The Philippine Legislative Policy Affecting HIV/AIDS: An Assessment of the Effectivity of R.A. 8504

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Abstract

This article looks closely into the provisions of the AIDS Prevention law. The author emphasizes that RA 8504 remains a model law absorbing many of the best practices cited in international discourse on HIV/AIDS but proposes a new agency attached to the DOH and DOF for purposes of policy consideration, the streamlining and strengthening of the PNAC secretariat, a provision to allow access by HIV/AIDS sufferer to affordable ARVs and supported drugs, and strengthening of HIV/AIDS education to further improve the law.

Keywords: HIV/AIDS, RA 8504, legislative policy.

Introduction: Philippine Legislative Policy on HIV/AIDS

In 1998, Congress passed the Philippine AIDS Prevention and Control Act (Republic Act 8504) to address growing concerns about the spread and impact of HIV/AIDS in the country. The law was intended to formulate a comprehensive national policy on HIV/AIDS following the recommendations of the Second International Consultation (hereinafter "Consultation") on HIV/AIDS in Geneva in 1996. Prior to its enactment, government policy on HIV/AIDS was embodied in the National AIDS Prevention and Control Program (1987), the National AIDS and STI Prevention and Control Program within the Department of Health (DOH)

in 1988, the establishment, through E.O. 39 in 1992 of the Philippine National Aids Council, and the country's Medium Term Plans (MTP I and II) for HIV/AIDS for 1988-1993 and 1993-1998, respectively.

By any standard, R.A. 8504 expansively fulfilled all the major guidelines of the Consultation. The law's success in incorporating the Consultation's "International Guidelines on HIV/AIDS and Human Rights" was lauded as a model for HIV/AIDS human rights legislation by the United States Agency for International Development (USAID) in 2000.[1] On paper, its human rights centered provisions broadly addressed concerns about legislative policy raised in the Second International Consultation and was cited by UNAIDS for "Best Practice" in national policy framework formulation and public health legislation reform.[2]

In its religious observation of the recommendatory guidelines of the 1996 Second International Consultation on HIV/AIDS, RA 8504 was deliberately intended to constructively advance the social change necessary to address the underlying determinants of infection and impact, adopt a coordinated multi-sectoral thrust and avoid discriminatory, restrictive, and coercive provisions that were universally considered to drive individuals at risk underground.[3] Thus, on the policy level, R.A. 8504's success as a piece of legislation lay in its religious adoption of the main components of the Consultation. This is seen primarily in the following key areas:

1. The protection of the rights of HIV/AIDS affected individuals and their families;
2. The incorporation of multi-sectoral cooperation in HIV/AIDS related activities; and
3. The assimilation of internationally recognized best practices in education and surveillance in HIV/AIDS.

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government acting in coordination with each other, as well as with the private sector and the Non-Government Organizations (NGO). The multi-sectoral approach ensured that every government department or agency tasked by RA 8504 with the implementation of specific programs would be fully equipped to fulfill their obligations under the law.

However, no additional logistical support was allocated for the implementation of the programs of RA 8504. Involved government branches and agencies were expected to act within their own existing budgetary allocations. Except for the Department of Health (DOH), no funds were earmarked for implementation at the department and agency level and participating agencies were expected to work within their existing budgets. Thus, while lauded for its inclusiveness in adopting international recommendatory instruments up to the date of its enactment, resources for HIV/ AIDS prevention, support and care programs have not been instituted[4] or if they have been instituted, participation has decreased considerably since the enactment of the Philippine AIDS Prevention and Control Act.[5]

I. Background of HIV/AIDS in the Philippines

As of December, 2004 the National AIDS Registry of the Department of Health recorded a total number of 2,200 HIV and AIDS cases in the Philippines. Of these, sixty three (63) per cent were males and sixty-nine were between twenty (20) to thirty nine (39) years old. Of the total number, 1,524 (69%) remain asymptomatic while 676 (31%) had full blown AIDS.

The 2,200 reported cases represents the cumulative number of cases of HIV/ AIDS in the country since the first case of HIV/AIDS was reported in 1984.[6] The average cumulative annual increase based on the DOH figures is 110 with the bulk of growth occurring between 1993-2004. This trend, often described as "low and slow" in the Philippine literature on HIV/AIDS seems suspect, when one compares the trend in the country with the growth of HIV/AIDS in other countries in South East Asia, particularly Thailand. In 1993, epidemiologist James Chin, utilizing computer models forecasted that the number of HIV/AIDS cases in the Philippines would reach about 100,000 in ten years.[7] Chin's 1993 projections prompted experts to reassess earlier estimates in the context of the "low and slow" growth. However,

even by the most pessimistic estimates the number of cases for 2000 was pegged at "no more than 13, 000."

UNAIDS reports that as of 2006, the most likely number of adults and children living with HIV/AIDS is 12,000. Compared to cases actually reported by the National Aids Registry, these figures are still considered quite high.[8] While it might be that existing surveillance and reporting techniques and programs possibly under-report the extent of the problem,[9] epidemiologic and other data appear to confirm that the number of "missed cases would not be that significant." The National Epidemiologic Center points out that nearly a million tests are conducted annually in the Philippines.[10] Furthermore, the number of hospital admissions for HIV/AIDS remain low. At the two key centers where HIV/AIDS cases are treated, namely, the San Lazaro Hospital and the Research Institute for Tropical Medicine, HIV-related admissions between the years 1994-1999 never surpassed 300.[11] Infected individuals would not be able to conceal their HIV/AIDS status for long. Owing to the nature of the disease, infection with the HIV virus is likely to progress to a state requiring unavoidable medical intervention at some point.

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The slow progression of HIV/AIDS may be a key factor responsible for the observation that overall, the "momentum of the Philippine response to the problem has unfortunately slowed down".[12] Government funding for HIV/AIDS programs have not increased.[13] Compliance with the mandate of Republic Act 8405 and its Implementing Rules and Regulations (IRR) has been incomplete and oftentimes grudging. Guidelines and protocols under the IRR "are yet to be fully disseminated and implemented nationwide, and pilot interventions that have shown promising gains are not sustained or scaled up."[14]

Experts warn that the situation could make a turn for the worse if the "low and slow" trend would lull government and key sectors in the fight against HIV/AIDS into complacency. Red flags indicative of a possible explosion of the HIV/AIDS

situation to epidemic proportions are reported to be widely present in the country. These "red flags" include increasing STD rates[15]; the growing number of cases of HIV/AIDS emerging from overseas workers; the fact that all the known routes of HIV transmission have already been recorded; the problem of intravenous drug use; the low incidence of condom use and limited educational efforts to warn against unprotected sex; and the generally low level of knowledge on HIV/AIDS in the general population. Rather than scaling down the response, the current trend should be seen as the "lull before the storm" providing a window of opportunity for government and all other key sectors to act forcefully to prevent an explosion and possibly contain and manage the HIV/AIDS situation in the country. Vigorous efforts towards education, prevention and multi-sectoral mobilization are important in getting ahead of the HIV/AIDS epidemic.[16] In the legislative area a thorough review of the impact and effectiveness of existing legislation is vital to a renewed and dynamic effort to stem HIV/AIDS and avoid an explosion.

THE SOCIAL BACKDROP OF HIV/AIDS POLICY AND LEGISLATION

Nineteenth Century protocols for the containment of infectious diseases[17] guided the first public policy and legislative responses to the AIDS epidemic.[18] It was quickly noted early in the epidemic however that draconian public health measures popular in the 18th and 19th century such as quarantine and containment would not work because HIV/AIDS presented problems quite unlike other epidemics.[19] While most infectious diseases affect the very young, elderly and debilitated, HIV/AIDS strikes at men and women in their most productive years. Because the HIV virus is communicated in circumstances likely to be private, it is resistant to traditional surveillance methods. To contain the disease, it was necessary that individuals affected with HIV/AIDS would not be driven underground by restrictive and coercive public health policies. This early recognition necessitated a public health policy response essentially different from traditional public health approaches.

Few diseases in human public health history possess the capacity to mingle social, political, cultural, and biological forces and illustrate how economics and

politics cannot be divorced from disease. The politics of drug production, costing and distribution and the economics of drug pricing by multinational companies has dominated discourse concerning HIV/AIDS lately. In the early history of the disease the discussion was rights-centered. The shift, however, simply reflects the success to which human rights concerns have infused policy formulation and legislation worldwide through the years since the first cases of HIV/AIDS were diagnosed in the early Eighties. It simply means that in the era of advanced anti-retroviral (ARV) and other supportive treatment, the battlefront is being fought in three key areas: human rights, funding and ARV availability.

From its onset, the AIDS epidemic has affected groups which are traditionally targets of social discrimination. Identification with the homosexual and intravenous (I.V.) drug population in the United States was blamed for the relative paucity of research funding for AIDS during the early stages of the epidemic. According to the latest surveillance reports from the Centers for Disease Control and Prevention (CDCP)[20], men having sex with men (MSM) still form the largest population of HIV infected carriers in the U.S. This is followed by intravenous drug users[21] and heterosexuals.[22]

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In the Philippines, the largest group of HIV infected individuals has been the commercial sex workers, followed by homosexuals. Given the demographics of HIV/AIDS in the Philippines, it is not surprising that a serious gap exists between policy and actual implementation. These are sectors that society has traditionally marginalized and oppressed. They are not on the priority list of health policy. However, the growing number of overseas workers affected with the HIV/AIDS virus might prompt the government to take a serious look at the effect of the spread of the disease in this group. While overseas workers do not comprise the largest HIV/AIDS demographic group in the country, the potential for infection among overseas workers and the resultant social and economic

disruption should alter government responsiveness to HIV/AIDS, in view of the implications of an HIV/AIDS explosion in this sector.

Demographics of the epidemic are important in formulating a rational legislative response. For example, from the early days of the AIDS epidemic, the crafting of a proper legislative response to the problem has been marked by sensitivity to the special social concerns of high risk populations, many of whom, even before the AIDS era, were already victims of social discrimination. Their involvement in the legislative agenda therefore was and remains an important aspect of dealing with the epidemic in terms of devising policy approaches because these unique concerns give rise to special legal problems exclusive to areas such as HIV/AIDS. From the onset of HIV/AIDS legislative history, definite tensions arose when existing public health norms clashed with individual rights. Legislative thinking required a normative shift - the task of determining those concerns that ought to take precedence in legislation was inevitably influenced by established international rights conventions and constitutional and legal principles in the area of civil and political rights and vigorously promoted by groups who stood to be seriously affected by legislation.

a) The State's Police Power in Public Health Legislation

Maintaining the social order for the protection of the public strongly infuses public health regulation. Whenever outbreaks of disease threaten the stability of the public, some of the protections generally accorded to the people are set aside for the purpose of containing the public health threat. The outbreak of SARS and avian flu in the first half of this decade in China, Vietnam, Hong Kong and other parts of Asia required the marshalling of traditional public health tools such as quarantine, containment and even travel restrictions. As a general proposition, the Latin maxim *salus populi est suprema lex,* which capsulizes the purpose of the state's police power, embodies the character of the entire spectrum of public health regulatory mechanisms that are usually invoked in dealing with disease outbreaks considered threats to public health and safety. Police power is an inherent attribute of sovereignty which "extends to all public needs."[23] It has been repeatedly characterized in jurisprudence as the least limitable[24] and certainly the most insistent. In *Guerin v.*

City of Little Rock[25] a court capsulized the importance of this area by emphasizing that if the state cannot enact regulatory measures aimed at the protection of public health, disease spread would be unabated leading to damage to the state itself.

