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ACKNOWLEDGEMENTS

This document is the result of a highly consultative process between the World Health Organization, the Department of Health and other government agencies, international development partners, civil society organizations, health professional organizations, academic institutions and relevant business organizations. It has been produced by a team of WHO staff from all three levels of the Organization, representatives of the Department of Health, led by the WHO Representative in the Philippines.
The health of every Filipino is one of the primary concerns of the Government of the Philippines. With this in mind, the Philippine Development Plan 2011–2016 focuses on the improvement of the quality of life of all Filipinos, including the attainment of universal health care as embodied in the Aquino Health Agenda.

This Country Cooperation Strategy (CCS) defines the broad framework for WHO’s work with the Government of the Philippines over the period 2011–2016. It articulates a coherent vision and priorities for WHO to support the Government in achieving universal health care goals of better health outcomes, sustained health financing and a responsive health system.

WHO and the Department of Health of the Philippines jointly developed this CCS. It is based on a systematic assessment of the country’s development challenges and health needs, government policies, and existing projects and programmes of other development partners. The process included consultations with all levels of WHO, the Department of Health, other relevant government organizations, United Nations agencies, multilateral and bilateral partners, and nongovernmental organizations.

Based on those assessments and consultations, the present CCS acknowledges the country’s achievements and strengths, as well as its challenges. Furthermore, the CCS harmonizes its priority areas with the United Nations Development Assistance Framework (UNDAF) 2012–2018, providing the health dimension not only for basic social service outcomes but for all UNDAF outcomes.

Thus, in the spirit of partnership and solidarity with Filipinos and the global community, this CCS serves as a key tool to guide cooperation between WHO and the Government of Philippines. It is anticipated that the implementation of this CCS will contribute significantly to improvements in the health of the people of the Philippines.

Mabuhay tayong lahat!

Honourable Enrique T. Ona, MD, FPCS, FACS
Secretary, Department of Health
Philippines

Shin Young-soo, MD, Ph.D.
WHO Regional Director for the Western Pacific
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<td>ADB</td>
<td>Asian Development Bank</td>
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<td>ARMM</td>
<td>Autonomous Region of Muslim Mindanao</td>
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<td>APSED</td>
<td>Asian Pacific Strategy for Emerging Diseases</td>
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<td>AusAID</td>
<td>Australian Agency for International Development</td>
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<td>Chronic Obstructive Pulmonary Disease</td>
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<td>DALYs</td>
<td>Disability Adjusted Life Years</td>
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<td>DaO</td>
<td>Delivering as One</td>
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<td>DENR</td>
<td>Department of Energy and Natural Resources</td>
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<td>MDG</td>
<td>Millennium Development Goal</td>
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<td>MIC</td>
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<td>MNCHN</td>
<td>Maternal, Neonatal and Child Health and Nutrition</td>
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<td>MMR</td>
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<td>Medium –Term Strategic Plan</td>
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<td>Medium Term Philippine Development Plan</td>
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<td>Neonatal Mortality Rate</td>
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EXECUTIVE SUMMARY


The process used in developing WHO’s strategic agenda ensures that the Organization’s support is anchored on national health priorities as well as country health challenges. Meanwhile, in line with the United Nations’ “Delivering as One” approach, the Country Cooperation Strategy (CCS) harmonizes with and contributes to the United Nations Development Assistance Framework (2012–2018).

In formulating the strategic agenda, the Organization focuses its contribution on the following cross-cutting priority areas: (1) supporting the Universal Health Care Agenda of the Department of Health; (2) achieving the Millennium Development Goals (MDGs) by 2015 with special focus on MDGs 4, 5 and 6; (3) addressing the social and environmental determinants of health; and (4) managing health security risks and health in emergencies.

For the next six years, the Organization’s support to the country shall focus on the following strategic priorities:

• strengthening health systems to provide equitable access to quality health care with special focus on the MDGs and priority non-communicable diseases;

• enabling individuals, families and communities to better manage their health and its determinants; and

• improving the resiliency of national and local institutions against health security risks.

In contributing to these strategic priorities, the Organization elaborates further on the specific main focus areas and related strategic approaches.

In achieving these strategic priorities, the Organization leverages its core functions with special emphasis on (1) articulating the research agenda, generating, managing and disseminating knowledge; (2) providing ethical and evidence-based policy options; and (3) providing technical support towards delivering results, with focus on catalyzing change and assisting in institutional development.

The “systems approach” of the CCS requires the team to shift from working independently to collaborating across programmes, especially in cross-cutting themes. It shall also assist the Department of Health leadership in responding to the health agenda by leveraging its brokering role to form joint partnerships in areas where critical actions are required, capitalizing on the strong (though untapped) presence of the private sector, civil society and academe.

In implementing the CCS, the Organization will take full advantage of the in-country capacity of the WHO Representative Office and that of the WHO Western Pacific Regional Office.
MULTI-STAKEHOLDERS CONSULTATIVE MEETING

The CCS Team led by WHO Representative in the Philippines, Dr. Soe Nyunt-U during the Multi-Stakeholder Consultative Meeting held 12 October 2010 at the Crowne Plaza Galleria Manila. This was part of a consultations and purposeful dialogue involving national authorities, local and international partners, civil society organizations and other stakeholders at the country level to identify and analyze key issues that need to be addressed and to strengthen WHO support in order to contribute to national health development.
SECTION 1: INTRODUCTION

The WHO Country Cooperation Strategy (CCS) for the Philippines (2011–2016) is the medium-term vision of the Organization’s technical cooperation for the country, responding to its realities while contributing to the Organization-wide Medium-term Strategic Plan (MTSP) for 2008–2013. In line with the Paris Declaration on Aid Harmonization, the CCS contributes to the Department of Health’s Administrative Order No.2010-036 “The Aquino Health Agenda: Achieving Universal Health Care for All Filipinos”. It also serves as a reference document for United Nations partners as they carry out the United Nations Development Assistance Framework (UNDAF) for 2012–2018. Through a reiterative process of dialogue between the Government, WHO and United Nations partners, refinements were made to the CCS to ensure alignment with the national health priorities and harmonization with the UNDAF.

The CCS team consists of members from all levels of the Organization and focal persons from the Department of Health. Weekly team discussions led to the identification of an initial set of strategic priorities that was among the themes raised during the UNDAF discussions. In a decentralized health care system, with key players at different levels of the health sector, the development of the CCS called for a highly consultative process, leading to the identification of potential areas of partnership among the different stakeholders. Key informant interviews and self-administered questionnaires served to identify WHO’s contribution to the health sector and the Organization’s comparative advantage. Input from these various sources was used by the team during its strategic priority exercise. Thereafter, a validation meeting was conducted wherein Department of Health senior management and technical staff — joined by representatives of development partners, other national Government agencies, local government units (LGUs) and civil society — were able to review, discuss and validate the proposed strategic agenda.

Figure 1. Road Map of the WHO CCS for the Philippines 2011–2016
SECTION 2: HEALTH AND DEVELOPMENT CHALLENGES

2.1 MACROECONOMIC, POLITICAL AND SOCIAL CONTEXT

The Philippines has a land area of 300 000 square kilometres (km²), encompassing more than 7 000 islands. The country’s population was 88.6 million in 2007, with an annual growth rate of 2.04%. A majority of the Filipinos (81.04%) are Roman Catholic, while a substantial Muslim minority are concentrated in Mindanao.

The Filipinos are governed by a presidential form of government, having a strong executive branch headed by a President, which is balanced by a bicameral legislature and an independent Supreme Court and judiciary system.

In 1991, the Congress enacted the Local Government Code, which transferred responsibility for the provision of health, social and agricultural services from the national Government to the LGUs, with significant transfers of revenue through the internal revenue allotments. For the health sector, the devolution resulted in a fragmented health care delivery system.

2.2 OTHER MAJOR DETERMINANTS OF HEALTH

2.2.1 Poverty

The percentage of the population below the national poverty threshold declined from 45.3% in 1991 to 32.9% in 2006. However, as a result of the global financial and economic crises of 2008, soaring food and fuel prices in 2007-2008, natural disasters caused by typhoons Ondoy and Pepeng in September and October 2009, and the recent El Niño phenomenon in 2009-2010, the poverty level has worsened, reversing the declining trend achieved prior to 2006. This puts the country on an uncertain track to reach the MDG target of 22.7% below the national poverty threshold by 2015.

Among poor families, 65% of family heads have only an elementary education, 29% do not have access to safe water, and 24% do not have sanitary toilets. In June 2010, 21.2% of the households surveyed nationwide by Social Weather Stations reported experiencing hunger in the past three months. That rate was higher than hunger rates reported in the same month of each of the previous seven years. In fact, reported hunger rates increased successively in each of those years.

2.2.2 Social Determinants

Population growth and spatial trends. With an annual growth rate of 2.04%, population growth in the Philippines is one of the highest in Asia. Despite long-standing high female education rates, population growth rates have remained relatively high in the Philippines due to cultural and political factors.

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As of 2010, 63% of the population were living in urban areas; this is expected to increase to 70% by 2015. The increasingly urban character of destitution increases the burden on the health care system as problems of population pressure and environmental degradation, combined with the urban lifestyle, put the urban poor under higher risk.

**Food security.** In a recent global evaluation of food security risks, the Philippines was rated as “high-risk” in terms of food security and ranked 52nd out of 163 countries based on criteria including cereal production, GDP per capita, risk of extreme weather events, quality of agriculture and distribution infrastructure, conflict and effectiveness of government. As expected, the food price shock which occurred in late 2007 to early 2008 created a significant negative impact on the well-being of the poor, including small rice farmers, most of whom are net buyers of rice for household consumption. In its broader sense, food security exists when all people, at all times, have physical, social and economic access to sufficient, safe and nutritious food to meet their dietary needs and food preferences for an active and healthy life. Therefore, attention to enhancing food safety will also contribute significantly to food security in the Philippines.

**Literacy and education.** The Philippines had a basic literacy rate of 93% in 2003, one of the highest rates in the world. Literacy is higher among females (94.3%) than males (92.6%). Functional literacy (which includes not only reading and writing but also numeracy skills) was 84% in 2003, higher among females (86.3%) than among males (81.9%).

However, the country’s chance of meeting the MDG on achieving universal primary education is highly improbable. In 2008, an estimated 3 million children in the 6-15 years age group were out of school. Almost 53% of 6-year-olds do not enter the formal school system at all and those who enter begin dropping out soon thereafter, especially between grades 1 and 2. Furthermore, for every 1000 children who enter public school in grade 1 and graduate in grade 6, only seven have sufficient mastery of English, mathematics and science.

**Gender.** From the Human Development Report of 2009, the Philippines’ Gender Development Index (GDI) value of 0.748 is 99.6% of its Human Development Index (HDI) value of 0.751. Out of the 155 countries with both HDI and GDI values, only 39 countries have a better ratio than the Philippines. Despite these positive indicators of women’s status, women continue to suffer from a lack of reproductive rights, given the legal, regulatory, political and cultural constraints on women’s ability to exercise their reproductive rights. Other issues include the feminization of overseas employment and its implications for the women and their families, and women in armed conflict.

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5 World Food Summit, 2009.
8 The GDI measures achievements in the same dimensions using the same indicators as the HDI but captures inequalities in achievement between women and men. It is simply the HDI adjusted downward for gender inequality. The greater the gender disparity in basic human development, the lower is a country’s GDI relative to its HDI.


Section 2: Health and Development Challenges

2.2.3 Environmental determinants

*Natural hazards and climate change.* Due to its location along the Pacific Ring of Fire and the typhoon belt, the country is prone to various natural hazards such as typhoons, landslides, volcanic eruptions and earthquakes with their attendant consequences. In 2009, the Philippines topped the list of countries with the most number of reported natural disasters. It ranked third in terms of mortalities (1334 deaths) and second in terms of number of victims (13.4 million).\(^{10}\) The magnitude of some of these disasters compelled the Philippine Government to request assistance from international organizations, including from WHO.

