Action Fiche N°1– Philippines

1. Identification

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<th>Title/Number</th>
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2. Rationale and country context

2.1. Country context and rationale for SPSP

2.1.1. Economic and social situation and poverty analysis

Over the past 20 years, the Philippines has made progress in the fight against poverty and in improving human development outcomes. Poverty incidence declined from nearly half of the population (45 percent) in 1991 to one-third (33 percent) in 2006 (National Statistics Office, 2006), while average real GDP per capita growth rate was 2.7% (2001-2006), the lowest in the region. In recent years however, the economic expansion does not seem to have translated into lower levels of poverty. Between 2003 and 2006 poverty incidence increased from 30 percent to 33 percent, back to its level in 2000. The Philippines also lost its position in the 2006 HDI, from its rank of 90 (out of 177 countries) in 2005 to a rank of 102nd (out of 179 countries).

The disconnection between growth and poverty reduction can be partly explained by high rates of inequality. Socioeconomic development in the Philippines is uneven and poverty is characterized by wide disparities across regions and population groups. The country’s Gini coefficient at 0.45 is higher than it was 20 years ago and is also the highest in Southeast Asia. The income of the richest decile of the population is about 19 times that of the poorest decile (2006). The poorest regions in 2006 were the Autonomous Region in Muslim Mindanao (ARMM), Caraga, and Region IV-B (MIMAROPA) while Regions VI (Western Visayas) and V (Bicol region) continue to have the biggest share in the total number poor families.

Meanwhile, the 2007 Mid-term Progress Report on the MDGs showed mixed results. Gains have been made with regard to certain goals and the targets to eradicate extreme poverty and hunger, increase enrolment rate for girls, reduction of infant mortality, and less than a 1% HIV prevalence are likely to be met. On the other hand, the Philippines could miss two MDG targets if it does not step up its efforts to tackle MDG 2 on achieving universal primary education and MDG 5 on improving maternal health and access to reproductive health services.

At the same time the intensity of adverse effects of climate change is increasing in the Philippines and could if unaddressed in the context of development co-operation compromise
progress. Increasing risk of flash flooding and extreme weather events, and subsequent spread of disease as well as higher prevalence of certain vector borne diseases pose a new challenge to the health profession and the sector that needs to be addressed carefully in the planning, training and budgeting for the sector.

In addition, the current economic crisis and lack of progressive policy on reproductive health has seen Philippines population grow (>2%) at a rate significantly higher than its most comparable neighbours, undermining poverty reduction efforts and access to quality social services, and has the potential to worsen already pressing issues like poverty, malnutrition and maternal and child death.

2.1.2. National development policy

The overall national development policy of the Philippines is articulated in the Medium-Term Philippine Development Plan (MTPDP) 2004-2010. Its main objective is to reduce poverty and to ensure a better quality of life for all citizens.

Responding to basic needs of the poor is one of the priorities of the MTPDP and includes intensified efforts to achieve the MDGs, particularly in the area of poverty reduction and human development, through improved accessibility and affordability of essential services and reducing by half the cost of medicines through measures to facilitate the supply of lower cost medicines. The MTPDP recognises that despite a general improvement of the health status of the population major challenges remain, characterised by an inefficient delivery of basic services, and outlines major strategies to address these issues further detailed in sectoral plans (see also section 2.2).

The 2005-2010 Medium-Term Public Investment Program (MTPIP) translates the goals and policy thrusts drawn up in the MTPDP into a set of priority programs and projects (PAPs) linked to annual measurable output targets, and investment requirements/cost estimates over the MTPIP period. The MTPIP is regularly updated per annual budgetary process and agency/corporation performance, reflecting changes in the economic and financial macro parameters and attainment of targets, as well as to incorporate changes in status of project preparedness of those proposed or in the pipeline and in the performance of continuing or ongoing programs and projects.

Each government agency is responsible for the monitoring and performance measurement of their respective sector plans. The achievements towards meeting the goals of MTPDP of each sector are summarised in the yearly socio-economic reports published by the National Economic and Development Authority (NEDA).

2.2. Sector context: policies and challenges

2.2.1. Sector context and policy

The health situation in the Philippines has been characterised by a slowing of progress against key indicators, leaving the country behind its neighbours. Main contributing factors are high income inequality, high population growth and overall inequity and inefficiency of the Philippines health system in terms of both, financing, health management and service delivery arrangements, partly resulting from the devolution of responsibilities for health care provision to local governments brought about by the Local Government Code in 1991. Since then, health services provided by the public sector are shared between the Department of Health (DoH) and the local government units (LGUs). The DoH, as the lead agency and steward for health, is responsible for the development of health policies, regulations and standards and the
management of priority public health programmes. The DoH is exercising its functions through the central and regional offices. However, so far the role of the Centres for Health Development (CHDs) as regional offices has been limited and not well defined. In future, the CHDs will be strengthened and play a key role in Health Sector Reforms. Local Government Units (LGUs) are responsible for the direct provision of health services to the population. Local hospitals, except for the regional medical and speciality hospitals, which are retained by DoH are the responsibility of provincial and city governments while Rural Health Units (RHUs), municipal health offices (MHOs), city health offices (CHOs) and Barangay Health Stations (BHS) are under the municipal governments.

Under devolution, health systems performance is generally considered to have deteriorated due to the fragmentation of service delivery, driven by local politics, to become mainly curative and hospital oriented with some protection for public health from national government. Inadequate resource allocation and inefficient and inequitable expenditure at national and local level, resulting in chronic under funding with high out of pocket expenditures for health care (approx. 57%¹), continue to threaten the achievement of the MDGs in health, nutrition and water and sanitation. The challenge is to improve access to quality health care services in a fully decentralised environment through structural change and health sector reform and will only be achieved within a longer term perspective.

In 1999, the DoH launched the Health Sector Reform Agenda (HSRA) as a comprehensive response to health sector challenges to improve the way health care is delivered, regulated and financed. To operationalise the reform agenda, the present administration adopted an implementation framework called “FOURmula ONE for Health” (F1) to implement critical health interventions as a single package in 16 convergence provinces. F1 focuses on tangible results as captured in the National Objectives for Health (NOH) 2005-2010 and in consonance with the Millennium Development Goals (MDGs) and the Medium Term Philippine Development Plan (MTPDP) 2004-2010. Its major goals are: better health outcomes, more responsive health systems and equitable health care financing, especially for the poor through interventions in four areas:

- Financing: increased, better and sustained investments in health.
- Regulation: assure access to quality and affordable health products, devices, facilities and services.
- Service delivery: improve accessibility and availability of health care.
- Governance: enhanced health system’s performance at national and local level, in particular through improved PFM and sector-wide management.

Each of these reform components has been operationalised into flagship programs, projects and activities (PPAs) for implementation at the national as well as at the local levels and costed in the National Health Development Plan 2006-2010.

While there have been some notable accomplishments in the public health system, major geographic inequities in access to health facilities and services still exist or continue to worsen as the share of total health expenditure paid out of pocket¹. Some major challenges remain especially in the implementation of reforms at local level, service delivery in particular.

¹ Unofficial figure from 2006 is 57% OOP, latest official statistics from 2005 rate the OOP expenditures at 49%
The main achievements can be observed at central level rather than at LGU level in paving the way for access to affordable medicines, better health insurance coverage and enhanced service delivery especially in the area of maternal and child health through the development policy and strategy papers.

