behavior change communication. Even though most LGUs were late in paying stipends, the teams operated as planned. By the end of the project, these teams were fully financed and almost all LGUs had established health teams. The project

also established the Basic Emergency Obstetric Care Team and the Comprehensive Emergency Obstetric Care Team. The project also financed 29 training centers.

3.30 **Policy reforms.** The project supported pilot initiatives at the provincial and the LGU level as pilots. The project developed the Women's Health and Safe Motherhood standards for training and accreditation, which were adopted nationally. The project also led to issuance municipal, provincial, and eventually national orders that mandated the project's approach to facility-based deliveries and safe motherhood.[11] The project also supported the development of the standard package that PhilHealth now offers for all deliveries, which includes prenatal and postnatal visits in addition to the attended, facility-based deliveries.

3.31 **PhilHealth financing.** The project aimed to increase the coverage of PhilHealth's sponsored programs by financing the LGU's share of premiums. This was to be done as a reimbursement to the LGU for each eligible beneficiary. This was unsuccessful and proved unnecessary as the national government assumed responsibility for financing sponsored premiums. With the project's support, PhilHealth established a comprehensive package that included prenatal and postnatal care, combined with facility-based delivery. PhilHealth paid a fixed amount to facilities for normal deliveries, which proved to be an important incentive for both public and private providers.

3.32 As discussed in the evaluation of the NSSHR project, the coverage of PhilHealth increased substantially. By 2013, more than 90 percent of LGUs had PhilHealth coverage rates of 75 percent or higher. This exceeded the target of 75 of percent of LGUs reaching this coverage level. Overall, 88 percent of the poor population was covered by PhilHealth by the end of the project, surpassing the target of 75 percent.

3.33 **Upgrading and accreditation of birthing facilities.** The project supported the establishment of accreditation criteria for birthing facilities. Almost all facilities in the covered LGUs were eventually accredited by PhilHealth. PhilHealth provided important resources for public health providers, allowing them to expand their capacity. This effectively replaced performance-based grants, which were often paid very late.

3.34 **Procurement of drugs and commodities.** The decentralization of health services led to fragmentation of the drug and commodity procurement system because each LGU was nominally responsible for its own purchases. The project attempted to address this with alliances as well as new rules to ensure that the poorest areas got the top priority in receiving free drugs and contraceptives. By project's end, four of the five provinces had passed ordinances on contraceptive self-reliance to improve procurement. By the end of the project, none of the rural health units in the covered areas had suffered from stock-outs of contraceptives in the previous six months. This was a marked improvement over the baseline. In 2006, only 16 percent avoided stock-outs. By all accounts, facilities continue to have a stock of contraceptives, vaccines, and basic drugs.

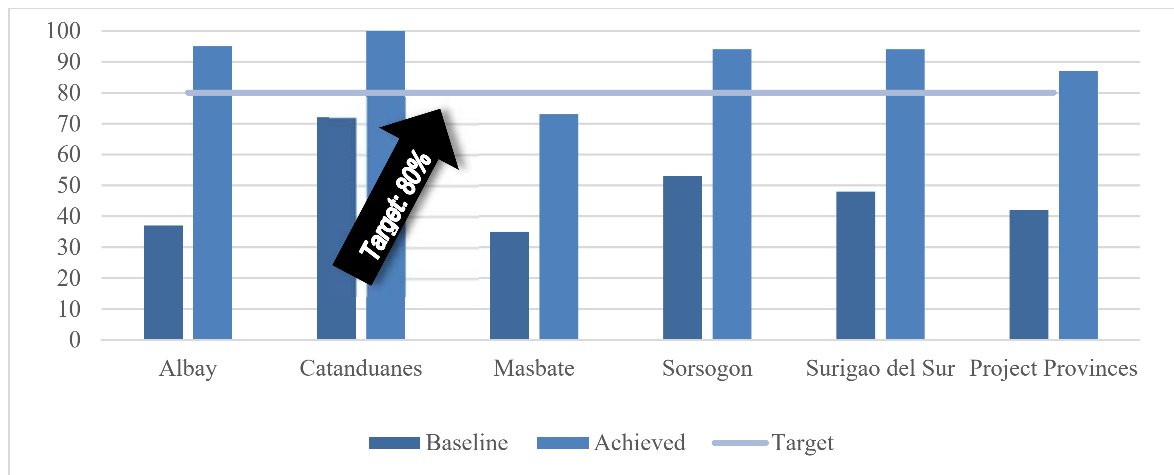
3.35 **Support for women at high risk.** The project design provided some support for programs that targeted commercial sex workers and overseas workers returning home. The project never initiated these activities. Other projects and initiatives supported the strengthening of social hygiene clinics, which perform a similar function. However, none

of the LGUs faced serious issues with HIV and AIDS, which are relatively rare in the Philippines and largely confined to men.

Outcomes Related to Safe Motherhood

3.36 One of the project's major actions was to increase the number of facility-based births. Until the project, the government's policy was to encourage skilled birth attendants to support home-based deliveries. As can be seen in figure 3.1, the utilization of facilities approximately doubled. Apart from Masbate, all the provinces exceeded the project target of 80 percent. Masbate province had the lowest baseline and had one of the largest increases in coverage. This increase was matched by an increase in the number of prenatal and postnatal visits.