The Philippines ranked 10th in the Global Climate Risk Index 2009 among countries most affected by extreme weather events from 1998 to 2007.\(^ {11}\) The country is one of those that are most vulnerable to climate change and is particularly susceptible to multiple climate change hazards (e.g. sea level rise, drought).\(^ {12}\) Furthermore, the Philippines reported the highest number emergencies among countries in the Western Pacific Region from 2008-2010.\(^ {13}\)

*Pollution, water supply and sanitation.* Water pollution, air pollution, poor sanitation, and unhygienic practices contribute to an estimated 22% of all reported disease cases and nearly 6% of all reported deaths.\(^ {14}\) Most regions in the Philippines identified the transport sector\(^ {15}\) as the major source of air pollution, with an increased carbon monoxide load caused by the increasing population of gasoline-fed vehicles, including cars, motorcycles and tricycles.

Achievement of total sanitation coverage is constrained by poor hygiene practices, prohibitive costs of facilities, and availability of appropriate technology. In 2008, the country had 76% coverage overall — 80% in urban areas and 69% in rural areas.\(^ {16}\) Sewerage systems are still insufficient with only 10% coverage. Open defecation is still practised by 8% of the population.

The quality of sources of drinking water (e.g. rivers, lakes, and groundwater) has deteriorated with indiscriminate disposal of solid wastes and inadequate wastewater treatment and disposal. Although there was an observed improvement in the country’s water supply coverage, from 87% in 1990 to 91% in 2008,\(^ {17}\) some populations shifted their preference to water refilling stations and bottled water despite the higher costs. This was due to the presence of sediments and the discoloration of the water supply after heavy rains. Sources of safe drinking water supply are limited. In 2005, of 525 bodies of water classified by the Department of Environment and Natural Resources (DENR), only 41% were classified as being of sufficient quality to serve as sources of drinking water.\(^ {18}\)

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\(^{13}\) Emergencies and Humanitarian Action: Disasters in the Region. Manila, World Health Organization, 2011 (http://www.wpro.who.int/sites/eha/disasters/summary.htm)


\(^{15}\) *National Air Quality Status Report.* Manila, Department of Environment and Natural Resources, Government of the Philippines.

\(^{16}\) WHO/UNICEF Joint Monitoring Programme on Water and Sanitation, 2010

\(^{17}\) WHO/UNICEF Joint Monitoring Programme on Water and Sanitation, 2010

### 2.3 HEALTH STATUS OF THE POPULATION

The projected life expectancy of Filipinos at birth in 2010 is 73.1 years for females and 67.6 years for males,

19 up from 71.6 years for females and 66.3 years for males in 2000. These gains in overall life expectancy, however, mask significant variations across regions. For instance, for the period 2005–2010, females in the Ilocos Region could expect to live 14 years longer than females in the Autonomous Region of Muslim Mindanao (ARMM) (Figure 2).

**Figure 2. Gains in overall life expectancy mask significant variations across regions (2005)**

The country faces a double burden of disease with the majority of the 10 leading causes of morbidity being communicable diseases and the leading causes of mortality in the country being mainly non-communicable diseases. Over the last five decades, non-communicable diseases steadily increased while communicable diseases diminished in scale (Figure 3).

**Figure 3. Long-term mortality trends are dominated by non-communicable disease**

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Source: Notes: S. – Southern; C. – Central; W. – Western; N. – Northern; E. - Eastern Regions are sequenced according to average annual family income as of 2003, with the National Capital Region (NCR) having the highest and Autonomous Region of Muslim Mindanao (ARMM), the lowest.

2.3.1 Burden of communicable diseases

Eight of the 10 leading causes of morbidity in 2008 were infectious in origin, namely: acute lower respiratory tract infection and pneumonia, acute watery diarrhea, bronchitis/bronchiolitis, influenza, tuberculosis, malaria, acute febrile illness, and dengue fever.

_Tuberculosis, malaria and HIV/AIDS._ In 2003, it was estimated that over 500,000 disability adjusted life years (DALYs) were lost due to illness and premature mortality from tuberculosis (TB) in the Philippines annually. This was equal to 9% of all years of life lost. Over a three-year period (2005 – 2007), the TB prevalence rate showed an exponential decline (1.8% per year). Although this annual rate of decline has decreased recently, if this trend is maintained, the Philippines will likely be able to meet the MDG and STOP TB partnership target of a 50% reduction in TB prevalence by 2015 relative to the 1990 level.20

Significant improvements have been made in malaria prevention and control. As of 2008, only five provinces out of 79 remained highly endemic while the number of provinces declared malaria-free almost doubled to 22. In terms of morbidity and mortality, the number of cases fell by more than half from 2005 to 2008 while the number of deaths decreased by more than two-thirds over the same period. Given these improvements, the Department of Health is currently repositioning its malaria programme from “control” to “pre-elimination”.

Meanwhile, the changing epidemiological profile of HIV prevalence is a concern. Based on the UNAIDS Report on the Global AIDS Epidemic 2010, the Philippines is one of the seven countries where new cases increased by more than 25% from 2001 to 2009. While sexual transmission is still the predominant mode of transmission (90%), shifting was noted in 2007 from predominantly heterosexual to bisexual and homosexual transmission. Transmission through sharing and re-using injecting drug equipment accounted for 3% of the reported cases, while mother-to-child transmission accounted for 1%. No data was available for 6% of the cases reported.21 Moreover, HIV prevalence among people who inject drugs raised an alarming concern, increasing from 0.40% in 2007 to 0.59% in 2009 then jumping to 53% in 2010.22

_Rabies._ Human rabies is still a public health threat. The country is one of the top 10 rabies-affected countries globally. Control of animal rabies, specifically canine rabies, is the major prevention approach.

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21 Philippine HIV and AIDS Registry. National Epidemiology Center, Department of Health.
22 Integrated HIV Behavioral and Serologic Surveillance system of the National Epidemiology Center, Department of Health.
Section 2: Health and Development Challenges

Infectious diseases outbreaks. The Philippines continues to witness outbreaks of emerging infectious diseases including epidemic-prone communicable diseases such as dengue, cholera, typhoid and leptospirosis. Dengue, especially, has become a serious public health problem, imposing a significant burden on hospitals and other health care services. The most common disease outbreaks are food-borne and water-borne diseases like cholera, salmonellosis and shigellosis. Meanwhile, the Philippines continues to face health security threats from newly emerging diseases.

2.3.2 Burden of chronic and noncommunicable diseases including injury

Noncommunicable diseases and risk factors. Six of the top 10 causes of mortality are due to noncommunicable diseases. Diseases of the heart and vascular system are the leading causes of mortality, comprising nearly one-third (31%) of all deaths. Other leading noncommunicable diseases include malignant neoplasms, chronic obstructive pulmonary disease (COPD), diabetes mellitus, and kidney diseases. Meanwhile, injury (mortality rate of 39.1/100,000) is the fourth leading cause of death, with road traffic accidents as the leading cause of injury deaths. Among children aged 0-17 years, drowning still tops the list of the leading cause of injury deaths, with road traffic accidents coming in second (mortality rate of 5.85/100 000).

2.3.3 Health throughout the life cycle

Pregnancy, birth (intrapartum) and postnatal (postpartum) health. With a decline of less than 2% per year, the current maternal mortality ratio seems to have leveled off at 162 maternal deaths per 100 000 live births (in 2006). This translates to more than 4000 Filipino women dying per year during or shortly after childbirth. At the current rate of decline based on the National Demographic and Health Surveys, the Philippines is highly unlikely to achieve the MDG target of 52 maternal deaths per 100 000 live births by 2015.

Official estimates reveal that the vast majority of maternal deaths can be prevented by having skilled care at birth and reducing unwanted pregnancies. In 2008, 36% of deliveries were assisted by a traditional birth attendant. The top three barriers to accessing maternal delivery services are lacking money, having to take public transport and not wanting to go alone.

Quality of care remains a problem. A nationwide observational study of obstetric practices in hospitals revealed that current practices were still not aligned with best-practice standards. A health facility drug supply assessment showed that one-third of the hospitals were lacking oxytocin, as well as other essential medicines.

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Section 2: Health and Development Challenges

**Postnatal (newborn).** While the country is presently “on track” to reach its MDG 4 target of reducing under-five mortality by two-thirds, this status is threatened because neonatal mortality has not improved in the last 15 years. Deaths in the first 28 days of life account for almost half of all under-five deaths.\(^{30}\) Almost half of the neonatal deaths occur during the first two days of life from largely preventable causes: birth asphyxia (31%), complications of prematurity (30%) and severe infections or sepsis (19%).\(^{31}\) A nationwide study involving 51 large hospitals in the country revealed that the medical care given to newborn babies in the Philippines was below WHO standards, leading to high rates of neonatal sepsis and mortality.\(^{32}\) In 2008, the rate of initiation of breastfeeding at the first hour was at 54%, while the exclusive breastfeeding rate for infants below six months was at 34%, both unchanged from 2003 rates.

**Infancy and childhood.** Under-five mortality decreased from 48 per 1000 births in 1993 to 34 in 2008.\(^{33}\) Infant mortality rate per 1000 births declined from 35 to 25. However, challenges remain even in the presence of such achievements, including persistent regional disparities and deficiencies in the vital registration system of registering and reporting of newborn deaths and stillbirths.

The percentage of fully immunized children rose from 69.8% to 79.5% between 2003 and 2008,\(^{34}\) but measles vaccination coverage is still not high enough to prevent outbreaks and meet the international target. Appropriate care-seeking for pneumonia was only 50% (2008) while antibiotic treatment for pneumonia was given to only 42% of children with suspected pneumonia. Of children under 5 years who had diarrhea, 58.6% were given oral rehydration therapy.

Undernutrition remains a major public health problem in the Philippines, linked principally to high levels of poverty. One out of every four Filipino children below 5 years old is underweight and stunted.\(^{35}\) While the prevalence of underweight children declined from 34.5% in 1990 to 24.6% in 2005, a rate that had been on track to meet the MDG target of 50% by 2015,\(^{36}\) the latest survey shows that this decline has reversed (since 2005). At the other end of the malnutrition spectrum, obesity is increasingly affecting the young. The Seventh National Nutrition Survey in 2008 indicates that 2% of children 0-5 years old and 1.6% of children 6-10 years old are overweight.

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\(^{33}\) NDHS 1998 and NDHS 2008.

\(^{34}\) NDHS 2003 and NDHS 2008.

\(^{35}\) Seventh National Nutrition Survey. Manila, Food and Nutrition Research Institute, Department of Science and Technology, 2008.

Adolescence. Road traffic accidents, pneumonia and drowning accounted for the largest percentage of deaths among 10-19 year olds in the Philippines in 2005. The percentage of underweight adolescents had hovered around 16% since 1993, while 4.8% are overweight. The Global School-based Student Health Survey in the Philippines revealed a high prevalence of risky health-related behaviours that lead to chronic medical problems in adulthood, such as lack of physical activity (29.3% or respondents), engaging in physical fight (50%), and heavy drinking of alcohol (24.3%). In the same survey, 42% of respondents reported mental health problems such as feelings of sadness or hopelessness, and 17% had seriously considered committing suicide. The percentage of students aged 13 to 15 who currently smoke cigarettes is 17.5%, while 54.5% are exposed to household second-hand smoke. Nationally representative self-reported rates of “ever experiencing adverse childhood experiences” are 90% for physical abuse, 60% for psychological abuse and 12% for sexual abuse.

According to the 2002 Young Adult Fertility and Sexuality Study (YAFS 3), among youth aged 15-24, the average age of sexual debut was 18 years old. As per 2008 NDHS, among females aged 15-19, 13.6% have ever had sexual intercourse, of which only 4.7% had used a condom at first sexual intercourse. Only 1.6% were currently using a modern method of contraception and 1.5% were currently using a traditional method, despite 96.3% having knowledge of modern method of contraception. The percentage of adolescents who have begun childbearing has risen to 10% from 8% in the 2003 NDHS.