One of the major development challenges in the Philippines is poor access to Reproductive Health (RH) services especially for the poorest, resulting in high Maternal Mortality and high population growth of more than 2%, putting at risk health improvements achieved in the Philippines during the last few decades. The reduction of Maternal Mortality has been very slow and it is still among the highest in South East Asia at 162/100,000 live births in 2006, a long way of the MDG target of 52/100,000 by 2015. This means that an average of eight women die every day of pregnancy- and childbirth- related causes. Associated with this, another 'disturbing' fact is the increasing occurrence of illegal abortions. In 2008 54% out of 3.4 Mio pregnancies where unwanted with around 1/3 ending in abortion\(^2\). The inequity in the access to RH services becomes apparent in the statistics showing that women in the richest quintile have on average 2 children, while women in the lowest quintile have an average of 6 children.

One reason for this is the difficult political situation and the strong influence of the Catholic Church in the country. The President has adopted a political stance in support of the position of conservative Catholic bishops that the only form of family planning that should be supported is the ‘natural’ method. At the same time, somewhat anomalously, Local Government Units are permitted to implement their own contraceptive self-reliance strategies and are now beginning to access a DoH performance based grant scheme, but the effort is by no means yet commensurate with the urgency of the problem.

On the other hand, infant mortality declined more markedly by nearly half from 46/1000 life birth (1988) to 24/1000 life birth (2006). However, neonatal mortality represents more than 50% of infant mortality and remains unchanged for the last decade, slowing down progress noticeably. Malnutrition of children under 5 years old also remains a major concern with 28% being underweight\(^3\).

Other important challenges are (i) the continued burden of communicable diseases like tuberculosis, respiratory tract infections, malaria etc. (ii) the increasing importance of non-communicable and life-style diseases (cancer, cardio-vascular, diabetes etc.), already ranking among the 10 major causes of morbidity and especially mortality, (iii) increasing HIV prevalence within what remains a low level, (iv) poor and inadequate sanitation facilities, (v) limited health insurance coverage of the poor resulting in high financial burden, (vi) limited access to essential medicines for the poor despite declining prices over the past years and expansion of Botika ng Barangays (BnBs) due to inefficient supply chain management, and (vii) slow progress in the establishment of functional Inter-Local Health Zones (ILHZ) resulting in inefficiency of local health systems.

The DoH initiated the roll out of F1-for-Health to 21 additional provinces in 2008 and since January 2009 the national roll out to include the remaining 44 provinces is underway. An update of the National Objectives for Health (NOH) for the next medium-term (2011-2015) is currently also in process and will lead to the formulation of a bridging plan for health to carry on Health Sector Reforms before a final update through the new administration in 2010 will come into effect.

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\(^{2}\) Meeting Women's Contraceptive Needs in the Philippines, Guttmacher Institute, 2009

\(^{3}\) A Country Specific Strategic Analysis for Reaching the Health Related MDGs in the Philippines, UNICEF, 2008
2.2.2. Sector Budget and Medium Term Financial Perspective

The Government budget allocation for health has increased continuously over the last 3 years from PHP 16.074 billion in 2006 to PHP 18.356 billion in 2007 and to PHP 22.896 billion in 2008. These translate to a 14.2% and 24.7% increases, from 2006 to 2007 and 2007 to 2008, respectively.

In 2006 the DoH prepared a Health Sector Expenditure Framework (HSEF) which was designed to improve its budgetary planning. This framework provides medium-term estimates for the health sector and compares financial requirements with the amount of funds projected to be needed for the implementation of critical programmes and projects. The DoH is currently in coordination with the DBM, and consistent with the DBM ongoing budgetary reforms preparing its MTEF (2010-2012).

2.2.3. Sector and donor coordination

Within the framework of F1-for-Health, the DoH with support from the European Commission (EC) adopted the Sector Development Approach for Health (SDAH) to organise the planning and management of international and national support for the implementation of the sector strategy. Under the SDAH, the DoH is requesting its donor partners to align their support with the reform objectives and to coordinate reform activities in the health sector under a single national implementation plan and through single province-wide investment plans for health (PIPH).

The EC and the World Bank are formally working together in support of the F1 approach and other donors are supporting or developing assistance packages that support areas of F-1 implementation or provide technical assistance for reform. However, most partners still operate in project mode and do not fully implement SDAH.

Several mechanisms are in place to ensure proper coordination within the SDAH, among others the Health Partners Forum, providing a venue for monthly dialogue with government and development partners, the Joint Assessment and Planning Initiative (JAPI), a forum of partners in health, meeting twice a year to assess the implementation of F1-for-Health and to draw attention to specific issues, and the Joint Appraisal Committee (JAC), which serves as an advisory body to DoH and the F1 provinces with regard to PIPH implementation. The Technical Assistance Coordination Team (TACT) under the DoH has the responsibility to coordinate different TA programmes in the sector and to ensure alignment to F1.

Recently, the DoH initiated the transfer of responsibilities for the coordination of sector wide reform implementation to its regional offices, the Centres for Health Development (CHDs), particularly for the development of the Province-wide Investment Plans for Health (PIPHs) and for monitoring and supervising implementation of the PIPHs. The CHDs will therefore in future play a pivotal role for provincial initiatives in terms of technical and financial support as well as stewards of Health Sector Reforms.

Despite strong ownership and willingness to lead the SDAH by DoH, these structures and mechanisms need further strengthening to ensure a more strategic approach and appropriate follow-up and to enable DoH to use their resources efficiently. The EC Delegation will remain a major partner in this endeavour and engage in intensified policy dialogue in order to assist DoH in strategising efforts for improved sector coordination and leadership in SDAH.
2.2.4. **Institutional assessment and capacity development**

The HSPSP II seeks to address the weaknesses of the current system and to build on existing strengths and opportunities. Management is the major factor impeding delivery of services especially for the poor who rely on public facilities for both curative and preventive services. Health services for the poor (Government facilities) are understaffed\(^4\) and under-funded\(^5\); lack drugs, medical equipment and supplies; and provide poor quality care. Patients are bypassing rural primary care facilities and using the outpatient facilities at provincial and teaching hospitals for minor ailments. This leads to both operational and allocative inefficiency in the use of health care resources with excessive resources allocated to secondary and tertiary level facilities and inadequate resources allocated to primary level facilities and preventive health. Improved management, reorganization and additional financial resources are needed to improve quality of care at the primary health care level and to improve access to quality health services by the poor.

The decentralization in 1991 was undertaken with little discussion on the process of developing the capability of Local Government Units (LGUs) to administer the devolved services and the revenue structure for devolved services was formulated separately from the expenditure structure. Expenditures and resources were matched only at the macro level and did not continue on a per LGU basis. This resulted in the fragmentation of the local health and financing system and the severing of the referral chain linking local health centers and units with secondary health services. This affected integrated approaches to health care delivery, efficiency of the health care system and the quality of local health care services. Despite ongoing efforts of DoH and the LGUs to build up a well-functioning and high performing hospital and public health system nation-wide, the shortfalls remain and LGUs have not been adequately capacitated in all aspects of programme implementation including strategic planning and budgeting and procurement. At the same time, DoH did not sufficiently assume the role of steward and supporter of LGUs in Health Sector Reform implementation. Therefore there is a need to build the capacity of the LGUs in all aspects of health sector planning and implementation and also to build the capacity of the DoH central office and more importantly the DoH regional offices, i.e. the CHDs, to support a devolved health system, including efficient budget allocation end execution especially within the context of DoH introducing performance based budgeting in support of the provinces.

