Financing the MDGs

HIV/AIDS: Waiting for a full bloom?

By Annalyn Sevilla Santiago

I. BACKGROUND

A. The Millennium Development Goals

The Millennium Development Goals or **MDGs** is a commitment born of the historic Millennium Declaration adopted by 189 countries at the United Nations Millennium Summit in September 2000. Governments, aid agencies and civil society organizations everywhere are reorienting their work around the specific Eight Goals, which are:

1. Eradicate Extreme Poverty and Hunger
2. Achieve Universal Primary Education
3. Promote Gender Equality
4. Reduce Child Mortality
5. Improve Maternal Health
6. Combat HIV/AIDS, Malaria and other Diseases
7. Ensure Environmental Sustainability; and
8. Develop a Global Partnership for Development

However, despite the welcome commitments in principle to reduce poverty and advance other areas of human development in practice, many countries still do fall short in keeping in track with the targets. This was mainly due to financial constraints/ gap to implement programs and projects that are responsive to the goals.

The best indicators of the political will and agenda for MDGs, aside from right and good policy ideas attempting to meet these goals, are nationally owned and nationally driven financial development strategies and sufficient resources such as the national budget or the General Appropriations Act and Official Development Assistance (ODA).

This paper shall focus on the financing/funding side of a particular MDG. Aside from finding out what has been happening in attaining this particular goal, the identification of the budgetary support (domestic and foreign) shall be the primary concern.

Specifically, the paper aims to answer the questions: ARE THERE RESOURCES AVAILABLE FOR THE ATTAINMENT OF THE ASSIGNED MDG? And if there is/are; ARE THESE RESOURCES SUFFICIENT TO ATTAIN THE TARGET OF THE ASSIGNED MDG?

B. Identification of the Assigned MDG Goal and Target

GOAL 6

COMBAT HIV/AIDS, MALARIA AND OTHER DISEASES

Target 9: Halt and reverse the spread of HIV/AIDS by 2015

"The cumulative number of HIV/Ab seropositive cases increased from 1,451 in 2000 to 2,200 in 2004: despite the increase, the prevalence rate remains below one percent. However, the presence of preconditions for a full-blown

epidemic was noted, and the Philippine National AIDS Council (PNAC) describes the epidemic to be *hidden and growing*".[1]

MDG Number 6, specifically battling HIV/AIDS, is among the health goals: child mortality and maternal health that suffers from severe shortage of trend data, hence the difficulty to appraise its likelihood of its achievement.[2]

1. Definition of terms:

   a. Human Immunodeficiency Virus (HIV) –refers to the virus that causes acquired immune deficiency syndrome (AIDS); it replicates in and kills the helper T cells

   b. Acquired Immune Deficiency Syndrome (AIDS)- a condition characterized by a combination of signs and symptoms, caused by HIV contracted from another person and which attacks and weakens the body's immune system, making the afflicted individual susceptible to other life threatening infections[3]

2. History:[4]

   The first AIDS case in the Philippines was recorded in 1984, with the death of a foreign national from pneumonia. In 1987, the Department of Health established the HIV/AIDS Registry, a passive form of reporting system, to help monitor the HIV epidemic in the country. Reports were received from accredited hospitals, clinics and laboratories and blood banks for HIV screening. In 1993 the National HIV Sentinel Surveillance System (NHSS) was established through the AIDS Surveillance and Education Project (ASEP), funded by the United States Agency for International Development (USAID) and technical assistance from the World Health Organization (WHO). From two sentinel cities in 1993,

NHSSS gradually expanded to include 10 cities by 1996. These are the cities of Angeles, Baguio, Cagayan de Oro, Cebu, Davao, General Santos, Iloilo, Quezon , Pasay and Zamboanga.

The NHSSS has two components, serologic and behavioral. HIV serologic surveillance (HSS) was started in 1993 to provide periodic estimates and monitor the prevalence of HIV infection among vulnerable groups in the sentinel sites. Behavioral sentinel surveillance (BSS) was introduced to NHSSS in 1997 to monitor trends in knowledge and behaviors of the vulnerable groups. Information from both the HSS and BSS could be used to focus appropriate interventions.

HSS serosurveillance (HSS) methodology entailed the collection of blood samples from 300 individuals belonging to the following high risk groups: registered female sex workers (RFSW), and freelance sex workers (FFSW) in all sites, men having sex with men (MSM) in Quezon and Cebu Cities, and injecting drug users (IDUs) in Cebu. IN addition, new military recruits of the Armed Forces of the Philippines were included as a surrogate group for the general population. Blood samples were tested for HIV and syphilis antibodies.

3. Indicators:

   a) HIV prevalence among 15-24 year old pregnant women

   b) Condom use rate of the contraceptive prevalence rate

   c) Number of children orphaned by HIV/AIDS (to be measured by the ratio or proportion of orphans to non-orphans aged 10-14 who are attending school)

Table HA-1: HIV/AIDS Prevention Indicators, CY 2003

HIV/AIDS Prevention Indicators				
Indicator	**Value**	**Data Unit**	**Year**	**Source**
HIV Prevalence proportion: Adults (15–49 years)		Data Not Available		
Estimated number of people living with HIV: Adults and Children	9,000		2003	UNAIDS-2004
Estimated number of people living with HIV: Women (15–49 years)	2,000		2003	UNAIDS-2004
Estimated number of people living with HIV: Children (0–14 years)		Data Not Available		
Males Reporting Condom Use With Last Non-Regular Partner		Data Not Available		
Females Reporting Condom Use With Last Non-Regular Partner		Data Not Available		

Source: USAID Country Health Statistical Report, Philippines June 2005

Most of the data for HIV/AIDS prevention indicators are not available. The estimated numbers of people living with HIV/AIDS (PLWHA) for the year 2003 were also far from the actual number of PLWHA.

