

**PHILIPPINE COUNTRY REPORT:
Human Resource Development in the Sectors
of Welfare and Health ~ with a
Focus on Capability Building of Service
Providers and Employability Promotion of
Vulnerable People ~**

**A Collaboration of the Department of Social Welfare and
Development, the Department of Health and the
Department of Labor and Employment**

**Philippine Country Report for the 9th ASEAN & Japan High Level Officials
Meeting on Caring Societies
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4Ps	Pantawid Pamilyang Pilipino Program
BHS	Barangay Health Station
BMBE	Barangay Micro Business Enterprise
CBR	Crude Birth Rate
CDR	Crude Death Rate
CHT	Community Health Team
DOH	Department of Health
DOLE	Department of Labor and Employment
DSWD	Department of Social Welfare and Development
FLEMMS	Functional Literacy, Education and Mass Media Expenditure
GDP	Gross Domestic Product
GNI	Gross National Income
HFCE	Household Financial Consumption Expenditure
HRH	Human Resources for Health
HRHN	Human Resources for Health Network
IHPDS – NIH	Institute of Health Policy Development Studies – National Institute for Health
IMR	Infant Mortality Rate
LFS	Labor Force Survey
LGU	Local Government Unit
MDG	Millennium Development Goals
MPM – HSD	Master in Public Management – Health Systems Development
NGO	National Government Organization
NHIP	National Health Insurance Program
PGR	Population Growth Rate
PWD	Persons With Disabilities
RHTPP	Rural Health Team Placement Program
RHU	Rural Health Unit
SSS	Social Security System
SY	School Year
TESDA	Technical Education and Skills Development Authority
TFR	Total Fertility Rate
TULAY	Tulong Alalay sa Taong May Kapansanan
UHC	Universal Health Care
WIE	Workers in the Informal Economy

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PHILIPPINES COUNTRY REPORT

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Part I. FOLLOW UP TO THE 8th HIGH LEVEL OFFICIALS MEETING

The Philippines continues to support regional initiatives in line with poverty alleviation and social protection through participation in high level meetings, workshops, fora and conferences. These included but were not limited to the following:

- ASEAN Socio-Cultural Community (ASCC) Council Meetings¹
- Global Conference on Ageing, International Federation on Ageing (IFA)²
- ASEAN Workshop on Social Welfare for Disabled Persons³
- High Level Meeting on Social Protection as Development Policy by UN Economic and Social Commission for Asia and the Pacific (UNESCAP)⁴
- ASEAN Ministerial Meeting on Social Welfare and Development (AMMSWD)⁵
- Regional Workshop on the ASEAN Roadmap for the Attainment of MDGs and the 7th Senior Officials Meeting on Rural Development and Poverty Eradication (SOMRDPE)⁶
- Senior Officials Meeting on Social Welfare and Development (SOMSWD)⁷
- 67th Session of the Economic and Social Commission for Asia and the Pacific (ESCAP)⁸
- Regional Workshop on Community Driven Development (CDD) and Institutional Sustainability in Asia⁹
- Fourth Session of the Conference of State Parties to the Convention on the Rights of Persons with Disabilities¹⁰

At the national level, actions on the recommendations in the areas of holistic planning, budget appropriation and systematic collection of data to support social protection, poverty reduction and health promotion are addressed through the following:

Adoption of a National Social Protection Framework

¹ Held in Da Nang, Vietnam from August 13-17, 2010

² Held in Melbourne, Australia from May 3-6, 2010

³ Held in Beijing, China from September 20-21, 2010

⁴ Held in Bangkok, Thailand from October 27-29, 2010

⁵ Held in Brunei Darussalam from November 25-26, 2010

⁶ Held in Bangkok, Thailand from January 24-28, 2011

⁷ Held in Thailand from September 19-23, 2011

⁸ Held in Bangkok, Thailand from May 22-25, 2011

⁹ Held in Jakarta, Indonesia from June 21-22, 2011

¹⁰ Held in New York, USA from September 7-9, 2011

In 2009, the Technical Working Group on Social Protection comprised of DSWD, NEDA, the Social Security System (SSS) and the National Anti-Poverty Commission (NAPC) formulated the SP Strategy Paper which highlights the coordination and complementation of efforts from the national to sub-national levels on social protection which should be strengthened and harmonized to achieve greater synergy and program impact in achieving an improved quality of life for the poor and vulnerable sectors of the society. The strategy paper identified the following imperatives for action: a) collaboration of key stakeholders; b) complementation of social protection programs and projects; c) monitoring and evaluation; and d) formulation of a graduation scheme.

During the National Economic and Development Authority-Social Development Committee (NEDA-SDC) Cabinet Level Meeting on 29 October 2009, the Sub-Committee on Social Protection (SCSP) was created by virtue of SDC Resolution No. 2, series of 2009.

The adoption of the social protection framework by the National Government provides the basis for the convergence strategy adopted by the DSWD.

Reform Budget of 2011¹¹

The Government of the Philippines designed its 2011 Reform Budget to one that is biased for the poor and vulnerable. Social services received the almost a third of P560.8 billion or more than 31.7 percent of the national budget. This year, the social services sector's budget increased by 14.0 percent to P521.4 billion due to the marked increases for basic education, public healthcare and social protection. Economic services (for infrastructure, agriculture, natural resources, tourism, R&D and others) follows with 22.0 percent; general public services with 17.5 percent; and defense, with 6.2 percent.

Among the critical allocations funded by this increase in the sector's budget are: the expanded Conditional Cash Transfer (CCT) program of the DSWD; Department of Health's (DOH) Health Facilities Enhancement program, immunization and the National Health Insurance Program for indigent Filipinos; and the Department of Education's (DepEd) programs to address critical resource gaps, such as the Basic Educational Facilities Fund and Education Service Contracting

Convergence of Social Protection Strategies

Pantawid Pamilyang Pilipino Program

Pantawid Pamilyang Pilipino Program (Pantawid Pamilya) is a poverty reduction strategy that provides cash grants to extremely poor households to allow their family members to meet certain human development goals. The focus is on building human capital in the poorest families (through investments in their health/nutrition and education) as low schooling and poor health are strongly linked with the poverty cycle in the Philippines. It provides social assistance through health and education conditional cash grants which are transferred upon the compliance of beneficiaries with the program conditionalities. The Program is designed to provide beneficiaries with a viable exit strategy through sustainable livelihood. The two tracks are micro-enterprise Development through Self-Employment Assistance Program (SEA-K) and Guaranteed Employment through private and public partnerships.

¹¹ The President's Budget Message. http://www.dbm.gov.ph/dbm_publications/PB2011/I.pdf

A feature article¹² on the DSWD's Convergence Strategy captures the developments in the area of collaborative work.

The three-pronged poverty reduction led by the Department of Social Welfare and Development (DSWD) respond indisputably to the unique contexts of various segments of the poor. Sensitive to the capacities and needs of the people, each of the three programs has its own strategies and outputs. In every stage of development, both public and private sectors have identified their contributions for the improvement of the beneficiaries' well being.

It must be mentioned that the Convergence Strategy is supported by the Social Protection Framework¹³ adopted at the National Level.

As of the end of the third quarter this year, 2,230,021 households were registered out of the targeted 2.3 million households. This translates to 5,741,406 children (0-14 years old). The DoH as part of its commitment to the Program, has deployed 10,000 nurses in 1,221 municipalities including 907 Pantawid Pamilya areas; 553 physicians in hard to reach areas and critical municipalities; and 173 Rural Health Midwives. DOH further supplied 7,180,000 deworming tablets in all public schools across the country and vaccines for all Health Centers in Pantawid Pamilya areas.

The Department of Education as part of its commitment to the Program ensured the availability of teachers and provided additional classrooms, seats, textbooks, toilets, teacher items, school feeding program in the amount of P1,118,466,666. Both DOH and DoE help the DSWD in program monitoring as far as the compliance of the beneficiaries with the conditions for health and education.

Impact of the Program

Recent studies by the University of the Philippines National College of Public Administration and Governance (UP-NCPAG), the World Bank (WB) and Social Weather Station's (SWS) Quantitative Assessment have shown that the Program contributes to empowerment and socio-cultural behavioral and value formation as well as human resource development through health and educational assistance (UP-NCPAG); the conditions set have helped improve the education and health of children (WB); high awareness and compliance of the beneficiaries to the conditions set (SWS). The studies also validated the reliable and trustworthy control and accountability mechanisms embedded in the core program design.

Based on simulated impacts on poverty, given the observed compliance rates, the Pantawid Pamilya increases annual incomes of beneficiary households by 12.6 percent. This

¹² DSWD's Convergence Strategy. Zambo Times, Online News, December 11, 2010
<http://www.zambotimes.com/archives/26388-Feature-DSWDs-convergence-framework-for-poverty-reduction.html>

¹³ The definition of SP was formulated in 2007 through SDC Resolution no.1, series of 2007. With this, National Economic and Development Authority (NEDA) formulated the SP Framework.

suggests increase in income significantly reduces the incidence of poverty and the income gap of the poor in areas targeted by the program¹⁴.

Identifying Poor Households

The NHTS-PR is an information management system developed by DSWD that identifies who and where the poor are and records them in a database. This database identifies the poor at the household level allowing for more directed delivery of social protection services and minimizing exclusion and leakage.

The NHTS-PR database serves as guide to national government agencies and other stakeholders in identifying qualified beneficiaries of their social protection programs. This means that there will be more focused social protection programs that yield better impact. DSWD's Pantawid Pamilya Pilipino Program and Social Pension for Indigent Senior Citizens are both using NHTS-PR data in identifying their beneficiaries. PhilHealth and the Department of Health (DOH) have also entered into Memorandum of Agreements (MOA) with DSWD on the use of NHTS-PR data in the implementation of their social protection programs.

Executive Order No. 867 or "Providing for the Adoption of the National Household Targeting System for Poverty Reduction as the Mechanism for Identifying Poor Households Who Shall Be Recipients of Social Protection Programs Nationwide" was issued to ensure that efforts to the needs of the poor and disadvantaged are consolidated and focused, reducing leakages through availment of non-poor.

Financial risk protection for the poor has stepped up. Through the Filipino Income Expenditure Survey done in 2008, DSWD identified the poorest segment of the country using a National Household Targeting Survey (NHTS). A total of 5,219,936 households whose monthly income not more than Php3,460 a month or the poorest quintile have become the direct beneficiaries for the country's social health insurance through the National Health Insurance Program (Philhealth). The next quintile or the near poor or whose income is no more than Php6.073 shall also have their premiums but this time, payment is shared by the local government.

To ensure financial risk protection during confinement, DOH will strictly implement the no balance billing policy in DOH-retained hospitals. No balance billing means that sponsored program members confined in government hospitals will not be asked to pay for the use of their services, neither would they be asked to have their prescriptions filled outside of the hospital.

To improve availment of benefits from PhilHealth should be removed such as:

- a. Streamline documentary requirements specially for the poorest sector
- b. Improve Information Technology to fast track transactions
- c. Intensify information on benefits through the Community Health Teams (CHT), PhilHealth Knowledge Officers, and trimedia campaigns

¹⁴ Velarde, Rashiel and Luisa Fernandez, "Welfare and Distributional Impacts of the Pantawid Pamilyang Pilipino Program". Philippine Social Protection Note No.3. July 2011

- d. Provide PhilHealth desks in hospitals (government) to guide and assist members in availing their benefits and to guide and assist unregistered families to enroll and become members
- e. Harmonize PhilHealth accreditation and DOH licensing to increase the number of accredited facilities
- f. Implement the 22 case payment list of PhilHealth in all government hospitals so that the poorest households will have no balance billing.
- g. Revisit the capitation fund policy for the improvement of health services.

Other major activities include Kalusugan Pangkalahatan (KP) or universal health care deliberately focusing on the poor and working towards the equity goal. Apart from financial risk protection, KP also provides access to quality health services through the provision of facility upgrade, and the attainment of health related MDGs by scaling up public health interventions.

Part II. GENERAL INFORMATION

Geography

The Philippines is a democratic government headed by a President. It is an archipelago composed of 7,107 islands situated in Southeast Asia. It has a total land area of 299,764 square kilometers. The country is divided into three geographical areas: Luzon, Visayas, and Mindanao. It has 17 regions, 80 provinces, 138 cities, 1,496 municipalities, and 42,025 barangays or local communities.

GNI per capita

Although considered a developing country, the Philippines is one of the most promising economies in Asia in terms of growth potential. With projected population reaching 95.1 million, per capita GDP grew by 2.9 percent while per capita GNI grew by 1.7 percent and per capita Household Final Consumption Expenditure (HFCE) grew by 2.9 percent. Philippines is ranked at 149th in terms of its purchasing power parity and despite the economic crisis, the country was kept afloat by its resilient service sector, remittances from overseas Filipino workers, and renewed private spending. The table below provides yearly GNI using current prices vis-a vis constant 2000 prices.

