ALTERNATIVE BUDGET

Fiscal Year

2019

Alternative Budget Initiative

SOCIAL WATCH PHILIPPINES

Table of Contents

LIST OF TABLES **PAGE**

LIST OF FIGURES

ALTERNATIVE BUDGET PROPOSAL FOR AGRICULTURE AND FISHERIES

URGING FAST AND COLLABORATIVE INTERVENTIONS/ACTIONS TOWARDS COMPETITIVENESS, RESILIENCY AND CLIMATE READINESS OF PHILIPPINE AGRICULTURE AND FISHERIES

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I. CONTEXT

There are several reasons why agriculture and fisheries needs urgent and special attention for 2019. In summary, there is urgency as we attempt to:

- put in measures to counter possible impact of rice liberalization,
- address high poverty despite continuing national economic growth,
- respond to global calls for local climate actions and
- ensuring international commitments for a more inclusive and gender fair agriculture and fisheries policies and programming in the Philippines
- Pro-actively address El Nino occurrence in the latter part of 2018 and its slow onset impacts possibly until 2019

Racing Against Rice Liberalization

With President Rodrigo Duterte's go-signal to pursue rice trade liberalization, there is immediate need to fast-track competitiveness measures and increased production in rice. Filipino rice farmers have to brace for the potential surge in rice imports to 4 to 5 million metric tons of imported rice. Philippine rice stands to lose with rice produced at 12 pesos per kilo and reportedly increasing to 13 pesos production costs because of TRAIN law versus the 7 pesos to 8.8 pesos of Vietnam and Thailand.

The country needs to do a lot to bring down production costs to 9 pesos per kilo to achieve a minimum level of competitiveness.

We contend that rice importation is not the solution to the problems confronting the rice sector in the Philippines, nor will it address the long-term food security concerns of the country. Lifting the QRs on rice imports is not the panacea to inflation or high rice prices, as some economic planners have persistently claimed. Making sustained investments in our rice industry so that our rice farmers have a decent income and livelihood and can compete with producers in other countries, in a way that preserves the productivity of our farms, is the only sustainable solution. It is the solution that should have been done many years ago, but has now become even more urgent as we liberalize our rice market.

Government planners should undertake a deeper and more comprehensive analysis of the effects of rice trade liberalization, so that the necessary contingency measures can be put in place before the QRs are removed. At present, government planners are simply claiming that the QR removal will allow more and cheaper imports to come in, leading to lower prices of rice for consumers. However, there is no assurance that rice prices will go down significantly once the rice trade is liberalized through the removal of QRs. Importers will maximize their profits and sell at the highest price they can, even if they bought the rice for a very cheap price abroad. Hoarding, price

manipulation and cartelized trading will not disappear; in fact, there is every possibility that a large portion of the rice trade will be taken over by well-financed speculators who will instigate sudden movements in rice prices in order to make a quick profit, regardless of its effect on consumers. Further, a sudden surge in the demand for rice imports from the Philippines will invariably lead to higher international market prices for rice, particularly because of the limited volume of traded rice in the global market. If large rice consuming countries like China and Indonesia suddenly decide to import rice, the Philippines might not even be able to source enough rice from its traditional suppliers.

The economic managers also do not measure the long-run effects on rice farmers who will then have to absorb lower prices for their products, and on rural communities that will be affected correspondingly. The reduction in farm incomes may also spur the conversion of rice lands to non-agricultural uses and irreversibly threaten the long-term food security of the country. Also, the whole rice market chain will be affected as millers, traders, truckers, and other service providers could be dislocated by the influx of massive volumes of rice imports that will displace local produce.

Addressing High Poverty Especially in Visayas and Mindanao

The Second Quarter 2018 Social Weather Survey, done on June 27-30, 2018, found 48% (est. 11.1 million) of families considering themselves as *Mahirap* or Poor. This is 6 points above the 42% (est. 9.8 million families) in March 2018, and is the highest since the 50% in March 2017. The 6-point nationwide increase in Self-Rated Poverty (SRP) in the second quarter of 2018 was due to sharp increases in Mindanao, Metro Manila, and the Visayas offset by a slight decrease in Balance Luzon. SRP rose by 18 points in Mindanao, from 42% in March 2018 to 60% in June 2018. This is the highest since the 70% in September 2015. It rose by 13 points in the Visayas, from 54% in March to 67% in June. This is the highest since the 71% in December 2015. It also rose by 13 points in Metro Manila, from 30% in March to 43% in June. This is the highest since the 43% in December 2014.

This high poverty persists despite sustained positive economic growth since the time of President Aquino. Thus in order for growth to be felt at the ground level, there should must be stronger efforts to reach and effectively target farmers and fishers in areas of high poverty incidence.

Ensuring commitment to the 2018 UN Commission on Status of Women Are Observed

On 12-23 March 2018, the Philippines supported the recommendations of the Agreed Conclusions of the 62nd Session of the UN Commission on the Status of Women (CSW 62) that focused on the *Challenges and opportunities in achieving gender equality and the empowerment of rural women and girls*. UN member-states agreed that while “women contribute significantly to the food produced worldwide, women and girls are disproportionately affected by hunger and food insecurity, in part as a result of gender inequality and discrimination.” Such reality is reflected in the women and girls living and working in agriculture and fishing communities, where most of their work remains unpaid and unrecognized. The Agreed Conclusions need to be translated into programs and actions for 2019. Further, the decreasing number of women employed in agriculture also needs to be investigated and addressed, i.e. decreased by 5% last 2016 which is higher than the average 3% decrease annually from 2012 to 2016 (PSA 2017 AIS).

Global Call for Local Climate Actions

The global climate negotiations and the Paris agreement mandates for the stepping up of Pre-2020 local climate actions. There is particular demand for local climate actions for agriculture through the Korinivia Work Program. The Philippine government drafted its submission identifying actions on the said mandate

Meanwhile, In COP 24 of UNFCCC, there was also an attempt to strengthen partnerships for climate action with non-party stakeholders such as CSOs and the private sector to support stepping up local climate actions, strengthening collaborations and tracking implementation of these climate actions through the Marrakesh Partnership to raise ambitions to solve the climate crisis.

EL NINO WATCH is now in effect

While we continue to be in ENSO-neutral conditions for July-August season, PAGASA based on different models used, reveal a 60% chance of El Nino developing in the last quarter of 2018.

SPECIAL BUDGET CONCERNS FOR THE AGRICULTURE SECTOR

Integrating Child's Rights in Agriculture Budget Advocacy

The Alternative Budget Initiative strongly advocates for children's rights. Currently, the different working groups within ABI are converging to address various issues related to child's rights, among them are the elimination of the worst forms of child labor and affording stronger protection for the working child which is currently provided for in Republic Act No. 9208. The Philippine Government also committed itself to take immediate action to prohibit and eliminate the worst forms of child labor by ratifying ILO Convention No. 182.

Hence, ABI is positively taking action through this budget advocacy.

Child labor in the Philippines remains a big problem. Child labour, which is work that interferes with compulsory schooling and damages health and personal development, based on hours and conditions of work, child's age, activities performed, and hazards involved. Data from the 2011 Survey on Children conducted by the National Statistics Office (now Philippine Statistics Authority), in collaboration with the ILO, showed that 3.21 million children (ages 5-17) are engaged in child labor and 2.99 million of them are in hazardous work. Particularly in agriculture, poverty is the main cause of child labour. In many countries, child labour is mainly an agricultural issue.

Worldwide 60 percent of all child labourers in the age group 5-17 years work in agriculture, including farming, fishing, aquaculture, forestry, and livestock. This amounts to over 98 million girls and boys. The majority (67.5%) of child labourers are unpaid family members. In agriculture this percentage is higher, and is combined with very early entry into work, sometimes between 5 and 7 years of age[1]. Agriculture is one of the three most dangerous sectors in terms of work-related fatalities, non-fatal accidents and occupational diseases. About 59 percent of all children in hazardous work aged 5–17 are in agriculture. While participation of children in non-hazardous labor activities can be seen as positive as it contributes to the inter-generational transfer of skills

and children's food security, it is important, however, to distinguish between light duties that do no harm to the child[1].

However, concretely, we believe that one of the ways to prevent this in the agriculture sector is to ensure family incomes from farming are sufficient by providing enough support to the agriculture sector.

Taxing Tobacco to the Max: Assisting Farmers to be affected by Increased Tobacco Taxes

One of the proposed tax reforms that may have significant implications for agriculture and farmers is now filed in Congress. Senate Bill 1605 seeks to increase tobacco tax to P90 per pack. Aside from the health impact of taxing tobacco, the passage of the Senate Bill 1605 will support the funding needs of the universal health care bill or Senate Bill 1896. The same law is expected to also support the Filipino farmers particularly those in the tobacco industry. Senator JV Ejercito is the main sponsor of the Senate Bill 1605 and Senate Bill 1896, certified as urgent measure by President Duterte.

Increasing tobacco taxes can have double implications. On the one hand, increase in tobacco taxes is expected to displace tobacco farmers. According to the World Health Organization, raising tobacco taxes is the most effective and cost-effective strategy for reducing tobacco use. Data below shows significant reduction in hectarage and the number of farmers planting tobacco for 2017 compared to 2015. However, production value per kilo seems to be on the rise –from 70.30 per kilo in 2015, Ph75.396 per kilo in 2016 and Ph75.66/kilo in 2017.

Table 1: Number of Farmers and Areas

Number of Tobacco Farmers and Areas (2015-2017)

TOBACCO TYPE	2015		2016		2017	
	No. of FCs	Area (In has.)	No. of FCs	Area (In has.)	No. of FCs	Area (In has.)
Virginia Tobacco	28,757	21,453	25,225	18,374	18,523	13,242
Burley Tobacco	8,995	6,324	9,151	7,417	7,370	5,028
Native/Dark Tobacco	8,779	4,984	9,249	4,857	8,572	4,434
GRAND TOTAL	46,531	32,761	43,625	30,648	34,465	22,704

Meanwhile, this tax legislation is also seen as positive because it can make available resources to facilitate alternative economic activities. Under the bill, sin tax collections will be earmarked for health and for tobacco farmers as provided for in RA 7171 which states that 15% of collected excise taxes on cigarettes should go to projects that support:

- Cooperative projects that will enhance better quality of products, increase productivity, guarantee the market and as a whole increase farmers income
- Livelihood projects particularly the development of alternative farming systems to enhance farmers income

[1]Child Labor in Agriculture https://www.ilo.org/ipec/areas/Agriculture/lang--en/index.htm.

- Agro-industrial projects that will enable tobaccor farmers in the Virginia tobacco producing provinces to be involved in the management and subsequemt ownerhip of these projects such as post-harvest and secondary processing like cigarette manufacturing and by-product utilization
- Infrastructure projects such as farm to market roads

Should the senate bill of Senator Pacquiao or Senator Ejercito pass, the tax on tobacco would translate to an estimate amount of Ph9 billion to Ph13.5 billion pesos for tobacco farmers.

II. ALTERNATIVE BUDGET PROPOSALS

1. AUGMENTING DA's BUDGET WITH AN INITIAL 10 BILLION FUND FOR RICE

We support proposals to immediately augment the budget of the DA to fast-track important competitiveness-enhancing programs while rice liberalization talks are ongoing and provisions for the set-up of a Rice Competitiveness Enhancement Fund is still being set up and tariff collections have yet to be accumulated. There is no reason why the government should wait to QRs to be lifted before acting on the threats that farmers face from cheaper imports. A proposal of 10 Billion pesos on top of the regular rice budget to cover initial measures below can be considered:

- Support an additional 500,000 rice farmers in their small machines requirement and social protection needs
- Provide support to some of the most vulnerable rice farmers and communities and promote low carbon rice technologies.
- Offer immediate grant support to 500 highly organized rice farmers groups to support them further in their competitiveness and productivity needs
- Support additional SFRs to encourage 2 seasons palay production in rainfed areas
- Capacity Building Support to Farmer Technicians and LGUs
- Among others

A. Assisting Small Rice Farmers in their Machinery Needs

The use of simple machines, low-maintenance, time and cost-saving farm devices appropriate for individual farm use and gender and age-appropriate farm devices to distriute to highly unorganized communities and farmers with small farm size. Some of these simple machines are:

- Rotary weeders
- Farmalyte for corn planting
- Rice harvester/grass cutter
- Water pumps for SFR beneficiaries

B. Social Preparation and Community Organizing

In order to better prepare for competitiveness, farmers need to be organized into strong self reliant organizations. To achiieve this, we need investments on community and preparing farmers into clusters and groups for market access and accessing support services as well as for community preparedness and facilitation.

C. Grants Support for Organized Farmers Groups

Immediate attention is to be given to organized farmers groups and their specific needs. Organized groups can have access to a grant support to help them improve farm efficiency, allow income diversification and social enterprise set-up. Activities that could be financed can include large grains processing centers, machinery rentals and services, insurance and credit retailing, market/ price information system on prices and trading services.

D. Social Protection for Rice Farmers

Crop insurance as well as individual life insurances can also be provided to our rice farmers, particularly the most vulnerable farmers.

E. Promotion of System of Rice Intensification (SRI).

SRI should not just be seen as water management rice technology but can also be promoted as a low carbon rice production technology. It is also improves production efficiency due to lower costs in seeds, gasoline and water use. Some argue that its labor intensive, but employing labor is not necessarily negative when labor displacement is becoming widespread due to the use of machines. It is also known to fare well with strong winds and extreme events because of the good root system that helps prevent lodging.

F. Support to SFR development.

The construction of small farm reservoirs in rainfed areas can intensify rice production by capturing rain water for use during the dry season.

G. Heavily-investing on Soil Fertility Measures.

According to Dr. Concepcion (BSWM), studies showed serious soil fertility reduction despite increased use of fertilizers. Over the years the use of chemical fertilizers have not really contributed to soil fertility as shown by table below indicating the nutrient substitution/supplementation happening in recent periods in farming in the Philippines. The same can be said of the growing pests problems that are usually addressed by harmful chemicals.

Table 2: Historical Data on Nutrient Substitution / Supplementation in Farming

Period	Fertilization requirement
1960-1970	Nitrogen fertilizer is required
1970-1980	Nitrogen plus phosphorus are generally required
1980-1990	Nitrogen, phosphorus plus potassium, including micronutrients are generally required in rice and Mg in corn

H. Comprehensive Resiliency Program For Poor And Vulnerable Communities Thru Expansion Of DA's Adaptation And Mitigation Initiatives For Agriculture (Amia) Program

Poverty reduction and climate resiliency actions should focus on the most vulnerable communities and municipalities. Based on poverty data and vulnerability to climate related hazards, Visayas

and Mindanao and those in the eastern seaboard can be given focus for its resiliency programming.

Resiliency is achieved with delivery of simultaneous actions for specific communities on the ground including the **installation of Climate Services for Agriculture.** Regular information for better production risk management and ensured productivity. Early warning is needed to help manage risks to farm production can help sustain productivity by providing dynamic advise and extension support including climate risks management advisories for farmers

For this purpose, we are proposing concrete support from village to village and simultaneous actions on the ground to deliver the following resiliency outcomes:

- Reduction of climate related losses in agriculture and fisheries
- Increased biodiversity count
- Increased incomes
- Reduced seasonality of incomes in agriculture and fisheries
- Achieved health well-being and preventive health in agri-fish communities
- Supported the most vulnerable
- Presence of Emergency support, quick response and social protection in times of disasters
- Increased adoption of low carbon/ghg farming technologies
- Organized communities for better market access and community preparedness

I. Set up of Community Seed Reserves to address Seed Needs for Locally/Climate Adapted Seeds

Community seed reserves and community-based seed production will promote seed availability and and address gaps for locally and climate-specific adapted seeds. The at the same time ensure availability of seeds in times of disasters.

J. Other Local Specific Actions to be Identified by Organized Groups

The competitiveness budget should also allow flexibility for organized groups to select the type of activities that they want supported based on their collective aspirations and productivity needs. This is subject to a small proposal request from farmers groups.

2. NFA'S BUFFER STOCKING.

We believe that the NFA should be retained, particularly its buffer stocking functions, to ensure that stocks will be available in case of calamities and emergencies. We believe that NFA should stock on local palay to ensure longer shelf life.

In the event of liberalized rice trade, NFA's buffer stocks should come from local farmers and NFA buying should be competitive and moves according to market prices instead of a fixed rate of 17 pesos per kilo.

Government subsidy for NFA will also save government billions of pesos in interest payments for its rice procurement activities. NFA pays 5B to 7B pesos in interest payments alone for bank loans for its rice marketing intervention programs.

3. REVERSING THE DECLINE IN FISHERIES AND ENSURING BENEFITS OF FISHERY MANAGEMENT GOES TO SMALL COASTAL COMMUNITIES

A. Support development and conservation of FMAs in 13 over-fished bays

Fisheries is usually a major driver in economic development in coastal municipalities, particularly in 13 major bay areas. Unfortunately, many of our bays are now overfished and its ability to sustain life and livelihoods are at risks. This will persist if no major conservation and management measures are immediately put in place.

For fisheries, we are proposing that BFAR initiate the delineation and demarcation of fishery management areas in 13 bays and bay-wide co-management and development planning with all stakeholders and providing an initial seed fund to support the implementation of the FMA co-management plan by all stakeholders. This is of course, to be implemented with counterpart funding from the different local government stakeholders of the bay.

B. Support to village level fish processing in order to optimize surplus production in highly regulated fishing areas

We recognize that fishery management (i.e declaration of closed and open season of some fisheries areas) are yielding positive results in terms of actual increases in fish catch in the area. However, this increase fish productivity has benefitted mainly the commercial industry since small fishers communities lack the post-harvest infrastructure needed to process the surplus fish. Thus to democratize the benefits of increased fish in the area, we call on government to set up village level community kitchens where they can sanitarily process fish surplus and offer income diversification to coastal communities.

C. Supporting Fisherfolk Cooperative Building in Areas with Community Fish Landing Centers

To fully benefit from the integrated operations of the CFLs, we are proposing the organizing of fisherfolk cooperatives. This will help in the operationalization of BFAR's CFL program in the different municipalities all over the country.

4. IMPROVING AGRICULTURE AND FISHERY GOVERNANCE BY BETTER LOCAL AGRI-FISH PLANNING AND CITIZEN PARTICIPATION

A. Sustained Private Sector Led Agri-Fisheries Implementation Monitoring

Program delivery needs to be ensured in terms of program beneficiaries, program usefulness, appropriateness, level of reach by the DA's service delivery. We are proposing additional budget to support the MAFC monitoring in other unfunded areas.

B. Piloting a Coherent, Responsive and Efficient Local and National Agriculture Planning

This aims to provide support and tools for Local Governments to conduct strategic, multi-year participatory comprehensive agriculture and fisheries planning. The DA can use the outputs as basis for RFO's programming and programs development. This ensures appropriate support and interventions are delivered and realistic outputs are achieved. This aims to avoid cases where DA support lay wasted because it is inappropriate for a certain area.

C. Trade Data Provision for Private Sector

This proposal aims to establish an accessible trade data system to be managed by PCAF. This data consolidation program aims to agri-fisheries stakeholders in making business decisions based on domestic and international data to achieve fair trade. PCAF will consolidate data submitted by different DA useful for their sectors.

D. Creation of a PCAF Special Committee for Women and Providing Funds thereof

A special committee on Women will ensure mainstreaming of gender concerns at the DA and to facilitate the women consultations for a more gender transformative programming and services.

E. Farmer-led Inventory of Rice Lands at the Barangay and Municipal Levels

Responding to the urgency of securing food and racing against land conversions, we need to do a people/farmer-led inventory of rice lands. This can be a simple tool that will be cascaded among organized groups, in cooperation and partnership with the LGUs. National and Regional offices, along with national CSOs and other sectoral councils, can help develop the concept and process.

5. REGISTRY OF CHILD LABORERS IN AGRICULTURE

While the national survey of PSA in 2011 says we have the 3.1 million children in child labor[2], the Listahanan database of the Department of Social Welfare and Development (DSWD) only recorded a total of 85,570[3] chld labor cases in the agriculture sector. There is a need to update this registry of child laborers so the national government can also include their families in the conditional cash transfer program of government and for monitoring compliance purposes in DOLE's Department Order No. 149-A, issued on Tuesday, January 17 2018, classifies farming-related work as hazardous and considers it one of the worst forms of child labor. The order reiterated the ban on employing children in the following activities:

- clearing of land, plowing, harrowing, irrigating, constructing paddy dikes, and cutting.
- Exposure to harmful fertilizers and pesticides, as well as carrying heavy loads, are now considered hazardous labor.
- Farming activities include grafting, budding and marcotting, and tending work involving weeding of soil.
- de-husking, scooping, sacking of products
- charcoal making
- hauling of products as led by animal guide
- loading and unloading of packed farm products
- coconut kilning and de-meating from shell or core
- sealing and carting of produce for warehousing
- transport to market and all ancillary work such as clearing cleaning, and recycling of farm waste
- rearing such as collecting, loading, unloading, and transporting of feeds
- maintenance and care of large and/or dangerous animals
- collecting and disposal of dead animals, animal manure, and other waste materials

[2] http://www.bwsc.dole.gov.ph/programs-and-projects-submenu1/clpep/help-me-convergence-program-against-child-labor.html

[3] https://www.rappler.com/nation/158769-dole-expansion-ban-child-labor-agriculture

- administering of vaccines and vitamins
- handling of disinfectants used for cleaning animal pens
- The order also strictly prohibits minors from working in slaughterhouses.

6. SUPPORTING FARMERS PLANTING TOBACCO

Farmers cultivate tobacco for various reasons. In a study done by Action for Economic Reforms, nearly half of the respondents say that they learned it from their parents who also grew tobacco and they took over their parents' land with nearly half of respondents. The second most common answer – nearly 19% - was the farmers' perception that it was the only viable crop for their land. The farmers' perception that tobacco had a ready market was another popular answer (~11%), as was the answer that tobacco producers influenced their decision (~10%). Meanwhile, when asked about why they continue to grow tobacco, more than a one-third of farmers still answered that they continue to grow because their parents did. However, more than 20% reported that they thought that it was the only viable cash crop. And ~18% pointed to the existence of a ready market for their tobacco.

Notably, the coefficient for experience is positive, suggesting that more experienced farmers are more open to switching. The FGD results suggested strongly that most farmers feel that there has been a long, steady downward trend in prices and profits, so their perspective is a longer term one. The coefficient for hectares dedicated to tobacco farming is negative suggesting that the farmers cultivating more tobacco are less likely to switch.

PROPOSED ALLOCATION OF THE EXCISE TAXES ON CIGARETTES

1. Multi-Year Comprehensive And Participatory Municipal Agriculture And Fisheries Planning

This study points to the need to better equip farmers in terms of information and skills necessary to make the shift to other alternative livelihoods. Livelihood diversification or even shifting away from tobacco should start with a comprehensive and participatory planning exercise to approach the livelihoods planning comprehensively and scientifically.

The Department of Agriculture has produced crop suitability maps to guide farmers on the best suited alternative crops to grow in their particular areas considering soil characteristics, climate and many more information. These information are already available online for livelihoods planning. Below are sample crop suitability maps for the 2 major tobacco producing areas such as Ilocos Sur and Ilocos Norte.

Figure 1. Sample crop suitability maps for Ilocos Norte

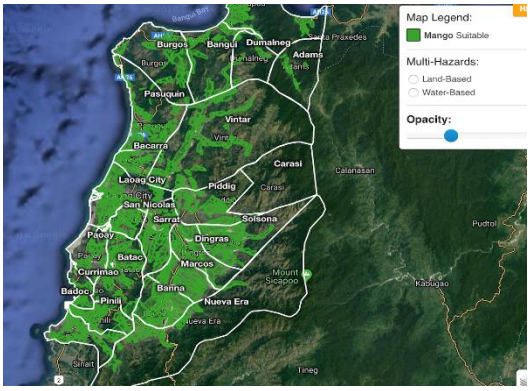
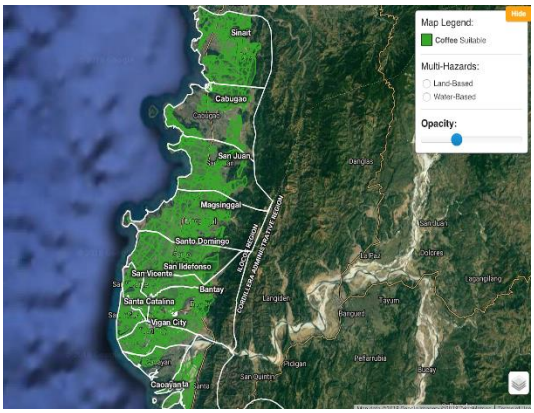
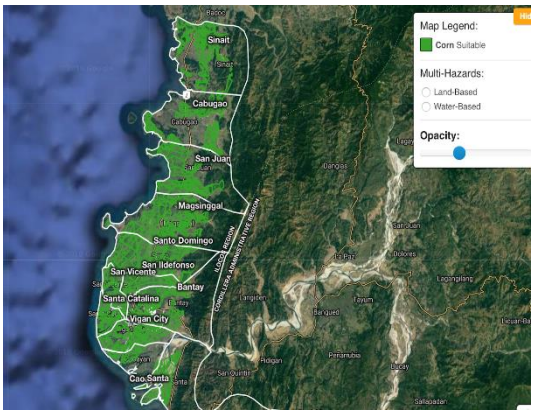


Figure 2. Sample crop suitability maps for Ilocos Sur





All tobacco growing municipalities should be assisted in getting maximum value from tobacco production as well as support those farmers to be displaced as a result of decreased demand with increased taxes. Using the available tools such as the farmers guide map as well as participation of farmers particularly of tobacco farmers in the planning exercise, the LGUs can carefully plan out the interventions. The DA Philippine Council for Agriculture and Fisheries can assist local governments in this exercise.

2. Support to Plan Implementation

Once plan is finished, an allocation from the collected excise taxes will support the municipal agri-fish plan in part. Allocation is dependent on the number of tobacco-growing farmers per municipality financing the multi-year plan. The support is aimed to support specific tobacco growing barangays in the municipality. (please see registry below)

3. Community Organizing

A critical component of the developmental work in tobacco growing areas is community organizing particularly to improving market participation in the value chain of tobacco farmers to improve incomes as well as to ensuring sustainability and viability of investments made to support the shift from tobacco to other viable crops.

4. Specific Support to Tobacco Farmers

Community organizations of shifting tobacco farmers as well as continuing tobacco farmers should also be supported in their collective plans and aspirations. To be able to support each, a group has to have a prepared organizational plan and propose a specific viable business model to be supported

Table 3: Registry of Tobacco Farmers by Municipality (from NTA website)

	Municipality	No of Registered Farmers
Abra (14)	Bangued	317
	Bucay	22
	Danglas	3
	Dolores	56
	Luba	122
	Manabo	1
	Penarubia	96
	Pidigan	345
	Pilar	1277
	San Isidro	570
	San Juan	25
	San Quintin	157
	Tayum	210
	Villaviciosa	309
Ilocos Norte (17)	Bacarra	176
	Burgos	32
	Pasuquin	278
	Piddig	255
	Sarrat	160
	Vintar	156
	Badoc	1343
	Batac	
	Currimao	267
	Dingras	422
	Espiritu	
	Marcos	365
	Nueva Era	210
	Paoay	64
	Pinili	
	San Nicolas	121
	Solsona	94
Ilocos Sur (27)	Cabugao	1710

	Magsingal	670
	San Juan	617
	Santo Domingo	60
	Sinait	1693
	Alilem	66
	Banayoyo	410
	Burgos	962
	Candon	1632
	Cervantes	24
	Galimuyod	605
	Gregorio del Pilar	543
	Lidlidda	275
	Nagbukel	646
	Narvacan	1764
	Quirino	159
	Salcedo	707
	San Emilio	818
	San Esteban	414
	Santa Cruz	888
	Santa Lucia	568
	Sta Maria	1002
	Santiago	1069
	Sigay	344
	Sugpon	9
	Suyo	16
	Tagudin	156
La Union (17)	Bacnotan	118
	Balaoan	850
	Bangar	211
	Luna	54
	San Fernando	238
	San Juan	198
	Santol	262
	Sudipen	135
	Agoo	171
	Aringay	280
	Bagulin	1
	Bauang	720
	Caba	149
	Naguilian	66

	Rosario	248
	Sto Tomas	164
	Tubao	109
Pangasinan (25)	Binmaley	1
	Mangatarem	11
	Bayambang	28
	Malasique	386
	Mapandan	10
	San Carlos	9
	Santa Barbara	107
	Manaoag	97
	Mangaldan	1
	San Fabian	941
	San Jacinto	131
	Alcala	714
	Bautista	8
	Binalonan	6
	Laoac	246
	Sison	191
	Villasis	619
	Asingan	46
	Balungao	334
	Rosales	32
	San Manuel	16
	Santa Maria	132
	Santo Tomas	32
	Tayug	1
	Umingan	5
Cagayan (13)	Alcala	502
	Baggao	229
	Gattaran	174
	Lasam	6
	Piat	83
	Rizal	46
	Amulong	1064
	Enrile	1
	Iguig	2
	Penablanca	64
	Solana	155
	Tuao	325

	Tuguegarao	454
Tarlac (8)	Anao	9
	Camiling	25
	Mayantoc	24
	Moncada	29
	Pura	5
	San Jose	22
	San Manuel	278
	Sta Ignacia	50
Nueva Ecija (2)	Bongabon	1
	Cuyapo	4
Kalinga Apayao (3)	conner	7
	Pinukbok	37
	Tabuk	5
Nueva Vizcaya (4)	Bagabag	39
	Bayombong	14
	Quezon	1
	Solano	3
Quirino (1)	Maddela	33
Ifugao (2)	Alfonso Lista	1
	Paracelis	3
Isabela (26)	Cabagan	652
	Delfin Albano	224
	Ilagan	751
	San Pablo	32
	Santa Maria	17
	Santo Tomas	393
	Tumauini	654
	Aurora	1038
	Benito soliven	38
	Burgos	196
	Gamu	59
	Malig	631
	Naguilian	15
	Quezon	121
	Quirino	1585
	Roxas	1413
	San Mariano	47
	Angadanan	1
	Cabatuan	137

	cauayan	33
	Luna	131
	Reina Mercedes	518
	San Mateo	48
	Echague	3
	Jones	21
	San Agustin	4
Mindoro (1)	Magsaysay	23
	Rizal	70
	San Jose	1299
Cebu (6)	Bogo	186
	Borbon	232
	Cebu City	3
	San	16
	Sogod	129
	Tabogon	36
Iloilo (8)	alimodian	46
	bn	42
	Cabatuan	9
	Dingle	173
	Janiuay	66
	Maasin	12
	Pototan	241
	alimodian	46
Leyte (4)	Calubian	115
	San Isiro	595
	Tabango	19
	Villalba	25
Negros Oriental (1)	Guihulngan	482
Bukidnon (2)	Damulog	53
	KIbawe	60
Misamis Or (6)	Alubijid	583
	El Salvador	256
	Gitagum	360
	Laguindingan	515
	Libertad	21
	Opol	20
Maguindanao (1)	Datu Montawal	231
Cotabato (1)	Pikit	471

Sarangani (1)	Alabel	43
Zamboanga del sur (3)	Mabuhay	139
	Olutanga	160
	Talusan	235
	193	52,827