C. Purpose of the Goal and Target

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. Since majority of HIV victims are people of working age, the absence of the victim themselves and the people caring for them have a negative impact on businesses and other work organizations. The impact on productivity may also decrease an economy's attractiveness to foreign investments. Savings rates and disposable income will also be

reduced. Finally, aside from the influences on aggregate economic performance, the disease is likely to infect individuals working in sectors that involve mobile and sex-segregated labor, including the military, fishing, trucking, and other vulnerable sectors like healthcare and tourism.

Also, according to ADB report[5], poverty reduction will also become more difficult due to the foreseen economic impacts of AIDS. Though Asia has seen huge reductions in poverty rates, particularly in China, the spread of HIV/AIDS may become a major barrier to the poor's continued emergence from poverty. Around the world, it is evident that poorer countries are harder hit by the disease. The world's most impoverished region, Sub-Saharan Africa, has the highest infection rate and overall, 95 percent of persons living with HIV/AIDS are from developing countries.

On the other hand, early preventive action to combat AIDS can result in huge economic benefits. ADB cited the case of Thailand as an example. As in most Asian countries, in the beginning, the spread of the disease in Thailand was slow and was not expected to become a very serious problem. However, the late 1980's saw a very alarming increase in the infection rate among injection drugs users in Bangkok, reaching a high of 30 percent in 1988 from one percent during the previous year. Rates in sex workers showed similar increases. All of Thailand's 14 provinces also reported sexually transmitted infections in men, and infections in pregnant women.

D. National Response

The Government of the Philippines' development strategy/action to prevent the spread of HIV is the creation of a National AIDS Prevention and Control Program which was established in 1987. And in 1995, the Philippine National AIDS Council—the central advisory, planning, and policy body for all HIV/AIDS prevention and control activities in

the country—developed a national HIV/AIDS strategy. One of the AIDS Council's most significant accomplishments was the enactment of the Philippine AIDS Prevention and Control Act of 1998, which has become a model for HIV/AIDS-related human rights legislation. UNAIDS has highlighted the legislation and the participatory process used for its formulation as a "best practice." Key aspects of the legislation include:

1. Prohibition of compulsory testing for HIV
2. Respect for human rights, including privacy of individuals living with HIV/AIDS
3. Integration of HIV/AIDS education in schools from intermediate to tertiary levels
4. Provision of basic health and social services for individuals with HIV
5. Promotion of safety and precautions in practices that carry the risk of HIV transmission
6. Prohibition of discrimination against persons living with HIV/AIDS in the workplace, schools, and hospitals, and in
7. insurance services

However, while the law provides a clear basis for policies and plans to address the problem of HIV/AIDS, its effectiveness has yet to be proven. Six years after its passage, the law has been inadequately implemented and put into action.

In 1993, with funding from the U.S. Agency for International Development (USAID) and technical assistance from the World Health Organization, the Department of Health established the National HIV/AIDS Sentinel Surveillance System.

Today, the Philippines conducts both serological and behavior surveillance at ten sentinel sites. Although an evaluation of USAID assistance conducted in 2001 showed that surveillance, education, and policy initiatives had been successful, the evaluation also indicated that several gaps need to be filled. These include better HIV sentinel and

behavioral surveillance; better education and policy activities; and stronger advocacy efforts, especially for the most underserved and at-risk populations, such as freelance female sex workers, men who have sex with men, and injecting drug users.

E. Policies, Programs and Laws in Attaining the Goal and Target

The government has actively responded to the HIV/AIDS concern since the first AIDS case was diagnosed in 1984. Sero surveys were undertaken on a regular basis and in 1987, the DOH officially declared the government's initial official response to the problem. The following are concrete policies and programs that support the HIV/AIDS goal:

1. Supportive Policies and Programs

The first Medium-Term Plan (MTP 1) on HIV/AIDS for the period 1988-93 was formulated and adopted. The plan covered five program components, namely: surveillance; care and support for HIV infected persons; diagnostic and laboratory facilities; information, education training; and program management.

For MTP 1, the following major events are worth noting:

- creation of the National AIDS Prevention and Control Program (NAPCP) in 1988 leading to the eventual creation of the Philippine National AIDS Council (PNAC) through EO 39 in 1992;
- drafting and approval of 12 policy guidelines of HIV Infection/AIDS Prevention and Control in 1989;
- formulation of the National HIV Sentinel Surveillance in 1991;
- signing of the bilateral agreement for the AIDS Surveillance and Education Project (ASEP) between the government and USAID; and

- integration of the Sexually Transmitted Diseases (STD) Control Program into the NAPCP in 1993 and the emergence of what is now called the National AIDS/STD Prevention and Control Program (NASPCP) which covers the following:
    - Continuous assessment of the status of infection in the country to guide appropriate interventions;
    - information, education and dissemination of information for individuals at risk as well as for the general population on a voluntary and confidential basis; and
    - Strengthening clinical management.

While awareness-raising was the main thrust of MTP 1, prevention of transmission and reduction of HIV/AIDS were the priority strategies of the second Medium-Term Plan (MTP II). Some of the achievements under the MTP II include:

- adoption of Republic Act (RA) 8504 or the Philippine AIDS Prevention and Control Act of 1998;
- implementation of Memorandum Order (MO) 495 s.1996 integrating HIV/AIDS education in all schools nationwide by the DepEd; and
- Implementation of foreign assisted projects such as European support for HIV/AIDS and STD in the Philippines, USAID Model Community Health/STD Facilities in Commercial Sex Areas in the Philippines, and JICA Project for the Prevention and Control of STD etc.

