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 report[1] *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

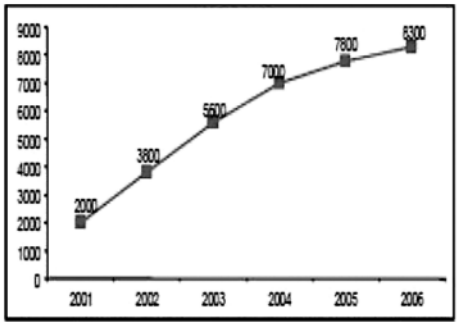
Trends

On HIV/AIDS

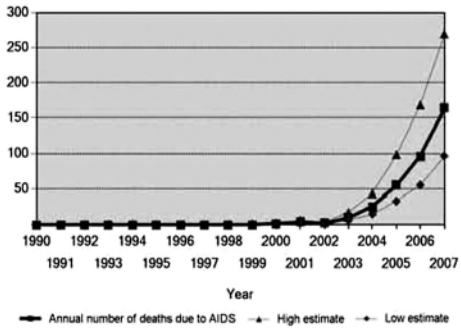
No country has been spared by the epidemic. Since the first HIV case was first detected in 1984, the incidence of the epidemic remains low[2] (see Figure 1) and its prevalence remains to be below 0.01% among people aged 15-49. As stipulated in the Philippines Midterm Progress Report on the MDGs in 2007, 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 2010[3] (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]

Figure 1. Estimated number of people living with HIV, 2001-2007

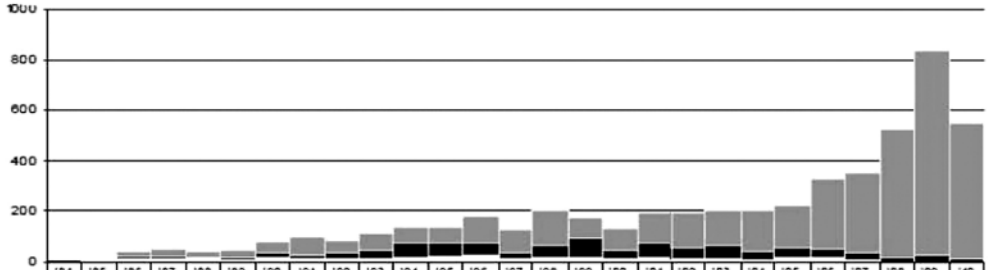


Source: UNAIDS/WHO, 2006 Report on the global AIDS epidemic, July 2008



Source: UNAIDS 2008[6]

Figure 2: Number of HIV/AIDS cases in the Philippines (Jan. 1984-April 2010; 4,971)



	'84	'85	'86	'87	'88	'89	'90	'91	'92	'93	'94	'95	'96	'97	'98	'99	'00	'01	'02	'03	'04	'05	'06	'07	'08	'09	'10
TOTAL	2	10	29	36	32	39	66	85	72	102	118	116	154	117	189	158	123	174	184	193	199	210	309	342	528	835	547
Asymptomatic	0	6	18	25	21	29	48	68	51	64	61	65	104	94	144	80	83	118	140	140	162	171	273	314	508	806	539
AIDS	2	4	11	13	11	10	18	17	21	38	57	51	50	23	45	78	40	56	44	53	37	39	36	28	20	29	8
Death	2	4	10	12	9	8	15	13	13	11	19	24	27	10	16	17	9	20	11	10	5	16	15	8	9*	1	1

* Five initially asymptomatic caees reported in 2008 died due to AIDS in same year

[2] Table 8. Comparative epidemiological features of the HIV AIDS epidemic, Southeast Asian countries, 2000 in Simbulan, N.P. & Balanon, V. (March 2003)."Confronting the HIV/AIDS Problem in the Philippines: Challenges and opportunities".
[3] DOH. NEC. Philippine HIV and AIDS Registry. April 2010.
[4] Simbulan, N.P. & Balanon, .L. "Confronting the HIV/AIDS Problem in the Philippines: Challenges and opportunities" March 2003. P2.
[5] Fourth AIDS Medium Term Plan: 2005-2010. Philippine National AIDS Council.
[6] Philippine Epidemiological Fact Sheet on HIV/AIDS. December 2008.