TABLE 4: ALTERNATIVE BUDGET PROPOSALS

Objective	Main Strategy	Activities	Details	Existing Budget	Proposed
Rice Competitiveness, Productivity/ CCA Support					**10,000,000,000**
Social preparation and Community organizing			Social prep for the groups (500 groups x Ph500,000)		250,000,000
Grants to Organized Rice Farmers Groups	community-determined support service program subject to proposal	proposal on competitiveness measures support	Ph5 M x 500 groups can be Integrated services (i.e. rice milling, thresher, solar powered drying, shed, etc) or others		2,500,000,000
Supporting 10,000 small rice farmers (farms less than 1 hectare) from poor and vulnerable areas	Mechanization	Support individual farmers in their simple farm machinery needs	Rotary weeder (1500) Mechanical Cutter/harvester (10,000 /pc x 50000 beneficiaries) Farmalyte for corn planting (1500 x 50000 corn farmers)		75,000,000 500,000,000 75,000,000
SOIL conservation	Improving soil's water holding capacity and nutrient condition	Provision of 30 bags of organic fertilizer support to 10,000 farmers	30 bags/farmer @ 350/bag x 10000 farmers	BSWM	105,000,000
Water Capture and Reuse	Support to SFRs construction in el nino prone areas	Support to 10 sfrs per LGU	(75,000/sfr x 10 sfrs per LGUx 500 LGUs)	BSWM	375,000,000
		water pumps	50,000 x 500		25,000,000
Fast-tracking climate Actions in poor and vulnerable areas (priority areas	Support to more LGUs to do AMIA in additional 30 LGUs in Visayas and Minda	bundled/ comprehensive support programs from village to village per LGU/multi-year support. Range of support includes	□ CIS □ Ecological/low carbon technologies □ Livelihoods/social enterprise □ Support for insurance and credit	94,000,000 (DA SWCCO for est 30 LGUs)	150,000,000 (for addiitional 50 LGUs)

			Support to community organizing and marketing Community seed reserve and local buffer etc		
Promotion of Low GHG tech, water mgnt, cost saving production tech and biodiversity conservation	SRI Promotion	Season long training	Ph500,000 x 70 provinces		35,000,000
		Support to adopting farmers (i.e. seeds, extension, rotary weeder)	Ph500,000 x 70 provinces		35,000,000
Community Seed Reserves and Seed production	1 least 1 municipality per province		Ph10 M x 70 provinces		700,000,000
	Capacity building of women on seed storage and exchange; Women seed fairs		50 women farmers groups x 1 million		50,000,000
	Seed Support for most vulnerable and poor farmers		Ph2000 x 500,000 farmers x 2 seasons		2,000,000,000
Social protection for Rice Farmers	crop insurance and life insurance		P5000 x 500,000 small rice farmers		2,500,000,000
National and Regional Rice Summits	3 regional summits and 1 national				30,000,000
Farmers-led Invetory of Rice Lands	Action research for Food Self-Sufficiency	Meetings and workshops Data gathering and consolidation	PCAF		15,000,000
Technology Trainings and Support for Farmer Technicians/LGU Capacity Building					550,000,000
M and E for 10 B rice augmentation /rice competitiveness program					30,000,000
Rice Buffer Stocking					**17,000,000,000**
NFA Palay Procurement	to procure palay from local farmers for buffer stock and to help reduce NFA's interest payments to banks for their	procurement activities	Competitive buying (25/kilo budget x (15 day buffer requirement)		17,000,000,000

	market intervention programs				
FISHERIES MANAGEMENT AND ENSURING BENEFITS GO TO SMALL FISHERS AND COASTAL COMMUNITIES					**360,000,000**
Fishery Management Area (FMA)planning and implementation	delineation process, and	13 bays = 13 FMAs=	20,000,000 / FMA		260,000,000
	co-management planning	Multi-stakeholder (13 FMAs			
	plan implementation support (with co-financing from the different LGUs)	Livelihood support for communities			
		Fishery Management Development Activities			
		Secretariat operations			
		Fisherfolks/stakeholder mobilization and social prep			
Livelihood Support	Support to Village level processing	Establishment of community kitchens for processing in regulated fishing areas (closed seasonfishing grounds	20 kitchens x Ph 2,000,000 (Zamboanga peninsula, Visayan sea, Balayan Bay, Palawan, etc)		40,000,000
To set up fisherfolk cooperatives in all community fish landing sites	Social Prep	Econ Survey	First 200 CFLs Ph300,000 x 200	0	60,000,000
		General Assembly and Coop seminar			
		Business Planning			
		Plan support			
		Linking to ACPC and BFAR			
AGRI-FISHERIES GOVERNANCE					**95,500,000**
To ensure farmers/fishers /rural stakeholders/LGU input on DA's programs and implementation	LGU /Provincial Comprehensive, Multi Year, Risk Informed, Participatory Agri Fish Planning	Pilot of 4 provinces and its LGUs Ph500,000/LGU x 105 LGUs for participatory agri-fish planning Ph1,000,000 consolidation and planning process-province wide	Nueva Ecija-average yield per hectare at 5.9 (32 municipalities, plus provincial) Ilocos Norte- average palay yield at 4.97 (23 municipal govt plus provincial) Northern Samar- no 4 poorest in (2016) and ave yield at 2.77 (24 towns and provincial) Western Samar, No 14 poorest and ave yield at 2.70 (26 municipalities/cities plus provincial	0	56,500,000

Additional support for CSO monitoring down to the Municipal level	MAFC monitoring—	Monitoring operations and meetings	Expand operations from 512 MAFCs to 1611 MAFCs supported in their local monitoring activities	With existing PCAF budget	20,000,000
Increase substantive participation of rural women (farmers & fishers) in AFCs (all levels)	Establish special committee on women in agriculture (in all levels)	Meetings and conference/policy study on women's concerns and implementation of Magna Carta of Women (MCW) provisions	Regular pcaf women's committee meeting Conference for women stakeholders in agriculture Polic study		4,000,000
	Gender equality and women empowerment strategies	Provincial workshops to identify needs and priorities for local programs (pilot areas)			5,000,000
Data Information and sharing	PCAF's Trade Data Service	Establish an office/service for private sector accession of trade data	staff and operations requirement	without budget	10,000,000
EXCISE TAX ALLOCATION for TOBACCO FARMERS					
To strategically support both tobacco farmers that may be displaced by higher cigarette prices and continuing farmers in tobacco production	Multi-year Comprehensive and Participatory Agri-Fish Planning	municipal plans of 193 tobacco growing municipalities	Ph500,000 x 193 municipalities/provinces		96,500,000
	Support to Plan Implementation (i.e. FMR, livelihood diversification, insurance coverage,	Availability of financing to support plan implementation	Assuming Ph1,000,000 support for every 100 farmers registered per municipality to support Comprehensive Municipal Agriculture and Fisheries Plan (est. 60,000 farmers rounded off)		600,000,000
	Community Organizing and Social Enterprise Staff	Organizing of social enterprises of (former) tobacco farmers	Ph 30,000 x 24 provinces Ph 30,000 x 24 provinces Ph10,000,000 x 24 provinces MOOE		18,720,000 240,000,000
	Support to Municipal Organizations of Former Tobacco Producers and Continuing Producers	Additional Income support for tobacco farmers	Ph 5,000,000 x 193		965,000,000
	Monitoring and Evaluation	M and E planning	MOOE budget above		
				Subtotal	1,920,220,000

To locate child laborers in agriculture	Survey/Registry	Record of industries and families employing child labor			100,000,000.00
			TOTAL		**29,475,720,000**

ALTERNATIVE BUDGET PROPOSAL FOR EDUCATION

BUDGET FOR INCLUSION, PROTECTION AND WELL-BEING IN EDUCATION SYSTEM

I. DEVELOPMENT AND EDUCATION LANDSCAPE

Sustainable Development Goal 4 or Education 2030

Building on the successes and lessons of the Millennium Development Goals (MDGs), world leaders in the United Nations Sustainable Development Summit, in September 2015, adopted a new set of goals to serve as global framework in addressing development issues such as ending poverty, protecting the environment, democratic governance and peace building. The Sustainable Development Goals (SDGs) provide clear guidelines and targets for all countries to adopt in accordance with their own priorities and for mobilization of stakeholders and resources towards common goals.

Education plays an important role in achieving the SDGs. It is recognized by nations that the success of SDGs is driven by the education goal encapsulated in a stand-alone goal which is the SDG 4. SDG4 sets the education commitments of nations and further supported by world education community through the Incheon Declaration-"Education 2030 Framework for Action: Towards inclusive and equitable quality education and promoted lifelong learning for all ", signed in May 2015.

SDG4 attends to the 'unfinished business' of the Education for All (EFA) agenda and the education-related MDGs, and addresses global and national education challenges. It focuses on achieving access, equity and inclusion, quality and learning outcomes, within a lifelong learning approach.

Table 5: SDG Goal 4: Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all
4.1 By 2030, ensure that all girls and boys complete free, equitable and quality primary and secondary education leading to relevant and effective learning outcomes;
4.2 By 2030, ensure that all girls and boys have access to quality early childhood development, care and pre-primary education so that they are ready for primary education;
4.3 By 2030, ensure equal access for all women and men to affordable and quality technical, vocational and tertiary education, including university;
4.4 By 2030, substantially increase the number of youth and adults who have relevant skills, including technical and vocational skills, for employment, decent jobs and entrepreneurship;
4.5 By 2030, eliminate gender disparities in education and ensure equal access to all levels of education and vocational training for the vulnerable, including persons with disabilities, indigenous peoples and children in vulnerable situations;
4.6 By 2030, ensure that all youth and a substantial proportion of adults, both men and women, achieve literacy and numeracy;
4.7 By 2030, ensure that all learners acquire the knowledge and skills needed to promote sustainable development, including, among others, through education for sustainable development and sustainable lifestyles, human rights, gender equality, promotion of a culture of peace and non-violence, global citizenship and appreciation of cultural diversity and of culture's contribution to sustainable development;

4.a Build and upgrade education facilities that are child, disability and gender sensitive and provide safe, non-violent, inclusive and effective learning environments for all;
4.b By 2020, substantially expand globally the number of scholarships available to developing countries, in particular least developed countries, small island developing States and African countries, for enrolment in higher education, including vocational training and information and communications technology, technical, engineering and scientific programmes, in developed countries and other developing countries;
4.c By 2030, substantially increase the supply of qualified teachers, including through international cooperation for teacher training in developing countries, especially least developed countries and small island developing States.

Aside from SDG4, there are other SDGs that relate to education and in fact, education is crucial to the achievement of other SDGs. Some of them are the following:

- ✓ SDG 2.2-By 2030, end all forms of malnutrition, including achieving, by 2025, the internationally agreed targets on stunting and wasting in children under 5 years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women and older persons.
- ✓ SDG 3.7-By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.
- ✓ SDG 3.a-Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate.
- ✓ SDG 5.2-Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation.
- ✓ SDG 16.1-Significantly reduce all forms of violence and related death rates everywhere.
- ✓ SDG 16.2-End abuse, exploitation, trafficking and all forms of violence against and torture of children.

SDG4 will again be the pivotal important step in further development of Philippine education system. Philippine needs to create an enabling environment for the realization of the new education goals which is broader than the K-12 program. There must be sound policies and planning, efficient implementation arrangements and a significant and well-targeted increase in public spending on education.

Philippine Development Plan 2017-2022

The Ambisyon Natin 2040 envision that “The Philippines shall be a country where all citizens are free from hunger and poverty, have equal opportunities, enabled by fair and just society that is governed with order and unity. A nation where families live together, thriving in vibrant, culturally diverse, and resilient communities”. This vision further elaborated in medium term plan- the so called Philippine Development Plan 2017-2022 which include priority for accelerating human capital development.

Accelerating Human Capital Development

The PDP target is that by 2022, Filipinos will have more opportunities to develop their full potential. They will have better access to health care services and opportunities to acquire 21st century skills and competencies. At the same time, they will have easier transition to the workforce.

Strategies for Education

To create a globally-competitive knowledge economy, citizens must be provided with access to lifelong learning opportunities. These opportunities will be extended even to the vulnerable sectors and those who cannot be reached for formal education. The following strategies will be implemented to ensure lifelong learning opportunities for all:

To achieve quality accessible, relevant, and liberating basic education for all:

- Strengthen early childhood care and development programs.
- Pursue full implementation of the K to 12 program.
- Strengthen the inclusion programs to reach stakeholders outside the formal education system.
- Develop and improve interventions to keep children in school.
- Continue curricular reforms.
- Enhance teacher competencies.

These key strategies in basic education is further elaborated in the Ten-Point Agenda of the Secretary which gave emphasis to the importance of reforming alternative learning system and promote inclusion in public education system on top of fulfilling the support system to implement K to 12 program.

And strategies to improve the quality of higher and technical education and research for equity and global competitiveness are:

- Enhance community-based training for special groups.
- Provide access to equality and relevant Technical-Vocational Education and Training (TVET) opportunities.
- Ensure globally-competitive TVET programs.
- Expand access to higher education.
- Integrate 21st Century competencies.
- Promote creative arts.
- Strengthen Quality Assurance Mechanism.
- Improve research, innovation, and extension services.
- Expand Government-Academe-Industry collaboration.
- Promote excellence among higher education institutions.
- Allow and attract reputed foreign professors and researchers, especially in the Science, Technology, and Innovation Field, to be appointed in higher education institutions.

It is important to note that year 2018 is the first year of the implementation of the law on Universal Access to Quality Tertiary Education with the hope to facilitate inclusion and quality in higher education.

Strategies for Health

The government will work to improve nutrition and health. Below are some of the targets and strategies for health in accelerating human capital development which education sector plays a vital role.

- Provide quality nutrition and health care interventions at all life stages.
- Improve health-seeking behavior of the citizens, especially the most vulnerable.

Philippine Plan of Action on Eliminating Violence Against Children (PPAEVAC 2017-2022)

The plan aims for a safe environment for children, free from violence, abuse, neglect and exploitation (goal 3 of the strategic framework). Several strategies are necessary to achieve this goal; however, the most relevant strategy related to protection of children in school is strategy number 3.4 which states the "Reduction of all forms of violence against children from 80% in 2015 toward subsequently ending them by 2022.

The efforts on the promotion of positive discipline and modelling school contribute in three out of six of the intended outcomes of the plan such as parents and care givers are aware of and practicing evidence-based parenting skills and positive discipline towards building a safe, nurturing, and protective environment; children and adolescents demonstrate skills in managing risks, protecting themselves from violence, reporting their experience of violence, and seeking professional help when needed; and all VAC related laws are in-place and are effectively enforced.

II. ISSUES AND GAPS

Access to Education

The Philippines scored 82 (*with 0% indicating the right to education is absent and 100% representing the ideal best, higher number are therefore better*) in the 2016 Right to Education Index (RTEI). Philippines scored high in the area of Governance, but Availability and Adaptability indicators appear to present challenges to the satisfaction of the right to education, with indications of considerable deficits concerning Classrooms. Out of school education and education for Children with disabilities indicators also decreased the Philippines' RTEI scores. Cross-cutting themes further revealed that education Beyond K-12 and the overall state of education for children with disabilities are additional focus issues in the right to education in the Philippines.

Philippines ranks high as one of the countries with a sizable number of out-of-school children. The Philippine Statistics Authority (PSA) reported, in 2013 FLEMMS, that the number of children 5-17 years old not attending school was estimated at 3.249 M.

Table 6: Children 5-17 Years Old Currently Not Attending School By Age Group, Philippines (2009-2013 - In Thousands)

Age Group	2009	2010	2011	2012	2013
PHILIPPINES	4,344	4,153	3,660	3,500	**3,249**
5-9 years old	1,646	1,477	1,175	909	812
10-14 years old	771	763	649	688	628
15-17 years old	1,927	1,913	1,836	1,904	1,809

Source: Philippine Statistics Authority, 2013[4]

[4]Philippine Statistics Authority. 2014 Yearbook of Labor Statistics (YLS)–Chapter 6– Working Children. http://labstat.psa.gov.ph/ARCHIVES/YLS/2014%20YLS/STATISTICAL%20TABLES/PDF/CHAPTER%206/Tab6.2.pdf

Available figures from the Department of Education (DepEd) also show that there has been no significant movement in drop-out rates among elementary and high school students in the last ten years. Those children population that do not have access to basic education are from poor families, those living in far-flung areas, and marginalized communities.

Financing for Education

The Global Campaign for Education (GCE), where E-Net Philippines is a member put forward the "4S of Budget" as crucial in financing for education: 1) increasing the Share of the budget for education, 2)the Size of the budget overall, 3) the Sensitivity and 4)the Scrutiny of the budget. Countries including Philippines must dedicate 20% of national budgets as a reasonable 'share' for education. This benchmark is widely used (regularly referenced by GPE/GEMR) – though the Education 2030 Framework for Action opted for the range of "at least 15-20%", emphasizing that the least developed countries may need to exceed this. The other benchmark that is widely used is 6% of GDP should be spent on education.

The Philippine constitution states that "The state shall assign the highest budgetary priority to education and ensure that teaching will attract and retain its rightful share of the best available talents through adequate remuneration and other means of job satisfaction and fulfillment."

The general comment (GC) on Public Budgeting for the Realization of Children's Rights adopted in June 2016 by the United Nations Committee on the Rights of a Child (UNCRC) provides detail guidance for ensuring sufficient, equitable, and effective resource mobilization, budget allocation and spending for the well-being and protection of all children.

Basic Education Budget

The trend of budget for basic education shows upward trend which means steadily increasing through the years. The obvious factors are the implementation of K to 12 program adding Kindergarten in the elementary level and two years of Senior high school. The big amount of money goes to personal services which is almost 64% of the total budget, followed by capital outlay, 22% of the total budget, and monthly overhead and operating expenses, 14% of the total budget.

In addition, DepEd has this so-called big ticket items- a priority national program that support the implementation of K to 12 program and other priority policies of the department.

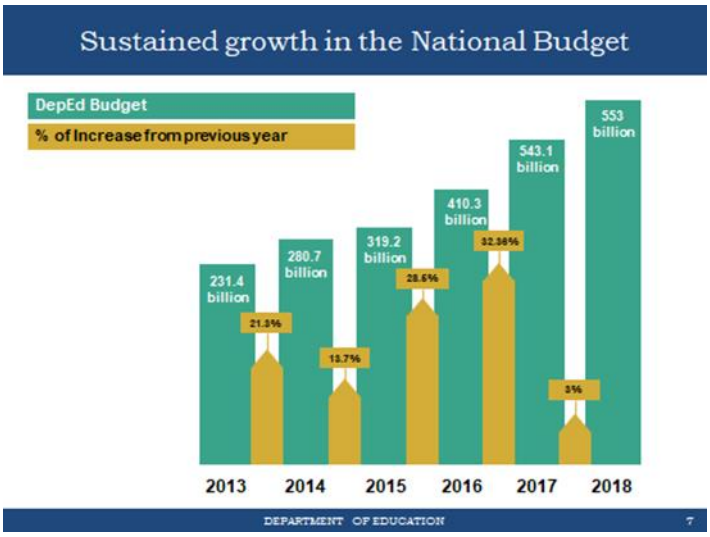


Figure 3: Sustained Growth in the National Budget

Table 7: 2018 Major Programs of DepEd

What are the major programs of DepEd?

Program	Amount in billions
Operations of Schools	305.02
Provision and Maintenance of Basic Education Facilities	105.46
Government Assistance and Subsidies	26.27
Computerization Program	8.65
Learning Tools and Equipment	7.8
School-Based Feeding Program	5.3
Human Resource Development for School and Non-School Personnel	3.41
Textbooks and Instructional Materials	2.99
Flexible Learning Options	0.53
Madrasah Education	0.51
Indigenous Peoples Education	0.13

Though budget increases in nominal terms, but in real terms is almost the same over the years. Also, in terms of GDP share, Philippine budget for education is pegged at 2.5% for the last ten years, slightly jumped to 3.1% in year 2018, but still fallen short of the UNESCO benchmark of 6% of GDP that should be spent to education. Philippines is behind its ASEAN neighbor countries such as Malaysia, Thailand, Singapore, Indonesia and recently overtook by Vietnam. This despite the need to invest more on education to implement K to 12 Program. The DepEd proposed budget for 2019 has drastically decrease and cut budget for inclusion programs. The government should not practice backward approach in financing for social services, including education.

The UN Committee on Economic, Social and Cultural Rights, observed the insufficient level of resources dedicated by the Philippine government to financing school facilities and qualified teachers, and to ensuring the effective enjoyment of the right to free primary and secondary education for all Filipinos.

Budget for Human Resource Development

The Philippine constitution states that “The state shall assign the highest budgetary priority to education and ensure that teaching will attract and retain its rightful share of the best available talents through adequate remuneration and other means of job satisfaction and fulfillment. However, government allocation is not enough and in fact decreasing from 55.07 Billion in year 2017 to only 45.16 Billion in year 2018. The decrease in budget allocation for new teaching and non-teaching personnel is due to almost 50% budget cut by the Department of Budget and Management indicated in the Veto Message of the President despite his campaign promise to increase salary of teachers. The DBM cut is also due to the low performance of DepEd to filled-out teaching position.

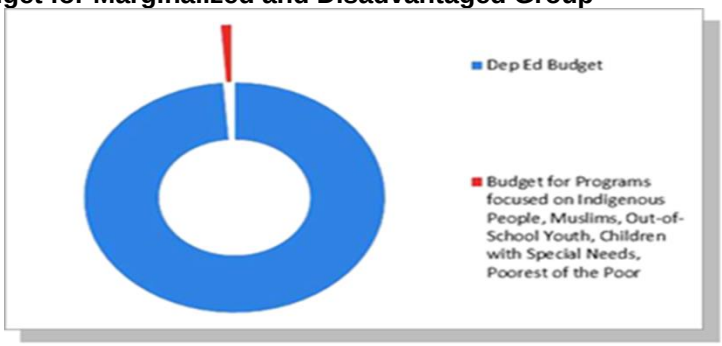
On the positive note, there are several special provisions of the GAA 2018 that provide benefits and welfare for teachers such as Php 5,000 Net Take Home Pay, Hazard Pay, Increase Chalk Allowance, and basic pay of teacher 1 due to tax exemption among others.

Strategically, government should uphold the constitutional mandate by ensuring that teaching will attract and retain its rightful share of the best available talents through adequate remuneration and benefits comparable to other profession like uniformed personnel. DepEd on its part should uphold and fully implement the RA7460 or the Magna Carta for Public School Teacher- a special law which cannot be superseded by any law, special provisions and interpretation. The constitutional and other legal mandate would address the clamor of teachers on adequate number of teachers, salary increase, welfare and benefits, work load, and more importantly dignity of teaching profession.

Inequitable Basic Education Budget

Budget allocation for education programs that cater to marginalized and disadvantaged groups including Indigenous Peoples, Muslims, and the out-of-school add up to a meager less than 1% of total budget for basic education. Aside from small budget allocated for inclusion programs, the budget for this programs are decreasing; case in point the budget for indigenous peoples education program which is 162 Million in 2016 and reduce to 130 million in 2018. Also the case of madrasah education program from 604 Million in 2016 and reduce to 505 Million in 2018. The same case with budget for education of children with disabilities from 50 million in 2017 and only 40 million in 2018. Aside from reduction of budget for education of children with disabilities, their budget is lump with Student Inclusion Division budget which is more difficult to track and inclusion of budget in the MOOE using Boncodin's Formula may not responsive to the budget needed for children with disabilities.

Figure 4: DepEd Budget for Marginalized and Disadvantaged Group



Child Protection Issues in Education System

The National Baseline Study on Violence Against Children commissioned by the Council for the Welfare of Children with support from UNICEF, last 2015 shows alarming cases of violence committed against children to wit:

- 80% (13-24 yrs. old) experienced violence, with high prevalence in males (81.5%) than females (78.4%).
- 59.2% experienced physiological violence.
- 65% experienced bullying.
- 43.8% experienced cyber bullying.
- 3 in 5 respondents or (66.3%) experienced physical punishment since childhood and occurred mostly 60% at home setting.
- 3 out of 5 children verbally abused, threatened and/or abandoned by their parents or guardians.

The CWC further reported that the situation has been exacerbated by rapid population growth, poverty, natural/human-induced disasters, discrimination, and poor access to social services.

DepEd also received increasing number of violence and child-abuse at school-setting through the years, the top cases are student bullying, corporal punishment, and a number of school-based gender related violence despite the issuance of DepEd's Child Protection Policy and Anti-Bullying Act of 2013. Many schools do not have trained guidance counselor and not functional child protection committee.

DepEd has allocated budget for strengthening child protection mechanism in school especially for enhancing the capacities of child protection specialist and teachers and students on awareness on Anti-Bullying Law. However, the budget allotment is insufficient and only for training of regional child protection specialist. For 2018, a total of 8.3 Million is allocated for capacity building of DepEd personnel on Child Protection to strengthen the Department's efforts to protect learners from violence in schools. But DepEd reported as of 3rd quarter of this year that this budget is still not being utilized and it will endanger/impact the future child protection budget of the Department based on the policy of the DBM.

Well-being Issues in Education System (School Health and Nutrition)

The ABI pushes for a whole of society approach in addressing health issues and therefore social determinants of health are important to address altogether in which education is critical. Education system plays important role in addressing issues related to access to safe and potable water and adequate sanitation in school, child nutrition and access to health-related education and information, gender discrimination, culture, among others.

UNICEF revealed in its paper on the Situation of Children in the Philippines 2017 alarming data related to health, nutrition, water and sanitation. Below are some of them:

- Infant mortality rate of 21 deaths in 1,000 live births and under-five mortality of 27 deaths in 1,000 live births (NDHS, 2013);
- 33% of children under 5 years are stunted (NDHS, 2013);
- 21.5% of children under 5 years are underweight (NDHS, 2013);
- Only 62% childhood immunization coverage, decline from 89% in 2013 to 62% in 2015 (WHO and UNICEF, 2015);
- Rising rates of teen fertility from 49 (in 1997) to 59.2 births per 1,000 women aged 15-19 years in 2015 (NDHS, 2013);
- HIV infections rose to 230% among at risk groups of young people between year 2011 and 2015;
- Contraceptive prevalence it at 42.8% among married women aged 15-49 years, with only 35.7% using modern methods;
- In 2017, 6.66% of the population continues to drink from unimproved water sources and only 75% of people use basic sanitation services;
- 5.74% of people also practice open defecation and a large number of schools; 3,819 lack adequate water and sanitation facilities.

DepEd in its part has been doing efforts based on its mandate to address some of these issues. In the case of wasted and severely wasted learners, DepEd implemented School-Based Feeding Program targeting around 1,836,793 learners in 2018. Though the policy objective of the program is to increase school attendance for wasted and severely wasted learners but it will not have significant impact with it comes to the nutritional status of learners. Besides, the program covers

only grades 1-3 before it was expand as envisage in the Law on National School-Based Feeding Program. However, Deped targets in 2018 and 2019 is remained the same based on the 2019 National Expenditure Program.

On access to water and sanitation facilities, DepEd has continued to provide water and sanitation facilities in both construction of new classrooms and repair of existing classrooms. However, still a large number of schools, lack adequate water and sanitation facilities based on UNICEF finding. The Right to Education Index in 2016 revealed that Score for school sanitation is at 77 (*with 0% indicating the right to education is absent and 100% representing the ideal best, higher number are therefore better*) because of the lack of clear standard on pupil/student to toilet ratio and current ratio of pupil/student to toilet is far from global standard.

On health-related education and information, it is among the top ten agenda of the Secretary to improve teaching of reproductive health in public education but needs drastic efforts to address issues such as integration of health and nutrition concepts in the school curricula, developing and providing adequate materials, training teachers to handle sexuality education, and teaching learners' skill on safety among others.

Government should address other issues like lack of adequate school nurse, changing mindset and modality of child immunization in schools.

On financing for school health and nutrition program, the current budget of the Department of Education in National School-Based Feeding Program and Water and Sanitation Facilities is not adequate. There should be funding for strengthening reproductive health in public education system.

School Inclusion

The UNCRPD defines accessibility for persons with disability to live independently and participate fully in all aspects of life, States Parties shall take appropriate measures to ensure to persons with disabilities access, on an equal basis with others, to the physical environment, to transportation, to information and communications, including information and communications technologies and systems, and to other facilities and services open or provided to the public, both in urban and in rural areas. Further, States Parties recognize the right of persons with disabilities to education by ensuring an inclusive education system at all levels and lifelong learning. DepEd shall enable children and youth with disabilities to learn life and social development skills.

In order to help ensure the realization of right to education of children and youth with disabilities, government should take appropriate measures such as employing teachers, including teachers with disabilities, who are qualified in sign language and/or Braille, and to train professionals and staff who work at all levels of education.

UNICEF in 2016 estimates there are about 3.3 million children with disabilities in the Philippines, or about 8 percent of the population between ages 0 to 18.[5] For children with disabilities, schools are often physically inaccessible or unable to cater to their needs. In fact, only less than 3% of Filipino children with disabilities has access to education.[6] Limited and un-updated data from the

[5]http://www.gmanetwork.com/news/lifestyle/healthandwellness/574156/unicef-focus-on-capabilities-of-kids-with-disabilities-ensure-their-rights/story/
[6]http://www.savethechildren.org.ph/our-work/the-challenges/education

DepEd reported that 97% of children with disabilities aged 7-12 years old were not in school (2007-2008). For SY 2015-2016, DepED has recorded around 250,000 enrollees with certain exceptionalities at the elementary level and around 100,000 at the high school level. It has recognized a total of 648 SPED Centers and regular schools offering special education program for CYWD - 471 for Elementary students and 177 for High School students. However, field data collected by the Philippine Coalition for the UNCRPD show that enrollment in the Special Education programs are predominantly fast learners / gifted, and not children with disabilities. Also, data has revolved only on enrollment (at start of schoolyear) figures and thus, is largely excluded from the rest of basic education programs and targets, and corresponding monitoring and evaluation.

DepEd efforts to ensure right to education of children and youth with disabilities has long way to go despite their policy on inclusive education. The Right to Education Index 2016 Score for theme of Children with Disabilities is 56 due to lack of reasonable accommodation measures for children with disabilities in schools, low percentage of teachers trained to teach children with disabilities, and small percent of children with disabilities that being reached.

The manifestation of which is DepEd's low target this year which is .99% or equivalent to 236,607 children with disabilities, mostly gifted children in 12,449 schools with allotment budget of 40 million from 50 million in 2017. In 2019 National Expenditure Program (NEP), the target is almost same, 1.04% or equivalent to 240,629 children with disabilities in 12,449 schools/centers.

The Philippine Coalition on the UNCRPD, in its 2013 Report on "Enabling CRPD-compliant Budget Advocacy" mentioned that for 2011, disability-specific appropriations for children with disabilities was estimated to be 0.44% of the DepEd budget (equivalent to 0.0510 of the national budget, and 0.00978 of the GDP). Budget utilization of national budget subsidies for Special Education Centers also display variable utilization, lapsed appropriations and even misutilization.

Government should use it available resources to progressively realize the right to education of children and youth with disabilities by investing on the following: Availability of educational and resources for learners with disabilities at all levels; training of teachers including sign language, and supported teaching staff, school counselors, psychologists, and other relevant health and social service professionals; hiring of Program Specialists in the DepEd such as Deaf/Filipino Sign Language (FSL) Specialist, Braille Experts among others; scholarships and subsidies for learners with disabilities pursuing tertiary education;

Meanwhile, the UN Committee on Economic, Social and Cultural Rights backed E-Net Philippines claimed on financing and privatization in education in its Concluding Observation of the combine 5th and 6th periodic review of the Philippine implementation of the Economic, Social, and Cultural Rights. Below are the summary of the findings of the committee on right to education.