Figure 3.1. Share Facility-Based Births, by Province

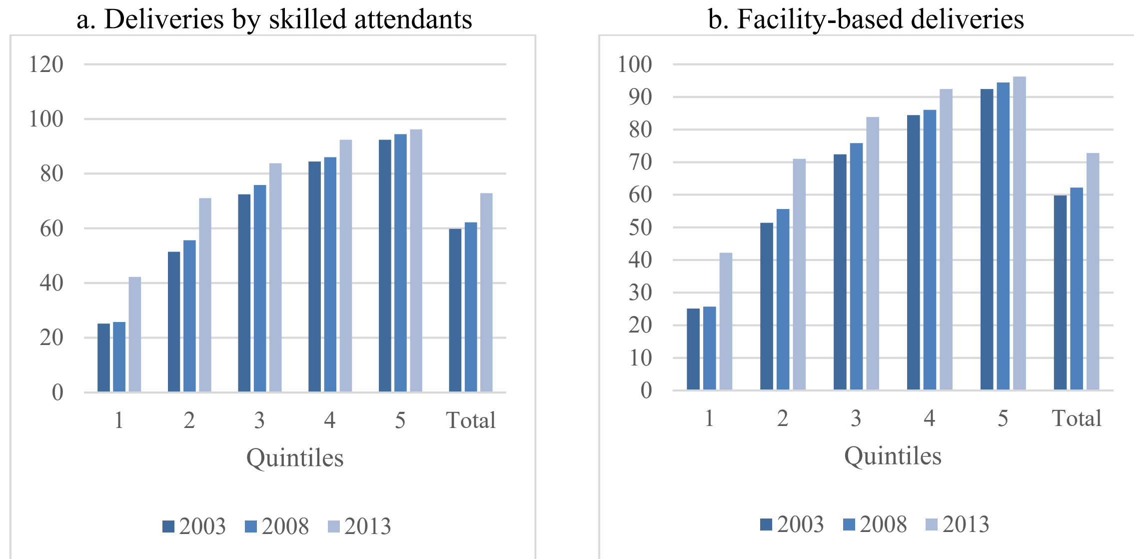


3.37 The increase in facility-based delivery was almost certainly driven by the project. There was no important change in education, income, or other explanatory factors. Changes of this magnitude are the result of policy reforms. The Women's Health Team played a central role in this process. The teams were in contact with virtually all pregnant women in their barangays. Their activities included behavior change communication, encouraging women to receive prenatal checkups and to deliver babies in facilities. The presence of traditional birth attendants in the team helped convinced women to use facilities for births. As shown in box 3.1, Philippine women seem to be well disposed to use facilities for delivery, with cost and distance as the major constraint. In addition to behavior change communication and providing information, the teams worked with PhilHealth to expand its comprehensive safe motherhood package.

3.38 The Department of Health's administrative order ("Adopting New Policies and Protocols for Essential Newborn Care") in 2009 played an important role in encouraging municipal health workers and facilities to change their focus from home-based to facility-based deliveries. Local governments issued complementary orders to their medical staff. This change was supported by PhilHealth's financing, which provided additional resources that were needed to expand coverage. PhilHealth financing also contributed to an increase in the number of private birthing facilities.

3.39 As these reforms were incorporated at the national level, there was a similar trend. Figures 3.2, panels a and b, show the change in the percentage of skilled and facility-based deliveries. It shows that there were few gains for the first and second quintiles between 2003 and 2008. Between 2008 and 2013, the utilization of skilled attendants and facilities-based deliveries increased significantly for the poorest. This was driven by the establishment of Women's Health Teams, the approval of orders by LGUs, and PhilHealth financing. Appendix B, table B.8, provides additional data on maternal health services.

Figure 3.2. Change in Percentages of Skilled and Facility-Based Deliveries



3.40 Maternal mortality is a relatively rare occurrence, particularly at the level of a LGU, so statistical significant trends are difficult to see. During the past decade, the crude maternal mortality rate has declined in each of the five project provinces, but the sample size is too small to show statistical significance. At the national level, the maternal mortality rate declined from 129 per 100,000 in 2008 to 121 in 2013 and 114 in 2015. The mortality rate was in the range of 127 to 129 from 2001 to 2008, which itself represents an increase from the level of the 1990s. It is possible that the move to facility-based delivery contributed to this decline after several years of stagnation and reversal.

Outcomes Related to Family Planning

3.41 Family planning has long been controversial in the Philippines. For example, in 2012, the Supreme Court issued a restraining order on the newly approved Family Planning Law that would have facilitated the free distribution of contraceptives (Mirkin 2016).

3.42 During the project period, there appears to be a reduction in the use of modern contraceptive methods. The project's baseline for contraceptive usage rate was 38 percent, based on Department of Health data. By project closing, the usage rate was virtually unchanged at 39 percent compared with a target of 48 percent. This general trend is reflected in survey data on the Bicol region, which if anything, show poorer

results. According to the DHS, in 2003, the contraceptive prevalence rate was 24 percent. In 2008, it remained at 24 percent and declined to 21 percent in 2013. This is contrary to the national trends that see a small but general increase in contraceptive use. The Bicol region had a fertility rate above the national average and it has declined at a slower rate than in the rest of the country.

3.43 The DHS shows that knowledge of modern family planning is nearly universal—in the range of 98 percent to 100 percent—from 2003 to 2013. Clearly the low level of coverage reflects a lack of access or a decision not to use family planning. In 2013, the DHS reports that about 62 percent of the total demand for family planning was satisfied. Without data from previous DHSs, it is not possible to see if this has changed.

Other Health Outcomes

3.44 The Philippines is considered a low-prevalence HIV and AIDS country, with an HIV infection rate below 0.1 percent. The heaviest concentration of infection is among men who have sex with men and injecting drug users in some urban areas. Only 15 percent of the infected population are women. Furthermore, HIV and AIDS are highly concentrated in large metropolitan areas (Philippines, Department of Health 2015). According to the 2003 DHS, knowledge of HIV and AIDS was relatively high, although there was a lot of ignorance about the details. By the 2013 DHS, the population was slightly more aware of the details of HIV and AIDS. Detailed knowledge appeared to be better distributed in 2013 across the socioeconomic and income scale.

3.45 The Philippines does not have national data on sexually transmitted diseases, so it is difficult to follow trends. When the project was prepared, sexually transmitted diseases were primarily concentrated in specific populations (FHI 2007). Evidence from the DHS shows little change in sexual practices, such as the use of condoms or having multiple partners, from 2003 to 2013.

3.46 There is no evidence that the project had any impact on the prevention and control of sexually transmitted diseases. However, given the context, it appears unlikely that this was a significant issue in the project provinces and that there could have been a measurable impact. Levels of knowledge were already reasonably high and infection rates were low. At best, the project could have provided more detailed knowledge about sexually transmitted diseases.

Did the Project Contribute to the Objective?

3.47 The evidence shows that the project was highly effective in increasing the number of attended births and, more importantly, the number of facility-based births. The results exceeded a set of very ambitious targets. The project made a clear contribution through its support of the creation and deployment of Women's Health Teams, which was complemented by its support in promoting accreditation of birthing facilities. These changes have been transformational; they reflect a major change in government policy and household behavior. This transformation has the potential to lead to lower maternal mortality, better child health, and reduced financial risk.