Legislation aimed at addressing the problems associated with AIDS essentially falls under the state's plenary power to enact measures protecting the public health. Thus, regulations issued to deal with an epidemic have been sustained generally by courts as a proper exercise of the police power. Significantly, inadequate legislative and regulatory issuances affecting government ability to take appropriate measures against HIV/AIDS have been identified in making dire economic projections for Thailand and Africa.

Notwithstanding the state's police power, it has been a principle recognized early in the history of HIV/AIDS policy formulation that government cannot act capriciously in invading private rights. There must be a showing that the power is in fact exercised to reasonably promote the public health, and that measures taken to achieve public health goals are narrowly drawn so as not to be oppressive.

b) Legislative policy and individual rights

Institutional legal rights are generally created or abolished by decisions made by the appropriate people or appropriate authority, and include those enshrined in the Constitution and in statutes. Some rights impose obligations for the performance of certain acts while other rights impose the duty not to do certain things.[26] What is important is that "Individual rights are political trumps held by individuals and are crucial in representing the majority's promise to the minority that their dignity and equality will be respected."[27] Clearly, apart from government institutions, the sectoral participation of private HIV/AIDS advocates are unavoidable in preserving this covenant.

Early in HIV/AIDS, many responses to the AIDS crisis from governments, including such measures as obtaining lists of HIV-infected individuals from private physicians and entities for the purpose of making policy decisions, mandatory testing, and quarantine, etc. - set the governments' power and duty under the police power

to protect the public health against the individual's universally recognized and guaranteed rights. Ignorance about the exact nature of the problem, its invariably fatal course, and the huge social and economic impact of the disease gave justification for the exercise of the government's power to enforce laws designed to control the spread of the epidemic.[28] Violations of two sacrosanct individual rights namely, the right to privacy and the right against unreasonable searches in some countries were widespread. Johnson describes the early public health strategy this wise:

> "The strategies to prevent and contain the spread of HIV/AIDS were in the 1980s, based on fear and blame. Hard images of tombstones and the plague were used in an attempt to coerce individuals into behaviour modification. Homosexuality, promiscuity, and drug use were all targeted as blameworthy behaviour and the disease prevention message was often directed against the activity or the people engaged in it rather than against the disease."[29]

3) A Rights Approach to Legislation: A Paradigm Shift in HIV/AIDS and other Health Concerns

That legislation in HIV/AIDS invariably affects individual rights were recognized early. "AIDS makes explicit, as few diseases could, the complex interaction of social, cultural and biological forces."[30]

In the early formulation of policy, Osborne, in 1988 warned that "private behavior is at issue (and) the most effective policies will be those that enlist the cooperation of those at greatest risk, thus optimizing both human rights and (concern for) the health of the public."[31] Suggesting a rights approach to future AIDS legislation, this author, in 1992 proposed that any form of legislation or public health regulation in the area must not only "limit or narrow down any public health measure only to those directly affected"[32] with HIV/AIDS but must also "select the least restrictive alternatives in addressing the problem."[33] The clearly negative social impact of driving HIV/AIDS sufferers underground by the enforcement of restrictive public health measures renders some of the public health responses that

were deemed acceptable in SARS and bird flu counterproductive in the case of HIV infection. Consequently, following mistakes recognized in early policy, "[t]he new public health brought with it a different approach based upon community action and self-empowerment."[34] This strategy recognized that "behaviour is not simply a matter of open-ended individual choice, but a response to the powerful influence of social, economic and political forces that lay substantially beyond the control of the individuals who were affected by them."[35]

HIV/AIDS Legislative Policy

The enactment of Republic Act 8504 recognized the looming AIDS threat and prescribed the need for State action, consistent with the country's international commitments in the area. The law aimed to "promote public awareness about the causes, modes of transmissions, consequences, means of prevention and control of HIV/AIDS"[36] and "to extend to every person suspected or known to be infected with HIV/AIDS full protection of his/her human rights and civil liberties"[37].

For this purpose, R.A. 8504 laid down a national HIV/AIDS information and education program, a comprehensive HIV/AIDS monitoring system and strengthened the Philippine National AIDS Council. The law enunciated the country's response to the various areas involving the HIV/AIDS problem, namely:

1. Education and Information (Article I)
2. Safe Practices and Procedures (Article II)
3. Testing, Screening and Counseling (Article III)
4. Health and Support Services (Article IV)
5. Monitoring (Article V)
6. Confidentiality (Article VI)
7. Discriminatory Acts and Policies (Article VII)

Because of its compliance with the general recommendations of the Consultation, the Act, as mentioned earlier, has been repeatedly cited as a model for Aids legislation.

Evaluation of HIV/AIDS Legislation: R.A. 8504 and its Implementing Rules and Regulations

This study evaluates the effectiveness of AIDS legislation from the time of passage of RA 8405 and its IRR up to 2005. The evaluation was intended to be forward looking, beginning with major provisions of RA 8504 intended to implement the goals of the Consultation and look into the structures and mechanisms put into place by law to deal with HIV/AIDS, their effectiveness, strengths and weaknesses. With this, the study aims to propose amendatory legislation that directly affects the targets of the law, the HIV/AIDS sufferers. This study was therefore crafted to draw from the experience gained from ten years of RA 8504 and translate experience into effective action.

A. Policy Content

From the very beginning, the Philippine HIV/AIDS law was consciously crafted to conform to the guidelines of the Second International Consultation on HIV/AIDS held in Geneva in 1996. For a better understanding of the relationship of the crafting of the law with the Consultation, it would be necessary to look at the guidelines, to wit:

Guideline 1

States should establish an effective national framework for their response to HIV/AIDS which ensures a coordinated, participatory, transparent and accountable approach, integrating HIV/AIDS policy and program responsibilities across all branches of government.

Guideline 2

States should ensure, through political and financial support, that community

consultation occurs in all phases of HIV/AIDS policy design, programme implementation and evaluation and that community organizations are enabled to carry out their activities, including the fields of ethics, law and human rights effectively.

Guideline 3

States should review and reform public health legislation to ensure that they adequately address the public health issues raised by HIV/AIDS, that their provisions applied to casually transmitted diseases are not inappropriately applied to HIV/AIDS and that they are consistent with international human rights conventions.

Guideline 4

States should review and reform criminal laws and correctional systems to ensure that they are consistent with international human rights obligations and are not misused in the context of HIV/AIDS or targeted against vulnerable groups.

Guideline 5

States should enact or strengthen anti-discrimination and other protective laws that protect vulnerable groups, persons living with HIV/AIDS and people with disabilities from discrimination in both the public and private sectors, that will ensure privacy and confidentiality and ethics in research involving human subjects, emphasize education and conciliation and provide for speedy and effective administrative and civil remedies.

Guideline6

States should enact legislation to provide for the regulation of HIV related goods, services and information so as to ensure widespread availability of qualitative prevention measures and services, adequated HIV prevention and care information and safe effective medications at affordable price.

Guideline 7

States should implement and support legal services that will educate people affected by HIV/AIDS about their rights, provide free legal services to enforce those rights, develop expertise on HIV-related services and utilize means of protection in addition to the courts, such as offices of ministries of justice, ombudspersons, health complaint units and human rights commissions

Guideline 8

States should, in collaboration with and through the community, promote a supportive and enabling environment for women, children, and other vulnerable groups by addressing underlying prejudices and inequalities through community dialogue, specially designed social and health services and support to community groups.

Guideline 9

Changing discriminatory attitudes through education, training and the media. States should promote the wide and ongoing distribution of creative education, training and media programmes explicitly designed to change attitudes of discrimination and stigmatization associated with HIV/AIDS to understanding and acceptance.

Guideline 10

Development of public and private sector standards and mechanisms for implementing those standards. States should ensure that Government and private sector develop codes of conduct regarding HIV/AIDS issues that translate human rights principles to codes of professional responsibility and practice, with accompanying mechanisms to implement and enforce these codes.

Guideline 11

States should ensure monitoring and enforcement mechanisms to guarantee HIV-related human rights, including those of persons living with HIV/AIDS, their families and communities.

To meet the Consultation's parameters, the AIDS law centered on four major areas of concern 1) prevention; 2) protection of rights of persons afflicted with the virus; 3) establishment of a nationwide monitoring system; and 3) strengthening of the Philippine National AIDS Council.[38]

Limitations of the Study

This study was undertaken in anticipation of amendments being proposed in congress to strengthen the AIDS Law. The study was conducted over a very short period and primarily involves analysis of legislation comparing its provisions with

the structures erected to deal with the problem. It involved interviews and meetings with key stakeholders and partners in the prevention and control of HIV/AIDS in conjunction with a thorough review of the local and regional literature pertaining to the subject of the study up to 2005. Analysis of specific aspects of the law, i.e., as to how the law would impact on overseas workers (or, conversely how HIV/AIDS among OCWS, would affect development and the economy) for example, will require longitudinal studies that combine quantitative surveillance methods and qualitative tools. The current study was designed mainly to look into the strengths of existing provisions of law directly or indirectly affecting HIV/AIDS; and to uncover possible weakness that may be addressed either by new laws or by mere amendatory legislation.

A. General Evaluation

The law's creation was clearly intended to conform to the guidelines set by the 1996 Geneva Consultations. Toward this end RA 8504 comprehensively addresses issues about the protection and promotion of rights of HIV/AIDS affected individuals and their families, specifically targets vulnerable groups and manifests attempts to translate human rights principles into professional codes of conduct. More importantly the law's use of an inter-agency and community-based approach to the problem is intended to ensure a coordinated, participatory, transparent and accountable approach that would integrate HIV / AIDS policy and program responsibilities across all branches of government, and foster community partnerships with key stake holders like NGOs and people living with HIV/AIDS (PLHA).

However, while the law contains provisions clearly defining institutional responsibilities and processes and provides for community partnerships, its attempt to broaden inter-agency participation by expanding the composition of the Philippine National Aids Council has resulted in an unwieldy national coordinating body that over-diffuses responsibilities without installing mechanisms for monitoring results in key areas (KRAs) and for accountability. In stark contrast to the large and unwieldy structure of the PNAC is the absence of an effective implementing and coordinating body or mechanism, since the law glosses over the role and importance of the

Secretariat. This causes problems in implementation because a working secretariat is necessary to integrate and coordinate the tasks assigned to various departments and agencies and to monitor at every stage fulfillment of the tasks.

