5th AIDS Medium Term Plan

2011-2016 Philippine Strategic Plan on HIV and AIDS

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FOREWORD

Towards the end of the implementation of the Fourth AIDS Medium-Term Plan 2005-2010, the prevalence of HIV and AIDS in the country has remained at less than one percent of the Filipino population. With significant contributions from our partners in delivering HIV prevention and control efforts to communities of persons at-risk for, vulnerable to, and living with the disease, we have kept the impending epidemic of HIV at bay.

However, the challenge remains. Our accomplishments in the coverage of HIV prevention, AIDS treatment, care and support programmes still fall short of our targets to demonstrate concrete and sustainable impact in halting the spread of the epidemic. In several urban and highly populated settings, and amongst most-at-risk communities, HIV prevalence has breached the one-percent benchmark. **The United Nations Global Report in 2010 noted that the general trend of HIV epidemic in the world is declining; however, the Philippines is one of seven countries to have registered more than 25 percent increase in HIV incidence.**

We must intensify our efforts more than ever to stop the spread of the virus. The Department of Health, beginning this year, has embarked on improving the country's health systems to ensure Universal Access to Health Care, a priority in President Benigno Simeon C. Aquino III's platform, his Social Contract with the Filipino People.

The Fifth AIDS Medium-Term Plan 2011-2016 (5th AMTP) resonates our renewed commitment for urgent actions. It calls upon the nation to act collectively in scaling up comprehensive HIV interventions. Harmonizing our efforts under the 5th AMTP ensures that the Philippines will stay on track in meeting the Millennium Development Goal of halting the further spread and beginning to reverse the trend of HIV and AIDS.

On behalf of the members of the Philippine National AIDS Council (PNAC), I urge leaders and stakeholders of key development sectors, both public and private, at the national and local levels, and our development partners to combine all prevention and control efforts under the 5th AMTP.

Mabuhay Tayong Lahat!

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MEMBERS OF THE PNAC

ASP	AIDS Society of the Philippines
CHED	Commission on Higher Education
DBM	Department of Budget Management
DEpEd	Department of Education
DFA	Department of Foreign Affairs
DOH	Department of Health
DILG	Department of the Interior and Local Government
DOJ	Department of Justice
DOLE	Department of Labor and Employment
DSWD	Department of Social Welfare and Development
DOT	Department of Tourism
HAIN	Health Action Information Network
HOR	House of Representatives
ISSA	Institute for Social Studies and Action
LCP	League of Cities of the Philippines
LPP	League of Provinces of the Philippines
LUNDUYAN	Lunduyan sa Pagpapalaganap, Pagtataguyod at Pagtatanggol ng mga Karapatang Pambata
NEDA	National Economic and Development Authority
PHA	Philippine Hospital Association
PIA	Philippine Information Agency
PPA	Pinoy Plus Association
PAPFI	Positive Action Foundation Philippines Incorporated
SOP	Senate of the Philippines
TESDA	Technical Educational Skills and Development Authority
TLF Share	TLF Sexuality Health and Rights Educators Collective
TUCP	Trade Union Congress of the Philippines
WHCF	Women's Health Care Foundation

ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
AMTP	AIDS Medium Term Plan
AMTP IV	Fourth AIDS Medium Term Plan
AMTP V	Fifth AIDS Medium Term Plan
ART	Anti-Retroviral Therapy
CHD	Center for Health and Development
CHED	Commission for Higher Education
CUP	Condom Use Program
DepEd	Department of Education
DILG	Department of the Interior and Local Government
DOH	Department of Health
DSWD	Department of Social Welfare and Development
FLSW	Free Lance Sex Workers
HIV	Human Immunodeficiency Virus
IEC	Information, Education and Communication
LAC	Local AIDS Council
LGU	Local Government Unit
M&E	Monitoring and Evaluation
MARP	Most-At-Risk Population
MDG	Millennium Development Goals
MSM	Men having Sex with Men
MTPDP	Medium Term Development Plan
NEC	National Epidemiology Center
NDHS	National Demographic and Health Survey
NGO	Non-Governmental Organization
OFW	Overseas Filipino Worker
OI	Opportunistic Infections
OWWA	Overseas Workers Welfare Agency
PDEA	Philippine Drug Enforcement Agency
PIP	People in Prostitution
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
PNAC	Philippine National AIDS Council
POEA	Philippine Overseas Employment Agency
PWID	Persons Who Inject Drugs
RA	Republic Act
RAAT	Regional AIDS Action Teams
SHC	Social Hygiene Clinics
STD	Sexually Transmitted Diseases
STI	Sexually Transmitted Infections
TCS	Treatment, Care and Support
TESDA	Technical Education and Skills Development Authority
UNAIDS	United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
UP	University of the Philippines
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

EXECUTIVE SUMMARY

The Philippines has maintained a low prevalence rate in HIV and AIDS. With the current spike in the number of reported cases, however, the country may not be able to keep it at the present level. There is growing evidence that the next Country Response to HIV and AIDS must catch up with, if not overtake, the spread of the epidemic at its present rate.

The 5th AIDS Medium Term Plan (5th AMTP) envisions the halt to the present rate of HIV infection in the Philippines by preventing the further spread of HIV infection and reducing the impact of the disease on individuals, families, communities, and various sectors. It aims to broaden its reach among the general population, especially those most-at-risk and are found to be the present drivers of the epidemic such as Men having Sex with Men (MSM) and People Who Inject Drugs (PWID). This shall be done principally through an improvement in the standard quality and a scaling up in the coverage of comprehensive programs/services and interventions for prevention among the most-at-risk population, as well as in treatment, care, and support. It shall seek to develop the capacities of service providers, communities, and organizations in undertaking advocacy and work for the creation of an enabling evidenced-based policy environment, specifically pertaining to infection control, harm reduction, and access to prevention services and commodities.

It shall likewise enhance and promote a decentralized structure of implementation for the Country Response through local government units (LGUs) and other local structures and processes such as the Local AIDS Councils (LACs) and the Regional AIDS Action Teams (RAATs). It shall further expand, build, and strengthen management systems and supports specifically in the areas of monitoring and evaluation, existing structures such as the PNAC and the Secretariat, partnerships and collaboration among and with the private sector and LGUs, and resource mobilization and investment planning.

INTRODUCTION

Four Medium Term Plans have been implemented in the Philippines since Republic Act No. 8504, or the AIDS Prevention and Control Act, was enacted in 1998.

The 4th Country Response (AIDS Medium Term Plan-IV) ended in 2010 after a six-year period starting 2005. It envisioned "greater access to a holistic response" and sought to prevent "the further spread of HIV and AIDS infection" as well as reduce "the impact of the disease on individuals, families, and communities." It enjoined all sectors – including all key players in health and development, service providers, and those living with and affected by the epidemic – to become actively engaged in the concerted effort to prevent and control the spread of HIV and AIDS in the country. National line agencies and local governments were likewise urged to continue their participation in the formulation and implementation of policies and programs/services, provide interventions for the benefit of those already infected with HIV and their families, and prevent the further spread and impact of the disease.

These thrusts have become even more urgent today, as the incidence of HIV infection in the country has doubled since 2007. This is evident in the last Country Report of the Philippine National AIDS Council (PNAC) to the United Nations General Assembly Special Session on HIV (UNGASS) covering the period January 2008 to December 2009. The most recent report of the National Epidemiological Center of the Department of Health (NEC-DOH) in April 2010 alone shows a five-fold increase in the number of reported cases from the end-2007 figures. While the national AIDS response has managed to maintain the normatively low prevalence rate of the epidemic in the country (remaining below one percent of the total population), there has been an exponential increase in reports of new cases among the Most-At-Risk Populations (MARPs) like People in Prostitution (PIP), Men Having Sex with Men (MSM), and Persons Who Inject Drugs (PWIDs) [formerly called Injecting Drug Users or IDUs]. Moreover, the age groups found with the most number of reported cases are in the productive ages of 20 to 39 years, and are equivalent to 80 percent of the total population infected with the epidemic.

A mid-term review of the 4th AIDS Medium Term Plan (4th AMTP) in 2008 showed that a comprehensive and appropriate plan was drafted to include the relevant stakeholders and address the drivers of the epidemic and its target groups. During the period covered, the Philippine National AIDS Council (PNAC) made significant advances in the campaign to curb the disease. One of these was the Council's adoption of the Three Ones' Principles of the UNAIDS on behalf of the country. It also spearheaded the development of the National AIDS Monitoring and Evaluation system. The PNAC's efforts led to important strides in prevention interventions among children and young people, migrant workers, PIP, MSM, and PWIDs, and the scaling up of quality treatment, care, and support services.

However, certain programmatic and systematic areas of concern need further strengthening, and efforts to address resource needs to implement the response are imperative. Insufficient budgetary commitments from the national government have compounded the situation, which is further aggravated by the non-sustained responses from LGUs that continue to grapple with diverging religious and political views. These issues are further complicated by the lingering problem of stigma and discrimination against those infected and affected by the virus, even from service providers, and redress of their grievances remains wanting.

Indeed, challenges continue to hound the country's response to the HIV and AIDS epidemic today. The PNAC, thus, recognizes the importance and urgency of easing the slow and stringent processes in decision-making and implementation, sustaining initiatives undertaken for strategic intervention such as inter-agency collaboration and partnerships, consolidating and sharing current epidemiologic data, and enforcing a monitoring and evaluation scheme for establishing baseline and progress targets.

The mid-term assessment, through its recommendations, pointed out areas in the national response that require strengthening. These recommendations flow from the analyses of the findings of the assessment addressing program design and strategies as well as systems and policies. The table below presents the details of these recommendations.

Table 1. Recommendations and Ways Forward to Strengthening the National Response Mid-term Assessment of the 4th AMTP, 2008

Program Design and Strategy
a. Building an evidence base for responses The targets have been fixed in percentages and the denominators based on estimates done recently, which are reportedly very different from field reality. It is necessary to undergo a countrywide estimation exercise particularly for the MARPs and for selected vulnerable groups. This has been planned as part of the research agenda and it is important to note that this activity should be top priority. Without estimates, vulnerability in a low prevalent country cannot be established. Without this information, it is difficult to ascertain the program gaps, the needs, and the funding cost. ***b. Prioritizing interventions to maximize impact with low resources*** The AIDS Commission report recommends focus on MARPs, particularly in low prevalent countries with low resources. With the increasing trend among MARPs in the Philippines, the PNAC may want to consider focusing and further accelerating their interventions for the MARPs given the limited resources. **c.** ***Nuanced definitions of migrant workers and responses through action research*** Migrant Workers are a population group identified as vulnerable groups within the AMTP IV; however, the operational definition seems to vary across the project sites. This creates confusion of priority, strategy, and approaches. It is therefore imperative that the PNAC develop operational definitions of migrant workers in consultation with the various program implementers and disseminate guidelines for migrant worker interventions. Based on the operational definitions, it is necessary to specify some broad guidelines of approach, and methods of monitoring and costing. ***d. Address the weaker thematic areas*** Some critical areas with minimal or negligible progress need to be focused on for the second half of the plan. Specifically urgent is policy support for harm reduction, where there is a draft policy but no active engagement with the Dangerous Drugs Board, as well as action toward the implementation of a harm reduction strategy. In case harm reduction seems too radical for the Philippine context, there must be efforts toward the most appropriate in-country IDU-HIV intervention. Another neglected area is the expansion of networking among HIV and STI practitioners. This is critical for a well-aligned, coordinated, and optimum human resource strategy to address the STI and HIV care needs of the people. Franchising and accreditation are among the models that could be piloted. The advocacy and communication plan is still on paper and has not been endorsed by the PNAC. It is imperative that this is reviewed, endorsed quickly, and piloted within the next two years. The AIDS Commission report recommends the scaling up and saturation of interventions for High-Risk groups such as FSWs, MSMs and IDUs. In the case of the Philippines where resources are limited and the epidemic drivers are the High-risk groups, it is recommended that priority be placed on targeted interventions over general population interventions.

e. Facilitation of decentralized implementation, including guidelines and processes

The response at the local level is critical to the success of the national program. There is a need for funds, clarity of role, and monitoring. Local responses need more support from the national level on how to access funds and plan programs.

Some amount of money must be kept aside for capacity building of LACs, especially on fund raising, planning, and program management. Some LACs are very effective and the PNAC Secretariat should provide the platform for sharing and cross learning. The Regional AIDS Action Teams or RAATS can also provide a platform for sharing and cross learning. RAATs are ideally placed to address concerns of the LACs at the regional levels.

f. Package of services approach

A package of services approach may help in streamlining and harmonizing the program in the different project sites. Some of the steps to developing a package of services approach are as follows:

1. Map geographies which have similar settings;
2. Develop a package of services for each setting;
3. Develop minimum standards and implementation modalities;
4. Package strategies for each of the MARPS;
5. Develop a manual of operations for each package;
6. Develop costing guidelines; and
7. Develop costing per package.

The above steps will promote nuanced implementation and serve as a basis for monitoring.

Systems Strengthening

a. Enhance M&E systems

The pilot monitoring and evaluation system has brought to the fore several lessons and good practices. It is recommended that these lessons be used to develop a stronger, workable, and simple M&E system. It is imperative to identify focal points from each player. The baselines, targets, and performance indicators need to be clearly defined and there needs to be rigorous capacity building on operating and using M&E systems. Partnership and agreement with development partners is necessary and should be geared towards sharing information with PNAC.

The Philippine National AIDS Council (PNAC) Secretariat is the nodal agency whose capacity must be developed so it can perform its role. The PNAC Secretariat must also be positioned to serve as the country's repository for all program-related information. This can be done online to enable LGUs and other partners to access critical information related to either the epidemic or the programmatic response. All the guidelines and studies (those without confidential information) should also be readily available on this online platform. Once a year, the PNAC Secretariat should host learning seminars where the LGUs as well as government and non-government agencies can share their experiences and learn from each other. It is important to identify M&E focal points within each major agency who, in turn, will liaise with the M&E Unit within the PNAC Secretariat. An M&E system protocol should be developed and followed, with systems for regular updates. Clear Terms of Reference as well as regular capacity development initiatives should be given to each M&E focal point. A costed M&E Plan and routine program monitoring should also be part of the system e.g. blood safety, education, workplace, etc.

b. Increase and improve human resources

In response to the shortage of human resources and capacities, a thorough workload assessment for typical kinds of interventions must be carried out. The human resource requirements need to be revisited and revised, resources for capacity development identified, and a human resource (HR) policy put in place in response to the needs of the program.

c. Increase the effectiveness of existing structures (Secretariat, Council)

It is imperative for the PNAC to identify one clear leader/driver mandated to drive accountability. Sub-structures like Committees must work on schedule and towards fixed objectives in order to be effective. Agendas should be fixed beforehand, schedules shared, and one person in each committee should drive the process of the meetings of the committees. Each action plan for the committee can have a set timeline within which the action/decision must be taken.

There must be a Capacity Development Plan for the PNAC and the PNAC Secretariat. One of the most urgent

concerns is the need to address transient leadership – and move towards semi-permanence and systems for continuity. Human resource policies of the DOH may have to be reviewed and reforms advocated. The Secretariat should have a clear work plan, which is specific and time bound, for each year. It is recommended that there be a planned and interactive organization development process as a follow-up to the PNAC capacity assessments.

d. Improve partnership with the private sector and FBOs

Partnerships are critical to the success of the program. Some types of partnership have either not taken off or not blossomed in the last few years, particularly those with the private sector and faith-based organizations as well as those within different government agencies. Partnerships with donor communities have also not been fostered very strongly. Such partnerships need not be in the form of PNAC membership; however, the Committees and the Secretariat can take the lead in fostering these partnerships.

e. Resource mobilization and investment plan

A new costed operational plan covering the next two years must be developed. The collection of expenditure data must also be mainstreamed into the M&E system. The experiences and recommendations of the implementers must be taken into consideration during the costing. Costing guidelines and standards must be developed and shared, and a plan to raise additional resources developed. Systems for managing and coordinating with NEDA for proper documentation need to be streamlined.