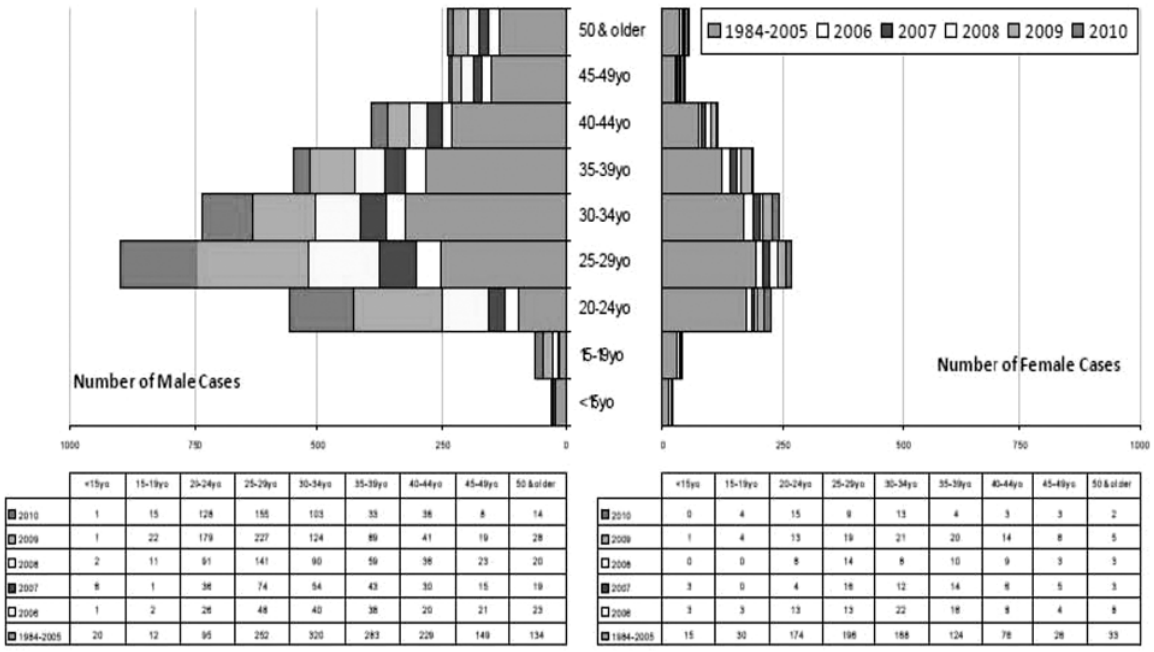
Sexual transmission remains to be the most common mode of HIV transmission in the Philippines (see Table 1). A total of 164 returning overseas Filipino workers (OFWs) were reported to be infected with HIV in 2009. This is the highest number since 1984 but accounts for only 18% of all individuals reported 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

Modes of Transmission	2009	2008	2007	2006	Cumulative (1984-2009)
Unsafe sexual contact	804 (96.29)	502 (95.08%)	320 (93.6%)	300 (97.1%)	3,994 (90.28%)
Male-Male Sex	336 (41.79%)	215 (42.83%)	107 (33.4%)	81 (27.0%)	1,171 (29.32%)
Male-Female Sex	216 (26.87%)	160 (31.87%)	139 (43.4%)	193 (64.3%)	2,214 (55.43%)
Bisexual contact	252 (31.34%)	127 (25.3%)	74 (23.1%)	26 (8.7%)	609 (15.25%)
Sharing of the infected needles (among IDU)	0	1 (0.19%)	0	0	8 (0.18%)
Mother-to-Child	2 (0.24%)	2 (0.38%)	8 (2.3%)	4 (1.3%)	49 (1.11%)
Contaminated Blood Products	0	0	0	0	19 (0.42%)
Contaminated Needle Prick Injuries	0	0	0	0	3 (0.07%)
No Data on Mode of Transmission	29	23	14	5	351
Total	**835**	**528**	**342**	**309**	**4,424**

Source: Country report of the Philippines January 2008-December 2009. PNAC.