Table 1: *Gross National Income
(in million pesos)*

Year	At Constant Prices	At Constant 2000 Prices
2003	68,037	59,998
2004	75,456	62,977
2005	83,867	66,034
2006	97,638	67,967
2007	97,334	70,566
2008	108,075	72,852
2009	115,503	75,778
2010	127,600	80,429

Source: National Statistical Coordination Board as of May 2011

Poverty Rate

Poverty is a complex phenomenon with many dimensions including health and nutrition, education, housing and leisure. While the Philippines is not one among the poorest countries, there exists spatial disparity in poverty rates. The table below provides a summary of the poverty incidence and the magnitude of the poor in the country.

Table 2: *Annual per Capita Thresholds, Poverty Incidence and Magnitude of Poor*

Statistics	Estimate			Inc/Dec		Coefficient of Variation		
	2003	2006	2009	2003 to 2006	2006 to 2009	2003	2006	2009
Annual Per Capita Poverty Threshold (PhP)	10,976	13,348	16,841	21.6	26.2			
Poverty Incidence (%)								
Families	20.0	21.1	20.9	1.1	(0.2)	2.3	2.3	2.1
Population	24.9	26.4	26.5	1.4	0.1	2.1	2.1	1.9
Magnitude of poor (in million)								
Families	3.29	3.67	3.86	11.5	5.0	2.3	2.3	2.1
Population	19.8	22.17	23.14	12.0	4.4	2.1	2.1	1.9
Subsistence Incidence (%)								
Families	8.2	8.7	7.9	0.4	(0.8)	3.4	3.3	3.2
Population	11.1	11.7	10.8	0.6	(0.9)	3.2	3.2	3.1
Magnitude of subsistence poor (in million)								
Families	1.36	1.51	1.45	11.3	(3.8)	3.4	3.3	3.2
Population	8.8	9.85	9.44	11.9	(4.2)	3.2	3.2	3.1

Source: National Statistical Coordination Board

Adult Literacy Rate

Basic literacy rate is at 93.4% with females slightly higher at 94.3% as compared to 92.6% in males (Table 3). Functional literacy for females is at 86.3% for female as against 81.9% for males. Functional Literacy, Education and Mass Media Survey (FLEMMS) literacy is categorized into four (4) levels for 10 to 64 years old:

- Level 0 – persons who can only read and write are illiterate
- Level 1 – persons who can only read and write are considered basically literate
- Level 2 – persons who can read, write and compute are considered functionally literate
- Level 3 – persons who can read, write, compute and comprehend are considered functionally literate

Results of the survey showed that 1 out of 10 (7 million) cannot read and write; 8 out of 10 (51 million) can read and write and 5.1 percent (2.6 million) cannot compute or lack numerical skills. About 49 million are functionally literate⁴. Further, Cohort survival rate at the secondary level experienced increments starting in SY 2006-2007, and hovering near the

80 percent mark, thereby exceeding the target in the last five years, except in SY 2005-06 (Figure 1). Dropout rate at the secondary level improved starting from SY 2006-2007 and remained at around 8 percent in the succeeding years; thus, the target has been attained (Figure 2).

Table 3: *Simple Literacy of the Populations
10 years old and over (in percent)
1989, 1994, 2000, 2003*

Area / Region	1989 a/			1994 a/			2000 b/			2003c/		
	Both Sexes	M	F	Both Sexes	M	F	Both Sexes	M	F	Both Sexes	M	F
Philippines	89.8	89.8	89.8	93.9	93.7	94.0	92.3	92.1	92.5	93.4	92.6	94.3
Urban	95.4	...	...	96.5	96.6	96.5	...	...	...	...	...	...
Rural	86.2	...	...	91.2	91.1	91.3	...	...	...	...	...	...
Metro Manila	98.1	...	...	98.8	98.9	98.8	98.1	98.2	98.1	99.0	98.9	99.1
Cordillera Administrative	86.4	...	...	88.8	89.9	87.5	90.5	90.9	90.1	91.6	92.0	91.1
Ilocos Region	90.6	...	...	95.5	96.1	94.8	95.2	95.4	95.0	97.4	97.6	97.3
Cagayan Valley	88.4	...	...	93.3	93.7	92.8	91.8	91.4	92.1	92.7	92.1	93.5
Central Luzon	93.7	...	...	96.3	96.5	96.1	94.8	94.8	94.8	96.9	96.8	96.9
Southern Tagalog	93.2	...	...	96.4	96.8	96.0	94.0	94.0	94.1	94.2	94.1	94.3
Bicol Region	87.3	...	...	96.9	94.8	95.0	92.7	92.4	93.6	95.0	93.8	96.3
Western Visayas	87.7	...	...	91.9	90.8	93.0	93.0	92.5	93.6	92.8	91.6	94.0
Central Visayas	88.0	...	...	93.1	93.4	92.8	91.7	91.5	91.8	92.4	91.5	93.2
Eastern Visayas	81.7	...	...	90.9	89.2	92.7	89.9	88.8	91.1	90.1	87.0	93.3
Western Mindanao	80.4	...	...	89.7	89.1	90.1	85.3	85.3	85.2	88.9	96.8	90.9
Northern Mindanao	90.5	...	...	94.6	93.8	95.5	91.4	90.7	92.1	91.8	90.1	93.5
Southern Mindanao	90.5	...	...	92.0	91.6	92.4	90.2	89.8	90.5	90.3	88.0	92.7
Central Mindanao	78.3	...	...	90.8	90.3	91.4	87.0	87.1	87.0	87.3	85.9	88.8
Caraga	...	...	...	...	...	...	92.0	91.4	92.6	92.1	89.5	94.6
Autonomous Region of Muslim Mindanao	...	...	...	73.5	75.6	71.4	68.7	69.8	67.7	70.2	71.0	69.4

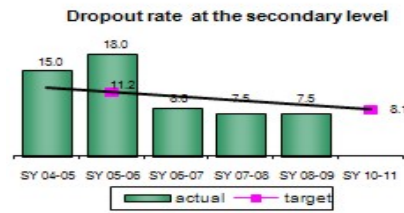
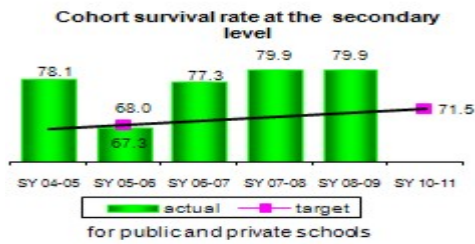
M - Male; F - Female

a/ Functional Literacy, Education and Mass Media Survey; b/ 2000 Census of Population and Housing, c/ 2003 FLEMMS

Sources: 1. National Statistics Office; 2. Department of Education

Figure 1:

Figure 2



Source: National Statistics Office

Urban Population

Based on the 2000 Census of 76.5 million persons, 36.7 million or 48.0 percent were in urban barangays. In 2005 and 2008, the recorded urban population is at 43.7 as 65 percent respectively. The average annual growth rate of urban population from 2000 to 2008 was 3.2 percent. As of 2011 the World Population Prospect reports a Philippine urban population at 49.1 percent.

Budget for Health and Social Welfare Sectors

The budget of Php10,623,500,000 (\$235,189,294.46) for social welfare in 2009 is 119% increase from its Php 4,848,513,000 (\$107,339,233.93) budget in 2008. For 2010 it has reached to Php15,314,440,000.00 (\$339,040,084.59), an increase of 44%. Figures 3 – 6 show that in 2008, the DSWD budget comprises 0.45% of the total budget while in 2009 and 2010, it increased to 0.91% and 1.17%, respectively.

Figure 3:

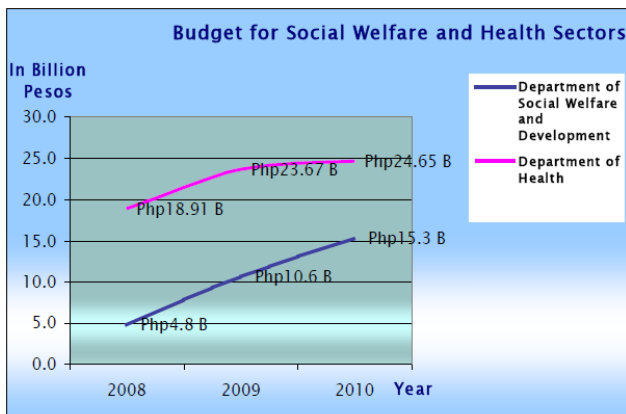


Figure 4:

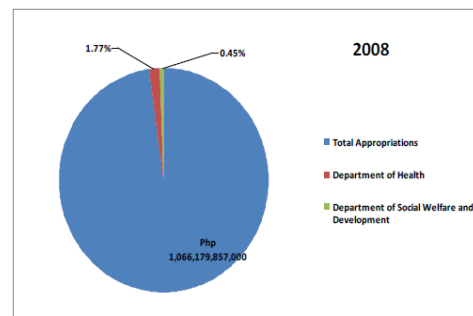


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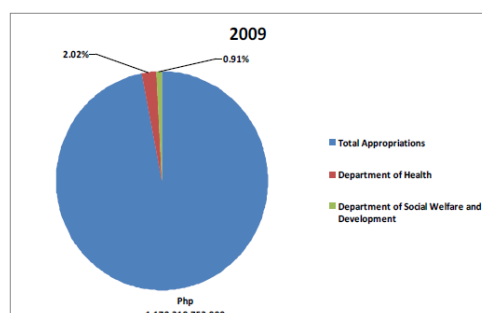
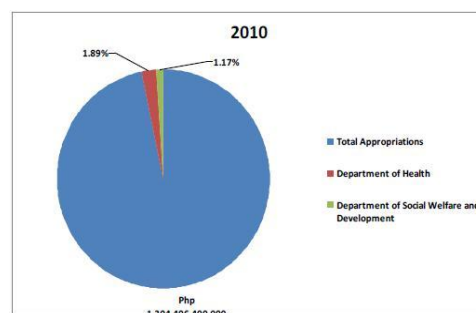


Figure 6:



The country's total health expenditure showed improvements from 2005 to 2007, but at decelerating growth rates both at current and constant prices. At current prices, the total outlay for health went up from Php198.4 billion in 2005 to Php234.3 billion in 2007, registering a growth rate of 9.1 percent in 2006 and 8.3 percent in 2007. Discounting the effect of inflation, total health expenditure grew at only 4.6 percent in 2006 and even slower at 4.0 percent the following year. When considered on a per capita basis, these growth rates translate to miniscule increases in per capita health spending of Php14 in 2006 and Php11 in 2007.

Table 4: *Total Health Expenditure as Percent of GDP and GNP, 2005 - 2007*

ITEM	2005 ¹	2006	2007	Average Annual Growth Rate, 2005-2007
Total Health Expenditure (in billion pesos, at current prices)	198.4	216.4	234.3	8.7
Gross Domestic Product (GDP, in billion pesos, at current prices) ²	5,444.0	6,031.2	6,648.6	10.5
Gross National Product (GNP, in billion pesos, at current prices) ²	5,891.2	6,532.1	7,230.1	10.8
Health Expenditure as % of GDP	3.6	3.6	3.5	(1.7)
Health Expenditure as % of GNP	3.4	3.3	3.2	(1.9)

1/ Revised

2/ National Statistical Coordination Board, National Accounts of the Philippines with Consolidated Accounts, Income and Outlay Accounts, CY 2004 to 2006, May 2010.

In 2008, the health budget was at Php18.91 billion (\$400,509,203.75) which represents 1.77% of the total budget. In 2009, there was a 25.14% increase from the year 2008 amounting to Php23.67 billion (\$510,670,819). This increase was at 2.02% of the total budget in 2009. While there was an increase of 4.15% from 2009 resulting to Php24.65 billion- budget (\$532,765,131), its shares from the total budget decreased to 1.89%. *Note: Php45.17 – 1 US\$*

The budget of the Department of Labor and Employment was at Php6.27B (\$138.8K) which is 0.9% of the total national budget. In 2009, the DOLE's budget amounted to Php7.01B (\$155.2K) which increased by 11.79% compared to 2008 budget and represents

0.76% of the total budget. In 2010, DOLE's budget was at Php6.42B (\$142.3K) or a decrease of 8.4% over 2009 budget, with a share of 0.49% in the total national budget. *Note: Php45.17 – 1US\$.*

Part II. POPULATION and VITAL STATISTICS

The Philippine Population: Growth Rates and Age Groups

As of August 1, 2007, the Philippines had a total population of 88,566,732 persons, an increase of 12,062,655 persons over the May 1, 2000 population count of 76,504,077 persons. The 2007 census figure is almost twelve times the Philippine population in 1903 (7,635,426 persons), when the first census was conducted (Table 5). The increase in Philippine population translated to an average population growth rate (PGR) of 2.04 percent annually during the period 2000 to 2007 (Table 6). The annual PGR recorded during the period 1995 to 2000 was 2.36% and is decreasing to 1.96% towards 2010 (Table 2). As of 2011, the Philippines has become the 12th most populous nation with a staggering population of 94,013,200 Filipinos living in and out of the country (2010 estimate). If the trend continuous, the country's population will balloon to 102,965,300 by the 2015.