Meanwhile, the MTP III for the period 2002-04 is currently being implemented. It calls for the acceleration of the country's response to get ahead of the epidemic and prevent the infection from taking off beyond its current low

level. Program activities are implemented with the cooperation of the NGOs, GOs, LGUs, private sectors and the concerned communities.

2. Legislations and Policies

Republic Act Number 8504 is a response to the need for an institutionalized and comprehensive multi-sectoral effort at the highest levels of government. The law reaffirms the rights of HIV/AIDS infected individuals. It mandates measures on education, information, and adoption of safe practices and procedures, as well as the conduct of testing, screening and counseling and provision of health support services. It formalizes the creation of the Philippine National AIDS Council (PNAC) which serves as the country's central advisory policy making and program directing body on HIV/AIDS matters. Basic policy guidelines and technical standards have been issued by the government on such matters as laboratory testing for HIV, management of AIDS patients in hospitals, prevention and control of sexually-transmitted diseases, quality of informational and educational materials on HIV/AIDS, and implementation of safe blood services, among others. Rules and regulations to implement RA 8504 have also been issued. These policies were disseminated to relevant agencies and organizations responsible for their implementation.

3. Organization and institutional arrangements

The Philippine National AIDS Council (PNAC) is the legally established body to coordinate and direct the nationwide implementation of the Philippine AIDS Prevention and Control Act of 1998. It utilizes various organizational networks and operational channels for its activities. In several localities, local

AIDS councils have been established by local legislation partly in response to the passage of the Act and to advocacy by the PNAC. A nationwide network of sentinel surveillance sites operated by DOH with Philippine Progress Report on the Millennium Development Goals 42 LGUs was present in 10 cities. It has been operating since 1993 and has been regularly providing the most reliable set of information on status of the HIV infection and the level of risks.

II. CURRENT STATUS OF THE ASSIGNED MDG GOAL AND TARGET

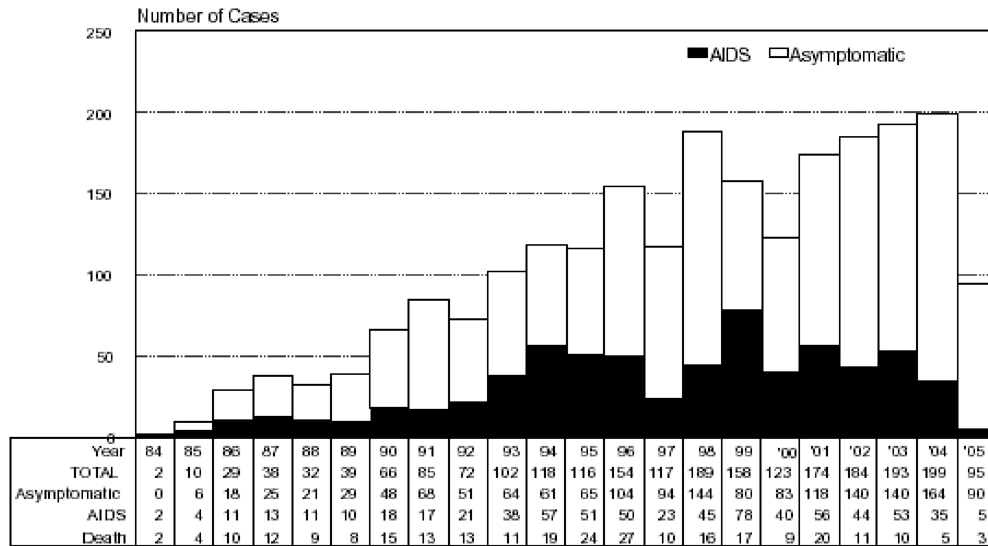
In 1993, experts on HIV/AIDS projected that by the year 2000 there would be 100,000 HIV/AIDS cases in the Philippines (WHO-Western Pacific Region, 2000). This estimate was based on very limited information available at that time. In 1996, both passive and active HIV surveillance data showed a very low HIV prevalence, and based on available information, the Philippine Department of Health (PDOH) adjusted the estimate to 38,000 HIV infections by the year 2000 (WHO-Western Pacific Region, 2002)[6].

The low prevalence/slow transmission scenario may not continue for long, because the ingredients for an explosive epidemic, including low consistent condom use rate among sex workers (less than 30%), the increasing practice of anal sex, and the high prevalence of STDs, are already present. Much more alarming is the 2002 NHSSS report stating that sharing of needles among IDUs in Cebu City may be as high as 77% (PDOH, 2003)[7].

Illustration HA-1: National Epidemiology Center: HIV/AIDS Registry on the Internet

Source: NEC website

Table HA-2: HIV/AIDS Registry: Ab Seropositive Cases, June 2005



Year	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	'00	'01	'02	'03	'04	'05
TOTAL	2	10	29	38	32	39	66	85	72	102	118	116	154	117	189	158	123	174	184	193	199	95
Asymptomatic	0	6	18	25	21	29	48	68	51	64	61	65	104	94	144	80	83	118	140	140	164	90
AIDS	2	4	11	13	11	10	18	17	21	38	57	51	50	23	45	78	40	56	44	53	35	5
Death	2	4	10	12	9	8	15	13	13	11	19	24	27	10	16	17	9	20	11	10	5	3

Source: NEC website

With regards to keeping in track of the epidemiology of HIV/AIDS in the Philippines, the DOH maintained a passive surveillance system, the HIV/AIDS Registry. The registry continuously logs Western blot-confirmed HIV cases reported by hospitals, laboratories, blood banks, and clinics. Unfortunately, the number of subjects tested by year cannot be ascertained and, therefore, rates cannot be calculated. Likewise, data input into the registry is limited, because mandatory HIV testing is prohibited by Philippine laws, and voluntary counseling-and-testing services for HIV is limited. Thus, the registry may not be that sensitive to capturing potential HIV cases.