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



	<15yo	15-19yo	20-24yo	25-29yo	30-34yo	35-39yo	40-44yo	45-49yo	50 & older
2010	1	15	128	155	103	33	38	8	14
2009	1	22	179	227	124	89	41	19	28
2008	2	11	91	141	90	59	38	23	20
2007	0	1	36	74	54	43	30	15	19
2006	1	2	26	48	40	38	20	21	23
1984-2005	20	12	95	252	320	283	229	149	134

	<15yo	15-19yo	20-24yo	25-29yo	30-34yo	35-39yo	40-44yo	45-49yo	50 & older
2010	0	4	15	9	13	4	3	3	2
2009	1	4	13	19	21	20	14	8	5
2008	0	0	8	14	8	10	9	3	3
2007	3	0	4	18	12	14	6	5	3
2006	3	3	13	13	22	16	9	4	8
1984-2005	15	30	174	196	168	124	78	28	33

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.[7] 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.[8] 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 (PWHAs) and their families.[9]

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.

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

[7] *"ARMM doctors alarmed by unreported HIV-AIDS cases"*, February 10, 2010. Philippine Daily Inquirer.
[8] Moving forward with the Millennium Development Goals: May pera pa ba? Social Watch Philippines.2006.
[9] Simbulan, N. P. & Balanon, V., March 2003.

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 the LGUs 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.

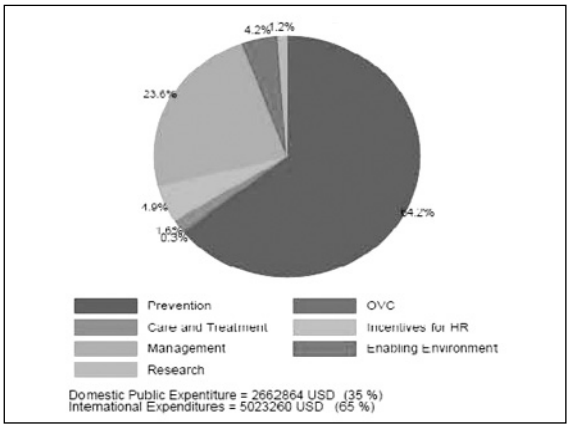
Financing and expenditures

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),

From 2000 to 2007, the average total spending for AIDS was about Php 311 million (or approximately US$ 7,407,407). Domestic spending averaged Php 63 million (US$ 1,500,000) per year, while spending from external sources averaged Php 223 million (US$ 5,186,046). Greater than half of total spending is from external sources. In terms of spending by activity, prevention initiatives remain the highest followed by programme support costs, and treatment and care activities. (see Figure 4)

Figure 4. Distribution of expenditures by spending category, Philippines 2006

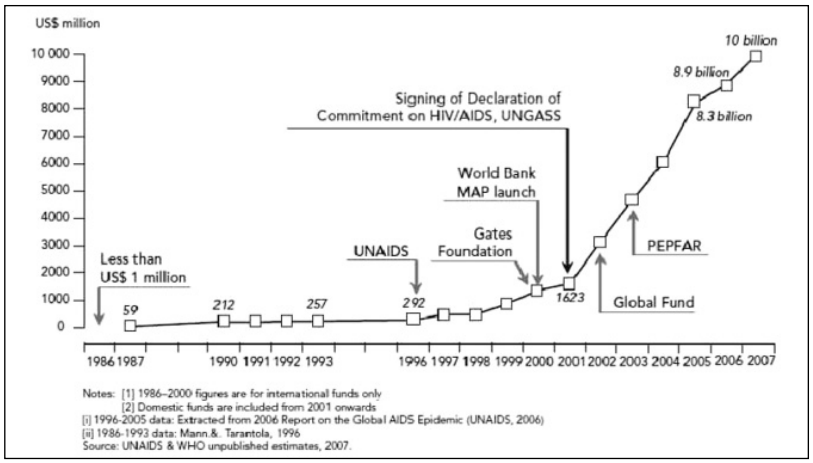


the financial requirements for 2007 and 2008 was about Php 849million (US$ 20,214,286). Given the average total spending of about Php 311million (US$ 7,407,407) per year, there is a funding gap of about Php 227million (US$ 5,404,762) or Php 113.5million (US$ 2,702,381) per year.[11]

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-

[10] Simbulan, N.P.
[11] Philippines Country Review 2008 – AIDS Data Hub

Figure 5. Total annual resources available for AIDS,1986-2007



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.