Reproductive and pre-pregnancy health. Maternal deaths can be reduced by as much as 40% by limiting the number of pregnancies and increasing birth intervals. However, women's access to modern contraceptives is compromised by social and political factors. As such, the contraceptive prevalence rate for modern methods among currently married women is just 34%, half of the desirable level while only one out of three women of reproductive age (15-49) use modern methods of contraception. Less than half (43%) of births in the Philippines are planned while 20% are mistimed and 16% unwanted. Twenty-two percent of currently married women in the Philippines have unmet need in terms of spacing (9%) and limiting births (13%).

Abortion is illegal in all circumstances, even when a woman's life or health is in danger or when a pregnancy is the result of rape or incest. Despite this, many women in the Philippines go to great lengths to end their pregnancies. Out of 3.1 million pregnancies in 2000, more than 473,000 women unsafely terminated their pregnancy with two-thirds of them employing
methods not involving a health professional. Fifty percent of these women were young women aged 15 to 24 years. Complications from such unsafe, clandestine abortions are among the principal causes of maternal deaths. Post-abortion care is lacking and suffers serious quality issues.

2.3.4 Environmental health

Water pollution and poor sanitation conditions account for almost 17% of reported disease cases and 1.5% of the reported deaths in the Philippines, causing significant diseases such as acute diarrhea, typhoid, cholera, and intestinal parasitism. Poor air quality from outdoor air pollution in urban areas and indoor air pollution causes respiratory diseases (including acute and chronic bronchitis, pneumonia) and cardiovascular diseases (accounting for an estimated 5% of all reported disease cases and 4% of all reported deaths in the country). The Philippines is prone to climate-sensitive diseases such as dengue, malaria, diarrhea and cholera.

2.3.5 Health of specific vulnerable population groups

*Indigenous Peoples.* Within the Philippines, some of the highest maternal mortality ratios, neonatal mortality rates and unmet needs for contraception are found among the geographically isolated and disadvantaged areas of Mindanao, populated mostly by indigenous peoples. These areas suffer from a lack of access to a wide range of maternal, neonatal, child health and nutrition services. Continued civil unrest in southern Mindanao also significantly affects the vulnerable population groups in the area.

*Populations affected by natural and human-generated disasters.* Frequent typhoons and other natural emergencies affect the health of affected populations, either directly or indirectly when living conditions deteriorate or when delivery of basic social services is disrupted. The longstanding armed conflict in Mindanao has been ongoing for more than four decades with periods of relative calm alternating with intensified fighting. This has resulted in chronic displacement of people from the affected communities, with current 20,000 families currently seeking refuge in evacuation centers and host communities.

2.4 NATIONAL RESPONSES TO OVERCOME HEALTH CHALLENGES

2.4.1 Major developments in the health sector

A series of legislative and policy actions adopted over the past two decades have had defining impact on the Philippine health sector. An underlying characteristic of the change has been a shift of emphasis to systemic approaches to health sector development, with attention to sector-wide issues of equity and efficiency, including health care financing.

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48 Ibid.
Since the late 1980s, four major laws affecting the health system have been passed, namely: (1) *Generic Drugs Act of 1988*, promoting the use of generic drugs, including mandating prescription in generic form; (2) *Local Government Code of 1991*, devolving public responsibility for much of health care to local governments and transferring corresponding shares of the national health budget to LGUs; (3) *National Health Insurance Act of 1995*, introducing mandatory health insurance and universal coverage with subsidized premiums for the poor and creating the Philippine Health Insurance Corporation (PHIC), also known as PhilHealth, to manage the national health insurance programme; and (4) *Universally Accessible Cheaper and Quality Medicines Act of 2008*, allowing for parallel importation of cheaper drugs and medicines and granting the President power to impose price ceilings on various drugs based on recommendations of the Health Secretary.

Concern about the slow and unsatisfactory implementation of the three earlier legislative measures led to the adoption in 1999 by the Department of Health of the *Health Sector Reform Agenda (HSRA)*, a far-reaching plan for long-term systemic reforms country-wide. Updated in 2005 to reflect subsequent political priorities, the HSRA was renamed the *FOURmula ONE (F1)* for Health but essentially retained the four major components of the HSRA: health financing, health regulation, service delivery and good governance.

In December 2010, the Department of Health Administrative Order No. 2010-0036, entitled “The Aquino Health Agenda: Achieving Universal Health Care for All Filipinos,” was signed. The agenda is seen as the Government’s continuing effort towards reform. The overall goal of the agenda is to ensure the achievement of the health system goals of better health outcomes, sustained health financing and a responsive health system by ensuring that all Filipinos, especially the disadvantaged group in the spirit of solidarity, have equitable access to affordable health care. This shall be attained by pursuing three strategic thrusts:

1. Financial risk protection through expansion in NHIP enrolment and benefit delivery — the poor are to be protected from the financial impacts of health care use by improving the benefit delivery ratio of the NHIP;

2. Improved access to quality hospitals and health care facilities — government-owned and operated hospitals and health facilities will be upgraded to expand capacity and provide quality services to help attain MDGs, attend to traumatic injuries and other types of emergencies and manage noncommunicable diseases and their complications; and

3. Attainment of the health-related MDGs — public health programmes shall be focused on reducing maternal and child mortality, morbidity and mortality from TB and malaria, and the prevalence of HIV/AIDS in addition to being prepared for emerging disease trends and prevention and control of non-communicable diseases.

### 2.4.2 Programme-specific policy responses

In parallel with the above macro developments, a range of programme-specific policy actions is being pursued by the administration. One of the most prominent though controversial policies is the *Reproductive Health Bill*, which mandates the national Government to promote a full range of family planning methods based on the fully informed choice of the individual.
This bill has been pending in Congress since 2002, but has so far failed to pass on numerous attempts as debates among interest groups have been unrelenting.

Another important development has been the adoption by the Department of Health in 2008 of the Maternal, Neonatal and Child Health and Nutrition strategy,\(^ {49}\) which aims to rapidly reduce maternal and neonatal mortality through capacity building of LGUs to deliver Basic Emergency Obstetric and Newborn Care services.

Other programme-specific policy responses have been in the areas of (1) disease surveillance and response; (2) the Clean Water Act of 2004, accompanied by issuance of national standards for drinking water; and (3) the Climate Change Act of 2009, accompanied by a national framework of action for climate change and health.

### 2.5 HEALTH SYSTEMS AND SERVICES

#### 2.5.1 Health services delivery

The Philippine health sector is a public-private mixed system, with the private sector dominating the market. In 2005, 59% of total health financing came from private sources.\(^ {50}\) However, the public sector plays a significant role in the provision, financing, as well as regulation of health services.

Private sector services are generally perceived to be of better quality, but are also more expensive.\(^ {51}\) At the other extreme, traditional healers and traditional birth attendants continue to serve as inexpensive and easily accessible private sources of health care in both urban and rural areas, but particularly in the latter.

The public sector provides both personal care and public health services, principally (though not exclusively) to the lower income classes. The Local Government Code of 1991 split responsibility for health services among all levels of government, with national, provincial and larger city governments principally responsible for tertiary and secondary care and smaller city, municipal and barangay governments providing primary care. Responsibility for public health care services is shared between the national Government — which manages essential programmes like maternal and child health, family planning, TB, malaria, neglected tropical diseases, HIV/AIDS control, promotion of healthy lifestyles — and the municipal and barangay levels, whose staff and facilities implement these programmes with substantial operational inputs from the national government.

Utilization patterns are affected by financial barriers, negative perceptions or lack of awareness of services. Of the Filipinos who sought medical advice or treatment in 2008, 50% went to public health facilities, 42% went to private health facilities, and almost 7% sought alternative or non-medical care.\(^ {52}\) The poor tend to use primary health facilities more than

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\(^ {49}\) Department of Health Administrative Order 2008-0029 — “Implementing Health Reforms for Rapid Reduction of Maternal and Neonatal Mortality”.

\(^ {50}\) http://www.nscb.gov.ph/stats/pnha/2005/sources.asp


hospitals because services in such facilities are largely free. Further, since the majority of the population cannot afford the co-payments and balance billing (i.e. remaining payment to be shouldered by patient after PhilHealth payment has been deducted), which are demanded by both government and private hospitals, government hospitals intended to serve the poor are also being utilized by a large non-poor clientele who cannot afford private facilities. In contrast, those who can afford to pay tend to bypass government hospitals and lower-level facilities because of perceived issues of quality.

2.5.2 Health systems financing

Financing for health care comes from multiple sources (Figure 4), dominated by out-of-pocket payments (54.3% share in 2007). The national Government and LGUs had almost equal shares of 13.0% and 13.3% in 2007, respectively. Health expenditure from social insurance, meanwhile, indicated a decreased share in health spending from 9.8% in 2005 to only 8.5% in 2007.

Figure 4. Source of funds for health care, 2007

![Figure 4: Source of funds for health care, 2007](image)


Moreover, the limited scope and support levels of PHIC benefits, the difficulties in accessing such benefits, and the lack of information on how to do so all reduce levels of financial protection. These problems are particularly acute and magnified among the poor, who are frequently unable to comply with the administrative requirements and to afford the co-payments.

Resource allocation in the country is hindered by the lack of clearly defined of the package of essential health services to be provided at each level of care. This is true for government as well as private health facilities. In the absence of such a formally defined, costed, and enforced package, budget allocations tend to preserve the status quo through incremental budgeting approaches. Budget discussions can even become quite ad hoc or dependent on the most vocal proponent of particular health programs. Resource allocation difficulties also arise from patient referral bypass, which is
Section 2: Health and Development Challenges

quite common. Some patients go directly to a higher-level health facility as a point of entry because of the weak, or nonexistent, gatekeeper system. The problem is compounded by the lower-level facility (e.g. rural health unit or district hospital), which the patient should have gone to first, does not exist in the locality or lacks essential staff and material resources. Thus, regional and referral hospitals often also act as primary care providers of their catchment areas, with the consequent deleterious effects on budgeting and resource allocation.

Financial fragmentation also reduces PhilHealth's influence in shaping the types of services to be provided and in improving provider or technical efficiency since PhilHealth continues to be a minor funder of health services, accounting for only about 11% of the total health expenditure. PhilHealth's potential monopsony power as a likely single buyer of health services, and the capability of controlling costs inherent in such power, is also undermined by its low support value and its persistent preference for hospital-based coverage over out-patient care.

Because of these problems — financing fragmentation, supply-side lack of an essential health service package norm and enforcement, and demand-side patient referral bypass — appropriate resource allocation embodying economic principles of both efficiency and equity is difficult to achieve. Thus, to make economic resource allocation work, one must first address the key problems of fragmentation, PhilHealth's limited scope and support level and other shortcomings, lack of a service package norm, and patient bypass.

2.5.3 Health workforce

While the overall supply of doctors and nurses is not a problem in the Philippines, there is large scale out-migration, the country being one of the largest suppliers of trained nurses in the world. Among the consequences of these external job opportunities are the mushrooming of nursing schools in the country, many of which are not at par with the standards required for nursing education. Meanwhile, doctors who are practicing in the country are largely concentrated in urban/peri-urban areas. Furthermore, the public sector experiences a shortage of skilled health workers, particularly in remote, unattractive locations. Achieving and maintaining a competent and effective health workforce, particularly in far-flung areas, remains an ongoing struggle.

2.5.4 Health Information System

The national health information system is essentially a complex one and the quality of the national data is affected by the fragmented local health system. Devolution of health services and budgets to LGUs has made it difficult to enforce regular and quality submission of data from the field. Irregularities in data submission from the local level limit the ability of the health information system to adequately monitor and evaluate performance with respect to both efficiency and equity. Data from the private sector are limited, depending on the capacity of the local health information system. Meanwhile, within the Department of Health, there are other stand-alone data sources at the programme level.