Illustration HA-2: HIV/AIDS Registry: Ab Seropositive Cases (Narrative), June 2005

<u>New HIV Ab Seropositive Cases</u>

For the month of June 2005, there were 16 new HIV Ab seropositive cases reported. Of these, 12 were males and 4 were females. The median age was 34 years (age range 24-44). Reported modes of transmission were sexual contact (15) *[heterosexual (11) and homosexual (1) bisexual (3)]* and unknown (1).

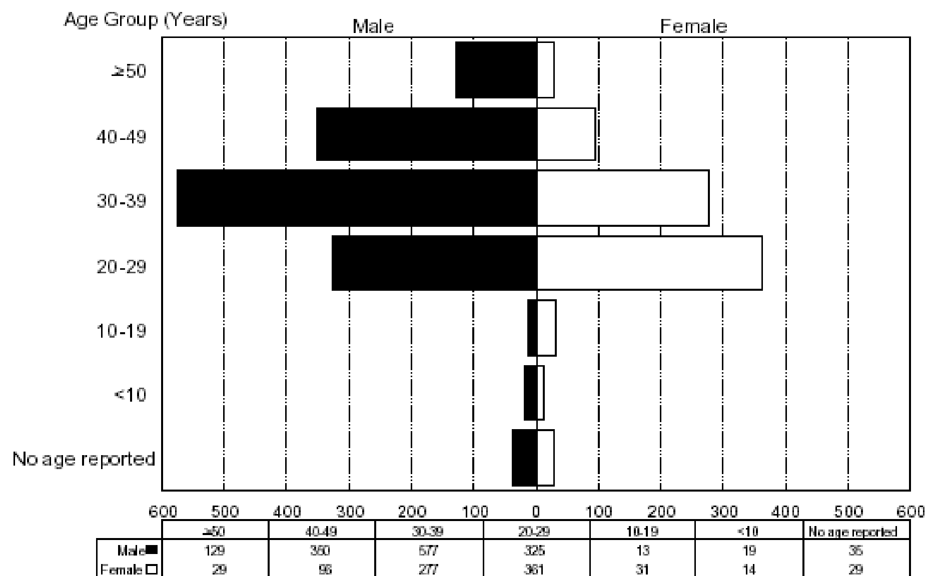
<u>New AIDS Cases</u>

Of the 16 new HIV Ab seropositive cases, 3 were reported as AIDS case. The mean age was 40 years (age range 31-44). Reported mode of transmission was heterosexual.

<u>Cumulative No. of HIV Ab Seropositive and AIDS Cases</u>

From January 1984 to June 2005, there were 2,295 HIV Ab seropositive cases reported (Figure 1), of which 1,611 (70%) were asymptomatic and 684 (30%) were AIDS cases. Sixty nine percent (1,541) were in the 20-39 years age groups and sixty three percent (1,448) were males (Figure 2). Sexual intercourse (84%) was still the leading mode of transmission (Table 1). Of the AIDS cases, 268 (42%) were already dead at the time of the report due to AIDS related complications.

Fig. 2. HIV Ab Seropositive Cases by Gender and Age Group
HIV/AIDS Registry, January 1984-June 2005 (N= 2,295)



	≥50	40-49	30-39	20-29	10-19	<10	No age reported
Male ■	129	350	577	325	13	19	35
Female □	29	96	277	361	31	14	29

Note: 10 cases had no reported age and gender. (1 in 1991, 3 in 1993, 3 in 1994 and 3 in 2000)
1 case had no reported gender (2003)

Source: NEC website

Data from the current registry (June 2005) revealed that there are cumulative (from January 1984 up to June 2005) 2,295 reported HIV seropositive cases in the country, of which 1611 or 70% were asymptomatic and 684 or 30% were AIDS cases.

Table HA-3: HIV/AIDS Registry: Reported Modes of Transmission, June 2005

Table 1. Reported Modes of Transmission
HIV/AIDS Registry, January 1984-June 2005 (N= 2,295)

Reported Modes of Transmission	Jan. 1984-June 2005 N= 2,279	June 2005 n= 16
Sexual Transmission:		
Heterosexual contact	1,411	11
Homosexual contact	398	1
Bisexual contact	123	3
Blood/blood product	19	0
Injecting Drug Use	7	0
Needle prick injuries	3	0
Perinatal	33	0
No exposure reported	301	1

Source: NEC website

HIV infection is found in all regions of the country, although it appears to be concentrated in the urban areas of Luzon, Mindanao, and Visayas Islands. Sexual intercourse remains the predominant mode of transmission, accounting for up to 86 percent of all infections. Mother-to-child and other modes of transmission, such as via blood and blood products, needle-stick injuries, and injecting drug use, account for smaller percentages of infections.

Illustration HA-3: HIV/AIDS Registry: Other Information , June 2005

Other Information

Of the 2,295 HIV seropositive cases, 765 (33%) were Overseas Filipino Workers or OFWs (Figure 3), of which 273 (36%) were seafarers, 127(17%) were domestic helpers, 69 (9%) were employees, 56 (7%) were health workers (nurses, caregivers, health educator, medical technologist, pharmacists, physical therapist, dentist and physician) and 51 (7%) were entertainers. Seventy five percent of OFWs (574) were males. Sexual intercourse (92%) was the leading mode of transmission for both sexes (Table 2).