Figure 6. Philippine Report of AIDS spending, 2005-2006

UNGASS indicator 1. Country Reports of Domestic and International AIDS Spending by service categories and financing sources.										UNGASS indicator 1. Country Reports of Domestic and International AIDS Spending by service categories and financing sources.									
Region/Reporting Country	Year of the expenditure	Total reported Domestic Public and International Expenditure (Million US Dollars)	Share by financing source					Total HIV Expenditures in selected services (Million US Dollars)			Total HIV Expenditures in selected services (Million US Dollars)								
								Prevention			Prevention			Care and Treatment		Orphans and Vulnerable Children	Programme Support			Other HIV Expenditures
			Domestic Public (%)	International				Total for Prevention	Communication for social and behavioral change	Voluntary counseling and testing	Programs for sex workers and their clients for MSM and programme for harm reduction for IDUs	Condom social marketing, public and commercial sector condom provision and female condom	Prevention of mother to child transmission	Total for Care and Treatment	Anti-retroviral therapy		Total for Program and management support	Programme management, planning and coordination	Monitoring and Evaluation[ii]	
				Bilaterals (%)	Multilaterals		All other international sources or not specified (%)												
					Global Fund (%)	UN and all other Multilaterals (%)													
Philippines	2005	$6.842	18.9%	35.6%	28.7%	15.2%	1.7%	$3.187	$0.566	$0.064	$1.331	$0.360	NA/NR	$0.550	$0.394	$0.011	$2.109	$0.782	$1.135	$0.985
Philippines	2006	$7.686	34.6%	40.8%	8.0%	15.5%	1.0%	$4.936	$2.362	$0.085	$1.531	$0.003	$0.062	$0.123	$0.008	$0.023	$1.814	$0.832	$0.883	$0.791

Source: 2008 Report on the Global AIDS Epidemic. UNAIDS

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.

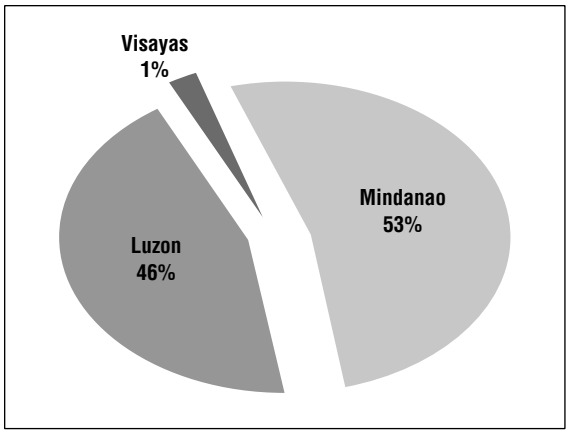
Malaria

About 3 percent of the population in the Southeast Asian region dies annually of malaria.[12] 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[13] (see Figures 7 & 8). However, 90 percent of cases are only found in 25 provinces.[14] 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. In 2006, Benguet, Cavite and Masbate were classified malaria-free. The 13 other provinces were pronounced free of the disease in 1999, and remain so today.[15] Malaria is a mirror of poverty in the Philippines. The areas where the disease

[12] "MDG International Assessment 2010. UNDP.
[13] Philippine Malaria Country Profile. 2008.
[14] Villanueva & Santiago. 2006. Combat HIV/AIDS, malaria and other diseases.
[15] IRIN Website.

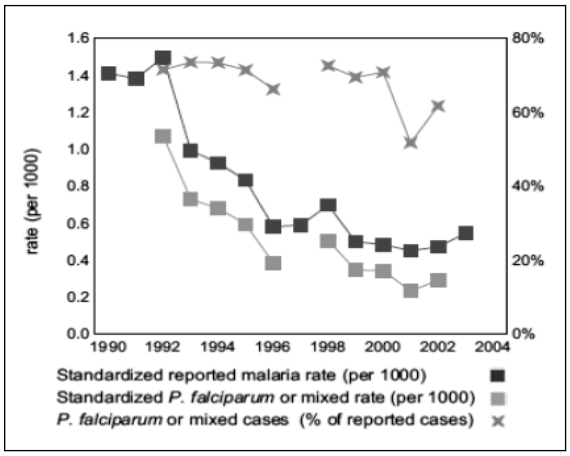
Figure 7. Frequency distribution of reported malaria cases 1991-2001



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.