Development of the 5th AIDS Medium Term Plan

The drafting of the Fifth HIV and AIDS Medium-Term Plan (5th AMTP) began in the face of a rapidly expanding epidemic, inadequacies in HIV prevention coverage, and challenges to the strengthening of the AIDS country response systems. The process was initiated following the dissemination forum of the Department of Health's National Epidemiological Center (DOH-NEC) and the High-Level Meeting of the PNAC government agency members in December 2009 and January 2010, respectively. Alarmed at the emergence of epidemic concentrations among Men having Sex with Men (MSM) and Persons Who Inject Drugs (PWIDs) in major urban geographic areas, HIV stakeholders and advocates started discussions specifically to address immediate and longer-term implications of this shift in the epidemic. Some initiatives resulting from these discussions are as follows:

- The formation of task forces to further investigate these epidemics;
- "Emergency" planning for the last-mile efforts of the 4th AMTP implementation, including mobilizing for additional resources for MSM and PWID interventions; and
- Intensifying advocacy engagements in the first quarter of 2010 to resolve policy conflicts on interventions such as harm reduction and condom distribution.

The PNAC Plenary resolved to immediately commence development of the 5th AMTP in the second quarter, prior to the HIV Summit in April 2010, and launch the Plan before yearend. Partners in the national response who attended the HIV Summit received this resolution, after which several PNAC members and NGO partners met to determine the initiation of the 5th AMTP. In a workshop, the group reviewed accomplishments under the 4th AMTP implementation, examined the scenario and process of the 4th AMTP development, and drew up recommendations that included the formulation of guiding principles and a development process for the strategic plan and terms of reference for the formation of a Development Core Team. The PNAC Executive Committee, in a meeting, endorsed these recommendations.

The 5th AMTP Development Core Team consisted of representatives from PNAC. Five from government agencies were members, namely: the Department of Health (DOH, particularly the National AIDS/STI

Prevention and Control Program and the Health Policy Development and Planning Bureau), the Department of Education (DepEd), the Department of Labor and Employment (DOLE), the Department of Social Welfare and Development (DSWD), and the National Economic and Development Authority (NEDA). The Action for Health Initiatives (ACHIEVE), the Philippine NGO Council on Population, Health and Welfare (PNGOC), and the Positive Action Foundation Philippines Inc. (PAFPI); private business enterprise *Pilipinas* Shell Petroleum Corporation (PSPC); and community organizations *Pinoy* Plus Association and *Babae* Plus representing the civil society groups. The Joint UN Programme on HIV/AIDS (UNAIDS) and World Health Organization (WHO), two of the Council's development partners, were invited to join the group to provide technical inputs.

The Core Team primarily focused on problem and response analysis, drafted the 5th AMTP Strategic Framework, and provided guidance to ensure that participatory processes were observed in the multi-sectoral effort to translate the Framework into a National Strategic Plan. Thereafter, the Council members ratified the draft 5th AMTP.

In the third quarter, the 5th AMTP Strategic Framework was validated among partners through a dissemination forum organized for the 2010 United Nations General Assembly Special Session on HIV (UNGASS) Country progress report. The PNAC Executive Committee, in a meeting, endorsed the Strategic Framework and the proposed process for the National Strategic Planning earlier validated by partners. In between Core Team meetings, two so-called narrow-scale activities were held to bring attention to underdeveloped and/or under-capacitated areas in existing HIV prevention and AIDS treatment and care strategies. With the growing interaction among program implementers and researchers, the narrow-scale activities eventually brought to light the priorities for the strategic plan.

Four consultative assemblies were organized to intensify participation among local response partners in refining the draft version of the strategic plan. Two such meetings were held in Metro Manila, one for partners in the National Capital Region and another for partners in Luzon sites outside NCR; one in Cebu City for partners in the *Visayas*; and one in Davao City for partners in Mindanao. The assemblies were attended by Regional AIDS Assistance Teams (RAATs), members of the Local AIDS Councils (LACs), elected officials and local champions as representatives of local government units, civil society organizations, and persons-living-with-HIV (PLHIV) communities. In general, the participants zeroed in on three areas of concern, namely:

- Their continued participation in finalizing and implementing the strategic plan, including planning for operations and costing;
- Improved facilitation of a decentralized and partnership-based implementation in order to ensure that plans set the right priorities as well as realistic targets while underscoring the critical role of local government and non-government responses; and,
- The harmonization of policies at the national level and making them clearly understandable at the operational level to improve efficiency in the delivery of critical interventions to at-risk, vulnerable, infected, and affected communities.

Small informal meetings among Men Having Sex with Men (MSM) and Persons Who Inject Drugs (PWIDs) were also conducted in Metro Manila and Cebu City, respectively, to orient and update community members on the 5th AMTP and provide insights on the discussions emerging from the consultative assemblies. Discussions particularly revolved around the concepts of the comprehensive

packaging of focused interventions and the strengthening of community capacities for accessing and delivering services.

All these efforts are ultimately aimed at harnessing the collective capacities and will of various stakeholders, with the Council at the forefront, to curb the disease in the face of this unprecedented rise in HIV cases. Now more than ever, there is greater awareness and a more abiding sense of urgency among those involved in this campaign on the need to expand public awareness on HIV and AIDS. Efforts were undertaken to help the public understand the greater harm that discrimination and stigma can inflict on those afflicted with the disease, gather more support for prevention activities, bring together all available resources to arrest the spread of HIV infection, and provide greater access to quality treatment, care, and support for those who are living with it. These goals, among others, lie at the very core of the 5th AMTP.

Purpose of This Document

The PNAC, as reconstituted and strengthened by the AIDS Prevention and Control Act or R.A. 8504, has the mandate to develop strategies to respond to the challenge posed by HIV and AIDS in the country. Comprehensive long-term planning is specifically provided under said law as the key function of the Council, while its task of conducting medium-term planning is stipulated in the implementing rules and regulations (IRR) of the AIDS law. This document is also consistent with the rules of legal interpretation in terms of its structure and content.

This document utilizes the evidence-based approach, whose usefulness and reliability have been ascertained from a series of assessments of previous efforts and the collective analysis of the changing face of the epidemic. The national Strategic Plan herein defines the general direction the country must take to address HIV and AIDS. The document is intended to serve the following purposes:

- To enable lead agencies and other partners to anchor their respective HIV and AIDS strategies on a common rationale;
- To guide technical working groups, institutions, organizations, and LGUs in structuring and formulating their respective HIV and AIDS operational plans;
- To arm advocates and technical assistance providers with the basis for promoting the prioritization of HIV and AIDS among national and local high-level stakeholders;
- To promote the cost-effective, efficient, and harmonized HIV and AIDS initiatives toward achieving a more coherent and effective multi-sector response; and
- To provide the basis for monitoring and evaluating the national response.

PART I: SITUATIONER

Understanding HIV and AIDS from a development and governance perspective

To maximise the contribution of role players to the above principles, it is important for political leaders, officials, and community members to become 'HIV and AIDS competent' and be familiar with two sets of key HIV and AIDS concepts and approaches to the epidemic. These are:

- Bio-medical concepts aligned with the perspective of HIV and AIDS as a health issue; and,
- Development concepts aligned with the perspective of HIV and AIDS as a development and governance issue.

HIV and AIDS as a bio-medical issue

AIDS is a chronic disease that arises from HIV infection, although being infected with HIV is not the same as having AIDS. Most People Living with HIV (PLHIV) only show signs and symptoms of the disease after many years.

Secondary infections caused by lower immunity occur at stages of the disease before the onset of AIDS itself. Some diseases that are termed "AIDS-defining conditions" occur at the end stage of the disease. Diseases that are typically associated with HIV infection include tuberculosis, diarrhoea, and pneumonia. Bio-medical prevention, treatment, and care efforts are vital elements of the response to HIV and AIDS. While the introduction of Anti-Retroviral Treatment (ART) represents an important turning point, this alone is unlikely to resolve the crisis entirely.

Some of the challenges that remain include:

- Socio-cultural and socio-economic resistance to behaviour change in such practices as the use of condoms and breastfeeding;
- Lack of knowledge about one's HIV status, which is a necessary precondition to accessing ART and living positively. Factors such as personal denial, stigma, and poor geographical accessibility of Voluntary Counselling and Testing (VCT) sites combine to make it difficult for many to access services such as treatment;
- Obstacles to accessing comprehensive care. In rural areas, particularly in remote villages, access to such care is difficult as transport costs to sites where care is available are prohibitive for most people;
- Lack of access to basic services due to poverty plays an important role in depriving PLHIV of the opportunity to sustain their needs and look after their well-being; and
- Stigma and discrimination.

HIV and AIDS as a development and governance issue

The developmental and governance perspective of HIV and AIDS is based on the understanding that:

- Individuals tend to be more susceptible to HIV infection in situations of poverty, underdevelopment, and inequality;

- HIV and AIDS have an adverse impact on the development resources and prospects of communities, especially those living in poverty;
- Individuals, households, and communities that are empowered, cohesive, and have access to life-sustaining goods and infrastructure are in a stronger position to minimize the spread of HIV and are less vulnerable to the negative economic and social impacts of the disease; and
- Within the context of local government, the epidemic can adversely affect the capacity of municipalities to function effectively and deliver on their mandates.

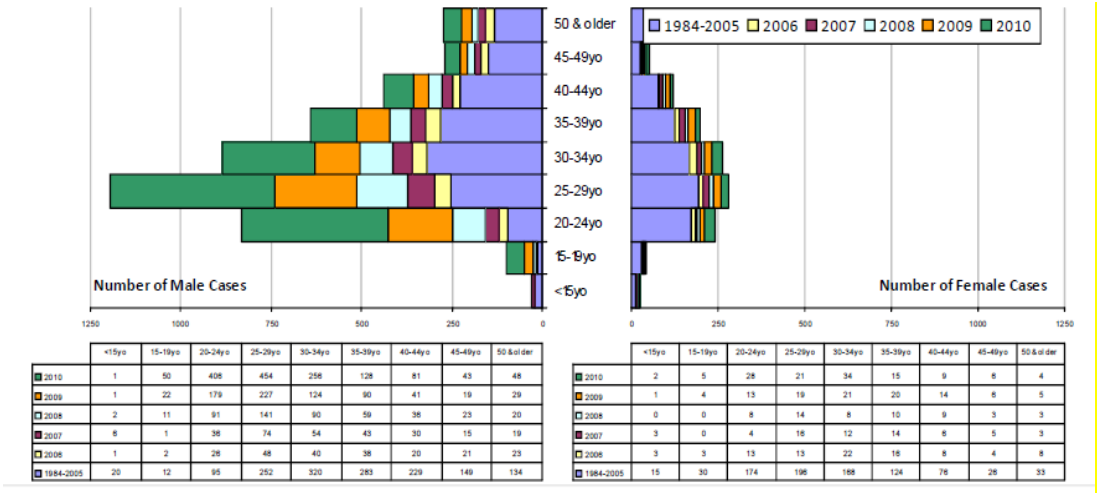
Development conditions alone do not define the factors driving the spread of HIV and AIDS. However, development conditions have a significant influence on the risk of HIV infection, the rate of progression from HIV to AIDS, and the impact of AIDS on individuals, households, and communities.

Current Epidemiological Profile

The Philippine AIDS Registry of the National Epidemiology Center of the Department of Health reported 6,015 HIV Ab sero-positive cases from January 1984 to December 2010. Of the total number of cases, 5,158 (86%) were asymptomatic while 857 (14%) were AIDS cases. Seventy-three percent (73%) are male.

Ages of reported cases ranged from 1 to 73 years (median 30 years). The age groups with the most number of cases were 20-24 years (18%), 25-29 years (25%) and 30-34 years (19%). A deeper analysis of the data shows that since 2006, overall HIV infection increased five-fold among the total reported cases from 309 in 2006 to 1,591 in 2010. During the same period, HIV infection among 15-24 year olds increased ten-fold from 44 in 2006 to 489 in 2010."

Figure 1. A Comparison of the Distribution of Male and Female HIV Cases by Age Group and Certain Highlighted Years Philippine AIDS Registry, January 1984 to December 2010



	<15yo	15-19yo	20-24yo	25-29yo	30-34yo	35-39yo	40-44yo	45-49yo	50 & older
2010	1	50	408	454	256	128	81	43	48
2009	1	22	179	227	124	90	41	19	29
2008	2	11	91	141	90	59	38	23	20
2007	8	1	38	74	54	43	30	15	19
2006	1	2	28	48	40	38	20	21	23
1984-2005	20	12	95	252	320	283	229	149	134

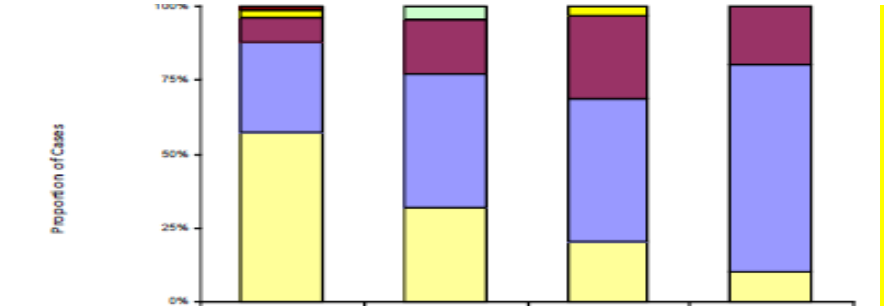
	<15yo	15-19yo	20-24yo	25-29yo	30-34yo	35-39yo	40-44yo	45-49yo	50 & older
2010	2	5	28	21	34	15	9	8	4
2009	1	4	13	19	21	20	14	8	5
2008	0	0	8	14	8	10	9	3	3
2007	3	0	4	16	12	14	8	5	3
2006	3	3	13	13	22	16	8	4	8
1984-2005	15	30	174	196	168	124	76	26	33

The cumulative data on reported HIV cases revealed that sexual transmission is still the primary mode of transmission (90%). This is followed by needle sharing among injecting drug users, now referred to as Persons Who Inject Drugs (PWIDs) at 3 percent (155 cases), and mother-to-child transmission at 1

percent (52 cases). Of those infected through unprotected sex, data from 1984 to 2010 show that a majority (46%) were infected through heterosexual contact, 34 percent through homosexual contact, and 20 percent through bisexual contact.

However, data from 2007 to 2010 show a sharp difference in the mode of transmission: 41 percent of sexual transmission was homosexual (from 29%), 32 percent heterosexual (plummeting from 55%), and 28 percent bisexual (from 15%). The National AIDS Registry (passive surveillance) alone shows a remarkable increase of 54 percent in the number of reported HIV cases in 2008 and rose further to 58 percent in 2010 (Figure 2).

Figure 2. Proportion of Modes of Transmission of AIDS Cases by Year
Philippine AIDS registry, January 1984 to December 2010



	1984-2007	2008	2009	2010
Needle Prick	2	0	0	0
Blood Transfusion	10	0	0	0
MTCT	16	0	1	0
IDU	3	1	0	0
Bisexual Contact	60	4	8	4
Homosexual Contact	234	10	14	14
Heterosexual Contact	433	7	6	2

*Note: 28 did not report mode of transmission

While reported infections among returning overseas Filipino workers (OFWs) in 2009 comprised only 18 percent (as against 31 percent in 2007) of all individuals reported to have contracted HIV that year, it is by far the highest rate of infection documented since 1984.

