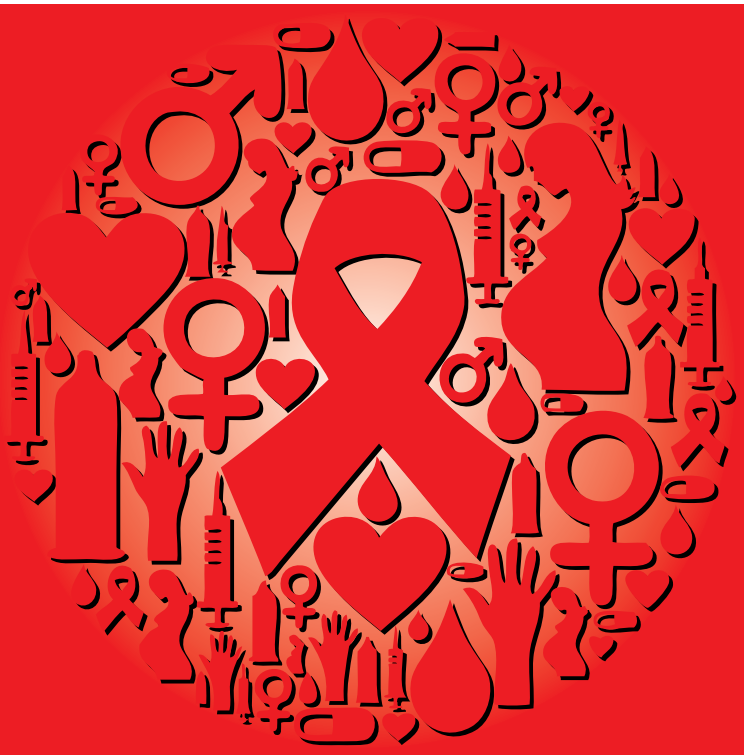
PEOPLE COUNT

PLCPD POLICY BRIEF



A Policy Brief on the HIV and AIDS Legal Framework

By Jonas Bagas

A 'fast and furious' HIV epidemic is happening in the Philippines. While the HIV prevalence in the country is still low at 0.04%, the increase in HIV incidence across various key populations beginning 2007 points to growing concentrated HIV epidemics in highly urbanized centers. The rise in new cases is most alarming among males who have sex with males (MSM), transgenders (TG) and among people who inject drugs (PWID), which reflects low reach of prevention interventions in communities that are most vulnerable to HIV infection. Around 80% of new HIV cases are due to unprotected male-to-male sex, and the HIV prevalence among the MSM and TG communities has already reached 1.6%. Among PWID, the prevalence has already reached 13.5% in 2011, with most of new cases detected in Region 7.[1]

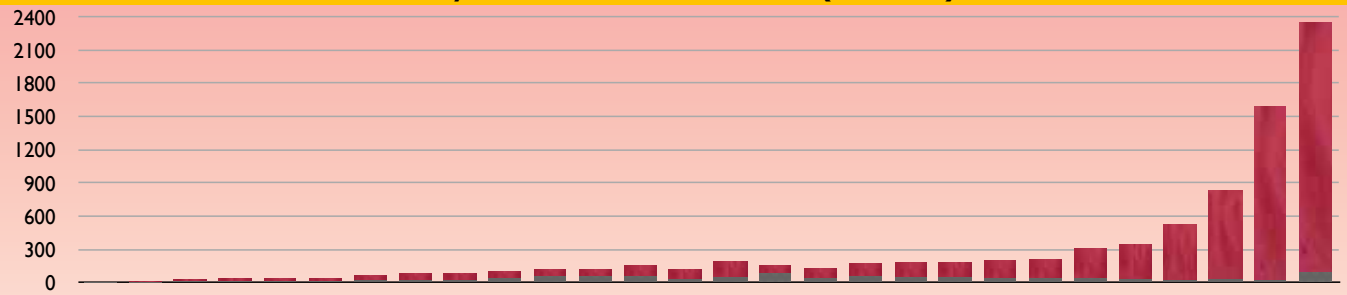
This shows a shift in the trend of the epidemic from the time HIV was first detected in the country during the early (1980s). Where previously most of the new cases were among

women and migrant workers, the face of HIV is now predominantly male. The HIV epidemic in the country used to be 'low and slow', but now it is concentrated and furiously expanding, making the Philippines one of the only nine countries worldwide with a rapidly increasing HIV incidence as of the 2012 World AIDS Report.[2]

A growing HIV epidemic in the Philippines was expected. Indeed, even before the detection of the increasing number of new cases in 2007, there were already indications that the situation is prime for an escalating HIV epidemic. A survey done among young Filipinos in 2002, for instance, has shown that 90% of men from 15-24 years old who experienced 'premarital sex' practiced unprotected sex.[3] In 2003, then Health Secretary Manuel Dayrit reported of an increasing incidence of sexually transmitted infections (STI) among Filipinos, warning that "where there is an epidemic of STIs, AIDS cannot be far behind."[4] Alarm bells were already ringing then but were not heeded.