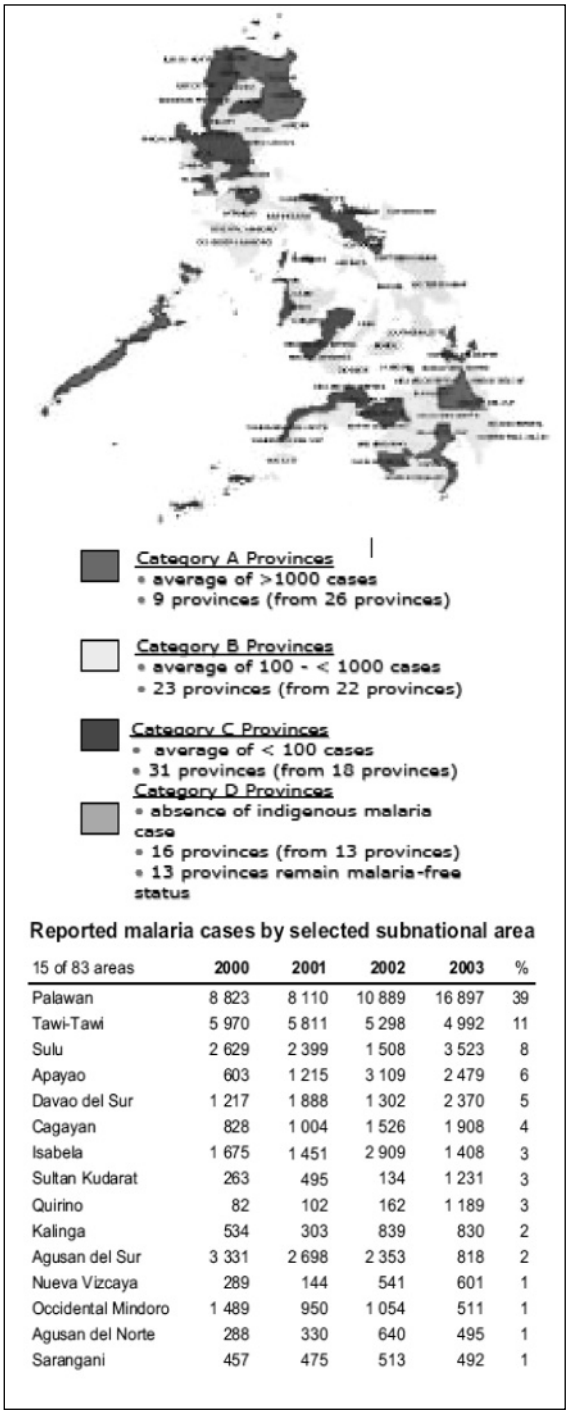
The ADB report indicated that malaria is no longer a serious health problem and no longer a leading cause of death in the country.[16] In a separate article, malaria cases were said to have been decreasing since the 1990's.[17] However, recorded figures tell otherwise with an increasing trend from 1999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

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



Source: Philippine Country Profile 2004

Figure 8: Geographical distribution of malaria cases 2001-2005



Reported malaria cases by selected subnational area

15 of 83 areas	2000	2001	2002	2003	%
Palawan	8 823	8 110	10 889	16 897	39
Tawi-Tawi	5 970	5 811	5 298	4 992	11
Sulu	2 629	2 399	1 508	3 523	8
Apayao	603	1 215	3 109	2 479	6
Davao del Sur	1 217	1 888	1 302	2 370	5
Cagayan	828	1 004	1 526	1 908	4
Isabela	1 675	1 451	2 909	1 408	3
Sultan Kudarat	263	495	134	1 231	3
Quirino	82	102	162	1 189	3
Kalinga	534	303	839	830	2
Agusan del Sur	3 331	2 698	2 353	818	2
Nueva Vizcaya	289	144	541	601	1
Occidental Mindoro	1 489	950	1 054	511	1
Agusan del Norte	288	330	640	495	1
Sarangani	457	475	513	492	1

[16] ADB Report Chapter 5.
[17] Gonzales, E. Malaria in the Philippines. MB. March 29, 2010.
[18] WHO, World Malaria Report 2009 in GlobalHealthfacts.org.