The Consultation's guidelines require the strengthening of management support systems for the national response. This has not been fulfilled because of the absence in the law of an effective management mechanism. In fact, AMTP III identifies this as an important area in meeting the goals of the national response. Further, AMTP III's desired "expansion of the coverage and integration of HIV/AIDS in the development priorities at the local level, giving priority to high risk goals" could not be accomplished without an effective implementing arm. Apart from the absence of an effective management response the major gaps in the enforcement of the Consultation's guidelines reflected in the law are described in the next section.

Policy and Implementation Weaknesses

Seven years into the law, the effectiveness of RA 8504 has been measured primarily on the basis of its success in policy formulation or improvement in policy response[39] and not on its actual implementation. There are many problem areas in the implementation of the Act, some of which are described and discussed hereunder:

1. The law places too much focus on the reporting of policy improvement and policy formulation. There are few actual details about mechanisms of implementation, the agencies answerable for implementation (actually identified in reporting), key result areas, evaluation indices and targets, actual implementation and extent of implementation; and reasons for lack of implementation (e.g. budgetary constraints) for the purpose of addressing the lack thereof. Policy Guidelines on HIV/AIDS Prevention and Control[40] are reasonably and adequately covered by RA 8504 and its Implementing Rules and Regulations, however, the existing PNAC Secretariat itself could not provide, for example, a matrix of targets, accomplishments based on measurable targets, weaknesses found in the implementation of targets,

measures undertaken to address these weaknesses in the actual operationalization of the Policy Guidelines. Overemphasis on policy making at this point in time mistakes the trees for the forest: that the target is actual enforcement i.e., whether or not the law at this point directly touches and affects the subjects of policy. This deficiency is itself recognized by the 4th Aids Medium Term Plan (AMTP 4) when it states that:

"Though RA 8504 provided a clear legal basis for action, various government agencies have not yet operationalized their mandates through concrete...programs and services."

Likewise, deficiencies in reporting are actually recognized. According to the 4th AMTP 2005-2010: "[m]onitoring and evaluating the trusts of the national response has been inadequate." It adds "[e]fforts have been limited to partial assessments that do not provide the complete picture."

2. While the Act and its IRR go into specific details regarding education and information programs, it nevertheless neglects to provide specific, sustainable mechanisms to ensure long-term implementation and program development. The idea of assigning the operationalization of specific tasks to concerned members of the PNAC is a good idea only if resources are clearly earmarked and released for the purpose. Expecting, for example, the Department of Education to set aside a portion of its over-stretched funds for the purpose of effectively trickling down HIV/AIDS education to the lowest rung might be too much to ask because the department's primary concerns may lie in its more direct tasks (filling the demand for classrooms, employing more teachers, training of teachers, etc.). Owing to limited financial resources, the reach of training initiatives of the education departments (including CHED and TESDA), the PNAC secretariat points out, "have not been produced in adequate quantities". Most of the actual trainors have not received training modules. The same problem affects other departments and agencies granted specific tasks under the law. "For example, the

establishment of an HIV/AIDS program in the workplace is not enforced due to inadequate number of personnel in the DOLE."

3. The private sector, including local companies, NGOs, and PLHA organizations are expected to raise their own funds for HIV/AIDS programs with little logistical support from government, hence, many programs are donor-money driven and are, consequently, "stop and go" programs . Additional government funding is available but only for the education and information campaigns of local government units. Yet these funds are inadequate.
4. The gathering of surveillance, monitoring and other data is scattered, sporadic and un-coordinated. There is a need to ascertain once and for all the nature of the HIV/AIDS problem in the country. We may be on the verge of an HIV/AIDS explosion, but the absence of data from sustained surveillance affects government response. Moreover, a new law must provide for a central clearing house for such data to confirm once and for all the exact progression and extent of HIV/AIDS in the Philippines.
5. The Act fails to emphasize community based countermeasures as a long-term response to the HIV/AIDS problem in light of the comprehensive nationwide multi-agency educational and informational campaign. A new Act or its IRR should provide indices and targets for compliance.
6. While the Act provides for penalties for unethical practices, unsafe practices and procedures, and discriminatory acts and policies, the Act itself is largely ineffective in enforcing compliance with specific preventive campaigns, such as pre-and post testing counseling by private testing laboratories and clinics.
7. The Act and its IRR fail to identify and/or provide for appropriate workable mechanisms for redress of grievances against discriminatory acts, policies, or human rights violations committed against those affected by HIV/AIDS.
8. There is no provision in the Act or its IRR for legal support services for PLHA, many of whom are poor, marginalized and financially burdened by the cost of prevention and care.

9. With its focus on HIV/AIDS as primarily a health issue, a fully supportive and enabling environment appears to be the responsibility mainly of the health sector alone with the rest simply acting as supporting groups. This has its disadvantages, as we will see later in discussing structure.
10. Provisions pertaining to and affecting OCWs are inadequate or inexistent.
11. In spite of the focus of the law on HIV/AIDS as a health issue, provisions on care and treatment, low cost ARVs, distribution of drugs and support are absent.
12. There is a tendency to make motherhood statements in reports without identifying specific deficiencies and specific measures (how to obtain budget for programs) to address deficiencies.

Addressing the Gaps: Key Areas

A casualty analysis of the HIV/AIDS situation in the country has traced the weaknesses in the implementation of RA 8504 to the lack of a clear strategic plan. However, it is clear from AMTP III and AMTP IV that the problem lies not in the lack of strategic policy directions which are clearly outlined in these documents and in various documents from UNAIDS and the PNAC secretariat but from the absence of a political will to provide adequate logistical support for the programs embodied in the law and its implementing rules and regulations. The HIV/AIDS effort, based on RA 8504 are undertaken primarily by three major departments (in addition to other member agencies of the PNAC): Health, Education and Local Governments, all of which are expected to enforce provisions of the law with no additional budgetary support apart from their regular government allocations. As the lead agency for the HIV/AIDS effort, the Department of Health (DOH) is expected to provide for the largest budgetary share. However, the DOH has been chronically strapped for funds for its major programs. The share of the DOH in the national budget for the past two years (2004-2005) was only 3% of the total. Consequently, the amount provided by the DOH to the national HIV/AIDS program has decreased over the years.

In any event, reforms in the following major areas are necessary for revitalizing the national HIV/AIDS program:

1. Reforms in the structure and composition of the PNAC including an expansion of its secretariat to enable the latter to carry out many of the PNAC's functions under the law;
2. Reform in education, surveillance and monitoring implementing the intended role of the Department of Education as the principal agency for the information and education effort. In the area of education and surveillance particular focus should be devoted to OCWs which loom large in future demographics in HIV/AIDS in the Philippines;
3. Reform in the procurement and distribution of Anti-Retroviral Drugs and drugs necessary in the treatment and maintenance of the sequelae of infection; and
4. Revision of specific provisions of law addressing identified loopholes and gaps in legislation.

The PNAC and Its Secretariat

The reconstitution of the Philippine National AIDS Council (PNAC) was central in integrating the various programs for HIV/AIDS prevention and control among the concerned government agencies through a central advisory, planning and policy-making body.

Prior to Republic Act 8505, the PNAC was created by President Fidel V. Ramos in 1992 through Executive Order No. 39. The creation of the Council at that time responded to a need to constitute a body having a definite institutional mandate to carry out the functions of a central coordinating body for HIV/AIDS.

The passage of the 1998 HIV/AIDS Prevention and Control Act was constructively intended to provide the PNAC with the much-needed powers to implement the national HIV/AIDS effort under the law. The newly reconstituted PNAC was crafted to jump start the program, as clear mandates and responsibilities were given to specific agencies and stakeholders to implement a national and comprehensive response.

After the passage of Republic Act 8504, the Chair of the Council, then Secretary Carmencita Reodica through the Office for Special Concerns initiated the process of multi-sectoral consultations for the passage of the AIDS law's implementing rules and regulations. A core group was formed "to synthesize the inputs from various stakeholders and to harmonize the intent and directions of the implementing rules and regulations" to be promulgated by the reconstituted PNAC. The initial leadership of the council focused on uplifting the conditions of the marginalized and underprivileged sectors in society affected or touched by the AIDS problem.

Four main committees of the PNAC, evolved from the strategic plan, namely:

1. Research, Surveillance and Monitoring
2. Information, Education, Communication and Advocacy
3. Care and Support
4. Managerial and Coordination

The PNAC committees effectively addressed the issues and concerns raised by the new law as it moved swiftly to chart the directions of the Philippine response to HIV/AIDS. The initial activities of the four committees were jumpstarted by the Special Development Fund of UNAIDS for the 1999-2000 Biennium. It has been noted that the committees' initial activities were catalytic in nature. The actual implementation and continuity of the HIV/AIDS response rested on the PNAC member agencies and cooperating organizations.

In 1999, PNAC passed Resolution No. 1 promulgating the Implementing Rules and Regulations (IRR) of R.A. 8504. The early adoption of the IRR was essential not only in the law's enforcement but also in carrying out the goals and strategic objectives of the Third AIDS Medium Term Plan (AMTP III, entitled *"Seizing the Opportunity"*). AMTP III mirrored the directives of the Consultation, the newly enacted law and the revitalized Philippine response.

The structural requirements of the AMTP III required the PNAC in 2000 to reconfigure its committees to further hasten the Philippine HIV/AIDS effort, to wit:

1. Scientific Committee
2. Committee on Advocacy
3. Committee on Education
4. Committee on Local Responses

This restructuring did not result in any improvement in the PNAC's functions since the PNAC under the law essentially kept its role as a policy making board under which the different member agencies were supposed to act. Attendance reports obtained from the PNAC secretariat indicate that few department secretaries actually attended PNAC meetings and relegated their participation to mid-level officers. The secretariat, whose function was to coordinate the work of the agencies was hampered in its tasks by its low budget, its small staff complement and dwindling funds. As of the period for of researching this paper, the PNAC secretariat's office was tucked away in two small rooms at the end of the corridor of the DOH legal department. Declining interest in a serious HIV/AIDS program is illustrated by the fact that in 1998, the PNAC was given a budget of PHP 20 million. By 2005 this small outlay shrunk to PHP 9 million.

Thus, a small secretariat, chronically faced with inadequate financial resources bravely oversees the PNAC's primary function of supervising and monitoring an ambitious integrated and comprehensive approach to HIV/AIDS control in the Philippines. In all consultations preparatory to this paper, a broad range of stakeholders strongly urged legislation to address the current structure of the PNAC, suggesting the following:

1. Reconsidering the current attachment of the PNAC with the Department of Health;
2. Amending the law to place the HIV/AIDs program under the Office of the President or the Department of Finance
3. Changing the outlook towards viewing the HIV/AIDS situation not as a health issue but one which is essentially a socio-economic issue;

4. Amending the law to create a fully functioning implementing arm, secretariat or agency having staff possessing multi-disciplinary expertise capable of addressing a comprehensive national response to HIV/AIDS;
5. Ensuring an adequate budget and budgetary autonomy enabling the PNAC and its secretariat to fully meet its mandate.