If not halted and reversed, the Philippine National AIDS Council (PNAC) said that the total number of HIV cases could rise to 35,900 to 46,500 by 2015 from the current estimate of 22,800.[5]

Number of HIV and AIDS Cases and Deaths Reported in the Philippines by Year, January 1984 to December 2011 (N=8,364)

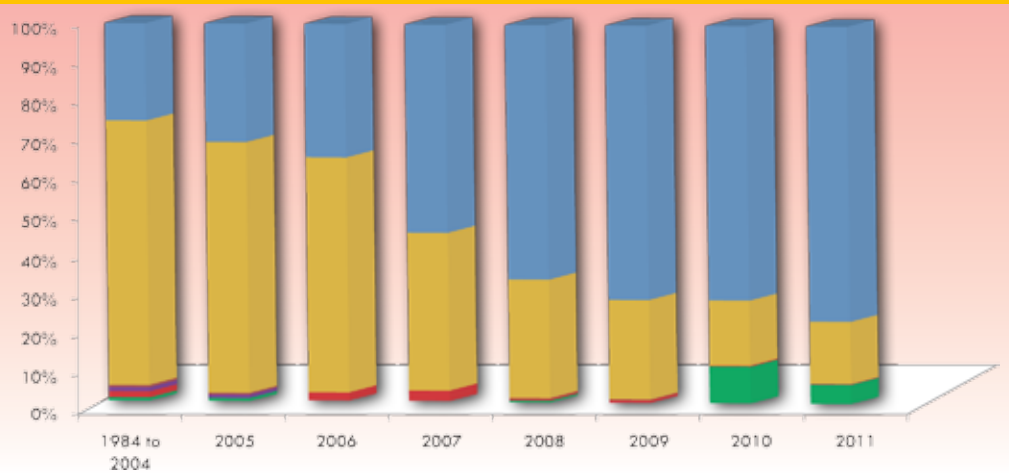


	'84	'85	'86	'87	'88	'89	'90	'91	'92	'93	'94	'95	'96'	97	'98	'99	'00	'01	'02	'03	'04	'05	'06	'07	'08	'09	'10	'11
TOTAL	2	10	29	38	32	39	66	85	72	102	118	116	154	117	189	158	123	174	184	193	199	210	309	342	528	835	1591	2,349
Asymptomatic	0	6	18	25	21	29	48	68	51	64	61	65	104	94	144	80	83	118	140	139	161	171	273	312	506	806	1571	2,255
AIDS	2	4	11	13	11	10	18	17	21	38	57	51	50	23	45	78	40	56	44	54	38	39	35	30	22	29	20	94
Death	2	44	10	12	9	8	15	13	13	11	19	24	27	10	16	17	9	20	11	11	8	16	18	10	7	1	2	*17

*Nine initially asymptomatic cases reported in 2011, died due to AIDS that same year.

2012 Global AIDS Progress Report, Philippines

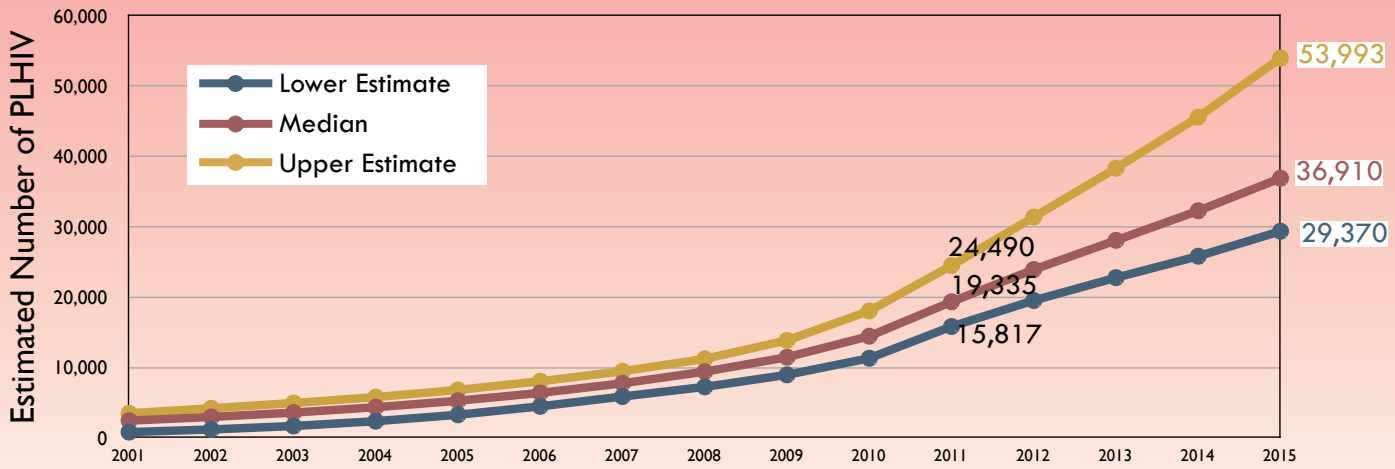
Proportion of HIV Transmission in the Philippines by Year, 1984-2011