Table 2: Reported Malaria Cases[19]

	1999	2000	2001	2002	2003
Philippines	37,061	36,596	34,787	37,005	43,644

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.[20] 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[21]

	1999	2000	2001	2002
Philippines	755	536	439	71

Table 4. Malaria Morbidity and Mortality Rates

Year	Morbidity Rate (per 100,000)	Mortality Rate (per 100,000)
1990	123	1.5
1995	86	0.9
1998	72	0.8
2005	55	0.17
2007	27.5	0.08
2008	24	0.06

Source: Department of Health (DOH)

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.[22] 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 (1.11percent) 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

[19] http://apps.who.int/globalatlas/dataQuery/reportData.asp?rptType=1
[20] 2006 FHSIS Report Health Status Statistics.
[21] Loc cit.
[22] "May pera pa ba?" Social Watch Philippines. 2006.

Table 5. Annual estimated cost for programs and projects to fight Malaria[23]

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

Source: DoH, 2005

Table 6. DOH Annual Budget 1993-2003

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

Source: DOH

trees.[24] Traditional beliefs, considering the diverse cultures of the indigenous peoples of the country, should be taken into account in the development of intervention programs.

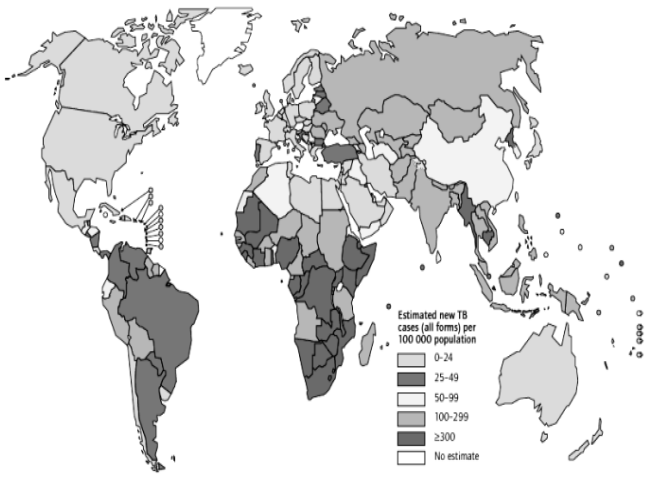
Tuberculosis

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[25] 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.[26]

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
[25] Global Tuberculosis Control: A short update to the 2009 report. WHO 2009.
[26] What will it take to achieve the Millennium Development Goals?: An international assessment.UNDP. 2010.

Estimates of epidemiological burden, 2007[b]	ALL	IN HIV+ PEOPLE
Incidence		
All forms of TB (thousands of new cases per year)	255	0.9
All forms of TB (new cases per 100 000 pop/year)	290	1.0
Rate of change in incidence rate (%), 2006–2007	**–1.8**	**2.4**
New ss+ cases (thousands of new cases per year)	115	0.3
New ss+ cases (per 100 000 pop/year)	130	0.3
HIV+ incident TB cases (% of all TB cases)	0.3	–
Prevalence		
All forms of TB (thousands of cases)	440	0.4
All forms of TB (cases per 100 000 pop)	**500**	0.5
2015 target for prevalence (cases per 100 000 pop)	**400**	–
Mortality		
All forms of TB (thousands of deaths per year)	36	0.3
All forms of TB (deaths per 100 000 pop/year)	**41**	0.3
2015 target for mortality (deaths per 100 000 pop/year)	**44**	–
Multidrug-resistant TB (MDR-TB)		
MDR-TB among all new TB cases (%)	4.0	–
MDR-TB among previously treated TB cases (%)	21	–

Source: WHO 2009

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.[27] 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.[28] 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.[29] 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.[30] 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.[31]

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.[32]

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.

[27] Philippine country profile. USAID.
[28] http://www.manilatimes.net/national/2009/march/24/yehey/metro/20090324met1.html.
[29] May pera pa ba? Social Watch Report. 2006.
[30] DOH. Comprehensive and unified policy for TB control in the Philippines. March 2003.
[31] Ibid.
[32] DOH. Philippines and World Health Organization. Joint tuberculosis programme review: Philippines, 2009.

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.[33] 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.[34] 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.[34] 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

[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 progra***m 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.

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