3.48 Though the project did not support PhilHealth to the extent that was originally planned, this reflected the support from the government and the NSSHR project to PhilHealth. Likewise, the project did not support civil works as originally planned because there were several other programs supporting infrastructure.

3.49 The project did not appear to contribute to reducing HIV/AIDS and other sexually transmitted diseases, because the number of cases in the targeted area is very low. Though it did work to expand access to family planning, it appeared to have little impact.

3.50 This objective is rated **substantial.**

Efficiency

3.51 The project was quite successful in increasing the utilization of facility-based deliveries. While there is limited rigorous evidence on the cost-effectiveness of facility-based births in reducing maternal mortality, there is evidence that suggests that it is an effective intervention (Chinkhumba et al. 2014).

3.52 When the project closed, a total of US$4.6 million (35 percent of the total amount) was canceled. From the beginning, it was clear that the project was not disbursing its resources as planned and that it was likely to have serious delays throughout its life. A midterm review was held two and half years into project implementation, when only 5 percent of the project was disbursed. The project was restructured two years later. The funds were not canceled either time, even after the government adopted the project's policy reforms and started financing several elements with its own resources. In the first five years of the project, only 18 percent of funds were disbursed. Even in the context of a pilot project, which involves taking risks and maintaining flexibility, this represents a misallocation of resources that could have been used for other interventions or other projects.

3.53 Efficiency is rated **modest.**

Ratings

OUTCOME

3.54 The relevance of objective was rated high, reflecting its alignment with both government and World Bank country strategies. The relevance of design is rated modest because it focused on strengthening maternal health services at the expense of other elements in the objective. The efficacy is rated substantial, reflecting the project's contribution to increasing the number of facility-based deliveries. Efficiency is rated modest reflecting the project's slow disbursement and significant delays.

3.55 The outcome is rated **moderately satisfactory.**

RISK TO DEVELOPMENT OUTCOME

3.56 The project's approach to safe motherhood is well established in policy and procedure across the country. In addition to the national regulations, most LGUs have issued ordinances establishing Women's Health Teams and promoting facility-based

deliveries. Current data show that the proportion of facility-based deliveries has increased nationally, as have the number of prenatal and postnatal visits. PhilHealth is continuing to expand its coverage of maternal benefits, and is expanding its network of accredited providers.

3.57 The risk to development outcome is rated **low to negligible.**

WORLD BANK PERFORMANCE

3.58 **Quality at entry.** Given the low ratings from the First Women's Health and Safe Motherhood Project, the preparation reviewed recommendations from the Operations Evaluation department and incorporated them in the discussion of the project's risk in the PAD. The risk section was reasonable but did not fully consider the risk associated with working with LGUs. The project did not account for the complications of fund flows to LGUs or difficulties of procurement at the local level.

3.59 The team did attempt to compensate for this by collaborating with a World Bank local government support project and an Asian Development Bank health project. The difficulty in "recruiting" provinces and cities to the project also suggests that more work was needed to identify potential sites and to understand the constraints that LGUs might face in joining the pilot. The project was developed as a pilot with the clear goal of bringing the project nationwide; as such, it is surprising that after a two-year design period, the World Bank did not hold a formal review meeting to discuss the issues associated with the project.

3.60 The World Bank was quite successful in identifying partners within the department to develop a different approach to safe motherhood. Encouraging facility-based deliveries represented a major change in government policy after more than a decade. This support played a major role in strengthening champions within the department. The quality at entry is rated **moderately unsatisfactory.**

3.61 **Quality of supervision.** The project had three team leaders in eight years, all of whom were based in the Philippines. The World Bank carried supervision missions on a regular schedule and prepared 16 supervisions reports, which follows World Bank guidelines. The supervision reports provided a candid review of the issues and bottlenecks that the project faced.

3.62 Though the project team was active in trying to improve the project's performance, delays remained, and there were many bottlenecks. The World Bank did process a restructuring, but only after five years when the project had only disbursed 18 percent of its resources. Notwithstanding major delays and change on the ground, the restructuring was not extensive and made no changes to the project's design or to the results framework. The restructuring reallocated resources to the performance-based grants. There was no major adjustment in this component, though the team was aware of the bottleneck in disbursing resources to LGUs. The project had not established a monitoring system and many LGUs were still unable to meet the administrative requirements to apply for the grants.

3.63 There were significant delays in collecting data for the results framework, and the supervision team did not address this at the time of the restructuring. The team also did not take advantage of other data sources such as the extensive administrative data that the department collects. The quality of supervision is rated **moderately unsatisfactory.**

3.64 The overall World Bank performance is rated **moderately unsatisfactory.**

BORROWER PERFORMANCE

3.65 **Government performance.** The proposed project intervention had high ownership with the department and LGUs. Champions within the department worked hard to introduce a new strategy at different levels of the government. This led to the approval of a new strategy for safe motherhood in 2009, which was based on the reforms that the project introduced. The department then worked with LGUs to implement this model nationwide, including providing capacity building and additional resources.

3.66 Though the government was supportive of the project and tried to improve its performance, many of the bottlenecks were the result of government policy. For example, the government was late in issuing a Special Allocation Request Order to incorporate the loan funds in the budget and provide counterpart funding. However, the final order was larger than originally agreed and provided more flexibility. The quality of government performance is rated **moderately satisfactory.**

3.67 **Implementing agency performance.** The implementing agency (primarily the Unified Project Management Division and the Maternal Health Unit) had a high degree of ownership of the project. It played a major role in promoting the concept within the government and with LGUs that were ultimately responsible for implementation. Although many elements of the project were delayed, the department carried out capacity building such as training and workshops. Respondents indicated that this capacity building was essential to creating the Women's Health Teams and expanding facility-based deliveries. However, it appears that this was more noticeable in the first two provinces (Sorsogon and Surigao del Sur) than in the later provinces.

3.68 At the time the project became effective, the Unified Project Management Division only had two staff members to cover all World Bank health projects. This was clearly insufficient for the project, particularly considering the work needed to prepare the National Health Sector Reform Project.