Source: Philippine HIV and AIDS Registry, DOH-NEC

2012 Global AIDS Progress Report, Philippines

Projection of the Total Number of People Living with HIV in the Philippines by Year, 2001-2005



Lower Estimate	806	1,174	1,666	2,354	3,267	4,464	5,864	7,232	8,947	11,307	15,817	19,524	22,766	25,818	29,370
Median	2,434	2,953	3,578	4,339	5,260	6,377	7,743	9,401	11,454	14,442	19,335	23,922	28,072	32,278	36,910
Upper Estimate	3,477	4,189	4,934	5,779	6,799	8,034	9,461	11,212	13,843	18,034	24,490	31,382	38,325	45,609	53,993

Source: 2012 Philippine Estimates of People Living with HIV, PNAC

2012 Global AIDS Progress Report, Philippines

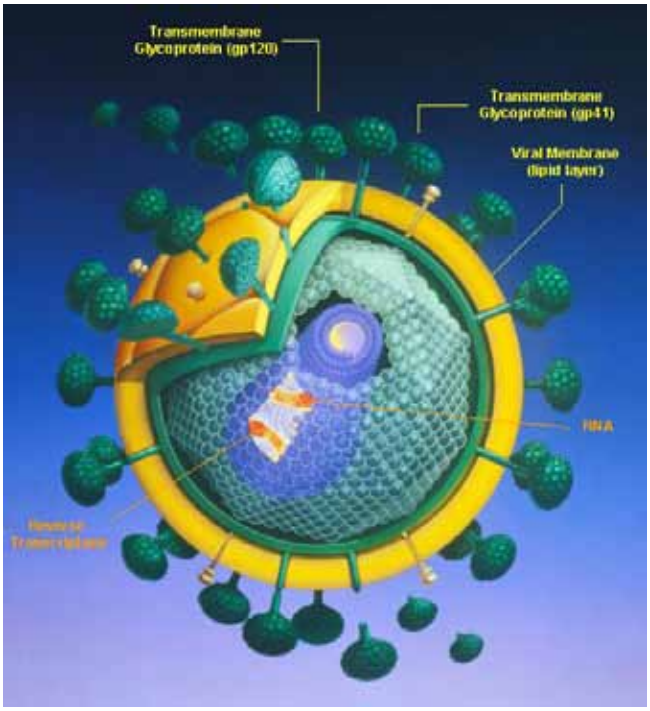
I. Gaps in the HIV response

The situation presents serious gaps in the country's response to the HIV epidemic. In the recently conducted Integrated HIV and Behavioral Serologic Surveillance, risky sexual practices and risky behavior among affected and at-risk populations continue to increase while at the same time prevention services are unable to scale up their reach. For example, only 23% of MSM and TGs have been reached by prevention interventions, while across various vulnerable or at-risk populations, access to voluntary HIV counseling and testing, a life-saving service, has been low.[6]

The AIDS Medium Term Plan V, which presents the 2011-2016 national roadmap on HIV and AIDS, underscores the persistence of HIV risk and vulnerability factors that the country has been unable to address, among them the low awareness of HIV among populations affected by or vulnerable to HIV; risky sexual activities among young Filipinos; low condom use; and policy inconsistencies that hamper the HIV prevention services. Interestingly, these are almost the same gaps that the previous national strategic plan (AMTP IV) sought to cure, the only difference is the scale of problem: as the epidemic expands and accelerates, these programmatic challenges have become more manifest and chronic.

The current epidemiological trend provides a compelling imperative for investment in, and implementation of, the AMTP. Yet the country's strategic plan has always been

saddled with confusion and inertia among the duty-bearers of the response; lack of political leadership; insufficient funding, and consequently, inability to deliver the scale needed to generate impact; conflicting policies; and other limitations imposed by a climate of stigma and discrimination, thus impeding access to and effectiveness of HIV services.