Evaluation

Most international instruments dealing with the HIV/AIDS emphasize the centrality of an integrative and sectoral approach that maximizes cooperation among government agencies and the private sector. The first guideline of the 1996 consultations underscores how important an effective central monitoring and supervising agency is to the AIDS effort by suggesting that "[s]tates should establish an effective national framework for their response to HIV/AIDS which ensures a coordinated, participatory, transparent and accountable approach, integrating HIV/AIDS policy and program responsibilities across all branches of government." A working central agency is a *sine qua non* to the effectiveness of any national HIV/AIDS program.

1. Organization of the PNAC

The present structure of the PNAC is flawed and inadequate. Major issues concerning its programs and organizational structure highlight the need for a re-evaluation of its structure and composition to ensure efficient government agency responsive to HIV/AIDS.

The central thrust of the original organizational structure of the PNAC was to locate responsibility of implementation with the various agencies and organizations that composed it. Thus, the Department of Education, the Commission on Higher Education and TESDA were primarily responsible for education and the dissemination of information, the Department of Labor and some of the agencies attached to it were included to address problems involving HIV/AIDS in the

workplace as well as those problems which involved HIV/AIDS among overseas Filipino workers.

However, noting the country's experience so far with devolution, it is fairly apparent that decentralization would work only if:

1. Resources are clearly and specifically earmarked and set aside for the agency's functions;
2. Authorities and managers of the program are identified and their particular responsibilities and decision-making authority are properly delineated;
3. Program managers are empowered to manage HIV/AIDS resources;
4. At the lower levels, such authorities work with NGOs and other key stake holders such as PHLAs as partners to implement decentralized programs; and
5. At the minimum they possess organizational, operational, and technical capability.

As originally conceived, the Council itself provides strategic planning at the national level. Individual members of the Council are responsible for operationalizing specific tasks. The PNAC Secretariat coordinates and integrates these tasks.

Deficiencies of the current structure are immediately apparent when we analyze the organization and structure on the basis of the four elements considered necessary for making a decentralized system work:

1. Resources:

One of the issues raised at the Fontana Workshop conducted between the PNAC and its partners in 2002 was the absence of clarity in the mandate of PNAC in terms of mobilizing resources available from government funds and private donors. With respect to private funds, should PNAC be a central clearinghouse for all funds entering the country through private donors? If it would be under a new law a central clearinghouse, how would this be enforceable? If the law requires a

clearinghouse, what are its effects on the flow of HIV/AIDS donations to NGOs and other private organizations?

It is proposed that any new law or any new amendments to the law contain provisions that would foster increased and efficient mobilization of government funds for HIV/AIDS. It would be difficult, however, to insist by statute that all funds, including private donations be coursed through a central clearing house. Certain donors would prefer to deal with NGOs directly and are sometimes wary of turning over private donor funds to governments. Amendments to the law can identify which funds go directly the central clearing house and which funds go the private organizations and NGOs with provisions for accountability.

Responsibilities of different organizations should be clearly spelled out and delineated with the budgetary allocations for carrying out specific functions identified and earmarked. It is one thing to assign the task of education and information to DECS, TESDA or CHED. Without proper budgetary allocation many of the policies and programs conceived at the policy level - the PNAC level - would not trickle down to targeted sectors. At the local government level, many decentralized and devolved programs of government have suffered because of the gap between government policy and actual implementation.

Ideally, the current mechanism of allocating responsibility among the member agencies and departments of the PNAC should be preserved. HIV/AIDS prevention efforts are more effective when programs and activities are integrated into existing large-scale infrastructures that operate across a range of sectors. Independent interventions are generally wasteful and not cost efficient. New legislation should simply strengthen the budgetary allocation of member agency funds for HIV/ AIDS.

2. Program Management and Decision Making

The existing Act clearly places decision making authority within the Council itself. Program management is accomplished directly through the member-departments and agencies and through the PNAC Secretariat. If program management through departments and agencies is to survive a new or amended

law, it is important that the functions of the Secretariat and these agencies be properly delineated both in the law itself and in the IRR..

3. Implementing Arm: The Secretariat

It has been observed that the Secretariat has been strong in policy formulation (wish lists) but low in results accountability. For instance, in the process of assisting the PNAC secretariat with its Accomplishment Report, the author requested a matrix of identified goals at the beginning of the report period with measured results identified at the end of the reporting period. The author was informed that no specific goal setting was made.

To reduce the tendency of agencies, including the secretariat to make motherhood statements and repeat policy pronouncements, the new law or its IRR should require the secretariat, at the beginning of the year to set specific goals. Accomplishments should be reviewed periodically with these goals as yardsticks. At the end of the year, the goals should be measured against accomplishments for the purpose of identifying how and why certain goals were not met and what adjustments could be made to meet targets and expectations.

However, it is the author's observation that the secretariat is not entirely at fault: a small staff complement, the absence of distinctions between functions of the PNAC and the secretariat, and a low budget all conspire to set the secretariat up for failure. Obviously, amendatory legislation should provide for a fully functioning secretariat with a proper staff complement either by strengthening it or by creating an agency-type autonomous structure reporting to a board or council.

4. Integration with Key Stakeholders

This is a key element to the success of the PNAC and its secretariat. What systems and structures exist to reach a large number of people? While the Act contains provisions mandating linkages in education, local governments, overseas workers, etc., there are no specific mechanisms in the law or the IRR to foster actual linkages between sectors.

Involving key stakeholders is significant in effecting an integrated and multi-sectoral response to the HIV/AIDS problem.

Protection of Rights of Persons Afflicted with HIV/AIDS.

Early on, the Philippine response to the HIV/AIDS problem was marked by an adherence to and respect for basic human rights principles. Protections are afforded to both individuals suspected and actually known to be infected with HIV/AIDS.[41]

Discrimination based on "actual, perceived or suspected HIV status" was forbidden especially in the areas of medical care, employment and livelihood, admission to schools, access to credit and insurance and decent burial services, among others.

Discrimination based on "actual, perceived or suspected HIV status" was forbidden especially in the areas of medical care, employment and livelihood, admission to schools, access to credit and insurance and decent burial services, among others.

In particular, compulsory HIV testing was also prohibited as a precondition to employment, admission to educational institutions, freedom of abode, entry or continued stay in the country, or the right to travel, the provision of medical service or any other kind of service, or the continued enjoyment of said undertakings.[42] Although the prohibition on compulsory testing admitted of enumerated exceptions[43], it recognized that persons afflicted with HIV/AIDS are not to be deprived of their enjoyment of human and civil rights and liberties.

Persons so afflicted are guaranteed their right to privacy and to object to HIV testing, unless they voluntarily submit to such testing.[44] Before a person is subjected to HIV testing, however, his/her written and informed consent must first be obtained.

Furthermore, the HIV/AIDS Prevention and Control Act also ensured that any medical records, files, data or test results are handled with a view to strict observance

of the person's confidentiality.[45] Releasing results of HIV/AIDS tests were strictly limited to the person who submitted to such test, either parent if a minor, a legal guardian in case of insane persons or orphans, person authorized to receive such results under the AIDSWATCH program or to a justice of the Court of Appeals or Supreme Court as so provided.[46] Mechanisms for anonymous HIV testing are other measures provided for to ensure confidentiality and anonymity.[47]

Duly DOH-accredited HIV testing centers, aside from warranting confidentiality and anonymity, are also required to provide and conduct free pre-test counseling and post-test services to persons who meet the DOH standards.[48]

The statute also protects the rights of those not so afflicted by obliging all persons with HIV to disclose his/her HIV status and health condition to his/her spouse or sexual partner at the earliest opportune time.[49] The law is comprehensive in its adherence to the Guidelines of the 1996 Consultation although a few changes in the law are suggested below to fine tune the rights-centered provisions of RA 8504

Nationwide Monitoring System

"AIDSWATCH" was established under the HIV/AIDS Prevention and Control Act. Its primary purpose is "to determine and monitor the magnitude and progression of HIV infection in the Philippines".[50] The AIDSWATCH, as a monitoring program, is envisioned to be instrumental in developing adequate and efficient countermeasures against the spread of HIV/AIDS in the country. The AIDSWATCH program culls reports related to HIV/AIDS from several sources, including medical records, data and files from hospitals, clinics and testing centers. AIDSWATCH receives, collates and evaluates data without compromising the confidentiality of such records.

The law however, provides no effective mechanism for the gathering of data from non-mandatory sources or from data bases not captured by the mandatory reporting requirements of existing law.

A new provision strengthening the monitoring and evaluation is proposed in a later section of this paper. To make this provision more effective, the applicable

provision in the Implementing Rules and Regulations should set up the following under the amended law:

1. A clear-cut monitoring system under a Division or branch fully answerable for the monitoring and evaluation program;
2. The establishment of a central clearing house of HIV/AIDS-related data;
3. An adequate staff complement;
4. A list of minimum competencies;
5. A requirement for specific, measurable targets and a mechanism for reporting of compliance with such targets;
6. Budgetary support; and
7. Annual reporting and accounting of accomplishments.

Penalties for failure to report, in addition to existing penalties for breaches in confidentiality should ensure adequate capture of data sufficient for program and policy projections and other related uses of the HIV/AIDS program.

Role of Local Governments

One of the most significant aspects of devolution of power and functions to local governments under the Local Government Code was the devolution of health services. Republic Act No. 7160 otherwise known as the Local Government Code of 1991 provides:

> "SECTION 17. Basic Services and Facilities. — (a) Local government units shall endeavor to be self-reliant and shall continue exercising the powers and discharging the duties and functions currently vested upon them. They shall also discharge the functions and responsibilities of national agencies and offices devolved to them pursuant to this Code. Local government units shall likewise exercise such other powers and discharge such other functions and responsibilities as are necessary, appropriate, or incidental to

efficient and effective provisions of the basic services and facilities enumerated herein.

(b) Such basic services and facilities include, but are not limited to, the following:

(1) For Barangay:

xxx xxx xxx

(ii) Health and social welfare services which include maintenance of barangay health center and day-care center;

xxx xxx xxx

(2) For a Municipality:

xxx xxx xxx

(iii) Subject to the provisions of Title Five, Book I of this Code, health services which include the implementation of programs and projects on primary health care, maternal and child care, and communicable and non-communicable disease control services, access to secondary and tertiary health services; purchase of medicines, medical supplies, and equipment needed to carry out the services herein enumerated;

(3) For a Province:

xxx xxx xxx

(iv) Subject to the provisions of Title Five, Book I of this Code, health services which include hospitals and other tertiary health services;

xxx xxx xxx"

Local governments play a key role in ensuring the institutionalization and sustainability of the response at the local level. Under Article 24 (a) of the

Implementing Rules and Regulations (IRR) of the Local Government Code (LGC), "the provision of basic services...will be devolved from the national government to the provinces, cities, municipalities and barangays so that each LGU shall be responsible for a minimum set of services and facilities in accordance with established national policies, guidelines, and standards." In addition, under (c) and (d) of the same articles, local governments are mandated to provide health and social services through "implementation of programs and projects on primary health care, maternal and child care, and communicable and non-communicable disease control services," and "programs and projects for the welfare of the youth and children, family and community, women, the elderly, and the disabled."