Source: NEC website

Filipinos continue to seek employment abroad. The Philippine Overseas Employment Administration (POEA, 2001) indicates that overseas employment has increased at a rate of 5% annually. The total number of OFWs deployed rose from 660,122 in 1996 to 866,590 in 2001, with an annual remittance to the Philippines of up to $U.S. 6 billion. This accounts for about 7% to 8% of the Philippine government's gross national product. As of June 2002 the Commission on Filipino Overseas reported that over 7 million Filipinos were deployed in more than 120 countries.

Table HA-4: HIV/AIDS Registry: Reported Modes of Transmission among OFWs, June 2005

Table 2. Reported Modes of Transmission among OFWs
HIV/AIDS Registry, January 1984-June 2005 (N= 765)

Reported Modes of Transmission	Jan. 1984-June 2005 N= 765	June 2005 n= 7
Sexual Transmission:		
Heterosexual contact	544	5
Homosexual contact	117	1
Bisexual contact	41	1
Blood/blood product	10	0
Injecting Drug Use	1	0
Needle prick injuries	3	0
No exposure reported	49	0

Source: NEC website

In a study conducted among seamen who had worked abroad and returned to the Philippines, 35% admitted to having sex abroad; of those, 36% had unprotected commercial sex. These high-risk sexual encounters were mostly with female sex workers (FSWs) in countries such as Brazil, Vietnam, and Thailand. Likewise, the same study revealed that 85% of seamen had commercial sex with FSWs and consensual sex with unpaid partners in the Philippines. The threat that the seamen will serve as the bridge for HIV to the general population is highly likely.

The rising number of HIV cases occurring among overseas workers, shows that there is no effective surveillance of this population. The infection status is only discovered once they reapply for another work stint abroad, where by that time they could have spread the virus to their partners already. Because this population has been known to engage in high-risk behaviors outside of the country, **these individuals should be encouraged to undergo**

testing upon their return and to obtain their results immediately so they can protect their partners and seek treatment if they are indeed infected.

Although the Philippines has had some success keeping the AIDS epidemic at bay, an active sex industry and a population of injecting drug users pose an ongoing threat for future spread of the disease. Behavioral data from 1997 to 2001 indicate knowledge of AIDS and prevention practices is increasing, yet many Filipinos continue to practice behaviors that place them at risk for HIV infection.

Dr. Nafis Sadik, the UN secretary general's special envoy for HIV/AIDS in Asia and the Pacific has also indicated a "huge explosion potential" in the Philippines. This is primarily because all known routes of HIV transmission exist in the country: low condom use, even among commercial sex workers, high-risk adolescent sexual activity, a large number of overseas workers who are vulnerable to infection while abroad, and rising prevalence of other sexually transmitted diseases and infections.

III. FINANCING THE ASSIGNED MDG GOAL AND TARGET

A. Resource Mobilization

1. Government's annual budget allocation, as a line item in the DOH's budget,
2. Local public financing through the Local AIDS Board; and
3. External funding from multi-lateral & bilateral agencies

For the FY 2006, the Department of Budget and Management's Budget Call stressed for the consideration of the attainment of MDGs in preparing the FY 2006 budget proposals. Though not so specific in procedures, it was the first time that the words, "Millennium Development Goals" were included in such a national budget memorandum.

A more recent DBM policy release is Local Budget Memorandum No. 47 (July 2005) which specifically stressed on the "Inclusion of a Special Provision on HIV/AIDS Surveillance in the 2006 Budget Proposal of the DOH and all LGUs".

However concrete these financial policies are to support the HIV/AIDS goal, the national (internal) budget provided for the HIV/AIDS activities is ironically low.

The DOH has the following offices specializing for this particular Goal:

- Philippine National AIDS Council (PNAC)
- National Center for Disease Prevention and Control (NCDPC)
- National Epidemiology Center (NEC)

The HIV/AIDS program/activity is a line item in DOH budget[8] for CYs 2003-2004-2005, as follows:

A.III.c.1	*Epidemiology, Disease Surveillance and Laboratory Network*	*P 12.458M*
A.III.c.2.f	*Infectious Disease and Control Program*	*P 20.000M*
A.III.c.2.h	*Operation of the PNAC*	*P 9.445M*

The HIV/AIDS Sentinel Surveillance System budget is lumped together with the rest of the National Epidemiology Center's budget. It has to compete with the other infectious and emergent disease, such as SARS and avian flu, for the budget. The PNAC budget is for the use of the activities of the Council and the annual budget has to be approved by the Council. In most cases, the DOH Secretary has to source additional funds to cover expenses of the Council.

Most of the budget appropriated for these DOH line agencies are just enough as payment for personnel compensations and benefits. So little funding was provided for HIV/AIDS project related activities specifically for surveillance, prevention, control and treatment.

The national government and a number of local governments are funding HIV/AIDS prevention activities. Since 2003, HIV/AIDS activities have been supported through the Local Enhancement and Development for Health Project implemented by the Management Sciences for Health. This project continues to provide technical assistance in strengthening the national HIV/AIDS surveillance system and assists in building the capacity of local government units in HIV prevention, counseling, and testing.

The funding counterpart of the LGUs for HIV/AIDS activities are also minimal compared to the total allocated health budget for provinces and cities. Although the presence of the Local AIDS Council and the Social Hygiene Clinics at the local levels are very vital and critical, the funding for its operations is not fully supported.