2.2.5. **Performance measurement**

The DoH has developed an extensive Monitoring and Evaluation System for Equity and Effectiveness (ME3) for the health sector. ME3 is a monitoring and evaluation tool that is to evaluate the impact of the F1 on the population and the progress in meeting the F1 goals including the National Objectives for Health. However, data collection is lagging behind and so far only the LGU scorecard has been finalised and data collected are only for 2006 (baseline) and 2007. Several reviews (JAPI, HSPSP MTR) highlighted some limitations since the monitoring mainly relies on the Field Health Services Information System (FHSIS). FHSIS is a facility-based information system and does not provide estimates of service

\[^4\] Doctor to bed ratio is 1 to 50 in Government Hospitals while the recommended ratio is 1 to 10. Nurse to patient ratio in provincial and district hospitals is 1:40-50 while the recommended ratio is 1:20. (National Statistics Office, 2005)

\[^5\] Government health spending has deteriorated by 1.2% annually since 1999 and in real terms the DOH budget had declined by 6.9% per year since 1998 (World Bank, NSSHRP Appraisal 2006)
delivery gaps and quality of services. Routine household surveys on the other hand often do not disaggregate the data to LGU level.

2.3. Eligibility for budget support

The proposed financing modality is sector budget support and the Philippines continue to meet the eligibility criteria.

2.3.1. Sector Policy

See section 2.2.1

2.3.2. Macro-economic framework

In recent years, the GoP has been regularly praised for sound macro-economic management, which is now challenged by the global economic crisis. The country seems to have weathered the international financial/economic crisis reasonably well thus far. According to the IMF, significant reforms in fiscal and banking sectors in the past, as well as the build-up of reserves in good time, limited exposure to failed financial institutions and the insulating effect of remittances (still growing at some 13%, for a projected total of over US$16 billion in 2008) have lessened the Philippine economy's vulnerability, but have not made it immune to the global turmoil. Declining prices of local and foreign-currency denominated financial assets are however, putting pressure on bank balance sheets and raising external financing costs. Moreover, economic growth has slowed to 4.6% in 2008 from 7.2% in 2007, due to weaker exports, investment and consumption and is, according to a recent IMF projection in April, expected to go down to 0% growth in 2009. On the other hand, inflation reached 12% in mid-2008 but slowed down again towards the end of the year (8% in December) as commodity prices eased.

While monetary authorities have promptly taken several measures (including changes in accounting rules, additional lending facilities, reductions in reserve requirements and policy rates) to improve liquidity and financial stability, the fiscal response to the crisis has been much slower. A PHP 330 billion 'Economic Resiliency Plan' (ERP) has been announced, aiming to stimulate the economy through a mix of government spending (largely on infrastructure projects and expanding the social protection programme), tax cuts and public-private sector projects. This points towards a return to an uncomfortably high deficit and has led the IMF to call for a sustained revenue effort.

2.3.3. Public Financial Management

Reforms of Public Finance Management (PFM) remain a high priority for the government in general, including the DoH and the Department of Budget and Management (DBM). The Philippines has improved its accountability and transparency systems and instituted more effective public finance management at all levels of the Government and in the private sector during the past several years. The government has taken a number of actions to instil and promote an accountable, transparent and corruption-free environment throughout the country.

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6 IMF: Public Information Notice: IMF Executive Board Concludes 2008 Article IV Consultations with the Philippines; February 17, 2009
7 IMF Article IV Consultations still states 2.9% growth for 2009 however projections are constantly revised and differ from source to source
Public sector and PFM reforms are ongoing with the rationalisation of government agencies, focusing on enhancing aggregate fiscal discipline, improving resource allocation, promoting operating efficiency, improving public expenditure management and policy based budgeting, of forward estimates and strengthening of the accounting system through roll out of the electronic National Government Accounting System (e-NGAS). However, reform activities appear to be more of a fragmented nature and a national strategic and visionary approach is not evident. Effective coordination in PFM reforms continue to be hampered by the wide split of PFM responsibilities among the central oversight and financial management agencies DOF, DBM, NEDA and CoA.

The World Bank supported a Public Expenditure and Financial Accountability (PEFA) Assessment during November and December 2006 PFM assessment (PEFA) in the Philippines but the draft report prepared in early 2007 has yet to be formally adopted and distributed by the GoP. Nevertheless, current reform activities are mostly focusing on the areas identified as weaknesses. The PEFA assessment will be a useful tool for future planning of PFM reforms and could form the basis of the development of a comprehensive Philippine PFM Reform Strategy. It will also be used as baseline for HSPSP II. In May 2009, a PEFA conference-workshop organised by the DBM was held to discuss the PEFA findings of 2006 and consequently the underlying PFM reform priorities. All the relevant government agencies (DBM, Department of Finance, Bureau of Customs, Department of Public Works and Highway, Department of Social Welfare and Development, Department of Education, Bureau of Internal Revenue, Commission on Audit), participated in this conference together with development partners (such as the EC, WB, ADB, AusAid, USAID).

Following the PEFA conference, the EC Delegation has held bilateral meetings with the DBM, at which DBM has confirmed that PFM reform will continue to focus on key identified areas, including MTEF, Internal Control and OPIF. DBM also suggested that a government owned PEFA assessment might be carried out in 2010, which could form the basis for an integrated national PFM Reform Programme.

Besides its continuous support to PFM at central (DBM, DoH) and local government level, the EC Delegation has initiated discussions among donors (ADB, AusAID, WB) engaging in PFM reforms. An informal PFM donor group (AusAID, ADB, WB, USAID and EC) has been established in 2008 initiated by the EC Delegation and now led by AusAID. The group aims to better harmonise PFM reform efforts and to jointly promote the adoption of a comprehensive and strategic PFM Reform Strategy by GoP involving all stakeholders.

Despite the fact that the 2006 PEFA assessment has not (yet) been formally adopted and a coherent time-bound PFM Action Plan does not yet exist, the commitment of the GoP, especially the DBM, to address key PFM reform priorities has gained sufficient momentum according to the EC Delegation to justify continued budget support.

See also section 2.2

2.4. Lessons learnt

Lessons and experiences can be drawn from the ongoing EC supported Health Sector Policy Support Programme (HSPSP) and Mindanao Health Sector Policy Support Programme (MHSPSP) and other health sector review initiatives like the JAPI.

The MTR review confirmed the relevance and validity of the programme and the absolute need for continued support to ensure the achievement of the country's development objectives, especially with regard to MDG goal 5. Despite the achievements made so far in
improving access to basic services through policy and strategy development (e.g. cheaper medicines act, health financing strategy, drug management etc.), major outstanding challenges can only be addressed through a long term engagement. But the MTR also showed that since past efforts were mostly channeled to support policy development and capacity building at central level, reform implementation at local level is lagging behind. As a result, at mid-term progress at LGU level has been limited and the pro-poor focus of the programme could not be validated. Systems have therefore to be put in place to ensure that required resources are reaching the level where services are provided to the community and key issues directly affecting the health and welfare of poor people must be addressed at local level, in particular the issue of access to reproductive health services and the public response and preparedness to cope the increased health risks resulting from climate change, which is in the current political situation a responsibility of local governments.

Experience has also showed that the planning, approval and fund release processes introduced by DoH for provinces to obtain additional financial resources for health within the context of F1 implementation was long and tedious and was difficult to absorb by DoH. As a result, DoH has initiated the streamlining and facilitation of procedures and deconcentration of responsibilities to the CHDs, especially in view of the implementation of the national roll-out of F1.

PIPHs are province-wide plans. As such they are in effect compilations of multiple procurement entities corresponding to the municipal and provincial governments. Each procurement entity is answerable to the local government chief executives, each independent from the others. The need to define a management system that will monitor execution of the different planning and implementation entities in the PIPH and AOPs is one lesson of Phase I that will be addressed for this Phase II.

In addition, in terms of TA it has been proven useful to have TA embedded in central and local government institutions to increase ownership and facilitate implementation at local level especially in view of lack of coordination and communication between central and local government. In this context the importance of LGU involvement in all stages of programme planning and implementation to ensure ownership and subsequent success of the intervention at local level has to be considered as highlighted in the ROM report of the Mindanao Health Sector Policy Support Programme (see also section 2.5).