- The insufficient level of resources dedicated by the State party to financing school facilities and qualified teachers, and to ensuring the effective enjoyment of the right to free primary and secondary education for all;
- The proliferation of so-called "low-cost private schools" at the primary and secondary level owing to inadequacies in the public school system, which have being expanded to the senior-high school level through the Senior-High School Voucher Programme;
- The low-quality of education provided by these private schools, the top-up fees to cover the full cost of private education imposed on parents, and the lack of regulation by State authorities of these schools, which have led to the segregation or discriminatory access to education,

particularly for disadvantaged and marginalized children, including children living in rural areas; and

- The high percentage of children with disabilities who are not fully included in the educational system (arts. 13 and 14).

III. THE ALTERNATIVE BUDGET PROPOSAL

The ABI education cluster reiterates its position that adequate resources must be invested to improve access, quality, protection and well-being of the poor and marginalized groups to education - putting more resources for those in need most and ensuring wise spending and accountability over the allocated budget. Along this line, it proposes the following key measures:

- *Investment to ensure free quality education of MEVs – urban and rural children and youth, indigenous peoples, Moro and learners with disabilities;*
- *Investment to ensure education of Out of school children, youth and adults;*
- *Investment to ensure education of people living in disaster and conflict-affected areas;*
- *Investment to ensure protection of children in schools;*
- *Investment to ensure well-being of children*
- *Investment to ensure inclusion of children with disabilities in formal education system and alternative learning system;*
- *Investment for teachers to improve their conditions and capacities and to provide quality of education;*
- *Improve efficiency and accountability of budget*

Table 8: DETAILS AND JUSTIFICATION OF THE PROPOSED BUDGET

Budget Item	2019 NEP Amount (in PhP'000)	Proposed Amendment (in PhP'000)	Amended Amount (in PhP'000)	Rationale
1.Implementation of alternative learning & delivery mode programs including establishment of learning centers;	306,637	450,000	**756,637**	PhP. 450 million additional yearly budget aims to contribute in reducing 3.2 million out-of-school children and youth in the whole term of Duterte Administration. The amended amount has corresponding increase in unit price of Alternative Learning System from roughly PhP2,000 to PhP3,000 per learner but still below global standard of $100 per learner. PhP3,000/Learner x 150,000 Learners = PhP450,000,000
2.Implementation of Indigenous Peoples	57,096	35,000	**92,093**	The additional PhP35 million for Indigenous Peoples (IP) education shall be used for the establishment

Education Program				of community learning centers (CLCs) in identified IP communities without access to government school. This is on top of the IKSP mainstreaming in selected public schools. E-Net proposes to allocate fund for enriching IP curriculum and IP Teacher, including IP Cultural Master. P350,000/CLC/Indigenous communities (ICs) x 100 CLCs in ICs= P35,000,000
3.Madrasah Education Program	359,863	114,119	**473,982**	The additional PhP114 million will aim to enroll and integrate additional twenty three thousand poor muslim through the Standard Madrasah Curriculum (SMC) as per DepEd Order No. 55. PhP5,000 subsidy x 22, 823 children to be enrolled in private Madrasah nationwide thru SMC = PhP114, 119,000. In addition, E-Net proposes to allocate fund for enriching madrasah curriculum and training of Asatidz in public school.
4. Education of Persons with Disability	0	33,200	**33,200**	The additional PhP33.2 million will be used for establishment of 100 resource centers. This is on top of the current implementation of education program for children with disability in public school while transitioning to full inclusive education. PhP332,000/Resource Center x 100RC = PhP33,200,000 This costing is based on the exercise done by the Philippine Federation of Deaf which includes teachers, sign interpreters, MOOE and Learning Materials.
5. Textbooks and other Instructional Materials	1,794,499	0	**1,794,499**	Prioritize funding for assistive devices and universal design materials for education of children with disabilities.
6. Policy Development in Child Protection-Review and	8,499	3,000	**11,499**	Part of the fund on child protection program should be used for impact assessment of DepEd's Child Protection Policy.

Impact Assessment of DepEd's Child Protection Policy				1,000,000 for each of the 3 regions sample equal to 3,000,000.
7. Policy Development in Child Protection-Research on best practices in child protection in school setting.	1,703,607	0	**1,703,607**	Allocate at least 3 million of the fund on policy and research program for research on best practices in child protection in school setting.
8. Teaching-related Human Resource (New School Personnel Positions	32,191,953	55,697	**32,247,650**	The additional PhP55 million for hiring additional 3,000 Teachers 1 for kindergarten, senior high school, guidance counselor, and interpreter in poorest regions.
8.1 Implementation of the grant of cash allowances, hardship pay, equivalent records forms (ERF), Conversion to master Teacher (MT) Re classification of positions and payment of step increments	6,150,422			Teacher Plantilla-PhP18,549 minimum salary per teacher x 3,000 more teachers = PhP55,647,000 For teachers' benefits, we urge the Secretary who has the sole authority as per Magna Carta for Public School Teachers to use the formula prescribed in the special law (i.e. 25% of annual salary of teachers expose to hazards). Php.10,000 increase salary across the board (salary grade 17), by three tranches.
8.2 Continuing Education – Teacher Quality and Development Program	8,169	1,700,000	**1,708,169**	The additional PhP1.7 billion will be used for Capacity building of public school teachers on child rights, inclusion and positive discipline in everyday teaching. The unit price of Php 3,000 per trainee will eliminate the current practice in in-service training that required registration fee from teachers attending IN-SET. Training-PhP3,000 per teacher x 500,000 teachers = PhP1,500,000,000 Training for SHS Teachers-PhP3,000 x 80,000 = PhP240,000,000.
9. School MOOE-Teachers' Seminar on roll-	57,647	0	**57,647**	Allocate fund for PD integration in the curriculum, continuing improvement plan of teacher in the

out of PD integration in School Curriculum				School Improvement Plan, and Learning Action Cell of Teachers.
10. Education, Skills and empowerment activities for children-rights awareness, leadership training, child protection risk assessment, reporting, social media skills, character building, and literacy on health-related issues and skills including sex safety and others- (Development and Promotion of Campus Journalism)	2,152	0	**2,152**	Used portion of the fund intended for Development and Promotion of Campus Journalism for Education, Skills and Empowerment Activities especially for members of the supreme pupil/student government.
11. Early Language Literacy and Numeracy	25,877	0	**25,877**	
12. ESC and Voucher Program for Non- Deped public senior high school	29,428	0	**14,714**	The 50% cut from subsidy to voucher program should instead be used to subsidize non-deped public schools like state universities and colleges, community colleges, TESDA training centers that offer senior high school. The arrangement is easier than allocating bigger funds to private schools which are not subject to COA. Vouchers can be considered as stop-gap measure while DepEd is transitioning to full provision of senior high school.
13. School Based-Feeding Program	3,967,473	2,600,000	**7,680,000**	The additional amount of 2.6 billion is twice the previous GAA of P3,840,000,000 x 2 (to cover 240 days for severely wasted and wasted learners; and add 4,360

				schools in the poorest regions) = P7,680,000,000. There must be effort to cover lunch meal.
14. School-Dental Health Care Program	2,281,547	0	**2,281,547**	School must have regular staff nurse to do the Dental Health Care Program not relinquishing to teachers. Portion of budget should be used for proper assessment and monitoring of health and nutritional status of pupils and students.
15. Education of People Affected by Disaster-Disaster Preparedness and Response Program Allocate portion of the Quick Response Fund amounting 2 Billion for this proposal.	135,119	26,500	**161,619**	The additional 26.5 million will be used for a DepEd comprehensive program for climate change adaptation and disaster risk-reduction program. This amount will be used for the following: ✓Plantilla position for dedicated DRRM officer/focal person per district/town ✓Awareness-raising and school-based hazard mapping ✓Training of Trainers on Disaster Risk-Reduction (ToT- 5 days) ✓Facilitate the provision of Education in Emergency ✓Facilitate curriculum and materials development-integration of environmental education and education for sustainability ✓Strengthening Solid Waste Management ✓School-mini carbon Olympics-competition on zero waste, water and electricity foot print-high school science teachers) ✓Gardening (Gulayan sa Paaralan) ✓CCA materials/poster inside classroom
16.a Basic Education Facilities- (New Construction including Water and Sanitation Facilities)	14,163,825	0	**14,163,825**	There should be special provision for ensuring potable water and adequate sanitation facilities, and accessibility and reasonable accommodation measures for establishment of new classrooms. Also, encourage Commission on Audit (COA) to include in the priority

				program for Citizens Priority Audit (CPA) the school building.
16.b Basic Education Facilities- New Construction including Water and Sanitation Facilities- Repair of Classroom including Water and Sanitation Facilities)	10,500,000	0	**10,500,000**	Ensure potable water and adequate sanitation facilities in repairing classroom, and accessibility of schools for children and youth with disabilities.
17. ECCD- Development of policies, standards, and guidelines	3,959	0	**3,959**	Include policy on referral for early medical assessment of children with disabilities.
18. ECCD- Capacity-Building and Institutional Development of Intermediaries and other Partners	23,268	0	**23,268**	Include funding for assessment of children with disabilities and training of Development Workers on Inclusion.

ALTERNATIVE BUDGET PROPOSAL FOR HEALTH

UNIVERSAL HEALTH CARE NOW!
"Kahit sino ka man, kahit nasaan ka man, kahit kalian, may de-kalidad na serbisyong pangkalusugan tungo sa buhay na may Dignidad"

Alternative Budget Initiative Health Cluster Proposal for FY 2018/2019 budget

People's Declaration of Principles for the Universal Health Care for All

We, from the network of civil society and people's organizations, members of the social/mass movement composed of more than 70 organizations collectively called ABI-Health Cluster-Social Watch Philippines, strongly support the push for the comprehensive transformation of an inequitable, narrow and fragmented health system to one that is human rights-based, responsive, and inclusive - a health system where no one gets left behind.

Universal Health Care ensures equal health care access for all, resolves the fragmentation of the health system, bridges the gaps and thoroughly reduces the steepness of the health gradient within, between and among groups, sectors and classes to achieve equity. It is one that works towards the progressive transformation of the health system while at the same time taking immediate affirmative actions to address each and everyone's distinct needs at different points in one's life course. This means pursuing a delicate balance of integrative, blended (targeted universal and/or proportionately universal, whichever is appropriate) approaches of 'health equity action' (Carey, Gemma 2015) and services for both individual and public health, cohesively achieving total human development.

From the mainstream fragmented, narrow and mostly vertical approach to health that is skewed towards disease management, we push for a Universal Health Care with the following key elements:

A. ON A RIGHT-TO-HEALTH APPROACH IN STRENGTHENING HEALTH SYSTEMS

1. Progressive Realization and Affirmative Action To Building A Responsive And Inclusive Health System.

We strongly adhere to the principles of human rights as a basic foundation of Universal Health Care; that the right to health is a fundamental human right of all. The State, as the recognized duty bearer, is obligated to respect, protect and fulfill the highest attainable standard of health. On the other hand, the citizens, as recognized claimholders, are responsible for claiming this right and taking control over their health.

Obligation to respect and fulfill. As dutybearer, the Philippine State should endeavor, as primary aim of the Universal Health Care, the progressive realization of everyone's right to the highest attainable standard of health. Specifically, this refers to the right of all to healthy living, working, schooling conditions ***and for sufficient quantity and quality promotive, preventive, curative, rehabilitative, and palliative health services that can be equitably accessed by all, without discrimination. Further, this is one that reduces out-of-pocket expenditures, is affordable and does not cause anyone financial hardship, when paying for services.***

At present, affirmative actions must already be undertaken to enjoy the benefits of an improving healthy environment/setting and health care services. In addition, Universal Health Care must ensure that its health actions are applied universally in a scale and intensity that are proportionate to the level of disadvantage of those who will receive them (WHO).

The right to health complements the other rights and is, at the same time, dependent on the fulfilment of other human rights in the economic, social, cultural and even political spheres. In fulfilling these other rights enshrined in various United Nations conventions and treaties, the normative elements of the right to health, such as: availability, accessibility (physical, economic and information-wise), and quality, should be fully realized, according to the people's needs and choices, among health providers, across long-neglected urban and rural near poor/poor and marginalized sectors – stateless/homeless, battered/abused women and children (including those in conflict with law), indigenous peoples (IPs), persons with disability (PWDs, including those with developmental, mental and intellectual disability), elderly and senior citizens, natural and human-induced crises' refugees, informal and precarious labor sector, farmers and fisherfolks, LGBTIQ, and others.

Obligation to protect. Universal Health Care, being a rights-based health system reform, should also strongly uphold public over corporate interests and trade influences from international institutions. The State, as dutybearer, must ensure that business enterprises, whether they are small, medium or large, be they national, multinational or transnational corporations, must respect human rights by strictly complying with set/to be set government regulations, standards, protocols and applicable laws (UN Guide on Business and HR). Appropriate and effective remedies and mechanisms should be in place, and can be accessed by the aggrieved party, as well as functional, when there is a breach or violation of set regulations (OHCHR). The latter ensures that the right to health becomes justiciable. Thus, we strongly support a Universal Health Care law with strict regulatory and conflict of interest provisions.

2. The Principles of Accountability, Transparency and Civil Society Participation At All Levels, Across All Health System Building Blocks.

We strongly uphold these principles because a rights-based approach to health is concerned with both process and outcome. It is not only interested with what the health system does (e.g. provision of health care services) but also, how it does things (e.g. transparently, in a participatory manner, without discrimination and ensures accountability).

With increased funding and demand for results, accountability becomes an intrinsic part of governance. It manages the relationships of various health stakeholders so that they may work seamlessly. Greater accountability also comes with effective oversight, in all stages of the health system; coherence, with the whole-of-government, whole-of-society and health in all policies approach; strong regulation, where violations against right to health and conflict of interest are remedied justly; and critical attention to health system design, where each government and societal institutions have roles to play in the fulfillment of the right to health.

On the level of civil society participation, we strongly reaffirm the Alma-ata Declaration on Primary Health Care (1978), which emphasized the full [meaningful and effective]

participation of communities in making practical, universally accessible, scientifically-sound, socially-acceptable and affordable [if there is an associated cost] methods and technology, so that communities and the country can maintain self-reliance and self-determination at every stage of development. We adhere to this because public health is one of the commons: collectively-owned/decided upon, and managed by the people together with the support of the State. Therefore, we strongly push for the establishment of public oversight and other participatory mechanisms at all levels, and across the health system's building blocks, so that everyone, regardless of gender, age, disability, nationality, color, ethnicity/race, religion, political orientation and status in life, can meaningfully participate in the decision-making process of an issue that impacts their lives.

B. COMPREHENSIVE, SYSTEM-WIDE TRANSFORMATION OF THE HEALTH SYSTEM

*3. **Comprehensive and integrative in content, scope and approach**.*

More than just the absence and management of diseases, equally important to address is the need for a healthy setting to achieve total well-being for a life of dignity.

To reach this, Universal Health Care should make each building block of the health system, including the horizontal and vertical programmes in place, work seamlessly to address the full range of physical, emotional, mental, social, spiritual and environmental influences that affect a person's health, (i.e., underlying / social determinants of health, or SDH). These include the conditions in which a person is born, grows, lives, works, and ages in, and the wider set of forces and systems shaping the conditions of daily life (WHO), such as the distribution of money, power and resources at global, national and local levels.

The most widely known SDH are: food and nutrition, water and sanitation, clean air and biodiversity, decent housing, decent work, public transport, safety culture, access to justice, peace and order, social support, and others. Normally, these are addressed by setting-up supportive physical and social environments at national and local levels through, inter-agency and multisectoral actions.

On the other hand, other complex SDH such as gender, family environment, relationship/non-relationship violence (e.g., rape), disability, and others, will need much more multisectoral and structural interventions such as the development of physical, social, attitudinal and environmental support (e.g., "corrective", nurturing relationships), which maybe beyond the current health programmes that the government offers. Universal Health Care as a comprehensive, integrative and responsive health system must still be able to provide for these distinct needs.

*4. **System-wide transformation***

For transformation in the health system to happen, we fully support a Universal Health Care that will embark on radically changing the current system to include, but not limited to, the following: a) re-organization, streamlining and setting-up of new inclusive, coordinative and participatory mechanisms, while at the same time dismantling and eliminating all discriminatory practices; b) system-wide re-orientation of planning, implementation, monitoring and evaluation of programs, within and outside the DOH; c) recruitment, retraining/re-orientation, retention, regulation and periodic reassessment of health workers and administrative personnel in the DOH; d) re-allocation and consolidation of all available resources and generation and mobilization of new, additional fund sources

within the State to ensure sufficient and sustainable funding for Universal Health Care and its related programmes; and e) the collection, organization and analysis of regular, accurate, disaggregated, interoperable data and development of a more proactive research agenda that addresses currently non-prioritized, neglected issues and concerns, but have major impacts on the health of the people.

As part of the system-wide transformation, we strongly propose primary care to be applied in the Universal Health Care for the people's easy navigation of the health system and its service delivery networks (SDN). This would also mean the expansion of the health workforce pool that will service the SDN, to include professionals, community-based workers (barefoot doctors/nurses, BHWs, BNS, CHWs, indigenous healers, therapists and personal assistants and others) – with or without disabilities – and people's organizations and NGOs that have long-served geographically-isolated and/or disadvantaged areas that filled the gaps of government in the provision and delivery of services. More than just recognition of the latter, this can be an example of a model of "people helping people" or public-public partnerships that the State should harness and incentivize through provision of fund sources and in-kind support, and when needed, further capacity-building.

For the mainstream health workers, a safe, supportive, conducive and decent working environment (i.e., security of tenure, living wage with benefits) within the facilities and the communities where they work, must be upheld by the UHC so that they may function well to serve the people.

5. An enabling and empowering health system that is context-specific and based on need

We strongly uphold a Universal Health Care that believes first and foremost, in the ability of the individual and the body to heal itself, and likewise, in the ability of the community to participate in the development and management of their own local/alternative health/health care system as the fulfillment of their aspiration for sovereignty and self-determination.

There are already concepts in public health, such as primary health care and health promotion, which recognize and support the process of enabling people to take control over their health. Universal Health Care must be able to reclaim these and allow people to participate in the healing process of their own well-being, their communities and the environment. Therefore, in the Universal Health Care, the people become an integral part of transforming and strengthening the health system, making them partners/providers and not mere beneficiaries of health services.

The vibrancy of progressive social movements in the country, with years of accumulated lived experiences and involvement of people in various in-depth issues and struggles, have enriched their knowledge and skills. These ought to be recognized because they offer the necessary foresight, wisdom and unique expertise, which make their proposals and recommendations more appropriate and grounded. We firmly support a Universal Health Care that democratizes and expands its sight to such expertise, beyond solely what scientists, medical and health professionals can offer.

Consistent with the individual (body)'s ability to heal itself, and paramount to the implementation of the Universal Health Care, is the integration of the various indigenous and emerging complementary and alternative health care systems into mainstream

modern medicine. People-centered health care means expanding people's options and empowering them to choose the most appropriate healing system according to their needs and conditions.

We support an integrative Universal Health Care, which applies context-specific, holistic strategy in dealing with various health issues because each individual/community needs is distinct. Interventions to address these differing health concerns must be appropriate, available, accessible, affordable, acceptable, safe and effective to help people and communities regain and/or maintain optimal health.

We push for a Universal Health Care that will be formidable as a safeguard against 1) a practice or tendency to prioritize corporate interests and trade influences over public health interests, 2) natural and human-induced crises, and 3) further health inequity, impoverishment and discrimination.

We consider these principles as our absolute bottom line that define our framework for a genuine, truly pro-people Universal Health Care. We strongly urge that these principles be operationalized in the entire (and in all sections of the) Universal Health Care Act and its IRR.

OUR PEOPLE DESERVE NO LESS.

The Health Situation: Inequities Persist

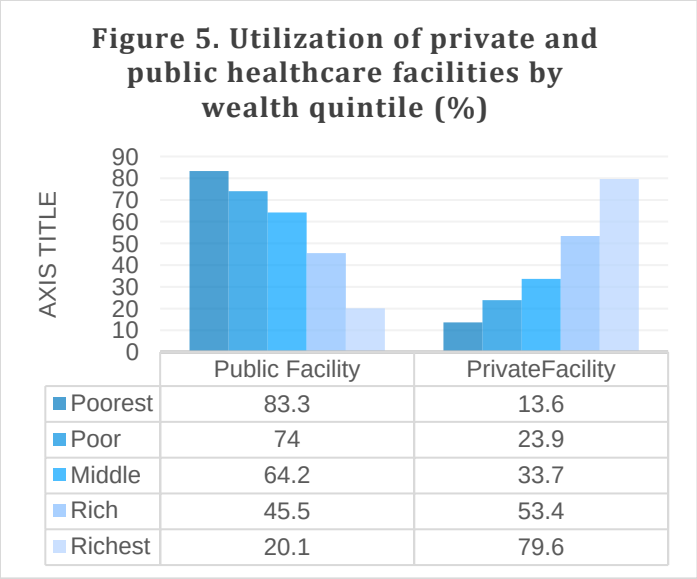
The diseases the country faced decades ago hardly changed. Infectious diseases, such as tuberculosis and pneumonia, cause most deaths. Non-communicable diseases (NCDs), such as stroke, heart attack and cancer brought about by modernization and deteriorating lifestyles continue to rise, leading to 300,000 deaths a year. This double burden has strained the healthcare delivery system to its limits, exacerbating inequities in health care access and health outcomes from womb to tomb.

Table 9. Top 10 Causes of Mortality, Philippines
Number and rate/100,000 population
Three-period trend: 1993, 2003, and 2013

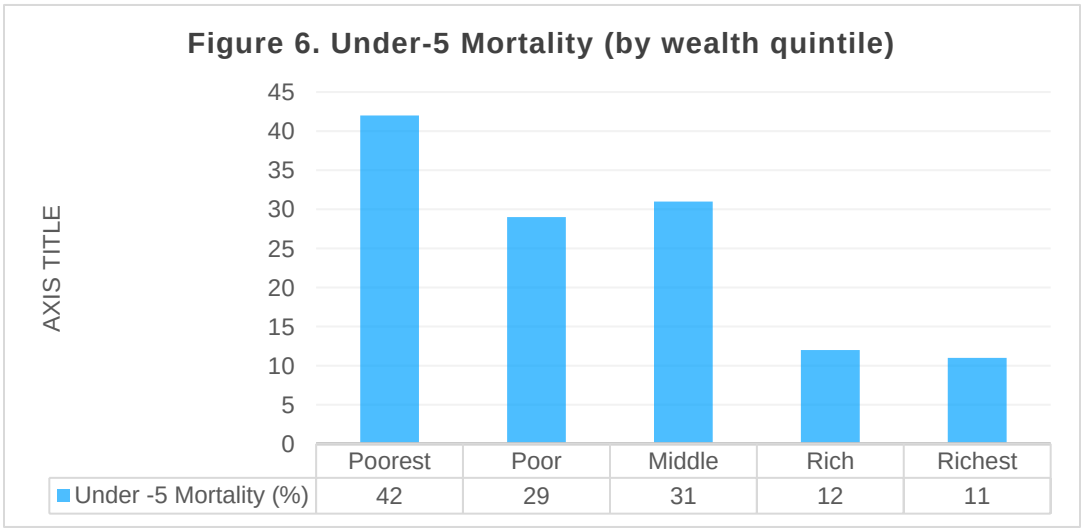
1993			2003			2013		
Causes	Number	Rate	Causes	Number	Rate	Causes	Number	Rate
Diseases of the heart	48,582	72.5	Diseases of the heart	67, 696	83.5	Diseases of the Heart	118,740	121.1
Diseases of the vascular system	37, 358	55.8	Diseases of the vascular system	51, 868	64.0	Diseases of the vascular system	68,325	69.7
Pneumonia	35, 582	53.1	Malignant neoplasms	39, 295	48.5	Malignant neoplasms	53, 601	54.7
Malignant neoplasms	25, 399	37.9	Accidents	33, 966	41.9	Pneumonia	53,101	54.2
Tuberculosis (all forms)	24, 580	36.7	Pneumonia	32, 055	39.5	Accidents	40, 071	40.9
Accidents	13, 477	20.1	Tuberculosis, all forms	26, 771	33.0	Diabetes mellitus	27, 064	27.6

Chronic obstructive pulmonary disease and allied conditions	11,154	16.7	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	21, 363	26.3	Chronic lower respiratory diseases	23, 867	24.4
Other diseases of the respiratory system	6, 955	10.4	Chronic lower respiratory diseases	18,905	23.3	Tuberculosis, all forms	23, 216	23.7
Diarrheal diseases	5, 759	8.6	Diabetes mellitus	14,196	17.5	Nephritis, nephrotic syndrome and nephrosis	14, 954	15.3
Nephritis, nephroyic syndrome and nephrosis	5, 510	8.2	Certain conditions originating in the perinatal period	14, 122	17.417	Certain conditions originating in the perinatal period	10, 436	10.6
Source: Department of Health, http://www.doh.gov.ph/sites/default/files/publications/2013%20Philippine%20Health%20Statistics.pdf Table from WomanHealth Philippines, 2016								

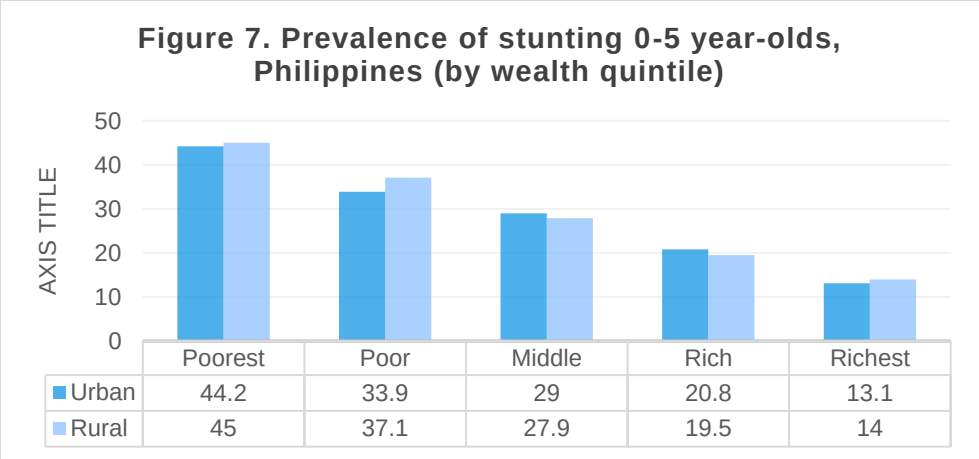
Citing a 2013 Acta Medica Philippina journal article, a Primary Care roadmap drafted by the Coalition for Primary Care and Universal Healthcare Study Group (2015) noted that only 33 percent of the poor are able to utilize their PhilHealth benefits, compared to 88 percent among the rich. This is despite claims of 100 percent health insurance coverage. Even more disturbing, as shown in the roadmap, is that almost six of 10 deaths among Filipinos are unattended by any healthcare provider.



In addition, the latest 2017 National Demographic and Health Survey reports the irony that while the majority of health facilities are provided by the private sector, these remain beyond the reach of the majority of Filipino households, most of whom are low-income earners and are from the poorest brackets. Instead, poor Filipinos resort to medical confinement in extremely crowded places, treated by dedicated but overworked doctors and nurses in public health facilities which are oftentimes inadequate, run-down and neglected (see figure 5).

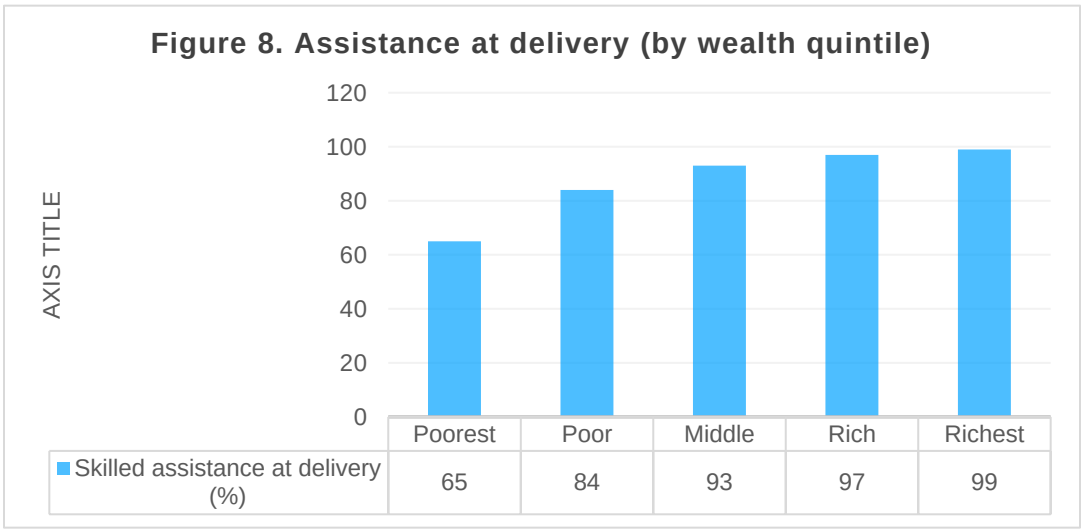


Source: 2017 Philippine National Demographic and Health Survey, computations by ABI Health Cluster



Source: 8th National Nutrition Survey: Malnutrition among 0-5 years old show that the poorest households are almost 4x likely to suffer from stunting compared to the richest households.

More children from the poorest and poor households do not live past the age five. The percentage of under-5 mortality among children among the middle-income households is also interesting to note.



Source: 2017 Philippine National Demographic and Health Survey

Assistance at delivery is least among the poorest households. The 2017 NDHS reports that births among the poorest are delivered by midwives and traditional birth attendants and hilots (31% each).

Most of the perennial causes of mortality and morbidity (see Table 9) may only be completely addressed by involving other agencies and employing a whole-of-government approach. However, it is still imperative that the DOH leads and shepherds other national bodies and local government units in addressing the health outcomes.

One example is the deaths and disabilities caused by road accidents under the jurisdiction of the Department of Transportation (DoTr), Department of Public Works and Highways (DPWH), and other concerned government bodies. The roads are no longer safe for the people. 'Accidents' is constantly on the top 10 causes of deaths in the country. Another example is food insecurity, which shapes hunger and malnutrition. These directly impact on health outcomes – stunting of growth, other ailments, etc. It is thus imperative that the health outcomes should define the national food production program and therefore, health becomes an integral part of the Department of Agriculture's mandate. A case for an agriculture-health convergence is synergy in managing Non-Communicable Diseases (NCDs) which aims to "*derive insights from information from the health sector to guide agriculture in responding to needs related to NCD management.*" (Lizada, 2015)

Challenges in the Health Sector

Administrative fragmentation, health policy fragmentation through vertical programming, and workforce shortage are among the main challenges in the health sector. The Coalition for Primary Care and the Universal Health Care Study Group (2015) outlined these problems, causing the inability of the healthcare system to cope with the double burden of disease thus, exacerbating existing inequities in health in the country

Workforce Shortage

Despite the fact that more poor Filipinos use public health facility, of the 66,000 physicians, 500,000 nurses and 74,000 midwives registered with the Professional Regulation Commission (PRC), only 3,000, 5,000 and 17,000, respectively, work in a public facility as of 2013. This means that for every 20,000 population in many areas, only ten healthcare workers – usually one physician, two nurses, and seven midwives are serving them. This number is much less than the 50 per 20,000 threshold set by the WHO, as a target number needed to address the Millennium Development Goals (MDGs) of just the maternal and child health. This estimate excludes the needed human resource to address chronic, non-communicable diseases and other infectious diseases. It must be emphasized however, that these estimates are based on highly unreliable data on the number of actively practicing doctors, nurses, and midwives in the country. Available data do not reflect the accurate number on the supply of dentists, pharmacists, occupational therapists, physical therapists, speech pathologists, medical technologists, nutritionists and other allied medical professionals, including our partners in healthcare, the community health workers. The government had attempts to curb this problem. Between 2010 and 2014 for example, the DOH deployed 324 physicians through the Doctors to The Barrio (DTTB) Program. However, the impact of these numbers on doctor-to-population ratios is minor.

