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Saan aabot ang 1-3% mo? Mainstreaming LGU tobacco control program funding through strategic budgeting

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EXECUTIVE SUMMARY

This study examined selected LGUs at the provincial, city, and municipal levels to assess how far they have progressed in budgeting for local tobacco control. In municipalities, the health budget accounts for around 8% of total annual LGU funds. Of this 8%, less than 1% is devoted to various anti-smoking program needs, whether in a 1st-class or 5th-class municipality. Surprisingly, these funds are enshrined in a local ordinance, ensuring LGUs make them available as a statutory obligation when preparing their annual budget. These show that clear local policies setting a minimum amount for anti-smoking programs strengthen budget availability and withstand the regular budget process.

With a less than 1% 'starter kit' budget, LGUs can jumpstart their anti-smoking programs by funding the dual intervention of increasing awareness of constituents for the program and enforcement of guidelines, preferably through an ordinance. For provinces, this budget can help maintain smoking cessation clinics usually available in tertiary hospitals, which may be funded by less than a 1% allocation from the MOOE in their health budgets. Cities, on the other hand, may have larger requirements of around 3%, considering the population density of urban areas and the need for more resources.

Keywords: *Health Justice, Local Tobacco Control Program, Local Government Unit*

POLICY CONTEXT

A practical smoke-free program costs around 1-3% of LGUs' health budget.

Even before the passage of RA 9211, or the Tobacco Regulation Act of 2003, LGUs had been strategizing TC programs and finding a place for them among the many priorities in the local health sector. Some LGUs actively advocate for smoke-free or anti-tobacco programs and have found ways to operationalize these strategies by providing space to fund various program components.

The WHYs of the 1-3%

Taken together, the evidence shows that it reflects 1-3% of the local health budget.

Locating the LGU's local tobacco control program budget is challenging and cannot be immediately identified by walk-in researchers or by budget and health officers. While smoking is undeniably a leading cause of cross-cutting health concerns, LGUs mostly do not have a budget dedicated specifically to the program. Based on the budgeting patterns of the selected LGUs, TC

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budget is found in the non-communicable disease (NCD) component of the health budget. Furthermore, it is widely spread as part of other programs related to smoking, and even IEC materials are lumped together in other health programs' budgets. Personnel services are rarely given funds, even for smoking cessation clinics.

A specific percentage can account for differences in LGU income classes.

Apart from the blurry reality of identifying anti-smoking budgets in the Local Health Investment Plans (LIPH), despite having ordinances, LGUs do not directly provide a minimum amount for allocation. Some indicate funding as "as necessary," which does not provide a concrete basis for the budget. While some may point out income class or financial capacity as a probable cause for not allotting specific amounts, the example provided by the 5th class municipality of Corella, Bohol tells otherwise – even at less than 1%, it endeavored to provide a budget for anti-smoking, whether it is an environmental or health concern, and achieved a White Orchid award for it. It also provides enough flexibility to raise the budget, "as necessary," since it indicates a minimum.

Moreover, LGUs have different policies and different levels of priority for the program. As a "soft" project, it may be less attractive than infrastructure projects for local leaders who want to leave tangible results in their areas, despite the program's potential to contribute to favorable outcomes for the general population.

Multisectoral nature may require both convergence funding and statutory minimum funding for basic PPAs.

Local tobacco control programs do not rely solely on the local health department/office. It requires a "whole-of-LGU approach" by involving different teams carrying out monitoring, information dissemination and advocacy, and enforcement. Thus, for a functional local tobacco control program to thrive, different LGU departments must converge in planning, budgeting, and implementation. Thus, more funds for TC can be secured by tagging related programs for funding.

For non-health personnel involved in enforcement, such as business establishment inspectors, sanitation officers, public safety officers, and the police, as well as barangay and purok leaders, misplaced smoking adds to the long list of violations they must track. Some LGUs also involve educational institutions to integrate the anti-smoking campaign to the health education of young students and thus become part of their teaching efforts – thus further justifying the non-involvement of personnel services and requiring a reasonable minimal amount.

A start-up TC program only requires four (4) major activities that can fit into 1-3% of the health budget.

Based on the findings, and as validated, there were four basic or foundational PPAs on tobacco control that can funded by LGUs at the onset of the program. First is on building the baseline data on tobacco use and behavior in the LGU. Second is on funding for information and education campaign materials and activities such as roadshows and learning sessions in schools. Third is capacity-building/training personnel for anti-smoking implementation and/or health promotion and advocacy. Lastly, the fourth one is establishing and/or maintaining a smoking cessation clinic which can be regularly found in tertiary health facilities. These align with the actions promoted by the WHO MPOWER initiative. As such these four items provide a menu of LGUs to properly prioritize minimal funding based on the identified needs for anti-smoking implementation.

The funding proposal considers the differences in TC program roles of various LGU levels.

Despite all being LGUs, treatment of how budgets and roles are assigned between provinces, cities and municipalities also have implications on fund utilization. The selected LGUs have shown a pattern by which municipalities and cities tend to have a more direct implementation approach where enforcement is better served at their level, as opposed to the provincial level. Provinces, on the other hand tend to focus on technical

assistance for their component LGUs. However, there are instances wherein duplication of roles such printing of citation tickets or acceptance of violation penalty fees are quite unclear. Likewise, in the case of smoking cessation clinics, lower income municipalities may have to refer quitters to the provincial level, while cities and higher income municipalities manage at least one clinic based on their capacity and even population density. Identifying these roles can also contribute to determine fiscal space for LGUs who have less.

WAY FORWARD

Prospects for local tobacco control program funding in PH

The local tobacco control program and the health sector can look into achievements under GAD and DRRM/CCA to ensure predictable funding for health under the conditions of expanded fiscal space due to Mandanas Ruling and the prospects of the Universal Health Care (UHC) Act.

Certain LGUs such as Carmona, Cavite have looked into GAD funding to support an incentive program called Smoke Free Homes, aiming to address the issue at the household level by using incentives.

In 2022, the increase in shares from the IRA as a result of the Mandanas-Garcia ruling provides opportunities for funding by including smoke-free programs as part of the devolution transition plan for local health services and PPAs.

On the part of the UHC Act, section 20 provides for a Special Health Fund (SHF) that seeks to fund health system integration at the province and city levels. This may also be an opportunity to include the smoke-free program health services for financing, especially for population-based and individual-based programs.

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