2.5. Complementary actions

Since 2006, most health sector donors have increasingly focused assistance programs on the SDAH and have collaborated with DoH in the F1 implementation strategy. The EC and the World Bank are formally working together in support of the F1 approach through the EC HSPSP and the World Bank’s National Sector Support for Health Reform Project (NSSHRP). The NSSHRP supports the medium term Health Sector Expenditure Framework (HSEF), the DOH budget strategy for financing F1, and a related set of reforms for DOH budget management. The Spanish Cooperation (AECID) recently signed a Memorandum of Agreement with the DoH for a sector budget support programme. The first allocation amounts to €5 Mio for 3 years (2008-2010). Subsequent allocations are still to be determined. The programme will make use of the account used for HSPSP.

Other donors also are supporting or developing assistance packages that support F1 implementation or provide technical assistance for reform. This includes ADB which has provided a $200 million program loan and $13 million in project support for specific provinces; GTZ which is supporting reform implementation in the Philippine Health Insurance Corporation, at DoH, and in the CHDs and its three provinces; KfW which is
supporting monitoring and evaluation and other areas of health reform implementation, and has recently approved a €10 Mio ($13 Million) soft loan to support reform implementation; and, the Global Fund which is providing $220 Million for Malaria, HIV/AIDS and TB control programs. USAID is providing technical assistance for F1 Policy Development, LGU Systems Strengthening and also for Nutrition, Contraceptive Self-Reliance, Behavioural Change Communication, TB control, and for health systems strengthening in the ARMM, and its support is aligned with F1 implementation. Other donors include JICA, WHO, UNICEF, and other UN organizations. Some implementing agencies collaborate with the DoH in supporting F1 while balancing their commitment to F1 with their contractual obligations. A total of more than US$700 million has been committed by development partners to support the SDAH.

The Mindanao Health Sector Policy Support Programme (MHSPSP, €12 Mio) forms part of the European Commission’s commitment to support the Government of the Philippines in its reform efforts within the health sector and it does not differ significantly from HSPSP but is implemented through a TF arrangement with the WB on a much lower scale. The MHSPSP is supporting 13 second phase ‘roll-out’ provinces that joined the health reform in 2008 (see also section 2.2.1) and will conclude in 2012. It covers provinces in Mindanao and includes the Autonomous Region of Muslim Mindanao (ARMM).

### 2.6. Donor coordination

See section 2.2.3

### 3. Description

The Health Sector Policy Support Programme II represents a continuation of the ongoing EC support to the Health Sector Reform Agenda of the Government of the Philippines under its implementation framework, the FORMULA One (F1) for Health. The intervention aims to ensure continuous and strategic implementation of the reform agenda, building on the lessons learnt and the gains and the momentum created during the implementation of the current Health Sector Policy Support Programme (HSPSP), with the goal of further contributing to an improved health status of the country’s poor, underserved and disadvantaged populations.

The MTR review confirmed the relevance of the programme and the need for continued support due to the fact that major outstanding challenges can only be addressed through a long term engagement. This follow-on programme will serve to a) consolidate and further develop reform achievements; b) ensure that the reform programme continues to focus on pro-poor interventions; c) replicate successful reform strategies; and d) further strengthen the Department of Health’s (DoH) core functions.

### 3.1. Objectives

The objectives are fully in line with the Government’s health sector goals.

The overall objective is to contribute to the improvement of the health status of the population especially the poor and most vulnerable and the attainment of health-related MDGs through a more effective, efficient and equitable health system.
The **programme purpose** will be to assist to improve equitable access to and utilisation of affordable and financially sustainable, quality essential health services and to consolidate and further develop health sector reform achievements through contributing to the implementation of governments Health Sector Reform Agenda.

### 3.2. Expected results and main activities

The expected results and main activities are (by F1 pillar):

**F1 Pillar No 1: Health Financing**

1. Increased financial protection especially of poor women and men through extended social health insurance coverage.

   This will include the identification and sustainable enrolment of the poor in the Social Health Insurance Scheme, the delivery of enhanced benefit packages to members of the sponsored programme, the promotion of the utilisation of services by the members and accreditation of health facilities for PHIC reimbursement.

**F1 Pillar No 2: Health Regulation**

2. Improved accessibility, quality and safety of health products and services

   The programme will further capacitate DoH and LGUs as effective regulators of health care providers and strengthen local implementation of drugs and health services related regulations. This also includes accreditation of health services closely linked to the financing pillar (result 1).

**F1 Pillar No 3: Service Delivery**

3. Increased utilization of quality primary health care services, including safe water and sanitation.

   This includes the delivery of a comprehensive primary health care package and quality assurance of primary health care. Special emphasis will be given to equity and accessibility of Indigenous Peoples (IPs), Geographically Isolated Disadvantaged Areas (GIDAs) and other vulnerable and disadvantaged groups.

4. Enhanced implementation of an integrated Maternal, Neonatal and Child Health and Nutrition (MNCHN) strategy at LGU level.

   In particular, assist the LGUs in implementing the Maternal, Neonatal and Child Health and Nutrition (MNCHN) policy as a comprehensive SRH package including access to a wide range of family planning services and adequate nutrition programmes. Special attention will be given to ensure that hard to reach populations (IPs, GIDAs) are taken into account.

5. Increased access to essential medicines including modern contraceptives.

   In particular, effective drug management systems are in place; increased number of community based drug outlets in remote, poor areas.

6. Increased cost-effectiveness and efficiency of quality health services delivery.

   In particular, rationalisation plans are developed and implemented; referral systems are in place and functioning (ILHZ); hospital management reforms; quality management and
resource sharing; establishment of public private partnerships (PPP); involvement of Civil Society; innovative approaches of service delivery for IP communities and GIDA.

F1 Pillar No 4: Governance

7. The leadership and supervisory capacities of DoH in implementing Health Sector Reforms is strengthened in accordance with the DOH institutional and capacity development plan.
   In particular, the donor coordination mechanism (SDAH) is improved; DoH central and regional (CHDs) capacities are improved to assist LGUs in implementing Health Sector Reforms. This may include the review of the decentralization arrangements and of roles and responsibilities in decentralized context.

8. Improved participatory health planning, monitoring and evaluation at central and local level.
   In particular, Provincial Health Plans are regularly produced in consultation with local stakeholders including civil society and implemented; health planning and budgeting cycles are harmonized with regular government budget; timely availability of accurate data and its use for decision making. The potential for integrating the health plans into the overall development plans of the provinces will be followed up.

9. Improved public finance management at central and local level.
   In particular, to address priority public finance management issues, including procurement, internal audit functions and efficient budget allocation and execution at both LGU level and central level. The support should have a strategic PFM focus including LGUs' implementation of its Budget Operations Manual and in coordination with other donors.

The above stated results reflect key priority implementation areas of the DoH’s “F1” sector reform and LGUs and form the basis for the allocation of financial and technical resources under the programme. Government sector coordination mechanisms will ensure the synergy of the activities with other donors and maximise results in F1 implementation.