The Department of Health through its National Epidemiology Center is attempting to improve health data collection, monitoring and evaluation by creating the Philippine Integrated Disease Surveillance and Response (PIDSR) system. PIDSR aims to get electronic-based reports for outbreak detection and disease monitoring that will inform timely response within a few days/weeks rather than months/years. Later, a web-based information system providing access to timely and improved quality data will be established. The Field Health Services
Information System (FHSIS) and all other disease-specific surveillance data will be made available and linked for a better holistic data base and improved analysis.

Based on a recent health information assessment, the Philippine Health Information Network developed a strategic plan to improve the country’s health information system. However, implementation of this plan has yet to be initiated.

2.5.5 Medical products

The cost of medicines in the Philippines continues to be among the highest in the region\textsuperscript{54,55,56} although competition in the pharmaceutical industry has intensified in some segments of the market with locally manufactured generics now accounting for nearly half of all the medicines sold. The Universally Accessible Cheaper and Quality Medicines Act of 2008 aims to improve access by promoting the use of quality and affordable generic medicines, and by improving competition. However, with no insurance package for out-patient medicines (which account for 89% of the market) out-of-pocket payments are very high. As such, generic medicine prices, as well as branded medicines under the Department of Health price control, are still beyond the means of the poorest.

Availability of essential medicines is poor in the public system and is one of the reasons why patients (even poor members of the PHIC Sponsored programme) resort to higher-priced private hospitals and self-medication. The Department of Health’s “P100” initiative, as well as the Botika ng Barangay (BnBs) program, aims to provide a limited list of low-cost medicines in facilities and remote areas. The sustainability of both programmes, however, is challenged by stocks replenishment and supervision issues. Their actual impact in terms of access has not been assessed. Issues on quality assurance and rational drug use are also limiting the efficiency of the system.

2.5.6 Leadership and governance

Passage of the Local Government Code in 1991 resulted in the fragmentation and diminished coherence of the public health care system, with governance responsibility devolved to multiple levels of local government (currently 79 provinces, 122 cities, 1512 municipalities and more than 40 000 barangays), each with a separate budget for health and with independently operated local health facilities. Though initially slow to respond to changes that affected its own role (and budget) to an unprecedented degree, the Department of Health gradually faced up to the challenge of leadership in the sector, mainly through implementation of its “convergence strategy” under the HSRA. Under this strategy, it offers financing and technical assistance to LGUs, particularly in the preparation and implementation of Province-wide Investment Plans for Health (PIPHs). The establishment of Inter-Local Health Zones (ILHZs) in 89% of the

\textsuperscript{54} Batangan DB et al. The Prices People Have to Pay for Medicines in the Philippines. Quezon City, Institute of Philippine Culture, Ateneo de Manila University, 2005.
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provinces serves to address the fragmentation of the health care system by enhancing inter-
government cooperation. An evaluation of the PIPH and ILHZ approaches with respect to
their impact on health outcomes has yet to be undertaken.

Other challenges engaging the health sector include the full implementation of the electronic
new government accounting system (e-NGAS) and government-wide electronic procurement
system and delays in procurement that hamper timely and effective health service delivery.

2.5.7 Response of other sectors

Financial access through conditional cash transfers (CCT). Access to health care for the
poorest families is expected to improve substantially with the introduction of the Pantawid
Pamilyang Pilipino Programme (4Ps) in 2008. This national programme, managed by the
Department of Social Welfare and Development, provides regular cash transfers to the poorest
families on condition that children attend school regularly and that pregnant women and
young children comply with Department of Health protocols for prenatal and early childhood
care (e.g. vaccination and nutrition programmes for children aged 0-3 years). Similar CCT
programmes have proven effective in improving access to health care in a number of other
countries worldwide.57

The health delivery system plays a key role in ensuring the success of 4Ps. First, health
care workers are responsible for monitoring compliance by beneficiary families to the health
conditionalities of the programme. Without the health worker’s signed verification, cash benefits
are withheld. Second, and more critically, the health sector must ensure that the health services
required for compliance are available to 4Ps beneficiaries. Supply-side shortcomings are often cited
as a reason for failure of similar CCT programmes in other countries.

One further link between the health sector and 4Ps lies in the use of the National Household
Targeting System (NHTS) developed under 4Ps to identify and prioritize the poorest families
as potential beneficiaries for the PhilHealth-sponsored programme. Transitioning to the use
of the NHTS — in lieu of the highly politicized selection process currently in use — would
significantly improve targeting efficiency of the sponsored programme.

2.6 CONTRIBUTION OF THE COUNTRY TO THE GLOBAL HEALTH
AGENDA

Breastfeeding. The Philippines has fervently advocated for the implementation of the
International Code of Marketing of Breast milk Substitutes (and related national law) which
has become an example internationally. Other actions have been taken by the Philippine
Government to increase breastfeeding rates (with the support of World Health Organization,
United Nations Children’s Fund [UNICEF] and nongovernmental organizations) including
development and implementation of a national policy and plan of action on Infant and Young
Child Feeding and work to promote breastfeeding counselling in communities.

57 Sobel HL, Oliveros YE, Nyunt-U S. Secondary analysis of a national health survey on factors influencing women in the Philippines to
Section 2: Health and Development Challenges

Emergency humanitarian action. Despite the need for response to domestic emergencies, the Department of Health has deployed health teams to acute emergencies around the world. Given its expansive experience with disasters, the country has developed the knowledge base for contributing to the global expertise on emergency humanitarian action, including participating in regional training activities and providing technical experts to regional emergency preparedness activities. It has also spearheaded regional efforts to support the United Nations global campaign on safer hospitals/health facilities in emergencies and disasters.

Urban health interventions. Developed by WHO Centre for Health Development (WHO Kobe Centre) in 2008, the Urban Health Equity Assessment and Response Tool (Urban HEART) was piloted for feasibility and enhancement in seven cities in the Philippines. In relation to the Urban HEART, the Short Course on Urban Health Equity was piloted in the Philippines in partnership with the Department of Health and the Development Academy of the Philippines. It has since been mainstreamed as an intervention for strengthening the urban health system.

As interventions are made at the LGU level with regard to assessment and planning, WHO has piloted the Reaching the Urban Poor (RUP) strategy to ensure coverage and access of health services by the poor. An adaptation of the Reaching Every District Strategy, RUP was introduced in December 2004 as a strategy to improve maternal and child health indicators. Since then, RUP has been introduced in 35 selected barangays located in four highly urbanized cities. Indicative of the programme’s success, measles vaccination coverage has increased 32% across all sites. The Programme was recently presented at the Global Immunization Meeting in Geneva and is documented in the WHO publication “Reaching the Urban Poor: The Philippines Experience.” Efforts are now aimed towards scaling up RUP as part of the overall citywide health systems strengthening for the urban poor.

Tobacco free initiatives. The Philippines has a strong tobacco surveillance system that started with the implementation of the Global Youth Tobacco Survey in 1999. It is one of a handful of countries in the Western Pacific Region that has been able to produce trend data on smoking among the youth. The country has also recently completed the Global Adult Tobacco Survey, which serves as a baseline for adult prevalence, exposure to second-hand smoke and the status of enforcement of tobacco control policies and programmes. The Philippines has also pioneered the development of a subnational approach to tobacco control called “Tobacco-Free Plan-It” (based on the US CDC’s “Healthy Plan-It”) and has aggressively adopted the MPOWER training package as a strategy to mobilize local government support to curb the tobacco epidemic in support of the WHO Framework Convention on Tobacco Control.
Section 2: Health and Development Challenges

*Human rabies programme.* The Philippines is one of three countries implementing a WHO-coordinated rabies projects that aims to prevent human rabies through the control and eventual elimination of canine rabies, creating a paradigm shift for human rabies prevention in Asia. Because the National Rabies Prevention and Control Programme is being piloted in island provinces providing a geographic containment of the problem, the expansion of the programme across the country would face additional challenges not seen in the current pilot sites.

*Global and regional health security.* The Philippines has its national surveillance and response systems that contribute to detecting, assessing and responding to disease outbreaks and public health emergencies of international concern. The country also participates in the regional system for preparedness, alert and response.
### Key Health Achievements, Opportunities and Challenges

<table>
<thead>
<tr>
<th>Achievements/opportunities</th>
<th>Challenges</th>
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<tbody>
<tr>
<td><strong>On health outcomes:</strong></td>
<td>1. Dual burden of communicable diseases and noncommunicable diseases.</td>
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<tr>
<td>1. Decreased infant mortality.</td>
<td>2. Growing international concerns not only on emerging and re-emerging diseases but also on health security in general.</td>
</tr>
<tr>
<td>2. Progress in malaria control.</td>
<td>3. Slow progress in maternal health and nutrition.</td>
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<tr>
<td><strong>On health sector development:</strong></td>
<td>4. High population growth.</td>
</tr>
<tr>
<td>1. Adoption of Universal Health Care agenda as the government’s continuing commitment to implementing the health sector reform agenda.</td>
<td>5. Food security including food availability, accessibility, and food quality and safety, require coordination from farm to table and from national to local levels.</td>
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<tr>
<td>2. Adoption of Sector Development Approach for Health as a government initiative to ensure alignment of development partner’s financial and/or technical contribution to that of the national health priorities.</td>
<td>6. Vulnerability to disasters and chronic emergency in Mindanao.</td>
</tr>
<tr>
<td>3. Enactment of the Cheaper Medicine Act of 2008 as the legal mandate for Department of Health to use TRIPS flexibilities and control prices and to make generic prescription compulsory.</td>
<td>7. Widening health inequity; disparity in health service delivery and utilization.</td>
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<tr>
<td>4. Establishment of the Medicine Transparency Alliance to enable different key stakeholders of the sector to be engaged through a formal council.</td>
<td>8. High out-of-pocket payment and low health expenditure.</td>
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<tr>
<td>5. Establishment of the Philippine Infectious Disease Surveillance and Response to develop local health systems for surveillance and response.</td>
<td>9. Fragmentation in health financing and service delivery.</td>
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<tr>
<td>6. Development and implementation of national plan for emerging diseases (APSED, National Pandemic Preparedness and Response Plan) and guidance for other public health events of national and international concern.</td>
<td>10. Inefficiencies due to the current payment mechanisms of PhilHealth.</td>
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<tr>
<td>7. Department of Health as a recognized leader and resource institution in health emergencies at the national and regional (i.e. Asia-Pacific) level.</td>
<td>11. Maldistribution of skilled health workers.</td>
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<tr>
<td>8. Urban Health Equity Assessment and Response Tool (Urban HEART) as a planning and response tool for local government units to invest in urban health issues.</td>
<td>12. Poor quality of data and information.</td>
</tr>
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SECTION 3: DEVELOPMENT COOPERATION AND PARTNERSHIPS

3.1 AID ENVIRONMENT IN THE COUNTRY

The Philippines is classified as a lower Middle Income Country (MIC), implying less reliance on aid and a better capacity to shape its own development. The blueprint for the Government’s economic and social development policy is set by the Medium-term Philippine Development Plan (MTPDP), now known as the Philippine Development Plan (PDP), which is the main tool for government expenditure planning. For this CCS, WHO will refer and contribute to the achievement of goals and targets of the Philippine Development Plan 2011-2016.

In 2006, total net official development assistance (ODA) for the Philippines was USD 562 million, accounting for 0.4% of gross national income (GNI). However, this figure does not capture China’s relatively significant contribution.58

The results of the 2008 Survey on Monitoring the Paris Declaration for the Philippines, as summarized in Table 1, reflect the responses of 17 out of 28 donors, representing approximately 95% of total ODA disbursed. Japan, the Asian Development Bank and the World Bank were the top three donors.