3.69 Several major initiatives were delayed at the beginning of the project because of procurement delays. The baseline survey was carried out in 2009 because of delays in the contracting the survey firm. Likewise, there were delays in hiring a firm to develop a targeting scheme. The latter proved unnecessary because the health sector adopted the National Household Targeting System. The project never hired financial management, procurement, and communication specialists.

3.70 LGUs were critical in implementation. On the positive side, LGUs showed a high level of support and ownership. Women's Health Teams were established in almost all barangays covered by the project. However, many of the LGUs faced significant shortfalls in their capacity to carry out many of the project activities. Although LGUs

were required to open bank accounts and to make initial deposits of counterpart funds by December 2005, this was not finalized until late 2007. Without resources in the account, the LGUs were not able to initiate many activities. This reflected the complicated budget rules that few LGUs had the experience to navigate. The quality of implementing agency performance is rated **moderately unsatisfactory.**

3.71 The overall borrower performance is rated **moderately satisfactory.**

Monitoring and Evaluation

3.72 **Design.** The project had a well-developed results framework and results monitoring framework, complemented by a detailed plan for results monitoring. The PDO-level indicators largely focused on safe motherhood outcomes (four out of six), with one focusing on contraception prevalence and one on health sector strengthening. These were supported by many intermediate indicators, organized by components. The structure shows a clear results chain, from input to outputs to outcomes.

3.73 Most of the PDO indicators had baselines and target values. Many of the targets were ambitious, requiring significant changes in policy and behavior. However, most of the intermediate indicators did not have baselines. These baseline values required the input of a survey, which was to be followed up by an end of project survey. Targets were also established, often with a goal of 100 percent; for example, no rural health units have drug stock-outs. Some of the data also relied on administrative data from the Department and PhilHealth.

3.74 The results monitoring plan included a review of indicators at the midterm review to adjust for changes in the project and the incorporation of other LGUs into the pilot. In addition, it included an outline for impact evaluations for key outcomes. This would rely on household and facilities surveys as well as administrative data. Likewise, the plan proposed special studies on innovative interventions as well as operations research focusing on difficult to reach groups. These activities were all budgeted.

3.75 **Implementation.** The baseline survey was conducted two years late because of contracting issues. Although the project planned to hire an evaluation specialist, this was not done and the original arrangement model was not changed.

3.76 For the most part, the project was collected data for all the PDO indicators. When available, the supervision reports provided periodic updates of the intermediate outcomes, however there were many gaps and there appeared to be little attempt to use alternative data sources. As there was no end of project survey, the ICR relied on administrative data for many of the reported final values.

3.77 The World Bank worked with other development partners to develop special evaluation studies. These were not as ambitious as the impact evaluations that were originally planned. The results framework was not changed during the midterm review however the project adopted a shorter-term approach focusing on “rapid results” that focused on short-term achievement that would ultimately build-up to the project’s targets.

3.78 **Utilization.** Despite the limitations in the implementation of the monitoring and evaluation framework, data did play an important role in the project. This was particularly noticeable for data collected at the facility and LGU levels. For the most part, LGUs were aware of their performance and used data to identify weaknesses; for example, LGUs used data on PhilHealth accreditation of birthing facilities. In some cases, the LGU administration could provide more support to ensure that a specific municipal target was met. Likewise, LGUs reported in the field mission that became careful in collecting health data (such as maternal mortality) and spent more time analyzing each case. At the national level, the government monitored the project's success in improving the proportion of facility-based births. This led to the decision to adopt the project's safe motherhood framework nationally.

3.79 Monitoring and evaluation is rated **modest**.

4. Lessons

4.1 **When designing results frameworks, and identifying the associated data sources, especially for outcome-level data, project teams should take into consideration data sources beyond those collected at the project level.** Much of the data that this evaluation relied on to measure outcomes were captured outside of the project, such as the Demographic and Health Survey and commonly-available health and epidemiological data. Although these data were available at the time of project preparation, they were not fully incorporated in the results framework. There was a further missed opportunity at the ICR stage, as these additional sources were not included because the ICRs restricted themselves to what had been captured by the projects' monitoring and evaluation systems.

4.2 **There are many possibilities in working across projects and sector silos.** Both projects achieved their objectives in large part because of to their collaboration with other interventions. PhilHealth played a major role in achieving the ambitious targets in the Second Women's Health and Safe Motherhood Project as its financing permitted the expansion of both public and private birthing facilities. This turned out to be a better alternative than the original plan to encourage LGUs to increase investment in their public health facilities. The financing would not have been available if the National Health Sector Reform Project had not had such a large contribution to increasing PhilHealth coverage. The World Bank's support for creating the National Household Targeting System played a major role in strengthening PhilHealth. Likewise, the World Bank's support for introducing sin taxes contributed significantly to PhilHealth's growth.

4.3 While much of this synergy was planned (particularly with regards to PhilHealth), some of it arose during implementation. This was particularly true for the two project's interactions with other World Bank sectors (Social Protection and Governance). This demonstrates the importance of flexibility, allowing projects to take advantage of opportunities as they present themselves.

4.4 **The consequences of not considering legal structures can lead to delays or reduced effectiveness.** Both projects knew about the World Bank's experience in the Philippines and working with LGUs. Despite this, many of the shortcomings were associated with difficulties at the LGU level. While much of the focus was on LGU

capacity, the projects did not fully consider national rules on financial management, procurement, and LGU conduct. These rules proved to be strict and changing. For example, the Second Women's Health and Safe Motherhood Project it proved to be quite challenging for LGUs to open bank accounts as required in the loan agreement

4.5 This emphasizes the importance of going beyond capacity and developing a deeper understanding of legal structures. The World Bank had a strong governance program in the Philippines and has worked to reform the myriad of rules and legal requirements at different levels of government. While there was dialogue with other government agencies on policy, there was room for greater collaboration on administrative issues. Better coordination on basic issues could have improved the project's efficiency.

4.6 **Small interventions and pilots can have transformational impact.** The FOURmula One health sector reform was built on implementing many new initiatives to improve the efficiency and effectiveness of health care in the Philippines. Both projects were designed to pilot certain elements of the reform while supporting specific elements of the reform. Both project included several interventions that drove much of the reform's positive impacts. The NSSHR project introduced a targeting system, which was a relatively small intervention and played a major contribution to the rapid increase in PhilHealth. Likewise, the increase in the facility-based delivery was driven by the growth in PhilHealth and the Second Women's Health and Safe Motherhood Project's support for Women's Health Teams. This proved to be more impactful than capital expenditures.