In August 2010, there were 108 new HIV sero-positive cases reported to the Philippine AIDS Registry, a 77-percent increase compared to the same period in 2009. Most of the cases (93%) were male, with a median age of 27 years. This time, the burden of the infection is in the age bracket of 20-29 years (57%), an increase of 19 percent from 2009 alone. Fifty-two percent (52%) of the reported cases were from the National Capital Region. The reported mode of transmission was sexual contact (96%) and the re-use of needles among Persons Who Inject Drugs or PWIDs (4%). The predominant type of sexual transmission occurred through Males having Sex with Males or MSM (80%). Nevertheless, all reported cases were still asymptomatic at the time of the reporting.

To date, an average of five (5) new HIV cases per day or one (1) in every five (5) hours is reported in the country, a sharp rise from two (2) cases reported per day at the end of 2009 and one (1) reported case per day in 2007. While the national HIV prevalence remains below one (1) percent of the adult

population, HIV prevalence among the most-at-risk populations (MARPs) shows a pronounced upsurge from 0.08 percent in 2007 to 0.47 percent in 2009.

In summary, the current epidemiological profile indicates that:

- ***More are infected.*** The 4th AMTP commenced with one reported case for every two (2) days. The 5th AMTP is commencing with one reported case for every five (5) hours, or 5 reported cases per day.
- ***Those infected are young.*** The median age for persons infected with HIV is 27 years. The 2009 IHBSS findings revealed that the period of initiation to sex and drug use among the most-at-risk populations is from 14 to 19 years of age.
- ***People infected are those in their most productive years.*** Reported cases are between 20 and 34 years old.
- ***More males are infected.*** The mode of transmission is principally through male-to-male sex and bisexual contacts.

The need to do more is important and the urgent call to action is paramount**.** Our intended targets for curbing the spread of the infection, especially among segments of the general population that are most at risk, have not been adequately covered by our interventions.

Risks and Vulnerabilities

While the 4th Country Response described the spread of the epidemic as "hidden and growing," the current epidemiological profile shows it is consistently expanding.

A number of risk and vulnerability factors remain, to wit:

Awareness of the Epidemic among the Most-At-Risk Populations*.* The 2009 Integrated HIV Behavioral Serologic Survey *(*IHBSS) results show that HIV knowledge among MARPs (representing Free Lance Sex Workers (FLSWs), Males having Sex with Males (MSMs), and Persons Who Inject Drugs (PWIDs) has remained low and that only 32 percent both correctly identify ways of preventing sexual transmission and reject misconceptions. Total coverage reached among MARPs was only at 38 percent.

The 2008 National Demographic and Health Survey (NDHS) reveals that the percentage of Filipino women with comprehensive knowledge of AIDS was low at only 22 percent, 21 percent of whom were aged 15-24 years while 26 percent of them were from urban areas and another 17 percent from rural areas. Of particular concern is the low level of knowledge among women with little or no education, comprising about 3 percent.

HIV information for departing and arriving Overseas Filipinos Workers (OFWs) has remained dismal, and as the 2008 mid-plan review states, "prolonged isolation from normal social situations and the lack of awareness about local cultures of countries of destination are factored into their vulnerability."

High prevalence of risky sexual activities among young people**.** The 2002 National Demographic and Health Survey (NDHS) shows that one out of four (4) young people (aged 15-24 years) engaged in sex before marriage, and among those that were sexually active, three (3) out of ten (10) engaged in

sexually risky behaviors—that is, sex with multiple partners, casual sex or sex with new acquaintances, and commercial or unprotected sex— and, as such, betray their low perception of risk for HIV infection. Only one (1) out of every five (5) sexually active young people used contraceptives to protect themselves from unplanned pregnancy and sexually transmitted infections (STIs). These findings are further reflected in the 2009 IHBSS of the National Epidemiology Center of the Department of Health. The results revealed that most-at-risk populations are predominantly young: 65% of MSM, 62% of FSW and 55% of IDU were 15-24 years of age. Age-disaggregation showed that young people most-at-risk below the age of 18 had equal levels of risk behaviors (e.g., anal sex without condoms, and number of sex partners among MSM) as adult MARPs. However, young people had lower knowledge than the adult MARP population (18-24% compared with 31-46% among adult MARP) and they have limited access to services (e.g., only 5% of FSW and 0.5% of MSM under 18 accessed HIV testing, compared with 24% and 10% in the adult population).

Condom Use. The 2009 Integrated HIV Behavioral Serologic Survey *(*IHBSS) reports no change in the low rate of condom use specifically among MSM. Condom use among People in Prostitution (PIP) is moderately high (60%) but still low as to anticipate an impact. According to this Survey, the country response continues to face the challenge of intensifying the promotion of correct and consistent condom use among the MARPs and vulnerable populations.

A 2010 study on street children in the highly urbanized cities of Manila, Cebu, Iloilo, Zamboanga, and Davao shows that even an adequate level of HIV information does not guarantee change in sexually risky behaviors, thus validating the 2009 IHBSS report that knowledge of HIV infection does not automatically translate to changed behavior.

Ambivalent and/or Conflicting Views and Policies on Condoms and Needle Use. The policy inconsistency between R.A. No. 8504 (the Philippine AIDS Prevention and Control Act of 1998) and R.A. No. 9165 (the Comprehensive Dangerous Drugs Act of 2002) is a major concern that must be addressed in light of the rising number of HIV infections in the country. To some extent, R.A. No. 9165 criminalizes the possession and distribution of drug paraphernalia such as needles and syringes, thereby hampering the formulation and implementation of a sound and rational harm reduction or infection control policy for preventing HIV infection and compromising HIV-prevention initiatives to curb the impact of needle use and sharing.

National and Local Responses, including Policy Environment and Institutional Responses

In the 2009 country progress report to the UN Declaration of Commitment to HIV and AIDS (UNGASS), HIV prevention programs more often fell far from the lower limits of the Universal Access principle, with the exception of reported condom use of FSW on their clients. Programs for treatment and care fared better in ensuring access to PLHIV in need of live-saving treatments and other services. The table below is a snapshot of the Philippines's last two UNGASS progress reports. The limited results shown may be worth reflecting upon against achievements reported by institutions and sectors of the response.

Table 2. National Scorecard of Selected Key Indicators for the United Nations General Assembly Special Session on HIV and AIDS (UNGASS) Report

UNGASS Indicators	2007	2009
HIV Prevalence	0.08%	0.47%
Level of knowledge on HIV among women and men 15-24 years old		
Know preventive measures		54.30%
Reject misconceptions		20.70%
Reach of prevention programs among the most-at-risk population (MARPs)		
Female Sex Workers (FSW)	14.0%	55.00%
Male having Sex with Male (MSM)	19.00%	29.00%
People who inject drugs (PWID)	14.00%	11.00%
Level of Knowledge on HIV among the most-at-risk population (MARPs)		
FSW	2.00%	30.00%
MSM	10.00%	34.30%
PWID	26.00%	44.60%
Percentage of MARPS that had an HIV test and know the result		
FSW	12.00%	19.00%
MSM	16.00%	7.00%
PWID	4.90%	1.40%
Condom Use		
FSW	65.00%	65.00%
MSM	32.00%	32.00%
PWID		11.00% as client 22.00% as sex worker
Reported use of sterile injecting equipment among PWIDs		
PWID	48.00%	85.00%
Other indicators		
Blood units are screened for HIV		96.00%
PLHIV adults and children with advanced HIV are receiving ARV	56.00%	84.00%
HIV+TB co-infected cases treated for TB and HIV	49.00%	80.00%

A. The National Response

The 4th AMTP was formulated to provide clear guidelines and direction towards a national response to HIV and AIDS which are reflected in the Philippine Millennium Development Goals Plan (PMDGP) and the Medium-Term Development Plan (MTDP). Since 1988, the country has developed in its national response the following mechanisms:

1. ***One National AIDS Coordinating Authority.*** The Philippine National AIDS Council or PNAC serves as the driver of the integrated and comprehensive country response to combat HIV and AIDS;
2. ***One Agreed Strategic Framework.*** Anchored on the principle of universal access to prevention, care, treatment and support, the goal of AMTP-IV is to prevent the further spread of HIV infection and reduce the impact of AIDS on individuals, families, and communities; and,
3. In 2004, ***One Agreed National Monitoring and Evaluation (M&E) System was developed.*** Among the essential tasks of the M&E system are the generation of precise, accessible, and timely data as the evidence base for program planning, which includes such critical tools as the geographic vulnerability mapping and the Integrated HIV Behavioral Serologic Survey (IHBSS), and research studies to build evidence for future program thrusts and priorities.

These three vital components of the national response are in harmony with the principle of "Three Ones".

The PNAC remains the highest advisory, planning, and policy-making body on HIV and AIDS. Its member national line agencies take the lead in, manage various aspects of the HIV and AIDS prevention, and control program.

The Department of Health (DOH). In terms of direct health services and surveillance, the DOH remains the lead agency that oversees and coordinates HIV and AIDS program implementation. Said program deals with comprehensive prevention, treatment, care, and support for HIV and AIDS in the health system. HIV interventions are likewise integrated with reproductive health and other health concerns.

The DOH has organized HIV and AIDS Core Teams (HACT) in hospitals in key cities throughout the country to respond to the needs of People Living with HIV (PLHIV), a program for providing treatment, care, and support in partnership with non-governmental organizations of PLHIV. It has developed policy guidelines including training on its 100-Percent Condom Use Program, policy guidelines on Post-Exposure Prophylaxis for HIV and other blood-borne diseases, technical assistance in surveillance and data estimates, interventions for Persons Who Inject Drugs (PWIDs) and on procurement and supply of antiretroviral drugs (ARVs), with support from the World Health Organization (WHO). The DOH has adopted as its target the need to keep HIV prevalence in the country below one (1) percent, based on a 2007 review of the progress of the Millennium Development Goals (MDGs).

The Department of Labor and Employment (DOLE). The agency institutes policies and strategies in dealing with people who have sexually transmitted infections (STIs) and AIDS in the workplace. It also coordinates the work on HIV and AIDS among overseas labor sectors. Furthermore, the DOLE ensures through TESDA the provision of HIV and AIDS education and information to students taking vocational courses.

The Department of Education (DepEd) and the Commission on Higher Education (CHED). These agencies are tasked to implement HIV and AIDS education in all public and private schools (primary, secondary, and tertiary) across the country. However, this national response has yet to fully take off.

The Department of Social Welfare and Development (DSWD.) The DSWD has effectively ensured that Persons Living with HIV (PLHIVs) are provided with the necessary welfare services and other forms of assistance to mitigate the impact of the disease especially on underprivileged Filipino PLHIVs. To date, it has completed and is in the process of operationalising a multi-sectoral referral system for PLHIVs.

The Department of Foreign Affairs (DFA). The agency continues to assist OFWs in HIV-related cases and has trained its Foreign Service Officers in handling HIV and AIDS cases. In lieu of the agency's mission and its mandate under the Philippine AIDS Prevention and Control Act of 1998 (R.A. 8504), the DFA coordinates with the PNAC and other relevant Philippine government agencies in the formulation and articulation of a coherent and consistent Philippine position on and/or inputs vis-à-vis HIV and AIDS issues in multilateral fora.

The Department of the Interior and Local Government (DILG). The exercise of its mandate to coordinate and monitor the response of local governments to the HIV and AIDS problem leaves much to be desired.

On a positive note, the DILG's Local Government Academy (LGA) has trained the 17 Regional AIDS Assistance Teams (RAATs) to provide support to local government units (LGUs) in establishing and enhancing their respective local HIV programs.

The National Economic and Development Authority (NEDA). The NEDA principally monitors the National AIDS Spending Assessment (NASA), analyzes annual AIDS spending to inform the operationalisation of the national response, and ensures that HIV is integrated in the country's overall development plan through the Medium-Term Philippine Development Plan (MTPDP) for 2004-2010. Likewise, the NEDA monitors and evaluates the attainment of the MDG target on HIV and AIDS and provides recommendations as reflected in the MDG Progress Reports.

The stakeholder groups that have actively and substantively contributed to the achievement of the Country Response are as follows:

Local Government Units (LGUs). As the principal health program implementers at the local level in a decentralized political structure of government, LGUs continue to play a critical role in the prevention and control of HIV. Service providers in Social Hygiene Clinics (SHCs) of city or municipal health offices are tasked to diagnose STIs, provide STI treatment, do voluntary or provider-initiated counseling and testing (V/PICT), and conduct blood donation education and activities. All of these accomplished activities are regularly reported to the Centers for Health Development of the Department of Health (DOH).

Civil Society Organizations (CSOs). The CSOs assist national agencies and LGUs in implementing sector-specific responses at numerous geographic sites. CSOs also implement community-based outreach and education programs in close collaboration with the Centers for Health and Development (CHDs), LGUs, and/or treatment hubs. Presently, there are about 50 CSOs across the country contributing to the achievement of the Country Response targets.

Faith-Based Organizations (FBOs). Though not officially a member of the PNAC, FBOs have undertaken some remarkable initiatives. The Roman Catholic Church through the National Secretariat for Social Action and Justice of the Catholic Bishop Conference of the Philippines, in partnership with the PNAC and UNAIDS, developed a Training and Resource Manual for Catholic Pastoral Workers that has been effectively rolled out in selected dioceses. Many other activities related to care and support have been implemented in partnership with other religious organizations.

Moves toward setting up a national HIV and AIDS Monitoring and Evaluation system were also initiated in 2003. A contingent group composed of representatives from both government and civil society organizations have since convened regularly, actively planning and implementing the system. To date, however, the system has yet to be finalised and operationalised in all stages and at all levels of the plan implementation.

The PNAC likewise renewed its efforts toward the creation of the Local AIDS Council and the enforcement of local AIDS legislations in at least 32 LGUs. Even as an advocacy communication plan was drafted in 2007, it has yet to be effectively carried out. In 2007, the Council reviewed the Philippine AIDS Prevention and Control Act (R.A. 8504) and identified the following legal issues relating to HIV and AIDS in the country, namely:

- That R.A. 8504 provides for confidentiality and non-discrimination of persons living with HIV, and for prohibition on compulsory testing and partner disclosure;
- That even as sex work is prevalent in many areas, it has remained illegal;
- That drug use is criminalized and therefore not seen as a social or health issue to be addressed; and
- That persons who inject drugs (PWIDs) are made more vulnerable in the absence of a law that supports harm reduction or infection control strategies.

Moreover, the Council has passed resolutions on a number of concerns, as follows:

- The defined roles and responsibilities of the PNAC Secretariat;
- The budget for the 4th AMTP's operational plan for 2007-2008;
- The creation of Regional AIDS Action Teams (RAATs) to facilitate the local response to HIV and AIDS;
- Guidelines on the Prevention, Treatment, Care and Support of HIV among PWIDs; and
- The setting up of a referral system for PLHIV in the country.

From 2008 to 2009, the DOH successfully established the following guidelines and protocols:

- Policies and Guidelines on the Prevention of Mother-to-Child Transmission of HIV (PMTCT);
- Guidelines on Anti-Retroviral Therapy (ART) among adults and adolescents with HIV;
- Policies and Guidelines in the collaborative approach to TB and HIV prevention and control; and
- Anti-Retroviral Therapy (ART) for HIV infection, recommendations for adults in the Philippines.