Table 5: *Population: Census Annual Growth Rate (in Percent)
Years 1799 to 2007*

Year	Population	Average annual rate of increase (%)
1799	1,502,574	-
1800	1,561,251	3.91
1812	1,933,331	1.80
1819	2,106,230	1.23
1829	2,593,287	2.10
1840	3,096,031	1.62
1850	3,857,424	2.22
1858	4,290,381	1.34
1870	4,712,006	0.78
1877	5,567,685	2.41
1887	5,984,727	0.72
1896	6,261,339	0.50
1903	7,635,426	2.87
1918	10,314,310	2.03
1939	16,000,303	2.11
1948	19,234,182	2.07
1960	27,087,685	2.89
1970	36,684,486	3.08
1975	42,070,660	2.78
1980	48,098,460	2.71

1990	60,703,206	2.35
1995	68,616,536	2.32
2000	76,504,077	2.36
2007	88,574,614	2.04

Note: Population from 1799 to 1896 excludes non-Christians.

a - Includes the household population, homeless population, Filipinos in Philippine Embassies/Consulates and missions abroad and institutional population who are found living in institutional living quarters such as penal institutions, orphanages, hospitals, military camps, etc. at the time of the census taking.

Table 6:

Population Growth Rate

Country Name	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Brunei Darussalam	2.49	2.46	3.43	1.57	2.89	2.90	3.50	1.80	2.10	2.10
Cambodia	1.52	1.52	1.52	1.52	1.52	1.33	1.33	1.33	1.33	1.50
Indonesia	0.95	1.36	1.34	1.33	1.32	1.30	1.30	1.30	1.28	1.25
Lao PDR	2.02	2.02	2.02	2.02	2.02	2.02	2.22	2.12	2.23	2.00
Malaysia	2.53	2.21	2.17	2.12	2.12	2.15	1.95	1.99	2.00	2.10
Myanmar	2.02	2.02	2.02	2.02	2.02	2.02	2.02	1.70	1.53	1.53
Philippines	2.07	2.07	2.07	2.15	2.05	2.03	1.95	1.94	1.92	1.96
Singapore	1.75	2.73	0.92	0.20	1.30	2.40	3.20	4.30	5.50	3.10
Thailand	0.70	0.96	0.93	0.89	0.86	0.88	0.73	0.71	0.67	0.63
Viet Nam	1.35	1.28	1.17	1.17	1.20	1.17	1.12	1.09	1.07	1.06

Source: Asian Development Bank. *Key Indicators 2010*.

Note for Philippines: Data for 2000–2009 are based on the 2000 census-based medium assumption population projections.

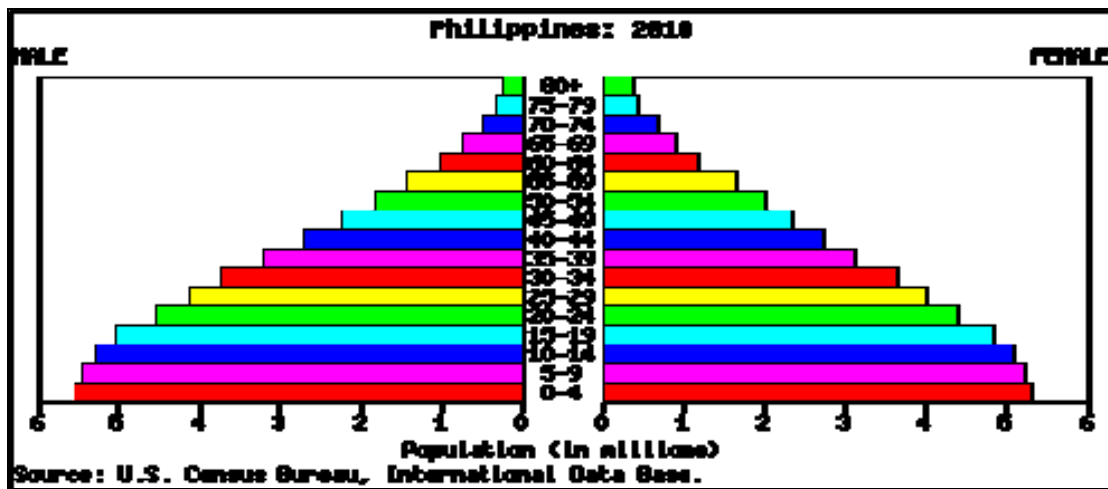
Annual Population Growth Rate

Country Name	1960-1970	1970-1980	1980-1990	1990-2000	2000-2007	2005-2010
Philippines	3.01	2.75	2.35	2.34	2.04	1.95

Source: Philippine National Statistics Office

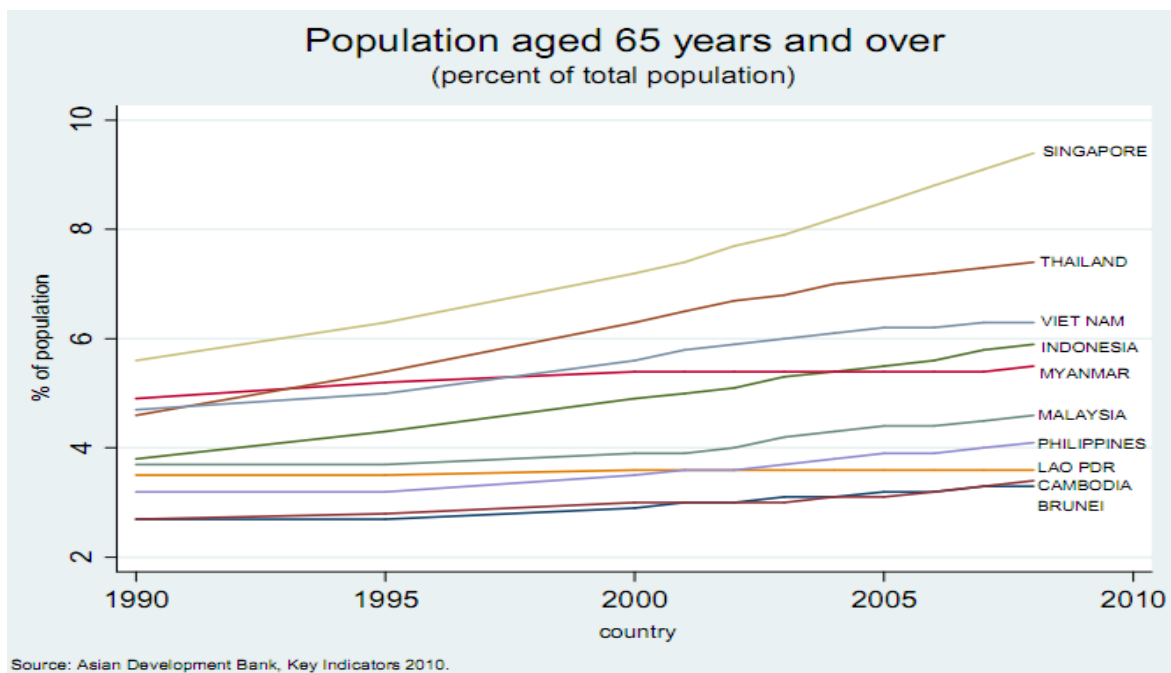
The Philippine is inhabited by a relatively young population. Almost half of the populace is below 30 years old as demonstrated in figure 7. The 0-14 age group population comprises 18.89 percent for male and 18.12 percent for female, while the 15-64 age group is 29.75 percent for male and 29.41 for female. Percentage of population for 65 years old and older is 1.71 for male and 2.12 for female.

Figure 7: *Philippine Population Pyramid 2010*



The 2000 Census of Population and Housing reported a total of 4.6 million elderly persons accounted for almost 6 percent of the Philippine population, a marked increase of 22.18 percent from the 3.7 million elderly persons in 1995. This yields an average annual population growth rate of 4.39 percent from 1995 to 2000, as compared to the growth rate of 3.06 percent from 1990 to 1995. Amongst selected Asian countries, the Philippines still has a low growth rate for elderly persons (Figure 8). It is estimated that the number of older persons will further increase to 7 million in 2010 and twice as much in about 16 years if the 4.39 percent growth rate persists.

Figure 8:



Crude Death Rate

The continuous decrease of the crude death rate (CDR) proves a general sign of progress for the country. For several years, the Philippines experienced a slow albeit steady decline of the CDR among its regions. In 2007, the reported national CDR was 4.2 per 1000 population. In 2008, the national CDR did not show any significant change from the previous year. For 2009, the national CDR remained at 4.3 per 1000 population (Table 6).

Crude Birth Rate

The reported crude birth rates (CBR) in 2007 and 2008 have continued their steady decrease since the 1990's. The national CBR in 2007 was noted to be 21.0 per 1000 population. There was a slight increase to 21.2 per 1000 population in 2008 (Table 7).

Table 7: *Crude Birth and Death Rates*

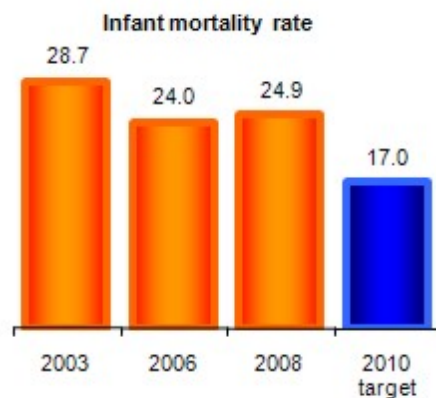
Year	Crude Birth Rate	Crude Death Rate
1990	26.87	5.17
1995	23.97	4.73
2000	23.09	4.80
2003	20.60	4.89
2004	20.70	4.88
2005	20.05	-
2006	27	5
2007	21	4.2
2008	21.2	4.3
2009		4.3

Source: Philippine National Statistics Office

Infant Mortality Rate

Between 2003 and 2006, the infant mortality rate (IMR) per 1000 live births was reduced from 28.7 to 24.0.6 per 1000 live births but inched upward in 2008 (Figure 9). 2009 IMR was at 20.6 per 1000 live births

Figure 9:

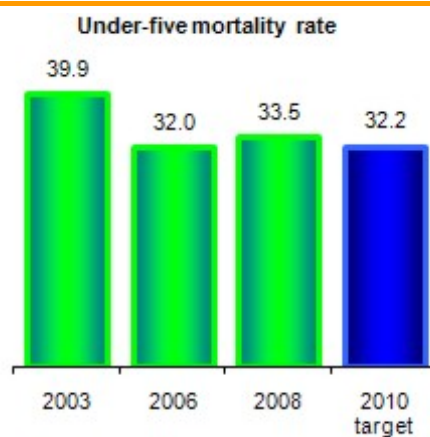


Source: Philippine National Statistics Office

Under – Five Mortality Rate

Under-five mortality rate (U5MR) target was met in 2006 but slightly went up again in 2008 as seen in the figure below.

Figure 10:



Source: Philippine National Statistics Office

Life Expectancy at Birth

In most parts of the world, life expectancy at birth rapidly increased as the twentieth century heralded improvements in public health, nutrition and medicine. In the Philippines, life expectancy in 2005 and 2006 was 67.5 years, with males having an average life expectancy of 67 years and females with 72.5 years (Table 7). From 2007 to 2009, the average life expectancy was 71.6 years (Figure 11). The target mean life expectancy has been attained for females, but not for males.