II. RA 8504: the legal framework on HIV and AIDS

The problems facing the HIV response reflect structural deficiencies that could be traced to RA 8504, or the Philippine AIDS Prevention and Control Act of 1998 – the central policy framework of the country on HIV and AIDS.

RA 8504 is the successor of Executive Order No. 39. Signed by then President Fidel Ramos in 1992, RA 8504 established PNAC as the main policy and advisory body on HIV prevention and control. EO No. 39 had laid down the multi-sectoral approach in the HIV response that the subsequent law adopted.

Touted as a model legislation because of its strong human rights-based approach and multi-sectoral orientation, RA 8504 institutionalized elements of the response in the areas of HIV information and education, prevention, health and support services, epidemiological surveillance, human rights protection, and governance.

HIV Among Female Sex Workers, MSM, PWID in Sentinel Sites, 2007 - 2011

Key Affected Population	2007	2009	2011
Female sex workers in Registered Entertainment Establishments (RFSW)	0.0%	0.23%	0.12%
Freelance female sex workers (FFSW)	0.05%	0.54%	0.43%
Males who have sex with males (MSM)	0.30%	1.05%	1.68%
People who inject drugs (PWID) in Cebu	0.40%	0.59%	53.8%

Source: IHBSS. DOH-NEC

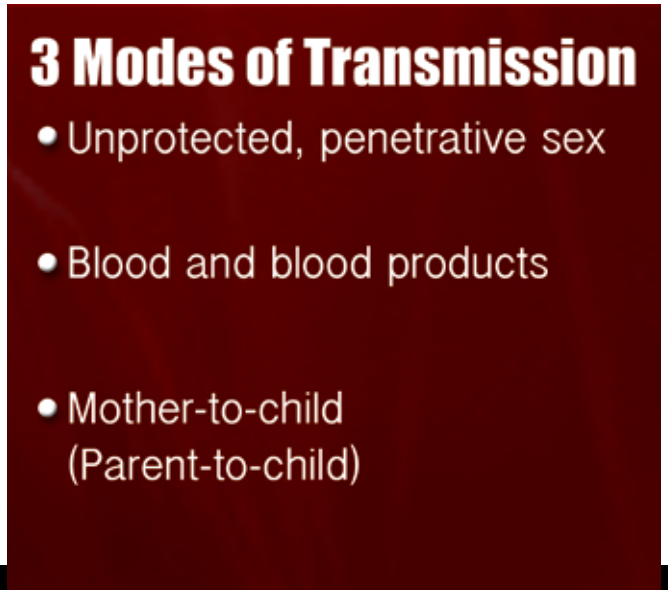
2012 Global AIDS Progress Report, Philippines

It established a secretariat that supports the functions of PNAC, which it adopted from EO No. 39, and it created an STI and HIV/AIDS program within the Department of Health that shall serve as the main implementor of HIV and AIDS prevention and control programs of the Philippines.

In the context of the profile of the HIV epidemic during the enactment of the law, the legal framework was sufficient. The main drivers of the new cases then were sex workers and overseas Filipinos, though the incidence remained low. Social hygiene clinics were set up, with the help of external donors, to halt the spread of HIV and other STIs among sex workers. Interventions for migrant workers were likewise set up. With the strong human rights provisions of the law, it was reasonable to think that the law is adequate.

But the rising incidence is begging for a review and an overhaul of the law. Clearly, the epidemic has outpaced RA 8504, with some of the provisions unable to address the new context of the HIV situation.

In an assessment of RA 8504 and its Implementing Rules and Regulations (IRR) conducted seven years ago, it



has been noted that there is "wealth of motherhood statements (in the law) but... (with) gaps between purpose and actual accomplishment." The same review said that the strength of the law was measured based on policy development and not on actual implementation.[7]

These deficiencies are now more evident with the pressure created by the accelerating HIV incidence. For instance, while the law has adequate provisions that address an HIV epidemic in the general population, it is silent and weak in responding to concentrated epidemics. Some provisions have been rendered outmoded by new laws that conflict with RA 8504. Its deficits extend to its inability to guide HIV and AIDS stakeholders to counter old and new barriers to the response.

Below are some of the problem areas that need to be addressed:

1. Structural ambiguity in the HIV and AIDS law and conflicts with other laws

One core problem in the response is the determination of which agency precisely has the duty to implement the country's

AIDS Medium Term Plan. Under RA 8504, an HIV and STI program was established within the health sector, but it fails to identify the extent of the health sector response, and which body outside the health sector must implement crucial HIV programs that were either not anticipated or were not explicitly stated.