Administrative Fragmentation

In a decentralized system with 7,169 islands, 81 provinces, 144 cities, 1491 municipalities and 42,000 barangays, the absence of a clear mechanism for coordination creates a huge challenge for healthcare management. The Local Government Code of 1991 envisioned a responsive delivery of health care services grounded on the needs and context of the people. Under this law, the DOH is mandated to govern the over-all public health system, and achieve the national health indicators. On the other hand, local government units (provinces, cities, and municipalities) are tasked with the management of local health systems.

This incomplete administrative devolution has resulted in the fragmentation of health care services. The supply chain, in particular, was disconnected, mainly because local spending for critical health inputs (e.g. human services) has become politicized, haphazard and insufficient. This caused great discrepancies between national programs and local capacity in the delivery of services, especially to underserved areas.

Health Policy Fragmentation

Currently, the DOH has 46 distinct healthcare programs addressing various health problems in different sectors of society. Typically donor-driven and motivated by commitments to the global community, these programs and projects are developed and implemented in the context of ever-changing health priorities. They may utilize different facilities, and financial and human resources, however similar or interrelated their objectives may be. Such an approach to healthcare delivery has four adverse consequences:

- Because planning is independent and uncoordinated, this system usually results in health policies that are either ineffective or inefficient. Narrowly focused health programs fail to benefit from the prioritization and coordination seen in integrated solutions.
- The system sometimes leads to disintegrated healthcare rather than a holistic healthcare, failing to pay attention to multiple interacting factors within individuals and within communities. People sometimes find themselves confused on where to go for a specific health concern.
- Program fragmentation also contributes to worsening inequities in healthcare. Because some programs favor specific sectors, disadvantaged populations may be left out.
- Lastly, these programs overburden healthcare workers themselves. Each new program represents additional responsibilities for providers who are already underpaid and overworked.

Health and the Sustainable Development Goals

The SDG 3 on health states, “Ensure healthy lives and promoting well-being for all at all ages reflect an expanded understanding of health across the lifespan.” The health MDGs include Reduce Child Mortality, Improve Maternal Health, and Combat HIV/AIDS, Malaria and other Diseases. These now fall under the 13 targets of SDG 3, which include sexual and reproductive health, maternal, newborn and children under-five deaths, pollution, road safety, tobacco and alcohol control, non-communicable diseases, access to services and commodities, human resource, and universal health coverage.

A multisectoral, whole-of-government, yet non-programmatic approach is effective in addressing the SDGs. Health in All Policies (HiAP), as stated in the Pan-American Health Organization (PAHO) Strategic Plan 2014-2019, is an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts in order to improve population health and health equity. It involves synergy between health promotion, social determinants of health, and human rights. This approach can link the goals, means and priorities associated with health in the SDGs. Achieving progress in SDG 3 necessitates coordination with the targets in other goals by which HiAP can be one of the means. However, its effectiveness at the national level is said to also depend on local government policies. (Fonseca, 2016)

Figure 9: Health in the SDG Era

Health is shaped by and affects all other sustainable development goals and targets. The linkages between health and other social, economic, cultural and political factor operate both at the individual and the societal level. The unfair and avoidable differences in health status seen within and between countries lie at the center of health inequities, with particular focus on disadvantaged groups that are excluded from social services such as a good education, health care and economic participation while facing higher burdens of disease and disability. The determinants of health interact with each other, leading to compounded inequities for the disadvantaged groups. (Government of South Australia & World Health Organization, 2017)

Despite the more comprehensive nature of the sustainable development goals and the expanded indicators on health, the perpetuating inequity within and among nations is still one of the main challenges in pursuing universal healthcare.

Whole Government Approach to Health/Health in All Policies

Context shapes health outcomes. It is the complementation of multiple development factors that determine the nation's health. Improvement in the health sector accounts for only 20% for the change in health status, while improvements in the social conditions account for the larger 80%. (Paterno & Herrera, 2010) It is imperative that the analysis and understanding of the health

situation include not only diseases but the social determinants of health[7], such as access to safe and potable water and adequate sanitation, food safety, food sovereignty and security, nutrition and housing, healthy occupational and environmental conditions including roads and public transportation, access to health-related education and information, gender discrimination, culture, among others.

To achieve true Universal Health Care, the social determinants of health need to be addressed as part of the comprehensive health systems approach. As such, the health and well-being of Filipinos should be considered the responsibility of the whole government, national and local, across agencies and institution. In this way, government resources will be used a most effective and efficient way.

In 2015, ABI Health Cluster began pushing for a whole-of-government approach to health and Health in All Policies – "an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts in order to improve population health and health equity." (World Health Organization, 2014). The continuing government-people partnership towards an improved health system is a critical ingredient in achieving equity, efficiency, quality, transparency.

An initial review of the alternative budget proposals from across clusters on education, social protection, agriculture, environment, indigenous peoples, and persons with disability for a decade (FY 2007-2017) shows that there are main proposals on determinants of health that cut across health and other concerns such as increased health and nutrition services (for in- and out-of-school youth and children), water, sanitation, and hygiene (provision and access to clean water), construction of rural roads, health promotion, child and adolescent and women-friendly spaces, Universal Social pension for older persons and budget for allowance for persons with disabilities personal assistants and sign language interpreters, ecological waste/water management, health human resources for primary care (first and continuing point of contact across the population; navigation of health services), support for irrigation and organic farming, and accessible health services for marginalized groups (health facilities, national health insurance corporation benefits)

The central tenet of the SDGs is "leaving no one behind." Achieving SDGs this way requires new ways of working by bringing together various government sectors, civil society, academia, development partners and communities. Governments and their partners to be more political, systemic and holistic in their thinking, recognizing linkages across health programs and sectors of policy-making in order to achieve the sustainable development agenda. (Government of South Australia & World Health Organization, 2017)

The Philippine Government Health Agenda: FOURmula One Plus

The new government's health agenda under the leadership of Secretary Francisco Duque III, the FOURmula One Plus framework focuses on these goals: better health outcomes, responsive

[7] Social determinants of health are the conditions in which people are born, grow, live, {learn}, work, {worship} and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels which are themselves influenced by policy choices. Accessed from the World Health Organization Website: http://www.who.int/hrh/resources/Ebook1st_meeting_report2015.pdf?ua=1 on 26 August 2015.

health systems, equitable healthcare financing with outcome/output on health financing, service delivery, regulation, and governance. As the health agenda is set to launch in the following days as of this writing, stronger and bolder DOH leadership in addressing the determinants of health in the context of the onset of a Universal Health Care Act, is crucial towards improving health outcomes.

ABI Health Cluster Proposal: The People's Health Agenda

The People's Health Agenda (PHA)[8,9], crafted through consultation and discussion among ABI Health Cluster members in 2016, follows the guiding principles of primary health care as a strategy to achieve the proposed goal: (1) the Q4A of health services, the core contents of the right to health: quality, accessibility, availability, affordability, acceptability; (2) partnership between the people/ communities and health agencies in the provision of quality, basic and essential health services; (3) community participation; (4) self-reliance; (5) recognition of interrelation between health and development; (6) social mobilization, and (7) decentralization (Galvez-Tan, 1996).

The PHA is guided by the following Vision, Mission, Goals, framework, and principles:

Table 10. The Alternative Budget Initiative Health Cluster – Social Watch Philippines People's Health Agenda (2016-2030 vision)	
Vision	Equitable health for, from and by the people in an ecologically-sustainable world. With emphasis on "equity" and "ecologically-sustainable," making big difference in the context today from the Health for All by 2000 of the Alma Ata Declaration.
Mission	Build a strong/formidable integrative health care system that can: (1) provide quality health care services, reaching even the remotest of areas; (2) address the relevant political and economic changes, and (3) respond to the new health challenges affecting the health care of all Filipinos in the global community.
Objectives	1. Redefine the Philippine health care system to achieve a happy, healthy and dignified life or all. 2. Strengthen the front-liners toward building an integrated health system. 3. Address the social determinants of health. 4. Protect the environment. 5. Ensure the sustainable allocation of public funds for health, and its efficient use to reduce inequity.
Framework	Building an integrated health system to support an integrative health care delivery system
Strategy	Primary Health Care (PHC) Human rights-based approach to health using the Q4A indicators and that health is a responsibility of all while an obligation of the state.
Key Principles	1. Health remains to be a common/social good and not a commodity 2. Self-reliance, community participation and partnerships – People are not mere beneficiaries but actors/partners of the system.

[8] Not to be confused with the Philippine Health Agenda (PHA) of the Philippine Government
[9] Consolidated draft by Steering Committee Member, Maria Fatima Villena

	However, they need support to be self-reliant, especially the marginalized communities. 3. Use of biomedical, local and indigenous resources (traditional medicine) and complementary and alternative medicine for health problems (whichever is needed depending on the context) 4. Health and health care service delivery are needs-driven 5. Solidarity beyond personal health
Focus (initial)	Primary Care/Strengthening the Frontliners
Other issues to address	Health Inequity, Health System Fragmentation, Health Governance/Leadership, and Social Determinants of Health
Time Frame	2016-2030 (14 years)

To operationalize the key principles, ABI Health Cluster identifies three major areas and proposals on three determinants of health: Water, sanitation and hygiene, food and nutrition, and access to rural roads (table 12)

Table 11: Proposals for key determinants of health

DETERMINANTS OF HEALTH PROPOSAL CONTENTS

[1] Water, Sanitation, Hygiene: access to clean water, sanitation facilities
[2] Health and Nutrition
[3] Road Access and Safety

[1] WATER, SANITATION, HYGIENE

Water and sanitation is one of the primary drivers of public health. I often refer to it as 'Health 101,' which means that once we can secure access to clean water and to adequate sanitation facilities for all people, irrespective of the difference in their living conditions, a huge battle against all kinds of diseases will be won." - Dr. LEE Jong-wook, Director-General, World Health Organization.

The result of the 2014 Annual Poverty Indicators Survey (APIS) shows that of the 22.7 million families, 85.5% percent have access to safe water supply[10] and the remaining 14.5% of families use unsafe source of water.[11] *Nonetheless,* there are observed disparities among regions. Only seven regions have proportion of families having access to safe water supply at par or higher than the national average, ranging from 84.7 to 98.9 percent, namely: Caraga (84.7 %), Region VIII (86.5 %), NCR (90.3%), Region I (90.7 %), Region IVA (90.9 %), Region II (96.0 %), and Region III (98.9 %). (Philippine Statistics Authority, 2015)

The National Household Targeting System (NHTS) reports that 455 municipalities remain waterless.[12] The main sources of domestic water requirements of households in those municipalities are shallow wells, deep wells, open dug wells, springs and rivers.

[10] Water coming from community water system piped into dwelling, yard or plot, public tap, and protected well.
[11] Unprotected well, spring, river, pond, lake, rainwater, and tanker truck or peddler
[12] The National Anti-poverty Commission defines "waterless areas" as municipalities outside Metro Manila or Barangays inside Metro Manila wherein less than 50% of the total household population are connected to any water supply system.

Government data show that more than 90% of the country's sewage is not collected or treated properly. (United Nations Development Programme (UNDP), 2006) This raw sewage ends up in open water bodies contaminating our water sources.

This is a concern even in highly urbanized cities. In Metro Manila, only 7% of the population has access to piped sewerage. (United Nations Development Programme (UNDP), 2006). The reality is that many Filipinos who have toilets do not have septic tanks. If they do, these have open bottoms. Worse, septic tanks may not be regularly desludged; and if sludge is removed, treatment and disposal is still a concern.

Access to at least 20 liters of clean water each day is the minimum requirement of having the right to water. "Not having access" to water and sanitation is a polite euphemism for a form of deprivation that threatens life, destroy opportunity and undermines human dignity. (United Nations Development Programme (UNDP), 2006)

Investing in water, sanitation, and hygiene is investing in health. Unclean water and poor sanitation have claimed more lives over the past century than any other cause. Water and sanitation are among the most powerful preventive medicines available to governments to reduce infectious disease. Investment in this area is to killer diseases like diarrhea what immunization is to measles—a life-saver. (United Nations Development Programme (UNDP), 2006)

Improved water supply, sanitation, water resource management address a number of health problems, including fatal diseases such as diarrhea, malaria, schistosomiasis, trachoma, intestinal helminths (Ascariasis, Trichuriasis, Hookworm disease), Japanese encephalitis, Hepatitis A, Arsenic, and Fluorosis.

[Ia] Proposal: Access to clean water

“Lack of financing in the Philippine water sector remains one of the biggest constraints to achieving total service coverage in the country.” The World Bank estimates that PhP 93 billion is needed until 2025 for Filipinos to have access to clean water, i.e., to put up new Level III (household connection to water supply) facilities and upgrade Level II (communal water system) into Level III household connections from 2013-2025.

The PhP 93 billion[13] requirement is feasible considering that it accounts for only 10% of the entire budget of the Department of Public Works and Highways (DPWH). (Rappler, 2015 and Manila Times, 2014, citing a 2013 World Bank estimate)

[Ib] Proposal: Sanitation

Different government bodies have multiple initiatives to come up with a comprehensive sanitation plan but the Philippines still has not invested much on proper sewage collection and treatment. For instance, the National Sewerage and Septage Management Program allocation began in 2013, with a total budget of PhP5.6B as the 40% National Government subsidy spread until 2020. Aside from limiting the program to the 17 Highly Urbanized Cities and for sewerage projects only, the 2014 allocation of PhP300 million have not been downloaded to the local government units.

[13] Costing estimates may change as the period gets adjusted

The Department of Health (DOH) has a five year plan on the provision and construction of sanitation facilities:

Current Status:

- Total no. of households in the Philippines: 18,387,717
- No. of households with sanitary facilities: 14,816,535 HH (80.58%)

Target: Increase the current status by 10 to 15% after 5 years
Output: 30 Hospitals equipped with autoclave machine, biodigester and wastewater treatment facilities
Timeline: 2018 to 2022
By the end 2022: No. of household with sanitary facilities: 16,548,945 households to 17,468,331 households (90 to 95 %)
No. of households to be served: 1,838,772 households to 2,758,158 households

Table 12: DOH Environmental and Occupational Health Office Consultation With Civil Society on the 2018 Budget. March 2018.

2018-2022		**Amount per Household or Facility (Php)**	**Total Amount (Php)**
A. Healthcare Waste Management • 6 Autoclave Machine • 6 Biodigester • 6 Wastewater Treatment Facility	6 Hospitals per year		200.0 Million
B. Toilet Facilities	(1,838,772) per year		
Individual Toilet /HH			
▪ VIP Latrine (20%)	367,754	10,000	3.67754 Billion
▪ Pour Flush Water Sealed Toilet (80%)	1,471,018	60,000	88.26108 Billion
Public Toilet (school, communal, health post)	68 Facilities (4 per region)	500,000	34.0 Million
C. Small Community Sewerage System (DEWATS)	34 Facilities (2 per region) per year	10.0 Million	340.0 Million
D. Septage Treatment Facility	34 Facilities (2 per region) per year	30.0 Million	1.02 Billion
With collection vehicle	68 Vehicles (4 per region) per year	5.0 Million	340.0 Million
Grand Total			**93.87262 Billion**

[2] HEALTH AND NUTRITION

Assessing adequate and nutritious food continues to be a challenge in most parts of the country both in terms of under and over nutrition, with women and children faring worst.

While there has been a minimal decrease in the number of underweight children from 20.7% in 2007 to 20.2% in 2011, wasting increased from 6% in 2003 to 7.3% in 2011. It is estimated that

7.36 million children in the country are malnourished. (Food and Nutrition Research Institute, 2015) Some 4 million children in the country suffer from stunted growth, the Philippines ranking 9th in the world in this regard. (United Nations Children's Fund (UNICEF), 2013) The Autonomous Region of Muslim Mindanao (ARMM) has the highest prevalence of underweight children. Child health and nutrition lie at the core of child development, and in the long run, of national development. Malnutrition and poor health during the critical, early stages of children's lives hamper their intellectual and physical development, diminishing their productive capacity as adults.

According to the 2013 World Food Insecurity Report of the Food and Agriculture Organization (FAO), 15.6 million Filipinos were undernourished from 2011 to 2013, making the Philippines the second biggest malnourished population in Southeast Asia, next to Indonesia. In the Social Weather Station (SWS) survey in the fourth quarter of 2014, 3.8 million households said they experienced hunger, 13.2 percent experienced moderate hunger while 4.1 percent experienced severe hunger. Pregnant women with children less than 5 years old are also vulnerable, particularly to malnutrition, with close to 12% of lactating mothers underweight. (Food and Nutrition Research Institute, 2015) Poor nutrition of mothers, both before and during pregnancy, has a direct impact on child development. The effects of malnutrition are permanent, irreversible, and fatal. The lack of access to adequate and nutritious food has detrimental effect on future generations. They persist even during adulthood. It lowers the physical work capacity of adults and diminishes their intellectual performance throughout their entire lifetime. It is the cause of the early onset of chronic degenerative diseases in adulthood.

Conflict and disaster-affected areas are greatly affected by hunger and food insecurity. This could be seen in the SWS survey in 2013 after Supertyphoon Yolanda devastated Visayas where 52 percent of Filipinos self-rated themselves as food poor. In 2014, the United Nations World Food Programme (WFP) verified this data with 27 percent of the population in Yolanda-affected areas remained food insecure.
The Philippines is evidently a food insecure nation despite its biodiversity and being an agriculture country. Availability and access to food and food systems are beyond reach by the most vulnerable sectors. Agricultural outputs remain at three percent for almost 30 years now and this is partly due to government's inability to provide strong support services, especially to small and medium farmers.

Several factors affecting hunger in the Philippines as stated in the draft report of CSOs during the visit of Ms Hilal Elver, UN Special Rapporteur on the Right to Food, are the following:

- Inflation
- Unemployment and underemployment
- Growing population with the steady decline of agriculture productivity
- Land grabbing affecting indigenous peoples and small holder farmers
- Lack of government assistance to small holder agriculture
- Lack of government assistance to vulnerable sectors: municipal/artisanal fisherfolk, urban food insecurity of informal sector, women, children, PWDs, conflict and disaster-affected areas
- Environmental abuse
- Incoherent government policy on farmer seed system

In the review of various materials, the global challenges that will greatly affect local food production and security are the following:

- Competition on agricultural land: urban development (real estate development); mono-crop/GMO plantations
- Climate change: Agroecology as a frame and approach
- Agricultural free trade as solution to food and nutrition insecurity
- WHO and FAO following a fragmented conceptual approach to nutrition and food security

Corporate control over the public sphere and people's resources (transnational corporations lording over food and food systems)

In order to keep pace with the growing population, the country would have to significantly increase its rice production. Moreover, it would be more effective if the self-sufficiency program will focus not only on rice but to include a diverse range of other staple food. It would also be beneficial if the budget allocated to encouraging rice self-sufficiency was shared to other sectors, such as fisherfolks and coconut farmers who are most vulnerable.
The following are recommendations from the CSO draft report during the visit of Ms Hilal Elver, UN Special Rapporteur on the Right to Food (Focus on the Global South, et.al, 2015)

- Support House Bill 3795 (Zero-hunger bill)
- National Food Policy (executive branch)
- Strict enforcement of land rights
- Government assistance to small holder agriculture: Food security and rice self-sufficiency program; Agricultural and Fisheries Modernization Act (AFMA) implementation; National Land Use Act passage into law
- Seed conservation
- To UN: call for a sustainable fisheries management (i.e. community-based control resource management - CBCRM)
- Ensure social protection programs for the urban poor/informal sector
- Address needs of women, children and PWDs
- Environmental reforms/push for climate justice
- Government attention to Mindanao

Food security needs to be tightly connected to nutrition. The human right to adequate food and nutrition (RtAFN) framework is a recent development. Movements recognize how the WHO and FAO addressed in a fragmented way, the food security and nutrition problems and developed the framework.

The focus of this proposal will be to ensure the availability, accessibility and quality of food thru the RtAFN. However, there is still a need to look at the holistic nature, and focus on the root causes of hunger and malnutrition to progressively realize it as a human right. *"Food security exists when all people at all times have physical, economic and social access to sufficient, safe and nutritious food to meet their dietary needs and food preferences for an active and healthy life. The nutritional dimension is integral to the concept of food security*" – Committee on World Food Security (CFS).

Within the RtAFN framework, adequate food/nourishment goes beyond mere ingestion of agricultural products or nutrients but the digestion and transformation into body and life.

[3] ROAD ACCESS AND SAFETY

The United Nation's Decade of Action for Road Safety (2011-2020) will end in two years' time. Many road safety initiatives have been accomplished, including institutionalizing national road safety action plans in various countries. While road traffic fatalities have slowly dropped and even plateaued, much work still needs to be done in order to reduce this, including severe injuries brought about by road crashes significantly. Due to this guiding tool, the international community was made aware of the increasing road traffic fatalities in different parts of the world, thus, giving it global priority and attention. Evidences of this are the recent international agreements developed and committed to by governments – the Paris Climate Agenda and the UN Sustainable Development Goals 2015.

To illustrate the current state of road safety globally, there are 1.25 million road traffic fatalities yearly, with no apparent sign of reducing significantly soon. Low and middle-income countries got the highest share of road traffic death rates, which are 26.1 and 18.1 per 100,000 population respectively. What is alarming to note here is that road traffic crash is the number one cause of death among those aged 15-29 years old, the most economically productive population (WHO 2015).

On the other hand, a Harvard study on the global burden of disease projects that road traffic crashes will be the number three (from number 10 in 1990) leading cause of death by 2020, if no interventions on road safety will be done. This does not account yet the deaths due to exposure to other health hazards related to road traffic in urban centers (i.e., asthma, chronic obstructive pulmonary disease, heart disease and stroke).

The same is happening here in the Philippines. According to the Philippine Statistics Authority's (PSA) data, road traffic fatalities have been increasing since 2006, with 10,012 in 2015. The number represents a 31 percent increase in the absolute number of deaths as compared to 2008 data (6,941 RTI deaths in 2008). Approximately half of all deaths on the country's roads are estimated to be among vulnerable road users - motorcyclists, pedestrians and cyclists. A heterogeneous traffic mix that includes high-speed vehicles sharing the road space with vulnerable road users as well as unsafe road infrastructure and vehicles that are in poor condition all contribute to the high fatality rates seen on the roads.

And like in the global, the country recorded in 2014 that 78.61 percent or 7,194 of road traffic fatalities were from the most economically productive population aged 20-29 years old.

Road safety must be institutionalised for it to work in the long-term. This can be done by implementing the Philippine Road Safety Action Plan (PRSAP) 2017-2022, which is currently being finalized at the level of the implementing agency, which is the Department of Transportation (DOTr). Three critical factors in this plan must be put in place - the National Road Safety Unit under DOTr (the office mandated to coordinate and monitor the implementation of the PRSAP), currently waiting for the approval of the Executive Order creating it; accurate, cohesive, interoperable data on road crashes; and assured funding for road safety.

[3a] Public Health and Road Access

Some of the biggest roadblocks to health care in remote areas of the Philippines are the roads themselves. Inadequate infrastructure is detrimental, particularly to pregnant women. "The

solution might not be building all these birthing centers. The solution is really to build roads." (Visconti, 2013, quoting former Undersecretary Teodoro Herbosa)

Hemorrhage is the most common cause of death during childbirth. In the rural areas, when hemorrhaging and other birth-related complications arise, it is difficult to receive emergency obstetric care due to poor road conditions and inadequate means of transportation. (Protecting the Lives of Mothers and Children in the Philippines, n.d.)

The 2017 National Demographic and Health Survey reports that access to a health facility is the second biggest problem in getting health care among women aged 15-49. (Philippine Statistics Authority (PSA) and ICF, 2018)

Access to health services is generally better in urban areas where infrastructure is improved.
Underinvestment in roads: Only 14% of local roads are paved, compared to 69% of national roads

For the FY 2016, the alternative proposal of the ABI Environment/Climate Change Cluster proposed an estimated PhP 140 Billion for the construction of rural roads of about 14,000 kilometers that costs PhP 10-12 million pesos per kilometer. This 14,000-km farm to market roads are part of the Aquino Administration's commitment. Thus far, around 2,000-km roads have been constructed.

Participation as an underlying Determinant of Health

People's right to participation is considered the "the right of rights," the basic right of people to have a say in how decisions that affect their lives are made (J. Waldron as cited in Halabi 2009). The United Nations Committee on Economic, Social and Cultural Rights (UNCESCR), in its General Comment No. 14: *The Right to the Highest Attainable Standard of Health (Article 12)* adopted in 2000*,* stipulates that participation in all health-related decision-making at the community, national, and international levels is an important aspect of the right to health. It particularly directs states to use participatory methods to adopt and implement a national public health strategy and implement a plan of action to achieve it. In addition, Article 4 of the 1978 Declaration of Alma-Ata on Primary Health Care states that, "people have the right and duty to participate individually and collectively in the planning and implementation of their health care." (Halabi, 2009).

The International Convenant on Economic, Social, and Cultural Rights (ICESCR), one of the binding international human rights covenants that the Philippines is a signatory of, includes participation as an underlying determinant of the human right to health. As stated in the UNCESCR, Article 12 of the General Comment No. 14, "The Committee interprets the right to health, as defined in Article 12.1, as an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health. A further important aspect is the participation of the population in all health-related decision-making at the community, national and international levels."

The Resources for Health

"Perhaps 80% of essential care and 70% of desirable health interventions can be delivered at the primary level, but an average of only 10% of health resources are used for primary level care in Asia. Six countries in the Asia Pacific region spent less than 20% on primary health care."
(World Health Organization, 2005)

A comparative analysis of DOH interventions identifying and clustering budget line items as "primary prevention and promotive health care" and "curative health care" will help scrutinize the elements of each. The preventive and promotive healthcare take 50 percent of the proposed budget for 2017 while the curative health care is at 44 percent of the budget.

The Department of Budget and Management's People's Proposed Budget for 2017 classified the following under the preventive and promotive health: National Immunization Program; hiring of doctors, nurses, midwives, and dentists; diagnosis of other infectious diseases, including HIV and AIDs, dengue, food and water-borne diseases, Tuberculosis Control Program; and programs to eliminate public health diseases such as malaria and filariasis.

Table 13. Budget by Continuum of care DOH Proposed Budget FY 2018

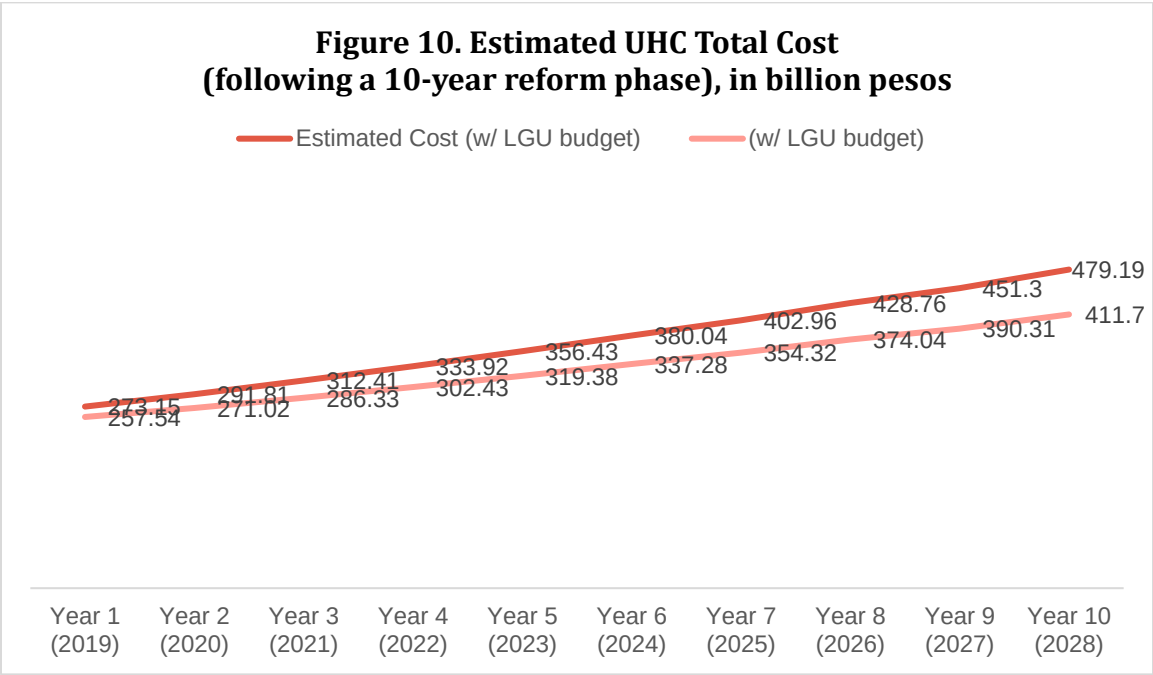
Continuum of Care	Amount in Billion PhP	% of Total
Preventive and Promotive Health Care (Public Health Management and Commodities, Health Prmotion, Human Resources Deployment, Capital Outlay Support to BHS and RHUs)	40.75	38
Curative and Rehabilitative Health Care (Operations of DOH Hospitals, Capital Outlay Support to LGU Hospitals)	53.07	50
Healthcare Governance (Policy, Training, Research, Regulations, Regional Office Operations, Information Management)	12.26	12
TOTAL	106.08	100

The DOH performance indicators and targets for the FY 2018 budget determine the direction of the health system – on both public health service provision and public health administration. Public health administration looks at the implications on health of other policies and programs – water and sanitation, roads, public transportation, food safety, food sovereignty and food security, gender discrimination, culture, among others. Meanwhile, direct health service delivery programs – immunization, health promotion, food and drug regulation, health facilities, health human resources, among others, are supposedly evident in the DOH annual budget.

It might be premature to assess the trajectory of the agency in the current (FY 2018) and proposed (FY 2019) budget alone beyond mortality and morbidity, given transitions that it has undergone and will be undergoing. In its long term plans, the DOH budget should put premium on wellness and well-being, both in its budget and health implications in the use or misuse of public funds by other national agencies.

The anticipated passage of the Universal Health Care Bill will be a game-changer for the health sector. The implementation will require multi-billion financing. Under the proposed legislation, funding for UHC will be generated from various sources, pooled, and will be utilized for health service provision.