3.3. Risks and assumptions

The climate of political uncertainty and possible constitutional reforms, coupled with macroeconomic instability, represent a risk for the programme. National presidential elections are scheduled for May 2010 and under the constitution, the current president is not eligible to run for another term. However, she and her party are attempting to revise the constitution to change the form of government from a presidential to a parliamentary system which would permit the party and the president to remain in power as long as they were able to maintain a parliamentary majority. This is unlikely to succeed, but the efforts to change the constitution represent a potential risk. Failure to stabilize the political situation could seriously affect fiscal reforms which have taken place, harm the currently favourable investment climate and deter the expected progress in poverty reduction. In addition, the national purchase and distribution of contraceptives by the DoH has been stopped in favour of the promotion of “natural” family planning methods. DoH officials recognise the critical importance of family planning supplies and services for effective population and family planning activities and reproductive health programs. However, absence of a conducive political climate towards contraceptives and effective reproductive health programmes, strongly supported by the Catholic Church,
remains a high risk factor. This can be mitigated through closely working with LGUs and enable them to effectively implement contraceptive self-reliance strategies.

Although the DoH expresses strong ownership of the programme, there is a risk that when the new administration comes after the election of May 2010, it would not feel bound by earlier commitments or that project approval would take much longer. The implementation framework for health sector reforms is also about to come to an end in 2010 and it is up to the new administration to formulate a new development plan and strategy. However, it is not very likely that the thrusts of reform will change significantly since the challenges remain valid.

In addition, the global financial crisis could adversely affect the budget allocation to the health sector, as fiscal resources are expected to tighten and government may re-prioritise spending to focus on labour-intensive and infrastructure projects. On top of this, the eligibility criteria for budget support (BS) in terms of macroeconomic stability might be at risk. The risk is not very high at present since the Philippines seem to have taken adequate steps to counterbalance the crisis.

Another risk is related to programme design. DoH is taking over the full management of the programme including the TA inputs needed to make an impact. A lack of capacity to manage big amounts of TA might hamper timely implementation and quality of TA procured. There is also a potential risk of diluting efforts through uncoordinated and unsystematic purchase of TA. These risks will be mitigated by ascertaining that the provision of technical cooperation services and actions are integral part of the comprehensive institutional and capacity development plan (specific condition for release of 1st tranche). Furthermore, the EC Delegation will closely follow up and support the planning and implementation of TA through its active participation in the monthly Health Partners Meetings and the twice yearly JAPI (see section 2.2.3). The EC Delegation will also have observer status in the Technical Assistance Coordination Team (TACT) during the course of HSPSP II implementation.

3.4. Stakeholders

The main beneficiaries of the programme are the population of the Philippines, especially poor women and men and the most vulnerable population groups, in particular indigenous people (IP) and other population living in remote areas. These are defined by DoH as geographically isolated and disadvantaged areas (GIDAs) and subject to special programmes under the PIPHs. Programme implementation is undertaken by the different departments and bureaus of DoH including the regional offices (FIMO, CHDs), DBM and the LGUs. Other important stakeholders are the development partners (ADB, WB, Spanish Cooperation, UN family, JICA etc.) and CSOs.

3.5. Crosscutting Issues

Gender:
The programme is focussing on equitable access to essential health services and takes the different needs of women and men into account at all levels. On major issue addressed is maternal and child health.

Human rights:
The promotion of human rights is reflected in the focus on equitable access to health services especially for the poor and disadvantaged population groups (IPs, GIDAs). Another crucial human rights issue taken on board are Reproductive Health rights, especially the access to family planning and free choice of methods.
Good governance:

Good governance is not only mainstreamed in the programme but integral part of the programme design expressed in the F1 Pillar No 4 (Governance) and result 9 in particular.

Environmental sustainability:

Environmental sustainability is promoted through result 1, supporting appropriate water and sanitation facilities. In addition particular effort will be made to integrate elements aimed to address the awareness raising needs of the health sector professionals and the public in view of coping with the adverse effects of climate change and improving sector resilience.

4. Implementation issues

4.1. Method of implementation

A Financing Agreement will be signed with the Government of Philippines.

The method of implementation will be centralised management through:

1) Sector Budget Support (SBS).

2) Service will be managed by the European Commission through the signature of service contract within current framework contracts.

The DoH is committed to further assist the LGUs with the adequate resources for effective and efficient reform implementation.

4.2. Procurement and grant award procedures

Service contracts related to monitoring and evaluation of the programme and the information communication and visibility activities will be awarded and implemented directly by the EC Delegation in accordance with the procedures and standard documents laid down and published by the Commission for the implementation of external operations, in force at the time of the launch of the procedure in question.

Participation in the award of contracts for the present action shall be open to all natural and legal persons covered by DCI Regulation.

4.3. Budget and calendar

The total amount of EC support is €36 000 000 with the following budget breakdown:

<table>
<thead>
<tr>
<th>Category breakdown</th>
<th>EC contribution (M €)</th>
<th>Total</th>
<th>Contracting Authority/Paying authority</th>
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<td>35</td>
<td>EC</td>
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<tr>
<td>2. Services</td>
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EN 14 EN
2.1 Monitoring and evaluation

<table>
<thead>
<tr>
<th></th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>Total</th>
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</thead>
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<tr>
<td>Fixed tranche</td>
<td>10 M€</td>
<td>5 M€</td>
<td>5 M€</td>
<td>5 M€</td>
<td>25 M€</td>
<td>71.4%</td>
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<tr>
<td>Variable tranche (max.)</td>
<td>3 M€</td>
<td>3.5 M€</td>
<td>3.5 M€</td>
<td>10 M€</td>
<td>100%</td>
<td></td>
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<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>35 M€</td>
<td>100%</td>
</tr>
</tbody>
</table>

The operational duration of the programme is foreseen to be 48 month as from the signature of the Financing Agreement.

The indicative budget disbursement calendar is foreseen as follows:

The DoH will allocate funds for technical assistance (TA) on capacity development. TA for capacity building will be used to strategically achieve the expected results as described above (section 3.2) and in the DOH Capacity Development Plan. Strong focus will be given to strengthen the capacity of the 16 CHDs and DoH-ARMM to take on their new role to lead the reform implementation and monitor health sector reforms at LGU level and at the same time to further strengthen leadership and financial management capacities of the DoH central office to provide performance-based financial support to provinces.

All required technical assistance needed will be contracted and managed by the Department of Health using national procurement rules and regulation. Within its sector budget, GoP intends to allocate tentatively an amount equivalent to approximately €10 Mio for this purpose.

4.4. Performance monitoring and criteria for disbursement

Despite the still prevailing limitations in the availability of relevant data, the proposed programme will primarily use the national ME3 system for monitoring and evaluation purposes, but also includes some other crucial indicators for performance measurement.

DoH is also committed to conduct yearly performance and results verification exercise forming the basis for the assessment of the agreed performance indicators and subsequently the disbursement of the performance tranche. Annual progress reports and planning documents will be provided by DoH as well as audit reports if appropriate.

General conditions for disbursement:

As general conditions for disbursement of all tranche releases, the following eligibility criteria will apply:

- Satisfactory implementation of national health policy and strategy,
• Satisfactory progress in maintaining a policy of macroeconomic stability,
• Satisfactory progress on implementation of the programme to improve and reform public finance management.

Specific conditions for disbursement:

As a specific condition for the disbursement of the first fixed tranche, the approval and availability of a costed institutional and capacity development plan for the health sector developed by DoH in its capacity of steward and oversight agency for the health sector.

The following 6 performance indicators have been chosen by DoH in agreement with EC as criteria for disbursement of the performance tranche of the EC SBS:
• of verified real poor enrolled in the national health insurance programme
• of provincial procurement plans implemented in compliance to the national government procurement reform act (RA 9184)
• fully immunised children
• Availability of essential drugs in public health facilities at all levels according to national drug formulary
• birth attended by skilled birth attendant and Facility based delivery
• Contraceptive prevalence rate.

The baseline and targets for each of the indicators will be determined prior to signature of the financing agreement (FA). Partial achievement of indicators in year N will result in partial disbursement of the variable tranche. However, if performance is reached in the following year N+1, the proportion of the variable tranche not released in year N may still be paid in year N+1. The exact scheme will be defined and agreed upon prior to signature of FA.

