The rising challenge of HIV/AIDS and other diseases

By MEDICAL ACTION GROUP

Summary

Progress in MDG 6 is very problematic. Of particular concern is the alarming trend in HIV cases. There have been improvements in addressing malaria and tuberculosis (TB) but total prevention and cure are still far on the horizon. The rapid rise in reported HIV/AIDS cases was attributed by the official report¹ to poor prevention combined with increased risky behavior, high level of misconceptions about HIV/AIDS transmission, and poor attitude on use of protection. The decline in morbidity and mortality rates for both malaria and TB was due to improvements in the government control programs. Probability of achievement was put at low to medium for HIV/AIDS and high in all indicators of malaria and TB.

But like other MDG health concerns (infant and maternal mortality rates), combating infectious diseases depends a lot on the progress of poverty eradication and environmental restoration and building our adaptive capacity to climate change.

¹ ‘Philippines Fourth Progress Report on the Millennium Development Goals (MDGs).’ Third Draft, July 2010 (n.p.).
Assessment of MDG 6 progress

Trends

On HIV/AIDS

No country has been spared by the epidemic. Since the first HIV case was first detected in 1984, the incidence of the epidemic remains low² (see Figure 1) and its prevalence remains to be below 0.01% among people aged 15-49. As stipulated in the Philippines Midterm Progress Report on the MDGs in 2007, the probability of attaining the target on HIV/AIDS is high. However, figures over the years and recent demographics on cases suggest that the number of infected cases has significantly increased in the recent past.

According to the Department of Health (DOH), 4,971 HIV cases had been reported from 1984 to April 2010³ (see Figure 2). However, although the country has a low HIV/AIDS prevalence rate, the number of reported cases has slowly and consistently increased through the years.⁴ While in the past years, an average of only 10 cases were reported per month, compared to the monthly average registration from 2002-2007, which was 20 per month, the AIDS Registry showed an average of 29 new HIV cases per month for 2007. The first and second quarter of 2008 had an average of 40-50 new cases/month. This has surpassed the total number of HIV cases annually since the AIDS registry started. Thus, from a low and slow character, it has become a growing phenomenon.⁵

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³ DOH. NEC. Philippine HIV and AIDS Registry. April 2010.
⁶ Philippine Epidemiological Fact Sheet on HIV/AIDS. December 2008.
Sexual transmission remains to be the most common mode of HIV transmission in the Philippines (see Table 1). A total of 164 returning overseas Filipino workers (OFWs) were reported to be infected with HIV in 2009. This is the highest number since 1984 but accounts for only 18% of all individuals reported in that year. In 2007, OFWs comprised 31% of all newly diagnosed individuals reported in the country. The rising proportion of infected OFW’s is indicative of the lack or absence of active surveillance and monitoring in their group. The majority of persons living with HIV belong to the young adults and the working group (see Figure 3). However, current statistics could just be a mask concealing the hidden identity of the epidemic in the country as it does not necessarily reflect the true prevalence of infection since it merely relies