This is complicated by the devolution of health services - if primary prevention activities are devolved from the Department of Health (DOH) and local governments deny ownership of the responsibility or tarry in implementing local HIV prevention programs, the tendency then is to rely on NGOs and external donors to fill up the gap. An example of this is the implementation of peer education programs, an approach where the populations at-risk or vulnerable to HIV infection themselves are educating and reaching out to their own peers. The national government argues that due to the Local Government Code, it is the responsibility of LGUs to deliver this service, with the latter insisting that this must come from the national government.

Another challenge is the conflict between AIDS law and newer laws. For instance, while the response recommends for the implementation of harm reduction programs for PWIDs, the enactment of the Dangerous Drugs Act of 2002 has made it illegal to distribute clean needles to drug users, an effective intervention that significantly reduces HIV transmission caused by sharing of needles.

The Anti-Trafficking Law, meanwhile, has been routinely abused by the police to conduct raids in establishments where condoms are found. This hampers the HIV response because it equates condoms with prostitution, thus making it difficult to encourage these establishments to promote condom use in private establishments. There was even one case where a youth outreach worker was arrested by the police for possessing condoms.

Credit: Microsoft Research

With more than 48,000 panels and 94,000 names, the AIDS quilt is a constantly growing testament to the deadly toll the disease has taken on the world. At roughly 1.3 million square feet, it is so large that it can't be displayed in its entirety in one place.

2. Governance of the response

PNAC is designed to be the central recommendatory, planning, and policy-making body for the response. However, its work is hindered by the "unclear delineation of the functions of the Council, the Secretariat and the working committees".[8]

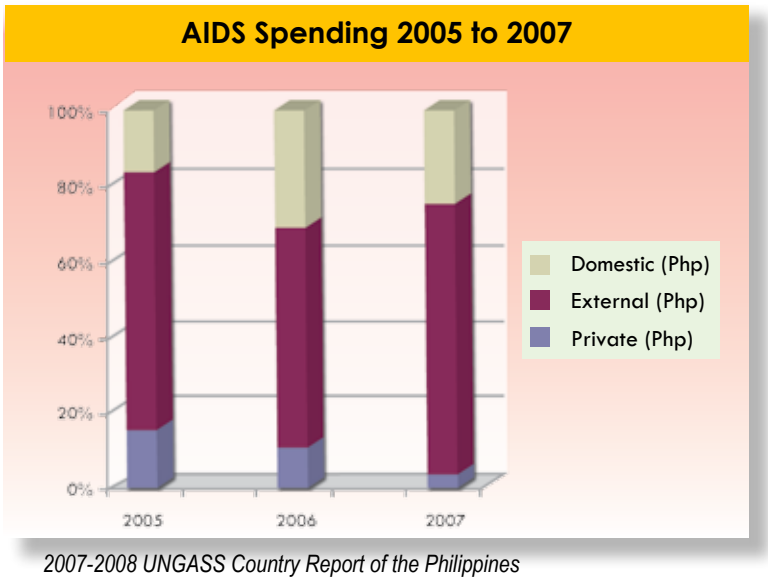
Thus, while the Council is able to plan centrally, the implementation of the strategic plan has been constricted by the ambiguity in the roles of Council members in mobilizing resources or managing HIV programs. That there is a notion that the HIV response is predominantly a health response did not help in clarifying this confusion.

In operational terms, the attachment of PNAC with the DOH has led to the financial dependence of the Council on DOH. Other member agencies have attempted to include allocation for their own HIV programs, but they were denied by the Department of Budget and Management (DBM) due to the operational framework that HIV is in the mandate of DOH. During the 14th Congress, PNAC attempted to include allocation for the member agencies, which was once again denied by the DBM.

As the main coordinative body, PNAC is vested with oversight functions. However, as an attached agency with no independent budget or an independent secretariat, performing its functions has been difficult for PNAC in the same manner that PNAC's relationship with DOH is tricky. If, for instance, DOH, the Chair of the Council, defaults on its role in leading the response, PNAC is unlikely to have the capacity to fulfill its function.