4.5. Evaluation and audit

The implementation of the programme will be subject to regular follow-up by the EC Delegation mainly through coordinated efforts within the SDAH using government lead joint sector performance reviews (JAPI). If needed external monitoring missions will be carried out under the ROM system.

The SBS is subject to the Philippines' regular auditing procedures which are the exclusive constitutionally mandated remit of the Philippine Commission on Audit.

4.6. Communication and visibility

In general, the EC visibility guidelines will apply for the action. In addition, an Information Communication Visibility Plan (ICVP) will be developed outlining ICV activities aimed at supporting the Philippine Health Sector Reforms and promoting Government's ownership and at the same time to display EC as major partner in the sector.
Action Fiche N° 2 - Philippines

1. IDENTIFICATION

<table>
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<td></td>
<td><strong>EC contribution:</strong> € 2 million</td>
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<td></td>
<td>Other contributions: € 41 million</td>
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<td>Project approach – joint management</td>
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<tr>
<td>Sector</td>
<td>Reconstruction and rehabilitation</td>
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2. RATIONALE

2.1. Sector context

The Philippines is a lower middle income country (US$ 1 300 per capita in 2005) beset by extreme inequality of wealth distribution. Furthermore, poverty appears to be increasing. According to the 2006 official poverty statistics the incidence of poor families in the Philippines increased by 2.5 percentage points to 26.9 percent from 24.4 in 2003. The total number of poor Filipinos reached 27.6 million in 2006, 16% more than the 23.8 million estimated in 2003. There are, moreover, geographical disparities. While 6 of the 10 poorest provinces are situated in Mindanao, the Autonomous Region of Muslim Mindanao (ARMM) recorded a particularly high poverty incidence of 55.3% in 2006. These ongoing high levels of poverty can largely be attributed to conflict and instability in the region.

Mindanao has a multi-ethnic society, including 'Moro' Muslims, Christians - mainly descendants of settlers from the Visayas and elsewhere - and indigenous people or 'Lumads'. Muslims make up 5-7% of the total in the Philippines and approximately 21% of Mindanao’s population. While fighting between Moro and Christian communities dates back to the 16th century, the current conflict, which has resulted in the loss of 120 000 lives and 2 million displaced persons, was triggered by the massive influx of settlers from other parts of the Philippines that was encouraged under the Marcos regime in the 1960s, as well as large-scale logging and mining activities that also date from that period. The Moro National Liberation Front (MNLF), which took up arms for an independent Muslim state in Mindanao was created very much as a reaction to this. The MNLF signed a ceasefire agreement with the Government of the Philippines (GoP) in 1976, but a low-intensity conflict continued with the emergence of a splinter group, the Moro Islamic Liberation Front (MILF), in 1984 advocating for the creation of an Islamic state in Mindanao.

There were further major armed confrontations under subsequent administrations. President Estrada's “all-out-war” on the MILF declared in 1998 resulted in the killing of over 1 700 and the displacement of more than 930 000 civilians, while another major confrontation between the MILF and the military in 2003 resulted in at least 411 000 internally displaced peoples (IDPs). A functional ceasefire agreement was reached in 2003, under which a Joint Ceasefire...
Coordinating Committee, consisting mainly of members of the Organisation of Islamic Countries (OIC), was tasked to monitor the agreement. Armed confrontation decreased substantially from almost 800 incidents in 2003 to less than 30 in 2005.

There then followed a period of increasing hope as exploratory GoP-MILF peace talks continued under the auspices of the Malaysian Government, achieving a near breakthrough in August 2005 through the drafting of a 'Memorandum of Agreement on Ancestral Domain' (MOA-AD). The MTF-RDP was initiated in this environment, when there were good signs that a comprehensive peace agreement would be signed. However, on 14 October 2008 the Supreme Court of the Philippines declared the MOA-AD to be unconstitutional. This triggered a renewed upsurge of fighting that has left over 200 people dead and resulted in prolonged large scale displacement with 600,000 displaced persons at its peak and around 200,000 persons still displaced, mainly in Maguindanao. Peace talks have not officially resumed, although the GoP Peace Panel has been reconstituted.

Against this background of unresolved conflict and worsening poverty, which will be exacerbated by the effects of the global financial crisis, the restoration of peace and security in Muslim Mindanao continues to be a main priority. The multi-donor Mindanao Trust Fund-Reconstruction and Development Program (MTF-RDP), which was established at the request of GoP, aims to build peace through community owned projects that focus on inclusion, good governance and sustainability. The EC’s continued support for the MTF-RDP is a strong reflection of its continued political commitment to the peace process in Mindanao. This corresponds to the priorities set out in the Strategy Paper 2007-2013, i.e. providing support to the most vulnerable sectors of society and in particular on stability and security issues in poverty-stricken Mindanao.

2.2. Lessons learnt

Preparation of the MTF-RDP is based on the Joint Needs Assessment (JNA) undertaken by a team of local and international consultants from August 2004 until December 2005, with EC participation. MTF-RDP was formally launched in March 2006 with initial contributions from Australia, Canada, New Zealand and the World Bank. Sweden joined in December 2006.

Over the past 2 years of implementation, MTF-RDP activities have focused mainly on capacity-building of the Bangsamoro Development Agency (BDA) and its local partners, specifically the 'peoples' organisations' (POs) established by communities and local government units (LGUs). The Report of the MTF-RDP covering the period April to October 2007 states that BDA has evolved from being inexperienced volunteers into an efficient and results-oriented organisation which responds to need for an accountable and well-functioning implementing agency in the conflict-affected and vulnerable areas of Mindanao. By the end of December 2008, the MTF-RDP had successfully implemented and completed 53 small-scale community sub-projects such as potable water systems, community livelihood centres, tire paths, solar driers, warehouses, etc. spread over 45 barangays in 40 municipalities throughout Mindanao. The successful implementation and completion of these various small-scale community sub-projects has contributed in bringing about peace, reconciliation and social cohesion in the conflict-affected and vulnerable areas of Mindanao.

Other important and specific lessons learned from MTF-RDP implementation include:

a.) greater commitment of the LGUs as a result of the implementation of the small-scale community sub-projects;
b.) the acknowledgement and appreciation by the LGUs of the resourcefulness of their own communities;
c.) high community involvement as a requirement for smooth implementation;
d.) the maximisation of benefits from sub-projects through relevant and appropriate training provided to communities;
e.) the sub-projects served as a platform for good interaction among the various ethnic groups that live in the community; and most importantly,
f.) none of the 45 barangays where MTF-RDP was implemented engaged in armed conflict although 3 of them experienced evacuation due to military activities.

While a full evaluation of the MTF-RDP is scheduled to be undertaken in mid 2009, some preliminary social and impact assessments have been conducted in the past 2 years\(^5\). In general, the results of these impact assessments have been overwhelmingly positive and showed that MTF-RDP has made a real difference in communities and its members' lives, in both tangible and intangible ways. The needs of the urban IDPs are also being addressed through the provision of livelihood skills.