The PNAC has also approved a resolution to develop guidelines on the prevention, treatment, care, and support of HIV-positive individuals among Persons Who Inject Drugs (PWIDs) but not much progress has taken place. The same holds true for the proposed sustainability mechanism for HIV and AIDS Program Funding and for systems to ensure sustained access to anti-retroviral drugs (ARVs), which awaits action to this day.

Furthermore, harmonizing laws that govern drug users with the provisions of the Philippine AIDS Prevention and Control Act (R.A. 8504) remains to be seen.

Thus, while policy statements manifest an alignment of the Country Response with the overall development plan of the country and enjoin all LGUs to integrate them in their annual investment plans, these have yet to be realised fully and effectively.

B. The Local Responses

Robust and systematized efforts have been made toward decentralizing the country HIV response. To date, 32 LGUs (Cities and Municipalities) have local AIDS ordinances with corresponding budgetary allocations, albeit small, and functional Local AIDS Councils (LACs) that direct and oversee the local response, with five more LGUs having concrete local responses. Thus, these LGUs have successfully highlighted initiatives and innovations that display the critical role of local governance in realizing national targets. Aside from these existing local responses, the provinces of Albay, Cavite, Aklan, and Bohol each have a Provincial AIDS Council.

Condom use is implemented 100 percent in 15 LGU sites, and public voluntary counseling and treatment have expanded to 75 such areas. All treatment hubs, selected social hygiene clinics, and civil society have been trained on PMTCT.

While many local initiatives are ongoing and are still very much a work-in-progress, encouraging innovations and heartening results can be gleaned from local responses in several areas. These are:

1. partnership mechanisms for treatment, care, and support (TCS) for Persons Living with HIV (PLHIV) and their affected families;
2. resource mobilization undertaken by a broad-based, multi-sectoral provincial AIDS Council to prevent the spread of the infection, and treatment and care for those already infected; and,
3. sustainability projects for young people of poor families who are at risk for and vulnerable to HIV infection, including development of entrepreneurship skills and undertaking of income-generating projects.

In summary, the 5th AMTP continues to focus on the Most-At-Risk Populations (MARPs), utilizing population-level measures to address the current drivers of the epidemic between Men having Sex with Men (MSM) and persons who inject drugs (PWIDs). At the same time, it recognizes the emerging opportunities for more targeted and tailored interventions to be more responsive to the varying contexts and subcultures within these populations. For a national Strategic Plan to be both realistic and sustainable, it will rely on the balance of population-level measures with targeted interventions. It likewise strongly enjoins local government units to know and make an assessment of the extent and level of the epidemic in their respective jurisdictions and formulate their local responses accordingly.

PART II: 5TH AIDS MEDIUM TERM PLAN (2011-2016)

The Strategic Plan for 2011-2016

A. Guiding Principles

In formulating the 5th AIDS Medium-Term Plan (5th AMTP), the following guiding principles have been employed. These are:

- ***Rights-Based:*** Underscore rights as an entitlement of the people as "claim-holders" and the state's obligation to respect, protect, and promote people's rights as "duty bearers," hence the emphasis on a rights-based approach in program implementation and policy formulation.
- ***Community Participation:*** Invoke the rights of citizens (communities, civil society organizations, and networks of people living with HIV) to actively participate and engage the state in addressing their needs and concerns.
- ***Integrated Development:*** Incorporate the AIDS Medium-Term Plan (AMTP) into the overall national development plans (through the Medium-Term Development Plan) and local development/investment plans.
- ***Comprehensive Interventions:*** Provide gender-responsive, age-sensitive and responsive, context-specific, and culturally appropriate comprehensive packages of interventions for HIV prevention and treatment, care, and support.
- ***Universal Access:*** Ensure that citizens have broad access to promotive, preventive, and curative health services, thus necessitating a minimum of 80-percent coverage of the target population in terms of prevention programs and at least 60-percent coverage of the target population in terms of disseminating correct knowledge and behavior to reverse the epidemic and stop HIV transmission. This will be done through the integration of comprehensive packages into the programs of key development sectors.
- ***Evidence-Based:*** Ensure the generation, analysis, and use of strategic information for evidence-based improvement of plan implementation and policy development.
- ***Policy Compliance:*** Ensure that all national and local governments understand and fulfil their constitutional and legal obligations with regard to HIV and AIDS and implement relevant governance and development responses.
- ***Equal Access:*** Promote universal distribution of services and the availability of adequate support systems especially for HIV-infected and affected individuals in all LGUs.
- ***Equity:*** Ensure equitable distribution of services in a manner that is non-discriminatory among individuals infected or affected by HIV and those not infected or affected by HIV and AIDS in all areas.
- ***Flexibility:*** Adopt a differentiated approach that determines current response levels, build on strengths, and tailor-fit interventions to meet local needs.
- ***Incrementalism:*** Roll out programs and other interventions in a progressive manner over time.
- ***Capacity Building and Leadership:*** Promote and develop appropriate competencies among all role players to carry out their responsibilities in responding to the HIV and AIDS challenge.

- ***Partnerships:*** Facilitate comprehensive stakeholder consultations and dialogue, encouraging partnership-driven development in the planning and implementation of relevant HIV and AIDS responses involving all spheres.

B. Vision

The spread of HIV infection is halted in the Philippines.

C. Goal

By 2016, the country will have prevented further spread of HIV infection by maintaining the prevalence of less than 66 HIV cases per 100,000 populations and reduce the impact of the disease on individuals, families, sectors and communities.

D. Strategic Objectives

The 5th AMTP carries the following strategic objectives:

1. To improve the coverage and quality of prevention programs for persons most at risk for, vulnerable to, and living with HIV;
2. To improve the coverage and quality of treatment, care, and support programs for persons living with HIV (including those who remain at risk and vulnerable) and their families;
3. To enhance policies for scaling-up implementation, effective management, and coordination of HIV programs at all levels;
4. To strengthen the capacities of the Philippine National AIDS Council (PNAC) member agencies to oversee the implementation of the 5th AMTP; and
5. To expand, strengthen, and build the capacity of partners in the national response including local governments, the private sector, and communities-at-risk, vulnerable, and living with HIV for the implementation of the 5th AMTP.

E. Outcomes of Change

- Persons at risk for, vulnerable to, and living with HIV avoid risky behaviors to prevent HIV infection.
- People living with HIV live longer and more productive lives.
- The Country AIDS Response is well governed and accountable.

Table 3 illustrates the outcomes framework of the 5th AMTP. Section F details the objectives, strategies, and major activities to achieve outputs.

Table 3. Outcome Framework of the 5th AMTP

VISION		
The spread of HIV is halted in the Philippines		
OUTCOMES		
Persons at risk for, vulnerable to, & living with HIV avoid risky behaviors to prevent HIV infection	**People living with HIV live longer, more productive lives**	**The Country AIDS response is well governed and accountable**
OUTPUTS		
▪ Comprehensive and sustainable services designed and implemented in a quality-assured manner	▪ Comprehensive and sustainable treatment, care, & support (TCS) services designed and implemented in a quality-assured manner	**HIV and AIDS Policy Environment** ▪ Policies formulated and put into place to support comprehensive and evidence-based programs ▪ Approaches and mechanisms strengthened to reduce stigma and discrimination among persons at-risk, vulnerable, living with & affected by HIV ▪ Gender-sexuality frameworks developed and built into policies, plans, and programs
▪ Persons at risk for, vulnerable to, & living with HIV are reached by comprehensive and sustainable prevention services	▪ Persons living with HIV, including pregnant women & children, are reached by comprehensive and sustainable treatment, care, and support services	**Phil. National AIDS Council** ▪ The capacity of PNAC strengthened to perform its function as the central advisory, planning, and policy-making body of the national response ▪ Inter-agency coordination and collaboration strengthened to monitor contributions in implementation of the 5th AMTP
		Partnerships on HIV and AIDS ▪ Capacities of local governments strengthened for coordinated, multi-sector HIV responses in priority strategic areas ▪ Capacities of communities at-risk, vulnerable, & living with HIV strengthened for program development and participation in governance ▪ Participatory governance structures & mechanisms of the HIV and AIDS response enhanced

F. Key Strategies, Outputs and Major Activities of Strategic Objectives

Every strategic objective has corresponding key strategies and major activities. Major outputs, respective implementation matrices, and notes in consideration of operational planning and costing are detailed for each major activity.

Strategic Objective 1

HIV Prevention Programs: to improve the quality and coverage of prevention programs for the persons most at risk for, vulnerable to, and living with HIV

Key Strategies

1.1. *Develop evidence-based, targeted, and comprehensive* programs/services for prevention;

1.2. *Capacitate service providers* in the delivery of a quality and comprehensive package of programs/ services for prevention;

1.3. *Provide equitable access* to comprehensive programs/services for prevention through health promotion; and

1.4. *Enhance decentralized implementation* of the 5th AMTP.

Major Activities

Strategic Objective 1 intends to contribute to enabling persons at risk for, vulnerable to, and living with HIV to avoid HIV risk. Its major outputs include the comprehensive design and scaled-up delivery of HIV prevention programs. Output 1.1 – *comprehensive HIV prevention program design* – includes four major activities establishing the program's design and implementation guides, its supporting referral system, capacitating of relevant personnel and programs, and assessment and testing of its effectiveness . See Table 3-A and corresponding notes below.

Table 3-A. Implementation Matrix for Strategic Objective 1, Output 1.1

Output 1.1	Comprehensive and sustainable services designed and implemented in a quality-assured manner						
Comprehensive HIV Prevention Program Design							
Major Activities	**Lead Agencies**	**Time Frame (Years)**					
		'11	**'12**	**'13**	**'14**	**'15**	**'16**
1.1.1 Program Design Establish a comprehensive program, including implementing guides, to prevent HIV among populations most at risk for, vulnerable to, & living with HIV	For sectoral programs ▪ DOH ▪ DSWD ▪ DepEd and CHED ▪ DOLE and TESDA For facilitating local programs ▪ DILG ▪ PLHIV community ▪ PNAC CSO members	■	■	■			
1.1.2 Referral Networks Set up referral systems to support	For wide, all-sector programs ▪ DSWD	■	■				

Output 1.1	Comprehensive and sustainable services designed and implemented in a quality-assured manner						
Comprehensive HIV Prevention Program Design							
Major Activities	**Lead Agencies**	**Time Frame (Years)**					
		'11	**'12**	**'13**	**'14**	**'15**	**'16**
service delivery networks implementing the comprehensive HIV prevention program							
1.1.3 Service Capacity Building Build capacities of programs and personnel that implement HIV-prevention services, including programs by communities at risk for, vulnerable to, & living with HIV	For sectoral programs ▪ DOH ▪ DSWD ▪ DepEd and CHED ▪ DOLE and TESDA For facilitating local programs ▪ DILG ▪ PLHIV community ▪ PNAC Civil Society Organization (CSO) members	■	■	■	■	■	■
1.1.4 Program Assessment Assess results of program implementation, as needed, & study its effectiveness to further enhance its design, standards, and/or implementing guides	For sectoral programs ▪ DOH ▪ DSWD ▪ DepEd and CHED ▪ DOLE and TESDA For facilitating local programs ▪ DILG ▪ PLHIV community ▪ PNAC CSO members	■	■	■	■	■	■

Output 1.1 – Contextual Guide for Operational Planning and Costing

Program design for HIV prevention (1.1.1) is intended to be both comprehensive and focused HIV education and other services that include building life skills to address HIV risk behavior. Focus on interventions designed to prevent HIV infection is the leading priority of the national response, in keeping with the country's low prevalence and concentrated epidemic status. Such an approach takes into account sexual and other primary health concerns, socio-economic vulnerabilities, mitigation of the impact of HIV, and the importance of resolving stigma and discrimination. Within a common frame, it assesses and actively addresses potential access barriers related to age, sex, sexual orientation and gender identify, risk behavior and other vulnerabilities to ensure equal access to the comprehensive set of services. The design can be packaged further according to learning settings, whether in communities, integrated in facility services, or through institutions of key development sectors.

The program design is interested primarily to provide adequate coverage for services intended to prevent sexually transmitted infections, sexual transmission of HIV and transmission through injecting drug use, HIV transmission through needle-stick injuries in health-care settings, and mother-to-child transmission, and provide testing for HIV and counseling. Of equal importance is its twin priority to trigger knowledge and behavior change among the most-at-risk and vulnerable populations. According to the 2010 UNGASS narrative report, Universal Access has targeted 80-percent coverage of prevention programs to make an impact on the epidemic, and aims to ensure at least 60 percent of the most-at-risk

and vulnerable populations gain the correct knowledge and behavior to reverse the epidemic and stop HIV transmission. However, for a general increase in knowledge among MARPs due to improved prevention coverage, the UNGASS report noted that there was no change in condom use among FSWs and MSM from the previous report to the present. With the low prevention coverage, low knowledge, and low condom use noted among MARPS in the previous report, the 2010 report registered an astounding 900-percent rise in HIV cases among these groups – specifically among MSMs and PWIDs. The national response was clearly nowhere near the UA targets, thus making it imperative to widen and intensify prevention interventions among the MARPs.

To enhance prevention outcomes, the importance of recognizing social and demographic changes and probable social trends that may have bearing in the HIV transmission is emphasized in the Technical Advisory authored by Oscar F. Picazo of the U.P. School of Economics. These include the prevalent use of information technology, urbanization, new work arrangements such as the graveyard shift for call center workers, and demographic realities such as the fact that 43.4 percent of the country's population is 24 years old and younger.

In this regard, thus, pertinent development activities consider best evidence, priorities defined in the 5th AMTP, aligning program packaging with the development strategies of response sectors, and supplementing design with standards, guidelines, and other tools to aid the set-up and management of programs.

Referral networks for HIV prevention (1.1.2) enrich program experience as well as consolidate responsiveness of service delivery points from different sectors. As a linking mechanism to fulfill the program design for HIV prevention, the referral networks build on the gains of the system established in the 4th AMTP and are sensitive to the multi-faceted nature of vulnerability among diverse beneficiaries.

Service capacity building (1.1.3) sees to it that the comprehensive program packages are settled in, utilizing existing and planned physical, fund, and human resources. As a set of actions transitioning between program design and delivery, it adjusts according to the situation at service delivery points – public or private, community level, or within facility services or institutional programs. Capacitating also means assuring quality compliance with standards, which may mean putting in place regulations in the conduct of services.

Program assessment (1.1.4) refers to the utilization of strategic information through routine monitoring, progressive assessment or evaluation, and where necessary, the employment of special studies to test the effectiveness of the implementation of comprehensive design packages. Activities should also consider participatory analysis and decision-making towards implementing modifications in program design and packages.

Output 1.2 – <u>comprehensive HIV prevention program delivery</u> – includes among its major activities instituting and budgeting programs, building capacity to access services, and service delivery (inclusive of necessary drugs, and other commodities and materials). See Table 3-B and corresponding notes below.