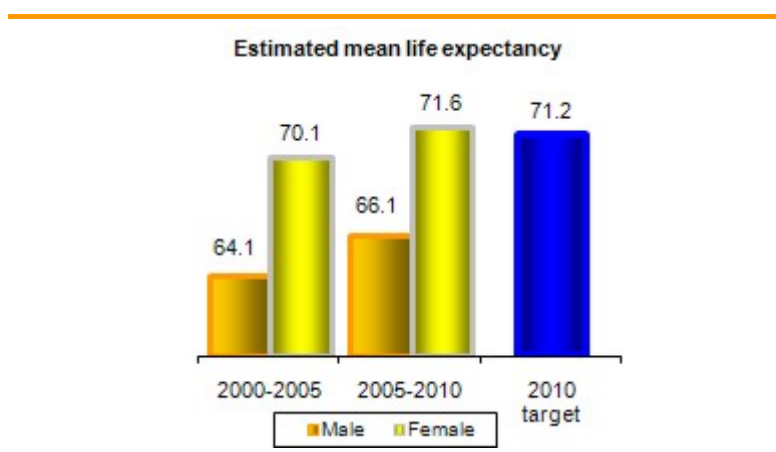
Table 8:

Life Expectancy at Birth by Sex

Year	2000	2001	2002	2003	2004	2005
Total	68.9	69.4	69.5	62.6	70.1	70.1
Male	66.3	66.6	66.9	67.2	67.5	67.8
Female	71.6	71.9	72.2	72.5	72.8	72.5

Source: Volume I 1995 Census-Based National and Regional Population Projections published by the NSO

Figure: 11

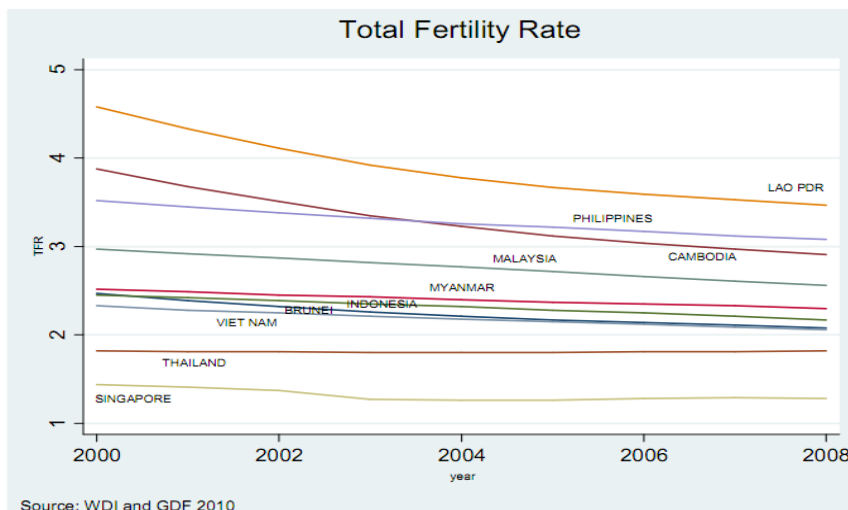


Source: Philippine National Statistics Office

Total Fertility Rate

The National Commission on the Role of Filipino Women estimated an annual fertility rate of 3.28 children per women for the period of 2005 – 2010. They made this estimation based on the assumption that there is a constant decline of 0.2% per 5 year interval of the computed total fertility rate (TFR) in the Philippines. The estimated rate was not far from the actual gathered results from 200 – 2008 (Figure 12). The 2006 and 2009 TFR is at 3.3 per woman while the year 2008 slightly deviated with a TFR of 3.8.

Figure 12:



Source: WDI and GDF 2010

Unemployment rate

The unemployed persons as of April 2011 totals to 2,871M. The unemployed persons by age group is described the table below.

Table 9:

**Unemployed Persons by Age Group
Philippines: 2009 – April 2011**
(In thousands)

INDICATOR	2009	2010 (Average)	2011 (as of April)
TOTAL	2,831	2,859	2,871
15-24 Years	1,437	1,460	1,435
25-34 Years	835	847	862
35-44 Years	270	266	284
45-54 Years	179	181	185
55-64 Years	91	87	87
65 Years & Over	19	19	18

The unemployment rate as described covering the period 2002 – 2011 (Table 10) was derived from the from results of a quarterly rounds of the labor force survey.

Table 9: *Total Unemployment Rate of 15 years old and over*

Period	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011 ^{p/}
Jan	10.3	10.6	11.0	11.3	8.1	7.8	7.4	7.7	7.3	7.4
July	11.2	12.6	11.7	7.7	8.0	7.8	7.4	7.6	7.0	7.1

Data are as of September 2011.

p/ - preliminary

Source: Philippine National Statistics Office (NSO).

Labor Force

Labor force data shows population amongst 15 years old and over in various industries. Data were derived from labor force survey.

Table 11: *Number and Percentage Distribution of Population 15 years old and over by Labor Force and Age Group : October 2009*

Age Group	Total Population 15 years old and over	Total Labor Force
Total	59,705	38,197
Number (in thousands)		
Total	100.0	100.0
15-24	30.2	21.6
25-34	23.0	26.5
35-44	18.0	22.1
45-54	13.7	16.9
55-64	8.5	9.0
65 and over	6.6	3.9

Source: Philippine National Statistics Office, October 2009 Labor Force Survey

Table 12: *Employed Persons by Major Industry January 2006 – October 2009 (in thousands)*

Industry Group	2011	2009	2008	2007	2006
Total	36,821	35,061	34,088	33,559	32,963
Agriculture	12,157	12,042	12,029	11,751	11,818
Agriculture, Hunting and Forestry	10,666	10,581	10,603	10,339	10,397
Fishing	1,492	1,461	1,426	1,443	1,417
Industry	5,617	5,092	5,047	5,121	5,005
Mining and Quarrying	230	166	158	148	141
Manufacturing	3,125	2,893	2,925	3,059	3,059
Electricity, Gas and Water	140	142	129	135	128
Construction	2,123	1,891	1,833	1,778	1,677
Services	19,046	17,924	17,011	17,403	16,142
Wholesale & Retail Trade, Repair of Motor Vehicles, Motorcycles & Personal Household Goods	7243	6,735	6,445	6,353	6,279
Hotels and Restaurants	1,043	1,010	953	907	892
Transport, Storage and Communication	2,705	2,679	2,590	2,598	2,491
Financial Intermediation	406	369	368	359	349
Real Estate, Renting and Business Activities	1,277	1,064	952	885	797
Public Administration Defense, Compulsory Social Security	1,940	1,749	1,676	1,551	1,513

Education	1,168	1,137	1,070	1,035	1,012
Health and Social Work	457	420	391	373	366
Other Community, Social & Personal Service Activities	954	877	833	849	811
Private Households with Employed Persons	1,851	1,880	1,728	1,740	1,626
Extra-Territorial Organizations & Bodies	2	2	1	2	2

Data are as of June 2011.

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Source: Philippine National Statistics Office (NSO).

Part III. HUMAN RESOURCE DEVELOPMENT in HEALTH, WELFARE and EMPLOYMENT

Organizational Structure

The Local Government Code (LGC) of 1991 mandated the devolution of the local health care institutions and the delivery of basic social services from the National Government to the Local Government Units (LGUs).

The new arrangement distributed the administration of the different components of the local health care system to local government executives. The Department of Health (DOH) acts as the central governing body responsible for the policy making, supervision and assistance. Provincial governors assume responsibility for the hospital system at the local level whereas municipal mayors manage rural health units (RHUs) and barangay health stations (BHS). Private facilities however continue to function independently, resulting in a dual health care system that consist of a private health sector and a devolved health system.

To address the concern, the DOH implemented a framework towards health reform to provide the Filipino people better health care access and consequently achieve improved health outcomes, a more responsive health system, and equitable health care financing. The Aquino Health Agenda to achieve universal health care (UHC) for all Filipinos provides for the expansion of the National Health Insurance Program (NHIP) enrollment and benefit delivery using national subsidies for the poorest families; improve access to quality hospitals and health care facilities through accelerated upgrading of public health facilities; and attainment of health related Millennium development goals (MDGs) by applying additional effort and resources in localities with high concentration of families who are unable to receive critical public health services. The functional organization of the DOH for the full implementation of UHC is attached in the annexes.

The Philippine government has mandated the Department of Labor and Employment (DOLE) to cater to the needs of the workers, including the vulnerable groups such as the workers in the informal economy, among which could be the elderly and disabled. The organizational structure of DOLE which was implemented in 2010 is attached in the annexes.

The Department of Social Welfare and Development (DSWD) in turn took a major paradigm shift considering that the passage of RA 7160 or the LGC of 1991 necessitated devolving all its implementing functions together with its programs and services, direct service workers, assets and liabilities, and the budget associated thereto. DSWD from direct service provider took on a new mandate which is directed at providing technical assistance to various partners and intermediaries in effectively implementing programs, projects and services that will alleviate poverty and empower disadvantaged individuals, families and communities for an improved quality of life as well as implement statutory and specialized programs which are directly lodged with the Department and/or not yet devolved to LGUs¹⁵.

The two Executive Orders magnified the Department's role as leader in social welfare and development (SWD) performing two functions – that of steering (navigating) and rowing (direct service). As the lead agency in social welfare and development, the Department exercises the following functions:

- Formulates policies and plans which provide direction to intermediaries and other implementers in the development and delivery of social welfare and development services.
- Develops and enriches existing programs and services for specific groups, such as children and youth, women, family and communities, solo parents, older persons and Persons with Disabilities (PWDs);
- Registers, licenses and accredits individuals, agencies and organizations engaged in social welfare and development services, sets standards and monitors the empowerment and compliance to these standards.
- Provides technical assistance and capability building to intermediaries; and
- Provides social protection of the poor, vulnerable and disadvantaged sector, DSWD also gives augmentation funds to local government units so these could deliver SWD services to depressed municipalities and barangays and provide protective services to individuals, families and communities in crisis situation.

The functional organizational chart and log frame of DSWD is attached in the annexes.

Policies and Regulations

The 1987 Philippine Constitution: Article II, Section 9 on State Policies mandates: “The State shall promote a just and dynamic social order that will ensure the prosperity and independence of the nation and free the people from poverty through policies that provide adequate social services, promote full development, a rising standard of living and an improved quality of life.” Article XIII, Section 2 on Health/Social Services likewise mandates: “The State shall adopt an integrated and comprehensive approach to health development which shall endeavor to make essential goods, health and other social services available to all people at affordable cost. There shall be priority for the needs of the underprivileged sick, elderly, disabled, women and children.” Article XV, Section 4 on the Filipino Family also mandates: “It is the duty of the family to take care of its older person members while the State may design programs of social security for them.” Further, the **Philippine Constitution** recognizes labor as a primary social economic force.

¹⁵ As provided for by Executive Order No. 15 s. 1998: *Redirecting the Functions and Operations of the Department of Social Welfare and Development* and Executive Order No. 221 s. 2003

The Labor Code of the Philippines provides protection to those workers, like the informal workers, which do not necessarily fall under the typical arrangement of employers-employee relationship. Herein are brief discussions of the policies and legislations related to promote employability for the vulnerable sector. Social justice, with emphasis on the right to engage in productive activities and earn a living and social protection, is the overarching concern of the State in defining the legal and State policies that impact on the WIE (Workers in the Informal Economy).

Republic Act 8425: **An Act Institutionalizing the Social Reform and Poverty Alleviation Program.** *It says: “The State shall afford protection to labor, promote full employment, ensure equal work opportunities regardless of sex, race or creed, and regulate the relations between workers and employers. The State shall ensure the rights of workers to self-organization, collective bargaining, security of tenure, and just and humane conditions of work.”* Specifically, Section 4 provides that cross-sectoral flagship programs shall be instituted in the forms of livelihood programs, expansion of micro-credit /microfinance services and capability, and infrastructure build-up and development.

Republic Act 9178: **An Act to Promote the Establishment of Barangay Micro Business Enterprises (BMBE)** aims to hasten the country’s development by encouraging the formation and growth of barangay micro business enterprises which effectively serve as seedbeds of Filipino entrepreneurial talents, and integrating those in the informal sector with the mainstream economy through the rationalization of bureaucratic restrictions, active granting of incentives and benefits to generate much needed employment and alleviate poverty.

The law promotes the so called “*Barangay Micro Business Enterprise*” (BMBE), which refers to any business entity or enterprise engaged in the production, processing or manufacturing of products or commodities, including agro-processing, trading and services, whose total assets including those arising from loans but exclusive of land on which the particular business entity’s office, plant and equipment are situated, shall not be not more that **Php 3,000,000.00**. It provides for the following incentives for registered BMBE:

- Registered BMBEs are exempted from income tax arising from the operation of the business. (Section 7);
- Local government Units (LGUs) are encouraged to reduce amount of taxes, fees and charges imposed on BMBEs or exempt them from the same. (Section 7);
- Exemption from the coverage of minimum wage law. (Section 8);

Republic Act 6939: **An Act Creating the Cooperative Development Authority to Promote the Viability and Growth of Cooperatives Instruments of Equity, Social Justice and Economic Development** recognizes cooperatives as associations organized for the economic and social betterment of their members, operating business enterprises based on mutual aid.

Republic Act 8435: **An Act Prescribing Urgent Related Measures to Modernize the Agriculture and Fisheries Sectors of the Country in Order to Enhance their Profitability, and Prepare Said Sectors for the Challenges of Globalization through an Adequate, Focused and Rational Delivery of Necessary Support Services, Appropriating Funds Therefore and for other Purposes.** Section 58 of the Act mandates the turn-over of

the management and supervision of the public markets and abattoirs to market vendors' cooperatives. The State protects small farmers and fisher folk from unfair competition such as monopolistic and oligopolistic practices by promoting a policy environment that provide them priority access to credit and strengthened cooperative-based marketing system.

Republic Act 8282: **An Act Further Strengthening the Social Security System (SSS) Thereby Amending for this Purpose RA 1161, otherwise known as Social Security Law** provides that the coverage in the SSS shall be compulsory for self-employed persons as may be determined by the Commission (SSS) under rules and regulations that it may prescribe

Republic Act 9442: **An Act Providing for 1% Budgetary Allocation for Persons with Disabilities (PWDs) and Elderly for programs and projects and other emerging trends/development related thereto** provides that the national government agencies shall allocate one (1%) their operating expenses for mainstreaming the PWDs and elderly in socio-economic development.