Table 1. 2008 Survey on monitoring the Paris Declaration: challenges and priority actions in the Philippines

<table>
<thead>
<tr>
<th>Dimensions</th>
<th>2007</th>
<th>Challenges</th>
<th>Priority</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ownership</td>
<td>High</td>
<td>Fiscal limitations to implement development plan; reforms not evenly adopted across government.</td>
<td>Government to prioritise and continue mainstreaming reforms.</td>
</tr>
<tr>
<td>Alignment</td>
<td>Moderate</td>
<td>Large portion of aid not recorded on the budget as some aid flows do not require appropriations; progress needed on predictability, untying and reducing parallel project implementation units.</td>
<td>Improve information sharing and capture on aid; continue reforms to improve public financial management (PFM) and procurement systems.</td>
</tr>
<tr>
<td>Harmonization</td>
<td>Low</td>
<td>Variable commitment to programme-based approaches (PBAs); slow progress toward joint evaluations.</td>
<td>Bi-lateral donors to increase aid through PBAs; major donors to increase joint missions.</td>
</tr>
<tr>
<td>Managing for results</td>
<td>Moderate</td>
<td>Lack of clarity of management of new systems; monitoring and evaluation processes not fully developed.</td>
<td>Complete roll-out of new systems; develop further monitoring and evaluation processes where necessary.</td>
</tr>
<tr>
<td>Mutual accountability</td>
<td>Moderate</td>
<td>Development partner support variable</td>
<td>Establish a system of mutual assessment.</td>
</tr>
</tbody>
</table>


3.2 STAKEHOLDER ANALYSIS

From 2005, ODA for health from more than 10 development partners, consisting of multilateral banks, bilateral agencies and the United Nations system reached US$ 747.8 million. ODA was used for the following: projects in support of MTPDP 2005-2010 and the national objectives for health such as the Health Sector Development Project (ADB-supported); national sector support for Health Reform Project and the Second Women’s Health and Safe Motherhood Project (WB-supported); and the health sector policy support (European Union-supported). Further support on health sector reform initiatives are given by KFW through its Health Sector Reform Project in selected sites, as well as those from the United States Agency for International Development (USAID), the Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) Japan International Cooperation Agency (JICA), Agencia Española de Cooperación Internacional para el Desarrollo (AECID) and Korea International Cooperation Agency (KOICA).

Ongoing support for achieving the MDGs is provided by all development partners including the Global Fund to Fight AIDS, Tuberculosis and Malaria and several United Nations organizations working on joint programmes, such as the MDG-F 2030: Ensuring Food Security and Nutrition for Children 0-24 months in the Philippines and the United Nations Joint Programme on Reducing Maternal and Neonatal Mortality (supported by the Australian Agency for International Development, AusAID). Other initiatives supporting the health sector are the tobacco free initiatives (Bloomberg), health care waste management (United Nations Development Programme [UNDP]), and Mindanao Health and Population Sector Programme (European Union).

3.3 COORDINATION AND AID EFFECTIVENESS IN THE COUNTRY

The Philippine Development Forum serves as the Government’s primary mechanism for facilitating substantive policy dialogue with development partners on the country’s development agenda, which is espoused in MTPDP, now known as the Philippine Development Plan. The forum also serves as a process for developing consensus and generating commitments toward critical actionable items of the Government’s reform agenda.

For the health sector, the Department of Health’s Sector Development Approach for Health (SDAH) is a system for harmonizing and improving implementation of development assistance by strengthening donor coordination. It has enabled the sector to consolidate resources from various sources to facilitate effective resource management at the provincial level. The SDAH principles have been applied to (1) the Joint Assessment and Planning Initiative (JAPI), which assesses F1 implementation in convergences sites and identifies issues

60 Bureau of International Health Cooperation, Department of Health Database as of September 2010.
and remaining gaps; (2) the creation of the Joint Appraisal Committee (JAC) to review and appraise the Provincial Investment Plans for Health and Annual Operational Plans for all F1 convergence sites; and (3) the Health Partners’ Meeting, which appraises donors of the SDAH and F1 implementation. Furthermore, a Technical Assistance Coordination Team was created to harmonize technical assistance among various partners and to reduce duplication. Overall, coordination between the Department of Health and development partners is handled through the Bureau of International Health Cooperation.

In a decentralized health care system, the Department of Health and development partners have made efforts to ensure alignment and harmonization at the LGUs by providing technical support in the development of Provincial and Citywide Investment Plans for Health that identify the various sources of funding support. However, coordination mechanisms have yet to take place at the local level to ensure full complementation of support during implementation.

3.4 UNITED NATIONS REFORM STATUS AND THE CCA/UNDAF PROCESS

Primarily a development partner, the contribution of the United Nations system to the overall ODA in the Philippines is minimal; however, the Government still acknowledges the importance of the United Nations in the country.

In 2007, the National Economic Development Authority (NEDA) affirmed its commitment for a One United Nations System in the Philippines by 2010. To date, ‘Delivering as One’ has yet to be fully implemented in the Philippines. The system has succeeded in setting up common operational services, but little progress has been made in relation to the development of a common strategic focus, programme coherence and alignment to national priorities.

As a way to move forward, the development of UNDAF 2012-2018 is being closely coordinated with that of the Philippine Development Plan 2011-2016 to ensure alignment of the United Nations’ work to the country’s development priorities.

These initial efforts at United Nations collaboration reveal the need for results-based joint programming to ensure optimal use of resources and capacities, a clear division of labour between United Nation agencies according to their comparative advantages, and the establishment of an appropriate management and coordination mechanism to facilitate inclusion and accountability of all agencies.

“We would like to recommend the development of the UNDAF Action Plan (UNDAP) to replace the Country Programme Action Plans (CPAPs) or agency equivalent documents. We are aware of the benefits of having a single plan for UN assistance in the country with UN agencies coordinating and working together as one as this will significantly reduce transaction costs for the Government in dealing with the UN.”

(From 18 Nov 2010 letter signed by NEDA Secretary)

61 Ibid.
In the context of “Delivering-as-one”, programme coherence, maximum effectiveness and minimum transaction costs will be established, including the articulation of a common UNDAF Action Plan (UNDAP), the joint determination of geographical areas of convergence and coordination, and the use of UNDAF Results Matrices to monitor accountabilities among United Nations agencies. Furthermore, UNDAF 2012-2018 will serve as a ‘living’ document which will help ensure the ongoing alignment of United Nations support with national priorities and programmes, the coordination and management of individual and collective United Nations agency support in each area of interest, and the monitoring and evaluation of results through regular reviews.62

3.5 KEY ISSUES AND CHALLENGES IN DEVELOPMENT COOPERATION

- Improving aid effectiveness in the country through optimum alignment of development partners’ work with national partners’ thrust.

- Focusing on “Delivering as One” at the technical programming level among the different United Nations agencies (including WHO), through results-based programming, ensuring optimal use of resources and capacities.

- Ensuring a clear division of labour and complementation between United Nations agencies according to their comparative advantages, and establishing an appropriate management and coordination mechanism to facilitate inclusion and accountability of all agencies.

- Coordinating donor support at the LGU level for the health sector to ensure complementation and prevent duplication of support.

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SECTION 4: REVIEW OF WHO COOPERATION OVER THE PAST CCS CYCLE

The Philippines joined WHO as a Member State on July 9, 1948. On June 1, 1951, the Philippine Government and WHO signed a Host Agreement for the establishment of the Regional Office in Manila. The WHO Representative Office was established in January 1973 but the WHO Representative post was vacant until 1981.

The WHO CCS for the Philippines (2005-2010) identified four strategic areas of support: (1) advocacy and partnership on the health of families; (2) health sector development, (3) health for unreached populations; and (4) control of disease risk. As the CCS was launched, the WHO Representative was supported by international professional staff from the WHO Expanded Programme for Immunization (EPI), as well as Tuberculosis and Malaria programmes, four general service staff and four staff under Special Service Agreement (SSA) contracts to assist in other technical programmes.

4.1 EXTERNAL REVIEW OF WHO’S COOPERATION

4.1.1 WHO contribution

Stakeholders have acknowledged WHO support to the development, implementation, monitoring and assessment of the national health plan. The key contributions of WHO in the health sector have been providing technical support and capacity-building for Department of Health staff and LGUs; building partnerships and undertaking joint programmes with other United Nations agencies; providing leadership support during emergencies; and providing norms and standards and monitoring their implementation.

4.1.2 WHO alignment to national health priorities and contributions to the achievement of the MDGs

During the second phase of the CCS 2005-2010 period, the Department of Health adopted the Health Sector Reform Agenda (HSRA), known as Formula One (F1) for Health. As part of WHO’s commitment to aligning country-level support to national health plans, an internal review was carried out to affirm that the CCS was still relevant in the context of the HSRA.

4.1.3 Areas where WHO contribution was required, but insufficient

The Department of Health has raised a few issues with regard to unmet expectations in the area of management, training, specific services and provision of technical assistance. These are:

- absence of the appropriate WHO focal person during key meetings to adequately address the concern of the programme;

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The external review was conducted through (1) key informant interviews, using open-ended interview guides from the Department of Health and its attached agencies that have collaborated with WHO across programmes; (2) self-administered questionnaires by other stakeholders including United Nations partners, LGUs, and local nongovernmental organizations; (3) review of the midterm assessment for the MTSP as answered by senior management of the Department of Health.
Section 4: Review of WHO Cooperation over the past CCS Cycle

- insufficient monitoring of the implementation of various surveillance systems that were introduced by WHO;
- need for regular updates on new resources mobilized to ensure alignment and avoid delays in implementation; and
- system flaws during the 2008 region-wide roll-out of the Global Management System that led to delays in budget release, procurement processing and programme implementation.

4.1.4 WHO as a member of the United Nations Country Team

The WHO Representative is an active member of the United Nations Country Team and has been seen to be effective when serving as a United Nations Resident Coordinator. WHO serves as the co-convenor for the Outcome on Basic Social Services for UNDAF 2005-2009 and will continue this role for Outcome 1 (Basic Social Services for the MDGs) in UNDAF 2012-2018.

4.1.5 WHO as a broker for health among partners and across sectors

WHO, together with the Department of Health, serves as co-lead of the Health Cluster for the coordination of emergency and humanitarian actions in times of crises. WHO is also the lead for the United Nations Pandemic Influenza Task Force.

The Task Force, originally intended as assistance to United Nations staff and their families during the pandemic, has subsequently served as a collaboration platform for United Nations agencies assisting the Government with preparedness activities.

Beyond the health sector, WHO has also brought together non-health stakeholders on issues such as the prevention of drowning, road traffic injuries and tobacco control.

4.1.6 Areas in which WHO has a comparative advantage

Among different stakeholders, WHO is seen to have contributed most to providing technical support, catalysing change and building sustainable institutional capacity; and to setting norms and standards and promoting and monitoring their implementation. Meanwhile, in the key informant interviews and multi-stakeholder self-administered questionnaires, WHO’s role in providing leadership on matters critical to health and engaging in partnerships where joint action is needed was also acknowledged.

For the next six years, it was recommended that WHO’s focus should be on (1) providing technical support, catalysing change and building sustainable institutional capacity; (2) shaping the research agenda and stimulating the generation, dissemination of valuable knowledge; and (3) articulating ethical and evidence-based policy options.
4.2 INTERNAL REVIEW

4.2.1 Consistency between CCS priorities and the National Health Plan

WHO’s support to the country in responding to the MDG challenges and achieving the national objectives for health were noted in the Performance Assessment Report 2008–2009. Control of disease risks supported the country’s successful efforts in tuberculosis, malaria and other neglected tropical diseases. As the country faced global health security threats, WHO supported the country’s APSED workplan implementation to improve capacity for IHR 2005 requirements. Organization of technical missions particularly on zoonotic emerging diseases along with resource mobilization to implement priority areas with identified gaps and critical needs was appreciated.

The strategic priorities on health sector development have led to support for the pursuit of the legislative agenda on medicines as well as the development of the Health Care Financing Strategy. In the face of natural disasters, the Department of Health has turned to the WHO to provide technical expertise and financial support. During disasters, WHO provided technical support in coordinating humanitarian response among development partners and improvement in the emergency information system.

The CCS priorities on “advocacy and partnership for health of families” and “health for the unreached population” have enabled WHO to provide approaches on reaching the urban poor as well as health systems strengthening in the urban setting. The Maternal, Newborn and Child Health and Nutrition strategy of the Department of Health was enhanced further through a series of hospital studies that led to the development of the Essential Newborn Care Protocol.