Table 3-B. Implementation Matrix for Strategic Objective 1, Output 1.2

Output 1.2	Persons at risk for, vulnerable to & living with HIV are reached by comprehensive and sustainable prevention services						
Comprehensive HIV Prevention Program Delivery							
Major Activities	**Lead Agencies**	**Time Frame (Years)**					
		'11	**'12**	**'13**	**'14**	**'15**	**'16**
1.2.1 Program Institution Adopt comprehensive HIV prevention program and allocate budgets for prevention services delivery	For wide, all-sector policy ▪ House of Representatives ▪ Senate ▪ NEDA For sectoral policy ▪ DOH ▪ DSWD ▪ DepEd and CHED ▪ DOLE and TESDA For facilitating local policy ▪ DILG ▪ League of Cities ▪ League of Provinces	■	■	■	■	■	■
1.2.2 Client Capacity Building Build capacities of communities at risk for, vulnerable to, & living with HIV to access prevention services	For direct service provision ▪ PLHIV community ▪ Civil Society Organizations (CSOs) with HIV programs	■	■	■	■	■	■
1.2.3 Services Delivery Provide HIV prevention services, utilizing (where necessary) STI drugs and reagents, HIV prevention commodities, BCC and other materials and services	For sectoral programs ▪ DOH (with direct services) ▪ DSWD (with direct services) ▪ DepEd and CHED ▪ DOLE and TESDA For facilitating local programs ▪ DILG ▪ League of Cities ▪ League of Provinces	■	■	■	■	■	■

Output 1.2 – Contextual Guide for Operational Planning and Costing

Program institution of HIV prevention (1.2.1) pushes for the buy-in and adoption of the comprehensive program design, packaged in appropriate scales according to sectoral structures and service delivery points. Related activities include advocacy actions, policy making, and development platforms like program and investment planning. These may be undertaken on a national scale in specific sectors, and at local levels.

Client capacity building (1.2.2) refers to both individual and community capacities to take up and maximize services, and sustain benefits from these. Largely delivered through community systems, it includes supporting interventions such as psychosocial services, impact mitigation, stigma reduction, and rights protection. Through these, by extension, primary health, sexual health, and social welfare programs may also be referring points.

Services delivery (1.2.3) is focused on the core – or essential minimum – of HIV prevention service packages. The 5th AMTP emphasizes that the core package be delivered through existing infrastructure, ensuring ample supply that already anticipates the surge in growth of demand, and minimizing spillovers and stock-outs. Greater priority is on intensified efforts to address risks associated with male-to-male (i.e., at-birth male) sex and sharing of needles among Persons Who Inject Drugs (PWID). This section also ensures that interventions are sustained and expanded for women in prostitution, interventions are built up for male clients of female sex workers, and access to interventions facilitated for Filipino migrant workers and younger segments of the population (youth at higher risk). The degree of efforts may vary across different geographical settings. With a referral network, interventions will be provided through a system of delivery points and facilitated by quality cooperative arrangements between sectoral programs and direct services. Likewise, targets in terms of structural and intervention support will be adjusted to ensure that certain prevailing policies and practices do not impede access to interventions of the most-at-risk and vulnerable populations.

Strategic Objective 2

Treatment, Care and Support Programs: to improve the quality and coverage of the treatment, care, and support package for persons most-at-risk for, vulnerable to, and living with HIV and their affected families

Key Strategies

2.1. Develop evidence-based, targeted, and comprehensive programs/services for treatment, care and support (TCS);

2.2. Capacitate service providers in the delivery of quality and comprehensive programs/ services on treatment, care, and support;

2.3. *Provide equitable access* to comprehensive programs/services on TCS through health promotion; and

2.4. Enhance the decentralized implementation of the 5th AMTP.

Major Activities

Strategic Objective 2 intends to help in enabling people living with HIV enjoy healthier, more productive lives. Its major outputs include the comprehensive design and scaled-up delivery of treatment, care, and support (TCS) programs. Major activities under Output 2.1 – *comprehensive TCS program design* – include establishing the program's design and implementation guides, improving its supporting referral system, capacitating relevant personnel and programs, and assessing and testing the effectiveness of program implementation. See Table 3-C and corresponding notes below.

Table 3-C. Implementation Matrix for Strategic Objective 2, Output 2.1

Output 2.1	Comprehensive and sustainable treatment, care and support (TCS) services designed and implemented in a quality-assured manner						
Comprehensive Treatment, Care and Support Program Design							
Major Activities	**Lead Agencies**	**Time Frame (Years)**					
		'11	**'12**	**'13**	**'14**	**'15**	**'16**
2.1.1 Program Design Establish a comprehensive program, including implementing guides for treatment, care, and support for PLHIV, including women and children	For sectoral programs ▪ DOH ▪ DSWD ▪ DepEd and CHED ▪ DOLE and TESDA For facilitating local programs ▪ DILG ▪ PLHIV community	■	■	■			
2.1.2 Referral Networks Improve referral systems to support service delivery networks implementing the comprehensive TCS program	For wide, all-sector programs ▪ DSWD ▪ PLHIV community	■	■				
2.1.3 Service Capacity Building Build capacities of programs and personnel that implement TCS services, including programs by communities at risk, vulnerable to, & living with HIV	For direct service provision ▪ DOH ▪ PLHIV community ▪ CSOs with HIV programs	■	■	■	■	■	■
2.1.4 Program Assessment Assess results of program implementation, as needed, study its effectiveness, to further enhance its design, standards and/or implementing guides	For sectoral programs ▪ DOH ▪ DSWD ▪ DepEd and CHED ▪ DOLE and TESDA For facilitating local programs ▪ DILG ▪ PLHIV community	■	■	■	■	■	■

Output 2.1 – Contextual Guide for Operational Planning and Costing

Program design for treatment, care, and support or TCS (2.1.1) emphasizes optimum standards of health and a comprehensive approach that is responsive to the various needs and concerns of PLHIVs, their significant others, and affected families. Focused on ensuring that PLHIVs continue to be socio-economically productive, the program design has the following requisites:

First, set within contexts of sexual and primary health needs, socio-economic vulnerability, impact mitigation, and resolving of stigma and discrimination;

Second, differentiated according to the age, sex, sexual orientation and gender identity, and continued risk and vulnerability situations of PLHIVs and HIV-affected people; and

Third, packaged according to learning and/or service settings.

Development activities consider the biomedical and social situations affecting people living with the disease, priorities in further strengthening health systems, contributory responses of other sectors' development strategies, and the need to supplement design with standards, guidelines, and other tools to aid the set-up and management of programs.

Referral networks for TCS (2.1.2) enrich program experience as well as consolidate responsiveness of service delivery points from different sectors. As a linking mechanism to fulfill the TCS program design, they further enhance the system established in the 4th AMTP, sensitive to the multi-faceted nature of vulnerability among diverse beneficiaries.

Service capacity building (2.1.3) tackles the settling in of packages of the comprehensive program, utilizing existing and planned physical, budgetary, and human resources. A set of actions transitioning between program design and delivery, it also diversifies according to settings of service delivery points – public or private, community level, within facility services or institutional programs. Capacitating also comes with assuring quality compliance with standards, which may mean enforcing regulations in the conduct of services.

Program assessment (2.1.4) refers to the utilization of strategic information through routine monitoring, progressive assessment, and where necessary, employment of special studies to test the effectiveness of packages of the comprehensive design as implemented. For purposes of implementing modifications in program design and packages, activities should also consider participatory analysis and decision-making.

Output 2.2 – *comprehensive treatment, care and support (TCS) program delivery* – includes among its major activities instituting and budgeting programs, building capacity to access services, and service delivery (inclusive of necessary drugs as well as other commodities and materials). See Table 3-B and corresponding notes below.

Table 3-D. Implementation Matrix for Strategic Objective 2, Output 2.2

Output 2.2	**Persons living with HIV, including pregnant women and children, are reached by comprehensive and sustainable treatment, care and support services**						
Comprehensive Treatment, Care and Support Program Delivery							
Major Activities	**Lead Agencies**	**Time Frame (Years)**					
		'11	**'12**	**'13**	**'14**	**'15**	**'16**
2.2.1 Program Adoption Adopt comprehensive TCS program and allocate budgets for TCS service delivery, including integration of TCS to the universal health care package	For sectoral programs ▪ DOH	■	■	■	■	■	■
2.2.2 Client Capacity Building Build capacities of communities of PLHIV and their families to access TCS services	For direct service provision ▪ PLHIV community ▪ CSOs with HIV programs	■	■	■	■	■	■
2.2.3 Services Delivery Provide TCS services, utilizing where necessary, ARV, OI drugs, medicines, reagents	For sectoral programs ▪ DOH	■	■	■	■	■	■

Output 2.2	Persons living with HIV, including pregnant women and children, are reached by comprehensive and sustainable treatment, care and support services						
Comprehensive Treatment, Care and Support Program Delivery							
Major Activities	Lead Agencies	Time Frame (Years)					
		'11	'12	'13	'14	'15	'16
and commodities, BCC and other materials and services							

Output 2.2 – Contextual Guide for Operational Planning and Costing

Program adoption (2.2.1) refers to relevant institutional and community work having adequate resources to integrate the comprehensive design of complementing clinical and psychosocial packages that represent the spectrum of responses to asymptomatic and symptomatic conditions of persons living with HIV (PLHIVs). Activities include intensifying advocacy actions, the resulting policy actions, and enhancing programs, including planned and assured investments to develop capacities. PLHIVs' family and community systems must also benefit from a health care package that sustains participation in TCS programs.

Client capacity building (2.2.2) refers to enabling both individuals and communities to acquire the skills to take up and maximize services, and sustain benefits from these. Capacity building among persons living with HIV (PLHIVs), their families, and communities shall focus on achieving a life balance or healthy adjustments in the context of HIV and related diseases, and strengthening lifetime commitment to survival from HIV. Largely delivered through community systems, capacity building includes supporting interventions such as impact mitigation, stigma reduction, and rights protection. Through these, by extension, programs on primary health, sexual health, and social welfare may also serve as referring points for HIV cases.

Services delivery (2.2.3) signifies the complex of essential health services for PLHIV such as monitoring progression of the infection, initiation and adherence to antiretroviral drugs (ARV) regimens, treatment and prophylaxis of opportunistic infections (OIs), nutrition, and palliative care. The 5th AMTP is about delivering services with adequate supply within existing infrastructure, anticipating the surge in growth of demand, with emphasis on minimizing spillovers and stock-outs. Considering the trend showing an increase in the number of asymptomatic and younger age cases, steps toward relevant patient services should be taken to curb the surging demand for anti-retroviral treatment (ART) initiation. Likewise, ART programs must strengthen adherence to regimens among enrollees. Targets for treatment, care, and support (TCS) are also oriented toward solidifying the establishment of more focused delivery systems such as that of the HIV/TB collaboration, prevention of mother-to-child transmission (PMTCT), and pediatric AIDS. With a referral network, comprehensive TCS implies quality cooperative arrangements between sectoral programs and direct services.

Strategic Objective 3

HIV and AIDS Policy Environment: to enhance policies for scaling up implementation, effective management, and coordination of HIV programs at all levels

Key Strategy

Provide an enabling environment for evidenced-based policies, standards, and guidelines at the local and national levels among government units and agencies

Major Activities

Strategic Objective 3, which focuses on the HIV and AIDS policy environment, is one of three 5th AMTP objectives that will contribute to a well-governed and accountable national response structure. Its major outputs include policies in support of upgrading comprehensive HIV prevention and TCS programs, mechanisms to address HIV stigma and discrimination, and setting a national gender-sexuality framework for HIV responses in view of its key strategy of providing an enabling environment. Major activities under Output 3.1 – policies supporting HIV prevention and TCS programs – include policy-making in support of sustainable access to commodities and services, policy-making to address behaviors at high risk for HIV transmission, and audits to determine if these policies are reflected in prevention and TCS packages. See Table 3-E and corresponding notes below.

Table 3-E. Implementation Matrix for Strategic Objective 3, Output 3.1

OUTPUT 3.1	**Policies developed and instituted to support comprehensive and evidence-based HIV prevention and TCS programs**						
Policies Supporting HIV Prevention, Treatment, Care and Support Programs							
Major Activities	**Lead Agencies**	**Time Frame (Years)**					
		'11	**'12**	**'13**	**'14**	**'15**	**'16**
3.1.1 Policies to Address Access Establish policies that enable sustainable access to drugs, commodities and services on HIV prevention and TCS in all domains of the response	For wide, all-sector policies ▪ House of Representatives ▪ Senate For sectoral policies ▪ DOH ▪ DSWD ▪ DepEd and CHED ▪ DOLE and TESDA For facilitating local policies • DILG	■	■	■	■	■	■
3.1.2 Policies to Address Risks Establish policies that enable appropriate and needed responses to risk behaviors associated with HIV transmission	For wide, all-sector policies • House of Representatives • Senate For sectoral policies • DOH For facilitating local policies ▪ DILG	■	■	■	■	■	■
3.1.3 Application of Policies Assure compliance of comprehensive HIV prevention and TCS packages with enabling policies	For national policy M&E ▪ NEDA For sectoral policy M&E ▪ DOH ▪ DSWD ▪ DepEd and CHED ▪ DOLE and TESDA For facilitating local policy M&E ▪ DILG			■			■

Output 3.1 – Contextual Guide for Operational Planning and Costing

Policies to address access (3.1.1) refer to the compulsory application of tools or resources to ensure ample and sustained provision of drugs, commodities, and services. This section may also call for an examination and review of existing policies, necessary updating of limiting policies, and establishing new policies where they are lacking to help ensure sufficient and sustainable availability of technologies, devices, prophylactics, and prevention and TCS services. Pertinent issues include public sector distribution of prophylactics, HIV counseling and testing services, shared medical confidentiality in service delivery norms, sustainability of anti-retroviral treatment (ART), and related health and diagnostic services.

Policies to address risks (3.1.2) refer to maximising discourse platforms to provide greater opportunities for establishing stronger bases to address HIV transmission and risk behaviors among persons who inject drugs (PWID), men having sex with men (MSM), and transgender communities as well as non-establishment-based women in prostitution, bridging the interactions of these populations with young people and lower risk males and females. Related activities may also include policy review and the setting of priority policy agenda.

Application of policies (3.1.3) needs appropriate tools for monitoring its compliance such as influencing (i.e., incorporation into) the development of comprehensive designs and adopting services into programming across levels and domains of the national HIV response. Methodologies may both include self-reporting among stakeholders and other duty-bearers and participatory assessment, through the composite indexing of policies, involving sectors and communities.

Major activities for Output 3.2 – *mechanisms supporting stigma reduction and protection from discrimination* – include human rights education for most-at-risk populations (MARPs), vulnerable, and persons living with HIV (PLHIV) communities, human rights protection in prevention and treatment, care and support (TCS) service delivery points, and the fulfillment of human rights guarantees through operational redress mechanisms. See Table 3-F and corresponding notes below.