The final report of the results-oriented monitoring (ROM) mission undertaken from March 9-12, 2009 likewise produced very positive findings: the program is in line with the EC Country Strategy Paper for the Philippines for the period 2007-2013; the decision to contribute into a wider donor trust fund is in line with the Paris Declaration principles of improved aid effectiveness; the logframe in place since the start of the program and updated in May 2008 clearly sets out expected outcomes; and cross-cutting issues such as human rights, governance and gender as key elements of a community-driven development approach are well integrated into program design, while environmental impact assessments are being carried out before the small-scale sub-projects are approved. With regard to efficiency of implementation, despite some delays linked to the stalled peace talks and the resurgence of violence in some areas, much has been accomplished. There is a need however to shift the focus of program reporting from input, activities and outputs to the more strategic level of outcomes and objectives. Impact, in terms of peace building, governance and social development will only begin to become apparent when the program increases its scope and coverage through a scaling up of the system of community-level participation in order to achieve effective local governance as a basis for service delivery. The major recommendation, therefore, which is very much in line with what has emerged from recent discussions with the other major donors contributing to the trust fund, is for the program to continue both to widen the scope of its assistance to include more communities, while also deepening its engagement through supporting a scaling up of activities in communities where initial small-scale activities have been successful.

### 2.3. Complementary actions

Mindanao is a priority area for most major donors, given its worsening poverty, peace and security issues and at the same time, its agricultural growth potentials. There is a wide range of complementary actions with the overarching goals of poverty reduction and conflict prevention, but with varying strategies and outcomes.

EC support for long-term development of Mindanao (some € 93 M over the past 2 decades, not including assistance from individual EU Member States), has included work in rural development and the environment, on agricultural education and agrarian reform. Most recently, focus has been on the health sector and on support to the MTF-RDP where EC is the largest single donor.

The health sector policy support program of the EC supports the FourMula One policy of the Department of Health for strengthening basic health services at the provincial level and building on the work carried out under the Women's Health and Safe Motherhood Project in the 1990s. The total EC grant for this program is € 33 M, of which a total of € 8.25 M is
allocated for the provinces of Agusan del Sur, North and South Cotabato and Misamis Oriental in Mindanao.

In addition, the Mindanao Health Sector Policy Support Program with a total allocation of €12 M divided between grant funds for the provinces through a World Bank trust fund and the provision of technical assistance, supports the health reform in the conflict affected provinces, specifically those in the ARMM (Lanao del Sur, Sulu, Tawi-Tawi, Maguindanao, Basilan) and Isabela City, Zamboanga Norte, Sur and Sibuguey, Lanao del Norte, Davao Oriental, Sarangani, Sultan Kudarat and Compostela Valley.

In the last quarter of 2008, the EC approved funding for 2 separate actions to address the plight of the civilian victims of the conflict in Mindanao. In response to immediate humanitarian needs, ECHO approved funding of €4 M to cover emergency food distribution, drinking water and additional sanitation facilities, non-food relief items, basic shelter assistance, health care and psycho-social support, emergency support to livelihood rehabilitation and protection. Longer term rehabilitation assistance for displaced persons and host communities affected by the conflict in recent years was provided through the (regional) Aid to Uprooted People programme in the amount of €3 M, to be implemented by the UNDP as part of their "Act for Peace" Program.

Under the Instrument for Stability (IfS), a grant of €1 million was approved in December 2008, to support confidence-building, dialogue and humanitarian protection actions in Mindanao. 3 separate grants have been signed within this total allocation, to be implemented by two international civil-society organisations (Centre for Humanitarian Dialogue, and Non-Violent Peace Force) and one Philippine civil-society organisation (Mindanao People's Caucus) to be implemented over a period of eighteen months, commencing in the first quarter of 2009.

2.4. Donor coordination

The overall forum for dialogue between the GoP and donors is the annual Philippine Development Forum (PDF), of which the Mindanao Working Group (MWG) constitutes one of the working groups, specifically focused on Mindanao. The MWG is co-chaired by the World Bank and by the Mindanao Economic Development Council (MEDCo), the government agency responsible for the promotion and coordination of the active participation of all sectors to effect the socio-economic development of Mindanao.

Under the MTF-RDP, an Interim Steering Committee was created composed of key government agencies, local key stakeholders, main donors, including the EC, and the World Bank which provides overall policy guidance and strategic guidance, reviews annual MTF-RDP workplans, provides guidance on coordination with other development projects in conflict-affected areas and coordination between MTF-RDP and other projects/activities funded by these other donors. This Committee is co-chaired by the OPAPP, the BDA and the World Bank.

3. Description

3.1 Objectives

The objectives of MTF-RDP are to assist in the economic and social recovery of the conflict-affected areas in Mindanao and to promote inclusive and effective governance processes. These objectives will be pursued through 3 interlinked activities:
a. inclusive governance processes are promoted through involvement of key Mindanao stakeholders both at the level of programme management through the Programme Steering Committee and at the level of the barangays and municipalities engaged in participatory planning and management of local development activities;

b. effective governance is promoted through the learning process of inclusive multi-stakeholder consultation and decision-making at the level of the Steering Committee, municipalities and barangays, supplemented by capacity-building targeting the BDA, implementation service providers, municipalities and barangays/communities to enhance an inclusive, transparent and effective planning process regarding the use of grant funding implemented supplemented by local contributions whether from the Program of from other funding sources; and

c. economic and social recovery is assisted by the provision of grants to barangays/communities and municipalities for sub-projects, where access to funding will be contingent on compliance with defined sub-project appraisal criteria requiring socially inclusive planning, equitable access to benefits, contributions towards capital and operation/maintenance costs and observance of technical and safeguard policy standards.

Key government counterparts are: 1) Office of the Presidential Adviser on the Peace Process (OPAPP); and 2) Mindanao Economic Development Council (MEDCO). The local counterparts are the Bangsamoro Development Agency (BDA); 2) ARMM Regional Government and LGUs; 3) civil society organisations and 4) indigenous peoples.

The MTF, as originally conceived, has two phases:

**Phase 1** (prior to the signing of the peace agreement) started its activities in early 2006 with the objective of providing capacity building to foreseen implementing agencies, mainly the BDA. Phase 1 also includes establishing the organizational set-up for implementation of sub-projects under Phase 2, and pilot sub-projects in several barangays and municipalities to be implemented by BDA, assisted by a contracted service provider. Activities to date include orientations for BDA, LGU, and other service providers, recruitment of BDA staff, municipal meetings and community mobilization, implementation of sub-project activities in pilot communities.

**Phase 2** will entail the implementation of the full program through disbursement of block grants to finance sub-projects (e.g. income-generating and livelihood activities, basic infrastructures) in conflict-affected areas. It also includes the provision of TA, the expansion of capacity building and a phased transfer of program management responsibility to the Bangsamoro entity to be confirmed after the peace agreement.

However, at the most recent Interim Steering Committee meeting (April 2009) it was agreed by major donors and government partners that, although the two phase strategy was appropriate when the prospect for peace was imminent, this was no longer relevant and that upscaling should now be considered in the light of increasing poverty in Mindanao and the consequent need to fast track the program. However, this will not involve a quantum increase to incorporate the original 'block grants' concept, but will be a gradual process with a number of activities. Specifically, assistance to urban IDPs will be expanded; LGU partnerships with BDA in the delivery of basic services will be strengthened; knowledge management aspects by partnering with other groups planning to conduct analysis and roundtable discussions on various issues linked to conflict and peace will be strengthened; the information and education
campaign to build constituencies for peace among the different sectors in Mindanao will be continued; BDA's capacity in community-driven development will be solidified; and training and advocacy at the community-level on gender and peace-building and conflict-resolution will be continued. The additional EC funding proposed in this AF will support this development.

3.2 Expected results and main activities

Based on the JNA, the MTF adopts a holistic multi-purpose approach, implementing a wide range of activities with a mutually enhancing impact on the beneficiary communities. A combination of a growing number of demand driven multi-sectoral sub-projects and capacity building efforts, accompanied by a range of implementation support and training activities will aim to achieve the following results:

1. Effective and inclusive governance processes with the involvement of key stakeholders set up at all levels of Program management, participatory planning, implementation, and management of local development activities, supplemented by capacity building at all levels.