4.2.2 Health-related outcomes of the UNDAF

WHO served as co-lead for the UNDAF outcome on basic social services, which is defined as “By 2009, increased and more equitable access to and utilisation of quality, integrated and sustainable basic social services by the poor and vulnerable”. Among its achievements were:

- providing guidance to the HIV/AIDS Theme Group in providing technical assistance to the Government and other development partners in preparing the Round 5 Country Proposal to the Global Fund to Fight AIDS, Tuberculosis and Malaria that was eventually approved;
- partnering with the business sector to formulate workplace policies on HIV/AIDS;
- supporting the Philippines to reach the global TB epidemiological targets of 70% case detection and 85% treatment success rate since 2004, while the 2007 Third National TB Prevalence Survey showed a 38% reduction in the TB cases; and
- approval of the three-year programme on the MDG-F thematic window on Children, Food Security and Nutrition amounting to a US$3.5 million.65

The following are the documents and source of data were reviewed: Performance Assessment Report 2008-2009, Midterm Review Report 2010-2011 and analysis of financial data in the Global Management System.

4.2.3 Country Office structure and workplan

The country office has a flat structure with the different programme officers independently working in their respective programmes and reporting directly to the WHO Representative while being supported by a Programme Management Officer and an administrative staff led by the Administrative Assistant.

4.2.4 Allocation of Resources

As seen in Figure 5, more than half of the resources supported the control of diseases risks, particularly HIV/AIDS, TB and malaria, and the outbreak response during the pandemic influenza A(H1N1) 2009 outbreak. The second largest supported CCS priority was health sector development, in the areas of essential medicines and technologies, health systems strengthening and emergency humanitarian action.

![Figure 5. 2010–2011 award budget per CCS priority (in US$)](image)

Source: Data Extracted from the WHO Global Management System (GSM), October 2010.

In the last three years of the CCS period, voluntary contributions steadily increased, reaching US$ 12 million by 2010, with a significant portion mobilized by the Country Office. To ensure timely implementation, the Country Office increased its human capacity by hiring seven national professional officers and an additional five general support service staff. Staffing complement was also enhanced with the entry of project-related SSAs and a United Nations Volunteer.

4.2.5 Support from other levels of the Organization

Support provided by the different levels of the Organization was mainly in the area of health security issues, particularly in managing threats to international health security and emergency humanitarian actions during natural disasters.

The Organization supported in-country training on public health emergency management to help build capacity in the Country Office and its government counterparts. In more
recent years, the Organization sent Regional Office and Headquarters staff or global experts in fields such as risk communication, logistics, resource mobilization, environmental health in support of responses to local emergencies. Visits from the Regional Director and Director-General after typhoon Ketsana (2009) sent a strong message to the country regarding WHO’s ready support for disaster response.

In the face of emerging and re-emerging disease outbreaks, the Organization has sent technical mission teams composed of staff from Headquarters, the Regional Office and the Country Office to investigate various outbreaks — of meningococcemia (2005), Ebola reston in pigs (2009), leptospirosis, post-typhoon flooding (2009), food safety crisis, and dengue (2010). Regular support is also provided through reviews by the Regional Office and Country Office of the implementation of the Philippine Integrated Disease Surveillance and Review.

The whole Organization has supported the country’s efforts in implementing the agreements of the Framework Convention on Tobacco Control. Headquarters provided the MPOWER, a package of six proven policies that will curb tobacco use based on the Framework Convention on Tobacco Control that was subsequently adopted for policy-makers and implementers at the sub-national levels.

4.2.6 Resource mobilization efforts

In the last half of the CCS cycle, resource mobilization initiatives of the Organization were generated across all levels, though a large portion came from the Country Office. Funds were generated for MDG-related programmes (TB, malaria, nutrition, maternal and neonatal health), that were through stand-alone WHO initiatives and that of the United Nations Joint Programmes. Health systems strengthening was supported through resources funding initiative on essential drugs management, preparedness and response during disasters and emerging disease outbreaks. Since 2005, voluntary contributions have increased, contributing to an estimated US$ 10 million out of the US$ 12 million of the Country Office resource by the end of 2010.
SECTION 5: THE STRATEGIC AGENDA FOR WHO COOPERATION

The Strategic Agenda leverages the strength and resources of the whole WHO Secretariat and optimizes opportunities to contribute to improving the health sector’s performance resulting in improvement in the health of Filipinos.

Cutting across concerns of the different stakeholders, challenges facing the health sector in the next six years can be consolidated into four common priority themes. In formulating the strategic agenda, careful consideration was given to how WHO can contribute to:

(a) supporting the Universal Health Care agenda of the Department of Health;  
(b) achieving the MDGs by 2015, with special focus on MDGs 4, 5 and 6;  
(c) addressing the social and environmental determinants of health; and  
(d) managing health security risks and health in emergencies.

Acknowledging growing concerns about delays in achieving the MDGs and the need to fast track progress within the CCS period, WHO technical cooperation supports the Department of Health’s Universal Health Care agenda across all levels of the health care system, including DOH-retained hospitals, DOH Center for Health Development and local government units. WHO also brokers joint partnerships in areas where critical actions are required, capitalizing on the strong (though untapped) presence of the private sector, civil society and academe.

As part of the United Nations efforts towards “Delivering as One” the CCS 2011-2016 harmonizes with and contributes to UNDAF 2012-2018. As health and development are closely related, the health-related dimension of development will be seen in areas of interest that support the four UNDAF outcomes.

5.1 THE STRATEGIC AGENDA

The Strategic Agenda focuses on the following Strategic Priorities:

- strengthening the health care system to provide equitable access to quality health care with special focus on health-related MDGs and priority noncommunicable diseases;
- enabling individuals, families and communities to better manage their health and its determinants; and
- improving the resiliency of national and local institutions against health security risks and threats.

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66 Department of Health Administrative Order No.2010-0036 – The Aquino Health Agenda: Achieving Universal Health Care for All Filipinos.
67 The four common themes were emerge from a reiterative consultative process amongst the Department of Health partners, United Nations Country Team Members, international and national development partners, academe, professional societies and the private sector.
STRATEGIC PRIORITY 1: Strengthening the health care system to provide equitable access to quality health care with a special focus on health related MDGs and priority noncommunicable diseases.

**Main Focus Area 1.1** Enabling national government agencies to deliver universal health care, focusing on health-related MDGs and priority noncommunicable diseases.

- **Strategic Approach 1.1.1** Facilitate the development of clearly defined package/s of essential health services/interventions with standards and health systems support requirements.

- **Strategic Approach 1.1.2** Work with public and private providers in establishing an enabling environment for the adoption and delivery of a package of essential health services.

- **Strategic Approach 1.1.3** Strengthen institutional capacities to ensure quality services, products and technology.

**Main Focus Area 1.2** Supporting national and local government agencies to implement and monitor the health financing strategic interventions in support of achievement of Universal Health Care.

- **Strategic Approach 1.2.1** Provide technical support to increase and improve the efficiency of use of resources for health.

- **Strategic Approach 1.2.2** Provide technical support to scale up risk pooling, prepayment and safety net schemes for health.

- **Strategic Approach 1.2.3** Provide technical support to monitor and track health expenditures at national and local levels, estimating economic consequence of illness, cost and effects of interventions.

**Main Focus Area 1.3** Supporting the generation of accurate and timely information as a basis for legal and policy frameworks for Universal Health Care.

- **Strategic Approach 1.3.1** Provide technical support to a more integrated health information management system. This includes harnessing information and communication technologies and mobile communications technologies for efficient interoperability, data generation, monitoring and evaluation.

- **Strategic Approach 1.3.2** Contribute to the building national capacity in health policy, information analysis and research generation, as well as dissemination of key research studies and best practices as basis for sound policies and decisions.
STRATEGIC PRIORITY 2: Enabling individuals, families and communities to manage better their health and its determinants.

**Main Focus Area 2.1** Improving health-seeking behavior of individuals, families and communities to manage communicable and non-communicable disease and their risk factors.

- **Strategic Approach 2.1.1** Provide technical support to develop evidence-based health promotion strategies and to establish an enabling environment (policy and legal) for health promotion.

- **Strategic Approach 2.1.2** Engage with different stakeholders to advocate for the development and implementation of integrated health promotion packages across different settings (e.g., workplace, schools, and shopping malls).

**Main Focus Area 2.2** Engaging national and local stakeholders, including LGUs, to address the social and environmental determinants of health.

- **Strategic Approach 2.2.1** Broker partnerships with government and non-governmental agencies and institutions to address social and environmental determinants of health.

- **Strategic Approach 2.2.2** Partner with government agencies to complement demand-side interventions (such as on the health component of the national CCT program and promoting use of PhilHealth benefits).

STRATEGIC PRIORITY 3: Improving the resiliency of national and local institutions against health security risks and threats.

**Main Focus Area 3.1** Increasing capacity of key government agencies and LGUs to manage health security risks following natural and human-induced disasters.

- **Strategic Approach 3.1.1** Together with the Department of Health, provide leadership in the health cluster and foster partnerships with other stakeholders in managing public health concerns during emergencies and disasters.

- **Strategic Approach 3.1.2** Provide technical support to develop system tools, policies and guidelines for risk reduction and emergency management, including human resources for health.

**Main Focus Area 3.2** Increasing capacity of key government agencies and LGUs to manage health security risks due to emerging and re-emerging diseases, food safety-related events and disease outbreaks.

- **Strategic Approach 3.2.1** Provide technical support for disease and public health event surveillance and response in line with the Asia Pacific Strategy for Emerging Diseases (APSED) and in compliance with IHR (2005). This includes reviewing and updating the national workplan for emerging diseases using the APSED framework and as required by IHR (2005).
Section 5: The Strategic Agenda for WHO Cooperation

- **Strategic Approach 3.2.2** Provide leadership and partnership on advocacy and information sharing, including development of evidence-based policy options for managing emerging and re-emerging diseases-related health security risks.

- **Strategic Approach 3.2.3** Provide leadership and technical assistance to strengthen the national food safety programme from farm to table both nationally and at the local government level.

**Main Focus Area 3.3** Increasing capacity of key national and local government agencies to manage the health impact of climate change.

- **Strategic Approach 3.3.1** Strengthen advocacy, policy and health systems support through partnership with other sectors and stakeholders.

- **Strategic Approach 3.3.2** Develop and test new technologies, tools and guidelines, including a monitoring and evaluation system for climate change interventions.

- **Strategic Approach 3.3.3.** Support epidemiological research to determine the nature and measure the impact of different aspects of climate change on health outcomes (to help in future priority-setting).