3. Investment in the HIV response

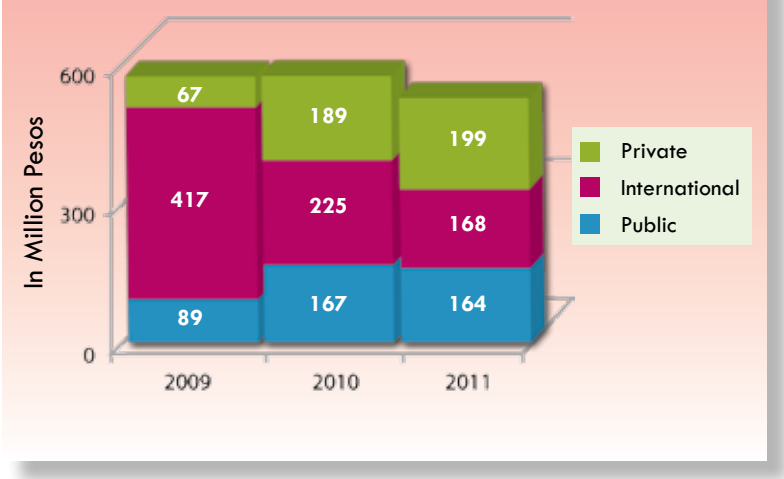
One crucial factor why the country failed to reach the scale set in its strategic plan is the tepid investment for HIV programs in the country. The Philippines relies heavily on foreign sources to fund its HIV and AIDS programs. From 2005 to 2007, the share of public spending on HIV and AIDS was only 20%.[9]



2007-2008 UNGASS Country Report of the Philippines

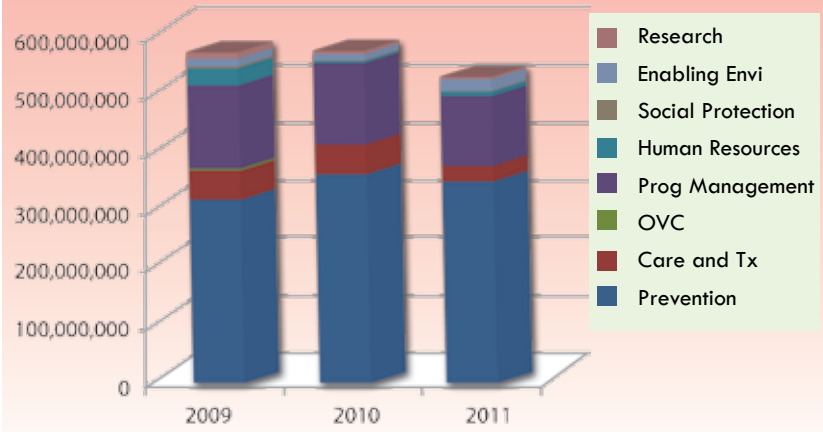
Ironically, despite the spike in HIV incidence, allocation under the annual national budget stagnated. In 2007 and 2008, when the country was detecting one new HIV case a day, the allocation per year was P71M, and it slightly increased to P89M in 2009, when health authorities was reporting three to four new HIV cases a day.[10] However, by 2010 and 2011, the General Appropriations allocation dropped to P65M per year, when new cases have already reached 7 to 8 a day.[11]

AIDS spending by Source, 2009-2011, Philippines



2012 Global AIDS Progress Report, Philippines

AIDS Spending by Function, 2009-2011



2012 Global AIDS Progress Report, Philippines

The funding gap puts into context the inadequacy of HIV services, especially in reaching key populations affected by the epidemic. In an investment plan approved by PNAC to identify the funding requirements of AMTPV, a targeted package of interventions in high incidence area - NCR, Cebu, Davao, and Angeles City - would cost P5.9 billion, amounting to a funding gap of P548 million annually.[12]

The changing landscape in global HIV and AIDS resources entails an act of brinkmanship for HIV and AIDS stakeholders. For one, in 2011, the Philippines' biggest donor for its HIV and AIDS services, the Global Fund for AIDS, TB, and Malaria, announced the cancellation of the next round of grants. This threatened the sustainability of life-saving HIV services, from support for prevention activities that are otherwise not funded by the public sector to access to treatment. Global Fund established a Transitional Funding Mechanism to allow countries with existing Global Fund-supported programs to apply for a two-year extension, and despite the recent approval of the country proposal, the extension fund would give neither the scale nor the sustainability that the response needs. The Transitional Funding Mechanism is by and large a status quo funding.

As a middle income country and a new lending country for the World Bank, the chances of the Philippines expanding its external donor base are low. International donor institutions have in fact been requiring the Philippines to demonstrate its capacity and willingness to increase the share of the country in funding domestic development needs.

The law could have provided direction for public spending in HIV and AIDS. However, under its current form, the only appropriation provision is for the PNAC Secretariat. Since the HIV and STI prevention program is within DOH, its appropriations come from the agency itself. But the HIV and STI prevention program is

just one aspect of the response - it is NOT the response. What is missing is a tacit mandate from the law that the country's roadmap to halt the epidemic - the AIDS Medium Term Plan - will have adequate resources.