Table 3-F. Implementation Matrix for Strategic Objective 3, Output 3.2

OUTPUT 3.2	Approaches and mechanisms strengthened to reduce stigma and discrimination among persons at risk for, vulnerable to, & living with and affected by HIV						
Mechanisms Supporting Stigma Reduction and Protection from Discrimination							
Major Activities	**Lead Agencies**	**Time Frame (Years)**					
		'11	**'12**	**'13**	**'14**	**'15**	**'16**
3.2.1 Awareness of Rights Improve rights awareness of persons at risk for, vulnerable to, and living with HIV	For direct service provision ▪ DSWD ▪ PLHIV community ▪ CSOs with HIV programs For facilitating sectoral responses ▪ DOH ▪ DepEd and CHED ▪ DOLE, CSC and TESDA For facilitating local responses ▪ DILG	■	■	■	■	■	■

OUTPUT 3.2	Approaches and mechanisms strengthened to reduce stigma and discrimination among persons at risk for, vulnerable to, & living with and affected by HIV						
Mechanisms Supporting Stigma Reduction and Protection from Discrimination							
Major Activities	**Lead Agencies**	**Time Frame (Years)**					
		'11	**'12**	**'13**	**'14**	**'15**	**'16**
3.2.2 Capacity Building for Rights Build capacities of HIV prevention and TCS programs and personnel to respect and uphold the rights of affected communities	For direct service provision ▪ DSWD ▪ PLHIV community ▪ CSOs with HIV programs For facilitating sectoral responses ▪ DOH ▪ DepEd and CHED ▪ DOLE, CSC* and TESDA For facilitating local responses ▪ DILG		■	■	■	■	■
3.2.3 Redress Mechanisms Establish mechanisms and processes to protect rights and address grievances of persons at risk for, vulnerable to, and living with HIV	For wide, all-sector structures ▪ CHR* ▪ DOJ For sectoral structures ▪ DOH ▪ DepEd and CHED ▪ DOLE and CSC* For facilitating local structures ▪ DILG	■	■	■			

Output 3.2 – Contextual Guide for Operational Planning and Costing

Awareness of rights (3.2.1) among communities at risk for, vulnerable to, and living with HIV (i.e., holders of rights to health) is the context that serves as the basis for increasing the capacity of people to access and participate in improvements to prevention and treatment, care, and support (TCS) service provision. It is a specific item in the agendum for strengthening community systems as well as an integral element of server-client interfaces as those in education and other communications activities. A necessary enhancement for the 5th AMTP implementation would be developing the means for monitoring and evaluation (M&E) systems to measure awareness and demonstration of integration in services.

Capacity building for rights (3.2.2) among providers, programs, and institutions that execute policies across the response domains shall be integral to building their capacities to deliver their respective packages in prevention and TCS. However, the application of a human right-based approach in the development of comprehensive designs, including subsequent behavior change communication (BCC) standards and related communications guides, serves as its starting point. As a standard in service performance, respect for and upholding the rights of clients may likewise be part of quality assurance.

Redress mechanisms (3.2.3) refer to the systems by which guarantees to the protection of rights, as embodied in the AIDS Prevention and Control Act or R.A. 8504, are fulfilled. In addition, a framework that demonstrates a strong shift toward a client-oriented approach, with a mechanism through which

PLHIVs and HIV-vulnerable persons can avail of legal services for the redress of their grievances arising from situations related to their health condition, will have to eventually integrate and cover all domains of the response. The mechanism's accessibility is also meant for integration into design development and the adoption of comprehensive programs, into capacity building of services and personnel, and into standards for education and other communications activities where its content is relevant. The M&E system must be enhanced to assure compliance with the mechanism, the effective functioning of the institutional arrangements, and safekeeping of records of resulting actions on investigations and the administration of justice for the sake of the aggrieved.

Output 3.3 – *gender-sexuality framework for HIV prevention and TCS* – includes among its major activities the building of a national gender-sexuality framework for HIV and AIDS as well as auditing to determine if the framework is reflected in prevention and treatment care, and support (TCS) packages. See Table 3-G and corresponding notes below.

Table 3-G. Implementation Matrix for Strategic Objective 3, Output 3.3

OUTPUT 3.3	**Gender-sexuality frameworks developed and instated in policies, plans and programs on HIV prevention and TCS**						
Gender-Sexuality Framework for HIV Prevention, Treatment, Care and Support							
Major Activities	**Lead Agencies**	**Time Frame (Years)**					
		'11	**'12**	**'13**	**'14**	**'15**	**'16**
3.3.1 Framework Development Establish a national framework that enables a sexuality- and gender-based national HIV and AIDS response	For wide, all-sector policy ▪ House of Representatives ▪ Senate For sectoral policy ▪ DSWD ▪ CSOs with related programs	■	■				
3.3.2 Application of Framework Assure compliance of comprehensive HIV prevention and TCS packages with the framework	For wide, all-sector policy M&E ▪ NEDA For sectoral policy M&E ▪ DOH ▪ DSWD ▪ DepEd and CHED ▪ DOLE and CSC* For facilitating local policy M&E ▪ DILG			■			■

Output 3.3 – Contextual Guide for Operational Planning and Costing

Gender-sexuality framework development (3.3.1) considers the general absence of a gender- and development-enabling framework that includes sexual orientation and gender identities, and a reframing necessary to strengthen the basis for facilitating safer behaviors in relation to risks in sexual health, including HIV. Related activities seek to maximize advocacy and policy-making platforms to elicit discourse and decision-making for suitable (or even transitional) guidance that could influence the formulation of a comprehensive prevention and TCS program. Platforms include networking activities that would bring together the stakeholders in gender and development issues.

Application of a gender-sexuality framework (3.3.2) looks primarily into mainstreaming HIV and AIDS into existing gender audit systems. This is part of an enhancement to the National Monitoring & Evaluation System and enables a level of assessment of the development of a gender-sexuality framework and its subsequent application in the comprehensive designs, including integration, as the programs are adopted across all domains of the response. It intends for the national response to be able to capture information for application to the comprehensive program, its implementing guides, its packages, capacity building of services and programs, and behavior change communication (BCC) services and supporting communications campaigns.

Strategic Objective 4

The Philippine National AIDS Council (PNAC): To strengthen capacities of the PNAC and its members to oversee the implementation of the 5th AMTP

Key Strategy

Expand, build, and strengthen management systems and supports, partnerships, and collaboration in the implementation of the national response

Major Activities

Strategic Objective 4 focuses on the PNAC and its members' oversight capacities and is the second of three 5th AMTP objectives pertaining to the management of the national response. By strengthening management systems and collaborative work with partners as a key strategy, its major outputs involve the PNAC's organizational development as well as internal coordination and collaboration mechanisms. Output 4.1 – *strengthened organizational functioning of the PNAC* – includes in its major activities the operationalisation of the 5th AMTP, strengthening of the PNAC members and Secretariat's respective capacities, and improvement of the PNAC's resident information systems. See Table 3-H and corresponding notes below.

Table 3-H. Implementation Matrix for Strategic Objective 4, Output 4.1

OUTPUT 4.1	Capacity of PNAC strengthened to perform its function as the central advisory, planning, and policymaking body of the national response						
Strengthened Organizational Functioning of PNAC							
Major Activities	**Lead Agencies**	**Time Frame (Years)**					
		'11	**'12**	**'13**	**'14**	**'15**	**'16**
4.1.1 5th AMTP Operations Implement budgeted 5th AMTP operational plans of PNAC and respective members	▪ PNAC members ▪ PNAC Secretariat	■	■	■	■	■	■
4.1.2 PNAC Members Strengthen capacities of PNAC members to perform Council and organizational functions	▪ PNAC members ▪ PNAC Secretariat	■	■	■			
4.1.3 PNAC Secretariat	▪ PNAC Secretariat	■	■	■			

OUTPUT 4.1	Capacity of PNAC strengthened to perform its function as the central advisory, planning, and policymaking body of the national response						
Strengthened Organizational Functioning of PNAC							
Major Activities	**Lead Agencies**	**Time Frame (Years)**					
		'11	**'12**	**'13**	**'14**	**'15**	**'16**
Strengthen capacities of PNAC Secretariat to perform organizational functions							
4.1.4 National M&E System Improve systems in HIV and AIDS program monitoring and evaluation of evidence-based policy & program development and planning	▪ PNAC Secretariat	■	■	■	■	■	■

Output 4.1 – Contextual Guide for Operational Planning and Costing

The **Fifth AMTP operations (4.1.1)** refer to the determination of annual performance targets – including resource mobilization requisites – through planning activities covering the first and second halves of the 5th AMTP implementation, and intervening assessments. Operational planning and costing are set within the context of strengthening the leadership and performance of the PNAC member agencies, particularly leadership and performance within key development sectors, and bridging leaderships with other levels and domains of the response. Related activities should also work toward securing high levels of political commitment, which also facilitate securing of existing and planned physical, fund, and human resources for the operations.

The PNAC members (4.1.2) pertain to the strengthening of capacities among the PNAC members in performing Council functions and their respective expectations and responsibilities in the national response. Council functions include the designation of representatives to the council organizational design, and participation in activities that aid the PNAC's performance of its mandates. Respective members' functions include management, coordination, and monitoring work which – in being aligned with performance in the 5th AMTP implementation – will mean undertaking institutionalization initiatives. This may also necessitate the development of agency-level codification of structures and performance expectations.

The PNAC Secretariat (4.1.3) is about the strengthening of the PNAC Secretariat's capacity to perform bridging/facilitating leadership roles to maintain Council functions, as well as coordinating and monitoring 5th AMTP operations among members and participating partners. This will require augmenting existing resources that manage the Secretariat, particularly in terms of its human resources. To advance, the organizational development of the Council, activities may include the development of the PNAC Manual of Operations.

The National Monitoring and Evaluation or M&E System (4.1.4), being at the core of the management information systems necessary for the fulfillment of the Council's oversight function, shall be enhanced according to the implementation arrangements for the national strategy. The system shall also develop and oversee implementation of research agenda to aid evidence-based policy formulations, programmatic guidance, and planning.

Output 4.1 – *strengthened coordination and collaboration in the PNAC* – includes among its major activities the strengthening of the Regional AIDS Assistance Teams (RAATs) and improving efficiency of the National M&E System's function. See Table 3-I and corresponding notes below.

Table 3-I. Implementation Matrix for Strategic Objective 4, Output 4.2

OUTPUT 4.2	Inter-agency coordination and collaboration strengthened to monitor contributions in implementation of the 5th AMTP						
Strengthened Coordination and Collaboration in PNAC							
Major Activities	Lead Agencies	Time Frame (Years)					
		'11	'12	'13	'14	'15	'16
4.2.1 Regional AIDS Assistance Strengthen capacities of RAATs in aiding 5th AMTP implementation in strategic priority areas	▪ DOH ▪ DSWD ▪ DILG	■	■	■			
4.2.2 M&E Performance Improve efficiency of National M&E System to track progress of 5th AMTP implementation	▪ PNAC members ▪ PNAC Secretariat	■	■	■	■	■	■

Output 4.2 – Contextual Guide for Operational Planning and Costing

Regional AIDS Assistance Teams or RAATs (4.2.1) are instrumental in carrying through comprehensive designs and sectoral responses to local governments in their areas of responsibility, with emphasis in fast-tracking 5th AMTP implementation in strategic priority localities, i.e. the local responses beset by heavier burdens of the epidemic. Likewise, capacity-building packages for executing advocacy, assistance to policy actions, and planning and program development are most urgent to responding RAATs. However, the approach will not negate the longer-term strategies or all RAATs' ability to facilitate comprehensive coverage of local responses as guaranteed by law.

Monitoring and Evaluation or M&E performance (4.2.2) is integral to RAATs' execution of advocacy and delivery of technical assistance for local responses, M&E being the binding management model with related national government agency members and the PNAC. The performance frameworks of national agencies' operations and cost plans, advocacy and technical assistance work plans of respective regional down lines, and results of services delivery and other activities comprising local responses must be commonly structured and guided by the 5th AMTP. The National M&E System must also ensure its ability to measure the efficiency of its modality.

Strategic Objective 5

Partnerships on HIV and AIDS: To strengthen partnerships with and develop the capacities of local government units (LGUs), civil society organizations (CSOs), the private sector, and community-based organizations, including those at risk, vulnerable to, and are living with HIV for the 5th AMTP implementation

Key Strategy

Develop capacity of partners in the national response to include local governments, the private sector, and communities at risk for, vulnerable to, and living with HIV in the implementation of the 5th AMTP

Major Activities

Strategic Objective 5, focuses on capacities of partnerships and networks across domains of the response, is the third objective in the 5th AMTP that also aims for good governance and accountability. With developing the capacities of partners and networks as a key strategy, its major outputs involve strengthening HIV governance and programs of local governments as well as communities at risk for, vulnerable to, and living with HIV, and enhancing further participation of other institutions and private sectors in the response. Output 5.1 – *strengthened local governments* – includes among its major activities the establishment of local partnership platforms, the localization of 5th AMTP implementation, and aiding the functionality of local HIV governance bodies and their members. See Table 3-J and corresponding notes below.

Table 3-J. Implementation Matrix for Strategic Objective 5, Output 5.1

OUTPUT 5.1	Capacities of local governments strengthened for coordinated, multi-sector HIV responses in priority strategic areas						
Strengthened Local Governments for HIV and AIDS Responses							
Major Activities	Lead Agencies	Time Frame (Years)					
		'11	'12	'13	'14	'15	'16
5.1.1 Local Partnership Platforms Establish partnership platforms with LGUs to strengthen 5th AMTP implementation in strategic priority areas	For facilitating local structures ▪ DILG ▪ League of Cities ▪ League of Provinces ▪ PNAC CSO members	■	■	■	■	■	■
5.1.2 5th AMTP Localization Implement in strategic priority areas budgeted local HIV and AIDS plans consistent with 5th AMTP framework	For facilitating local policies ▪ DILG ▪ League of Cities ▪ League of Provinces	■	■	■	■	■	■
5.1.3 Local AIDS Governance Assist building capacities of local AIDS governance bodies and their members to perform oversight and respective organizational functions	For facilitating local structures ▪ DILG (lead) ▪ DOH ▪ DSWD	■	■	■	■	■	■

Output 5.1 – Contextual Guide for Operational Planning and Costing

Local partnership platforms (5.1.1) enhance the implementation of the 5th AMTP within a decentralized system of health and other development programs. These activities complement the assistance and coordination mechanisms operated through the Regional AIDS Assistance Teams (RAATs) and the enhanced National Monitoring and Evaluation (M&E) System, and are designed to improve handholding

relations with local responses (with emphasis on responses in strategic priority localities) in terms of participatory reviews, decision-making, and reinforcing political commitments.

Fifth AMTP localization (5.1.2) is the basis of local partnership platforms and complementation to assistance in building capacities for functional LGU-level HIV and AIDS governance. Being the key theme of advocacy actions that are championed by Regional AIDS Assistance Teams (RAATs) and local leader allies, localization will not only translate the 5th AMTP into local response frameworks but will also affect political commitments among local chief executives and local legislative councils, resulting to policies and plans such as the integration of HIV and AIDS priorities in annual investment plans and budgets.

Local AIDS governance (5.1.3) mirrors organizational development efforts at the national level of the response. Through technical assistance mechanisms, these activities intend to animate oversight functions of multi-sector HIV and AIDS governance bodies such as local AIDS councils, work groups, and/or committees. It may also include efforts to facilitate the enactment of such mandates and structures, where non-existent. As the 5th AMTP's implementation considers the responsiveness of sectoral structures, so too should counterpart structures at the local level – where direct efforts from the national level may be included to complement the regional mechanisms.

Output 5.2 – *strengthened communities at risk for, vulnerable to, and living with HIV* – includes community systems' strengthening activities such as establishing the meaningful engagement of persons living with HIV (PLHIV), most-at-risk populations (MARPs), and other vulnerable groups in local leadership as well as their capacity to develop and run their own programs. See Table 3-K and corresponding notes below.

Table 3-K. Implementation Matrix for Strategic Objective 5, Output 5.2

OUTPUT 5.2	Capacities of communities at risk for, vulnerable to, and living with HIV strengthened for program development and participation in governance						
Strengthened Communities for HIV and AIDS Responses							
Major Activities	Lead Agencies	Time Frame (Years)					
		'11	'12	'13	'14	'15	'16
5.2.1 Participation in Governance Enable meaningful engagement of communities in governance and management of HIV and AIDS responses, particularly in strategic priority areas	For facilitating structures ▪ PLHIV community ▪ PNAC CSO members	■	■	■	■	■	■
5.2.2 Community-led Programs Establish programs led and directed by at-risk, vulnerable, & PLHIV communities as part of local HIV and AIDS responses	For facilitating structures ▪ PLHIV community ▪ PNAC CSO members		■	■	■	■	

Output 5.2 – Contextual Guide for Operational Planning and Costing

Participation in governance (5.2.1) consists of activities towards the able integration and active participation of organized representations of communities at risk for, vulnerable to, and living with HIV, with emphasis on the local communities in strategic priority localities. Participation includes contributing to oversight functions as well as monitoring and evaluation (M&E) in local governance bodies. Organizational development initiatives may be analogous to those of agencies representing development sectors and at the same time seeking to enhance leadership and engagement processes with the representatives' respective communities. This may also contribute to enabling national-level representation of communities to enhance network development.