Table 1: Comparative trend in the mode of HIV transmission from 1984-2009

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<tbody>
<tr>
<td>Unsafe sexual contact</td>
<td>804 (96.29)</td>
<td>502 (95.08%)</td>
<td>320 (93.6%)</td>
<td>300 (97.1%)</td>
<td>3,994 (90.28%)</td>
</tr>
<tr>
<td>Male-Male Sex</td>
<td>336 (41.79%)</td>
<td>215 (42.83%)</td>
<td>107 (33.4%)</td>
<td>81 (27.0%)</td>
<td>1,171 (29.32%)</td>
</tr>
<tr>
<td>Male-Female Sex</td>
<td>216 (26.87%)</td>
<td>160 (31.87%)</td>
<td>139 (43.4%)</td>
<td>193 (64.3%)</td>
<td>2,214 (55.43%)</td>
</tr>
<tr>
<td>Bisexual contact</td>
<td>252 (31.34%)</td>
<td>127 (25.3%)</td>
<td>74 (23.1%)</td>
<td>26 (8.7%)</td>
<td>609 (15.25%)</td>
</tr>
<tr>
<td>Sharing of the infected needles (among IDU)</td>
<td>0 (0.19%)</td>
<td>1 (0.19%)</td>
<td>0 (0.19%)</td>
<td>0 (0.19%)</td>
<td>8 (0.18%)</td>
</tr>
<tr>
<td>Mother-to-Child</td>
<td>2 (0.24%)</td>
<td>2 (0.38%)</td>
<td>8 (2.3%)</td>
<td>4 (1.3%)</td>
<td>49 (1.11%)</td>
</tr>
<tr>
<td>Contaminated Blood Products</td>
<td>0 (0.00%)</td>
<td>0 (0.00%)</td>
<td>0 (0.00%)</td>
<td>0 (0.00%)</td>
<td>3 (0.03%)</td>
</tr>
<tr>
<td>Contaminated Needle Prick Injuries</td>
<td>0 (0.00%)</td>
<td>0 (0.00%)</td>
<td>0 (0.00%)</td>
<td>0 (0.00%)</td>
<td>3 (0.03%)</td>
</tr>
<tr>
<td>No Data on Mode of Transmission</td>
<td>29 (29.2%)</td>
<td>23 (23.2%)</td>
<td>21 (21.2%)</td>
<td>18 (18.2%)</td>
<td>351 (35.1%)</td>
</tr>
</tbody>
</table>

Total 835 528 342 309 4,424


Figure 3: Male and female with HIV cases by age-group

Source: DOH-NEC
on the passive surveillance and reporting mechanism currently being carried out. The government could never be complacent with the unreported cases. In 2009, there were four cases of female OFWs in the Autonomous Region in Muslim Mindanao (ARMM) with AIDS. Voluntary reporting among those who are infected with the virus is problematic because of the stigma and discrimination that go with the disease. The Filipino’s conservative culture, family sensitivity and fear of being ostracized are among the factors which discourage people to go for the voluntary HIV-antibody test.

Though vulnerable sectors had been targeted and specified in the operational plans of the government in the Fourth AMTP, it failed to include the indigenous people’s sector which accounts for about 20 percent of the total population. The result is exclusion from the data which is often the basis for program development and delivery of services.

The extent of the effect of HIV/AIDS has an inevitable negative economic effect. High rates of AIDS-related diseases could reduce the value of human capital. In the Philippines, the impact of HIV and AIDS has generally been negligible. Its passive and latent character had minimal macroeconomic impact in the country’s economy. However, its impact is most seriously felt by persons living with HIV/AIDS (PWHA) and their families.

The low prevalence of the epidemic in the country compared to other neighboring countries in the Asia Pacific region should not lead the government to believe that this character of the epidemic will continue and to remain complacent. Several key factors are present that could transform the current state of HIV/AIDS into an alarming situation and an explosive epidemic. These include the increasing population mobility as exemplified by the increasing number of Overseas Filipino Workers (OFWs) who are infected with HIV, the thriving sex industry in the country – whether commercial or casual sex particularly amongst young people, high rates of sexually transmitted infections (STIs) in vulnerable sub-populations and their inadequate access to treatment, low and incorrect condom use and the invisibility of those infected.

**Responses**

It was said that the early response of the country towards the issues and concerns posed by the HIV and AIDS builds the strong foundation of the country’s AIDS programs. Since the first case was reported in 1984, the government undertook immediate measures regarding the HIV and AIDS concern. In 1987, the AIDS Registry was put in place which enabled the monitoring of the disease. However, the passive nature of the program was limited in nature since it only captured those individuals who submitted themselves for testing. In 1995, the Philippine National AIDS Council (PNAC) was created and tasked with developing a national strategy for the prevention and control of the disease in the country. Its most noted accomplishment was the creation and passage of the first AIDS law in Asia – the Philippine HIV/AIDS Prevention and Control Act of 1998 (RA 8504). However, though the law is committed to integrating HIV prevention in education in various levels, in practice many girls and young women report receiving no education on sexual and reproductive health or HIV and AIDS in schools. Where such efforts do exist, the information is sometimes inaccurate and the teachers lack the confidence and skills to properly discuss it. Furthermore, sex education in the country is not institutionalized.