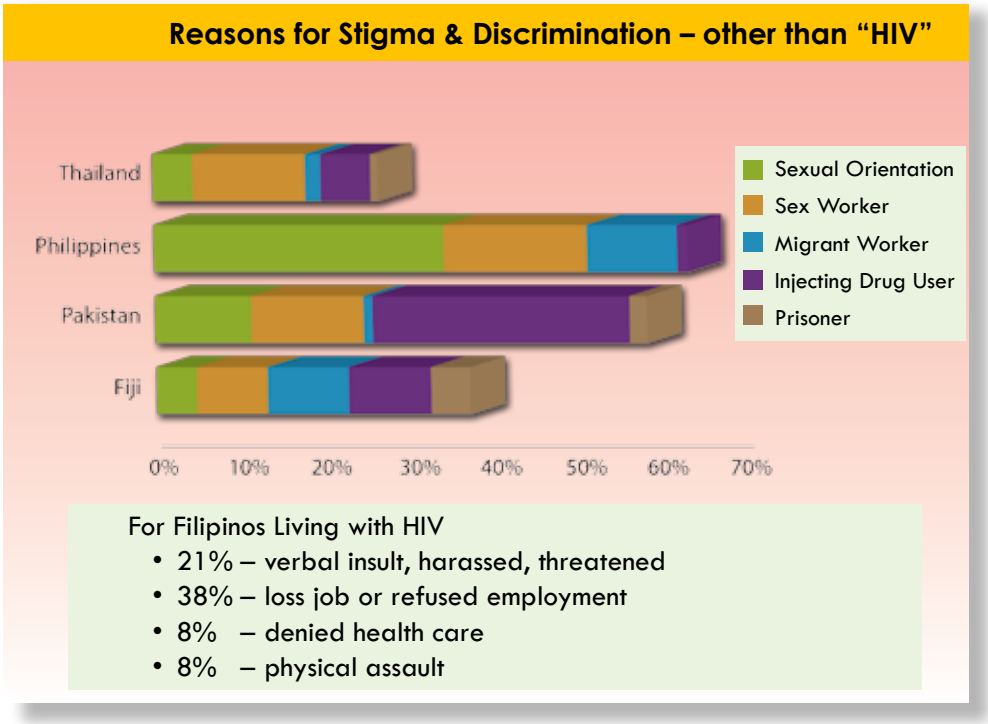
4. Persistence of stigma and discrimination

The strongest feature of the law is its adherence to internationally and constitutionally guaranteed human rights. It ensures that people living with HIV (PLHIV) are protected from a wide range of discriminatory practices and policies. It imposes confidentiality as a measure to prevent the stigmatization of PLHIV. It also bans mandatory HIV testing to assure that consent is present and no individual is deprived of his or her human rights.

However, stigma and discrimination against PLHIV and populations vulnerable to or affected by HIV continue to deepen. The uptake for the legal remedies provided by the law has been minimal, which indicate that these legal provisions on human rights need to be enabled by clear redress mechanisms, the strengthening and heightening of capacities of communities affected by the virus, and by the elimination of stigma from HIV services and mechanisms that are meant to protect and promote human rights. The absence of this enabling environment erodes the effectiveness of these human rights guarantees.

A civil society report on RA 8504 and its effectiveness against stigma and discrimination reveals that eight out of ten PLHIV have experienced 'strong to serious' discrimination.[13] In an Asia Pacific Stigma Index conducted in 2011, PLHIV in the Philippines reported experiencing loss of job or rejection of job application (38%), verbal abuse and threats (21%), denial of health services (8%) and physical assault (8%).[14]

The elimination of stigma and discrimination has become all the more crucial because of the growing concentrated epidemics among MSM and TG, PWID, and sex workers. It is by no means an accident that these communities are harder to reach with HIV services since stigma and discrimination are driving them underground. Homophobia, legal persecution, and harassment because of their risky behavior are de facto barriers to the response that cannot be skirted.



2012 Global AIDS Progress Report, Philippines

III. Policy options and recommendations

Beginning the 13th Congress, attempts had been made to introduce line item amendments to RA 8504. However, given the structural deficits in the legal framework, what is needed is an overhaul of the current legal design to protect and strengthen contents that remain crucial, such as the law's human rights framework, and to introduce new provisions that will make the law come up to evidence-informed standards.

An alternative is to initiate Executive action that, through the delegated powers of the President to reorganize the government, could be used to overhaul PNAC and cure some of its structural defects. This option, however, requires the support of the political leadership, the same leadership that is perceived to be absent in the response.