The Implementing Rules and Regulations of the Local Government Code likewise authorize local government units to accredit NGOs. Through the accreditation process, LGUs can identify NGOs they could work with and even fund. The basis for this could be found in Rule XIII, Article 62 of the Local Government Code of 1991 which states that: "LGUs shall promote the establishment and operation of Private Organizations, LGUs and the private sector, to make them active partners in the pursuit of local autonomy. For this purpose POs, NGOs and the private sector shall be directly involved in plans, programs, projects or activities of LGUs."

A response to HIV/AIDS concerns at the local level that captures the support and commitment of the local leadership are necessary building blocks to successful intervention.

The guidelines of the Consultation clearly require linkages with local governments for effective implementation of HIV/AIDS programs. The explosion of HIV/AIDS all over the world all the more emphasizes the need for Local Government support. A response to HIV/AIDS concerns at the local level that captures the support and commitment of the local leadership are necessary building blocks to successful intervention.

This support may be manifested by the enactment of supportive local policies such as executive orders and ordinances, and provision of funding and other

resources for initiative taken by the local HIV/AIDS network. More importantly, local government participation in a national HIV/AIDS effort could be institutionalized through coordination by all local government units, starting at the barangay level up to municipalities, cities, and provinces with a multi-sectoral regional body organizing key stakeholders directly under the PNAC or an expanded secretariat. Priority regions and local governments can be identified through the matrix of LGU vulnerability classification criteria developed for AMTP IV.[51]

Local chief executives exercise general supervision and control over all programs, projects, services and activities in their areas. Apart from their function of enforcing laws and local ordinances they implement all approved policies and programs, initiate and maximize generation of resources and revenues, and ensure the delivery of basic services and the provision of adequate facilities.

The importance of cooperation and partnership with LGU's is illustrated by the following examples cited by UNAIDS:

1. "During the early part of year 2000, The Program for Appropriate Technology in Health (PATH) carried out the AIDS Surveillance and Education Project (ASEP) in various LGUs. At the end of the PATH project, two best practices were cited. First was in education, where local officials created a scholarship fund to support high schools and college students that was by the LGU's development funds. The LGU also created a Skills Training Center to conduct informal and vocational education for out-of-school-youth. This commitment, translated to HIV/AIDS programs would ensure success in prevention and control even with limited funds. The key would be proper coordination with the PNAC, through the Department of Local Governments representative in the body."
2. "In another locality, the LGU was praised by PATH for its active and highly organized operations, which expressed its clear vision and mission. The LGU developed and regularly updated a three-year priority projects plan and created a Project Monitoring Council. This success was attributed to strong leadership."

3. "Another critical success factor was the ongoing support of FreeLAVA, an NGO active with HIV/AIDS which was cited as being the most effective NGO in the project because of its strong community building perspective."

In addition, the importance of local governments in the campaign against HIV AIDS is reflected in the primacy given to local government participation in the PNAC through the inclusion of the DILG Secretary in the Council and the Mayor's League and the League of Governors. Article IV of R.A. 8504 significantly targets local governments in the frontline of the delivery of health and support services.

Strengths: Local governments are ideally suited to form the frontline of actual delivery of health and support services. They are strategically equipped with knowledge of the health needs of their communities and have the resources necessary to deliver the range of services and activities for programs under the Aids Control Act directly to the people. However, with the exception of a few areas, this has not been the case. In fact, local government participation in the delivery of general health services, after a number of functions of the DOH were devolved following the enactment of the Local Government Code, has been dismal. Delivery of basic health services in both its preventive and curative aspects has deteriorated and there has been a clamor among local government executives to return many of the devolved health functions back to the national government through the DOH. A key element in the observed deterioration of services, likely to affect important programs for HIV/AIDS is the lack of financial support from the national government for the devolved function. Devolved services that used to be funded prior to devolution were transferred with little or even without the necessary financial complement.

Weakness: Clearly, the devolution of basic health services to local governments pursuant to the Local Government Code has not fulfilled the intent of legislation since LGUs obviously lack the logistic capability to deliver these decentralized functions, let alone services for HIV/AIDS. The other factor that affects delivery of services at this level is the level of political will exercised by local politicians in the delivery of health services. That some areas are more successful than others demonstrates that apart from financial and resource issues, if there is political will, activities related to HIV/AIDS can be carried out.

Overseas and Migrant Workers

Overseas and migrant workers currently do not compose the largest population of HIV/AIDS in the country. However, because of their exposure to HIV/AIDS in other countries and their mobility they comprise a highly vulnerable group. Out of the 1,374 reported cases of HIV/AIDS reported in the Philippines in 2000, for instance, 298 were OCWs or 20% of the total.[52] Among seamen who now number about 300,000[53], a study made by Nymia Simbulan in 1997 indicated that that knowledge levels about HIV/AIDS were low.[54] In spite of this fact, the same study observed exceptionally high risk sexual practices within this population.[55] Many of those who actively engage in high risk behavior were unprotected and knowledge of the benefits of protection, such as condom use was low.[56]

OCW's are at great risk for contracting HIV/AIDS for a variety of reasons. Solon and Barrozo identify some of the factors as follows:

1. Many OCWs work in occupations considered high risk, e.g. entertainers and service workers, including some as prostitutes;
2. OCWs with questionable travel papers are vulnerable to sexual exploitation and abuse; and
3. Many workers, especially sea-based workers, may be prone to engaging in high risk sexual activities, engaging in MSM relations or having multiple partners.

Many of those exposed are potentially sources of disease spread particularly since returning OCW's are not required to undergo HIV testing and oftentimes, many of those who return to their work places within their contract periods are likewise not required to undergo tests. With their number and mobility, HIV/AIDS within the OCW sector potentially imposes substantial external and internal costs on society.

The cost to the economy of an explosion of HIV/AIDS from the OCW sector is expected to be huge. These costs have been identified[57] as:

1. Direct costs of avoidance and preventive measures;
2. Direct costs in testing and out patient care;
3. Direct cost of in patient care;

4. Direct funeral costs.

Identified indirect costs include reduced productivity, the reallocation of labor and other productive assets, reallocation of labor for health maintenance, disutility, poor health of surviving family members, etc.[58] These costs do not factor the macro economic consequences of putting back into the local labor forced HIV sufferers among OCWs and the obvious reduction in foreign currency remittances.

Curiously, the estimated (Solon and Barrozo) number of OCW deaths utilizing EPIMODEL projections would have been 2,200 at the end of 2005. Like Chin's modeling projections[59] discussed earlier, the estimate greatly exceeds actual figures from the DOH. Solon and Barrozo however concede that their projections are "severely limited" by lack of data, among other factors.

Evaluation, Policy and Legislative Proposals:

At the level of the DOLE and other government agencies involved in the regulation of the hiring and contracting of overseas workers the following measures are required. For affectivity, they must be reflected in existing law (the Labor Code, the Migrant Workers Act) and in agency rules and regulations:

1. The imposition of stiff penalties on recruiting agencies and government personnel that violate existing labor migration laws and policies;
2. The requirement of full (universal) medical and health insurance from all foreign employers for Filipino workers especially domestic helpers through their recruitment agencies in the Philippines. This last portion is important for effectiveness, otherwise the rule will be observed only in the breach.
3. The imposition of mandatory HIV/AIDS testing as part of the health clearance package of all OCW's. The testing must be accompanied by adequate pre- and post testing counseling and mandatory reporting. Violators should have accreditation withdrawn.
4. The institutionalization of partnerships and collaborative programs with Filipino communities and other civic, religious and development organizations of host countries abroad to help protect the rights and welfare

of OFW's. These communities may be encouraged to provide orientation seminars on health, labor and other topics that migrant/mobile worker need to ensure their comfort, safety and security; and

5. The institutution of bilateral agreements with host countries for the purpose of acquiring accurate information of Filipino OCW's with HIV/AIDS under conditions of iron clad confidentiality and adopt memoranda of agreements with such countries for a uniform standard of reporting, surveillance and sharing of information;
6. The strengthening of training and education programs for overseas workers and their families, by requiring HIV/AIDS education as a necessary part of pre-departure orientation;
7. The identification of the sectors of overseas workers/seamen susceptible to HIV/AIDS infection through baseline and needs assessment studies; and
8. The intensification of surveillance efforts within these populations.

The significant growth in the number of OCW's afflicted by HIV/AIDS raises genuine concerns because of the large number of overseas workers in the country and the importance of this sector in our economy. This importance cannot be underestimated. After economists at the University of the Philippines warned about a burgeoning fiscal crisis potentially equaling the crisis that befell Argentina, members of the U.P. group underscored that the only factor that has so far prevented the country's economic collapse were the remittances from Filipino OCW's. With decreased productivity, decreased exports, and a fall in investments resulting from the protracted political crisis in the country, the economy has become even more heavily reliant on foreign remittances.

The economic factor affects government policies in a real sense. Men and women employed overseas belong to the most productive age group and represent substantial amounts of human capital.[60] Activities that pose a threat to this sector by either restricting further growth or by reducing the well of OCW remittances are either glossed over or frowned upon. In spite of evidence to the contrary, for example, government policy makers in foreign affairs and labor have managed to take a "see no evil hear no evil" approach in the area of Filipino workers in Japan, predominantly

female. Government efforts to try to find a way around new restrictions in Japanese immigration laws aimed at curbing trafficking in women clearly demonstrate how the country's policies in the area are blindsided and corrupted by the economic windfall from the OCW sector.

One area that cannot be glossed over in the fight against HIV/AIDS, government policies on OCWs notwithstanding is the area concerning the noticeable growth of OCWs afflicted with HIV/AIDS. A factor that would serve as impetus for government policy makers is the potential effect on an economy hugely dependent on the export of labor were an HIV/AIDS explosion to happen. HIV/AIDS affects overseas workers, and their families directly in terms of the cost of care, the cost of displacement, reduced income etc. HIV/AIDS imposes three categories of costs on the Philippine economy,[61] which are summarized, as follows:

1. "The costs representing resources used to provide medical care and the income foregone as the workers fall ill and die of AIDS;
2. The external costs imposed by those infected with HIV and AIDS who knowingly and unknowingly transmit the virus to others; and
3. The inefficiencies imposed by HIV infection and AIDS on the labor market as workers find working abroad less desirable and as overseas employers reorient their recruitment efforts to less risky pools of labor."[62]

The direct economic impact of HIV/AIDS based on a typology devised by Over, et.al. in 1991 are summarized in the following table.

These direct economic costs do not factor the impact of an AIDS explosion if foreign employers would look elsewhere. The burden on overall employment by the influx of displaced OCWs management of the HIV/AIDS. A coherent, workable and enforceable policy on HIV/AIDs clearly reflected and enforced through new or amendatory legislation is therefore urgently needed.