Figure 10. Estimated UHC Total Cost (following a 10-year reform phase), in billion pesos



Source: DOH running estimate as of September 2018

Table 14. HEALTH SECTOR ALLOCATION OF NATIONAL GOVERNMENT EXPENDITURES (IN BILLION PESOS) FYs 2008-2018

Particulars	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Department/Agencies	15.66	22.20	26.35	31.92	44.90	42.11	48.40	66.21	127.02	108.55	112.70
Department of Health	14.55	21.15	25.17	30.62	43.47	40.48	48.40	64.09	124.95	106.19	108.81
Other Executive Offices: Dangerous Drugs Board	0.185	0.139	0.146	0.172	0.171	0.183	0.185	0.200	0.195	0.205	0.232
Department of National Defense: AFP Medical Center; Veterans Memorial Medical Center	0.687	0.747	0.792	0.864	0.837	0.949	1.017	1.12	1.11	1.27	1.67
Department of Science and Technology: Food and Nutrition Research Institute; Phil. Council for Health Research and Development	0.230	0.164	0.240	0.270	0.422	0.492	0.705	0. 807	0.761	0.882	0.986
Budgetary Support to Government Corporation: Local Water Utilities Administration; Lung	2.91	1.19	4.65	8.58	1.29	0.948	36.58	38.74	2.47	51.89	63.79

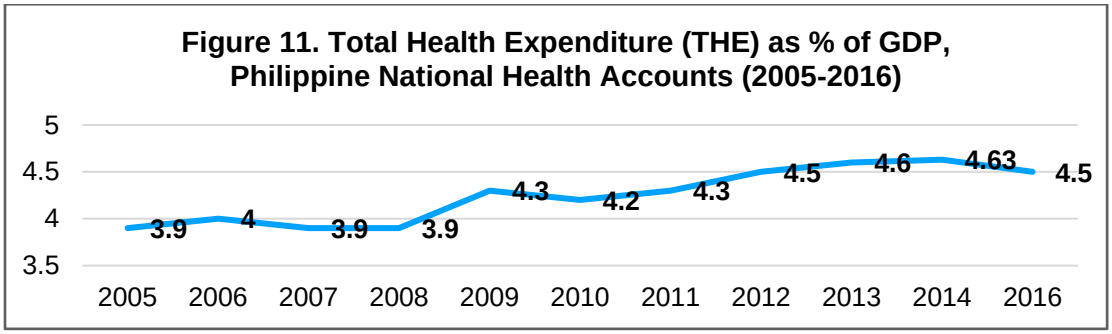
Center of the Philippines; National Kidney Transplant Institute; Philippine Children's Medical Center; Philippine Heart Center; Philippine Institute for Traditional and Alternative Health Care; Philippine Health Insurance Corporation											
Other Special Purpose Funds: Allocation to Local Government Units; Municipal Development Fund; Municipal Development Fund; Premium Subsidy for Indigents under the NHIP; Miscellaneous Personnel Benefits Fund; Calamity Fund; Rehabilitation and Reconstruction Program; Tax Expenditure Fund; Priority Development Assistance Fund; Health Facilities Enhancement Program*	0.076	0.022			4.363	16.96			3.246		2.87
Note: 2008-2012 are actual budgets copied from the Senate LBRMO Budget Facts and Figures "Health Sector: Budget Analysis" 2013 (actual), 2014 (actual), 2015 (actual), 2016 (adjusted), 2017 (actual), 2018 (program) from the BESF added by authors, rounding off of figures *Originally reported in the BESF under Priority Social and Economic Projects Fund but was transferred back to the DOH											

The accounting of health sector initiatives and allocation (budget by sector allocation) across governments is guided by the indicators set forth in the Philippine Development Plan.

The health sector is valued in terms of the immediate thrust of the DOH, government hospitals, anything that has to do with drugs, the Local Water Utilities Administration, food and health research units, and other special purpose funds that can be used to provide direct health service. This is a narrow appreciation and understanding of the health sector, and as such limits the synergy and intersection of resources and mandates of the different government branches, agencies and institutions.

There is a huge discrepancy between the actual health expenditures in the Philippine National Health Accounts by the National Statistical Coordination Board (NSCB) and the Health Sector Allocation in the Budget Expenditures and Sources of Financing (BESF) by the Department of Budget and Management (DBM). The discrepancy is due mainly to the inconsistency in the items considered as part of the health expenditures. An analysis done by the Senate Legislative Budget Research and Monitoring Office (2013) stated that the NSCB considered other health-related activities such as the allocation for the Philippine General Hospital (PGH), while the DBM reports it as part of the State Universities and Colleges allocation.

Total Health Expenditures on Health



Source: Philippine Statistics Authority as of 2018. Data on the 2013 THE has been revised

The percentage to the country's GDP of the Total Health Expenditure (THE) has been increasing from 2010 to 2016. The NSCB reported that the 2016 THE of 4.5 percent. However, the Philippines has consistently fallen short of the recommended 5-6% of GDP allocated to health[14][15]. (World Health Organization, 2005 and Savedoff, 2003).

Other Asian countries such as Indonesia, Malaysia, and Vietnam show a huge share of out-of-pocket health expenditure on health, as in the Philippines. There is high level of out-of-pocket payment from balance billing by members of PhilHealth in the Philippines. The relatively low out-of-pocket expenditure on health in Thailand may be attributed to its comprehensive benefit package that resulted in high level of financial risk protection, and low incidence of catastrophic health spending leading to less impoverishment of households. (Tangcharoensathien, et al., 2014)
(Tangcharoensathien, et al., 2014) (see Table 16)

Table 15. National Health Accounts, Selected Asian Countries (2010-2014)

Countries	Total Health Expenditure as % of GDP					Health Expenditures, Public (as % of total health expenditures)					Out-of-pocket health expenditure (% of private expenditure on health)				
	2010	2011	2012	2013	2014	2010	2011	2012	2013	2014	2010	2011	2012	2013	2014
Indonesia	2.7	2.7	2.9	2.9	2.8	37.7	37.9	39.6	39.4	37.8	75.8	76.3	75.1	75.3	75.3
Malaysia*	4.0	3.9	4.0	4.0	4.2	57.3	54.9	55.2	54.8	55.2	76.8	77.8	78.0	79.9	78.8
Philippines (World Bank Open Data)*	4.4	4.3	4.5	4.6	4.7	36.0	30.5	31.1	31.8	34.3	84.5	83.0	83.0	82.6	81.7
Philippines (PNHA)*	4.2	4.3	4.5	4.6	4.63	37.2	30.4	31.1	30.9	31.5	62.8	57.7	57.2	55.9	55.8
Thailand*	5.4	5.9	6.2	6.2	6.5	82.11	84.5	85.0	85.3	86.0	55.9	55.8	56.9	56.7	56.7
Vietnam	6.4	6.2	7.0	7.2	7.1	46.5	45.2	53.5	53.0	54.1	83.9	83.2	79.0	77.6	80.0

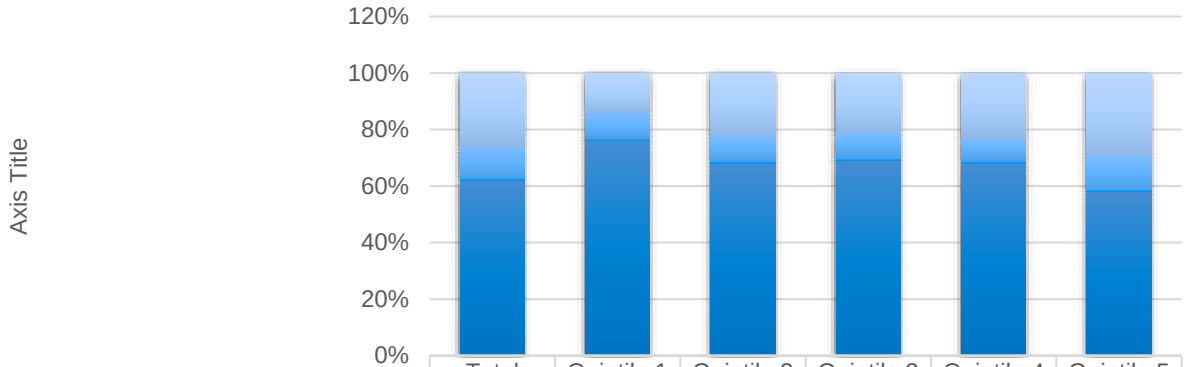
[14]http://www.jointlearningnetwork.org/uploads/files/resources/WHO_Exploring_the_thresholds_of_health_expenditure_Background_paper.pdf on October 8, 2015. The data presented here suggests that 15-20% of OOP as a share of total health expenditure and 5-6% of government expenditure on health as a share of GDP could considerably reduce the incidence financial catastrophe in a country. However, as we find in this study, the reality is almost all countries that have reached these levels are high and uppermiddle income countries.

[15] WHO "recommendation" that countries should spend 5 percent of GDP on health, a recommendation which was never formally approved

Source: Congressional Policy and Budget Research Department, House of Representatives. Agency Budget Notes, Department of Health (For FY 2015) citing World Bank Open Data. Philippine data from PNHA was added by the authors retrieved from http://psa.gov.ph/pnha-press-release/data
*Major revisions done on data based on the World Bank Open Data as of 2017 (observed changes from the 2010-2013 data were incorporated as revisions to the figures in the matrix)
2013 Private Out-of-pocket marked as revised in the 2013-2014 PNHA published by PSA
Note: Public health expenditure consists of recurrent and capital spending from government (central and local) budgets, external borrowings and grants (including donations from international agencies and nongovernmental organizations), and social (or compulsory) health insurance funds. Health expenditures, Public: aggregate of local, national, social health insurance, and grants

Filipino households still carry the heaviest burden of healthcare costs. Based on the latest figures from the Philippine National Health Accounts, The Private Out-of-Pocket accounted for 54.2% of the current health expenditure in 2016, equivalent to a share of PhP 342 billion. Even though this presents an improvement compared to the figure in 2014 (56.3%), this is still relatively high compared with the 45% Health Care Financing Strategy target of DOH.

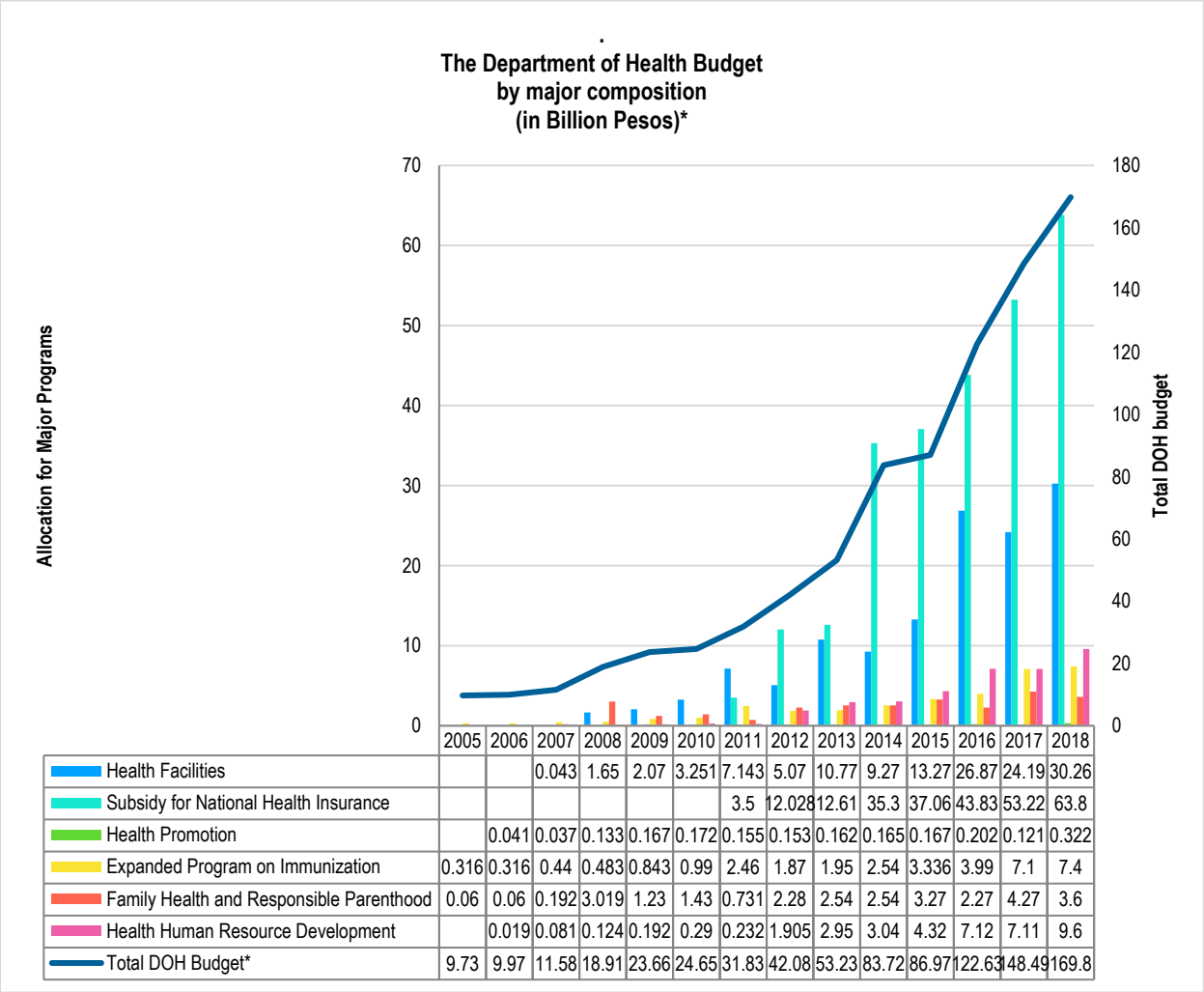
Figure 12. Out-of-pocket health spending, 2012, Philippines



	Total	Quintile 1	Quintile 2	Quintile 3	Quintile 4	Quintile 5
Inpatient services	26%	14%	22%	21%	23%	29%
Outpatient medical and paramedical services in cash	11%	9%	9%	9%	8%	12%
Other medical goods and supplies in cash	1%	1%	1%	1%	1%	1%
Drugs and medicines in cash	62%	76%	68%	69%	68%	58%

Figure adapted from Bredenkamp, C. and Bruisman, L., 2015, citing FIES 2000, 2003, 2006, 2009, and 2012. The Philippine Statistics Authority (2017) also affirms in a public report the consolidation made by Bredenkamp, C and Bruisman L (2015). Hospitals, specifically general hospitals were the recipients of OOP at 41.1 percent. Pharmacies came in second to general hospitals at 27.5 percent; followed by providers of preventive care at 8.5 percent.

Figure 13: DOH BUDGET IN MORE THAN ONE DECADE



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Health Facilities			0.043	1.65	2.07	3.251	7.143	5.07	10.77	9.27	13.27	26.87	24.19	30.26
Subsidy for National Health Insurance							3.5	12.028	12.61	35.3	37.06	43.83	53.22	63.8
Health Promotion		0.041	0.037	0.133	0.167	0.172	0.155	0.153	0.162	0.165	0.167	0.202	0.121	0.322
Expanded Program on Immunization	0.316	0.316	0.44	0.483	0.843	0.99	2.46	1.87	1.95	2.54	3.336	3.99	7.1	7.4
Family Health and Responsible Parenthood	0.06	0.06	0.192	3.019	1.23	1.43	0.731	2.28	2.54	2.54	3.27	2.27	4.27	3.6
Health Human Resource Development		0.019	0.081	0.124	0.192	0.29	0.232	1.905	2.95	3.04	4.32	7.12	7.11	9.6
Total DOH Budget*	9.73	9.97	11.58	18.91	23.66	24.65	31.83	42.08	53.23	83.72	86.97	122.63	148.49	169.8

*total budget of the DOH Proper only, excluding attached agencies National Nutrition Council, Commission on Population, attached corporation Philippine Institute for Traditional and Alternative Health Care and Corporate Hospitals Lung Center of the Philippines, National Kidney and Transplant Institute, Philippine Children's Medical Center, and the Philippine Heart Center. For purposes of comparison, the FY 2017 DOH budget includes the PHIC budget of 53.221 Billion, under the Budgetary Support for Government Corporations
Source: General Appropriations Act 2005-2018

With more money comes greater responsibility. Between two administrations alone, the allocation for the DOH increased by more than 10-fold -- from PhP9.97 billion pesos in 2006 to PhP122 billion pesos in 2016. It grew by an average of PhP3 to PhP4 billion pesos per year but the sharpest increase was during the Aquino administration, in 2013, soon after the passage of the Sin Tax Law in 2012, which provides 85 percent of its annual incremental revenue to health.

For the FY 2018, the resources for health continue to rise, with a 13-percent increase from the previous year's level, from P151 Billion in 2017 to P171 Billion. Increases are attributed to the Sin Tax Incremental Revenue for Health amounting to P 113 Billion, of which, P48 Billion is for PhilHealth's budget for premium subsidy for health insurance of the poor, senior citizens and families in conflict areas.

What remains to be the difficult task is ensuring that resources actually translate to health outcomes --- that the country is spending on the right things. Perhaps, in recent years, despite increases in resources, the DOH programs do not effectively address the primary causes of mortality and morbidity. As shows in the table above, the top three causes of deaths in the Philippines have been the same for more than a decade, each only shifting up and down the ranking, and are continuously increasing the number of deaths every year, yet none of DOH's well-funded programs were able to deal with the prevention of these conditions.

The question, are we spending on the right things? Remains. However, misplaced priorities is a problem that calls for the strengthening of the public health sector and safeguarding it against potential conflicts of interest. The growing population health needs warrants significant and substantive public investments.

Table 18: Alternative Health Budget Proposals[1]

SUB-CLUSTER PROPOSAL CONTENTS

[1] Health workforce [2] Health Promotion and Integrative Health [3] PhilHealth [4] Older Persons Participation in Primary Care [5] Persons with Disability [6] National Public Health Emergency and Management [7] The HIV Epidemic in the Philippines [8] Reproductive Health [9] Strengthening Good Governance in Medicines [10] Children and Youth, including Child Protection [11] A Better Democracy, A Better Health for All; Citizens' Participation in the Health Budget

[1] Health Workforce

The Sustainable Development Goals (SDGs) will not be attained if maldistribution and insufficiency of health service providers across the country persist Health Human Resource (HHR) is primarily responsible to give the public "access" to health care. No healthcare can be provided without the professional health care workers delivering quality services. HHR is vital to a functional national health system.

While it is only rational that the national government agencies current year's allocation should be based on the previous year's budget utilization rate, the country's Department of Budget and Management (DBM) should also be more prospective the country's growing population health needs.

Public health demands technical competency and adequate number of workforce at point of service delivery, technical and managerial capacities in policy-setting, and program management levels. There is a need to constantly strengthen the public health sector's organizational capacity and front-line workforce so that it can deliver the much-needed services, especially now that the country is about to embark on reforming the health system through the UHC Bill.

[1a] Strengthen the Front-Liners

Health Human Resource is a big part of attaining good health for all. Facilities, medicines and innovations are useless without people to handle, administer and utilize them. Thus, strengthening the Health Human Resource is vital and inevitable.

- Renationalize the Public Health Services
- Full Implementation of Magna Carta for Public Health Workers; Provide budget allocation for salary and statutory benefits under the Magna Carta for Public Health Workers. The Magna Carta of Public Health Workers (Republic Act or RA 7305) was enacted to ensure that health workers are properly compensated that will, in turn, benefit patients through the delivery of quality health care service. Thus, its intention was supposed to be for the benefit of the overall health care service delivery. (Lavado, 2011)

  Barangay health workers who selflessly serve with very indecent honorarium are the frontline in the delivery of health care. It is only right that they receive compensation in the principle of equal pay for equal work of equal value.

  In order to realize primary health care, adequate health workers shall be deployed to communities, to barangay health stations, rural health units and public health care facilities.
- Amend the Local Government Code: Revision of formula for computing the Internal Revenue Allotment (IRA) for local government units so as not to prejudice low income LGUs.
- Abolish Contractualization in the Government. No to Contract of Service or Job Orders by implementing the CSC-COA – DBM Joint Circular No. 1, series of 2017 dated June 15, 2017 – Rules and Regulations Governing Contract of Service and Job Orders in the Government.
- No to volunteerism. Mainstream the BHW to the personnel/staffing (plantilla) of the LGU. Provide at least contractual appointment to more than 400,000 daycare workers and barangay health workers who are working on voluntary basis while incrementally targeting the creation of plantilla items for them;

[1b] Rationalizing the Unfilled Plantilla Positions

- Reclassify/ update/upgrade plantilla position in the DOH Central, Regional Offices, and Hospitals:
- In case of no takers, those positions maybe be reclassified, there is an office in DBM for position compensation and classification while the CSC can look at the qualifications;
- Of the existing health personnel on job orders, contract of service and under deployment program, they can be absorbed as plantilla employees. Considering that their contracts have been renewed for years already, following the right to security of tenure- they should be regularized using those vacant posts;
- DOH should conduct Job Fair with the help of the DOLE PESO. Many nurses are either without job or employed not as a nurse;
- If vacancies are not entry posts, DOH can look at promoting deserving health personnel;
- DOH should invest on continuing staff development and strengthen in service training.; and
- DOH must meet the standards in terms of health population or patient ratio.

[1c] Proposed Sources of Funding

Funding for the HHR budget proposal can come from various allocations:

- FY 2013 – FY2016 savings from unfilled human resource permanent positions
- Another source of funding is the Special Purpose Funds (SPFs), particularly the Miscellaneous Personnel Benefits Fund (MPBF). SPFs are *budgetary allocations in the General Appropriations Act (GAA) for specific purpose. These are lump sums in nature and the recipient departments or agencies and/or the specific programs and projects are not yet identified during budget preparation and legislation*. (Department of Budget and Management, N.D.) MPBF is a special purpose fund for *government personnel-related expenditures, with the required amounts and the recipients determined only during budget execution, e.g., Performance-Based Bonuses determined after evaluation of departments' and civil servants' performance; requirements for the filling up of authorized positions and for the creation of new positions (originally these were provided within agency budgets but now incorporated under this SPF for a complete presentation of the total funding for unfilled positions); and other personnel services deficiencies)* (Department of Budget and Management, N.D.). In FY 2015, the DOH has PhP9.1B funding allocation from MPBF. (Department of Health, 2015)
- Sin Tax incremental revenue - the Sin Tax incremental revenue earmarked for health, can be utilized for health human resource, provided that the functions of the health personnel include health promotion. In the Health Annual Report of the DOH on the Sin Tax law incremental revenue, PhP88.97M was allocated for the deployment of human resource, specifically for the implementation of Doctors to the Barrios for FY 2014.
- Professional fee reimbursement from PhilHealth - The possible source of the payment for Magna Carta benefits is the professional fee reimbursement from PhilHealth. Currently, these are used by some hospitals to provide honoraria for their workers. In other hospitals, however, it is not clear where these funds are spent for. As opposed to the current practice of funding the benefits from personal services or MOOE "savings," an option worth exploring is earmarking these PhilHealth professional fee reimbursements for Magna Carta benefits. This will also provide an incentive for hospital workers to encourage patients to enroll in PhilHealth. (Lavado, 2011)
- Tax Revenue - Tax revenues are compulsory charges or levied imposed by government on goods and services, transactions, individuals, and entities, among others (e.g. income tax, value added tax, and special taxes such as the motor vehicle tax.

  "Taxes work to the benefit of the community, to the taxpayers themselves, and ultimately contributing to nation-building." (Bureau of Internal Revenue, N.D.)
- Special health fund as provided for in the Senate Bill 1896 or the Universal Health Care Bill

[2a] Health Promotion: Putting Health In The Hands Of The People

ABI Health Cluster is continuously pushing for a substantial increase in the allocation of funds to change/modify the health-seeking behavior of Filipinos and provide the necessary healthy and supportive environment that goes with the change in behavior.

DOH records show that more than 300,000 Filipinos die yearly from non-communicable diseases (NCDs) such as heart ailments, stroke, cancer and chronic lung disease[16]. PhilHealth also reported that the total amount claimed by members on cases and some procedures related to treating NCDs is on the rise and has reached PhP 15 billion in 2016[17]. The rising incidence of NCDs in the country, it has been noted, is largely caused by increased life expectancies, rapid urbanization, poor working conditions; and deteriorating lifestyles where smoking, excessive drinking of alcoholic products, eating an unhealthy diet and lacking physical activity take predominance.

Creating an "enabling environment" would encourage Filipinos to eat healthy and engage in more physical activities. This includes making healthy food more accessible, increasing the price of tobacco products to discourage smoking and providing the public with more walkways and open spaces. It's time to start looking into the viability of making space for physical activities to promote a healthy lifestyle while addressing the traffic congestion, in the metropolis. (Uy, 2016)

The proposed budget of the DOH Health Promotion and Communication Services (formerly the DOH National Center for Health Promotion) for 2018 increased to PhP 322.2 million from the previous year's PhP 121.8 million. It is a good step to scale up health promotion activities. However, the proposed budget is still considered small and far from the cluster's proposal of PhP 2 billion pesos.

This amount shall cover initial interventions in health promotion through robust community organizing:

- Development of a National Health Promotion Plan;
- On-granting mechanism to effectively promote healthy lifestyle and well-being (including mental health, oral hygiene, and road safety);
- Creation of a multi-sectoral committee to monitor and evaluate the National Health Promotion Plan;
- Provision of additional incentives to Community Health Teams (CHTs) doing health promotion work;
- Training of health workers and CHTs on rights-based approach to health towards quality and patient-sensitive health care for elderly, persons with disabilities, children and adolescents, women, etc.;
- Community-level promotion and awareness of PhilHealth benefits and procedures, particularly in poor areas; and
- Inclusion of oral health, road safety, and mental health development in health promotion programs.

Included in the proposal of children and youth is to enhance the conditions within which health development can take place:

[16] Department of Health (http://www.doh.gov.ph/mortality)
[17] Philippine Health Insurance Corporation (https://www.philhealth.gov.ph/about_us/statsncharts/snc2016.pdf)

- Strengthen advocacy on health promotion by providing orientation session for children on proper hygiene, accessing DOH services and right to health;
- Develop and distribute child-friendly information materials on said health concerns;
- Distribute hygiene kits to children, providing for their specific needs, according to sex and age group; and
- Strengthen advocacy and services (appropriate, safe, effective/beneficial, and quality products, services, and information) on Traditional Medicine/Complementary and Alternative Medicine (TM/CAM) in schools as catchment areas.

Achieving the target health outcomes:

- Lower smoking prevalence
- Lower alcohol consumption
- Increase in consumption of fruits and vegetables
- Increase in physical activities

Table 17. GAA DOH Health Promotion and Communication Services versus ABI Proposal

Budget Item	**DOH – Health Promotion and Communication Services**
GAA 2018	322,209,000
Proposed Budget 2019	292,200,000
ABI Proposal	4,000,000,000
Variance	4,292,200,000
Local or National	National
Source of Financing	RA 10351 (Sin Tax Law)

[2b] Integrative Health: Health is the Responsibility of All

The proposals of the sub-cluster is based on the foundations and principles of Primary Health Care (PHC), focusing primarily on people's participation, inter-sectoral collaborations and using local, endemic and indigenous resources for people's health.

Therefore, the sub-cluster proposes to the DOH and the House of Representatives to go beyond and further invest financial support to the Philippine Institute of Traditional and Alternative Health Care (PITAHC), the main agency mandated by the Traditional and Alternative Medicine (TAMA) Law or R.A. 8423 to advance and integrate the use of Traditional and Complementary Medicine (T&CM) into the Philippine Health Delivery System. The advancement should be done through promotion, advocacy and more researches.

T&CM is a significant public health resource especially now that new threats from climate change, increasing urbanization, etc. are getting more evident. Today, it is imperative to have a more holistic perspective on health, which goes even beyond the solutions being offered by modern sciences and biomedicine.

It is in this this regard that the sub-cluster proposes an additional PhP 15 million allocation to the original budget of the Philippine Institute of Traditional and Alternative Health Care (PITAHC) compared to the original budget of PhP 142.62 million.

For this year, the focus of the sub-cluster proposal will be the advocacy and promotional strategies (i.e. trainings, IEC and media) of PITAHC. These are directed towards mothers, school-age

children (Grades 4-6) and community health workers of the ten (10) poorest provinces and the various indigenous communities in the Philippines.

Table 18: *SPECIFIC PROPOSALS FOR PITAHC'S ADDITIONAL BUDGET PARTICULARLY ON PUBLIC EDUCATION UNDER THE SOCIAL ADVOCACY UNIT:*

BUDGET ITEM	PROPOSALS AND AMOUNT
GAA 2018	142,629,000,000
ABI Proposal	Development of IEC materials on TM/CAM: PhP3,721,150.00 Development/Strengthening of Curricula of TM/CAM Academic Programs: PhP800,000.00 Development/Strengthening of Modules of TM/CAM Training Program (short programs): PhP1.7 million Development/Strengthening of TM/CAM Orientation Modules of Mainstream: PhP1.7 million Development /Strengthening of TM/CAM Orientation Modules and CME Modules for Mainstream Media Practitioners - PhP2.6 million Other promotional activities through orientation seminars for medical and TM/CAM practitioners and photo exhibits, videos and other cultural activities: PhP2,848,850 Monitoring and Evaluation including Participatory mechanisms: PhP1,630,000 Total: PhP15,000,000.00
Local or National	National
Source of Financing	RA 10351 (Sin Tax Law)

The push for this additional budget by the sub-cluster is dependent on the final advocacy, communication and media plans to be presented by the agency for critiquing and final submission for implementation.

[3] PhilHealth: Key in Ensuring the Health of Filipinos

The Health Agenda for Universal Health Care of the previous administration appears to have made strides in improving the financial risk protection of Filipinos, especially the poor. Total benefit payments to PhilHealth members have more than tripled from PhP 24 billion in 2009 to PhP 78 billion in 2014. Almost 40% of the increase in payments was for the indigents pushing up the sector's share to 32% of total benefit payments, or nearly at par with the share of government and private sectors.

However, despite the doubling of PhilHealth benefit payments from 2009 to 2013, data from the National Health Accounts show only a slight increase in the contribution of PhilHealth to total health expenditure (from 8.1% in 2009 to 11.5% in 2013). Out-of-pocket expense also increased to 56% in 2013, mainly due to the decrease in health spending by local governments.

Majority of illnesses and services covered by PhilHealth are mostly for inpatient and/or catastrophic care. The slightly increasing PhilHealth contribution to total health expenditure may not also necessarily translate to improvement in the people's health outcomes and quality of life.

PhilHealth's non-coverage of outpatient and/or preventive care is not at all helpful in encouraging Filipinos to seek the more cost-effective primary care services; rather, it pushes many to seek care only when their illness or condition has already worsened.

Adding suspicion to the impact of PhilHealth's increasing benefit payments are the recent suspected fraudulent claims of some eye centers amounting to hundreds of millions of pesos. The effect of the fraud even goes beyond the financial losses and opportunity costs of paying for bogus services; some of the cataract surgeries have allegedly harmed patients and caused them to be blind. The cataract package is one of the many benefit packages that, in the absence of real-time and effective monitoring mechanisms, are vulnerable to fraud and gaming of providers and even patients.

Although seemingly less grave, the other schemes of gaming the system, such as artificially increasing the prices of services or professional fees instead of deducting PhilHealth benefits from the true cost of care or opting for confinement to take advantage of inpatient benefits even if outpatient care would suffice, also create leakages and inefficiencies that render the social health insurance ineffective. But unlike the cataract scam, these schemes are caused by poorly designed packages and implementation policies than the absence of a functioning monitoring system.