Republic Act 7432, as amended, otherwise known as **“An Act to Maximize the Contribution of Senior Citizens to Nation Building, Grant Benefits and Special Privileges and for Other Purposes”** gives support to the improvement of the total well-being of the elderly and their full participation in society as well as recognizes the role of the private sector in the improvement of their well-being.

Republic Act No. 7432 or the **Senior Citizens Act of 1991** was entitled **“An Act to Maximize the Contribution of Senior Citizens to Nation-Building, Grant Benefits and Special Privileges and for Other Purposes.”** allows among others senior citizens to render community services (e.g. consultancy services, teaching and specialized lectures).

Republic Act No. 7876 entitled **“An Act Establishing a Senior Citizens Center in all Cities and Municipalities of the Philippines, and Appropriating Funds Therefore”** provides for the establishment of Senior Citizens Centers to cater to older persons' socialization and interaction needs as well as to serve as a venue for the conduct of other meaningful activities. The DSWD in coordination with other government agencies, NGOs and people's organizations shall provide the necessary technical assistance in the form of social and recreational services, health and personal care services, spiritual services, livelihood services and volunteer resource services.

Executive Order No. 266: **Approving and Adopting the Philippine Plan of Action for Older Persons**, addresses the eight areas of concerns namely Older Persons and the Family; Social Positions of Older Persons, Health and Nutrition, Housing, Transportation and the Built Environment; Income Security Maintenance and Employment; Social Services and the Community; Continuing Education/Learning Among the Older Persons; and Older Persons and the Market.

Republic Act No. 7277 or the **Magna Carta for Disabled Persons**, affirms and mandates the rehabilitation, self-development and self-reliance and integration of PWDs into the mainstream society.

Executive Order No. 417 **Directing the Implementation of the Economic Independence Program for Persons with Disabilities (PWDs)** pursuant to RA 7277

enjoins all government agencies and LGUs to employ PWDs whenever applicable and to avail of services and products of PWDs cooperatives and organizations.

Republic Act No. 1179 entitled “**An Act To Provide For The Promotion Of Vocational Rehabilitation Of The Blind And Other Handicapped Persons And Their Return To Civil Employment**”. The law provides for the promotion of vocational training for the blind and other persons disabled by natural and/or accident causes resulting in jobs handicapped and preparing them for jobs suitable to their disabilities and talents.

Republic Act No. 4546 provides for the expansion and development of sheltered employment, and specialized training in specific skills to the trained PWDs. Services include on the job training, social and auxiliary, terminal employment and administrative services.

The Department of Health ‘**Human Resources for Health Master Plan**’ for 2005 - 2030 with the major objectives of (a) ensuring the number and category of health worker are responsive to the needs of the country (b) making more efficient use of available personnel through geographic redistribution and job fit (c) better compensation and management strategies to improve productivity and motivation of health workers. This document shall be the roadmap of every Filipino health workers so that he can help make our health system work and bridge the deadly gaps in our services.

Republic Act No. 9433 entitled “**Act Providing for a Magna Carta for Public Social Workers.**” The Magna Carta seeks to improve the social and economic well-being of public social workers, as well as their working conditions and terms of employment to enable them to function better in delivering social services and programs. The law covers all registered social workers in government service. The DSWD will head the Social Work Management and Consultative Council which shall oversee the implementation of the law. Some of the benefits provided to social workers under the Magna Carta are: provision of additional allowances such as hazard and “on-call” allowances entitlement to leave benefits; compensation from injuries; protection from reassignment except in the interest of public service; and provision of human resource development and management trainings

Administrative Order No. 16, DSWD setting the **Framework and Guidelines for Capability Building of DSWD Social Protection Intermediaries and Stakeholders**

Administrative Order No. 62 s. 2003, DSWD amending Administrative Order 33 s. 1993 entitled **Reorganizing the national Advisory Board and the Managing Boards for the Manila International Film Festival (MIFF) Fund for the Persons with Disabilities and Older Persons and Providing Guidelines for the management of the Fund Thereof** which provides guidelines on the management of the fund intended for programs and projects aimed at fostering the rehabilitation, self-development and self-reliance of persons with disabilities and older persons.

Stakeholders Related to Human Resource Development

The Department of health establishment the **Philippine Human Resources for Health Network** (HRHN) composed of government and private sector stakeholders in human resources for health. The Network has three subcommittees following the WHO work Lifespan framework of Entry, Workforce, and Exit & Re-entry. Membership comes from the

health academe, professional regulatory authorities, employers, professional organizations, recruitment and deployment organizations, labor unions, and professional leaders among others. Development partners provide the technical and administrative resources. As of yet, the Network implement strategies defined in the **Human Resources for Health Master Plan' for 2005 - 2030** with focus on unified HRH policy and a national HRH policy research agenda amongst its stakeholders, HRH information management database and system, installation and institutionalization of DOH based HRHMD programs and systems including the promotion of quality education, adequate production, workforce retention, ethical recruitment framework, mutual benefits and reciprocity, HRH capability building, quality management, and HRH Public-Private Partnerships.

Professionals and Workers

Human resources for health are the key to achieving health goals and improving health status. They are the main drivers of the health care system and are essential for the efficient management and operation of the public health system. Although the Philippines does not lack HRH, they are unevenly distributed throughout the country with a substantial proportion concentrated in urban areas. This paper shall limit its documentation for doctors, nurses, physical therapists, social workers and to a lesser extent massage therapists and healthcare givers. The lack of an aggregated database on HRH and Social Workers is a challenge for the Philippines. The Professional Regulation Commission (PRC) does not collect data aggregated by professions and practitioners in the field. There are government agencies and professional associations such as the Association of Health Workers and the Philippine Association of Social Workers, Inc among others that have initiated attempts to document and assess their ranks but their databases are limited to their roster of membership.

There are about 3,645 registered members to the Philippine Association of Social Workers, Inc. Licensed Social Workers in the country are unevenly distributed across regions. Anecdotal evidence shows that the Social Work is now among the professions that is declining in number. Enrollment in this field is also declining overall.

The following policies regulate the practice of the professionals in the Philippines and describe their qualifications and certification for practice. All the documents shall be attached as annexes.

- Republic Act No. 2382 or **The Medical Act of 1959** provides for and shall govern (a) the standardization and regulation of medical education; (b) the examination for registration of physicians; and (c) the supervision, control and regulation of the practice of medicine in the Philippines.
- Republic Act No. 5946: **An Act To Amend Certain Sections Of Republic Act Numbered Twenty-Three Hundred And Eighty-Two, Otherwise Known As "The Medical Act Of 1959" As Amended By Republic Act Numbered Forty-Two Hundred And Twenty-Four.**
- Republic Act No. 9173: **An Act Providing For A More Responsive Nursing Profession, Repealing For The Purpose Republic Act No. 7164, Otherwise Known As "The Philippine Nursing Act Of 1991" And For Other Purposes.** This Act shall be known as the "**Philippine Nursing Act of 2002**" assume responsibility

for the protection and improvement of the nursing profession by instituting measures that will result in relevant nursing education, humane working conditions, better career prospects and a dignified existence for our nurses. As such, the country is guaranteed with the delivery of quality basic health services through an adequate nursing personnel system throughout the country.

- Republic Act No. 5680: **An Act Creating the Board of Examiners for Physical Therapists and Occupational Therapists.**
- Republic Act No. 4373: **An Act to Regulate the Practice of Social Work and the Operation of Social Work Agencies in the Philippines and for Other Purposes** primarily concerns organized social service activity aimed to facilitate and strengthen basic social relationships and the mutual adjustment between individuals and their social environment for the good of the individual and of society.
- Presidential Decree 856 or **the Code on Sanitation** Section 62(a) that mandates a massage therapist be certified by the DOH Committee of Examiners for Massage Therapy before practicing this skill.
- **Technical Education and Skills Development Authority (TESDA)** sets the competency standards and eventual certification for **health caregivers.**

The succeeding tables provide a summary of the stock of health and allied professionals from the time it was first established in the country and its current population density.

Table 13: *Registered Medical Doctors per 100,000 population 1998-2008*

Year	Population ¹	Doctors ²	Doctor to Population density
1998	72,877,979	65137	89.38
1999	74,834,407	74950	100.15
2000	76,504,077	77124	100.81
2001	78,568,100	79377	101.03
2002	80,217,200	81703	101.85
2003	81,877,700	83867	102.43
2004	83,558,700	85998	102.92
2005	85,261,000	88552	103.86
2006	86,972,500	91144	104.80
2007	88,574,614	94074	106.21
2008	90,457,200	96639	106.83

Source: PRC and NSCB, processed by IHPDS-NIH 2008

¹ NSCB, 2009

² 1998-2003: PRC stock data

2004-2008: Derived from adding PRC stock with number of passers in medical licensure exam per year

Table 14: *Stock of Medical Doctors (Cumulative Count), 1910-2008*

Year	Count
1910*	883
1920*	1,606

1930*	2,684
1940*	5,661
1950*	6,961
1960*	14,960
1970*	27,952
1980*	36,995
1990*	56,540
1997	63,273
1998	65,137
1999	74,950
2000	77,124
2001	79,377
2002	81,703
2003	83,867
2004	86,018
2005	88,572
2006	91,164
2007	94,094
2008	96,661

Source: Professional Regulation Commission, 2009

*Cumulative counts every 10 years

Table 15: *Registered Nurses per 100,000 population*

1997-2008

Year	Population ¹	Nurses ²	Nurse to Population density
1997	71,096,055	284,144	399.66
1998	72,877,979	292,564	401.44
1999	74,834,407	300,044	400.94
2000	76,504,077	304,384	397.87
2001	78,568,100	307,897	391.89
2002	80,217,200	311,256	388.02
2003	81,877,700	316,892	387.03
2004	83,558,700	327,714	392.20
2005	85,261,000	351,229	411.95
2006	86,972,500	385,512	443.26
2007	88,574,614	442,084	499.11
2008	90,457,200	492,666	544.64
2009 (June)	92,226,600	544,967	590.90

Source: PRC and NSCB, processed by IHPDS-NIH 2008

¹ NSCB, 2009

² Cumulative number of NLE passers per year less retired and dead nurses;

Source: PRC, 2009

Table 16: *Stock of Registered Nurses (less retired and deceased), 1910-2008*

Year	Cumulative Total of NLE Passers	Less: Retired and Dead Nurses
1919	560	
1924	1,465	1,428
1929	2,623	2,555
1934	3,772	3,663
1939	4,992	4,837
1944	6,091	5,882
1949	7,140	6,627
1954	9,209	8,845

1959	14,263	13,718
1964	22,908	21,568
1969	35,383	32,799
1974	57,206	52,870
1979	100,150	93,472
1984	145,281	135,953
1989	164,565	153,066
1994	247,910	232,553
1999	318,575	300,044
2004	351,943	327,714
2009	612,487	578,723

Source: Professional Regulations Commission, processed by: NIH – IHPDS, 2010.

Table 17: *Registered Physical and Occupational Therapists per 100,000 population 1999-2009*

Year	Population ¹	Physical Therapy		Occupational Therapy	
		Total Registered ²	Density (per 100,000)	Total Registered ³	Density (per 100,000)
1997	71,096,055	4,852	6.82	400	0.56
1998	72,877,979	6,285	8.62	567	0.78
1999	74,834,407	8,426	11.26	871	1.16
2000	76,504,077	10,740	14.04	1,121	1.47
2001	78,568,100	13,081	16.65	1,439	1.83
2002	80,217,200	15,066	18.78	1,727	2.15
2003	81,877,700	16,532	20.19	1,932	2.36
2004	83,558,700	17,675	21.15	2,089	2.50
2005	85,261,000	18,738	21.98	2,216	2.60
2006	86,972,500	19,737	22.69	2,337	2.69
2007	88,574,614	20,533	23.18	2,414	2.73
2008	90,457,200	21,974	24.29	2,578	2.85
2009 (July)	92,226,600	22,294	24.17	2,609	2.83

Source: PRC and NSCB, processed by IHPDS-NIH 2009

¹ NSCB, 2009

² Cumulative number of Physical Therapists per year Source: PRC, 2009

³ Cumulative number of Occupational Therapists per year Source: PRC, 2009

Other health professionals working in the public health system at the local level are midwives, nutritionists, sanitary engineers and inspectors, and medical technicians.

Employment Rate for Vulnerable People Especially Elders and Disabilities

In line with the international commitment of the Philippines towards the achievement of the Millennium Development Goal (MDG) 1 by 2015, the proportion of own-account and contributing family workers to total employment or vulnerable employment rate is one of the employment indicators to be monitored in the eradication of extreme poverty and hunger.

The information below provides a summary of the demographic and economic characteristics of the vulnerable employed workers in 2010. The data presented refer to the averages of the four (4) survey rounds (January, April, July, and October) of the Labor Force Survey (LFS) conducted by the National Statistics Office (NSO).