Strengths: The biggest strength of the OCW group is that it is potentially one of the most organized and identifiable sectors. Proper coordination with crewing, manning and recruitment agencies by government agencies provides a pool of fairly accurate data for screening and monitoring. If suitably targeted information and surveillance campaigns in HIV/AIDS

Drug Availability: Antiretrovirals and Supportive Treatment

This discussion on the inadequacy of provisions in RA 8504 on ARVs and supportive medical treatment in HIV/AIDS should be taken in the context of the overall national problem of the high cost of branded drugs in the Philippines when compared to India and Thailand. Discourse of the problem and possible changes in policy and legislation affecting the issue of the cost of all branded drugs is properly the subject of a paper comprehensively dealing with the drug availability and cost problem and its trade and intellectual property ramifications.

As it were, the principal HIV/AIDS issue in a "low and slow" progression country like the Philippines is the issue of monitoring and surveillance and the existence of a working and effective national structure. In areas with a high incidence of HIV/AIDS such as West and South Africa, Thailand and India, the issue of availability of drug treatment, given the high incidence rates and the direct social and economic impact of the disease, availability of ARVs and the consequent issues relating to intellectual property rights are at the forefront. Nonetheless the most vulnerable groups affected by HIV AIDS in the Philippines are those who could least afford ARVs and supportive treatment. Within this context, the author discusses some of the problems arising out of the lack of ARV and drug availability provisions in the evaluation of the AIDS law.

Antiretrovirals are an important factor in the crusade against HIV/AIDS. Since their introduction in the mid-eighties, the use of ARVs has slowed down the progression from HIV to full blown AIDS and has been vital in the treatment and the maintenance of the quality of life of people with HIV/AIDS. Apart from their direct effect in treatment, ARVs have also helped in bringing down barriers against people with AIDS reducing the fear associated with the disease and enabling individuals with HIV/AIDS to maintain normal lives. ARVs offer the promise of making AIDS a manageable chronic disease resulting in the restoration of economic productivity and social functioning. These effects, however only occur where resources are available to make the drugs affordable and where health services capacities exist to enable sustained, safe and effective use.

However, while the approach to HIV/AIDS in many areas has been largely progressive and forward thinking, even international efforts to have HIV/AIDS drugs available at affordable levels has been essentially conventional and disappointing. For example, the UNGASS statement on states' pharmaceutical policies in HIV/AIDS has tiptoed around the interests of multi-national companies. In spite of increasing demands from developing countries and the third world to create exceptions from international commitments in intellectual property law given the uniqueness of the HIV/AIDS problem, because of the persistent lobbying effort from the United States and western multinational pharmaceutical interests, the UNGASS statement on ARVS amounted to a mere motherhood statement:

> "[T]o cooperate constructively in strengthening pharmaceutical policies and practices, including those applicable to generic drugs and intellectual property regimes, in order further to promote innovation and the development of domestic industries consistent with international law."[63]

HIV/AIDS Drugs

- ARVs to treat clinical AIDS
- ARVs for preventing mother to child transmission
- ARVs for needle stick prophylaxis
- ARVs for HIV patients to prevent or slow progression to AIDS
- Drugs to prevent opportunistic infections
- Drugs for palliative and supportive care
- Treatment of sexually transmitted infections (STI) to reduce HIV transmission
- Drugs to treat HIV related cancers

HAIN in the 2000 study "A Matter of Time," estimated that the annual cost of the use of ARVs for HIV/AIDS patients would be about PHP 360,000 a year for antiretrovirals alone. Patients with the full-blown syndrome will have to fork about Php 2000 a day for medications directed against opportunistic infections. The annual cost for laboratory examinations would be another Php 50,000.00. Translated into

today's peso value the cost/year for a patient with AIDS, discounting costs of hospitalization, would be:

Expense	Cost
Monitoring Costs	Php60,000.00/year
Medications forr Opportunistic Infections	Php2,500.00/day
Antiretrovirals	Php410,000.00/year

The estimate uses the cost of branded medications. From the figures discussed above, the use of branded medications is plainly out of the reach of most AIDS sufferers who come from the lower socio economic sectors of society. Dr. Roderick Poblete of the PNAC Secretariat estimates that were AIDS sufferers to use non-branded drugs brought in from India or Thailand, the ARV cost would drop from Php410,000.00 to around Php40-45,000.00 per year, a reduction of 90%. Even with this value, the toll on the household and the community is great.

Moreover successful management of cases of AIDS with ARVs is not that simple. The estimated monitoring costs listed above do not reflect the ideal situation where viral load monitoring, CD-4 cell counts, blood chemistry, transport and outpatient consultations are included. Specific services and facilities must exist and be in place before considering ARV treatment because of the complexity of treatment, the need for careful follow-up, and monitoring and the high cost not only of the ARVs themselves but of the treatment of opportunistic diseases. Incorporating a provision in the law providing for better access to ARVs requires a health system ready to embark on the actual treatment with the ARVs, with resources to pay for long term treatments, training of professionals and coordination and planning with PHLAs and other sectors. The Act in its current form does not embody these requirements.

Treatment, Care and ARVs in R.A. 8504

RA 8504 contains no specific provisions for Antiretrovirals. The general provisions on treatment and care are found in Sections 22 and 23 quoted hereunder:

SECTION 22. Hospital-Based Services. — Persons with HIV/AIDS shall be afforded basic health services in all government hospitals, without prejudice to optimum medical care which may be provided by special AIDS wards and hospitals.

SECTION 23. Community-Based Services. — Local government units, in coordination and in cooperation with concerned government agencies, non-government organizations, persons with HIV/AIDS and groups most at risk of HIV infection shall provide community-based HIV/AIDS prevention and care services.

Note that Section 22 provides a guaranty for "basic health services." There is a world of difference between basic health services and adequate health services for HIV/AIDS. Basic health services differ from locality to locality. The further one may be from large urban centers, the basic health services deteriorate in amount, quality and type. Basic health services in certain localities may be grossly inadequate for even the simplest sequelae of HIV/AIDS. It is suggested that Section 22 be amended as follows:

SECTION 22. Hospital-Based Services. — Persons with HIV/AIDS shall be afforded ~~basic~~ adequate health services in all government hospitals, without prejudice to optimum medical care which may be provided by special AIDS wards and hospitals.

This amendment is an important prelude to a new provision that addresses the issues raised with respect to ARVs. Amendatory laws on the HIV/AIDS Prevention and Control Act must approach the problem of procurement of ARV drugs and medicines with a view on realizing and respecting national rights and obligations under the DOHA declaration on the importation of ARVs, TRIPS and WTO agreements. Concomitant with this, changes must also be made to laws on the drug procurement, specifically Republic Act No. 8203 or the Act Prohibiting Counterfeit Drugs.

Obstacles

The country's national drug policies have to be adapted to reflect the needs of the HIV/AIDs program. The most important need in the area of care and treatment is the requirement for affordable ARVs. Under our current laws and international commitments the only way to secure affordable ARVs from countries that manufacture them are through the backdoor. This is inefficient and improper and will not sustain the demands of an effective drug distribution policy.

The Philippine Intellectual Property Code has, pursuant to the country's obligations under the Agreement on Trade-Related Intellectual Property Rights (TRIPS), reflected detailed obligations for protecting patent rights. Under provisions of the Intellectual Property Code the country would not be able to import affordable drugs from countries like India and Thailand where the importation would amount to a violation of the country's international commitments in the realm of intellectual property rights. However TRIPS does not establish a uniform international law and WTO member countries may legitimately enact laws and regulations that ensure a balance between minimum requirements for intellectual property protection and the public welfare. For this purpose, the following new provision after Section 23 is hereby suggested:

> SECTION 23. National Drug Policy for HIV/AIDS — The Philippine National Aids council shall adopt and implement a comprehensive national drug policy for the procurement and efficient distribution of cheap and affordable Antiretroviral drugs (ARVs) in coordination with the Department of Finance and the Bureau of Food and Drugs (BFAD) of the Department of Health. For this purpose, the PNAC shall explore all means consistent with the country's international commitments, including but not limited to parallel importation, for the procurement of ARVs. PROVIDED THAT: the BFAD and the Department of Finance shall together with the PNAC cooperate to enact mechanisms in the Implementing Rules and Regulations to avoid unreasonable delay and ensure effective procurement, clearance and distribution of Anti-Retroviral Drugs.

Evaluation and Recommendations for Specific Provisions of RA 8504

1. Section 2. Declaration of State Policies
   i. Education and information are the primary step in containing the further spread of HIV/AIDS. Providing timely, accurate, adequate, appropriate and relevant HIV education and information shall empower persons and communities to think and act in ways that protect themselves from HIV infection, minimize the risk of HIV transmission and decrease the socio-economic impact of HIV/AIDS.[64] Section 2 of R.A. 8504 and its counterpart provisions in the IRR adequately address this need.
   ii. Section 2 (b) relates to human rights and civil liberties. For symmetry, Sec. 2 (b) (4) should be taken out and made a separate provision [the new Sec. 2 (c)] as follows: "The State shall provide *adequate* health and social services for individuals with HIV. *Towards this end the State shall ensure adequate distribution and availability of affordable drugs for the treatment and care of HIV/AIDS.*"
2. Section 3. Definition of Terms (Note: additional definitions in the proposed law.)
3. Section 4. Education and Information
   a. Budgetary allocation

   The National HIV/AIDS Education and Information Program is aimed at extending information as a part of government health services through instruction in schools and in the workplace, including for Filipinos going abroad and for tourists and transients entering the country. These programs disseminate basic information on HIV/AIDS like its definition and differentiation between HIV and AID, its causes, modes of transmission and ways of prevention.

   Alarmingly, in spite of RA 8504, lack of information on HIV/AIDS is widespread. While there is general knowledge about AIDS, only about half are aware of the two major methods of preventing HIV/AIDS, namely, condom use and limiting sex to one uninfected partner.