These then raise the following questions: How much of the benefit payments are really protecting Filipinos from financial risks and improving their health and quality of life? What is really driving up benefit payments – artificially rising health care costs, fraudulent claims, or proper utilization of benefits? Who are actually benefitting from the increased payments – well-behaving providers or patients, or those who are cheating the system; needy patients, or those seeking more than what they need?

The abovementioned issues highlight PhilHealth's pivotal role in shaping the health care system. More than ensuring financial risk protection, it can influence health care spending priorities by its coverage or non-coverage of services. PhilHealth has leverage in promoting good behavior and penalizing bad practices of both providers and patients. It is in a good position to regulate and ensure affordability and quality of the health care system. It can also hasten the development of a national health information system through its accreditation and disbursement requirements.

On the contrary, if PhilHealth neglects its role, it will not only waste the limited resources for health but also worsen the status of the health care system. Ultimately, the country's failure to reform PhilHealth will directly and adversely affect the health and lives of Filipinos. For this reason, we propose that the following urgent measures be undertaken to prevent further leakages, contain health care costs, and begin investment on services that truly preserve health.

We hope that the Universal Health Care Bill will be able to give life to these proposals.

[3a] Prevention of Fraud And Leakages

As of this writing, PhilHealth's information system is still fragmented and has not been consolidated. While PhilHealth is already requiring the use of electronic medical records for its accreditation of providers, its databases are islands that do not speak to each other. There is not one dashboard that can aggregate all health information and utilization data to facilitate real-time tracking and verification of claims and payments. This obvious setback needs to be addressed immediately and PhilHealth must invest on establishing a functional and integrated health information system, once and for all.

To reinforce PhilHealth's monitoring efforts, a third-party monitoring system should also be instituted to improve the Corporation's transparency and accountability to the Filipino people. Aggregated and disaggregated data gathered by PhilHealth's information system, except those that will jeopardize the confidentiality of patients' health information, must be regularly made available to the public. Availability and accessibility of PhilHealth data on members' benefit utilization and reimbursements to providers by type of disease, sector, and geographical jurisdiction (both provincial and municipal/city levels) must be ensured.

In the meantime, more analyses and studies are needed to understand how coverage or non-coverage of services and how the design of packages are affecting behavior of providers and patients. For example, we can ask the following questions:

- Why does pneumonia have the highest number of claims? Is it due to the high prevalence of this ailment or the lack of controls and ease of claiming payments for the pneumonia case?
- Are providers really deducting PhilHealth benefits from the actual cost of care? If not, what is causing this behavior? Is it because of the uncertainty and delay in receiving payments from PhilHealth, the insufficiency of the case rates relative to the actual cost, or the mere lack of monitoring compliance of providers?
- Are patients being confined really need to be confined or is this more a result of the lack of coverage for outpatient care?
- How are PhilHealth's performance indicators affecting providers and patients behavior? How can PhilHealth improve on its indicators so that stakeholders really contribute to improving health outcomes?

The evidence gathered should then guide continual improvement of existing packages as well as development of new packages, including implementation policies. Inasmuch as we want to ensure that PhilHealth benefits are really responsive to the needs of the Filipino people, a participative and inclusive mechanism should also be infused in this systematic and evidence-based process of developing packages. No longer should packages be offered without a health technology assessment and financial plan to back it up. This way, PhilHealth ensures that proper incentives are in place, and needed benefits and cost-effective services are covered.

[3b] Containment of Health Care Costs

Faster roll-out of PhilHealth's "No Balance Billing" policy (NBB), including among private providers, is an initial step in regulating health care costs. Simultaneously, a review of the case rates should also be conducted given recent claims of local governments that the rates are not sufficient to cover the actual cost of services. The more public and private providers implement NBB, the greater the pressure for other providers to follow suit. This will then drive down the health care costs.

In addition, policies to foster transparency of private providers in their pricing of services and supplies should be instituted. For example, PhilHealth can include in its accreditation requirements the submission of "price lists" of services and supplies, including professional fees, which should be made available to the public. Making this information public will not only allow patients to have informed choices but also facilitate feedback and monitoring.

[3c] Investment on Cost-Effective Services

Ultimately, containment of health care costs can only be attained if we devote more resources in keeping our citizens healthy. In the short term, PhilHealth can begin investing in primary care, through the Primary Care Benefit package (PCB), to evolve the country's health care system into a primary care system. As many studies have already pointed out, strong primary care systems are associated with decreased healthcare spending, higher patient satisfaction, and better health outcomes leading to more equitable and accessible healthcare. With primary care providers acting as gatekeepers to the complex health care system, fraud and leakage will also be minimized.

Specifically, we propose that PCB should be made universal and immediately available to all PhilHealth members. While we recognize that insurance premiums must be eventually increased, a national subsidy of P30 billion to provide PCB to all PhilHealth members is initially necessary to gain public support for future premium increases and strengthen social solidarity. Financing can be sourced from government's increased fiscal space, underspending or savings, and/or PhilHealth's reserve fund[18].

Table 19: Breakdown of Philhealth Members to be covered by TSekAP

PhilHealth Members to be covered by TSeKaP*	Members	Dependents	Total Beneficiaries	Cost (PhP1,800 per family)
Informal sector	2,023,696	2,662,266	4,685,962	PhP 3.64 B
Kasambahay, Organized groups, Enterprise owners & Drivers	72,074	60,134	132,208	0.13 B
Self-employed & Migrant workers	1,342,823	1,322,169	2,664,992	2.42 B
Government employees	1,952,447	3,771,110	5,723,557	3.51 B
Private employees	11,003,394	10,222,297	21,225,691	19.81 B
TOTAL	20,854,988	19,526,037	40,381,025	PhP 29.51 B

*Under the Universal Health Care Bill, the following membership categories will be streamlined into two (2): Direct contributory and indirect contributory members

In addition, the PCB package must continually evolve to ensure that it creates the proper incentives for providers to deliver the highest quality of care at the most affordable cost, and patients to take care of their health and demand for appropriate care that is just sufficient (not too little and not too much)[19]. It must also be improved to influence private providers in serving the poor population so that it augments the limited capacity of public health facilities[20]. The PCB must also be adjusted so that it becomes more responsive to the needs of the people[21].

[18] The ending balance of the PhilHealth reserve fund was PhP 120 billion in 2014.

[19] There is an ongoing debate on whether the PCB should be providing general health checks for all members, both healthy and sick, as it is currently designed, or providing primary care for those who are sick. Studies have shown that general health checks are very costly to provide but are not beneficial in reducing morbidity and mortality.

[20] Currently, only government facilities can be accredited as a PCB provider since it is still uncertain if private facilities will be willing to provide primary care to indigents at the current PhP 1,800 per family budget.

[21] For example, the current prescribed fix allocation of the per family payment rate (PFPR) is restricting local public health providers from using the capitation to subsidize the transportation cost of patients that need to be referred to other facilities. Other local governments may also find that the prescribed 15% of PFPR is insufficient to compensate health workers.

In the long run, more interventions closely linked to addressing the social determinants of health should be considered. Simultaneously, PhilHealth's performance indicators must change to become more reflective of health outcomes and the quality of life.

[4] Older People's Participation in The Promotion of The Primary Health Care And Wellness Programs (Pilot Program)

Health is one of the greatest concerns of government, both at the national and local levels. It is at the local government level that the issue of health is most pressing and profound.

The country's lack of health human resource is a big factor on the inadequate direct health service in the community. While the Philippines is one of the world's largest exporters of doctors, nurses and other health professionals, the fact remains that there is an utter lack of health providers left in the country.

Having much time on our hands which can be used for more productive and useful endeavors, the older people sector proposes the harnessing of vast, untapped elderly resource if only to help address the dearth for health service providers in the community.

In order to beef up the Local Government Units' Health Teams, three able and committed older persons from each of the 50 randomly selected barangays will be capacitated and trained on the basics of Primary Health Care service, traditional health care modalities, food and nutrition and concepts of fitness and wellness.

They will join the Barangay Health Teams as augmentation and volunteer service providers. They will take blood pressure and blood sugar readings and check on vital signs; demonstrate and promote basic health practices; promote traditional health care modalities, fitness and wellness, and assist in other functions as may be required in the Barangay Health Program.

Where there are no existing fitness and wellness programs, they will organize regular aerodance and exercise sessions.

The program will be for pilot implementation in 50 barangays for one year and after which, an impact evaluation will be made to determine its viability and effectiveness. Continuation and replication will depend on the results of the pilot Program.

Table 20: Proposal for Older Peoples Participation in the PHC Pilot Program

PROPOSALS	AMOUNT
TRAINING (for expenses on Venue, transportation, food, kit, resource persons)	150 Pax X Php 500 x 5 days = Php 375,000
MID-YEAR ASSESSMENT AND YEAR-END IMPACT EVALUATION	150 pax x Php 500 x 2 days = PhP 150,000
EQUIPMENT (Sphygmomanometers, Blood sugar gauges, thermometers, etc.)	PhP 8,000 x 150
DEPLOYMENT	
Honorarium	=150 pax x Php 2,500/mo. X 13 mos. =Php 262,5000 x 13 mos. =Php 3,412,500
TOTAL BUDGETARY REQUIREMENT	PhP 5, 137,500

[5] Persons with Disabilities

Families with members having psychosocial disability spend significant amount of money for regular consultations just for transportation alone. Lack of regular evaluation and interrupted medication are also among the major factors that hinder the productive capacities of PWDs.

Qualified personnel per region for diagnosing children with possible impairments – We have newborn screening program that is good but what we need next is affordable and available service for diagnosis of possible impairments that have early childhood onset. As of the present, there are very few qualified service providers and, most of the time, the service is very expensive.

Therapists (PT, OT, SP) in provincial hospitals – RA 7277 provides in SECTION 19, ”Rehabilitation Centers: The DOH shall establish medical rehabilitation centers in government provincial hospitals, and shall include in annual appropriation the necessary funds for the operation of such centers. The DOH shall formulate and implement a program to help marginalized PWDs to avail of free rehabilitation services in government hospitals.” This rehabilitation service is a long-standing need that the government has failed to address, visibly a result of the general shortage of health human resource.

Psychiatric medical services in all regional hospitals – The instance someone is suspected of having psychosocial disability, the first thing that almost always comes to mind is to bring the individual to the National Center for Mental Health. This is not surprising since it is practically the only service provider for such concern. Families of patients with psychosocial disability from far-flung areas in the country spend a lot of money for transportation for regular consultations. Like in the case of PWDs, the patients’ lack of regular evaluation and interrupted medication are major hindrances in helping the affected individuals more productive and humanely treated by others. Thus, addressing these problems will also lessen the financial burden to the family.

Maintenance medicines of children with disabilities – Out-of-pocket spending for the maintenance medicines of children with disabilities (i.e. cerebral palsied, with autism, and others) is among the biggest burden of the patients’ parents and families, particularly those from the lower economic class. This takes out a large chunk of expense from the family’s income, yet, is always a priority with some members of the family, particularly the parents even missing out on their meals for this. Thus, medical assistance for these patients will lessen the financial burden on their families.

Table 21: Proposals for PWDs Healthcare

Proposals	AMOUNT
Psychiatric medical services in all regional hospitals	PhP 100,000,000,00
Maintenance medicines of Children with Disabilities provision of these medicines will lessen the financial impact of disability to the family	PhP 10,000,000,00
TOTAL	PhP 110,000,000.00

[6] National Public Health Emergency And Management

Health emergency management is critical at the national level as disasters as now perceived as the "new normal." In addition, the health impacts of recent global infectious disease outbreaks have demonstrated the importance of strengthening public health systems to better protect communities from naturally occurring and human-caused threats. Health emergency management now becoming an emergent field of practice that draws on specific sets of knowledge, techniques, and organizing principles necessary for the effective management of complex health events, hence requiring public investments. (Rose, et.al., 2017)

Currently, despite the devolved characteristic of health service delivery, the national level Health Emergency Management (HEM) should be able to respond to naturally-occurring and human-induced threats, especially at times when local governments are unable to respond.

The proposal for Capital Outlay (CO) investment for HEMB at the national level will cover financial requirements for the following:

- Emergency vehicles
- 6 Sea ambulance vehicles; according to strategic island provinces
- Motorcycles for 4 clusters of response (2 unit in each cluster and 4 in Central Office)
- Fully-equipped mobile hospital
- Warehouse

Table 22: Proposal for National Public Health Emergency and Management

BUDGET ITEM	PROPOSALS AND AMOUNT
GAA 2018	317,185,000
ABI Proposal	1,359,199,700 for Capital Outlay
Local or National	National
Source of Financing	General Appropriations Act

[7] The HIV Epidemic in The Philippines[22]

Although HIV prevalence remains low at 0.036% of the general population in 2011,[23] the Philippines is witnessing a rapid acceleration of the epidemic among key affected populations. Between 2011 and 2014 alone, the number of new HIV infections surpassed the number of cases reported in the first 25 years of the HIV epidemic in the Philippines (1984-2010).[24] At the end of 2014, the country had an average of 16 new HIV infections every day, compared to just one infection a day in 2007. The majority of the estimated 36,000 people living with HIV in the Philippines live in highly urbanized areas, particularly Greater Metro Manila, Metro Cebu and Davao City.

The epidemic is concentrated among males having sex with males (MSM). Overall HIV prevalence among MSM was 3.5% in 2013, but it is rising rapidly. This was caused by increasing

[22] Portions fully drawn from Investment Options for Ending AIDS in the Philippines by 2022: Modeling different HIV Investment Scenarios in the Philippines from 2015 to 2030. A paper commissioned by UNAIDS Philippines. January 2015.
[23] Philippines 2012 Global AIDS Response Progress Report, PNAC
[24] Philippine HIV Situation 2014 Update (presentation), UNAIDS Philippines

incidence of MSM having anal sex with almost two-thirds of them not using condoms.[25] Modeling indicates that unprotected male-to-male sex will continue to account for the majority of new infections in the future.

Certain cities, particularly Cebu and neighboring Mandaue, are recording alarming increases in HIV prevalence among men and women who are engaged in substance abuse through injection. This is a result of widespread use of non-sterile injecting equipment.[26]

HIV transmission is also found among those engaged in MSM who also have sex with their female partners. This has resulted in the increase in number of low-risk females being infected with HIV.

Coverage of HIV prevention programs for key affected populations is still far below than necessary to contain the epidemic. Using HIV testing coverage as a proxy, prevention interventions are reaching just 16% of "Female Sex Workers (FSWs)" and 6.3% of People Who Inject Drugs nationally. Less than 10% of MSM—the most affected by the epidemic—are being reached. Some regions are doing better, but still fall short of the targets. Moreover, the interventions seem to have relatively little impact. HIV biological and behavioral surveillance surveys in 2013 showed increasing rates of risk behavior among MSM and PWID (unprotected sex, use of non-sterile injecting equipment), and rising HIV and STI prevalence.

Only 20% of people estimated to be living with HIV was diagnosed and had access to treatment in 2013. The vast majority of those in need of Antiretroviral Therapy (ART) do not know their HIV status. Very low uptake of HIV Testing and Counseling (HTC) is a key factor, but even those who took the test would often not get their results. Although NGOs can now provide HTC using rapid tests, confirmatory testing is still centralized, and has to wait for several days. In 2013, only 30% of HTC clients in Quezon City returned to the test center to claim their results. The rest is considered 'lost to care'.

The significant leakages at each stage of the HIV cascade, illustrating the magnitude of the problem in the administration of response. Stigma, discrimination and marginalization are still inhibiting access to services for key affected populations. Weaknesses in health, social and education systems and capacity, and inadequate financing are obstacles to effective response.

A Growing Investment Gap

The HIV response in the Philippines is still critically underfunded. Although donor spending in-country has increased steadily over the last three years, the global trend of donor contributions to HIV and AIDS is on a downward trajectory. In the Philippines, domestic spending by the national government, local governments and the private sector is growing but it is still not good enough to meet the needs. Meanwhile, the resource gap is widening fast.

Available resources could be used more strategically, according to the 2011-2013 National AIDS Spending Assessment (NASA). Investments in prevention interventions, for example, need to target key affected populations, focusing on areas where the HIV burden is highest, to have the maximum impact on new infections. This is not yet happening. Between 2009 and 2011, just 20% of all AIDS investment in the Philippines was spent on Knowledge, Attitude, and Practice

[25] 2005-2013 IHBSS, DOH-NEC

[26] According to the 2013 IHBSS, only 30.7% of PWID used Sterile equipment the last time they injected, suggested that 70% of PWID are using needle/syringes that are contaminated—this may be due to sharing with friends, using discarded need needed, being injected by professional injectors.

interventions. As a result, the coverage of the two most affected communities—MSM and PWID—is under 10%.

Investment Scenarios

Several policy scenarios were generated. They show how different policy options will impact the trajectory of the epidemic and the investment need. Our proposed budget will be on the "Ending AIDS" Scenario.

Ending AIDS Scenario

This envisages a phased scale-up to universal access to ART while optimizing prevention interventions for MSM and PWID, expanding coverage incrementally to reach the targets by 2017. Thus, treatment coverage would be enhanced initially to 90% of People Living with HIV with weaker immune system (CD4 less than or equal to 500) before moving to full 'test and treat' mode in 2017. Meanwhile, prevention coverage has to intensify to cover 90% of MSM and PWID and sustained at present levels for FSW.

'Ending AIDS', therefore, calls for an average annual investment of P2.3 billion between 2015 and 2030.

Only the 'Ending AIDS' scenario reverses the epidemic, with the number of current infections beginning to decline in 2029. Conversely, the 'Accelerating treatment only' scenario results in a five-fold increase in the number of PLHIV by 2030.

Impact On New Infections

'Ending AIDS' reduces the number of new HIV infections to less than 500 per year by 2020, effectively abating the spread of the epidemic. At that level, HIV is no longer a major public health threat. Accelerating treatment will significantly reduce the number of new cases compared to the baseline due to the prevention benefits of ART. However, not accompanying it with intensified prevention efforts, the number of people infected will continue every year, and the opportunity to contain the epidemic will be lost.

Impact on Treatment Costs

Although the initial investment is high, the cost benefit of 'Ending AIDS' will be derived from: a few new cases to treat in a period of as short as 10 years (by 2024) and the annual ART cost falls below than that of the other scenarios. Under the other scenarios, the increase in new infections drives the treatment costs incrementally, year by year. Without additional investment in prevention ('Accelerate Treatment Only'), costs will escalate immediately.

The 'Ending AIDS' scenario shows a sudden increase in cost in 2017. This represents the expansion of ART coverage from ART initiation at a CD4 count of 500 or less, to treating all PLHIV irrespective of CD4.

Clearly, the 'business as usual' or without new investment in the response will allow the HIV epidemic to take hold in the Philippines, with serious implications for public health as well as major social and economic costs. On the other hand, focusing all investments on accelerating treatment would still lead to a continuous increase in new infections each year. The key to significantly

reducing new HIV infections, therefore, is to scale up the prevention coverage of MSM and PWID, sustain prevention coverage of "FSW," and at the same time, scale-up ART coverage among PLHIV.

The 'Ending AIDS' scenario shows that investing in prevention yields significant savings on treatment costs later, making the program affordable over the long term. However, if ART is scaled up without expanding and optimizing prevention coverage of the most affected populations, new infections continue to increase, treatment costs go upwards, and the program quickly becomes unsustainable.

The message from the scenarios is clear: only 'Ending AIDS' scenario will stop and reverse the epidemic before 2022.

[8] Reproductive Health

The full implementation of RA 10354 (Responsible Parenthood and Reproductive Health Care Act of 2012 is being challenged at all levels of governance and across the different branches of government. These challenges include: (1) the Supreme Court's (SC) Temporary Restraining Order (TRO) on public procurement and distribution of Implanon and the impending expiration of the certification of several family planning commodities; (2) gaps in provision of services and supplies caused by lack of coordination between national and local government units in terms of projecting family planning needs of their constituents; (3) regressive legislation at both national and local levels, and (4) constant threats of budget cuts during annual budget legislation. (PLCPD Secretariat, 2016)

The SC order restrained the FDA from granting any and all pending applications for registration and/or recertification of RH products and supplies including contraceptive drug and devices, restricted DOH from procuring, selling, distributing, dispensing or administering, advertising, and promoting the hormonal contraceptive "Implanon," and "Implanon NXT," resulting in a nationwide stock-out of family planning (FP) supplies in accredited public health facilities and in the commercial market. In addition, it prevented the market from reaping the benefits of a comprehensive RH program, as the TRO is a major stumbling block for the government's health, population, and development programs. (Cabral, 2017)

The 2014 NEDA MDG progress report cites various sources of maternal mortality ratio but all speaking of the same trend – increasing and alarming. The latest National Demographic and Health Survey (NDHS) data substantiate the figures with some stories behind the numbers – getting money for treatment, distance to health facility, and not wanting to go alone – as some key factors that hinder women from seeking care during pregnancy and at the time of delivery. Young women, women with more children, women who live in rural areas, women with no education, and women from the lowest wealth quintile are most likely to face at least one of these problems. (WomanHealth Philippines, citing 2013 NDHS and the 2014 NEDA MDG Progress Report)

Sexual and Reproductive Health of Adolescents and Youth

Pregnancy is considered "adolescent or teenage pregnancy" when the pregnant has not yet reached legal adulthood, which is usually within 13 to 19 years. The Philippine Statistics Authority's (PSA) presentation in the first National Summit on Teen Pregnancy showed there were 12 girls under 15 years old who gave birth to their third baby in 2010. (Ericta, 2012) These girls most likely gave birth for the first time at age 12 or even younger. To be more definite, the PSA

presented data on increasing births to women aged 13-19 from 2006-2010. The percentage of teens with children or are pregnant increased over the past decade. In a span of a decade, the number of girls aged 15 years old and below giving birth to their first child increased two-fold. From 616 in 2000, the figure rose to 1,260 in 2010.

Among 15-19 year old women, the figures reached 174,075 from 103,724, marking an increase of almost 70 percent during the same period. In 2010, 24 babies were born to women below 20 years old in every hour. This adds up to 569 per day compared to only 14 births per hour from the same age group or 345 babies born daily a decade earlier.

Another national-level study, the Young Adult Fertility and Sexuality Survey 4, conducted by the University of the Philippines Population Institute (2013) reported that the percentage of 15-19 year-old girls who have begun childbearing increased from 6.3 percent in 2002 to 13.6 percent in 2013. This is further emphasized by the fact that in the ASEAN region, the Philippines ranked as one of the countries with the highest rate of early pregnancy, with one out of 10 pregnant women being a child. In this situation, it is critical that young people have universal access to reproductive health in terms of commodities, options and services are made accessible. Health needs must be addressed by government programs.

In April 2014, however, the Supreme Court, upholds the requirement for minors to seek 'permission' from their parents before receiving reproductive health services (Section 23 (a)(2)(ii) 'insofar as it penalizes a health service provider who will require parental consent from the minor' was declared unconstitutional).

Among the teen-aged girls who had been or were pregnant, those belonging to the poorest quintile were five times more likely to be pregnant or to have children than young girls belonging to the richest quintile (NSO [Philippines] and ICF Macro, 2009). Unprotected sex was reported at 78% of the sexual initiation of young couples who were not married (University of the Philippines Population Institute, 2013). Even among teenagers who were already married or living in, only 14% were using contraceptives though 83% did not want to have children (NSO [Philippines] and ICF Macro, 2009)

Sexuality Education

Comprehensive health care also means access to information and recognition of the sexual and reproductive health and rights (SRHR) of adolescents and their capacity to make personal decisions. Sexuality education, a critical factor in ensuring sexual and reproductive health and well-being of people, especially of adolescents and youth, continues to be a contentious issue primarily owing to the stance of conservative groups led by the Catholic hierarchy. There are, however, ongoing efforts to define what "age-appropriate" sexuality education for students is, in both public and private school systems, as provided by the RP/RH Law.

Adolescents' access to reproductive health services is critically affected in the RH law. Minors, defined in the Philippines as adolescents, below the age of 18 are similarly prohibited from accessing contraceptives at public health clinics without parental consent. To work around this provision, channels such as social workers' proxy consent are sought at the community level. The provision in the approved legislation, allowing minor-parents or minors who have suffered miscarriage access to modern methods of family planning without written consent from their parents of guardian/s was voided in the 2014 Supreme Court decision.

In an official statement, Education Secretary Leonor Briones assured the public that the Department will follow the UNESCO guidelines on reproductive health, particularly in developing modules that will be used in schools. Teachers will also be trained on how to effectively discuss the dangers and emphasize the consequences of engaging in early sexual relations. (Department of Education, 2017)

Misconceptions and Poor Reproductive Health Outcomes

DOH consistently increases its annual budget but its priority is skewed on the curative rather than preventive side. Decades of campaigning against and spreading misconceptions about family planning/reproductive health have contributed to the low contraceptive prevalence as evidenced by the top reason for non-use cited above. Even among health and medical professionals, there is a divide on when life begins – moment of conception or implantation.

So much misconception and misinformation about the RPRH Law abound. Increasing the demand and utilization of RH services necessitates massive awareness and education campaign to change behaviours and complement the services that will be provided. Even if the allocation is sufficient to address supply, if the demand is low due to resistance and non-compliance out of fears and misconceptions, the budget will not be used. Against this backdrop and prioritizing the need to reduce poor reproductive health outcomes, especially of poor women of reproductive ages and young girls vulnerable to teen pregnancy, more budget allocation on family health is urgently called for.

Rights to Sexual and Reproductive Health of Indigenous Peoples

The National Indigenous Women Gathering held in October 2012 and attended by 42 indigenous women from 14 tribes within the country, came up with a National Indigenous Women Declaration 2012.29 This paper contains their issues with current government programs and policies that discriminate against them since their customary ways and traditions are not considered or recognized. Based on their reproductive rights issues, they call for the following:

- Stop criminalizing the traditional midwives from indigenous communities.
- Allow the traditional birth giving for women who have undergone regular prenatal check-ups.
- Provide training and certification to traditional midwives, and pass local ordinances that recognize them and the right of indigenous women to choose their own method of birth giving and care for themselves.
- Remove the 1,500 charge for every birth in health centers especially for those who are 4Ps beneficiaries.

Indigenous People-Maternal, Neonatal and Child Health and Nutrition (IP MNCHN), a multi-sectoral partnership initiative for the period of 2012 – 2016 was launched in Mindanao in November 2012. Based on the UNFPA's 2013 report, they are supporting the ongoing integration of traditional knowledge and practices associated with sexual and reproductive health of indigenous people into national and local policies. They conducted gender and cultural sensitization of health service providers, senior staff and policy advisers of the National Commission on Indigenous People (NCIP). They also provided reproductive health supplies and outreach health services to ensure availability and access to modern, safe and effective methods of birth spacing, including the provision of culturally-sensitive information on family planning and midwifery scholarships to young indigenous women.

ALTERNATIVE PROPOSAL: PHP 1.8 BILLION

In September 2016, during the legislation stage of the 2017 budget, legislators in the House of Representatives raised the unmet need for contraceptive in the Philippines, based on a Costed Implementation Plan (CIP) for Family Planning. The lawmakers cited the PhP 1.8 billion financial gap in order to fully implement national Family Planning programs.[27] (PLCPD Secretariat, 2016)

This proposed CIP of DOH and UNFPA focuses on the following:

- Leadership & management (Family Planning Unit, Systems, Monitoring and Evaluation)
- Supportive Environment (Contraceptive security, FP grants for demand generation & service delivery, nurse deployment program, purple ribbon award and Philhealth)
- Social marketing (media campaign)
    - PHP 426,740,089 for commodities
    - Target: 4,603,607 Women of Reproductive Age served: 3,689,165 (current users); 914,442 (new acceptors)
    - Based on projections of investments for 2017-2020: 23,900,680 women years of protection provided at a cost of PhP 11,468,634,385 or Php 480 per woman year of protection

[9] Strengthening Good Governance In Medicines

The current state of access to medicine and the dismal quality of pharmaceutical products are detrimental to realizing universal health care. ABI proposes the following measures to address this:

Accounting for Budgetary Allocation for Drugs, Medicines and Vaccines

To account for the substantial amounts allocated for the procurement of medicines every year, and in compliance with the conditions for budget approval, the DOH should regularly provide the following information in a transparent manner: (1) detailed list and breakdown of medicines that will be procured; (2) distribution list per health care facility; and (3) inventory and/or movement of medicines.

The information will help determine (a) equitable distribution throughout the country; (b) reach of medicines to poor households under the National Household Targeting System for Poverty Reduction (NHTSPR); (c) efficacy of medicines on local/specific health needs; and (d) procurement of health commodities at the best possible prices.

Ensuring the Safety, Efficacy and Quality of Medicines

As the guardian of people's health, and potentially the largest single buyer of medicines through Philhealth, the DOH should have the technical capacity to assess and ensure the safety, efficacy, quality and cost-effectiveness of drugs, medicines and vaccines procured for public distribution and use.

Adequate resources must be provided to the Food and Drug Administration (FDA) to ensure that it is capable of effectively enforcing its important regulatory functions that will safeguard

[27] The CIP is a multi-year actionable roadmap designed to help governments achieve family planning goals. It is focused on three components: (1) supportive environment through Contraceptive security through provision of FP supplies and services, FP grants for demand generation and service delivery, deployment of one RPRH officer per municipality under the nurse deployment program, purple ribbon award and PhilHealth services, an (2) social marketing, and (3) leadership and management.

consumers and patients against substandard and counterfeit medicines. As provided in the Cheaper Medicines Law (RA 9502), the FDA should be allowed to retain income generated for use in upgrading its resources including manpower, laboratory equipment and facilities, inspection and monitoring capacities, and information technology.

A strong FDA is crucial for the health of Filipinos. Currently, in addition to the voluminous load of registered products and licensed establishments under its review, the FDA has to deal with the problem of thousands of unlicensed establishments and unregistered products of doubtful efficacy and safety that are for sale to consumers. Moreover, FDA handles the implementation of emergent laws without the corresponding adjustment in manpower and budget.

Under RA 9711 or the FDA Strengthening Law, the FDA would undergo a five-year transition period into new organizations. After which time, it is hoped that it will be able to sustain itself on the basis of its income. It will be shifting to the new FDA which will reorganize into four-focused centers. During this period of development, it would urgently need support to address deficiencies in infrastructure, equipment, and manpower. Until the Department of Budget and Management approves this five-year business plan, the office's income sustainability remains uncertain.

Streamlining the Drug Management Process

It is recommended that the DOH invest in developing an effective and efficient model for pharmaceutical management that takes into consideration the current and future demands for medicine access programs, national health priorities on access and availability of medicines, and the legal framework for government procurement (RA 9184). Resources must also be dedicated to capacitating the DOH central office, regional DOH offices, and retained hospitals in maximizing the use of the said pharmaceutical management model to ensure regular access to medicines, in line with the thrusts of *Kalusugang Pangkalahatan.* The supply chain management system will (1) ensure transparency in and efficiency of the procurement process; (2) increase the level of technical capacity in warehousing, logistics and inventory management; (3) ensure the quality of medicines throughout the entire supply chain; and (4) ensure an appropriate system for managing drug donations, particularly during health emergencies.

Working with Local Governments

LGUs likewise allocate budget for the procurement of drugs and medicines for hospitals and health facilities that are managed by them, and for distribution to their constituents through rural health units and barangay health stations. A disconnect was observed between the policies and strategic directions at the national level, on the one hand, and the efforts of local governments to deliver health products and services and manage their resources for health, on the other.