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[1] The Demographic and Health Survey uses a wealth index to measure the household's standard of living. These indexes are correlated with expenditures (PSA and ICF 2014).

[2] The highest level of local governments are provinces and independent cities. Provinces are divided into municipalities and (nonindependent) cities. The country is also divided into administrative regions and the Autonomous Region of Muslim Mindanao.

[3] Since 1975, "pneumonia." In terms of total mortality, it has been ranked between second and sixth place during this period (Philippines Department of Health 2005, 2011).

[4] The Second Social Expenditure Management Project, implemented between 2002 and 2007.

[5] Social Welfare and Development Reform Project, implemented between 2009 and 2015.

[6] The World Bank commonly includes direct contracting with the United Nations Children's Fund in its projects.

[7] Interviews indicate that these were based on existing demographic assumptions and were not retroactively adjusted to reflect new estimates from the Philippine Statistical Authority.

[8] The City of Manila is the densest municipality in the world; eight of the 17 municipalities of the National Capital Region have population densities above 50,000 per square kilometer.
[9] The Philippines Development Policy Loan to Foster More Inclusive Growth series. Operations 1 (2011) and 2 (2012) were developed while the project was being implemented. Operation 3 (2014) provided continuity when the project closed.

[10] A barangay is the lowest level of local government, corresponding to a neighborhood or village.

[11] Many of the initiatives were codified in Administrative Order 2009-0025 ("Adopting New Policies and Protocols for Essential Newborn Care") were directly adopted from the project.

Appendix A. Basic Data Sheet

NATIONAL SECTOR SUPPORT FOR HEALTH REFORM (IBRD NO 7395-PH)

Table A.1. Key Project Data (US$, millions)

	Appraisal Estimate	*Actual or Current Estimate*	*Actual as % of Appraisal Estimate*
Total project costs	110.00	104.72	95
Loan amount	110.00	104.72	95
Cancellation	0.00	5.28	n.a.

Source: SAP—Project disbursement data.

Table A.2. Cumulative Disbursements Estimated and Actual

	FY07	*FY08*	*FY09*	*FY10*	*FY11*	*FY12*	*FY13*
Appraisal estimate (US$M)	5.53	22.73	46.23	75.98	110.00	110.00	110.00
Actual (US$M)	0.28	10.15	20.41	37.97	70.18	102.07	104.72
Actual as % of appraisal	5	45	44	50	64	93	95
Date of final disbursement: July 31, 2012							

Source: Project portal data.
Note: FY = fiscal year.

Table A.3. Key Project Dates

Project Stage	Original	Actual
Concept Review	7/25/2002	7/25/2002
Negotiations	5/09/2006	5/09/2006
Board approval	6/29/2006	6/29/2006
Signing	10/03/2006	10/03/2006
Effectiveness	3/27/2007	3/27/2007
Closing date	6/30/2011	3/31/2012

Table A.4. Task Team Members

Name	Title	Unit
LENDING AND SUPERVISION		
Cesar Palma Banzon	Team Assistant	EACPF
Jan Both	Consultant	EASHD
Melinda Good	Senior Counsel	LEGES
Loraine Hawkins	Lead Health Specialist	EASHD
Teresa Ho	Lead Health Specialist	EASHD
Janet I. Hohnen	Consultant	EASHD
Timothy A. Johnston	Senior Health Specialist	EASHH
Marites B. Lagarto	Human Development Specialist	EASHD
Cynthia F. Manalastas	Program Assistant	EACPF
Rekha Menon	Senior Economist	ECSH1
May Cabilas Olalia	Operations Officer	LCSPS
Maria Loreto Padua	Senior Social Development Specialist	EASPS
E. Gail Richardson	Consultant	EASHD
Noel Sta. Ines	Senior Procurement Specialist	EAPPR
Florence Tienzo	Health Specialist	EASHD
Josefo Tuyor	Senior Operations Officer	EASPS
Agnes Albert-Loth	Senior Financial Management Specialist	EAPFM
Dominic Reyes Aumentado	Senior Procurement Specialist	EAPPR
Eduardo P. Banzon	Senior Health Specialist	EASHH
Natasha Beschorner	Senior ICT Policy Specialist	TWICT
Alvin Valeriano de Borja Marcelo	Consultant	EASHH
Gerardo F. Parco	Operations Officer	EASPS
Joseph G. Reyes	Financial Management Specialist	EAPCO
Roberto Antonio F. Rosadia	Health Specialist	EASHH
Noel Sta. Ines	Senior Procurement Specialist	EAPPR
Tomas JR. Sta.Maria	Financial Management Specialist	EAPFM

Table A.5. Staff Time Budget and Cost for World Bank

Stage or Year of Project Cycle	**Staff Weeks** *(no.)*	**Finance, Including Travel and Consultant Costs** *(US$, thousands)*
LENDING		
FY02	10.44	62.94
FY03	16.11	57.62
FY04	17.49	108.71
FY05	27.08	103.69
FY06	46.84	176.22
FY07	3.41	9.41
FY08	0.00	0.00
Total	**121.37**	**518.59**
SUPERVISION AND IMPLEMENTATION COMPLETION AND RESULTS REPORT		
FY02	0.00	0.00
FY03	0.00	0.00
FY04	0.00	0.00
FY05	0.00	0.00
FY06	0.00	0.00
FY07	23.90	75.86
FY08	30.68	85.02
FY09	27.39	86.79
FY10	7.70	63.95
FY11	14.73	51.22
FY12	27.81	57.29
FY13	1.32	1.27
Total	**133.53**	**421.40**

SECOND WOMEN'S HEALTH AND SAFE MOTHERHOOD PROJECT (IBRD LOAN 7290-PH)

Table A.6. Key Project Data (US$, millions)

	Appraisal Estimate	Actual or Current Estimate	Actual as % of Appraisal Estimate
Total project costs	16.00	16.00	238
Loan amount	16.00	10.71	67
Cancellation	0.00	5. 2	n.a.

Source: SAP—Project disbursement data.