Community-led programs (5.2.2) are considered central to community systems strengthening among populations at risk for, vulnerable to, and living with HIV, with a view to mobilizing their collective determination to address HIV and AIDS. Focused on strategic priority localities, the delivery of prevention and treatment, care, and support (TCS) services are primarily forms and methods of collaboration between agencies of key development sectors and community-based organizations. Moreover, development initiatives need to establish structures and competencies for organizational development, program development, and programs and services management.

Output 5.3 – *enhanced network for the national response* – includes the expansion and mainstreaming of activities such as sustaining HIV and AIDS as a priority in development partnership forums, establishing contributory responses from other public and private institutions which includes networking among them. See Table 3-L and corresponding notes below.

Table 3-L. Implementation Matrix for Strategic Objective 5, Output 5.3

OUTPUT 5.3	Participatory governance structures and mechanisms of the HIV and AIDS response enhanced						
Enhanced Network of the National HIV and AIDS Response							
Major Activities	Lead Agencies	Time Frame (Years)					
		'11	'12	'13	'14	'15	'16
5.3.1 HIV and Development Sustain inclusion of MDG#6 on HIV and AIDS in the agenda of development partnership forums	For facilitating all-sector policies ▪ NEDA	■	■	■	■	■	
5.3.2 Public, Private Responses Establish HIV and AIDS policies, plans and programs among non-PNAC government and non-government partners	For facilitating sectoral responses ▪ CSC* ▪ PMA ▪ HAIN	■	■	■	■	■	■
5.3.3 Building Response Networks Build networks with non-government sectors to expand participation in the national response	▪ PNAC members ▪ PNAC Secretariat	■	■	■	■	■	■

Output 5.3 – Contextual Guide for Operational Planning and Costing

HIV and development (5.3.1) pursues the mainstreaming of HIV and AIDS in appropriate partnership forums in order to strengthen the integration of the vision of halting the spread of the epidemic (i.e. as a Millennium Development Goal) in multi-faceted country development contexts.

Public and private responses (5.3.2) pursue the longer-term mandates as provided by the AIDS Prevention and Control Act or R.A. 8504, ensuring a countrywide enabling environment for HIV and AIDS responses that, in all settings, enable appropriate programs to help maintain low HIV prevalence in the general population. Activities include assisting compliance of government workplaces with the Civil Service Commission directive to educate the workforces on HIV and AIDS, following through these agencies' development of appropriate HIV policies in the workplace, and continuing engagements with private sector enterprises (commercial and non-commercial) along the same lines.

Building response networks (5.3.3) intends that non-government participants in the response are able to establish network structures, as may be necessary, in order to synergize their work, have facilitating platforms in collaborating with the PNAC, and establish among them collegial accountability frameworks. This promotes the further development of maiden networks among the business enterprises and faith-based communities.

In summary, Table 4 illustrates the strategy framework for the 5th AMTP implementation.

Table 4. Strategy Framework for the 5th AMTP Implementation

VISION				
The spread of HIV is halted in the Philippines				
GOAL				
By 2016, the country will have prevented further spread of HIV infection by maintaining the prevalence of less than 66 HIV cases per 100,000 populations and reduce the impact of the disease on individuals, families, sectors and communities.				
STRATEGIC OBJECTIVES				
HIV Prevention	**AIDS Treatment, Care and Support**	**HIV and AIDS Policy Environment**	**Phil. National AIDS Council**	**Partnerships on HIV and AIDS**
KEY STRATEGIES				
▪ Develop evidence-based, targeted, comprehensive programs ▪ Capacitate service providers ▪ Provide equitable access to programs ▪ Enhance decentralized implementation		▪ Provide enabling environment	▪ Expand, build, strengthen management, partnerships and collaboration	▪ Develop capacity of partners
MAJOR ACTIVITIES				
<u>Comprehensive Program Design</u> ▪ Program Design ▪ Referral Networks ▪ Service Capacity Building ▪ Program Assessment <u>Comprehensive Program Delivery</u> ▪ Program Institution ▪ Client Capacity Building ▪ Services Delivery		<u>Policies Supporting Programs</u> ▪ Policies to Address Access ▪ Policies to Address Risks ▪ Application of Policies <u>Anti-Stigma and Discrimination Mechanisms</u> ▪ Awareness on Rights ▪ Capacity Building for Rights ▪ Redress Mechanisms <u>Gender-Sexuality Framework for HIV and AIDS</u> ▪ Framework Development ▪ Application of Framework	<u>Strengthened PNAC Functioning</u> ▪ 5th AMTP Operations ▪ PNAC Members ▪ PNAC Secretariat ▪ National M&E System <u>Strengthened PNAC Coordination and Collaboration</u> ▪ Regional AIDS Assistance ▪ M&E Performance	<u>Strengthened Local Governments for Responses</u> ▪ Local Partnership Platforms ▪ 5th AMTP Localization ▪ Local AIDS Governance <u>Strengthened Communities for Responses</u> ▪ Participation in Governance ▪ Community-led Programs

G. Target Groups and Sectors of the 5th AMTP

In advancing the integrated and comprehensive country response, the 5th AMTP recognizes key segments of the population, where evident risk behavior is fueling the acceleration of the epidemic. The country's epidemiological situation continues to show the burden among MARPs: while prevention gains may be attributed to program coverage among female workers in registered night entertainment establishments, prevention programs have little or no impact on the other populations, especially between MSM and PWID. The need to expedite the scale-up of effective focused interventions in consideration of these trends shall be prioritized. Table 5 contains the latest estimates and projections of population growth according to behaviors at high risk for HIV.

Table 5. National Size Estimates for Populations at Most Risk for HIV

Most-at-Risk Populations (MARPs)	2009 Estimates		2015 Projections	
	Low Estimate	High Estimate	Low Estimate	High Estimate
Female sex workers (FSW)	109,732 (0.49%)	125,662 (0.56%)	128,003 (0.49%)	146,289 (0.56%)
- **Registered Establishments (RFSW)**	94,049 (0.42%)		n.a.	
- **Freelance (FFSW)**	15,682 (0.07%)	31,612 (0.14%)	n.a.	n.a.
Male Clients of FSW	436,702 (1.90%)	1,149,215 (5.00%)	509,205 (1.90%)	1,340,012 (5.00%)
Males who have Sex with Males (MSM)	390,733 (1.70%)	689,529 (3.00%)	455,604 (1.70%)	804,007 (3.00%)
Injecting Drug Users (IDU)	12,705 (0.03%)	21,567 (0.05%)	15,877 (0.03%)	26,462 (0.05%)

Source: Philippine MARP Size Estimates 2009 using 2007 NSO Census, 2009 IHBSS and review of literature

The estimates utilized data from the active sentinel surveillance system, and may be limited by the framework within which the system operates. In light of this, the strategy towards developing comprehensive program design implies a need to complement the usual community setting interventions of MARPs with expansion into (and facing the challenge of) addressing risk behavior among more generalized population cohorts, immediately including young people and the workforce both locally based and being deployed overseas. In consideration of developing such responses through key development sectors, priority will be placed on establishing baseline information and mainstreaming HIV vulnerabilities according to how these sectors "frame" their program beneficiaries.

Improving the quality and enhancing the coverage of TCS programs for PLHIV, their significant others, and affected families share proportionate priorities in the 5th AMTP. Using the EPP and SPECTRUM model, Table 6 demonstrates a six-year projection of the HIV burden in the general population, in terms of both prevalence and incidence, and profiled according to sex, age, and treatment needs.

Table 6. National Estimates of Adults and Children Living with and Newly Infected by HIV

Population Groups	Yearly Projections (2010 to 2015)					
	2010	2011	2012	2013	2014	2015
HIV Incidence in Adults (%)	**0.01**	**0.01**	**0.01**	**0.01**	**0.01**	**0.01**
Adults and Children Living with HIV	**12,027**	**18,376**	**25,224**	**31,254**	**38,131**	**46,505**
Male PLHIV	8,439	12,919	17,744	21,980	26,805	32,679
Female PLHIV	3,587	5,457	7,480	9,274	11,325	13,826
Adults with HIV (ages 15 and above)	11,870	18,172	24,953	30,899	37,678	45,934
Children with HIV (ages below 15)	157	204	271	355	453	571
HIV Prevalence in Adults (%)	**0.02**	**0.03**	**0.05**	**0.06**	**0.07**	**0.08**
Adults and Children Newly Infected	**3,622**	**6,768**	**7,434**	**6,871**	**8,039**	**9,926**
Adults and Children Dying from AIDS	250	360	501	728	1,024	1,385
Adults Eligible for ART (CD4 <200)	1,494	1,937	2,596	3,507	4,641	5,986
Male PLHIV Eligible for ART	1,043	1,357	1,821	2,463	3,260	4,201
Female PLHIV Eligible for ART	450	580	775	1,044	1,381	1,784
Female PLHIV in Need of PMTCT	**215**	**311**	**440**	**562**	**682**	**822**

Estimates show that the country, even with the current state of the responses, may remain a low-prevalence country. This means that adults (i.e. people aged 15 to 49 years) living with HIV will not constitute more than one percent of the population. However, the staggering scale of year-on-year increases in HIV cases based on current projections underscores the need to intensify the national effort to curb the disease. If the current state of responses stays, the country will find itself unable to cope with the epidemic sooner than expected – that is, within the medium term. (Figures 3-A and B below demonstrate the caution graphically.

Figure 3. Line Graph of HIV Estimates Using EPP and SPECTRUM Model, 2005-2015

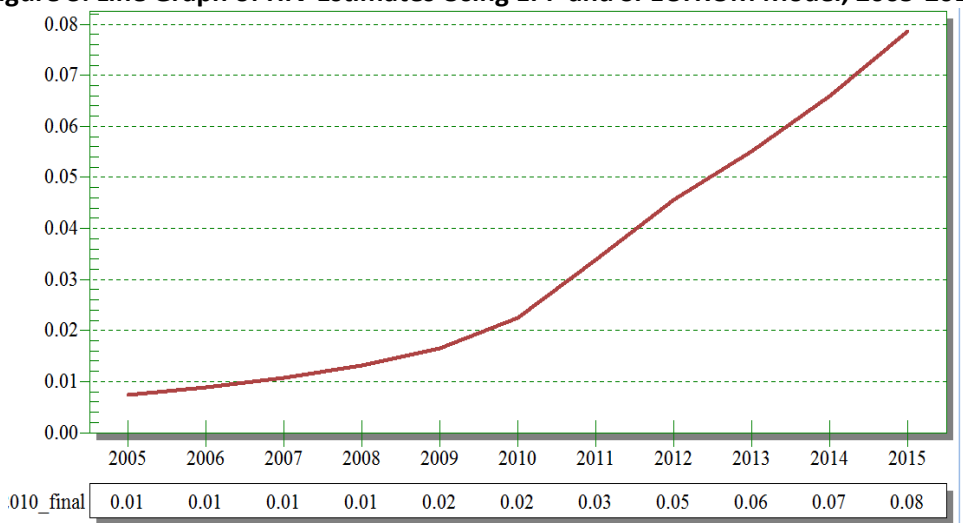
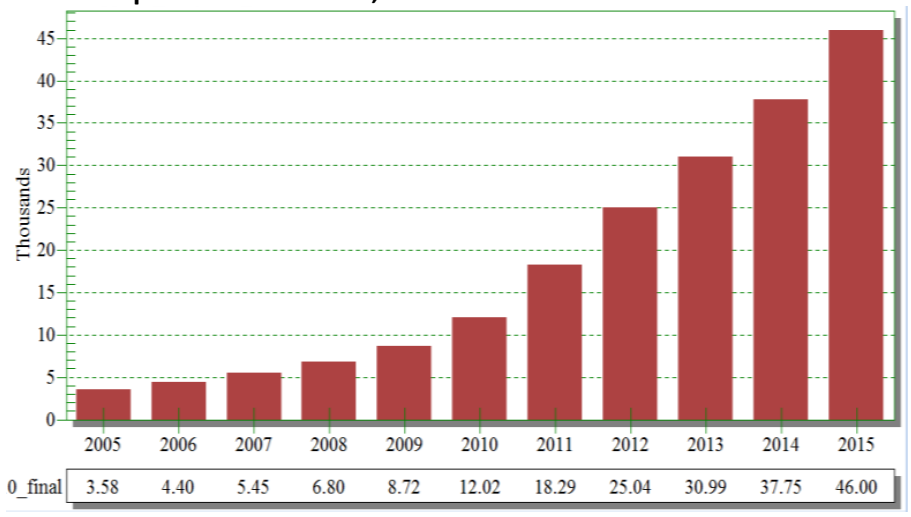


Figure 4. Bar Graph of HIV Estimates, 2005-2015



Source: National Epidemiology Center, Department of Health

Duty-bearers such as service deliverers, gatekeepers, and stakeholders are recognized as valuable secondary and tertiary targets, for they are the human and institutional resources that will ensure the primary beneficiaries' optimal access to HIV-related services. Enabling full and effective system support

in delivery of programs may be most apparent, where surveillance and vulnerability assessments commonly point to urban locales of the National Capital Region, Central Visayas, Southern Tagalog, Davao, and Central Luzon. Distinctly manifest in the 5th AMTP is the critical and strategic role of local governance, where successes in inter-agency collaboration and multi-sector approaches were evident even in the 4th AMTP's performance.

National-level key actors (particularly within the major development sectors and in terms of bridging leaderships) must expedite efforts to harness their facilitating systems in order to fulfill the policy ideals embodied in R.A. 8504, a truly national coverage that is itself an essential enabler for all other direct and focused interventions. Such initiatives may be synchronized, beginning in "hotspot" or priority regions then cascading henceforth. In the following section, a description of the institutional framework and imperatives in maximizing its capacity are laid down.

H. Institutional Arrangements

The AIDS Prevention and Control Act (R.A. 8504) draws the landscape of the response to HIV and AIDS at the national and sub-national or local levels as well as the public and private sectors. The institutional framework within which the 5th AMTP will be implemented is consistent with the Philippine National AIDS Strategy as outlined in rule 1 Section 3 paragraph (f) of the implementing rules and regulation (IRR) of the AIDS law. The 5th AMTP places great emphasis on developing the capacities of systems, institutions, and personnel toward enabling and delivering critical prevention, treatment, care, and support interventions.

The PNAC, as the coordinating body, is at the forefront of the national response. Its capacity to guide, oversee, and coordinate the national response will be strengthened by pursuing the organizational development blueprint begun with the 2006 PNAC Capacity Assessment Project. This includes a reworking of the organizational structure that will improve the execution of policy recommendations and issuances as well as country HIV and AIDS plans and technical advisories, including the reporting of the status of the AIDS Prevention and Control Act (R.A. 8504) and the progress of responses. Supporting delivery are strategies such as research, monitoring and evaluation, partnership building, advocacy and social marketing, and resource mobilization. It must be noted hereon that this arrangement is a related but distinct track from ensuring the capacity of the PNAC member and non-member organizations and response sectors to fulfill their respective mandates as provided by law.