In 2010, these vulnerable employed numbered 15.015 million or 41.7% of 36.035 million (Table 18). Workers in vulnerable employment modestly expanded by almost half a million (478,000) or a growth rate of 3.3 percent from 2006 to 2010 or an annual increase of less than 1.0%. A similar trend was exhibited by both self-employed, which grew by 3.2% or 0.8% annually, and unpaid family workers which went up by 3.6% or an annual average of 0.9%. Men in vulnerable employment outnumbered their women counterparts (Table 19). However, the pace of growth of women workers (5.7% or 1.4% annually) was higher compared to the growth of men workers (1.6% or 0.4% annually).

Table 18: *Employment of Vulnerable Groups
(in thousands)*

YEAR	Total	Self-Employed	Unpaid Family Workers
2006	14,537	10,525	4,012
2007	14,622	10,570	4,052
2008	14,815	10,654	4,161
2009	14,942	10,724	4,218
2010	15,015	10,858	4,157

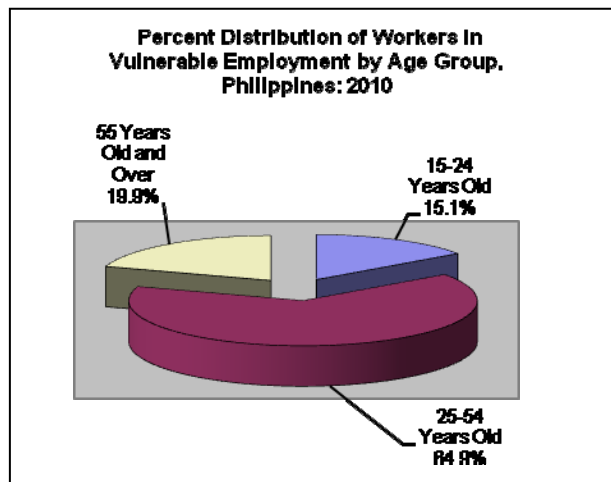
Table 19: *Employment of Vulnerable Groups by Sex
(in thousands)*

YEAR	Total	Men	Women
2006	14,537	8,584	5,954
2007	14,622	8,616	6,006
2008	14,815	8,759	6,056
2009	14,942	8,719	6,223
2010	15,015	8,719	6,296

Three out of 5 persons in vulnerable employment were men (8.719 million or 58.1%). Majority of them were in the prime working age of 25-54 years old with 9.750 million or 64.9% (Figure 13). Married workers constituted about 70.3% (10.559 million) of the total workers in vulnerable employment. Relatively large shares of the vulnerable employed were in agriculture (52.3%) and services (42.1%) sectors. About 31.8% of these workers were farmers, forestry workers and fishermen. Laborers and unskilled workers followed with 29.2% and managing proprietors at 23.8%. These groups together made-up 84.8% of total employed in vulnerable employment. Around 13 million (86.1%) of them considered their jobs as permanent in nature. More than half (52.8%) worked less than 40 hours a week or were in part-time employment. The mean hours worked per week of workers in vulnerable employment was 38.3. In the Philippines, massive dislocations in the workplace threatens to load off more workers into the informal economy.

The global financial crisis resulted downsizing and retrenchments in the formal economy. Returning migrant workers who were displaced will join the labor force to either seek formal employment, create their own employment, or opt to be employed in informal enterprises. The WIE situations are summed up from the sectors' objectives, as follows: "Increased legal protection, income security, productivity, and employability of WIE ensured."

Figure 13:



Constraints and Issues

In 2004, there was a noted boost in the enrollment in the nursing academic programs. The increase in the nursing graduates resulted in the disproportion in the skill mix amongst nurses with doctors, midwives and other health professionals. With the country touted as the major exporter of nurses in the international market, the phenomenon was more on the response for international demand rather than the domestic needs.

As to the employment of the socially vulnerable - why the goal of legal protection, income security, productivity, employability? The overarching goal of welfare, health and employment of WIE in caring societies is impossible to achieve without significant gains in the said socio-economic aspects in the lives of WIE. The existing legal and policy framework on legal protection for the vulnerable group generally does not apply to workers in the informal economy and if certain provisions do apply, they are not effectively enforced. Legal protection would require reforms in labor legislation and labor administration to ensure that their labor rights are effectively protected. For income security, the sector would want to reduce their vulnerability to financial risks and sudden loss of income. WIE want to expand their operations, recognize and seize market opportunities, and greatly enhance competitiveness that will eventually improve employability and productivity.

Part IV. CASE STUDY: GOOD PRACTICES

1. Department of Labor and Employment: “TULAY PROGRAM – Tulong, Alalay sa Taong May Kapansanan (*Building human bridges for the development of persons with disabilities through training and employment*) – A Special Program for Persons with Disabilities (PWDs).”

Overview

The TULAY Program of the Department of Labor and Employment is being implemented since 1994 pursuant to Republic Act No. 7277 (Magna Carta for Disabled Persons) and Proclamation No. 125 (Proclaiming the National Observance in the Philippines of the Asian and Pacific Decade of Disabled Persons). The program aims to

assist in the Integration of persons with disabilities into the society by providing them access to training and employment opportunities both in the formal and informal sector.

Problem Analysis

The PWDs are among the most vulnerable group in our society. The government recognizes that the opportunities for full participation in development and equality of persons with disabilities, particularly in the field of employment, continue to be far less than those available for their able-bodied peers.

Despite specific provision in Section 5 of the Magna Carta for Disabled that five percent (5%) of all casual, emergency and contractual positions in the Departments of Social Welfare and Development; Health; Department of Education; and other government agencies, offices or corporations engaged in social development shall be reserved for disabled persons, compliance is still very low. Social barriers persist which limit the fullest possible participation of disabled persons in the life of the group, which may include negative attitudes which tend to single out and exclude disabled persons and which distort roles and interpersonal relationships. They are sometimes viewed as deficient in performing an activity in the manner or within range considered normal for a human being, which shall ultimately affect productivity. This is being so despite the government's efforts to remove all social, cultural, economic, environmental and attitudinal barriers that are prejudicial to disabled persons.

Institutions or Organizations Involved

Private institutions engaged in social development and other government agencies/institutions are involved in TULAY program provide services and employment opportunities for the PWDs, whether for formal or self-employment.

The Technical Education and Skills Development Authority (TESDA), an agency attached to the DOLE, and private training institutions are also tapped to provide the trainings for identified needed skills of PWD TULAY project beneficiaries. Existing skills of PWD beneficiaries can also be enhanced through short-term formal trainings. Moreover, TESDA conducts competency assessment of its trained graduates, issues Competency Assessment Certificates, and provides data on certificate holders who are still unemployed.

Strategy Pursued

To address the vulnerability of the PWDs, the DOLE implements the TULAY Program under two (2) components: (1) employment facilitation, and (2) employment enhancement through skills training.

Employment Facilitation

- Wage Employment

PWDs whose qualifications are suited for wage employment shall be referred to private companies or government agencies where job vacancies are available for

them. For this purpose, a skills pool of PWDs as well as list of prospective employers shall be maintained for quick reference.

- **Self-Employment**

PWDs who are inclined towards self-employment shall be encouraged to set up their own self-employment through easy to learn livelihood undertakings. The DOLE had implemented livelihood or micro enterprise projects for PWDs from 1995 until the present under the banner of DOLE Integrated Livelihood Program (DILP). TULAY projects are implemented nationwide either as individually or in group.

The PWDs are provided with capacity-building services such as working capital in the form of materials/inputs, equipment, tools and jigs to be able to start a livelihood undertaking or enhance their existing livelihood undertaking and short-term skills training. Skills trainings include simple house-to-house or service-oriented technical and vocational trainings on massage, plumbing, cosmetology, electrical servicing, welding, native snack preparation, car wash, motorcycle repair, cellular phone repair, appliance repair and upholstery repair.

Employment Enhancement Through Skills Training

To enhance the employability of PWDs, skills training programs suited to their interests, potentials and circumstances shall be developed and skills trainings to be conducted by selected government and private training institutions in the areas of industrial, livelihood or entrepreneurship skills.

How the Strategy was Implemented

Several strategies are employed in the operationalization of TULAY program, to wit: (a) sourcing of opportunities for PWDs like job vacancies, trainings, self-employment programs and projects of other departments; (b) registration of PWDs and maintenance of PWD data bank; (c) capability building for program implementers; (d) establishing linkages with GOs, NGOs and LGUs; (e) awakening public concern through advocacy and informal campaign; and (f) close monitoring of enforcement of laws pertaining to employment of PWDs.

Impact on Policy

Over a period of sixteen (16) years (1994-2010), the DOLE has assisted 33,809 PWDs or an average of 2,113 annually, both in job placement and livelihood (33,649) and provided eyeglasses to visually impaired persons (160) during the celebration of the National Disability Prevention and Rehabilitation Week in 2010.

Every year, the Inter-Agency Committee on Employment Promotion, Protection and Rehabilitation of Persons with Disabilities created by then Philippine President Fidel V. Ramos pursuant to Executive Order No. 261, spearheads various relevant activities and projects for the development and recognition of successful PWDs in their respective pursuit for better life.

Potential for Up-scaling and Replication

To further awaken public awareness and raise their level of concern, a more aggressive advocacy and informal campaigns were undertaken.

Several executive orders, proclamation and administrative order were issued for better and meaningful operationalization of the Magna Carta of Persons with Disabilities.

The DOLE experience for self-employment initiatives for the PWDs are worthy of replication. Several livelihood projects initiated and operated by group of PWDs have been successful and can be showcased as model for other similarly situated groups to build their own income generating activities for the upliftment of their socio-economic well-being. Indeed, this is a display of greater and brighter opportunities for the PWDs in terms of employability and productivity.

2. Department of Social Welfare and Development: “Convergence Strategy in Social Protection Programs.”

Background/Overview

Implementing social protection programs was challenging in the absence of a coordinated and unified system for monitoring. Moreover, it was observed social protection in the Philippines has a very narrow base of beneficiaries – the poor and informal sectors have limited access, bargaining power, and influence on service providers. A survey of SP programs implemented early in this decade showed that although they are numerous but are characterized by the following: has limited reach, uncoordinated, inadequately funded and usually short lived. To address this, the Philippines started by adopting an official definition of Social Protection to wit:

Social protection constitutes policies and programs that seek to reduce poverty and vulnerability to risks and enhance the social status and rights of the marginalized by promoting livelihood and employment, protecting against hazards and sudden loss of income, and improving people capacity to manage risks. (Social Development Committee Resolution No. 1, S. 2007, “Adopting a Philippines Definition of Social Protection”)

The definition of SP was formulated in 2007 through SDC Resolution no.1, series of 2007. With this, National Economic and Development Authority (NEDA) formulated the SP Framework¹⁶. In 2009, the Technical Working Group on Social Protection comprised of DSWD, NEDA, the Social Security System (SSS) and the National Anti-Poverty Commission (NAPC) formulated the SP Strategy Paper which highlights the coordination and complementation of efforts from the national to sub-national levels on social protection which should be strengthened and harmonized to achieve greater synergy and program impact in achieving an improved quality of life for the poor and vulnerable sectors of the society. The strategy paper identified the following imperatives for action: a) collaboration of key stakeholders; b) complementation of social protection programs and projects; c) monitoring and evaluation; and d) formulation of a graduation scheme.

¹⁶ [The Social Protection Framework is in the Annexes.](#)

During the National Economic and Development Authority-Social Development Committee (NEDA-SDC) Cabinet Level Meeting on 29 October 2009, the Sub-Committee on Social Protection (SCSP) was created by virtue of SDC Resolution No. 2, series of 2009.

The SCSP is chaired by the DSWD Undersecretary for Policy and Programs with the NEDA Deputy Director General for Planning and Policy as Vice-Chairperson. It was created to operationalize the identified imperatives for action as well as the institutional arrangements including reporting of each of the responsible government agency/entity.

Presidential Administrative Order No. 232 (Subject: Social Welfare Reforms) provided that agencies dealing with social welfare shall be clustered together into a National Social Welfare Program to directly address the impact of the adverse global environment (signed on 08 July 2008). Since the National Social Welfare and Protection Cluster was an ad-hoc body to coordinate the SP efforts of government it was deemed ideal to mainstream the efforts of the government in line with SP. To do this a Sub-Committee on Social Protection was proposed for creation under the SDC. This Sub-Committee was created through the SDC Resolution No. 2, series of 2009.

The adoption of the social protection framework by the National Government provides the basis for the convergence strategy adopted by the DSWD.

Problem Analysis

The growing poverty concern in the country is multi-dimensional. Often a poor household deals with combined problems on poor health, very low if not no income at all, unemployment, political instability, and lack of access to basic social infrastructure such as potable water, school or health centers. A sporadic and disconcerted effort will not fully and effectively address the issues these households encounter. Poverty reduction programs should altogether be implemented in synchrony in order that combined resources and services of each program will better address many facets of the problems of poor families and communities.

It was determined that this is an area where the current implementation of the three core social protection programs of DSWD will have to be improved. At present, each program attempts to deal with one of more dimensions of poverty separately. There is a need for a more coordinated implementation of the three core programs to lead to more relevant changes in the lives of the target beneficiaries. Harmonizing and converging the efforts of the three programs should lead to maximized resources, minimized duplication and optimized results.