Table A.7. Cumulative Disbursements Estimated and Actual

	FY06	FY07	FY08	FY09	FY10	FY11	FY12	FY13	FY14
Appraisal estimate (US$, millions)	0.5	1.82	3.68	5.92	9.12	12.32	16.0	16.0	16.0
Actual (US$, millions)	0.38	0.47	0.74	1.40	2.55	4.80	7.56	8.94	10.71
Actual as % of appraisal	76	26	20	24	28	39	47	56	67
Date of final disbursement: December 31, 2013									

Source: Project portal data.
Note: FY = fiscal year.

Table A.8. Key Project Dates

	Original	Actual
Concept Review	1/29/2003	1/29/2003
Negotiations	3/11/2005	3/11/2005
Board approval	4/21/2005	4/21/2005
Signing	6/30/2005	6/30/2005
Effectiveness	12/28/2005	12/28/2005
Closing date	6/30/2012	6/30/2013

Table A.9. Task Team Members

Name	Title	Unit
LENDING AND SUPERVISION		
Ernesto Diaz	Senior Financial Management Specialist	EAPCO
Teresa Ho	Task Team Leader	EASHD
Noel Sta. Ines	Procurement Specialist	EAPCO
Cynthia F. Manalastas	Program Assistant	EACPF
Parivash Mehrdadi	Program Assistant	EASHD
Thomas Merrick	Consultant	WBIHD
Jose Tiburcio Nicolas	Operations Officer (Social Safeguards)	EASSD
E. Gail Richardson	Consultant	MNSHD
Sabrina Terry	Program Assistant	EASHD
Florence Tienzo	Health Specialist	EASHD
Josefo Tuyor	Operations Officer (Environment)	EASEN
Preselyn Abella	Senior Finance Officer	CTRLN
Agnes Albert-Loth	Senior Financial Management Specialist	EASFM
Kristine May San Juan Ante	Program Assistant	EACPF
Dominic Reyes Aumentado	Senior Procurement Specialist	EASR1
Cesar Palma Banzon	Program Assistant	GSDCS
Eduardo P. Banzon	Senior Health Specialist	EASHH
Jonas Garcia Bautista	Consultant	EASNS
Sadia Afroze Chowdhury	Consultant	SASHN
Rafael A. Cortez	Senior Economist (Health)	HDNHE
Timothy Johnston	Senior Health Specialist	EASHH
Gia Mendoza	Program Assistant	EACPF
Kumari Vinodhani Navaratne	Senior Health Specialist	SASHN
Maria Loreto Padua	Senior Social Development Spec	EASPS
Gerardo F. Parco	Senior Operations Officer	EASPS
Joseph G. Reyes	Financial Management Specialist	EASOS
Roberto Antonio F. Rosadia	Health Specialist	EASHH
Lilian Loza San Gabriel	Program Assistant	EACPF

Table A.10. Staff Time Budget and Cost for World Bank

Stage or Year of Project Cycle	**Staff Weeks** *(no.)*	**Finance, Including Travel and Consultant Costs)** *(US$, thousands)*
LENDING		
FY03		97.37
FY04		153.39
FY05		129.66
FY06		0.33
FY07		0.00
FY08		0.00
Total		**380.75**
SUPERVISION AND IMPLEMENTATION COMPLETION AND RESULTS REPORT		
FY03		0.00
FY04		0.00
FY05		4.01
FY06		111.63
FY07		44.95
FY08		64.95
Total		**225.54**

Appendix B. Additional Data

Table B.1. Economic Indicators

Year	GDP per Capita Growth Rate	GDP per capita, Real PPP (2011)	Consumer Inflation Rate	Unemployment Rate	Government Expenditure, % GDP	Public Health Expenditure, % GDP	Private Health Expenditure, % GDP
2000	2.2	4,227	4.0	11.2	11.4	1.5	1.7
2001	0.7	4,258	5.3	10.9	11.1	1.3	1.7
2002	1.5	4,322	2.7	11.5	10.6	1.1	1.7
2003	2.8	4,445	2.3	11.4	10.2	1.3	1.9
2004	4.6	4,652	4.8	11.9	9.4	1.3	1.9
2005	2.9	4,786	6.5	7.7	9.0	1.5	2.4
2006	3.5	4,954	5.5	8.0	9.2	1.5	2.5
2007	5.0	5,200	2.9	7.4	9.3	1.4	2.6
2008	2.6	5,336	8.3	7.3	8.8	1.3	2.7
2009	(0.3)	5,318	4.2	7.5	9.9	1.5	2.9
2010	6.0	5,638	3.8	7.3	9.7	1.6	2.8
2011	2.1	5,754	4.6	7.0	9.7	1.3	3.0
2012	5.0	6,042	3.2	7.0	10.8	1.4	3.1
2013	5.4	6,366	3.0	7.1	10.8	1.4	3.1
2014	4.5	6,654	4.1	6.6	10.5	1.6	3.1
2015	4.3	6,938	1.4	6.3	11.0	n.a.	n.a.

Note: GDP = gross domestic product.

Table B.2. Burden of Disease in the Philippines, 1990–2015

Cause	1990	2000	2005	2010	2015	Annual Growth Rate
Total DALYs Lost	24,497,011	25,039,390	26,814,940	28,146,770	28,905,992	0.7%
Communicable, maternal, neonatal, & nutritional diseases	52%	40%	35%	31%	26%	−2.1%
HIV/AIDS and tuberculosis	4%	5%	5%	4%	3%	−0.1%
Diarrhea and other common infections	27%	16%	14%	12%	10%	−3.3%
Neglected tropical and malaria	3%	3%	3%	2%	2%	−0.3%
Maternal disorders	1%	0%	0%	0%	0%	−1.0%
Neonatal disorders	12%	11%	10%	8%	7%	−1.4%
Nutritional deficiencies	4%	4%	3%	3%	3%	−1.3%
Other	1%	1%	1%	0%	0%	−2.8%
Noncommunicable diseases	39%	50%	55%	60%	65%	2.7%

Neoplasms	4%	6%	6%	7%	7%	3.6%
Cardiovascular	8%	11%	13%	15%	16%	3.4%
Chronic respiratory	4%	4%	4%	5%	5%	1.1%
Mental and substance use	4%	5%	5%	6%	6%	2.0%
Diabetes, urogenital, blood, and endocrine	4%	6%	6%	8%	8%	3.8%
Injuries	9%	10%	10%	9%	9%	0.9%