Under the law, the Department of Education, CHED and TESDA are tasked with the integration of "instruction on causes, modes of transmission and ways of preventing HIV/AIDS ...in subjects taught in public and private schools" at all levels. In various consultations during the study, it was repeatedly mentioned that the integration has not reached most of the target sectors or to the levels of actual integration and implementation, and, as found in the above-cited studies, misconceptions and lack of information on HIV/AIDS are high. Most of the training and development allocations came from PNAC budgets To rectify this situation the new provision should contain specific budgetary allocation for DECS, CHED and TESDA. Further, the new IRR should mandate that accreditation criteria for institutions under these departments and agencies should include compliance with HIV/AIDS education and information requirements. Section 4 (now Section 5) should read as follows

Section 5. HIV/AIDS Education in Schools. — The Department of Education, Culture and Sports (DECS), the Commission on Higher Education (CHED), and the Technical Education and Skills Development Authority (TESDA), utilizing official information provided by the Department of Health, shall integrate instruction on the causes, modes of transmission and ways of preventing HIV/AIDS and other sexually transmitted diseases in subjects taught in public and private schools at intermediate grades, secondary and tertiary levels, including non-formal and indigenous learning systems. For this purpose, the Department of Education, Culture and Sports (DECS), the Commission on Higher Education (CHED), and the Technical Education and Skills Development Authority (TESDA) shall earmark from their annual budget adequate funds for education, information, training and integration:

b. Neutral content

The latter part of Section 4 (Section 3) should be content-neutral. The law should not be concerned with the incidental effect on governmental programs, like population control, that are heavily influenced by the sectarian lobby. The goal of the law is effective AIDS policy. Provided there are multisectoral consultations, consent of sectarian school officials shall not be necessary. The latter part of Section 4 (Section 5) should read:

> Provided, That if the integration of HIV/AIDS education is not appropriate or feasible, the DECS and TESDA shall design special modules on HIV/AIDS prevention and control: Provided That all materials used in HIV/AIDS education are appropriate for age and purpose.
>
> Flexibility in the formulation and adoption of appropriate course content, scope, and methodology in each educational level or group shall be allowed after multi-sectoral consultations. As such, no instruction shall be offered to minors without adequate prior consultation.
>
> All teachers and instructors of said HIV/AIDS courses shall be required to undergo a seminar or training on HIV/AIDS prevention and control to be supervised by DECS, CHED and TESDA, in coordination with the Department of Health (DOH), before they are allowed to teach on the subject.

4. Section 5. One of the issues raised by some of those interviewed in the course of research for this paper was the absence of iron-clad confidentiality in the previous handling by all sectors in the health community of patient information and data. To emphasize the necessity of iron-clad confidentiality as a factor not only in treatment and respect for human rights but also in drawing out those afflicted with HIV/AIDS, the training of all health workers should emphasize the importance of confidentiality and the consequences of breach of confidentiality. Thus:

> SECTION 6. HIV/AIDS Information as a Health Service. — HIV/AIDS education and information dissemination shall form part of the delivery

of health services by health practitioners, workers and personnel. The knowledge and capabilities of all public health workers shall be enhanced to include skills for proper information dissemination and education on HIV/AIDS. It shall likewise be considered a civic duty of health providers in the private sector to make available to the public such information necessary to control the spread of HIV/AIDS and to correct common misconceptions about this disease. The training or health workers shall include discussions on HIV-related ethical and human rights issues and emphasize confidentiality, informed consent and the duty to provide treatment.

5. Section 6 (Section 7).
6. Section 7 (Section 8) The current provision bundles together education and information programs for all Filipinos working abroad including diplomatic, labor, trade and other government officials working abroad. The special issue of overseas workers as an important component in the HIV/AIDS campaign shall be discussed separately. However, the current provision should be cut into two sections, to wit:

SECTION 7. HIV/AIDS Education for Filipinos Going Abroad. — (a) Overseas Workers .The State shall ensure that all overseas Filipino workers shall undergo or attend a seminar on the cause, prevention and consequences of HIV/AIDS before certification for overseas employment. The Department of Labor and Employment and the Philippine Overseas Employment Administration in collaboration with the Department of Health (DOH), shall oversee the implementation of this Section. For this purpose, the Philippine Overseas Employment Administration or the Department of Labor shall allocate, from fees paid by Filipino overseas workers, a fund for education, information and counseling on HIV/AIDS.

(b) Government Officials and Employees. The State shall ensure that all diplomatic, military, trade, and labor officials and personnel to be assigned overseas shall undergo or attend a seminar on the cause, prevention and consequences of HIV/AIDS before assignment or posting abroad. The Department of Foreign Affairs, in the case of diplomats, consuls and other DFA employees, or the concerned department or agency shall coordinate with the Department of Health for the purpose of implementing this section.

7. Provisions on Safe Practices:

Universal precaution through safe practices and procedures is the basic standard of control of HIV/AIDS infection.[65] Article II of the Act directs mandatory testing by laboratories and institutions before accepting donations of blood, tissues and organs. Through the Department of Health, manuals and guidelines for various surgical, dental and other procedures were issued as standards for the prevention of HIV transmission. Violations or non-compliance with recommended universal precautions so provided were meted with penalties of imprisonment, and possible administrative sanctions like fines, suspension or revocation of license or permit.

In practice, many of the guidelines found under Section 13 of the Act are observed only in the breach. The guidelines have not been widely disseminated and there is very little literature available in dental clinics, laboratories, etc. that provide adequate instruction about precautions against HIV transmission during surgical, dental, embalming, tattooing or similar procedures. This problem requires more than amendments to Section 12 and Section 13 of the law but a structural change that would allow the PNAC to take charge of a revitalized campaign for safe practices and procedures on its own without budgetary dependence on the DOH. With a stronger structure supported by its own budgetary allocation, there should be no need to amend provisions under Article II of the Act.

8. Special Situations:

No presumption exists against the Right to Privacy. Confidentiality is required *in many situations not only as a guarantee arising from the right itself but also* because, without confidentiality, reasonable disclosure required for medical, legal, business and other transactions would be unavailing. A doctor requires all the facts necessary to come up with a proper diagnosis and treatment plan. To serve his client well, the lawyer must have all the information available to build a proper case or defense.

The situations mentioned in Section 15 of RA 8504 require the guarantee of utmost privacy. However, the provisions are not narrowly drawn to enable donors to maintain privacy. If a donor knows that he would be subject to posthumous testing, possibly subjecting him or his family to ridicule, he would decline to donate. Since there is no presumption against the right to privacy, the presumptions created by Section 15 are troubling and problematic. Section 15 should either be amended, or the instrument of donation should make it clear that the donor would be subject to HIV testing at a time when he would not be able to give consent, i.e., upon organ harvesting when he is dead. Section 15 provides:

> SECTION 15. Consent as a Requisite for HIV Testing. — No compulsory *HIV testing shall be allowed. However, the State shall encourage* voluntary testing for individuals with a high risk for contracting HIV: Provided, That written informed consent must first be obtained. Such consent shall be obtained from the person concerned if he/she is of legal age or from the parents or legal guardian in the case of a minor or a mentally incapacitated individual. Lawful consent to HIV testing of a donated human body, organ, tissue, or blood shall be considered as having been given when:
>
> (a) a person volunteers or freely agrees to donate his/her blood, organ, or tissue for transfusion, transplantation, or research;

(b) a person has executed a legacy in accordance with Section 3 of Republic Act No. 7170, also known as the "Organ Donation Act of 1991";
(c) a donation is executed in accordance with Section 4 of Republic Act No. 7170.

Amended as follows:

SECTION 15. Consent as a Requisite for HIV Testing. — *Compulsory HIV testing shall be allowed only in cases provided by law.* However, the State shall encourage voluntary testing for individuals with a high risk for contracting HIV: Provided, That written informed consent must first be obtained. Such consent shall be obtained from the person concerned if he/she is of legal age or from the parents or legal guardian in the case of a minor or a mentally incapacitated individual. *Consent to HIV testing of a donated human body, organ, tissue, or blood for transfusion, transplantation or research, or in accordance with a donation or legacy under Section 3 or Section 4 of Republic Act No. 7170 also known as the "Organ Donation Act of 1991," shall not be presumed unless the instrument of donation clearly provides that the donated organ may be tested for HIV/AIDS during the lifetime of the donor or posthumously.*

9. Pre-and Post Test Counseling

The current provision on pre-and post test counseling lacks teeth. This observation has been pointed out in talks with stakeholders and at the Roundtable Discussion at the Ateneo Human Rights Center on July 2006. The following amendments are hereby proposed:

SECTION 19. Accreditation of HIV Testing Centers. — All testing centers, hospitals, clinics, and laboratories offering HIV testing services

are mandated to seek accreditation from the Department of Health. *In addition to the requirement for pre-test and post-test counseling under Section 20 of this Act no testing center, hospital clinic or laboratory offering HIV testing shall be accredited without meeting and maintaining reasonable accreditation standards set by the Department of Health.*

SECTION 20. Pre-test and Post-test Counseling. — All testing centers, clinics, or laboratories which perform any HIV test shall be required to provide and conduct free pre-test counseling and post-test counseling for all persons who avail of their HIV/AIDS testing services. However, such counseling services must be provided only by persons who meet the accreditation standards set by the DOH. *Failure to perform proper pre-test and post test counseling services shall result in withdrawal of accreditation, in addition to other penalties and fines imposed under this Act, its Implementing Rules and Regulations and other Laws.*

10. Confidentiality

Section 28 is hereby amended as follows:

SECTION 28. Reporting Procedures. — All hospitals, clinics, laboratories, and testing centers for HIV/AIDS shall adopt measures to ensure reporting of all cases of HIV/AIDS. They shall observe iron-clad confidentiality in the reporting and handling of any medical record, personal data, file, including all data which may be accessed from data banks or information systems. The Department of Health through its AIDSWATCH monitoring program shall receive, collate and evaluate all HIV/AIDS related medical reports. The AIDSWATCH data base shall utilize a coding system that promotes client anonymity. *Any person having temporary or permanent custody of the record of HIV/AIDS patients who through an act or omission causes a breach in confidentiality shall be subject to the penalties imposed under Section 33 of this Act.*

The last sentence, which is not found in the current Act, is intended to give more teeth to measures providing for confidentiality under R.A. 8405. In spite of these provisions, violations of confidentiality are rampant in centers dealing with HIV/AIDS.

11. Government Services.

a. Hospital-Based Services.

The insufficient number of doctors trained in the treatment of HIV/AIDS poses a multitude of problems for persons with HIV/AIDS, especially for those living in the provinces. Presently, doctors with expertise on therapy and treatment of HIV/AIDS are scarce with most of them based in Manila. General medical practitioners and hospital staff must be trained in particular skills in responding to the specific medical needs of persons living with HIV/AIDS. A manual for hospitals shall be established that will serve as a guide in the treatment of PLWHA's.

> SECTION 22. Hospital-Based Services. — Persons with HIV/AIDS shall be afforded health services in all government hospitals, without prejudice to optimum medical care which may be provided by special AIDS wards and hospitals. A manual on the Standard Operating Procedures (SOP Manual) for the provision of a comprehensive and compassionate hospital-based care services for PLWHAs shall be developed by the PNAC, through a Committee.

b. Community-Based Services.

Community-based services in local government units are underutilized institutions in responding to the HIV/AIDS problem. The formulation of local policies and structures to address the HIV/AIDS problem is critical in guaranteeing the sustainability of local responses. By coordinating the efforts of local leaders, communities and other stakeholders at the local level, their appreciation of the

value of implementing effective prevention programs against HIV/AIDS is deepened. It is essential to house the local response with a certain organizational structure that will facilitate the visibility of the response and will also serve as the physical center of the response.

> SECTION 23. Community-Based Services. — Local government units, in coordination and in cooperation with concerned government agencies, non-government organizations, persons with HIV/AIDS and groups most at risk of HIV infection shall provide multi-sectoral education and information campaign and community-based HIV/AIDS prevention and care services. Each local government unit shall determine and institute a local body that shall be responsible for developing local services and programs.