Locally, the responses to HIV/AIDS have the same key elements and strategies similar to that of the

It is worth to take note that since the majority of the people living with HIV in the country are in their prime working years, too often, and because of the extended nature of Filipino family, it is the elderly population or grandparents left to take care of the rest of the family, particularly the children when the parents of the latter become infected and eventually die of AIDS. Taking care of their orphaned grandchildren and in addition to their old age condition and failing health, add additional burden on them as they now have to look for economic sustenance for the entire family.

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national response. Since health was devolved in the country, the Department of the Interior and Local Government (DILG), in response to the HIV problem issued a Memorandum Circular in 1999 which mandated the local government units (LGUs) to develop and implement programs and policies in consonance with the RA 8504. In general, local response to the epidemic has been limited and diffused. There were weaknesses in communication, coordination and cooperation between the different LGUs in mustering efforts to combat the epidemic. This has further worsened with the devolution of the country’s health programs and internal problems, and conflicts within theLGUs like too much politicking.10

The counterparts and initiatives from various non-government organizations, local and international, have contributed much to the battle against the HIV epidemic particularly on prevention and control focusing on information, education and communication among youth/adolescent and women sectors. However, some sectors are highly marginalized by receiving minimal attention from both the government and NGOs. Most notable among them are the injecting drug users or drug dependents and males having sex with males who account for the growing risk groups infected with HIV.10 Despite CSOs being one of the pillars of the country’s action against HIV, their sustainability is highly dependent on international and donor agencies making some of the projects donor-driven.

**Financing and expenditures**

The allocation for public health interventions is necessary and critical in achieving the MDGs. However, it is a fact that health has been under prioritized as shown by the less than 3.5 percent share for the health sector in the Gross Domestic Product (GDP) in spite of the government’s proclamations of its commitment. The annual budget allocation, in line with the DOH’s; the local government unit’s fund; and various bilateral and international donors; finance the national prevention and control program of the epidemic.

However, since the budget for HIV and AIDS programs is not exclusive from the DOH’s meager annual allocation, it competes with other programs. Based on the Operational Plan of the AMTP-IV (4th AMTP), the financial requirements for 2007 and 2008 was about Php 849 million (US$ 20,214,286). Given the average total spending of about Php 311 million (US$ 7,407,407) per year, there is a funding gap of about Php 227 million (US$ 5,404,762) or Php 113.5 million (US$ 2,702,381) per year.11

All in all, achievement of the HIV and AIDS target goal was generally ranked highly probable by the government. However, several points must be considered regarding the assessment. First, there was an increase in the prevalence rate between 1999 and 2001. Though this is not often shown in the statistics since most of the time, accumulated cases from its first detection in 1984 is combined with the figures in 2005. Another consid-
eration is the high probability that the epidemic has a huge potential to explode. And lastly, the limited or the diminishing resources allocated by the government and other stakeholders could hamper the implementation of necessary programs to fully achieve the goal.

**Malaria**

About 3 percent of the population in the Southeast Asian region dies annually of malaria. Accordingly, half of the global community is at risk of malaria.

Malaria is a mosquito-borne disease that has been eradicated in North America, Europe and Russia, but still prevalent in Africa, Central and South America, the Middle East, the Indian subcontinent, and Southeast Asia including the Philippines. The country has been listed by the World Health Organization (WHO) among the ten (10) malaria endemic countries in the Western Pacific Region. In the Philippines, 57 of the 79 provinces are malaria endemic (see Figures 7 & 8). However, 90 percent of cases are only found in 25 provinces. Only Cebu, Leyte and Catanduanes are malaria-free. In 2008, DOH declared six more provinces malaria-free, bringing the total to 22 out of 81 provinces. The provinces of Marinduque, Sorsogon, and Albay in Luzon; Eastern and Western Samar in the Visayas; and Surigao del Norte in Mindanao were declared malaria-free after having had no reported indigenous cases for five consecutive years.