Strategy Pursued

Convergence is the act of directing complementary and/or synergetic programs (interventions) to specified (targets) poor households, families, individuals and/or communities. In the context of its use in the poverty alleviation programs in the Philippines, the principle on convergence borders on going beyond the confines of individual agency capabilities in the implementation efforts in delivering programs and

services. The principle of convergence calls for the synchronization and coordination of all interventions of the government (national and local) and the private sector in one geographical area to ensure that reforms in terms of poverty alleviation, among others, are achieved.

While the long term goal of convergence at the national level is to harmonize all poverty reduction programs of various government agencies, DSWD has started to orchestrate its three major social protection programs. With the convergence strategy, a limitation of one program in addressing a social need of a family, household or community will be addressed by the two other programs alongside the other social protection programs of the Department.

The Convergence strategy aims to enhance the DSWD's contribution in the achievement of more sustainable and tangible impact on poverty reduction. It will attempt to (a) maximize resources allocated for social protection programs; (b) reduce duplication of efforts, strategies and activities at all levels; (c) harmonize and synchronize the processes involved in the implementation of the core social protection programs; (d) unify mechanisms for feedback, reporting, monitoring and documentation; (e) enhance partnership with the non-government organizations (NGOs), private organizations (POs) and civil society organizations (CSOs); and (f) enhance knowledge skills and attitude towards collaborative action among stakeholders.

This Framework is also known as the Public Private Partnership (PPP) Pathway out of Poverty.

Strategy Implementation

The DSWD is one of the agencies tasked to address the increasing poverty incidence in the Philippines. As the leader in the social welfare and development sector, the DSWD currently implements three major social protection programs: The Kapit-Bisig Laban sa Kahirapan – Comprehensive and Integrated Delivery of Social Services (KALAHI-CIDSS) Project, the Pantawid Pamilyang Pilipino Program (4Ps) and the Self Employment Assistance Kaunlaran (SEA-K) Program. These three core programs are key poverty reduction projects targeting the poor municipalities and poor households in the country. (A brief description of these programs is in the Annexes).

The three programs continue with its usual operation and delivery of service to the poor families, households and communities. However, with the convergence strategy, they are implemented in complementation with all other social protection programs in DSWD.

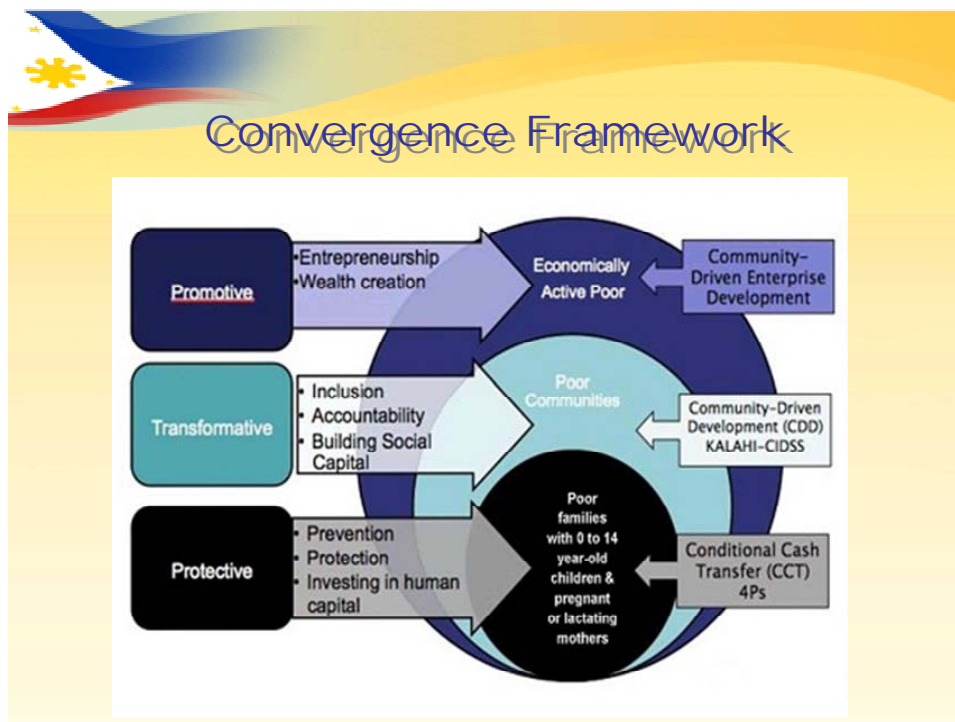
DSWD has identified 17 regions, (including ARMM); 53 provinces, and 289 municipalities where 4Ps, KALAHI-CIDSS and SEA-K will simultaneously operate.

In order to ensure convergence the following key elements have to be installed and/or integrated. These are:

- Unified targeting system. The NHTS-PR database will be used in the identification of beneficiaries to minimize leakages and ensure that the poor are served.

- Synchronized implementation of social preparation and mobilization activities.
- Harmonized engagement of the LGUs.
- Coordinated capability building.
- Harmonized monitoring and reporting.
- Social Case Management.
- Enhanced partnership with the NGOs/POs and the Civil Society
- Disaster Risk Reduction
- Creation of Convergence Committees
- Creation of a National Project Management Office or PMO
- Unified Project Management Meetings

Figure 14: *DSWD Convergence Framework*



Institutional Arrangements

The major implementation and stakeholders of the core social protection programs of the Department will be enjoined in the implementation of the convergence strategy, inter-agency Convergence Coordinating Committees will be created at various levels to provide policy directions and facilitate the creation of a conducive environment for the convergence of inter-agency poverty alleviation programs.

At the national level the Steering Committee shall be composed of:

- Department of Social Welfare and Development (DSWD)
- Department of Health (DOH)
- Department of Education (DepEd)
- National Anti-Poverty Commission (NAPC)
- Department of Interior and Local Government (DILG)

- National Economic Development Authority (NEDA)
- Department of Budget and Management (DBM)
- NGO Representative and;
- Philippine Health Insurance Corporation (PhilHealth)

Pilot testing of the Convergence strategy is on-going but has already showed positive results.

Impact on Policy

The implementation of the three core programs which are designed to support and sustain the most disadvantaged in society in synchrony illustrates a novel and timely approach to the issue of how social protection programs should be designed and implemented in order to have a significant impact in the lives of the beneficiaries.

It supports the Aquino Administration's call for good governance and public-private partnership.

Potential for Up-scaling and Replication

The Social Protection Framework provides the guide into how agencies involved in the managing and provision of social protection can work together to ensure that resources and energies are expended synergistically to achieve the intended outcomes for the vulnerable and disadvantaged sectors.

3. Rural Health Team Placement Program

Overview

The Rural Health Team Placement Program (RHTPP) is a composite of several human resources for health programs that utilizes a training cum employment approach designed for unemployed registered health professionals. The Program is aimed at increasing their employability through the provision of learning and development opportunities, and at the same time, foster independence in the community's healthcare delivery system and the provision of quality healthcare professionals. Notably, the program addresses the inequitable distribution of healthcare professionals and augments the need for human resources for health amongst the most vulnerable groups especially in rural, unserved and underserved, hardship communities towards the improvement of local health systems that will support the country's attainment of its Millennium Development Goal (MDG) targets. Moreso, RHTPP best practice outlines a scholarship-to-deployment scheme adapted by the Philippines' Department of Health (DOH) in response to a fragmented healthcare delivery system as a consequence to the instituted Local Government Code in 1991.

Problem Analysis

The Philippine health workforce's current situation is similar to other developing nations. The effects and consequences of the inequitable distribution of health personnel,

high incidence of underemployment, inadequate experience and competencies of those employed, poor retention and migration among others are deeply felt throughout the country but more so in geographically isolated, hard to reach, depressed/underserved areas where some people including the most vulnerable groups die without being seen by a health personnel. The situation has been made more complicated with the devolution of major health services from the national government to the local government units (LGU) contributing to the inaccessibility to basic health care services.

Despite the good intentions of a devolved set up to enhance the capabilities of LGUs in providing opportunities to participate in the implementation of national programs, this practice was beneficial only to local government units that saw health as a priority. The Local Government Code of 1991 was to bring health services closer to those in need by giving LGUs the authority to determine the necessities of their respective areas.

The Philippines' Department of Health (DOH) is spearheading the drive to address the inadequacy of human resources for health through the implementation of the Rural Health Team Placement Program (RHTPP) so as to respond to the health needs of our countrymen. The rural health team composed of the doctor, the nurse, midwives, a dentist, a medical technologist, pharmacist, and a nutritionist-dietician.

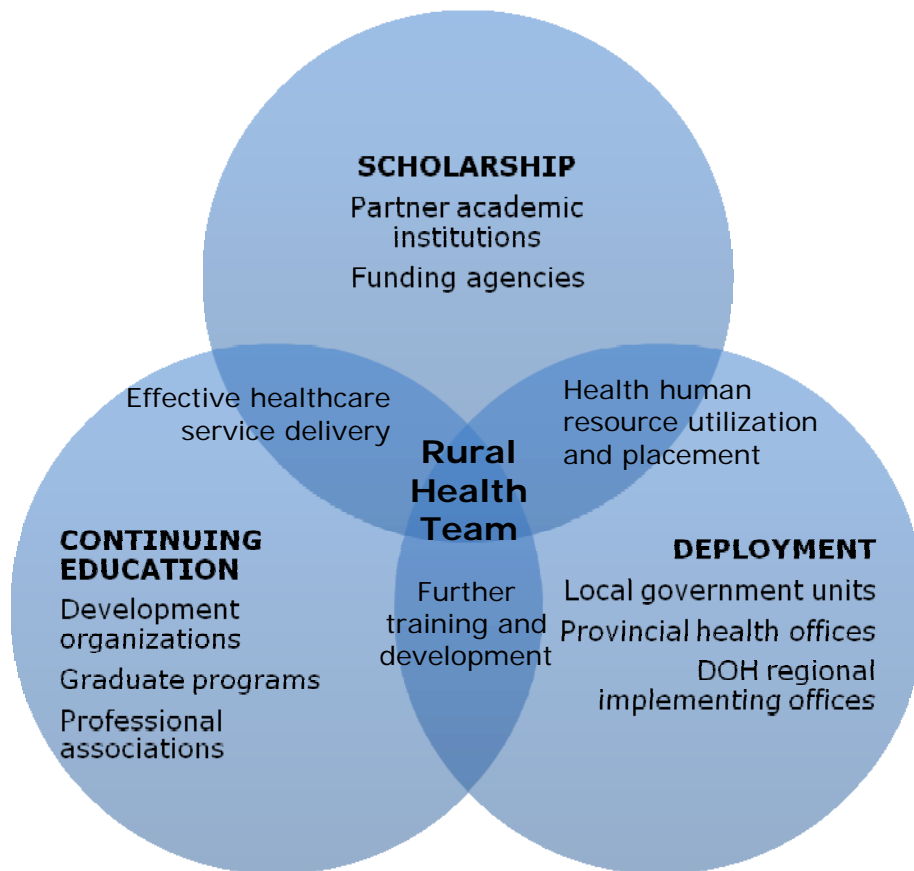
Institutions or Organizations Involved

The RHTPP is in collaboration mainly with DSWD to synchronize with the human resource requirements of the Pantawid Pamilya Pilipino Program (4Ps). The other major stakeholder are the local government units for their community health teams (CHT) in the provision of basic and comprehensive maternal, newborn, child, health and nutrition packages as well as services identified critical in their areas of assignment. Other stakeholder are government and private academic institutions not only because of their mandates to produce health workers but also on their social responsibility as academic institutions aspiring to yield competent community-oriented HRH to address the growing health care needs of the country; professional organizations are involved in the monitoring and follow through of HRH as they are assigned in communities; funding organizations and development partners that support the program financially and technically.

Strategy Pursued

The paradigm illustrates the framework in correspondence to the DOH mandate of guaranteeing equitable and sustainable health for all Filipinos. This framework below (figure 14) shows the scholarship-to-deployment scheme adapted by DOH in order to ensure the steady supply and retention of health workers. By financing the education of future physicians and midwives and other health workers, DOH is on target in achieving the goal of attaining WHO's recommendations on standard staffing requirements - that is 23 health workers per 10 thousand population to be able to deliver eighty percent quality health services. To complete the rural health team, other allied health professionals are likewise deployed and contribute to the over all achievement of the local health goals.

Figure 15: *Intervention Management for Ensuring the Continuous Supply of Human Resources for Health Workforce.*



The scholarship programs are implemented for doctors and midwives through the collaborative partnership of academic institutions, the Philippine Health Department, sponsoring agencies, and other agencies. As payback for the scholarship grant, graduates of the program are deployed in predetermined municipalities based on their human resource needs. To deliver effective health services during the course of their tenure, health workers under the RHTPP are provided with continuing professional education to enhance individual and career development. Together with the doctors and midwives, nurses and other health professionals are deployed in various health facilities across the country.