5.2 **CORRESPONDENCE BETWEEN WHO STRATEGIC AGENDA, NATIONAL HEALTH PRIORITIES AND UNITED NATIONS DEVELOPMENT ASSISTANCE FRAMEWORK (UNDAF)**

Table 2 shows the correspondence between each of the strategic priority areas of WHO Strategic Agenda 2011-2016, related UNDAF priorities and specific national health priorities as articulated in key reference documents of the Department of Health.68

### Table 2. Correspondence between WHO Strategic Agenda, national health sector priorities and UNDAF outcomes and areas of interest

<table>
<thead>
<tr>
<th>Strategic Priorities</th>
<th>Related National Health Sector Priorities&lt;sup&gt;69&lt;/sup&gt;</th>
<th>Related 2012-2018 (Draft) UNDAF Outcomes&lt;sup&gt;70&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategic Priority 1:</strong> Strengthening the health care system to provide equitable access to quality health care with a special focus on health related MDGs and priority noncommunicable diseases.</td>
<td>UHC Strategic Thrust no.1: Financial Risk protection — the poor are to be protected from the financial impacts of health care use by improving the benefit delivery ratio of the National Health Insurance Program (NHIP). UHC Strategic Thrust no.2: Improved access to quality hospitals and health care facilities — Government-owned and operated hospitals and health facilities will be upgraded to expand capacity and provide quality services to help attain MDGs. UHC Strategic Thrust No. 3: Attainment of the health related MDGs — public health programmes will be focused on reducing maternal and child mortality, morbidity and mortality from TB and malaria, and the prevalence of HIV/AIDS in addition to being prepared for emerging disease trends and prevention and control of noncommunicable diseases.</td>
<td>Outcome 1: Universal access to quality social services with focus on the MDGs.</td>
</tr>
<tr>
<td><strong>Strategic Priority 2:</strong> Enabling individuals, families and communities to better manage their health and its determinants.</td>
<td>UHC Strategic Thrust no.3: Attainment of the health related MDGs — public health programmes will be focused on reducing maternal and child mortality, morbidity and mortality from TB and malaria, and the prevalence of HIV/AIDS in addition to being prepared for emerging disease trends, and prevention and control of noncommunicable diseases.</td>
<td>Outcome 1: Universal access to quality social services with focus on the MDGs. Outcome 2: Decent and productive employment for sustained, greener growth Outcome 3: Democratic governance.</td>
</tr>
</tbody>
</table>

<sup>69</sup> DOH References:
- Administrative Order No. 2010-036 “The Aquino Health Agenda: Achieving Universal Health Care for All Filipinos.”
- Department Order No. 2010-0251 “Functional Clustering of DOH Units and Attached Agencies for Implementation of the Aquino Health Agenda to Achieve Universal Health Care.”

<table>
<thead>
<tr>
<th>Strategic Priorities</th>
<th>Related National Health Sector Priorities</th>
<th>Related 2012-2018 (Draft) UNDAF Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategic Priority 3: Improving the resiliency of national and local institutions against health security risks and threats.</td>
<td>UHC Strategic Thrust no.3: in addition to being prepared for emerging disease trends, and prevention and control of noncommunicable diseases. Republic Act No. 9711, 18 August 2009 to strengthen and rationalize the regulatory control of food and drugs to improve and maintain structures, processes, mechanisms and initiatives that are aimed at protect and promote the right to health and safe food and drugs for the Filipino people.</td>
<td>UNDAF Outcome 4: Resilience to disasters and climate change.</td>
</tr>
</tbody>
</table>
SECTION 6: IMPLEMENTING THE STRATEGIC AGENDA

6.1 CORE CAPACITY REQUIREMENT FOR THE NEXT SIX YEARS

In implementing the CCS the Organization considers the strong commitment of Government to achieving Universal Health Care and the need to fast-track progress in achieving the country’s MDG targets. This sense of urgency needs to be translated to work that is not “business as usual” but rather building capacities towards achieving Universal Health Care within a time frame of six years if not less. For WHO, as well as other development partners, there exists a collective commitment to harmonizing efforts towards contributing to the achievement of the health sector’s goals.

WHO has taken on the challenge of moving the health sector beyond “business as usual.” To maintain its relevance for its Member State, the Organization undertook an internal review to determine where each of the different CCS priorities lies within the policy/programme cycle and which core function(s) could best contribute towards achieving the country’s health goals. Table 3 shows results of this review, assigning relative “weights” to the different core functions on the basis of their relevance to the Main Focus Areas of the Strategic Agenda and where they could best reflect the comparative advantage of the Organization.

Table 3. Main Focus Areas of the Strategic Agenda and WHO Core Functions

<table>
<thead>
<tr>
<th>MFA 1.1: Delivery of UHC entitlements</th>
<th>Research Agenda</th>
<th>Ethical/Evidence Policy</th>
<th>Norms/standards</th>
<th>Leadership and joint action</th>
<th>Technical support</th>
<th>Monitor and assess health situation</th>
</tr>
</thead>
<tbody>
<tr>
<td>++</td>
<td>++</td>
<td>+++</td>
<td>+++</td>
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<td>+++</td>
<td>++</td>
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<tr>
<td>MFA 1.2: Health Care Financing</td>
<td>+++</td>
<td>+++</td>
<td>++</td>
<td>+</td>
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<td>+</td>
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<tr>
<td>MFA 1.3: Legal and policy framework</td>
<td>+</td>
<td>++</td>
<td>+++</td>
<td>+++</td>
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<td>+++</td>
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<tr>
<td>MFA 2.1 Health Seeking</td>
<td>+++</td>
<td>+++</td>
<td>+</td>
<td>++</td>
<td>++</td>
<td>++</td>
</tr>
<tr>
<td>MFA 2.2 Social and environmental determinants</td>
<td>+++</td>
<td>+++</td>
<td>+</td>
<td>+++</td>
<td>++</td>
<td>+</td>
</tr>
<tr>
<td>MFA 3.1 Disasters</td>
<td>+++</td>
<td>+++</td>
<td>++</td>
<td>+++</td>
<td>+</td>
<td>++</td>
</tr>
<tr>
<td>MFA 3.2 Health Security Risk</td>
<td>++</td>
<td>+++</td>
<td>++</td>
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<td>+++</td>
<td>+++</td>
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<tr>
<td>MFA 3.3 Climate Change</td>
<td>+++</td>
<td>+++</td>
<td>+</td>
<td>+</td>
<td>++</td>
<td>+</td>
</tr>
</tbody>
</table>

Rating: “+” Low; ++ - Moderate; +++ - High; based on relative importance
From the table, the top three core functions are:

- articulating the research agenda, generating, managing and disseminating knowledge;
- providing ethical and evidence-based policy options; and
- providing technical support towards delivering results, with focus on catalyzing change and assisting in institutional development.

The Department of Health also recommended WHO to focus on these three core functions.

6.2 WHO COUNTRY OFFICE

6.2.1 Staffing requirements

In the WHO Representative Office in the Philippines, staff size more than doubled during the CCS 2005-2010 period. In 2005, the WHO Representative was supported by three professional staff and four administrative support staff. By the end of 2010, the office was being staffed by ten professional staff (P-staff), consisting of three International P-staff, seven national professional officers and twelve general service staff (G-staff). Additional capacity requirements to support growing concerns in emerging disease outbreaks, disasters and MDG concerns were responded to through the hiring of supplementary staff, mostly technical coordinators and officers, under Special Service Agreement (SSA) contracts. However, it was assessed that at least four of the SSA staff were doing technical advisory and management work beyond projects while an international United Nations Volunteer took on a similar task of an international P-staff.

The upcoming CCS requires that the WHO Country Office provide timely and adequate technical support to the health sector as it moves to fast-track Universal Health Care, the MDG targets, and improve the resiliency of institutions against health security risks and threats. To support these endeavours, the WHO Country Office will further strengthen its technical capacity in the fields of health care financing, essential medicines and technologies, maternal and child health, malaria and integrated vector management (including dengue), TB, emergency humanitarian action and environmental health and/or climate change adaptation. To date, majority of these initiatives are being managed by supplementary staff, mostly SSA staff with one international United Nations Volunteer. Given the need for continuous technical and management support to the country in these fields and based on available resources, the Country Office will need to rectify contracts given to SSA staff or volunteers for WHO technical staff work by creating temporary or fixed positions.
Table 4. Project staffing complement for 2011-2016, Philippines

<table>
<thead>
<tr>
<th>Strategic Priorities</th>
<th>Current Level</th>
<th>Future Level</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>P</td>
<td>G</td>
</tr>
<tr>
<td>Strategic Priority 1: Health systems strengthening with focus on the MDGs and NCDs.</td>
<td>4.75</td>
<td>4.5</td>
</tr>
<tr>
<td>Strategic Priority 2: Managing one’s health and its determinants</td>
<td>2.75</td>
<td>0.5</td>
</tr>
<tr>
<td>Strategic Priority 3: Improving institutions’ resiliency against health security risks and threats</td>
<td>2.5</td>
<td>1</td>
</tr>
<tr>
<td>Management Support</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>TOTAL</td>
<td>12</td>
<td>12</td>
</tr>
</tbody>
</table>

* Note: Additional professional staff seen in 2011-2016 will be a conversion of WHO technical work currently being handled by supplementary staff (e.g. SSA staff and United Nations Volunteer).

6.2.2 Working collaboratively towards a “systems approach” and within the United Nations’ “Delivering as One” agenda

The current CCS requires a paradigm shift in how WHO works at the country level — from working independently in one’s field of expertise/responsibility to a more collaborative approach, working with fellow WHO colleagues, United Nations counterparts and other key stakeholders as it supports the Department of Health leadership and the health sector as a whole. A paradigm shift is required as the CCS takes on a systems approach that leads to each strategic priority being linked to programme-related and systems-related WHO Organization-wide strategic objectives. These linkages can further be seen in the identified cross-cutting themes; and as mentioned in the earlier section, in the harmonization of the strategic priorities with those of the UNDAF.

Table 5. Strategic priorities, related UNDAF outcomes, relevant MTSP strategic objectives and cross-cutting themes

<table>
<thead>
<tr>
<th>Strategic Priorities</th>
<th>Related UNDAF 2012-2018 Outcome</th>
<th>Relevant MTSP Strategic Objectives</th>
<th>Cross-cutting themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategic Priority 1: Strengthening health systems to provide equitable access to quality health care with a special focus on health-related MDGs and priority noncommunicable diseases.</td>
<td>Outcome 1: Universal access to quality social services with focus on the MDGs.</td>
<td>Strategic Objectives 1, 2, 3, 4, 10 and 11</td>
<td>Information System, Laboratory, Infection Control, Hospital, Health Promotion, Reaching the Urban Poor, Trade and Health</td>
</tr>
</tbody>
</table>
## Section 6: Implementing the Strategic Agenda

### Strategic Priorities

<table>
<thead>
<tr>
<th>Strategic Priorities</th>
<th>Related UNDAR 2012-2018 Outcome</th>
<th>Relevant MTSP Strategic Objectives</th>
<th>Cross-cutting themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategic Priority 2: Enabling individuals, families and communities to better manage their health and its determinants.</td>
<td>Outcome 1: Universal access to quality social services with focus on the MDGs. &lt;br&gt; Outcome 2: Decent and productive employment for sustained, greener growth &lt;br&gt; Outcome 3: Democratic Governance</td>
<td>Strategic Objectives 1, 2, 3, 4, 6, 7, 8, 9, 10, and 11</td>
<td>Health Promotion, Food Safety, Reaching the Urban Poor, Trade and Health, Health Information System</td>
</tr>
<tr>
<td>Strategic Priority 3: Improving the resiliency of national and local institutions to health security risks and threats.</td>
<td>Outcome 4: Resilience to disasters and climate change</td>
<td>Strategic Objectives 1, 5, 8 and 9</td>
<td>Risk communication, Food Safety, Trade and Health, Health Information System</td>
</tr>
</tbody>
</table>

Taking into account these realities, the following mechanisms need to be strengthened or established:

- Institutionalize the management team meeting and planning workshops to serve as a venue for discussing programme management concerns and identify areas of collaboration.

- Continue the country team’s brokering role, facilitating interactions between the Department of Health as sector leader and other key stakeholders within and beyond the health sector.

- Continue the regular WHO – Department of Health meeting at which prevailing issues and concerns can be discussed.

- Provide a communication focal person who will ensure regular communication within the Country Office and disseminate relevant information to the public.

- Include as a staff performance measure the level of collaboration with other team members and United Nations Country Team colleagues whenever relevant.
6.3 COLLABORATION ACROSS LEVELS OF THE ORGANIZATION

The WHO Representative Office in the Philippines has the advantage of having the Western Pacific Regional Office located in Manila. As such, it will take full advantage of the technical support that is readily available within the Regional Office to complement the capacity of the Country Office. Should the country require additional technical expertise, the Country Office will also explore secondment of Regional and Headquarters staff on a short term basis. At the same time, the Country Office will promote existing expertise within the country that can be mobilized at the regional or global level.