As shown in Figures 5 & 6, the global community has all the means and resources to prevent the emergence of new HIV/AIDS cases, reduce HIV related illnesses and death and mitigate the epidemic’s effects across various societies.

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12 MDG International Assessment 2010. UNDP.
15 IRIN Website.
is prevalent are among the most impoverished in the country where accessibility and availability of health information and services remains elusive, as most of them are in the rural and hard to reach areas.

The ADB report indicated that malaria is no longer a serious health problem and no longer a leading cause of death in the country.\textsuperscript{16} In a separate article, malaria cases were said to have been decreasing since the 1990’s.\textsuperscript{17} However, recorded figures tell otherwise with an increasing trend from 1999 (see Figure 9 & Table 2). In 2006, the number of malaria cases was estimated to be 124,152 cases.\textsuperscript{18}

Figure 9. Reported malaria by type and quality, 2004.

\textsuperscript{16} ADB Report Chapter 5.
\textsuperscript{17} Gonzales, E. Malaria in the Philippines. MB. March 29, 2010.
\textsuperscript{18} WHO, World Malaria Report 2009 in GlobalHealthfacts.org.
Table 2: Reported Malaria Cases

<table>
<thead>
<tr>
<th></th>
<th>1999</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>Philippines</td>
<td>37,061</td>
<td>36,596</td>
<td>34,787</td>
<td>37,005</td>
<td>43,644</td>
</tr>
</tbody>
</table>

Although it is no longer the leading cause of morbidity in the country, malaria is still a major public health threat. In 2006, malaria was the 9th cause of morbidity with a 27.6 rate per 100,000 population. In 2006, there were 222 deaths reported due to malaria. However, malaria national surveillance mechanisms vary differently in its quality and completeness thus giving little information on the real picture of the malaria burden in the country. Tables 3 & 4 show that the epidemic, in estimated average, declined for the past years in the country. However, aggregated data in the sub-national and regional level present another story. While some have made progress as evidenced by the decrease in reported cases, other provinces continue to have reported malaria incidence (see Figure 8).

Table 3: Reported Malaria deaths

<table>
<thead>
<tr>
<th></th>
<th>1999</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
</tr>
</thead>
<tbody>
<tr>
<td>Philippines</td>
<td>755</td>
<td>536</td>
<td>439</td>
<td>71</td>
</tr>
</tbody>
</table>

Sustained comprehensive malaria control is central in achieving this particular MDG. The Philippine government, through DOH, implements the Malaria Control Program (MCP). The DOH continues to implement the MCP using a multi-stakeholder approach that is engaging the local government units, the civil society and the communities at risk. It is through the MCP that the government was able to generate funds and resources for its malaria control activities seeking the assistance of international donors – primarily, the Global Fund and the Roll Back Malaria Projects. However, these resources were mainly spent on training and capacity building leaving fund deficiencies for the purchase of drugs, diagnostics and insecticides.

Furthermore, for the government to be able to halt and reverse the effect of malaria by 2015, it requires an estimated budgetary support of Php 1.727 billion yearly. The DOH, in its 2005 report which identified the available and needed funding for its programs for malaria and TB, indicated that from the presented budget above, only 21.65 percent is being financed through the national budget (1.11 percent) while 20.54 percent is being financed by various overseas development assistance (ODA) programs. Clearly, there is a funding gap of Php 1.353 billion or 78.35 percent of total annual funding requirement. For the 2005 to 2015 Malaria MDG operations, the amount of Php 18.997 billion is required (see Table 5). However, the available fund is only Php 4.113 billion. Hence, the projected 11-year financing gap for malaria alone is Php 14.884 billion – bigger than the entire annual budget of the agency (see Table 6).