How the Strategy was Implemented

The Rural Health Team is a composite of several human resources for health programs that utilizes a training cum employment approach designed for unemployed registered health professionals. To highlight, the most advance program provided for doctors deployed in difficult areas is a Masters in Public Management major in Health Systems and Development (MPM-HSD). This is a degree course that is composed of a series of independent unit-earning short courses. Each short course is tailor crafted as strategic components of the MPM-HSD to equip Philippine healthcare providers at different levels (policy makers, managers and implementers) with the capability to implement health sector reform (HSR). The concept behind creating independent unit-earning short courses is to be able to instill the appropriate knowledge and skill in all

healthcare delivery stages and grant providers an opportunity to earn a Masters Degree program. This phased provision will allow recipients of the course to acquire higher education while rendering continuous service in their areas. The contents and recipients of short courses are strategically phased and encompass the range from HSR introduction to adoption and implementation. Thus the courses were developed according to provider need and role. The academic institution and the Department of health joined forces in the development of the program.

Another highlight is the deployment of nurses for the implementation of the health component of the 4Ps and also to supervise CHTs. The community health teams composed of community volunteer health workers specifically assigned to a number of families for their health needs. The nurses see to it the community volunteers are provided the appropriate skills to follow through health care needs of the families assigned to them. It is also the nurses' responsibility to encourage the families to attend to their regular visits to the health units. In return, the nurses are able to develop their skills and increase their employability through the learning and development opportunities given to them.

The other health professionals included in the program that complete the rural health team are dentists, nutritionist-dieticians, medical technologists, pharmacists, and sanitary inspectors. Pharmacists participate in the establishment of village pharmacies (Botika ng barangay) to ensure access and availability of essential drugs

Impact on Policy

Augmentation of health human resource has been the objective of RHTPP in order to address the health situation of the country. Notably, the program has improved access to quality health care services; the health workers provision of learning and development opportunities through either customized academic and non-academic course has also increased their employability whether it be in the government or private sector, or even elsewhere; it has fostered independence in the community's health care delivery system as the towns folk has be empowered to take care of their own health; somehow, the program addresses the inequitable distribution of healthcare professionals and augments the need for human resources for health in rural, underserved, hardship communities towards the improvement of local health systems that will support the country's attainment of its Millennium Development Goal (MDG) targets; and, institutionalized local health systems in support of the country's thrust towards universal health care.

Potential for Up-scaling and Replication

Healthcare providers, policy makers and planners continue to participate as a response to their felt need for health sector reforms. The training and deployment strategy to adopt HSR and develop HRH professional careers while they render continuous service in their localities has brought forth significant Province-wide Investment Plans for Health, access to healthcare services and improved absorptive capacity of health facilities.

Also, the concept of linking independent unit-earning short courses to complete a degree can be applicable to nations that experience misdistribution and shortages especially in geographically isolated and depressed areas. The development of learning

and development courses were based on the existing health system structure of the Philippines.

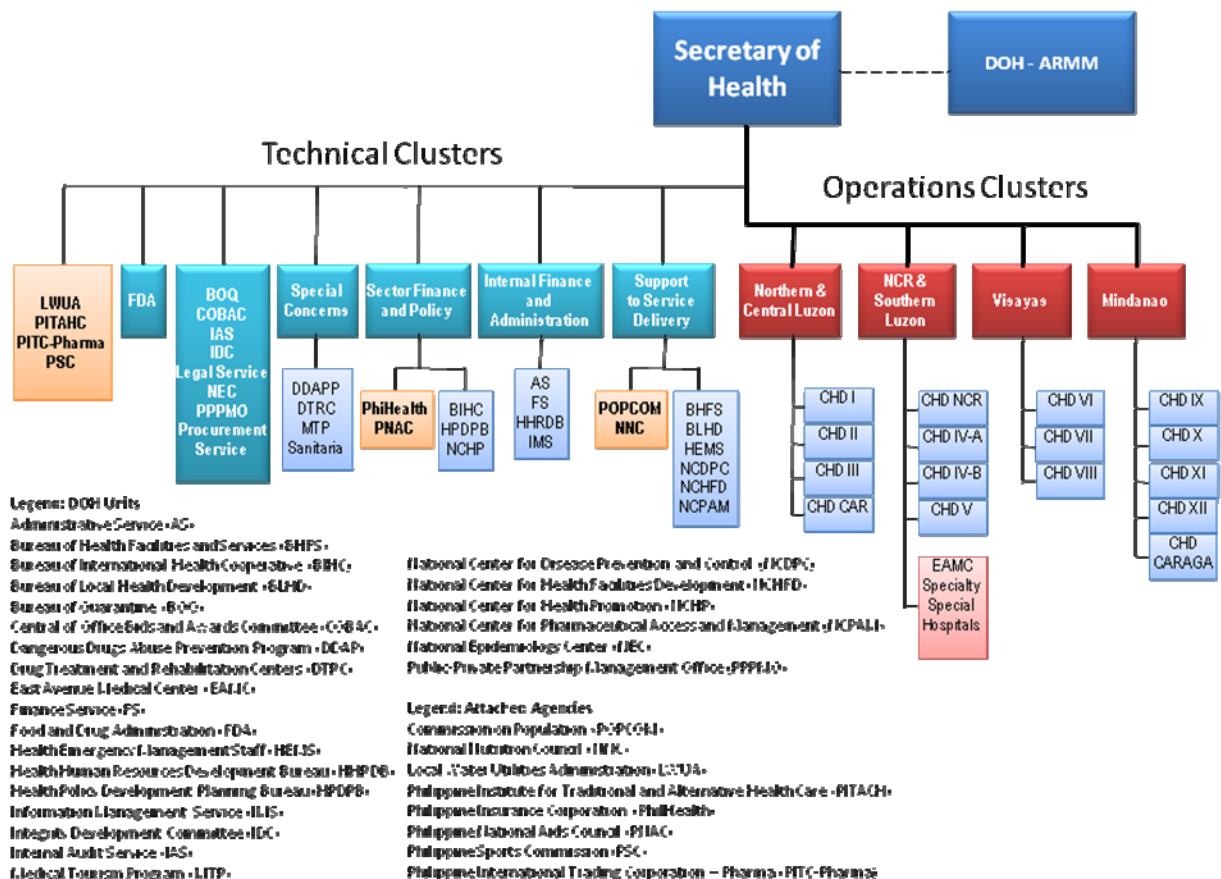
Fragmented healthcare delivery is a concern of countries composed of congregated islands. In this setup, conventional strategies to improve HRH development may not be effective. It is proposed that developing countries with similar health system concerns adopt a similar strategy for HRH career development to support the attainment of national health goals. RHTPP henceforth greatly contributes to the transformation of our country from poverty to genuine prosperity using health as a tool.

Sources:

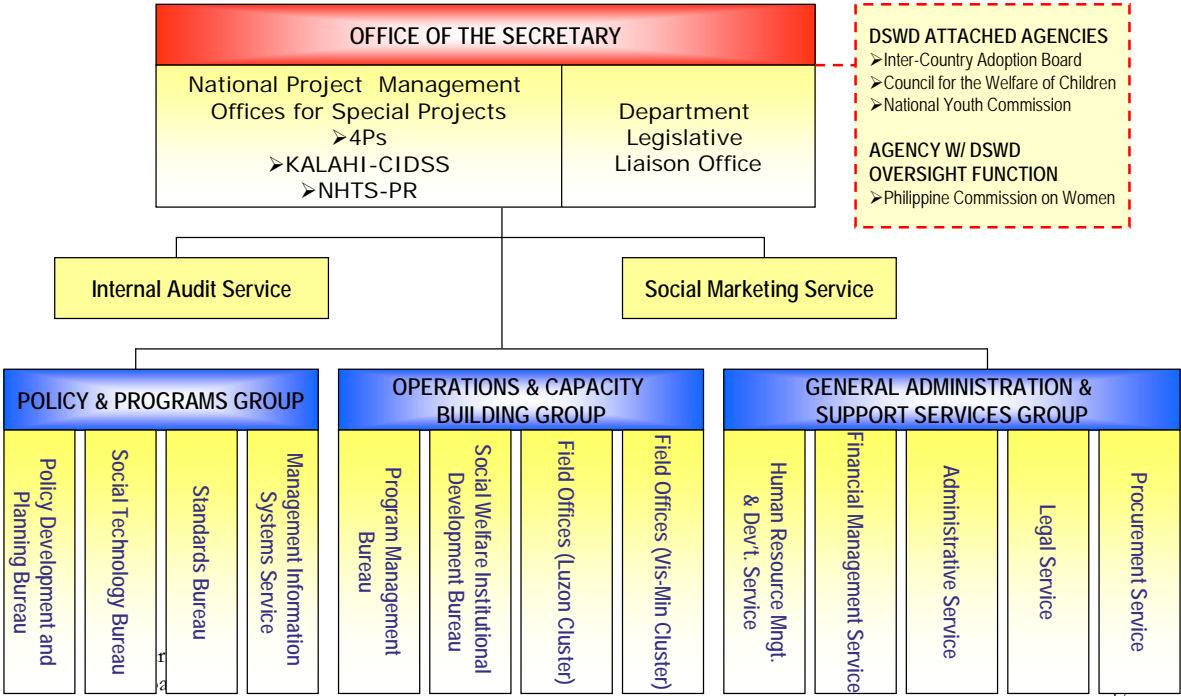
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DEPARTMENT OF HEALTH Functional Chart

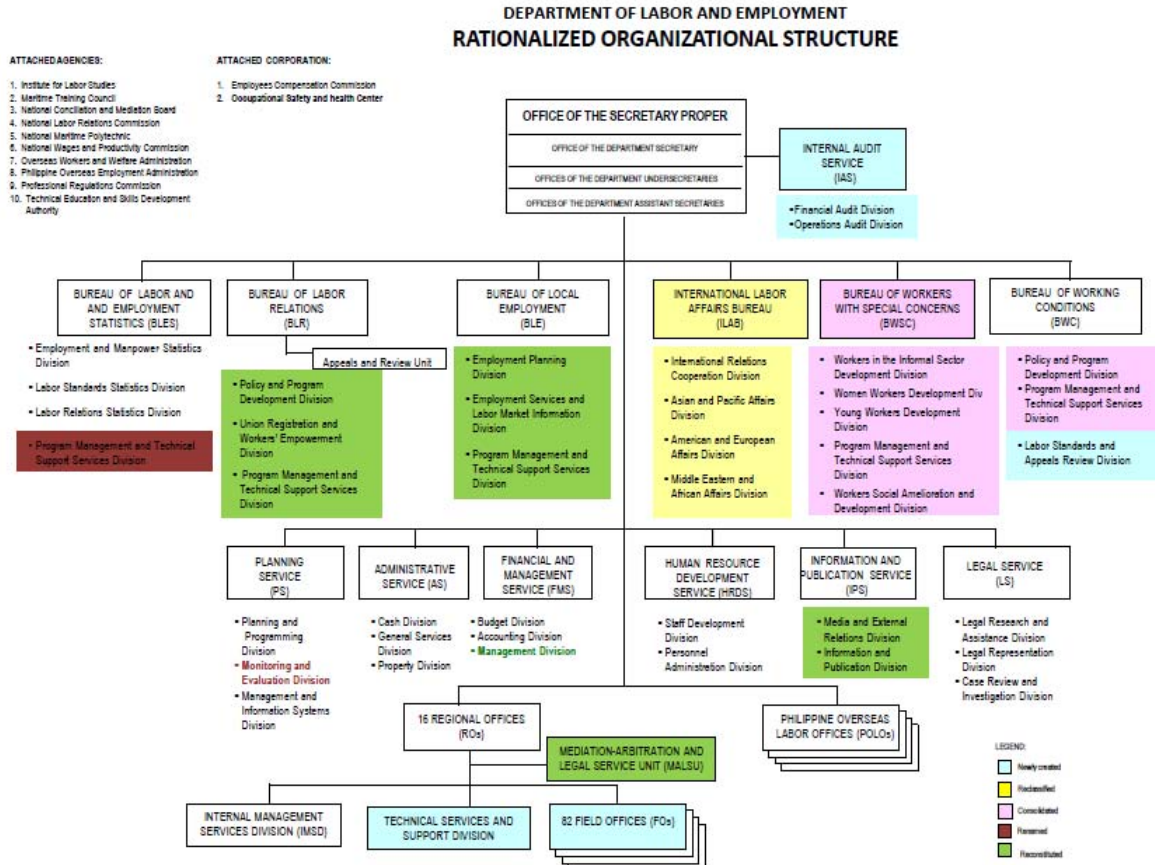
Functional Clusters for *Kalusugan Pangkalahatan* Implementation



Enhanced DSWD Functional Organizational Chart



DEPARTMENT OF LABOR AND EMPLOYMENT Organizational Chart



Department of Social Welfare and Development (DSWD) and Attached Agencies Logframe