2. Economic and social recovery of conflict-affected areas achieved through the provision of grants to communities, internally displaced people, and municipalities that will be used for livelihood/reconstruction and economic recovery. Access to funding will be contingent on compliance with defined standards regarding socially inclusive planning, equitable access to benefits, contributions towards capital and operation/maintenance costs, and observance of technical standards.

3.3 Risks and assumptions

While the outlook for a major breakthrough in the peace agreement seems bleak in the immediate future, the situation is not as dire as most often reported in Philippine press. The immediate task is to prevent further escalation of the conflict, which is currently confined to well-defined areas with sporadic incidents elsewhere, for both parties to return to the negotiating table and to preserve the gains already achieved in many areas where MTF-RDP has successfully piloted community-activities.

A breakdown in the peace talks could lead the 2 sides back to an "all-out war", although many analysts believe that both parties do not have the resources to sustain operations. Through close coordination and political engagement, donors should support the return of the parties to the negotiating table at the soonest time possible and to keep existing ceasefire mechanisms in place.

Elite capture of benefits and corruption are also critical risks. These are mitigated through participatory and transparent planning and budgeting processes, close monitoring and audits, as well as the use of sanctions, should gross misuse of funds take place.

3.4 Crosscutting Issues

The following cross-cutting issues have been taken into account in the JNA and MTF-RDP preparation: human rights, Internally Displaced Peoples (IDPs), gender, indigenous people (IPs), environment and land tenure.
IDPs represent the most vulnerable group in the conflict-affected areas as they are already poverty-stricken prior to the occurrence of the conflict. Priority therefore, will be given to the IDPs who have resettled to address their needs and improve their situation.

The MTF-RDP takes into account gender balance at all levels of the Program, as well as the specific needs and rights of women in the context of armed conflict. This includes their leading role in reconciliation and in ensuring social protection of their families. Moreover, the changing roles of Muslim, Christian and Indigenous Women and children in their respective communities and their specific vulnerabilities will be considered. The 2008 annual report of the MTF-RDP contains gender disaggregated data showing 48% women's participation in people's organisations, although only 3 out of 16 PO presidents are women.

Concerns of indigenous peoples will be considered through the inclusive participatory planning process at community level which is foreseen by the MTF-RDP. IPs will have the opportunity to develop proposals for sub-projects addressing their specific concerns and make use of the grievance redress arrangements within their barangays.

The Mindanao conflict has strong roots in the question of control over natural resources, especially land, but also mining, timber, oil, gas, and fishing resources. Access to land and resources, with its impact on the environment, has to be tackled as a priority to ensure sustainable peace. Land acquisition based on eminent domain will not be undertaken in the post-conflict context. Thus, projects involving involuntary land acquisition and resettlement will not be eligible for funding.

The MTF-RDP supports livelihood projects and agribusiness programs that encourage the link between production and predetermined markets foreseen to contribute to a reduction in human pressure on fragile environments, especially in the uplands. The MTF-RDP will also clean up debris left from armed conflict, implement agro-forestry and reforestation actions. The MTF-RDP will use an environment screening procedure that identifies prohibited sub-projects with adverse environment impacts. Mitigation of negative impacts from sub-projects not on the negative list will be addressed through environment impact assessments and through Environment Management Plans (EMP).

3.5 Stakeholders

The main stakeholders and target beneficiaries of the MTF-RDP are the communities in 150 Mindanao municipalities identified as conflict-affected areas (CAAs). Other important stakeholders are various GoP agencies at regional, provincial, municipal and barangay levels, the BDA, other concerned implementing agencies, service providers from civil society and the private sector, the various donors contributing to the MTF-RDP and the WB as coordinating agent.

4. IMPLEMENTATION ISSUES

4.1 Implementation method

Joint management through the signature of an Administration Agreement with the World Bank.

4.2 Procurement and grant award procedures

All contracts implementing the action must be awarded and implemented in accordance with the procedures and standard documents laid down and published by the World Bank and the
"Trust Funds and Co-financing Framework Agreement" signed between the EC and the World Bank Group.

4.3 Budget and calendar

Overall initial donor funding is estimated at US$ 50 million (or € 43 million) which would cover the establishment and operations of the MTF-RDP over a foreseen 6 year period. The EC contribution for AAP 2009 will be € 2 million.

<table>
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The project operational duration is 48 months as from the date of signature of the Administration Agreement.

4.4 Performance monitoring

The World Bank has an MTF Operations Manual, which contains provisions for performance monitoring. This also includes a detailed Financial Management Manual.

Implementation service providers will provide internal monitoring data on baseline conditions, inputs, outputs, and results to the Project Monitoring Office (PMO). A Monitoring Information System (MIS) is currently being updated by the PMO to furnish comprehensive internal monitoring reports to the Administrator and Interim Steering Committee (SC) on a quarterly basis. These reports will include the aggregate disbursements of block grants and financial progress of the Program. Consultants may be contracted by the WB to undertake studies, reviews and appraisals on specific topics relevant to the Program.

At community level, members of the community, including Barangay Project Committee representatives, should be involved in an exercise to define 3 key indicators for successful participatory decision-making and sub-project implementation. The community assessment will be included in the Implementation Service Provider’s quarterly progress report.

The EC monitors implementation through its participation at the MTF-RDP ISC meetings, review of the Quarterly and Annual Financial and Physical Progress Reports, inclusion of the MTF-RDP into its annual external ROM exercise and field missions either jointly with other donors or on its own.

It has been noted by both the EC and the ROM that the reports submitted by the World Bank so far have not been satisfactory. There has been a lack of clarity in the presentation of results

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1 Donors contributing to MTF-RDP as of the end of 31 December 2008: Australia: Aus$ 500 000; Canada: CND$ 1 750 000; New Zealand: US$ 200 000; World Bank: US$ 1 525 000; Sweden SEK 1 500 000; EC € 2 million (€ 1 million under RRM and € 1 million under AAP 2007); USAID: US $ 750 000.
and completed activities, exacerbated by a lack of precision in the terminology used. The World Bank has been requested by the EC to improve the quality of its reports and address the recommendations of the ROM by improving the visibility of outcomes-focused logframe and ensure that it is used systematically to review program performance both in reporting and in external oversight.

4.5 Evaluation and audit

The MTF Operations Manual envisages internal as well as external auditing. External review and evaluation will be undertaken by an independent Consultant to be contracted by the WB.

The WB provides an annual report on the progress of activities, and a final report within 6 months of the final disbursement to donors. The WB will also provide donors a management assertion together with an attestation from the Bank’s external auditors concerning the adequacy of internal control over cash-based financial reporting for trust funds as a whole, within 6 months following the end of each Bank fiscal year.

The WB will furthermore provide a financial statement audit of the Trust Fund done by external auditors within 6 months following the end of the Bank’s fiscal year and following the close of the Trust Fund. The WB shall also provide the EC with copies of all financial statements and auditors’ reports received by the Bank from the fund recipients.

A full evaluation of the ongoing MTF-RDP is currently being undertaken by the WB although various impact assessments were already done in the past 2 years which have provided positive results.

4.6 Communication and visibility

The EC and the World Bank have signed a letter of understanding on 2 June 2006 clarifying the visibility provisions of the Trust Funds Framework Agreement. The EC Delegation will ensure active participation in the MTF Interim Steering Committee to influence strategic decisions of the Trust Fund and to monitor that visibility provisions are respected.

The EC Delegation will also ensure appropriate communication activities such as print, electronic media, special events, alongside the traditional media and personal communication techniques, and will be maximised to the fullest to convey both general and specific communication messages (in the contexts of the EU and EC) to its intended stakeholders.