Among others, educating the Philippine communities, particularly the indigenous peoples of the hinterlands, on the prevention of malaria remains a greater challenge in the implementation of the government program. For instance, the belief among the Ata-Manobo in Davao del Norte ethnic areas is that malaria comes from the food or the leaves of certain...
Table 5. Annual estimated cost for programs and projects to fight Malaria

<table>
<thead>
<tr>
<th>MDGs Programs and Projects</th>
<th>Total Cost (P)</th>
<th>DOH Funding (P)</th>
<th>ODA Assistance (P)</th>
<th>Budget Gap (?) (P)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment of Cases</td>
<td>9,217,687</td>
<td>0</td>
<td>9,217,687</td>
<td>0</td>
</tr>
<tr>
<td>Prophylaxis for Pregnant Women and Visitors</td>
<td>1,109,180,000</td>
<td>0</td>
<td>41,676,536</td>
<td>1,067,503,464</td>
</tr>
<tr>
<td>Laboratory Supplies</td>
<td>1,395,600</td>
<td>0</td>
<td>1,395,600</td>
<td>246,000,000</td>
</tr>
<tr>
<td>Insecticide Impregnated Mosquito nets</td>
<td>410,000,000</td>
<td>0</td>
<td>164,000,000</td>
<td>246,000,000</td>
</tr>
<tr>
<td>Indoor Residual Spraying</td>
<td>35,000,000</td>
<td>0</td>
<td>601,384</td>
<td>34,398,616</td>
</tr>
<tr>
<td>Capability Building, Research, TA, Equipments, etc.</td>
<td>162,309,683</td>
<td>19,200,000</td>
<td>137,509,683</td>
<td>5,600,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,727,102,970</strong></td>
<td><strong>19,200,000</strong></td>
<td><strong>137,509,683</strong></td>
<td><strong>1,353,502,080</strong></td>
</tr>
</tbody>
</table>

Source: DoH, 2005

Table 6. DOH Annual Budget 1993-2003

<table>
<thead>
<tr>
<th>Year</th>
<th>Annual Budget (Billions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003</td>
<td>9,900,000,000.00</td>
</tr>
<tr>
<td>2002</td>
<td>11,420,000,000.00</td>
</tr>
<tr>
<td>2001</td>
<td>9,260,000,000.00</td>
</tr>
<tr>
<td>2000</td>
<td>10,740,000,000.00</td>
</tr>
<tr>
<td>1999</td>
<td>11,300,000,000.00</td>
</tr>
<tr>
<td>1998</td>
<td>13,059,476,000.00</td>
</tr>
<tr>
<td>1997</td>
<td>11,020,083,000.00</td>
</tr>
<tr>
<td>1996</td>
<td>9,301,912,000.00</td>
</tr>
<tr>
<td>1995</td>
<td>8,647,889,000.00</td>
</tr>
<tr>
<td>1994</td>
<td>7,418,233,000.00</td>
</tr>
<tr>
<td>1993</td>
<td>7,262,829,000.00</td>
</tr>
</tbody>
</table>

Source: DOH

trees. Traditional beliefs, considering the diverse cultures of the indigenous peoples of the country, should be taken into account in the development of intervention programs.

**Tuberculosis**

*The global burden of TB*

According to the World Health Organization (WHO), tuberculosis kills 1.7 million people annually, most often in their prime and productive years and mostly in developing countries. From the 8.3 million reported cases in 2000, the UNDP reported that there was a global increase of 1 million new cases of TB in 2008 with the Asian region having the highest incidence accounting for 55 percent of new cases followed by the Sub-Saharan region.

The Philippines ranks ninth on the list of 22 high-burden TB countries in the world, according to the WHO’s Global TB Report 2009. After China, it had the second highest number of cases in the WHO Western Pacific Region in 2007 (see Figure 10).