6.4 MONITORING PROGRESS OF THE CCS

The Country Cooperation Strategy straddles across the current Medium-Term Strategic Plan 2008-2013 and the next MTSP. By the end of the current MTSP, the CCS will have reached midway through its implementation period and will be assessed concurrently with that MTSP. In addition, WHO will be part of the annual review and updating of the UNDAF Action Plan.
ANNEXES
## ANNEX A

### Table A.1 Main causes of morbidity, 2005

<table>
<thead>
<tr>
<th>Rank</th>
<th>Cause of illness</th>
<th>Rate (*)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Acute lower respiratory tract infection &amp; pneumonia</td>
<td>809.9</td>
</tr>
<tr>
<td>2</td>
<td>Bronchitis/bronchiolitis</td>
<td>722.5</td>
</tr>
<tr>
<td>3</td>
<td>Acute watery diarrhea</td>
<td>707.6</td>
</tr>
<tr>
<td>4</td>
<td>Influenza</td>
<td>476.5</td>
</tr>
<tr>
<td>5</td>
<td>Hypertension</td>
<td>448.8</td>
</tr>
<tr>
<td>6</td>
<td>TB respiratory</td>
<td>134.1</td>
</tr>
<tr>
<td>7</td>
<td>Diseases of the heart</td>
<td>51.5</td>
</tr>
<tr>
<td>8</td>
<td>Malaria</td>
<td>42.3</td>
</tr>
<tr>
<td>9</td>
<td>Chickenpox</td>
<td>35.3</td>
</tr>
<tr>
<td>10</td>
<td>Dengue fever</td>
<td>23.6</td>
</tr>
</tbody>
</table>

(*) Deaths per 100 000 population  

### Table A.2 Main causes of death, 2005

<table>
<thead>
<tr>
<th>Rank</th>
<th>Cause of death</th>
<th>Rate (*)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Diseases of the heart</td>
<td>90.4</td>
</tr>
<tr>
<td>2</td>
<td>Diseases of the vascular system</td>
<td>63.8</td>
</tr>
<tr>
<td>3</td>
<td>Malignant neoplasms</td>
<td>48.9</td>
</tr>
<tr>
<td>4</td>
<td>Pneumonia</td>
<td>42.8</td>
</tr>
<tr>
<td>5</td>
<td>Transport accidents</td>
<td>39.1</td>
</tr>
<tr>
<td>6</td>
<td>Tuberculosis, all forms</td>
<td>31.2</td>
</tr>
<tr>
<td>7</td>
<td>Chronic lower respiratory diseases</td>
<td>24.6</td>
</tr>
<tr>
<td>8</td>
<td>Diabetes mellitus</td>
<td>21.6</td>
</tr>
<tr>
<td>9</td>
<td>Conditions originating in the perinatal period</td>
<td>14.5</td>
</tr>
<tr>
<td>10</td>
<td>Nephritis, nephritic syndrome &amp; nephrosis</td>
<td>13.0</td>
</tr>
</tbody>
</table>

(*) Deaths per 100 000 population  
### ANNEX B

Table B. Indicators of Health Expenditures of Selected Southeast Asian Countries and that of the Western Pacific Region, 2007

<table>
<thead>
<tr>
<th>Country</th>
<th>Total Expenditure on Health as % of Gross Domestic Product</th>
<th>General Government Expenditure on health as % of total expenditure on health</th>
<th>Private expenditure on health as % of total expenditure on health</th>
<th>General Government Expenditure on health as % of total government expenditure</th>
<th>External resources for health as % of total expenditure on health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Western Pacific Region</td>
<td>6.5</td>
<td>67.8</td>
<td>32.2</td>
<td>15.1</td>
<td>0.1</td>
</tr>
<tr>
<td>Indonesia</td>
<td>2.2</td>
<td>54.5</td>
<td>45.5.0</td>
<td>6.2</td>
<td>1.7</td>
</tr>
<tr>
<td>Malaysia</td>
<td>4.4</td>
<td>44.4</td>
<td>55.6</td>
<td>6.9</td>
<td>0</td>
</tr>
<tr>
<td>Philippines</td>
<td>3.9</td>
<td>34.7</td>
<td>65.3</td>
<td>6.7</td>
<td>1.2</td>
</tr>
<tr>
<td>Thailand</td>
<td>3.7</td>
<td>73.2</td>
<td>26.8</td>
<td>13.1</td>
<td>0.3</td>
</tr>
<tr>
<td>Vietnam</td>
<td>7.1</td>
<td>39.3</td>
<td>60.7</td>
<td>8.7</td>
<td>1.6</td>
</tr>
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</table>

Source: http://www.who.int/whosis/whostat/EN_WHS10_Part2.pdf
### ANNEX C: STATUS OF MDGS

#### Table C. MDG Progress at the National Level

<table>
<thead>
<tr>
<th>MDG goals, targets and indicators</th>
<th>Baseline data</th>
<th>Latest/ current data</th>
<th>Target by 2015</th>
<th>Official, UNSIAP method</th>
<th>adjusted, UNSIAP method</th>
<th>adjusted, ESCAP/ADB/UNDP method</th>
<th>probability</th>
<th>pace</th>
<th>probability</th>
<th>estimated year</th>
<th>on/off-track</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal 1: Eradicate extreme poverty and hunger</td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Prevalence of underweight children under-five years of age</td>
<td>34.5 (1990)</td>
<td>26.2 (2008)</td>
<td>17.3</td>
<td>MEDIUM</td>
<td>0.670</td>
<td>MEDIUM</td>
<td>2035</td>
<td>■</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proportion of households with per capita intake below 100% dietary energy requirement</td>
<td>69.4 (1993)</td>
<td>56.9 (2003)</td>
<td>34.7</td>
<td>MEDIUM</td>
<td>0.793</td>
<td>MEDIUM</td>
<td>2028</td>
<td>■</td>
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<tr>
<td>Elementary education net enrolment rate</td>
<td>85.1</td>
<td>85.1</td>
<td>100</td>
<td>LOW</td>
<td>0.000</td>
<td>LOW</td>
<td>—</td>
<td>▼</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Elementary education cohort survival rate</td>
<td>68.7</td>
<td>75.4</td>
<td>100</td>
<td>MEDIUM</td>
<td>0.663</td>
<td>MEDIUM</td>
<td>2070</td>
<td>■</td>
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<tr>
<td>Elementary education completion rate</td>
<td>66.5</td>
<td>73.3</td>
<td>100</td>
<td>MEDIUM</td>
<td>0.569</td>
<td>MEDIUM</td>
<td>2075</td>
<td>■</td>
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<tr>
<td>Goal 3: Promote gender equality</td>
<td></td>
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<tr>
<td>Ratio of girls to boys in secondary education participation rate</td>
<td>116 (1996)</td>
<td>116 (2006)</td>
<td>100</td>
<td>HIGH</td>
<td>0.000</td>
<td>LOW</td>
<td>▼</td>
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<tr>
<td>Ratio of girls to boys in elementary education cohort survival rate</td>
<td>115 (1996)</td>
<td>111 (2008-09)</td>
<td>100</td>
<td>HIGH</td>
<td>0.422</td>
<td>LOW</td>
<td>2041</td>
<td>■</td>
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<tr>
<td>Ratio of girls to boys in secondary education cohort survival rate</td>
<td>113 (1996)</td>
<td>111 (2008-09)</td>
<td>100</td>
<td>HIGH</td>
<td>0.244</td>
<td>LOW</td>
<td>2076</td>
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<tr>
<td>Ratio of girls to boys in elementary education completion rate</td>
<td>116 (1996)</td>
<td>113 (2008-09)</td>
<td>100</td>
<td>HIGH</td>
<td>0.297</td>
<td>LOW</td>
<td>2062</td>
<td>■</td>
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<tr>
<td>Ratio of girls to boys in secondary education completion rate</td>
<td>115 (1996)</td>
<td>113 (2008-09)</td>
<td>100</td>
<td>HIGH</td>
<td>0.211</td>
<td>LOW</td>
<td>2090</td>
<td>■</td>
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<tr>
<td>Goal 4: Reduce child mortality</td>
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<tr>
<td>Note: Neonatal mortality rate</td>
<td>17.7 (1993)</td>
<td>16 (2008)</td>
<td>5.81</td>
<td>0.210</td>
<td>LOW</td>
<td>2158</td>
<td>■</td>
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<tr>
<td>MDG goals, targets and indicators</td>
<td>Baseline data</td>
<td>Latest/current data</td>
<td>Target by 2015</td>
<td>Official, UNSIAP method</td>
<td>adjusted, UNSIAP method</td>
<td>adjusted, ESCAP/ADB/UNDP method</td>
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<td>estimated year</td>
<td>on/off-track</td>
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<tr>
<td></td>
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<td>probability</td>
<td>year</td>
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<tr>
<td><strong>Goal 5: Improve maternal health</strong></td>
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<tr>
<td>Maternal mortality ratio</td>
<td>209 (1990)</td>
<td>162 (2006)</td>
<td>52.3</td>
<td>LOW 0.469</td>
<td>LOW</td>
<td>2064</td>
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<tr>
<td>Contraceptive prevalence rate</td>
<td>40 (1993)</td>
<td>51 (2008)</td>
<td>80</td>
<td>LOW 0.269</td>
<td>LOW</td>
<td>2048</td>
<td></td>
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<tr>
<td><strong>Goal 6: Combat HIV/AIDS, malaria and other diseases</strong></td>
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<tr>
<td>Number of new HIV/AIDS reported cases</td>
<td>66 (1990)</td>
<td>835 (2009)</td>
<td>0</td>
<td>LOW</td>
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<tr>
<td>Number of population aged 15-24 with HIV</td>
<td>311 (~1995)</td>
<td>218 (2009)</td>
<td>0</td>
<td>MEDIUM 0.427</td>
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<td>2221</td>
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<tr>
<td>Malaria morbidity rate</td>
<td>123 (1990)</td>
<td>20 (2009)</td>
<td>0</td>
<td>HIGH 1.102</td>
<td>HIGH</td>
<td>2040</td>
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<tr>
<td>Malaria mortality rate</td>
<td>1.5 (1990)</td>
<td>0 (2009)</td>
<td>0</td>
<td>HIGH 1.316</td>
<td>HIGH</td>
<td>2009</td>
<td></td>
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<tr>
<td><strong>Goal 7: Ensure environmental sustainability</strong></td>
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<td></td>
</tr>
<tr>
<td>Proportion of population with access to safe water</td>
<td>73.8 (1991)</td>
<td>84.1 (2008)</td>
<td>85.9/96</td>
<td>HIGH 3.385</td>
<td>HIGH</td>
<td>2011/2028</td>
<td></td>
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<td></td>
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<td></td>
</tr>
</tbody>
</table>


**MDG Progress Classification:**
- ● early achiever: already achieved 2015 target
- ■ off track-slow: expected to meet target but after 2015
- ▲ on track: expected to meet 2015 target
- ▼ Off track- No progress/regressing: stagnating or slipping backwards
- — Cannot be determined because of insufficient information
ANNEX D: WHO MEDIUM-TERM STRATEGIC PLAN (MTSP) 2008–2013

Strategic Objectives

1. To reduce the health, social and economic burden of communicable diseases.
2. To combat HIV/AIDS, tuberculosis and malaria.
3. To prevent and reduce disease, disability and premature death from chronic noncommunicable diseases, mental disorders, violence and injuries and visual impairment.
4. To reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, and improve sexual and reproductive health and promote active and healthy ageing for all individuals.
5. To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact.
6. To promote health and development, and prevent or reduce risk factors for health conditions associated with use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex.
7. To address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches.
8. To promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health.
9. To improve nutrition, food safety and food security, throughout the life-course, and in support of public health and sustainable development.
10. To improve health services through better governance, financing, staffing and management, informed by reliable and accessible evidence and research.
11. To ensure improved access, quality and use of medical products and technologies.
12. To provide leadership, strengthen governance and foster partnership and collaboration with countries, the United Nations system, and other stakeholders in order to fulfil the mandate of WHO in advancing the global health agenda as set out in the Eleventh General Programme of Work.
13. To develop and sustain WHO as a flexible, learning organization, enabling it to carry out its mandate more efficiently and effectively.