The Department of Interior and Local Government (DILG) has its AIDS Medium Term Plan IV (2005 – 2010) with the following highlighted points:

- 48 cities identified as strategy priority areas for local responses
- Angeles, Pasay, QC, Davao & GenSan allocate resources for HIV/AIDS as of 2002
- All LGUs have "Social Hygiene Clinics" as the primary arm in delivering health services and in surveillance of the 14 communicable diseases, together with HIV/AIDS (critical role: field data collection & collection of blood samples from target clients)

Table HA-5: CYs 2001 and 2002 Local AIDS Council Budget of Selected Sentinel Sites

TABLE 15		
Local AIDS Council Budget ASEP Sites		
Sites	2001 (Php)	2002 (Php)
Davao		<500,000
General Santos	800,000	800,000
Zamboanga	2,500,000	2,500,000
Iloilo	46,150	112,000
Angeles	1,600,000	1,700,000
Pasay		1,500,000
Quezon City	1,009,000	1,200,000

Source: HIV/AIDS COUNTRY PROFILE Philippines 2002

It was in the year 2001 when General Santos, Zamboanga, Iloilo, Angeles and Quezon City started to have a local annual appropriation for the Local AIDS Council. Davao and Pasay followed such practice in 2002. However, the annual appropriation cited at the above table, correspond mostly to honoraria expenses of the members of Local AIDS Council and not for the prevention, control and treatment of HIV/AIDS.

The external funding from bilateral and multibilateral sources are great sources for HIV/AIDS advocacy and capacity building campaigns of the country. From 1993 to 2003, the U.S. Agency for International Development (USAID) AIDS Surveillance and Education Project (ASEP) has worked to prevent the spread of HIV in the Philippines. The Program for Appropriate Technology in Health (PATH), a USAID partner,

administered ASEP's educational component in the Philippines' eight largest cities. PATH worked with communities to establish local AIDS councils, reactivate local child protection councils, advocate with local governments to support HIV/AIDS prevention activities, and encourage entertainment establishments to promote condom use. Ordinances creating local AIDS councils and mandating basic HIV prevention policies were passed in all eight ASEP cities. In several of the cities, the ordinances also mandated 100% condom use in registered establishments.

PATH and its partners also mobilized pro bono media placements valued at more than $11 million and conducted mass media campaigns to increase public awareness of HIV/AIDS prevention.

There is also a Global Fund to Fight AIDS, Tuberculosis and Malaria which assists with expansion of care and support services in 11 risk sites. The intervention focuses on poor and marginalized populations where prevention is most needed—among sex workers, MSM, IDUs, and migrant workers—and also on people living with HIV/AIDS. Activities include a social mobilization and advocacy campaign to key stakeholders; outreach and education activities, including condom promotion and a needles/syringe program; capacity building of service providers and vulnerable populations; and strengthening of monitoring and evaluation mechanisms to track progress in project implementation. This project runs from 2004 through 2008, and, by the end of that period, it is expected that HIV prevalence will not exceed 1% for the vulnerable focal populations, and that 40% of the estimated HIV-positive population will be receiving adequate support, care, and treatment.

With regards to future resource availability, there are two available assumptions: the projected budget shares that are found in the Medium Term Philippine Development

Plan; and the historical average share of the HIV/AIDS related offices/sectors in the government's budget.

Meeting the resource requirements of the HIV/AIDS Millennium Development Goal will entail collaborative effort of the national and the local government units (LGUs), the private sector, non-governmental organizations and the external sources. The national government's financial support to the HIV/AIDs activities are not enough and most of the projects on HIV/AIDS are foreign- assisted and/or granted.

List of foreign-assisted HIV/AIDS projects:

- WHO-assisted surveillance program through the Naval Medical Research Unit (NAMRU) in 1986;
- USAID – funded AIDS Surveillance & Education Project (ASEP) starting 1996;
- European Union Support for HIV/AIDS & STD in the Philippines; AusAID-funded "model Community Health/STD Facilities in Commercial Sex Areas in the Phil;
- JICA's provision of technical equipment assistance for the development of STD/AIDS Cooperative Central Laboratory (SACCL) as center for HIV testing & the Prevention & Control of STD;
- Southeast Asian Ministers of Education Organization (SEAMEO) – Control of HIV/AIDS/STD Partnership Project in the Asian Region (CHASPAR); and
- Program Acceleration Funds from the UNAIDS and other activities of other UN agencies such as WHO, UNFPA, UNCEF, ILO and UNRC

More recent projects are:

- Global Fund AIDS Project: "Accelerating STI and HIV/AIDS Prevention Through Intensified Delivery of Services to Vulnerable Groups & People Living with HIV/AIDS in Strategic Areas in the Philippines"

- World Bank: Women's Health and Safe Motherhood Project 2 (commencing 2005) P106.122m

B. Expenditures: What and How Much it Takes to Meet the HIV/AIDS Goal

Calculating the additional public resources that would be used in meeting this particular health goal is difficult. The enormous uncertainties in data availability and the uncured stigma on HIV/AIDS put the links between public spending and health/education outcomes at a bleak picture.

An analysis of public expenditure on health, specifically on HIV/AIDS related issues show that little was provided for the treatment phase: such as medicines and consultations for positively identified AIDS patients. The extent to which the current and future (at least over the medium term) levels and composition of public expenditure, though consistent with the attainment of the MDGs, are not specific and not enough to meet the targets.

How much it takes to achieve the HIV/AIDS goal is the sum total of available expert opinion in the country on the type and quantity of interventions needed to achieve the MDGs. However, detailed costing estimates are not available for HIV/AIDS.