**Figure 10: Estimated TB incidence rates, 2008**

23 Ibid.
24 IRIN website
26 What will it take to achieve the Millennium Development Goals?: An international assessment. UNDP. 2010.
Domestically, TB has consistently been in the top 10 causes of morbidity and mortality in the country, ranking sixth in both categories. This was an improvement from the fifth leading cause of death in 1995. In 2007, approximately 100 Filipinos died each day from the disease, but significant strides have been made in increasing case detection and treatment. In 2004, the country achieved a TB case detection rate of 72 percent, exceeding WHO’s target of 70 percent, and reached 75 percent in 2007. The country’s current ranking translates to some 250,000 Filipinos being infected with TB annually and 75 patients dying every day from the disease. The data indicates that the mortality rate due to tuberculosis decreased from 38.7 deaths per 100,000 population in 1999 to 33 deaths per 100,000 population in 2003 and 31.2 deaths per 100,000 population in 2005. Based on the Social Watch Report 2005, there has been progress in the Philippines TB control program and its target could be attained. With the base year of 1994, there were 269 TB cases per 100,000 people. It was reduced to 168 cases per 100,000 in 2001. Indeed, there have been improvements in the statistics but it is still alarming considering that TB remains to be the sixth cause of mortality among Filipinos and the country still belongs to the top 10 nations with high TB cases. Thus, there is still much to be done by the government and other multi-stakeholders in halting and reversing the TB problem with the remaining 5 years.

The National Tuberculosis Program (NTP)

The NTP was initiated in the country in 1968 and integrated into the general health service based on WHO policy. Though the DOH remains to be the body tasked to formulate and monitor the program through its Center for Health Development (CHED), the direct delivery of NTP services is the responsibility of the LGUs in accordance with the devolution of health services. The main strategy of the NTP is the Directly Observed Treatment Short Course (DOTS). This strategy dramatically improved the cure rate.

The Public-Private Mix for DOTS (PPMD) was adopted as a national strategy to increase case detection and improve access to DOTS services in urban poor areas in 2003. Since then, a close collaboration between the NTP and the Philippine Coalition Against Tuberculosis (PhilCAT) has produced positive results. By the end of 2008, there were 220 PPMD units operating across the country. In 2008, case notifications increased by 18% in areas where PPMD was implemented. Treatment success rates among patients managed in PPMD units have been in the range 85–90%. Financial incentives that are part of a TB-DOTS outpatient package provided by the Philhealth offer the prospect of making PPMD financially sustainable, even when grants from the Global Fund end.

Financing of the Tuberculosis Control Program covers the treatment of TB cases, laboratory diagnosis, and capability-building of field health workers, opera-

Improvements in the indicators for TB may be attributed to the strengthened implementation of the National Tuberculosis Control Program. Specifically, the adoption of the DOTS strategy in 1996, the initiatives to engage all health care providers such as the public-private mix DOTS, the hospital DOTS, the Comprehensive Unified Policy mechanism as well as the promotion of the International Standard of TB Care (ISTC) have contributed to the achievement of the program targets.

Source: WHO 2009

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tion of Public-Private Mix Department (PPMD) units, advocacy, monitoring and evaluation and other operating expenses. In summary, an annual amount of Php 606.877 million is needed to finance the programs and projects to combat TB in the Philippines. Only Php 428.077 million is provided by DOH and ODA. A total gap of about Php 178.8 million per year, or roughly Php 1.967 billion for the 2005 to 2015 operations, is still required to finance TB control.

The financing gap in the full implementation of an effective TB program is only one among the requirements that have to be fulfilled. Similar factors have been enumerated such as chronic staff shortages, inadequate financial resources, poor laboratory capacity, low access to quality care, and flawed links between service providers in the public and private sector. The USAID had added that the social stigma that TB creates and the health seeking-behavior also limit the efficacy of TB program implementation success.

Conclusions and Recommendations

**HIV/AIDS**

The two decades of HIV and AIDS initiatives and concerted efforts in the Philippines which were carried out by various sectors and stakeholders, both State and the non-state actors, have produced lessons and valuable realizations that could serve as guideposts for the remaining years in the achievement of the MDGs. It should be stressed that HIV/AIDS is a development problem which poses a grave threat not only to a person’s health but to the country’s over all development. The government should adopt the rights-based approach in its programmatic response to HIV and AIDS since violations of human rights are risk factors to HIV. With the remaining five years, intervention should consider the following:

1) **Education is the best prevention.** Because there is no cure for AIDS, prevention is critical and is the most cost-effective means of addressing the epidemic. Empowerment of the people, particularly, the young and the women, through education and access to accurate and adequate information and services is an effective tool of preventing HIV transmission. This principle can be achieved through the institutionalization of sexual and reproductive health programs intended for the youth, a member of the high-risk group in the spread of the disease. This should include the incorporation of HIV prevention in the national school curricula and the creation of national guidelines that will facilitate their access to available services. Recognizing their right as an individual who could make their own decisions, parental consent stipulated in the RA 8054 should not serve as a pre-requisite.