12. Insurance for Persons with HIV

One of the guiding principles of HIV/AIDS prevention and control legislation is ensuring that the rights of PLWHA's are not impaired. Insurance policies coverage must reasonably include HIV/AIDS, if it is contracted or acquired after procurement of the policy. Discrimination solely based on HIV/AIDS in insurance policies should be prohibited as a violation against their right to health. The new provision reinforces the prohibition under Section 39 against exclusion of PLWHAs from insurance services.

> SECTION 26. Insurance for Persons with HIV. — The Secretary of Health, in cooperation with the Commissioner of the Insurance Commission and other public and private insurance agencies, shall conduct a study on the feasibility and viability of setting up a package of insurance benefits and, should such study warrant it, implement an insurance coverage program for persons with HIV. No PLWHA shall be denied coverage of an insurance policy solely based on his/her actual, perceived or suspected HIV/AIDS status. The study shall be guided by the

principle that access to health insurance is part of an individual's right to health and is the responsibility of the State and of society as a whole.

13. Monitoring Program.

The collation of data on HIV/AIDS in the country is sporadic and uncoordinated. A central clearing house of all HIV/AIDS data must be established in order to provide a comprehensive picture of the HIV/AIDS situation in the Philippines and to help in determining appropriate both national and local responses.

SECTION 27. Monitoring and Evaluation Program. — A comprehensive HIV/AIDS monitoring program shall be established under the Philippine National AIDS Council to determine and monitor the magnitude and progression of HIV infection in the Philippines, the adequacy and efficacy of the countermeasures being employed against HIV/AIDS and for monitoring and evaluating the actual over-all national response to existing programs. The Philippine National AIDS Council shall be the repository and clearing house of all data collected by the monitoring and evaluation program.

14. Contact Tracing.

Contact tracing under the current law is merely directory. Mandatory contract tracing by the Philippine National AIDS Council will contribute to necessary information and data that will be beneficial in providing a comprehensive response in favor of PLWHAs and their families.

SECTION 29. Contact Tracing. — The Department of Health is required to pursue HIV/AIDS contact tracing and all other related health intelligence activities: Provided, That these do not run counter to the general purpose of this Act: Provided, further, That any information gathered shall remain confidential and classified, and can only be used for statistical and monitoring purposes and not as basis or qualification for any employment, school attendance, freedom of abode, or travel.

CONCLUSION

International discourse over HIV/AIDS has gathered both theoretical momentum and practical value over the last twenty five years. Throughout this discourse, the language of human rights in HIV/AIDS policy formulation and national health legislation has been central, such as even the debate about access to ARVS has been largely cast in human rights terms. "Soft-law" rules rather than conventional legislation"[66] formulated by expert committees has largely dominated policy formulation in HIV/AIDS.[67] While policy formulation at the international level has been mainly anchored on "soft law" rules, UNDP, UNAIDS, the WHO and other international agencies focusing on the problem of HIV/AIDS has encouraged national governments to reflect much of these tested rules in national legislation for better enforceability.

RA 8504 remains a model piece of legislation absorbing many of the "best practices" cited in the international discourse on HIV/AIDS by international conferences on the subject. This paper is a modest attempt at looking closely into the provisions of the law, its strengths and weaknesses. On the basis of the author's analysis of the law, it is proposed that any amendments to the law center on the following areas:

1. The possibility of putting the HIV/AIDS effort under a new agency attached to the DOH and the Department of Finance simply for the purpose of policy coordination;
2. The streamlining of the PNAC and the strengthening of the PNAC secretariat to enable it to carry out the task of coordinating the multi-sectoral HIV/AIDS effort and to strengthen surveilance;
3. The inclusion of provisions that would realistically allow access by HIV/AIDS sufferers to affordable ARVs and supportive drugs.

Notes

1 *R.A. 8504: Where are we now? A Candid Snapshot of Philippine Observance of International Guidelines on HIV/AIDS and Human Rights*, Alterlaw, 14 (2003).

2 *Id.*

3 Avila, R., *The Human Rights Effect of the Public Health Response to the AIDS Epidemic, Balancing Society's Concerns Against Patient and Individual Rights*, 67 Phil. L. J. 125 (1992).

4 For instance, the law provides for strong educational and surveillance measures to deal with HIV/AIDS. However, the UN Theme Group on AIDS reports that "institutional mechanisms for wide-scale and sustained information dissemination on HBIV/AIDS are not yet in place." CASUALTY ANALYSIS OF THE HIV/AIDS SITUATION IN THE PHILIPPINES, 6 (2003).

5 *HIV/AIDS in the Philippines: Keeping the Promise* 5 (UNAIDS, 2005).

6 The first two cases of HIV/AIDS in the country were a commercial sex worker and an overseas contract worker.

7 J. Chin and S.K. Lwanga, *Estimation and Projection of Adult AIDS cases: A Simple Epidemiological Model*, 69(4) Bulletin WHO 399-406 (1991)

8 A number of important variables are necessary for modeling projections. Key information on sexual behavior, a necessary variable, is, for obvious reasons limited in the Philippines. Ramanathan and Hardon warn that inappropriate use of modeling techniques in a low-prevalence situation will not accurately predict the course of an epidemic. Moreover, Ramanathan cautions that "[e]very modeler will come up with his own model and these are often not replicable" *A Matter of Time, HIV/AIDS and Development in the Philippines* 14 (UNDP, 2000).

9 Underreporting is likewise being blamed for the absence of Bird Flu cases in the Philippines.

10 *Id*, at 12 .Interview with Dr. Roderick Poblete of the PNAC Secretariat.

11 The highest recorded number of admissions at San Lazaro Hospital was 263 in 1995. At the Research Institute for Tropical Medicine, the biggest number of admissions was 193, in 1999. *Id.*

12 *HIV/AIDS in the Philippines: Keeping the Promise*, in the UNAIDS PRIMER ON THE UNGASS DECLARATION OF THE COMMITMENT ON HIV/AIDS 6 (UNAIDS 2001).

13 The problem is not exclusive to the Philippines: '[M]any national AIDS programs have sought to involve ministries other than health (education, communication, defense, etc.) in HIV/AIDS work. Too often however, this has involved only superficial and token measures, such as including a few words about HIV/AIDS in an existing brochure published by another ministry. AIDS IN THE WORLD II, 460 (1996).

14 *Id.*

15 The 2004 STI/HIV/AIDS Technical Report revealed increasing patterns of STI rates among selected groups. With females being at greater risk.

16 In Africa, for instance, countries that were able to respond early to the HIV/AIDS problem have lower prevalence rates. A good example is Senegal, with an infection rate of 2% as opposed to 25-35% reported from other southern African countries. *Supra*, note 3 at 22.

17 FIDLER, D. INTERNATIONAL LAW AND INFECTIOUS DISEASES, 249 (1999).
18 *See,* SHILTS, R., AND THE BAND PLAYED ON, 1985, for an early anecdotal history of the AIDS Epidemic and the early government response to HIV/AIDS.
19 *Id. See also,* WILSON T, ENGENDERING AIDS: DECONSTRUCTING SEX, TEXT AND EPIDEMIC 1 (London: Sage 1997).
20 Glynn M. Rhodes, Estimated HIV Prevalence in the United States at the end of 2003. National HIV Prevention Conference, June 2005, Atlanta Abstract 595.
21 The prevalence of IV drug use and needle sharing is very low in the Philippines.
22 *Id.* The third biggest category of cases come from Men Having Sex with Men in combination with intravenous drug use. *Id.* Curiously, among individuals infected through heterosexual contact, females outnumber the men indicating vulnerability to exposure.
23 *Nobel and State Bank vs. Haskell,* 219 US 112 (1911).
24 *Smith, Bell and Co. vs. Natividad,* 40 Phil. 136 (1919).
25 155 S.W. 2d., 719, 721 (1941).
26 *Id.*, at 57.
27 *Id.*
28 *Mandatory Aids Testing* (note), 43 Vanderbilt L.R., 1607, 1617 (1990).
29 L. JOHNSON, PARTICULAR ISSUES IN PUBLIC HEALTH: INFECTIOUS DISEASES, 255 (2001).
30 BRANDT A., NO MAGIC BULLET: A SOCIAL HISTORY OF VENEREAL DISEASE IN THE UNITED STATES SINCE 1889, Oxford: OUP, 199-204 (1984).
31 Osborne, Aids: Politics and Science, 318 N. Eng J Med 444 (1988).
32Focused policies for MSMs, OCWs, for example, contrast this approach with the policy enunciated by the Philippine Supreme Court in *Villaflor vs. Summers,* 41 Phil. 62 (1920) and *Villavicencio vs. Lukban,* 39 Phil, 778 (1919).
33 *See supra,* Note 3.
34 *Supra,* note 29, at 255.
35 *Id.,* citing Department of Health, The Health of the Nation: A Strategy for Health in England, 1992, London HMSO.
36 RA 8504, Section 2 (a)
37 RA 8504, Section 2 (a)
38 Local Governance & HIV/AIDS: A Guide Book, POLICY Project The Futures Group International (December 2003).
39 4th AIDS Medium Term Plan 2005-2010, p. 9 (2005).
40 *Id.*
41 Very early in the history of HIV/AIDS in the Philippines the DOH rejected mandatory testing as a public health tool. Routine tests usually yield a good number of false negatives. Even if a person may be infected, antibodies take time to appear in the bloodstream creating a "window period" in which HIV may not appear utilizing well-known tests. Rejection of mandatory testing is only one example of this respect for human rights. RA 8504 comprehensively addresses discrimination in schools and in the workplace, among other protections.
42 RA 8504, Section 16.
43 RA 8504, Section 17.

43 RA 8504, Section 17.
44 RA 8504, Section 15.
45 RA 8504, Section 30.
46 RA 8504, Section 32.
47 RA 8504, Section 18.
48 RA 8504, Section 20.
49 RA 8504, Section 34.
50 RA 8504, Section 27.
51 Supra, note 27, at 41.
52 Supra, note 4, at 41.
53 The actual number is estimated to be double the official count if informal undocumented OCWs are included.
54 N. Simbulan, et. Al. *The Seafaring Population in the Philippines: Their Lifestyles and Work Environment.* 3 (1) UP Manila J. 18-30 (1997).
55 *Id.*
56 *Id.*
57 *Id.*
58 *Id.*
59 Note 6, supra.
60 Orville Solon and Angelica O. Barrozo, *Overseas Contract Workers and the Economic Consequences of the HIV and AIDS in the Philippines* in ECONOMIC IMPLICATIONS OF AIDS IN ASIA 111 (UNDP, 1993).
61 *Id.* At 112.
62 *Id.*
63 United Nations General Assembly Special Session (UNGASS) on HIV/AIDS, 25-27 June 2001.
64 RA 8504 Implementing Rules and Regulations, Section 6.
65 RA 8504 Implementing Rules and Regulations, Section 21.
66 Vignes, C. *The future of international health law: WHO perspectives* 40 International Digest of Health Legislation, 16 at 18 (1989).
67 *Id.*