It is recommended that the DOH collaborate with LGUs (possibly through their leagues) in linking their health programs so that the objectives for better health outcomes are achieved and resources are maximized. Such collaboration will address gaps, eliminate overlaps, and ensure prudent and wise spending of scarce government resources as well.
Investing in an extensive information and education campaign may facilitate this process.

Strengthening Transparency and Accountability in Access to Medicines Initiatives

Civil society must work with the DOH (and its attached agencies, regional offices and retained hospitals) in instituting a monitoring scheme that will provide information on:

- Level of utilization of budget allocated for specific medicine access programs (MAPs)

- Actual availability of medicines in identified health facilities and target access points
- Ease or difficulty of access by target beneficiaries
- Level of public awareness and information about the medicine access programs
- Results and outcomes of the specific medicine access programs.

The said scheme or tool should be able to provide information and evidence that will be useful for both planning and decision-making purposes at the national, local and facility levels; and monitor and track results, outcomes and the impact of access to medicines initiatives.

OTHER RECOMMENDATIONS

- For budget to be maximized and utilized, and since the DOH is the single biggest buyer of medicines, the DOH should base their decisions on the purchase of medicines and vaccines to purchase on a cost-effective study. This is, of course, aside from the need to ensure that it adheres strongly to transparent bidding, among others.
- Civil society monitoring of government procurement and disbursements of medicines.
- Medicines procurement should be driven by local demands and not based solely on national government decision
- CSO monitoring of whether the demands are met and the supply is appropriate.
- A cap with respect to time in the bureaucratic process (study, bidding, procurement, and disbursement) to avoid wastage and ensure that supply meets demand.
- National government to work closely with pharmaceutical providers (assuming all bidding processes are met) to create access points for medicines delivery in the provinces. This will aid the timely distribution of medicines and will decrease national government's burden in transporting and ensuring effective distribution when needed.
- Ensure medicines, especially those in the National Drug Formulary, and drugs for disasters or humanitarian situations are always available. Regular monitoring of agencies involved in disaster (e.g. DOH) and making them accountable is important.
- Aggressive information dissemination on Rational Use of Medicines (as provided in RA 9502) is still not being implemented. This will create options for Filipinos to buy medicines that are needed. It will also give the people the right to choose whichever health modalities (not only medicines). In addition, this will pave the way for increasing health promotion programs with budgetary support.

[10] Children and Youth

Child's Rights Guiding Principles

The guiding principles are crucial to understanding how to fully implement programs for the children. They provide the means by which the substantive articles are interpreted and achieved. In keeping with the indivisibility principle of human rights, each of the guiding principles must be considered alongside each article.

They are often described as instrumental rights – rights of good process that children should enjoy. It has been said that by adopting this approach, the Convention becomes more than a mere list of obligations.

The guiding principles of the Convention include non-discrimination; adherence to the best interests of the child; the right to life, survival and development; and the right to participate and

respect for children's views and opinion. They represent the underlying requirements for any and all rights to be realized.

The United Nations Convention on the Rights of the Child (UNCRC) is the most complete statement of children rights ever produced and is the most widely-ratified international human rights treaty in history. The Convention covers all aspects of a child's life and set out the economic, social and cultural rights that all children everywhere are entitled to. It also explains how adults and governments must work together to make sure all children can enjoy all their rights.

The UN Committee on the Rights of the Child General Comment No. 19 on Public Budgeting for the Realization of Children's Rights is the first UN document to provide detailed guidance to states on their legal obligation to invest in children. Since its adoption in 1989, the UN Convention on the Rights of the Child has been ratified by all countries of the world but one. Yet governments still need to do more to realize children's rights.
General Comment No. 19 recommends open, inclusive and accountable resource mobilization, budget allocation and spending. It clearly states that States must not discriminate against any child through resource mobilization, budgeting and spending.
States should also regularly ensure that children participate in budget decisions, allowing children to participate in those issues that concern them.

Government institutions are working on different databases that promote questions on the integrity of government's assumptions in drafting their programs/services for children.

Children need the guidance of the State alongside parents, teachers, and other adult support, and thus, government programs and services must not consider them a liabilities (e.g. children as collateral damage in the program of the government against drugs, MACR should not be lower than 18).

Parents/guardians are strong partners of the State in ensuring that children become productive members of society (e.g. mechanisms in medicine/health program administration should be consistent with due diligence in terms of consultation/proper information dissemination to parents/guardians as it should be in the case of dengvaxia, etc.)

Alternative Proposals

The framework of the DOH and its over-all goal to improve the health status of adolescents and to enable them to fully enjoy their right to health is a welcome development. However, improvement on health status should be universal and inclusive across all ages of children. Children should not only be seen as recipients of services but actors in attaining their right to health, thus recognizing their evolving capacities. This framework recognizes the four (4) principles of the UNCRC – survival and development, participation, non-discrimination, and best interest of the child.

What is crucial is to analyze how the budget for children's health is programmed and delivered and how children can access these programs and services. Government's investment on the health of the newborn and of the under-five age group is critical in ensuring a strong foundation for children's health and in addressing the MDG Goal 4 in reducing child mortality. However, the health needs of children above 5 years old, including adolescents, have fallen into the cracks and remained unaddressed.

Support is given to children's immunization and micronutrients supplementation as part of addressing the primary and preventive health care. However, children's changing needs have moved from merely physical health but towards including their mental health as well. The number of cases of depression and aggressive behavior among children and young people has been increasing. These behaviors push them to engage in activities that place their health at risk such as substance abuse and alcoholism, among others. Cases of suicide among children have also been reported, but these were treated merely as incidences or news rather than as mental health issues.

Children's right to health can be best achieved through responsive government programs and services and through children being able to participate actively in the designing, planning, implementation, and monitoring and evaluation of these programs and services. The children's proposals across all sub-clusters should be included in government health program and budget to ensure that children's right to health is given due consideration. In addition are the following inter-agency collaborative actions to ensure synergistic and complementing programs in comprehensively addressing children's health:

[10a] Health Services and Infrastructure

Health services and infrastructure through schools should match the needs of target constituents and not "blanket" policy / programs developed using urban centers/case studies of specific communities (existing budget but evidence-based programming)**.** Programs and services should go to constituents rather than the other way around (existing) and there needs to be a health database with sub sector for children sector

In talking about health services, focus should be given on the following issues/topics since "poor health and nutrition among children" is the focal problem for health and nutrition. Three direct causes for this problem were identified and these are poor maternal health, inadequate nutritious food intake, and vulnerability to infectious diseases. These direct causes have a number of root causes.

10a.1. Health Human Resource Development in the national and local government

- Integrating the UN Convention on the Rights of the Child (UN CRC) in developing modules for capacity-building of health service providers
- Hiring of health service personnel (one doctor, one nurse) per Barangay Health Unit focusing on children's health considering that there is no one to one correspondence in program management in the local and the central government

10a.2. Health Facilities

- Rehabilitation centers for children to address issues on drug/substance abuse
- Enhancement of facilities for children in hospitals should be done to include children's ward with special sections for treating children within out-patient department/emergency room child protection unit; and adolescent-friendly facilities within children wards, maternity wards and labor rooms. Consultation and engagement with children and groups working on children's rights should also be done prior to these enhancement and construction of new facilities.
- In order to ensure children's safety during disasters, the provision of separate toilets for girls and boys in evacuation centers is also proposed.

10a.3. Implementation of the Philippine Plan of Action for Nutrition (PPAN)

- Inadequate intake of nutritious food is caused by poor infant and young child feeding (IYCF) practices because of lack of knowledge on breastfeeding and complementary feeding. For older children especially school age, they have limited option for nutritious food while non-nutritious food is so accessible. This is largely influenced by the profit driven food industry and misleading advertisements. Lack of food security among families is largely caused by low income and if they live in areas frequently affected by disasters. Food shortage is a consequence of damages from disasters.
- Another direct cause of poor health and nutrition among children is the vulnerability to infectious diseases. The vulnerability is triggered by poor hygiene and sanitation practices of families and improper waste disposal. Another is the incomplete or lack of immunization of children caused by the limited capacities of health and nutrition personnel and lack of medical supplies.
- The identified root causes are not in one-on-one correspondence with the intermediate causes, instead they are entwined upwardly to more than one intermediate cause. These are the insufficient health and nutrition promotion, weak implementation of health and nutrition policies on national and local levels, poor value system and lack of political will on health and nutrition. Social stigma has been identified as a contributing factor to peer pressure and lack of parental guidance. Generally though, these root causes in one way or another influence more than one intermediate cause.
- The PPAN 2017-2022 comes with a budget estimate for the entire period of six years.

10a.4. First 1000 Days

- There is an on-going deliberation on the F1D bill at the Senate. The bill seeks to develop a comprehensive health care program for pregnant and lactating women and adolescent females giving preferential attention to those in Geographically Isolated and Depressed Areas (GIDA) or in nutritionally-at-risk regions.
- The First 1000 Days is a crucial window of opportunity (from pregnancy to two years old) to prevent irreversible damages of malnutrition to the child such as wasting (“too thin for age”) and stunting (“too short for age”). Poor nutrition in First 1000 Days has long term adverse effects on the child.
- Effects on stunting: increased risks to child morbidity (sickness) and mortality (deaths); reduced school performance and later on, poor job productivity which translates to approximately 1.37% in GDP losses
- 1 in 3 children under five years old in the Philippines is stunted

10a.5. Expanded Maternity Leave

- Mothers know that 60 days is just not enough to recover from the rigors of pregnancy and childbirth. And yet, the current law only allows 60 days of paid leave for mothers and only seven days of paid leave for fathers.
- The Expanded Maternity Leave Law of 2017 or Senate Bill 1305, which was authored by Senator Risa Hontiveros, hopes to make a difference in the lives of Filipino parents by giving them more time to care for their newborns. Senate Bill 1305 was approved on third and final reading at the Senate on March 6, 2017. It seeks to grant 120 days of maternity leave to expectant mothers.
- As of this writing, the proposed bill has already gained ground and already in the advanced stage of legislative process

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10a.6. HIV and AIDS on children[28]

Children affected by HIV/AIDS includes those under 18 years who: Have close family members living with HIV, lost close family members to HIV and AIDS, are infected with HIV

- The National HIV/AIDS Registry lists only known cases of HIV. If most of the estimated 9,000 people living with HIV (PLH) in the Philippines have children, that could mean thousands of children are affected.
- For children living with HIV, no pediatric formulations of anti-retroviral drugs (ARVs) are available, and children are forced to rely on adult formulations, often with strong side effects. The national government is procuring ARVs for 10 children, with the drugs expected to arrive by 2006. Because of the silence surrounding HIV, children are not diagnosed for HIV, nor treated for possible related ailments.
- Risky behaviour because of lack of parental guidance and peer pressure links to triggering factors that place children more vulnerable to infectious diseases[29].

10a.7. TB on children[30]

- Despite advances in medicine, the Philippines continues to be highly burdened in terms of incidence of tuberculosis (TB) compared to other countries in the world.
- Worse, children accounted for more than half of identified tuberculosis cases, Dr Cleotilde Hidalgo How, board member of the Philippine Coalition Against TB (PhilCAT). Hidalgo How said that of 26,000 TB cases screened in 2010, more than half, or 14,527 were kids.
- This a cause for concern, according to Hidalgo How, because, while childhood TB is not infectious, they "form a big reservoir for future adult TB cases when not diagnosed early and treated adequately."
- "Children, especially the very young, are most vulnerable not only to TB but to the most complicated forms like TB meningitis," Hidalgo How said.

10a.8. Adolescent sexuality and pregnancy

- Teaching health promotion and sexuality and reproductive health education in educational institutions
- Promote the creation of an enabling environment for adolescent mothers through automatic inclusion in the Department of Social Welfare and Development's Pantawid Pamilyang Pilipino Program (4Ps), facilitating their automatic enrolment to the National Health Insurance Program as sponsored members

[10b] Planning and Programming for Health

- To include resource persons on health rights advocates to inform the annual planning and programming of the government – including proper contextualization of "child participation" and citizen participation in health programs and services implementation not as compliance through a half-day's meeting with DOH program representatives who are not even able to respond to specific inquiries in programs/services implementation (existing

[28] https://www.unicef.org/philippines/children/hivaids_fastfacts.html

[29] WV Technical Programme on Health and Nutrition

[30] https://www.rappler.com/nation/2832-more-than-half-of-tb-cases-are-kids

but may need widespread mainstreaming of the importance of citizen participation across DOH and other government institutions through the PBB or related mechanism)

[10c] Strengthened Government Role and Coordination

- Concerted government agencies' work in strengthening of institutional support to children abused or alleged to be victims of abuse (existing but should be factored in rational allocation of health human resource and education workforce to ensure that this is among core functions of teachers and not just a dispensable addendum to their functions like being a Gender and Development Focal Person/Committee Member
- strict monitoring/regulatory authority of inter-agency of the government re: health promotion through products in school cafeteria – and for DA to have a strong role in this area
- DTI and DA to have strong collaborative work in making healthy options more affordable in markets than processed foods
- DOH to perform a strong consultative role in the implementation of women and children's desk (social protection services) by the PNP and the likes to ensure that programs are consistent with principles in health service delivery (e.g. holistic treatment accorded victims of abuse, abandonment, etc.)
- Strong regulatory role of DOH (with inter-government agency) in ensuring that hospital services are responsive to basic rights to health and not as commercial activities (existing but training programs should target this among core skills/mindset to be developed as opposed to rest and recreation disguised as lakbay arals)
- Addressing concerns on the children and young people's health-seeking behavior through an interagency intervention: values of children on health through the education curriculum and making health facilities and health workers child-friendly
    - Strengthen the role of schools as key players in promoting school health and nutrition
    - Come up with a comprehensive school health program that will encompass children of all ages
- Inclusion of disaster preparedness in the regular agency programming based on local data in order to determine the necessary programs for implementation
- Approaching comprehensive adolescent health framework as a joint program within the DOH. While the radical efforts of the central office to come up with a comprehensive adolescent health and development framework is commendable, the budget allocation seem to go mainly to adolescent vaccines, adolescent sexual and reproductive health training and advocacies. Other adolescent health issues and concerns—tobacco consumption among children and young people for instance—will be more effectively addressed through harmonized interagency initiatives.
- Nutrition:
    - Develop and adopt policies that promote the integration of nutrition and food security into agricultural programs.
    - Adopt policies to improve the availability and affordability of nutritious foods.
    - Conduct research to develop the evidence-based integration of nutrition and agriculture to improve child nutrition.
    - Conduct research to study the impact of agriculture on health, and the impact of agricultural interventions on rates of malnutrition,
    - Include nutritional indicators in agricultural plans and programs
    - Promotion of and support to farming systems that promote household nutritional needs – collaborate with the National Nutrition Council for such programs.

- Provision of support to small-scale farmers especially women farmers in the form of resources and knowledge, and ensuring agriculture nutrition interventions are suited to the land they own
- Integrate education about nutrition in all agricultural and fisheries programs, encouraging farers to spend their increased incomes on more nutritious food
- Design and implement programs to provide more appropriate support to women farmers.
- Promote urban gardening and other innovations in areas where there is no access to agricultural land
- Prioritize region where poorest farmers are to improve access to markets

[10d] Health Popularization

- Schools and public news agencies to be maximized in popularizing measures/perspectives that prevent health and psychological abuse (interagency government to include MTRCB, PIA, etc.)

[10e] Child Protection

ABI Health supports the development of a comprehensive child development and protection framework. As discussed above, the Convention on the Rights of the Child, of which the Philippines is a signatory, calls for a comprehensive and participatory approach to child protection.

Table 23: 10e.1 National Framework Development and Human Resource Provision for Women and Children Protection Units (WCPUs)

ABI Proposal	Budget Proposal and Source of Financing	Rationale
Consultative Workshops on Comprehensive Child Development Framework	Luzon = PhP 400,000 Visayas = PhP 400,000 Mindanao = PhP 400,000 National Validation = P500,000 Total: PhP 1,700,000 Source: DOH MOOE Budget	Budget allocation to support inclusive and participatory, island-wide workshops on comprehensive child development framework
At least one (1) social worker in every DOH retained hospital* dedicated to WCPU services *assuming network-based health service delivery under UHC Law in 2019, Social Worker can work within the network	PhP 314,304 x 72 retained hospitals = PhP 22,629,888 Source: DOH Personnel Services permanent hospital plantilla position review	Consistent to the proposals 1 on health human resource, plantilla positions in hospitals need to be reviewed based on population health needs. In view of the number of unfilled positions in DOH hospitals and the lack of social workers in health facilities, the proposal is to include in hospital staffing additional dedicated social workers who can address critical non-medical interventions that are crucial to people's health and well-being, such as women and children protection.

On-call* sign language interpreter in every WCPU in retained hospitals *assuming network-based health service delivery under UHC Law in 2019, sign language interpreter can work within the network	PhP 15,000/month x 12 mos x 72 retained hospitals = PhP 12,960,000 Source: DOH Personnel Services permanent hospital plantilla position review	Provision of sign language interpreters is crucial in ensuring accessibility of health and other social services.
Training on inclusive WCPUs for Social Workers and Service Providers	Meals and accommodation = PhP 2,000 x 40 pax x 2 days = PhP 160,000 Supplies and transportation = PhP 20,000 Honoraria = 5 x PhP 4,000 (?) = 20,000 x 3 = 60,000 PhP 160,000 x 3 (Luzon, Visayas, Mindanao) = PhP 480,000 PhP 20,000 x 3 (Luzon, Visayas, Mindanao) = PhP 60,000 PhP 20,000 x 3 (Luzon, Visayas, Mindanao) = PHP 60,000 Total: PhP 600,000 Source: DOH MOOE Budget	The training serves as a capacity development for WCPU providers on inclusive health service provision. Former Philippine Deaf Resource Center (PDRC) reported in 2014 that 1 in 3 deaf women in the Philippines is sexually harassed or raped. Despite the decrease in rape cases in the country, rape remains the most widespread crime against Deaf women, who are often misunderstood by the police at the time of reporting due to lack of trained and trustworthy sign language interpreters. Improvements are called for in handling the processing of deaf complainants: from the reporting of cases in police stations; to medico-legal examination of rape victims; and throughout the duration of court proceedings in order to address barriers to reporting and provision of appropriate interventions. Source: https://news.abs-cbn.com/focus/10/20/14/stories-silence-deaf-women-and-sexual-abuse, citing data from Philippine Deaf Resource Center
TOTAL	PS: PhP 1,700,000 (exclusive of mandatory benefits)	

	MOOE: PhP 36,189,888	

10e.2. Inclusive Children's Television Programming

Rationale

- Reach children / OSY nationwide who may not have access to formal or alternative schooling, or internet / computer resources;
- Implement mandates of inclusiveness according to Philippine laws and international commitments to the United Nations Convention of the Rights of the Child (CRC), Convention the Rights of Persons with Disability (CRPD), Convention on the Elimination of Discrimination Against Women (CEDAW).
- Prioritize overall literacy and health issues particularly: mental health issues, HIV / AIDS info, SHRH including personal safety for combatting sexual violence

Goals

- Progressively transform existing children's television (TV) into inclusive programming, primarily for accessibility for children with disabilities
- Promote new universally designed children's TV programs
- Prioritize general literacy and health information dissemination

Objectives

- Formulate policy (short-, medium-term plans) and develop practices for full accessibility for children with disabilities viewers, i.e., sign language use for the Deaf, supplemented by captioning; audio description for blind and low vision chlidren; Easy to Understand for children intellectual / developmental/ cognitive disabilities
- Initiate awareness raising, technical training for NCTV staff and partners
- Provide initial appropriations

Method

- Appropriate (up to the medium term) transformation of National Children's Television Foundation - an attached agency of the Department of Education, while building long term sustainability capabilities
- Promote partnerships / relationships with producers (including cooperatives of persons with disabilities) who can supply programs
- Coordinate with ECCDC, ALS to align with core target competencies for learners
- Facilitate affirmative action for these programs in the procurement process

Table 24: Proposal for Inclusive Children's Television Programming

ABI Proposal	Budget Proposal			Remarks
	PS	MOOE	CO	
POLICY				
Standard-setting		30,000		
Consultants		150,000		On deaf; blind; intellectual disabilities
Training for staff		20,000		Universal Design
Research		240,000		Continuing documentation of impact (20,000/mo)

Workshops for public		600,000		Children with disabilities and stakeholders; regional and nation-wide: Luzon, Visayas, Mindanao ARMM = 6 x 100,000
Subtotal, Policy	1,040,000			
Pilot financing for existing programming		1,250,000		Provision of past episodes with interpreting audio description: Batibot, Sineskwela, etc. – 5 programs; P250,000
Royalties				P100,000 x 5 programs
Sign language interpreting				P100,000 x 5 programs
Audio description				P100,000 x 5 programs
Easy to understand				P100,000 x 5 programs
Alignment with curriculum for ALS				
Admin/counterpart for PPP				P10,000 x 5 programs
Subtotal, existing program	2,080,000			
Pilot financing for new programming				
Workshop/traiing for prospective suppliers		900,000		
Standards dissemination		100,000		
Admin screening; procurement		150,000		
Seed financing for new programming		11,000,000		30-minute program, 1x/wk, airing for 10 months = 40 weeks; 40 weeks x P250,000/week = 10 Million; airtime: 1 Million
Subtotal, new programming	4,580,000			
TOTAL	Policy: PhP 1.04 Million PPP Existing Program: P2.08 Million New Program: P4.58 Million Grand Total: P7.7 Million			

10e.3. Proposals for implementation:

- PhilHealth benefit package for VAWC cases (assume UHC Law in 2019 and HTA process)
- Harmonization of Violence Against Women and Children Registries
- Inclusion of WCPU in the accreditation/licensing in delivery-based networks
- Inclusive and accessibility of services
- Issuance of circular clarifying roles of agencies in child development and protection, including who will allocate budget for the programs

A Better Democracy, A Better "Health for All": Citizen's Participation in the Health Budget

In a society, like the Philippines, wherein representative democracy is elite-dominated and political culture and governance practices are patronage-driven, better governance outcomes can be achieved by exercising the people's right to participate in governance. People's participation does not only bring back the state closer to the people, it fosters deeper democratic practices that will ultimately result in an empowered citizenry. "The more you institutionalize grassroots people's participation and involvement, the more you facilitate the forward and bottom-up transmission of what social needs are and how they can be addressed through public finance, resulting to better social outcomes. Consequently the more people will opt to join, legitimizing the whole democratization process." (Miraflor, 2012)

Currently, there are available spaces for participation in the government's development planning and budget process. However, these spaces are not power-neutral. Invited participatory spaces are laden with power inequalities and power relations. For example, in previous years, DBM's Budget Partnership Agreement (BPA) is not just exclusionary; it also suggests a token participation of civil society. By design, it deprives CSOs of the opportunity to be involved in planning and decision-making as it limits their participation in monitoring of government programs (i.e. in budget execution and not in budget preparation).

Reforms in the design of existing participatory spaces, like the BPA, should be undertaken to encourage substantial, broad-based/grassroots participation, and respect for the autonomy of civil society. In particular, documentary and reporting requirements of the BPA should be flexible to enable grassroots CSOs and the marginalized groups to participate. A prior consent from the government agency in the release of information and findings by the CSOs should be lifted as this conditionality curtails CSOs' autonomy and undermines transparency and accountability in governance.

The setting up of CSO Desk across all agencies will streamline peoples' participation in the budget. Participation should not only take place in the agency planning and budgeting. Equally important is civil society participation in the Development Budget Coordination Committee (DBCC), a body that determines the macro-economic framework of the budget, including the sectoral allocation of the national budget.

Citizens' participation is not only deemed essential in good governance but it is also an enabling right to the fulfillment of Filipinos' right to health care. A bigger challenge for CSOs and ordinary citizens is building their political and technical capacity to be able to make a difference in the exercise of their right to participate. Critical to this is the institutionalization of a law on Freedom of Information that shall ensure peoples' access to pertinent information and shall serve as a deterrent to corrupt practices in the government. This is especially relevant to the delivery of public health care which has been subject to many corrupt practices, a tool for promoting patronage and prone to profit motives for big corporations. Needless to say, the effective claim-making of people's right to health require the access to information.

Sources of Financing

If identification of sources of health financing is based on the primary causes of mortality and morbidity in the country, using the lens of the social determinants of health, then, alongside the general fund, earmarked funds for health in the Sin Tax Law, other sources should be tapped such as the Motor Vehicle User's Charge given that the 5th leading cause of mortality is road accident.

Table 25: Proposal for Healthcare Financing

Policy	Fund	Agency
Department of Health	General Fund	DBM, DOF
PhilHealth	PhilHealth Reserves	PhilHealth Board
Excise Taxation on Tobacco and Alcohol (RA 10351)	85% of incremental revenue	DOH, PhilHealth
Motor Vehicle User's Charge (RA 8794)	80% Special Road Fund 7.5% Special Road Safety Board 7.5% Special Vehicle Pollution Control Fund 5% Special Local Road Fund	DPWH, DOTC, other stakeholders
Clean Air Act (RA8749)	Fines and Penalties collected by EMB and LTO as stipulated by the law	DENR
Gaming and Amusement Tax (RA 6631/8407, 6632/7953)	Share of Franchise Tax/VAT	
Malampaya Fund		
Mining Fees/Fines		

Table 26: PROPOSED AMENDMENTS TO THE UNIVERSAL HEALTH CARE BILL SB 1896

ABI Health Cluster – Social Watch Philippines is particularly concerned about these ten (10) main parts of the bill for these may put the various members of the basic sectors at a great disadvantage:

1) Declaration of Principles and Policies. We propose for a comprehensive definition of health as the "state of complete physical, mental and social well-being and not merely the absence of disease" and a clear articulation of health as a right regardless of one's ability to pay; having health services free at point of service, pre-paid for by taxes or social health insurance included in the principles and policies to set the foundation of the UHC.

2) Definition of Terms. We propose for the adoption of rights-based and comprehensive UHC definitions such as guaranteed health services (instead of essential health services), the use and pursuit of the term Primary Health Care Network (PHCN) that adopts a whole-of-health systems, whole-of-government and whole-of-society framework (instead of service delivery networks); use of the term health system "navigator" than gatekeeper when pertaining to primary care providers are proposed herein.

3) Framework for Universal Health Care. The goal of achieving progressive realization of people's right to health is proposed to be clearly included in the framework for UHC, such that out of

pocket (OOP) share of Total Health Expenditure is reduced to 20 – 30%, an internationally accepted threshold for financial risk protection.

4) Health Financing
   a) In the current SB 1896, the individual and population-based guaranteed health services covered shall be financed through a mix of general and earmarked taxes, pooled funds from other national government agencies, and NHIP premium contributions. One main proposal of ABI Health-SWP to the bill is that instead of legislating the delineation of financing for the provision of individual and population-based services between PhilHealth and DOH and LGUs respectively, which in effect, may be too inflexible if legislated, a provision stating "The DOH and its attached agencies and PhilHealth shall coordinate to avoid overlapping of payment for services" should be used (see details on rationale in the attached matrix).
   b) For direct contributors, it is proposed that the premium ceiling shall be removed and all contributory members shall pay 2.75% of their monthly salary, equally shared by the employee and the employer. Any increases in the contribution drawn from employees' salary should undergo proper consultation and the removal of premium salary ceiling allows for more progressive contribution collection and funds redistribution.

5) Service Delivery Networks. The name defines the function. The proposal is for the country's UHC to pursue a Primary Health Care Network (PHCN), including the following proposed key components:
   a. Service delivery networks (i.e PHCN in the proposed amendments) whether publicly or privately owned or led shall be responsible for providing access to population-based and individual-based services, developing operational guidelines and standards, and implementing programs that improve health literacy, foster good health-seeking behavior, and support healthy lifestyle and environments.
   a. Minimum service capacity: should ensure social inclusion and full accessibility based on the local context, primary care team, and establishment and maintenance of electronic medical records
   b. Private Health Care Providers and the Service Delivery Network (we propose adoption of a Primary Health Care Network) – The proposal is for individual, institutional, and community health care providers in the private sector who constitute themselves into service delivery networks, shall do so as juridical entities, preferably of a non-stock, non-profit nature, mandated to provide a public good component.
   c. Income Retention. The proposal is for all contracted publicly-owned or led service delivery networks shall be authorized to retain and utilize 100% of its health-related income and pool these into the Special Health Fund; Provided that, a fixed percentage of retained health income shall be used as incentives for all public health workers within the network without prejudice to primordial role of the state to provide public health services; The special health funds is also proposed to be used for the purpose of financing either population-based or individual-based health services, including the required health human resources.

6) Health Human Resource. Considered as the heart and soul of the health system, it is proposed that the following be included in the bill:
   a) The National Health Human Resource Master Plan. The DOH together with other stakeholders shall ensure the formulation and implementation of a national health human resource master plan that will address the appropriate production, recruitment, retraining, regulation, and retention, reassessment of the workforce based on population health needs.
   b) In support of the production of health workforce, we propose that the Commission on Higher Education (CHED) and DOH shall develop and plan the expansion of local health-related degree programs and regulate the number of enrollees in each degree program based on health needs of the population this will include shifting the focus and learning outcomes of degree programs to respond to the health needs of the population. For programs not available locally, they shall develop a systematic capacity development program.

c) To enhance recruitment into the workforce, we also propose that the DOH position on return of service be included and that the required number of years of service rendered be set to at least four (4) full years. "All health professional graduates of public universities and colleges, and recipients of government-funded scholarships in private institutions shall be required to render at least four (4) full years of service, with compensation and under supervision, in DOH-determined underserved service delivery networks; *Provided that,* for medical graduates, such service shall be a pre-requisite to entering medical residency training, whether locally or internationally."

d) For the recruitment of health human resources into the workforce, we propose for the inclusion of this provision: "Underserved Areas. - In order to encourage service in underserved areas, government health workers shall be compensated based on 100% of Salary Standardization Rates."

e) To strengthen provisions on the retention in the workforce, we propose for the inclusion of this section: *Security of Tenure and Available Plantilla Items.* - The DOH, Department of Budget and Management (DBM), Department of Labor and Employment (DOLE), Civil Service Commission (CSC) and Department of Interior and Local Government (DILG) and LGUs shall work to ensure that the contractual health workers, both in public and private, transition as regular and permanent employees.

f) The proposal is also to put forth retention in the workforce through a competitive compensation package. In order to ensure that all health professionals, personnel, and staff both public and private sector, receive adequate compensation and benefits commensurate to their fundamental role in society and the amount of work that they render, the DOH in consultation DOLE, CSC, DBM, public sector unions and/or federations and national labor centers shall work for the increase in salaries and allowances of all health professionals

7) Regulation. A provision on supplementary coverage between the Philippine Health and Health Maintenance Organizations (HMOs) is proposed, which states, "Individuals with private health insurance (PHIs) and enrolled in HMOs shall utilize their benefit package from HMOs to be supplemented by PhilHealth if insufficient. The DOH shall work with the Insurance Commission to develop and monitor implementation of standard plans and co-insurance schedule for HMOs and PHIs. In addition, HMOs and PHIs are mandated to extend coverage of the insured beyond the current 60-year old cut-off."