Per presentation delivered by DOH assistant secretary Mario Villaverde on September 30, 2005 at the University of the Philippines, National College of Public Administration and Governance, the MDG costing for health related goals, specifically for HIV/AIDS amounts to P358.254M:

Table HA-6: MDG Costing for HIV/AIDS 2005 to 2015

MDGs PROGRAMS AND PROJECTS	TOTAL COST (P)	DOH FUNDING (P)	ODA ASSISTANCE (P)	BUDGET GAP (?) (P)
COMBAT HIV AIDS, MALARIA AND OTHER DISEASES				
HIV/AIDS				
Mass Treatment for STI	148,977,000	0	0	148,977,000
Clinical Care of HIV/AIDS Cases	34,000,000	8,000,000	3,000,000	23,000,000
Provision of TA to Field Health workers	9,999,000	0	0	9,999,000
Surveillance, Research, Treatment of Cases, etc	165,277,587	14,899,667	150,377,920	0
TOTAL	358,253,587	22,899,667	153,377,920	181,976,000

Source: DOH ASEC Mario Villaverde, Diliman Governance Forum, UP-NCPAG, September 30, 2005

Based on the above table HA-6, it is alarming that there is no funding or assistance for the mass treatment for STI and that the clinical care for HIV/AIDS cases has an approximately 68% funding deficiency. Transportation allowance to field health workers also lacks funding support.

The only funded activity for HIV/AIDS is the surveillance, research, treatment of cases, etc. amounting to 166 Pmillion for the whole 10 year period or roughly a national annual budget of 17 Pmillion only.

More alarming to note is that the total annual government funding for the HIV/AIDS accounts to only 6.4% of the total costing/requirement (23 Pmillion out of total P358 Pmillion). The HIV.AIDS prevention, surveillance, treatment, care and management system should be a national concern and priority, hence should also be supported financially at the national level.

C. Resource Gap

There is a **181.976 Pmillion** financing gap for the HIV/AIDS programs and projects, specifically for:

1.	Mass Treatment for STI	-	P148,977,000
2.	Clinical Care of HIV/AIDS Cases	-	23,000,000
3.	Provision of Technical Assistance to Field Health workers	-	9,999,000

This funding gap however, doesn't assume local funding shares of LGUs through the Local AIDS Council and Social Hygiene Clinics. It may be noted that the bulk of gap goes to the mass treatment of Sexually Transmitted Diseases and that no national or foreign assisted funding was allotted for this.

Further, the government's budget for HIV/AIDS has been decreasing over time.[9] The original amount of P35 up to P40 million for PNAC operations in 1998 to 1999 was cut to P9.5 million in 2003. The PNAC, a multisectoral and inter-agency body, had long contended that its budget should not be subject to changes in the overall budget ceiling for the Department of Health. But since the PNAC, as provided by Republic Act No. 8504, is attached to the DOH, its annual budget is still part of the DOH allocation and subject to that department's discretion.

As it is, the PNAC's P9.5-million budget is being used to finance small projects of NGOs and other government agencies. As of December 2003, only a small number of confirmed HIV/AIDS cases had been provided care and support, with only 4 percent (of 1,965 cases) receiving the necessary drug treatment.

This was attributed to the "poor financial capabilities" of both persons with HIV/AIDS and the government. There are no plans for the Philippines to manufacture its own anti-retroviral drugs to treat people with HIV/AIDS here and in other countries of the

Association of Southeast Asian Nations (Asean). Only a few of the 56 DOH-retained hospitals provides anti-retroviral treatment.

An official of the joint United Nations Program Against HIV/AIDS (UNAIDS) has expressed concern over the Philippine government's decreasing budget allocation for anti-AIDS campaigns. [10]

In a statement, UNAIDS deputy executive director Kathleen Cravero said the budget of the Philippine National AIDS Council (PNAC) was significantly reduced from P48 million in 1997 to P6 million in 1994.

UNAIDS estimates that a comprehensive campaign to curb the spread of AIDS in Asia cost $1.5 billion in 2003 but only $200 million was spent by combined public sources.

Cravero said that the resource gap in the region will continue to escalate as unmet needs grow. By 2007, it is estimated that the funding needed for AIDS prevention, care and treatment services in Asia will rise to $5.1 billion annually.

Since a large proportion of money spent on AIDS care and treatment services come out of the pockets of ordinary people, UNAIDS warned that this will carry off their savings and drive more families into *"grinding poverty from which they will never emerge."*

However, Clavero also said that Philippines should not trust the "low and slow transmission" of HIV/AIDS in the country because this can easily be reversed.

> *"Asia is home to some of the fastest-growing epidemics in the world, with well over 7.4 million people living with HIV. A country like the Philippines, with as*

much as 10 percent of its people living overseas, needs to pay attention to global trends,"

The provision in RA 8504 instructing the DOH and the Insurance Commission to conduct a feasibility study on possible insurance benefits for people with HIV/AIDS has not been implemented, again because of budget problems.

The government has failed to fully involve the private and religious sectors in the prevention program. Only minimal efforts were undertaken to mobilize church support during the period 2000-2003. Church's view towards the "sanctity of life", hinder the implementation of massive preventive measures such as the use of condom and oral birth control pills.

V. FINDINGS / CONCLUSIONS (WHAT SHOULD BE DONE?)

It is indisputable and inevitable that the HIV/AIDS epidemic would soon reach our nation. Like a cancer that silently, abnormally and uncontrollably decays one's body system, HIV/AIDS would soon add up to our financial, economic and cultural crises.

In conclusion, it is evident that although there are resources available (23 Pmillion – national; and 153 Pmillion – ODA) to support the attainment of the HIV/AIDS millennium development goal, such is NOT SUFFICIENT to finance even half of the total national HIV/AIDS requirement. The 182 Pmillion funding deficiency may even grow bigger when left unsolved.

Factors such as the youth, HIV/AIDS stigma, high exposure of OFWs to external environment and the poor financial capabilities of the country, if not managed seriously, will not help in the attainment of the goa,l but instead contribute to its aggravation.

We should act as soon as possible and deal with the foreseen problem with utmost urgency. The following are not the most certain answers to the possible occurrence of the epidemic but are preventive measures to ensure the attainability of the goal.