Note: DALY = disability-adjusted life year

Table B.3. Planned versus Actual Expenditure, by Component

Project Component	**At Appraisal: March 2006** *(US$, millions)*	**Restructured Amount: August 2010** *(US$, millions)*	**Final Disbursement: March 2012** *(US$, millions)*	**Percent Utilization**
Component A: Health Financing	40.0	40.0	44.0	110
Component B: Health Service Delivery	38.5	59.2	49.6	84
Component C: Regulation of Pharmaceuticals	0.5	0.2	0	0
Component D: Health System Governance	10.7	10.4	10.8	108
Unallocated	20.0	0	0	n.a.
Fees	0.3	0.3	0.3	100
Total	110.0	110.0	104.8	95.2

Note: Percentage utilization is based on the amount after the first restructuring; n.a.= not applicable.

Table B.4. Timeline of Major Events in the Health Sector

Year	Government Action	World Bank Support
1991	Local Government Unit Act formally transfers primary and secondary health care to local governments.	
1993		Urban Health and Nutrition Project approved.
1995	Establishment of PhilHealth to consolidate public health insurance programs.	Women's Health and Safe Motherhood Project I approved.
1997	All formal sector workers (public and private) are fully incorporated into PhilHealth.	
1998	Health Sector Reform Agenda	
2001		Urban Health and Nutrition Project closed, with an Unsatisfactory rating.
2002		Women's Health and Safe Motherhood Project I closed, with Moderately Unsatisfactory rating.
2005	FOURmula for Health to improve implementation of the Reform Agenda. Government's Sector Development Approach for Health to coordinate development partners better.	Second Women's Health and Safe Motherhood Project approved
2006		National Sector Support for Health Reform Project approved
2007		Trust Fund for Health Sector Reform approved
2008	PhilHealth agrees to use National Household Targeting System Generics Act ("Cheaper and Quality Medicines Act") approved to facilitate the purchase of generic medicine.	Mid-term review of Second Women's Health and Safe Motherhood Project
2009	Government adopts the Second Women's Health and Safe Motherhood Project's model for safe motherhood.	
2010	PhilHealth adopts the National Household Targeting System.	Mid-term review of National Sector Support Project. Second Women's Health and Safe Motherhood Project restructured.
2011		First Development Policy Loan approved
2012	"Sin taxes" approved to finance public health priorities. Responsible Parenthood and Reproductive Health Act approved.	Trust Fund for Health Sector Reform closed, with Unsatisfactory rating. Preparation of National Sector Support for Kalusugan Pangkalahatan (Universal Health Care) Project begins Second Development Policy Loan approved
2013	Temporary restraining order for the Responsible Parenthood and Reproductive Health Act.	National Sector Support for Kalusugan Pangkalahatan (Universal Health Care) Project dropped from lending pipeline
2014		Third Development Policy Loan approved, for US$300 million.

Table B.5. Coverage Rate and Total Doses Administered of Bacillus Calmette–Guérin Vaccination, in Selected Regions

Year	Philippines		National Capital Region		Ilocos Region		Bicol Region		Davao Region	
	Doses	Rate	Doses	Rate	Doses	Rate	Doses	Rate	Doses	Rate
2006	2,102,828	81.7	266,683	78.1	113,113	82.6	129,769	82.5	98,284	78.7
2007	2,097,171	79.5	282,754	82.0	118,104	86.6	127,055	82.9	99,429	79.7
2008	2,158,555	79.6	302,865	89.8	125,493	84.1	136,321	82.7	98,876	78.0
2009	2,180,030	88.7	305,285	99.2	107,409	78.4	119,603	81.9	101,805	102.1
2010	2,209,052	88.6	311,015	97.2	115,748	90.3	133,956	91.5	109,237	90.5
2011	2,038,563	78.8	299,076	93.7	99,715	76.5	131,643	87.8	108,611	86.9
2012	1,969,390	75.8	303,619	91.3	96,500	73.3	124,538	82.5	108,611	86.3
2013	2,073,356	78.3	298,032	88.1	112,507	84.5	123,186	80.4	102,536	79.9
2014	1,982,867	73.5	292,913	85.1	84,631	62.8	116,506	75.0	97,686	74.7
2015	1,991,807	72.5	282,135	80.5	92,397	67.7	103,762	65.8	98,624	74.0

Table B.6. PhilHealth Coverage

Year	Total Coverage *(millions)*	Percentage of Population	Subsidized Coverage *(millions)*	Percentage of Population
2007	64.47	73	13.64	15
2008	68.67	76	16.49	18
2009	n.a.	n.a.	n.a.	n.a.
2010	69.98	74	22.10	23
2011	78.39	82	38.45	40
2012	80.92	84	36.68	38
2013	76.90	79	31.38	32
2014	86.22	87	45.84	46
2015	93.44	92	47.81	47
2016	93.40	91	46.26	45

Table B.7. Utilization of Health Services by Quintile

		Diarrhea, Children under Age Five		Fever		Barriers to Healthcare Access for Women		
Year	Quintile	Prevalence in last two weeks	Institutional Treatment for Affected Children	Prevalence	Institutional Treatment for Affected Children	High Cost	Distance	Any Access Issues
2003	1	13.0	28.0	27.9	n.a.	87.1	59.1	93.5
	2	11.1	29.7	25.5	n.a.	80.1	33.8	87.1
	3	9.3	35.6	22.8	n.a.	73.0	22.2	80.8
	4	9.1	35.9	21.3	n.a.	62.9	18.7	73.6
	5	9.2	40.5	17.7	n.a.	45.6	13.6	59.7
	Total	10.6	32.4	23.8	n.a.	67.4	27.2	77.1
2008	1	10.3	30.4	24.8	33.3	74.0	57.8	92.3
	2	11.1	28.8	25.8	38.4	65.4	34.4	85.5
	3	8.1	37.4	23.0	37.4	59.7	26.4	78.6
	4	6.9	37.3	19.4	43.8	48.4	17.2	69.0
	5	7.4	48.8	15.2	56.5	38.2	12.9	57.2
	Total	9.0	34.2	22.4	39.3	55.1	27.4	74.6
2013	1	8.7	40.5	31.7	47.8	63.9	51.7	75.8
	2	8.9	45.0	29.9	50.4	57.7	34.9	68.3
	3	9.0	40.0	29.3	52.1	53.4	26.6	62.9
	4	6.1	43.4	23.6	47.9	43.4	19.4	52.8
	5	6.0	43.0b	17.7	56.5	28.8	13.2	38.3
	Total	8.0	42.1	27.5	50.1	47.7	27.4	57.8

Note: Skilled personnel refer to doctors, nurses, and midwifes. Postnatal care (also called postpartum care) refers to carry for the mother after giving birth.
a. Not statistically significant.
b. There were seven possible constraints in 2003, eight in 2008, and five in 2013.