8) Health Technology Assessment (HTA). The HTA process shall be open to appeal, public debate and scrutiny and shall ensure that its decision-making processes are transparent. The results of its deliberations shall be made public, ensuring people's meaningful and effective participation through periodic public consultations such as a national people's summit to review and propose changes. The same should also encompass economic, social, organizational, ethical, clinical, and legal perspectives in the identification of priority diseases, most effective and cost-effective interventions, and the special price.

9) Health Promotion. The promotion of the right to the enjoyment of the highest attainable standard of health is proposed, particularly, making the Health Promotion provision sustainable by mandating the development of a multi-sectoral roadmap on health promotion, mandating the allocation of at least 1% of the DOH budget for health promotion to ensure sustained financing, and mandating funding for Participatory Action Researches on Health Promotion to improve evidence gathering of effectivity of health promotion programs

10) Appropriations. The replacement of a much clearer provision on the appropriations section, in the list of funds to be pooled for Universal Health Care is proposed. From "a) Total sin tax collections as provided for in Republic Act (RA) No. 10351 of the Sin Tax Law; Provided, that the mandated earmarks as provided for in R.A. Nos. 7171 and 8240 shall be retained; to "a) Earmarked funds for health as provided for in Republic Act (RA) No. 10351," maintaining that the incremental revenues for health mandated by RA 10351 should be used for UHC.

As of August 2018

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ALTERNATIVE BUDGET PROPOSAL FOR PERSONS WITH DISABILITIES

ACCESSIBILITY: KEY TO INCLUSION AND PARTICIPATION IN COMMUNITY LIFE & CHILDREN'S TELEVISION AS A PLATFORM TO REACH AND INCLUDE CHILDREN WITH DISABILITIES

Alternative Budget Proposal for Persons with Disabilities

Accessibility: Key to Inclusion and Participation in Community Life

Preface

It has been ten years now since the Philippine ratification of the CRPD (2008). There is no evidence of any remarkable improvement in the implementation of the CRPD. Physical accessibility of the built environment and public conveyance is still a major concern. The MDG is considered by many as not much of a success. The sector of persons with disabilities glimpsed hope in the current SDG with its overarching principle of leaving no one behind.

The present administration is in a "Build! Build! Build!" and modernization frenzy. This is a good opportunity to include accessibility concern in development particularly on physical accessibility of the structures and facilities (including privately-owned establishments that are for public use) and public conveyance.

Our contention

Persons with disabilities face numerous barriers that hinder inclusion and participation in community life. These barriers are encountered in practically all stages of their life – when accessing health services, getting an education, obtaining employment, making a living, starting a family, and even up to securing retirement.

The latest World Health Organization (WHO) figures show that persons with disabilities comprise 15% of the total population. Using the WHO estimate of 15% of the population, there are about 15,000,000 Filipinos with disabilities.

In the Philippines, the 2010 Census of Population and Housing (2010 CPH) indicates that out of the 92.1 million household population in the country, 1,443,000 persons or 1.57 percent had disability[31]. The 2010 Philippine census may be erroneously low because of many factors. Nonetheless, with around 100M Filipinos, this still translates to 1,500,000 Filipinos with disabilities.

Around 25% of the 1.5 million Filipinos with disabilities belong to the children and youth population. This population will not be given the chance to achieve their full potential and become contributors to national development if interventions are not instituted immediately. They will face the current barriers to inclusion and participation. They will experience the same difficulties experienced by adult Filipinos with disabilities now.

[31] https://psa.gov.ph/content/persons-disability-philippines-results-2010-census

Even without looking at statistical data and population demography, it is not hard to imagine that the sector has the following characteristics:

- Lower educational achievements
- Lower levels of employment
- Poorer health outcomes
- Higher rates of poverty
- Increased dependency and reduced participation

The 1987 Philippines Constitution Section 10 states “The State shall promote social justice in all phases of national development” and Section 11 states “The State values the dignity of every human person and guarantees full respect for human rights.” The Philippine government has signed and ratified the Convention on the Rights of the Child (CRC) and the Convention on the Rights of Persons with Disabilities (CRPD). As part of the Philippine government’s commitment and state responsibility to the CRC and CRPD, it has enacted RA 7610 ("Special Protection of Children Against Abuse, Exploitation and Discrimination Act”). All these form the primary basis for the protection of the rights of children and youth with disabilities.

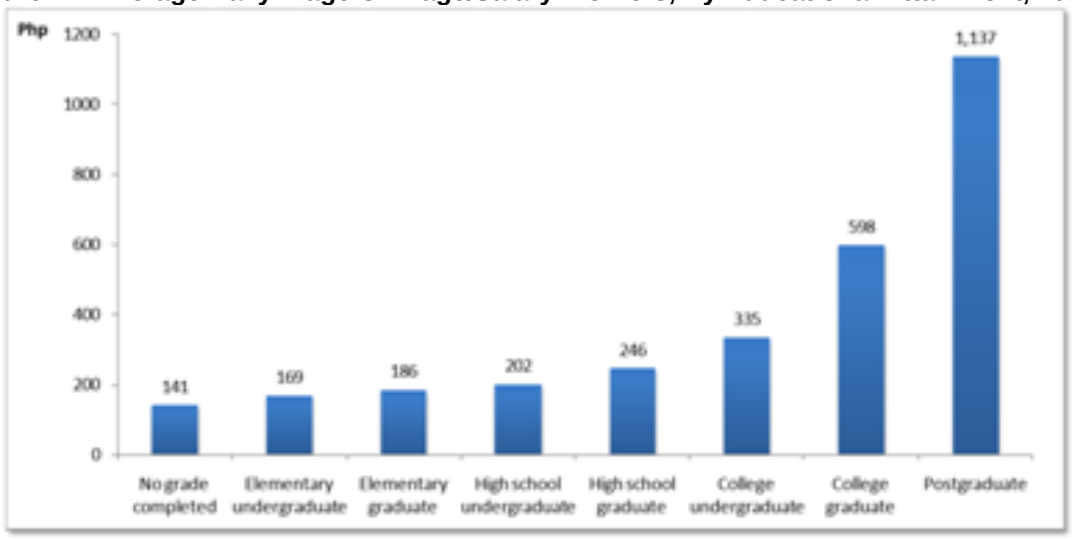
Discrimination and exclusion of persons with disability result from violation of existing policies and improper implementation of laws. One glaring discriminatory act of omission which is prejudicial to the normal development of a child is the inaccessibility of the built environment and public transportation system. This is a violation of RA 7610 (Article 1 section 3c "Circumstances which gravely threaten or endanger the survival and normal development of children"), BP 344 (Accessibility Law), and RA 7277 (Magna Carta for Persons with Disabilities).

Accessibility to physical environment, information, and communication is a major contributing factor to guarantee inclusion and participation of persons with disabilities in the community. It is very essential that it is one of the general principles of UN CRPD with a full article dedicated to accessibility only. Article 9 of the CRPD paragraph 1 states:

> *“To enable persons with disabilities to live independently and participate fully in all aspects of life, states parties shall take appropriate measures to ensure persons with disabilities access, on an equal basis with others, to the physical environment, to transportation, to information and communications, including information and communications technologies and systems, and to other facilities and services open or provided to the public, both in urban and in rural areas.”*

Awareness raising and monitoring will contribute to elimination of discrimination and exclusion. Interventions that will be instituted today will dramatically change the future of children with disabilities towards enjoyment of their fundamental freedom and realization of their full potential. Presence of accessibility features in the built environment and public transportation system will prevent social isolation of persons with disabilities. Learning facilities applying the universal design principles and compliant to the accessibility requirements will address simultaneously the right to education and social development of learners. Accessible public transportation system will contribute to improved personal safety of travelers whether it is for land, sea, and air travel. Commuters, particularly those with disabilities, will be safer and will experience less stress especially parents or carers and children with disabilities. Road and vehicle safety for persons with disabilities include safe access to public utility vehicles using ramps and having an allocated space for wheelchair-users (this safety issue also contributes to a healthy population). This couple of scenarios improved by ensuring accessibility will already increase the chances of children and youth with disabilities for a better future.

Figure 14: Average Daily Wage Of Wage/Salary Workers, By Educational Attainment, 2011



Source: Promoting Inclusive Growth Through the 4Ps [Discussion Paper Series No. 2013-09]

The Accessibility Sections 25 to 27 of R.A. 7277, CHAPTER 6 deal with barrier-free environment, mobility, and access to public transport facilities. This law cites Batas Pambansa Bilang 344, otherwise known as the Accessibility Law. BP 344, an act to enhance the mobility of persons with disabilities by requiring certain buildings, institutions, establishments and public utilities to install facilities and other devices. This Accessibility Law was signed on February 25, 1983.

It is ironic that the Philippine government ratified the UNCRPD in 1998 when it already has the Accessibility Law (BP344) in effect since 1983 yet, the compliance to its own law is very poor. As a State Party to UNCRPD, the Philippine government has the responsibility to implement the Convention. However, even the State Report presented a very unsatisfactory access audit finding. The Department of Public Works and Highways (DPWH), in its access audit in 2010, found that 4,994 out of 6,285 monitored buildings were found to be non-compliant to its national law on accessibility.

Disability is a cross-cutting issue. The success of the campaign for inclusion as manifestation of respecting and fulfilling the rights of persons with disabilities depends also on the amount of support that we gather from other CSOs working in rights advocacy. Representatives of Persons with Disabilities Cluster are participating in the other Clusters, namely Health and Social Protection. The campaign for accessibility complements the other advocacies. Ensuring accessibility and affordability of basic social services such as health and education will open up the opportunity for persons with disabilities, especially for the children and youth, to be active contributors to development. The Persons with Disabilities Cluster is working closely with the Health Cluster in pushing for an equitable Universal Health Care (UHC) policy. At the same time, we are also supporting the clamor for higher tobacco tax as one of the sources of funding for the UHC and to discourage smoking for healthier Filipinos.

Children's Television as a Platform to Reach and include Children with Disabilities

Situation

On the other hand, children with disabilities continue to be among the most marginalized children in the Philippines. They continue to face many discriminatory laws, existing in the periphery of the reach of government agencies including the Council for the Welfare of Children.

- There is a dearth of data on violence among children with disabilities and there is no systematic nationwide state entity, mechanism or program that addresses this need. Civil society organizations working on the ground are the only ones able to document the dire situation of these children.
- Formal education is unable to reach the majority of children with disabilities despite considerable efforts and success for Filipino children in general. The current shift from *special* education to *inclusive* education has not progressed satisfactorily continuing to exclude more than 95% of children with disabilities.
- Poverty continues to be the underlying barrier to the above, and social protection programs are unable to specifically reach children with disabilities and their families.

Rationale

The project aims to reach children / youth with disabilities who may not have access to formal or alternative schooling, or the internet or the computer resources. It shall implement mandates of inclusiveness according to domestic laws and international commitments to the Convention on the Rights of the Child, Convention on the Rights of Persons with Disabilities and the Convention on the Elimination of All Forms of Discrimination Against Women, It prioritizes overall literacy, including national health issues particularly on mental health, HIV / AIDS and sexual / reproductive health and personal safety for combatting sexual violence.

Project Goals

1. Progressively transform existing children's TV into inclusive programming, primarily for accessibility for children with disabilities
2. Promote new universally designed children's TV programs
3. Prioritize general literacy and health information dissemination

Objectives

1. Formulate policy (short-, medium-term plans) and develop practices for full accessibility for children with disabilities viewers, i.e., sign language use for the Deaf, supplemented by captioning; audio description for blind and low vision chlidren; Easy to Understand for children intellectual / developmental/ cognitive disabilities
2. Initiate awareness raising, technical training for NCTV staff and partners
3. Provide initial appropriations

Method

1. Appropriate (up to the medium term) transformation of National Children's Television Foundation - an attached agency of the Department of Education, while building longterm sustainability capabilities

2. Promote partnerships / relationships with producers (including cooperatives of persons with disabilities) who can supply programs
3. Coordinate with ECCDC, ALS to align with core target competencies for learners
4. Facilitate affirmative action for these programs in the procurement process

BREAKDOWN:

National Children's Television-Proper (MOOE) P1,040,000

Policy / Standard setting P30,000
Consultants P150,000
Training for staff P20,000
Research P240,000
Public workshops P600,000

Public -Private Partnership

Pilot financing for existing programming
P3,300,000, of which:
- Royalties / legal services P500,000
- Sign language interpreting P500,000
- Audio description P500,000
- Easy to understand version (alignment with ALS curriculum) P500,000
- Administrative counterpart for PPP P50,000

New programming P12,150,000, of which:
- Workshop / training for prospective suppliers P900,000
- Standards dissemination P100,000
- Administrative screening: procurement P150,000

- Seed financing for new programming P11,000,000

ALTERNATIVE BUDGET PROPOSAL FOR PERSONS WITH DISABILITIES

Department of Transportation (DOTr)
Regional awareness-raising regarding rights of persons with disabilities in relation to the mandate of the Department of Transportation (DOTr)

TOTAL: PhP 7,000,000.00

Rationale:

Lack of awareness on the rights of persons with disabilities in relation to the mandate of the DOTr exacerbates the condition of persons with disabilities when commuting through public transport or even with their own means of transportation. Prioritization and special treatment is not what the sector is advocating for. Respect for the rights of persons with disabilities as presented by UNCRPD starts with knowing about these rights. Regular awareness-raising activities will ensure this.

Department of Public Works and Highways (DPWH)

1. Regional awareness-raising regarding the rights of persons with disabilities, Accessibility Law (BP 344) in particular

TOTAL: PhP 7,000,000.00

2. Regional accessibility compliance monitoring team

TOTAL: PhP 50,000,000.00

Rationale:

An allocation of PhP50 million is recommended to the Department of Public Works and Highways (DPWH) to ensure the compliance and monitoring of BP 344 or the Accessibility Law. The law was found to have the most number of violations which has resulted to continuous deprivation of free movement of persons with disabilities in the Philippines.

Accessibility does not end with having ramps in the building. Women with disabilities have more requirements for privacy and toilet facilities. Fully able to navigate or having access to structures, toilets in particular, and need-appropriate (i.e. for the deaf, blind) signages should be put in place by monitoring teams.

Source: http://crpdparallelreport.net.ph/?p=21

3. Children's Television as a Platform to Reach and include Children with Disabilities

Rationale:

This project aims to reach children / youth with disabilities who may not have access to formal or alternative schooling, or the internet or the computer resources. It shall implement mandates of inclusiveness according to domestic laws and international commitments to the Convention on the Rights of the Child, Convention on the Rights of Persons with Disabilities and the Convention on the Elimination of All Forms of Discrimination Against Women, it prioritizes overall literacy, including national health issues particularly on mental health, HIV / AIDS and sexual / reproductive health and personal safety for combatting sexual violence.

TOTAL: PhP 16,210,000.00

Summary Table
Table 27: ABI PWD's CLUSTER ALTERNATIVE BUDGET PROPOSALS

Budget Item	NEP 2019 (in PhP)	ABI-Persons with Disabilities cluster Proposal (in PhP)	Variance [ABI Proposal less NEP] (in PhP)
Department of Transportation (DOTr)			
Regional awareness-raising on rights of PWDs in relation to mandate of DOTr Budget item: Conduct of conferences, seminars and trainings including the granting of scholarships	5,087,000.000	7,000,000.00	12,087,000.00
Department of Public Works and Highways (DPWH)			
Regional accessibility compliance monitoring team Budget item: Design of Public Works and Highways Projects	106,922,000.00	50,000,000.00	163,922,000.00
Regional awareness-raising on rights of PWDs, Accessibility Law (BP 344) in particular Budget item: Design of Public Works and Highways Projects		7,000,000.00	

Department of Education-National Council for Children's Television			
Children's Television as a Platform to Reach and include Children with Disabilities Budget item: Child Friendly Television Development Program	9,155,000.00	16,210,000.00	25,365,000.00
GRAND TOTAL (in PhP)	**121,164,000.00**	**80,210,000.00**	**201,374,000.00**

ALTERNATIVE BUDGET PROPOSAL FOR SOCIAL PROTECTION

Looking for Meaning

Overview

Even as it continued to rank among the top 10 departments given the biggest budget allocations, DSWD's 2019 budget is actually down 3.5% from P141.4 billion in 2018 to the current P136.4 billion. In a July 2018 press release, the Department of Budget and Management (DBM) glossed over this stating instead that funding for social welfare is higher by P8.9 billion, or 5.4%.[32] This is because they included the budget for Unconditional Cash Transfers (UCTs), mandated under the Tax Reform for Acceleration and Inclusion (TRAIN) Law enacted in 2017, as part of the budget for social welfare. The UCT however is lodged under the budget of the Land Bank of the Philippines (LBP) and not the DSWD. The reference therefore by DBM is to a combined welfare budget.

The UCT is a cash transfer of P2,400/family given to 10,000,000 families this year 2018. The amount goes up 50% to P3,600/family in 2019. Accordingly, for 2019, the minimum increase in the expanded social welfare budget should be P12 billion, not P8.9 billion, except for the real decline in DSWD's budget. As we also know that the 2019 national expenditure program is a cash-based budget and that departments have had amounts regularly not spent removed from their budget, the indication is that DSWD was lagging in the delivery of a number of its programs. Its proposed 2019 budget is a reversal of the 10.4% increase it was given in 2018, an increase which was already lower than the 15.9% raise given DSWD in 2017.

In past reviews of the DSWD budget, ABI's Social Protection Cluster consistently expressed its reservations with what was becoming the agency's primary function—the distribution of the government's conditional cash transfer and indigent senior citizens pension programs. These two forms of social transfers have made up 75%-80% of DSWD's budget with little money left over for other types of welfare assistance. Looking at its cash-based 2019 budget, we see how DSWD has truly reduced itself to functioning as a social pension and disaster relief distributory agency. With the proposed creation of a new government department on climate change and disaster risk management and mitigation, a part of its disaster relief operations will likely even become redundant.

Analysis of Budget

Much of DSWD's programs and activities suffered deep cuts (see attached Table 1). Even the amount allocated for the 4Ps program was lowered but this was largely due to the projected P273MM reduction in the program's financial expenses; otherwise, the amount of cash grants was maintained at P82.1 billion. Where real cuts were made was in the Sustainable Livelihood Program which was slashed from P5.1 billion to P2.3 billion, or by 54.90%, and the KALAHI-CIDSS program which was halved to P2.8 billion from P5.4 billion the previous year. A scaled-down SLP had been in the horizon after the budget peaked at P9.6 billion in 2016 and started coming down to P9.1 billion in 2017 and P5.1 billion in 2018. To improve program implementation

[32] https://www.dbm.gov.ph/index.php/secretary-s-corner/press-releases/list-of-press-releases/1118-proposed-2019-budget-to-prioritize-education-and-infrastructure

and the chances of success of its enterprise and employment tracks[33], policy enhancements were continuously made but problems persisted from the low collection rate to gaps in the training of the Implementing Program Development Officers (IPDO) to the sustainability of the SLP associations into which microenterprise development participants were grouped. In a statement published February 2018, Sen. Loren Legarda summed things up as follows, "Compared to other DSWD programs, the SLP registered a low utilization rate at 78% in 2017 . . . Having a low utilization rate only means that there are funds unspent for the intended beneficiaries of the program, which, in this case, are the poorest of our poor families."[34]

KALAHI-CIDSS, on the other hand, has progressively been replaced by other government programs, notably, Assistance to Municipalities which is managed by the Department of Interior and Local Government (DILG). The only ones spared major cuts in DSWD's budget were:

- General administration and support
- ICT Services and the NHTS-PR program
- Supplementary feeding program & BangUN, the feeding program for children in ARMM
- Social pension for indigent senior citizens
- SWD Technical Assistance & Resource Augmentation: provision of technical/advisory assistance, capability training, and other related services
- Quick Response Fund

ICT Services and the NHTS-PR (National Housing Targeting System for Poverty Reduction) were given funds to cover increased operating expenses and additional equipment and capital outlays. This follows from the government's increased reliance on data generated by NHTS-PR for new poverty alleviation efforts, such as, the distribution of subsidized rice and the TRAIN Law's unconditional cash transfers. As reductions in 2019's cash-based budget reflects an agency's inability to absorb their original allocations, we recognize DSWD's success in implementing its supplementary feeding program and in distributing the social pension for indigent senior citizens. Another positive note is the 8.7% increase in the budget for social welfare development (SWD) technical assistance and resource augmentation. There is need however to spend considerably more effort in scaling up and mainstreaming projects given technical assistance and resource augmentation to add these to the array of welfare programs and services available nationwide through DSWD's offices or through its partners'.

Proposals

DSWD's stated sector outcome is "Universal and transformative social protection for all achieved" but it has actually few programs and projects that address this issue on a national basis. It's flagship program is the Pantawid Pamilyang Pilipino Program, or 4Ps, which is meant to break intergenerational poverty but, as we have consistently noted, the impact of 4Ps is at best mixed. Quoting from the 2018 report of ABI's Social Protection Cluster:

> Interestingly, the number of households in 4Ps are more than the 3.7 million families tagged by the Philippine Statistical Authority (PSA) as poor in 2015. While PSA reported that the poverty incidence came down from 25.2% in 2012 to settle at 21.6% in 2015

[33] Marife M. Ballesteros, et. al., *Assessment of Livelihood Success and Implementation Issues on the Sustainable Livelihood Program of the DSWD*, PIDS Discussion Paper Series No. 2017-54.

[34] http://lorenlegarda.com.ph/legarda-urges-dswd-to-improve-rollout-of-sustainable-livelihood-program/

(PHDSD-1610-04 released 27 October 2016), the estimated number of poor families in 2015 was just 468,000 less than the estimated 4.2 million poor families in 2012. Matched against the P302.5 billion spent from 2010-2016 and 4Ps' coverage of 100% of families identified as poor, this seems underwhelming.

Also touted as supporting the education of children, we are told that there is almost universal enrolment among elementary school age children in 4Ps households. There are some 9.4 million children registered in 4Ps, 1.4 million of whom are under the program's extended coverage for high school children. This means that of the 14.9 million children in the elementary school system in SY 2015-2016 (both pubic and private), 54% are from 4Ps households. Despite their number, however, they do not seem to have influenced the performance of the education sector on the national level. A report of the Department of Education concedes that the net enrolment rate (NER) in elementary school has been deteriorating, coming down from 95.6% in 2010 when there was an explosion in the number of families enrolled in 4Ps to 90.5% in 2015.

The clue to why this is so can be found in DSWD's own 2014 impact evaluation study of 4Ps which states that "gross enrolment of elementary-aged children (6-11 years old) at the threshold is equally high for both Pantawid children and non-beneficiaries at 98%." Indeed, for households around the poverty threshold the study acknowledged that "enrolment and attendance rates of 6-11 year old children are already high." This supports the position that has long been held by the Social Protection Cluster that 4Ps as a solution to keeping elementary schoolchildren in school is like taking a sledgehammer to swat a fly. We might quibble over the decline in the net enrolment rate but, at the end of the day, our problem is bringing in the last 9.5% of children into the school system. As suggested in most last-mile situations, a more targeted and intentional approach should be adopted esp. so when children along that last mile are expected to belong to a very varied set of circumstances—children living in far-flung areas and ancestral domains or who work, have disabilities, are alone, or live in conflict areas.

It is instructive that with regard working children, the DSWD's study showed that "the incidence of child labor for children aged 10-14 years old at the threshold is the same for both Pantawid children and non-beneficiaries." Where membership in 4Ps mattered was in the number of days children worked in a month. This was lower for Pantawid children by approximately six days likely because "the program cash grants are not enough to completely keep children from working."

We need more and better ideas. Along this line, the members of ABI's Social Protection Cluster make the following recommendations:

PROPOSAL 1: USE AND MAINTENANCE OF PERMANENT EVACUATION CENTERS.

In the aftermath of Typhoon Ompong, President Duterte himself called for the construction of permanent evacuation centers to, among others, eliminate the use of school buildings during calamities which leads to the schooling of children being interrupted.[35] He has tasked the Department of Public Works and Highways (DPWH) to study the feasibility of such a project. We support this wholeheartedly and enjoin the DSWD to work with DPWH in order to ensure that we do not simply get buildings but centers whose design follow the laws on accessibility (BP344), are gender sensitive, and provide for child-friendly spaces. DSWD can add more value to these discussions by advocating for the alternative use of these spaces as community centers for children and youth with library, child minding facilities, games and sports areas for activities that

[35] http://www.pna.gov.ph/articles/1048170

do not require permanent structures, etc. This has the added advantage of enhancing the people- and family-centeredness of these facilities when they must serve as evacuation centers.

Budget Requirement: P10,000,000 annually to pay for the training and salaries of the core service staff and all other operating expenses of a children/youth/evacuation center.

PROPOSAL 2: EXPANSION OF EXISTING CASH TRANSFER PROGRAMS TO GIVE FAMILIES WITH CWDS AND PWDS A MINIMUM AMOUNT EQUIVALENT TO DOUBLE THE SUM GIVEN INDIGENT SENIOR CITIZENS, OR DOUBLE THE AMOUNT GIVEN TO FAMILIES FOR EACH CHILD UNDER THE 4PS PROGRAM.

It is acknowledged that families with children and other persons with disabilities experience greater financial pressures. PWDs who want and can work must be supported in that endeavor. We also need to lift some of the burden of caring for a child or person with disability from their families, esp., from the women and also other children in the home.

Budget Requirement: P18 billion annually to cover pay-outs to at least 1.4 million persons with disabilities, a number based on the Philippine Statistical Authority's Report Reference No: 2013-005 dated 10 January 2013.

PROPOSAL 3: ESTABLISHMENT OF CHILD MINDING CENTERS IN EVERY BARANGAY

To support women who work, want to work, or start a microenterprise, we propose the creation of child-minding centers in every barangay. DSWD already supervises a network of day care centers. These should be expanded or new centers established as child minding centers where young children up to Grade 2 can have supervised play, tutorials, and homework assistance.

Budget Requirement: P21.2 billion annually to cover the training of core service staff and the general salaries of staff to be hired for the daily maintenance and operation of the facility in 10,509 barangays.

PROPOSAL 4: PROVISION OF QUICK DISBURSING FUNDS FOR THE PSYCHO-SOCIAL SUPPORT OF CICLS AND CHILD VICTIMS OF VIOLENCE

Not all barangays and municipalities have sufficient emergency funds. In order to meet the immediate psycho-social support required by children in conflict with the law and child victims of violence, we propose the creation of quick disbursing funds, similar to the Quick Response Fund allocated for emergencies and disaster relief, to be made available to assist such children and facilitate the hiring of a psychologist/special consultant/counselor, cover the food and transportation expenses of child victims/CICLs in going to and from the court and counseling centers, etc.

Budget Requirement: P288 million annually to provide a subsidy of P4,800/case (P800/mo. for 6 mos.) to at least 60,000 cases involving children. We note here that DSWD reports that in 2017 it served 742,000 clients in its Crisis Intervention Units (NEP, p145.)

PROPOSAL 5: CREATION OF COMMUNITY KITCHENS

To eliminate child hunger, we need to institutionalize school lunches and build community kitchens where meals can be cooked by the children's parents and other community members.

The same community kitchen can serve as livelihood centers and function as a laboratory/business incubator for food-related enterprises esp. of women.

Budget Requirement: Capital outlay of P5.8 billion annually for the construction of community kitchens in 2,627 clusters of 4 barangays each plus P4.4 billion (doubling each year) to cover the cost of training the core service staff, the allowance of “cooks” and the salaries of staff needed for the daily maintenance and operation of the facility. Part of the funds for the day-to-day running of the facility may be sourced from cash-for-work programs as community kitchens create jobs and spur agricultural productivity in the area.

Table 28: Alternative Budget Proposals of Social Protection Cluster

ITEM	AMOUNT
Use and maintenance of permanent evacuation centers.	P10,000,000
Cash transfer to families with CWD/PWDs	P18,000,000,000
Establishment of child minding centers	P21,200,000,000
Quick disbursing funds for the psycho-social support of CICLs and child victims of violence	P288,000,000
Creation of community kitchens	P10,200,000,000
TOTAL	P49,698,000,000

Table 29: Summary of DSWD's 2019 National Expenditure Program (NEP)

In Pesos '000	PS	MOOE	FE	CO	Total	% Incr.
TOTAL NEW APPROPRIATIONS	**6,536,830**	**129,331,457**	**509,561**	**37,475**	**136,415,323**	**(3.5%)**
General Administration & Support	**214,025**	**511,926**	**0**	**0**	**725,951**	**3.6%**
General mgt. & supervision	181,732	511,926			693,658	1.1%
Administration of personnel benefits	32,293				32,293	114.6%
Support to Operations	**179,747**	**3,613,049**	**0**	**37,475**	**3,830,271**	**334.5%**
ICT services management	9,011	741,818			750,829	25.8%
Social marketing services	11,696	6,796			18,492	2.8%
Social technology dev. & enhancement	26,117	42,368			68,485	(2.8%)
Formulation & dev. of policies & plans	33,992	25,293			59,285	6.8%
NHTS-PR	98,931	2,796,774		37,475	2,933,180	1,985.7%
Operations	**6,143,058**	**125,206,482**	**509,561**	**0**	**131,859,101**	**(5.7%)**
Promotive Social Welfare Program	4,793,338	87,857,276	509,561	0	93,160,175	(6.7%)
4Ps	4,555,588	83,041,175	509,561		88,106,324	(1.5%)
Sustainable Livelihood Program	237,750	2,045,830			2,283,580	(54.9%)
KALAHI-CIDSS		2,770,271			2,770,271	(48.9%)
Protective Social Welfare Program	483,203	33,647,343	0	0	34,130,546	0.3%
Services for residential & center-based clients	391,780	1,357,195			1,748,975	(54.6%)
Supplementary feeding program		3,489,189			3,489,189	1.8%
Social pension for indigent senior citizens	26,683	23,157,534			23,184,217	20.2%
Implementation of Centenarians Act of 2016		109,140			109,140	(42.4%)
Protective service for individuals & families in difficult circumstances	42,740	4,105,211			4,147,951	(27.3%)
Assistance to PWDs & older persons		10,996			10,996	(11.6%)
Comprehensive project for street children, street families & IPs esp. Badjaos		34,387			34,387	(11.6%)

Table 29: Summary of DSWD's 2019 National Expenditure Program (NEP)

In Pesos '000	PS	MOOE	FE	CO	Total	% Incr.
Reducing vulnerabilities of children from hunger & malnutrition in ARMM, or BangUN project		158,819			158,819	1.8%
Tax reform cash transfer project		1,080,000			1,080,000	(8.8%)
Services to distressed overseas Filipinos	22,000	68,000			90,000	0.0%
Services to displaced persons (deportees)		52,473			52,473	0.0%
Recovery & reintegration program for trafficked persons		24,399			24,399	(2.9%)
Disaster Response & Management Program	0	3,495,988	0	0	3,495,988	(28.7%)
Disaster response & rehabilitation program		1,897,150			1,897,150	(11.7%)
National resource operation		46,645			46,645	1.8%
Quick Response Fund		1,250,000			1,250,000	0.0%
Implementation & monitoring PAMANA-Peace & Development Fund		302,193			302,193	(62.1%)
Social Welfare & Dev. Agencies Regulatory Program	20,746	40,484	0	0	61,230	(9.8%)
Standards-setting, licensing, accreditation & monitoring services	20,746	40,484			61,230	(9.8%)
SWD Technical Assistance & Resource Augmentation	845,771	165,391	0	0	1,011,162	8.7%
Provision of technical/advisory assistance & other related support services	829,453	141,073			970,526	8.9%
Provision of capability training programs	16,318	24,318			40,636	6.0%