Both options present challenges, but what is clear is that the current legal framework is no longer tenable.

The Civil Society Proposal

Civil society organizations, several of which are members of PNAC, initiated the formulation of a set of revisions to RA 8504. This proposal is now contained in a bill currently filed in the 15th Congress.[15]

The civil society-initiated proposed measure builds on the strengths of the existing law and introduces new provisions that address the gaps in the response. It retains the human rights-based and multi-sectoral approaches of the current design and expands them to ensure that the response is more flexible and can address the HIV epidemic, whether it's a general population epidemic or a concentrated one. The proposal is premised on strengthening the collaboration between and among sectors, and recognizes that both civil society and the State need to work together to halt the epidemic.

The amendatory bill has six core elements:

A. *Prevention.* The bill expands behavior change interventions so that they could respond to both concentrated and general population epidemics. It also institutionalizes evidence-based

29th IACM with Reps. Janette Garin and Angelo Palmones, PLCPD Executive Director Mr. Rom Dongeto and Dr. Genesis Samonte of National Epidemiology Center - DOH

prevention approaches and introduces a positive prevention program to encourage PLHIV to take part in the response. Furthermore, it resolves the conflict between the AIDS law and the Dangerous Drugs Act by providing for the creation of a harm reduction program in the country.

B. *Treatment, Care and Support.* It establishes a treatment policy that aims to ensure that treatment is accessible and free for all PLHIV. It corrects discriminatory practices in insurance coverage, which currently allows private HMOs to exclude PLHIV. It also expands care and support programs to ensure that PLHIV are economically empowered.

C. *Enabling provisions.* The bill ensures that stigma is removed in HIV services, and it clarifies the redress mechanism to ensure that the human rights protection provisions of the existing law are accessible. It corrects barriers to HIV services, especially for key populations, including MSM and TGs, sex workers, PWID, women and children.

D. *Governance.* It affirms the multi-year National Plan (modeled after the AMTP) and its local counterparts and clarifies the roles and functions of PNAC as the main governance body of the HIV response. It also ensures the independence of the Council.

E. *Penalties.* The bill enhances the penal provisions of the law to ensure that they are adequately applied to violations of the law.

F. *Funding.* The bill grants a P400M funding for the first year of the revised law and ensures the inclusion of the funding requirements of the response in the succeeding GAAs. It also reframes the funding structure such that the response itself, in accordance to the National Plan, is independently funded and not reliant on a particular member-agency.

Summary

The state of the national response cannot be divorced from the deficiencies of the existing law. The lack of scale and reach in HIV services, the funding gaps, and the confusing governance structure point to the need for a legislative remedy.

The amendments proposed by the civil society present the most comprehensive overhaul of the current legal framework. It is founded on the lessons that community organizations have acquired in the course of their own interventions to contribute to the national response. While the bill in the House of Representatives is awaiting report by the Committee on Health, the probability of the measure getting enacted remains to be seen.

References:

1 Source: 2012 Global AIDS Response Progress Report, Philippines

2 Source: 2012 World AIDS Day Report

3 Source: Young Adult Fertility and Sexuality Study 3 (2002). Note that the use of premarital sex as an indicator is premised on the assumption that sex within marriage would be monogamous and thus less risky. There is obviously an inherent limitation to this assumption, especially in the context of male-to-male sex.

4 Jerome Aning, "DOH Notes Rise in Sex Diseases," Philippine Daily Inquirer. September 30, 2003.

5 2011 Philippine Estimates of the Most-at Risk Population and People Living with HIV (Philippine National AIDS Council)

6 According to the 2011 Integrated HIV Behavioral and Serologic Surveillance,

7 Avila, R., Review of the Effectiveness and Impact of Philippine Legislation in the HIV/AIDS Arena: Focus on RA 8504 and its IRR, 2005.

8 Ibid.

9 2007-2008 UNGASS Country Report of the Philippines

10 2012 Global AIDS Response Progress Report, Philippines

11 Source: Congressional hearing for the 2012 DOH budget

12 HIV and AIDS Investment Plan 2011-2016 (PNAC).

13 An article on the research jointly conducted by Achieve and Pinoy Plus may be found here: http://www.achieve.org.ph/content/achieve-address-access-legal-services-plhivs-fight-stigma-and-discrimination

14 People Living with HIV Stigma Index: Asia Pacific Regional Analysis (2011)

15 The House of Representatives version, HB 5312, was filed by Representatives Kaka Bag-ao, Maria Isabelle Climaco, Bolet Banal, Arnel Uy, and Janette Garin. The Senate version, SBN 3072, was filed by Senator Miriam Defensor Santiago.

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