Table B.8. Utilization of Maternal Health Services

		Antenatal Care		Delivery		Postnatal Care	
Year	**Quintile**	**Skilled Provider**	**Given Iron Supplement**	**Institutional Birth**	**Skilled Provider**	**Checkup by 41 Days**	**Skilled Provider**
2003	1	72.4	64.7	10.4	25.1	64.8	21.4[a]
	2	88.1	75.3	24.8	51.4	65.8	42.5[a]
	3	90.7	80.6	43.3	72.4	67.8	56.7[a]
	4	92.2	82.2	59.8	84.4	63.6	72.1[a]
	5	96.6	86.9	77.0	92.4	68.0	86.6[a]
	Total	87.6	76.8	37.9	59.8	65.7	53.9[a]
2008	1	77.1	66.0	13.0	25.7	89.7	23.6[b]
	2	91.4	82.6	34.0	55.6	89.5	52.7[b]
	3	95.9	85.9	48.3	75.8	90.5	69.2[b]
	4	97.6	91.7	68.7	86.0	93.1	80.2[b]
	5	98.3	91.5	83.9	94.4	94.7	89.9[b]
	Total	91.1	82.4	44.2	62.2	91.0	59.9[b]
2013	1	88.5	85.1	32.8	42.2	78.3	49.8[b]
	2	96.3	92.5	55.0	71.0	88.2	75.7[b]
	3	96.7	93.9	69.0	83.8	92.4	85.5b
	4	99.4	96.2	81.5	92.4	96.4	93.4b
	5	98.6	95.6	91.2	96.2	98.2	96.9b
	Total	95.4	92.1	61.1	72.8	89.4	77.2b

Note: Skilled personnel refer to doctors, nurses, and midwifes. Postnatal care (also called postpartum care) refers to carry for the mother after giving birth.
a. For 2003, this refers to location of the postnatal care in hospitals or health clinics.
b. Includes women who do not receive any postnatal care.

Table B.9. Comparison of Ratings for National Sector Support for Health Reform

Criteria	ICR	ICR Review	PPAR	Remarks
Outcome	Moderately Unsatisfactory	Unsatisfactory	Moderately Unsatisfactory	—
Relevance of Objective	Substantial[a,b]	Substantial	Moderately Unsatisfactory	The project's principal interventions continue to play a major in the government's health strategy. Follow the country strategy, World Bank support continues to support the project's interventions.
Objective 1	n.a.	Modest	Modest	
Objective 2	n.a.	Negligible	Substantial	There is substantial evidence on access and utilization increased. This was not included in the ICR.
Objective 3	n.a.	Negligible	Modest	There is evidence on changing expenditure patterns of the poor.
Relevance of Design		Substantial	Substantial	
Efficiency	Modest	Negligible	Modest	The ICR Review does not give a rating on efficiency as a result of the lack of evidence through a cost-benefit analysis. This approach is not appropriate for a project supporting reform.

Note: n.a.= not applicable.
a. The ICR combined relevance of objective and relevance of design ratings.
b. The ICR rates individual components rather than objectives and uses an alternative rating system

Table B.10. Other Health, Nutrition, and Population Projects in the Philippines

Name	Dates		Amounts (US$, millions)		IEG	Remarks
	Approval	Closing	Committed	Final	Rating	
Urban Health and Nutrition Project (P004568)	03/1993	06/2001	70.0	37.5	U	
Women's Health and Safe Motherhood Project I (P004567)	03/1995	06/2002	18.0	11.6	MU	
Women's Health and Safe Motherhood Project II (PXXXXX)					MU	
Early Childhood Development (P004566)						
National Program Support for Health Sector Reform (PXXXXX)					U	
Trust Fund for Health Sector Reform (P102513)	06/2007	10/2012	8.6	16.1	U	Financed by European Commission. Provided grants to conflict- afflicted provinces for health sector reform.
Philippines Public Health Project (PXXXXX)					n.a.	Financed by Output-Based Aid Trust Fund. Provided support to improve quality of maternal health providers
National Sector Support for Kalusugan Pangkalahatan (Universal Health Care) Project (PXXXXX)	n.a.	n.a.			n.a.	Project was proposed but never submitted to the World Bank's Board of Executive Directors. Original proposal was for $300 million project.

Note: IEG = Independent Evaluation Group; MU = moderately unsatisfactory; U = unsatisfactory.

a. Financing corresponds to World Bank financing only.

Appendix C. List of Persons Met

Napoleon L. Arevalo	Regional Health Officer for Bicol Region	Department of Health
Lani Azacon	Senior Operation Officer	World Bank
Evelyn Bangalan	Senior Manager	PhilHealth
Eduardo Banzon	Senior Health Specialist	Asian Development Bank
Maylene Beltran	Director IV	Department of Health
Grace Buquiran	Medical Officer IV	Department of Health
Pura Carino	Division Chief	PhilHealth
Myrna Chua	Municipal Health Officer	Daraga Municipal Health Office
Fernando Depano	Supervising Health Program Officer	Department of Health
Loraine Hawkins	Former Lead Health Specialist and Task Team Leader	Retired (World Bank)
Erlinda Rayos del Sol	City Health Officer	Taguig City Health Office
Zenaida Recidoro	Supervising Health Program Officer	Department of Health
Marie Jane Revereza	Municipal Health Officer	Oas Municipal Health Officer
Roberto Rosadia	Health Specialist	World Bank
Olga Virtusio	City Health Officer	Paranaque City Health Office