A. Guard the young. Young people, between 13 and 24 years old, represent a high proportion of those who need to be reached by targeted prevention programs. Representing a significant proportion of the total Filipino population, youth are at higher risk for a number of well-known reasons, including their biological, social, and economic status. Among the sex workers (SWs), men who have sex with men (MSM), and injecting drug users (IDUs), young men and women predominate. Information regarding HIV/STI risk and protective behaviors should be appropriate, understandable, and delivered in a manner that reaches the young.[11]

Sexual attitudes & behaviors among young people should also be developed through responsible parenthood and school-based HIV/AIDS education (stronger information and education campaign by using mass media & peer groups to vulnerable groups and mobile population).

Contraceptives and use of condom have both negative and positive effects and the net benefit of using such should be a product of personal choice, will and belief.

B. Empower the victims. Key among the contextual factors that affect HIV prevention and care are the human rights environment in the country and the stigma environment at the community level. When a local community works to lessen stigma directed at those individuals and groups that are usually most

vulnerable to HIV transmission those individuals will be less afraid to seek services. They will also be more likely to receive and internalize prevention information and messages. In the same way, when a local community works to eliminate stigma directed at PLWHA, such individuals will not only be more likely to seek appropriate care, but will be more empowered to participate in the community's HIV prevention response. The governmental, community, and individual attitude change, as well as the requisite policy change to promote it, require both health and non-health sector collaboration. [12]

Various organizations recognize the necessity of involving people living with HIV/AIDS (PLWHA) in the decision-making processes at all levels of program development, implementation, and monitoring. Through the provision of technical support for organizational and advocacy efforts, organizations representing this population will be able to mobilize and provide support to their constituencies so that PLWHA may play an important role addressing the epidemic in the Philippines. Acting as educators and spokespersons for prevention, care and support messages not only empowers PLWHA, but serves to destigmatize the disease by reducing the social distance between those infected and those who are not. It also helps to demonstrate visibly the range of people affected by the epidemic, thereby making prevention messages more relevant and meaningful.[13]

C. Speciate the gender. Bringing a gender perspective to all of the programs is an essential element of making them effective. Men and women have different needs, perspectives, and experiences both in areas relating to HIV prevention and to care and support of those affected by HIV. Women are more concerned

with issues relating to pregnancy, childbirth, and childrearing. When a family member is infected with HIV and becomes sick, women bear the greater burden of health care, income loss, and increased workload. A common concern is managing to keep their children in school. Men typically tend to be more concerned about their health and continuing to work to support their families. [14]

D. Survey the OFWs. Regular HIV surveillance activities should be continued and implemented properly to serve as an early warning of increases in HIV prevalence and to guide decision makers in the formulation and prioritization of interventions. In particular, more effective surveillance among overseas workers should be established and wider surveillance coverage among MSM and IDUs should be implemented. HIV intervention measures such as behavioral change, communication, treatment of STDs, and condom promotion and social marketing should be an integral part of HIV prevention and control plans.

In order to reduce the risk of spread of the epidemic through the OFWs, there should also be an establishment of HIV/AIDS prevention measures, including counseling and the provision of adequate health treatment and services in the workplace.

E. Ensure Financing. The lack of convergence of individual budgets of the units involved in HIV/AIDS in the national level, specifically the Central Office of DOH should be addressed and integrated to a more rationalized body.

LGUs and its Social Hygiene Clinics, though Internal Revenue Allocation (IRA) dependent, should learn to become alert and competent for financial and commodity assistance regarding HIV/AIDS activities.

Capacity building through the assistance of foreign donors is currently implemented to answer the lack of information as to the total budget requirement for the conduct of AIDS related activities among LGUs. Seminars including technical assistance through consultation on budgeting practices are being conducted in the ten sentinel sites.

The prevailing view that LGUs finance health programs may not be totally correct because of their dependency on IRA, which is quite relative and inadequate. There should be a long term financing plan for HIV/AIDS Surveillance, Prevention, Control and Treatment at the national level. This will help ensure the continuity of the programs/ projects related to the attainment of the HIV/AIDS MDG.

The most vital factor in the attainment of the HIV/AIDS goal is the **ensured financing strategies** to support the above mentioned recommendations. Aside from the clear finding in the inadequacy of data, system and procedures in the campaign against HIV/AIDS, there is also a dire need for better health care financing initiatives, better targeting of financial resources/subsidies, and development of health insurance system that will prepare the country in case the "low and slow" epidemic has blown into full bloom.

ENDNOTES:

[1] NEDA and UN Country Team in the Philippines. 2nd Philippines Progress Report on the Millennium Development Goals.
[2] UNDP. 2003. Human Development Report 2003. Millennium Development Goals: A Compact Among Nations to End Human Poverty.
[3] Philippine AIDS Prevention and Control Act of 1998
[4] Department of Health, USAID and WHO. Status and Trends of HIV/AIDS in the Philippines. *The 1999 Technical report of the National HIV/AIDS Sentinel Surveillance System.*

[5] Asian Development Bank report January 2005. Poverty in the Philippines: Income Assets and Access. Manila. Philippines.

[6] Ricardo Mateo Jr., Jesus N. Sarol Jr., and Roderick Poblete "HIV/AIDS in the Philippines"

[7] Ibid.

[8] General Appropriations Act. CYs 2003-20045-2005. DBM

[9] Esplanada, Jerry E. Jul. 18, 2004. Drive for public awareness Uphill Battle for Advocates. Manila Time. http://www.inq7.net/nat/2004/jul/18/text/nat_4-1-p.htm

[10] Crisostomo, Sheila. November 29, 2004. Manila. Star: RP Budget vs. HIV/AIDS Too Low, says UN Official.

[11] Human Development Report Office based on David 2003. UNDP.

[12] Ibid.

[13] Ibid.

[14] Ibid.