2) **Ensure sustainability of financing.** Indeed, though money alone does not guarantee a long term victory over the epidemic, a comprehensive HIV/AIDS strategy cannot be sustained without a stable and adequate funding.

3) **Strengthen Pre-departure Orientation Seminar (PDOS)** extended to departing OFW’s with the incorporation of human rights orientation, HIV/AIDS education and ways of avoiding high-risk behaviors/practices. Raising the level of knowledge and understanding of OFW’s on human rights particularly in the context of the Convention on the Protection of the Rights of all Migrant Workers and Members of their Families can help reduce their vulnerability to acquiring sexually transmitted infections (STI) including HIV/AIDS. Knowledge what their rights are as OFW’s, and the available complaint mechanisms and structures they can utilize when their rights are threatened and/or violated, will surely contribute in encouraging them to take action and defending their rights.

4) **Raise the capability of local government units** (LGUs) and national government agencies in the application of the rights-based approach in the various aspects of HIV/AIDS work and response. The rights-based approach is a process anchored on the principles of health and human rights. Mainstreaming the framework among local government units and other national agencies will greatly contribute in capacitating State agents in developing policies, programs and services that more effectively and efficiently address the HIV/AIDS problem and its root causes.

**Malaria**

1. **Ensure the availability of anti-malarial drugs/medicines and the treatment of malaria patients.**

2. **Conduct massive health education programs and campaigns on malaria in malaria endemic areas of the country.** The health education programs should give particular emphasis on the prevention and control.

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33 DOH 2005.
34 Simbulan, N.P.
aspects of the disease. Communities should be made aware of how environmental conditions contribute to the spread and persistence of the disease and how they can actively participate in the elimination of the disease through effective environmental control measures adapted by the community.

3. **Conduct a rapid assessment of the Malaria Control Program (MCP)** in order to identify its strengths, gaps and weaknesses, and institute the necessary changes/adjustments in its implementation.

4. **Institute reliable monitoring and documentation mechanisms and systems** in all malaria endemic areas of the country to be able to develop appropriate and culturally-sensitive intervention programs especially in communities populated by indigenous peoples.

5. **Ensure the availability of sufficient antimalarial drugs/medicines in basic public health facilities** particularly in the endemic areas of the country to sustain medication/treatment of those with malaria.

**Tuberculosis**

1. **Implement the DOH initiatives of Family Package** to cover children with primary complex and address the TB patient/s in every Filipino family.

2. **Ensure the availability and sustainability of the DOTS program** by involving the LGUs in addressing TB cases.

3. **Conduct a rapid assessment of the National TB Control Program, including the DOTS and PPMD strategies** to be able to identify the strengths, gaps and weaknesses of the program and its implementation. Institute the necessary changes/adjustments in the program. The effectiveness of DOTS should be gauged not only with the number of cases treated or cured in the community in a particular timeframe, but also with the number and rate of relapse cases. There is a need to evaluate the DOTS which primarily focuses on the biomedical and behavioral dimensions of the disease in the context of the broader societal environment of those infected and affected by the disease.

4. **Institute a system of monitoring the implementation of the NTC program**

5. **Intensify the information campaign on TB** to raise public awareness on the disease and how to prevent and cure it, and control its spread. Develop IEC materials which are gender-sensitive, instructive, simple and with illustrations or drawings. These IEC materials should be made available in public health facilities particularly in areas/communities where there is a high incidence of TB.

6. **Evaluate the extent and character of the problem on multi-drug resistance cases** in order to effectively address the problem.

**References**


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