In developing the operational system of scaled-up, comprehensive interventions within the continuum of HIV prevention and AIDS treatment, care and support, the 5th AMTP will focus on building the systems capacities of key development sectors – Health, Social Welfare, Education, and Labor and Employment. This approach is consistent with the global consensus on HIV as a critical human development issue, underscoring R.A. 8504's policy declaration that the AIDS threat requires strong state action and, as a contribution to better health outcomes for Filipinos, enhancing the strategic position of HIV and AIDS in the National Development Agenda.

This focusing will not propose the development of new organizational layers within the sectors, but will endeavor to enhance the sectors' arrangements to integrate HIV and AIDS mandates into the capacities of the respective systems. It will ensure policy guidance and program support from the national levels – i.e. DOH, DSWD, DepEd, CHED and DOLE – to be more effective and efficient in its working relationships

with provincial, city, and municipal counterparts. It will definitely take off from the establishment of regional-level HIV and AIDS technical assistance as accomplished in the 4th AMTP. However, it will propose bridging leadership roles of structures in advocacy and technical support for local governance as well as socio-economic planning and development – particularly to enable local multi-sector AIDS coordinating bodies to achieve analogous levels of organizing and mobilization of at-risk, vulnerable, infected, and affected communities – to be able to synchronize their collective leadership and network for participation in both local and national AIDS governance.

This document is a blueprint for defining more concrete actions, a platform for operational and cost-inclusive planning. It lays out expectations for instituting and stabilizing system norms that may indicate an effective and efficient country response to HIV and AIDS. Some of these norms may be described as follows:

- **Operations and Cost Planning –** the 5th AMTP and scaled-up, comprehensive intervention approaches – adjusted according to the peculiarities and potentials of the respective systems – are translated into activities, services, and corresponding cost; processes are also re-engaged to respond to the evolving dynamics of the epidemic as well as operational scenarios;
- **Investments –** through engagement or bridging leaderships, gatekeepers both on domestic and external assistance investment platforms integrate HIV and AIDS priorities (in accordance with the above) and undertake a public and transparent accounting of the utilization of actual investments made;
- **Organizational Leadership Capacities –** in addition to the above, the PNAC, the local multi-sector AIDS coordinating bodies, the implementation mechanisms of development sectors (including potential and existing technical assistance functions in regional offices), and both high-level and technical/programmatic representatives guide and observe the respective counterpart duties in the HIV campaign, including capacity development initiatives for their implementation;
- **Program Management Capacities –** public and private sector-led HIV and AIDS programs demonstrate the capacity to fulfill the 5th AMTP strategic directions with publicly discernible actions, as well as accomplish performance targets according to plans both in capacitating and facilitating respective performances of sectors' duty-bearer client systems; and
- **Knowledge Management –** The PNAC, local multi-sector AIDS coordinating bodies, and implementation mechanisms of development sectors generate information based on monthly performance targets, analyze and report the progress of operations annually, strengthen strategic and operational designs to maximize the potentials of the 5th AMTP on its third and fifth years, and at high-levels of representation receive and own these bodies of information.

I. Steps Forward

The 5th AMTP is aimed at demonstrating the urgency of the problem and MOVE people to improve what they have been doing or to start taking steps toward our goal of reducing to zero the incidence of HIV infection in the future. As the driver of the plan, the PNAC must ensure that the following actions are IMMEDIATELY and URGENTLY undertaken:

One, that the *Council undertake its own strategic planning to formulate its priority thrusts and policies, and determine its major activities and interventions* (work plan) at least for the next three years (2011-2013), in synchronization with the 5th AMTP.

Two, that a *Communication and Promotions Plan* be devised to ensure that the 5th AMTP is shared, discussed, and set into motion by all PNAC member-agencies and organizations – government and non-government – in all levels, and by other stakeholder groups that give priority to local government units (LGUs), especially those in priority strategic areas.

The target coverage continues to be pegged at 80 percent of all geographic sites and sectors of the country.

Three, that all member agencies of the *PNAC formulate as a first step an agency-specific Operational Plan* that will determine ownership of tasks in the Country Response, spell out a clear set of major activities and interventions to be undertaken, and allocate accordingly their own resources to carry out HIV and AIDS activities at the local levels. Interventions inside the Council must include designating permanent representatives from member government agencies principally tasked to mainstream the Country Response in their departmental work plans, and establishing firm and consistent reporting and accountability procedures and mechanisms.

Each agency's initial Operational Plan will contain programs, systems, and processes for a three-year timeframe, and shall afterwards be standardized, collated, and aggregated. The PNAC shall perform the coordinating and clearinghouse roles, and check the consistency of each agency's plan with the mandate that R.A. 8504 gives each agency. This needs to be led by the Council members (who possess the overall strategic information), but with strong support from the Secretariat. These plans must also be complemented with operational planning and costing among key players in different sectors as well as local government units. The sector plans intend to determine specific targets, sites of implementation, the scope of intervention, and strategies in reaching priority groups. It is likewise important that these plans ensure the strategies are facilitating people's access to services provided by agencies. The local government planning involves key stakeholders in localities that shall marry the sector plans with a localization of the national agency plans.

Each agency may be oriented and capacitated on alternative modalities for delivering HIV and AIDS information, commodities, and services. In instances when agencies do not have the in-house capacity to manage HIV and AIDS programs, outsourcing and contracting – especially performance-based contracting – should be considered. After all, President Aquino is very much committed to making public/private partnerships, even in the health sector, the hallmark of his administration.

Four, that a *clearer and more defined resource allocation and budgeting be determined to cover all the major activities in the Plan* that are to be considered Council-led. To capacitate each agency to manage these approved functions/activities, the PNAC should advocate and work with donor-partners which have the capacity building funds (such as those for training, workshops, and monitoring) so that these agencies can be supported. More importantly, the PNAC should begin advocating with donor-partners, so that partners' new portfolios and projects can be oriented to the 5th AMTP implementation.

Further, the 5th AMTP will serve as the platform for the PNAC to initiate steps to explore financing options other than the existing and traditional financing arrangements. In keeping with the principles of the Sector-wide Development Approach to Health (SDAH), possible financing arrangements that can be considered for HIV and AIDS services aside from the general budget support by donors are:

a) DOH HIV and AIDS central grants to LGUs, which can be made conditional on LGU performance;
b) Specific LGU trust funds for HIV and AIDS;
c) Expansion of HIV and AIDS funding using the Internal Revenue Allotment (IRA) for the process established for the Province-wide and City Investment Plans for health (PIPH/CIPH); and,
d) Virtual financing through the PNAC acting as fund manager of central government agencies involved in the national HIV/AIDS program.

PART III: INDICATIVE RESOURCE REQUIREMENTS

Estimation of the 5th AMTP Investment Requirements

In the preparation of investment estimates for implementation of the 5th AMTP, the Resource Needs Model (RNM) was utilized, an HIV and AIDS program forecasting tool formulated by The Futures Group International (TFGI). In using the RNM, these assumptions were considered.

Most-at-risk population sizes are based on DOH-NEC estimates from IHBSS. Target coverage for MARPs by 2016 is 80 percent, in accordance with Universal Access targeting. Baseline coverage in 2009 show that only 55 percent of sex workers, 29 percent of MSM, and 11 percent of IDUs are reached by intervention.

Service unit costs were based on a UNAIDS costing study that mapped existing unit costs and current capacity/services available in Cebu, Zamboanga, Davao and General Santos cities. The unit costs are projected to increase annually by six percent, based on the target inflation rates of 3.5 percent and 5.5 percent. Table 7 summarizes the first and second assumptions.

Table 7. Most-at-Risk Population Size Estimates and Service Unit Cost Assumptions Used in Resource Needs Model (RNM), 2011 to 2016

Most-at-Risk Population	Population Size Estimates		Service Unit Costs	
	Low Estimate	High Estimate	In US$	In PHP*
Female sex workers	109,732	125,795	33.33	1,428.46
Men having sex with men	390,733	689,529	32.15	1,382.45
Injecting drug users	12,705	21,576	89.09	3,830.87

**Conversion rate: US$ 1.00 = PHP 43.00*

1. Target coverage for treatment and care of PLHIVs is derived from the project antiretroviral therapy need using the SPECTRUM model (UNAIDS).
2. Other unit costs are either estimates from National AIDS and STI Prevention and Control Program, Department of Health (NASPCP-DOH) such as those for STI treatment, or data generated from the INPUT model such as those for ART, HIV counseling and testing, and youth and workplace focused interventions. Workplace programs cover 80 percent of estimated formal sector employees, and include peer education.
3. Program management cost includes monitoring and evaluation, research, policy, and training, among others. Its low cost estimate is 13 percent of the total program cost, RNM's default assumption. Its high cost estimate is derived from actual National AIDS Spending Assessment (NASA) data, around 35 percent of total program cost.
4. The subsequent detailed costing are preliminary estimates. Cost may change depending on the degree of comprehensiveness of intervention packages. Some variables which may have to be considered are the number of condoms distributed, peer educator to sex worker ratio, number of needles (for needle exchange program), and peers to IDU, among others.

Table 8 summarizes projections of HIV and AIDS investment requirements, which include high, medium and low estimation scenarios. The total indicative requirement for the implementation of the 5th AMTP ranges from 582.83 million US dollars (a little over 25 billion Philippine pesos) on the low end, to 920.58 million US dollars (almost 40 billion Philippine pesos) on the high end. An annual average of 97.14 million to 153.43 million US dollars (4.8 to 6.6 billion Philippine pesos) is required for the strategic plan to be implemented. Tables 9, 10, and 11 contain the yearly projections of low, medium, and high estimate scenarios, respectively.

Table 8. Summary of AIDS Investment Requirements using the RNM, 2011 to 2016

Interventions	Low Estimate		Medium Estimate		High Estimate	
	US$ Mil	Percent	US$ Mill	Percent	US$ Mill	Percent
Total (In US$ millions)	**582.83**	**100.00%**	**684.44**	**100.00%**	**920.58**	**100.00%**
Prevention Activities	**449.97**	**77.20%**	**539.79**	**78.87%**	**617.68**	**67.10%**
Most-at-risk populations						
Female sex workers and their clients	27.89	4.79%	27.89	4.07%	31.99	3.47%
Males who have sex with males	85.49	14.67%	85.49	12.49%	150.85	16.39%
Injecting drug users	0.45	0.08%	0.45	0.07%	0.78	0.08%
Other key affected populations						
Migrant workers	13.00	2.23%	13.00	1.90%	13.00	1.41%
Local workforce	60.91	10.45%	81.21	11.87%	81.21	8.82%
Young people	209.65	35.97%	278.42	40.68%	278.42	30.24%
Other service delivery						
Public sector condom provision	26.54	4.55%	27.29	3.99%	35.39	3.84%
STI management	0.93	0.16%	0.93	0.14%	0.93	0.10%
HIV counseling and testing	1.61	0.28%	1.61	0.24%	1.61	0.17%
Blood safety	23.50	4.03%	23.50	3.43%	23.50	2.55%
Treatment and Care Activities	**65.36**	**11.21%**	**65.36**	**9.55%**	**65.36**	**7.10%**
Antiretroviral therapy	43.91	7.53%	43.91	6.42%	43.91	4.77%
Non-ART care and prophylaxis	21.45	3.68%	21.45	3.13%	21.45	2.33%
Program Management Activities	**67.50**	**11.58%**	**79.29**	**11.58%**	**237.54**	**25.80%**
Policy, administrative, research, M&E	67.50	11.58%	79.29	11.58%	237.54	25.80%

In the low-estimate scenario (Table 9), an 80-percent coverage of low-estimate MARPs sizes was assumed, and coverage for other key affected populations was pegged at 60 percent by 2016. Program management cost was assumed to be 13 percent of total program cost.

Table 9. Low Estimates of the 5th AMTP Investment Requirements, Yearly Projections from 2011 to 2016

Interventions	Low Estimate Year-on-Year Projection (In US$ Mil)						Total
	2011	2012	2013	2014	2015	2016	
Total (In US$ millions)	**42.24**	**58.72**	**78.91**	**103.45**	**132.61**	**166.90**	**582.83**
Prevention Activities	**32.48**	**45.63**	**61.36**	**80.12**	**102.22**	**128.16**	**449.97**
Most-at-risk populations							
Female sex workers and their clients	2.91	3.47	4.12	4.88	5.75	6.76	27.89
Males who have sex with males	7.02	9.26	11.93	15.11	18.87	23.30	85.49
Injecting drug users	0.04	0.06	0.07	0.09	0.09	0.10	0.45
Other key affected populations							
Migrant workers	2.04	2.10	2.15	2.20	2.24	2.27	13.00
Local workforce	3.50	5.68	8.18	11.07	14.36	18.12	60.91
Young people	11.17	18.25	26.97	37.57	50.29	65.40	209.65
Other service delivery							
Public sector condom provision	2.42	3.07	3.82	4.69	5.69	6.85	26.54
STI management	0.10	0.14	0.17	0.18	0.18	0.16	0.93
HIV counseling and testing	0.09	0.15	0.22	0.29	0.38	0.48	1.61
Blood safety	3.19	3.45	3.73	4.04	4.37	4.72	23.50
Treatment and Care Activities	**4.87**	**6.29**	**8.41**	**11.35**	**15.03**	**19.41**	**65.36**
Antiretroviral therapy	3.28	4.23	5.65	7.62	10.09	13.04	43.91
Non-ART care and prophylaxis	1.59	2.06	2.76	3.73	4.94	6.37	21.45
Program Management Activities	**4.89**	**6.80**	**9.14**	**11.98**	**15.36**	**19.33**	**67.50**
Policy, administrative, research, M&E	4.89	6.80	9.14	11.98	15.36	19.33	67.50

In the medium-estimate scenario (Table 10), MARPs sizes used were still low estimates but service coverage for other key populations was targeted at 80 percent by 2016. RNM's default of 13 percent of total program cost was used for program management.

Table 10. Medium Estimates of the 5th AMTP Investment Requirements, Yearly Projections from 2011 to 2016

Interventions	Year-on-Year Projection Medium Estimate (In US$ Mil)						Total
	2011	2012	2013	2014	2015	2016	
Total (In US$ millions)	**47.45**	**67.49**	**92.02**	**121.74**	**157.09**	**198.65**	**684.44**
Prevention Activities	**37.08**	**53.38**	**72.95**	**96.29**	**123.86**	**156.23**	**539.79**
Most-at-risk populations							
Female sex workers and their clients	2.91	3.47	4.12	4.88	5.75	6.76	27.89
Males who have sex with males	7.02	9.26	11.93	15.11	18.87	23.30	85.49
Injecting drug users	0.04	0.06	0.07	0.09	0.09	0.10	0.45
Other key affected populations							
Migrant workers	2.04	2.10	2.15	2.20	2.24	2.27	13.00
Local workforce	4.66	7.57	10.91	14.75	19.15	24.17	81.21
Young people	14.56	24.04	35.73	49.93	66.96	87.20	278.42
Other service delivery							
Public sector condom provision	2.47	3.14	3.92	4.82	5.87	7.07	27.29
STI management	0.10	0.14	0.17	0.18	0.18	0.16	0.93
HIV counseling and testing	0.09	0.15	0.22	0.29	0.38	0.48	1.61
Blood safety	3.19	3.45	3.73	4.04	4.37	4.72	23.50
Treatment and Care Activities	**4.87**	**6.29**	**8.41**	**11.35**	**15.03**	**19.41**	**65.36**
Antiretroviral therapy	3.28	4.23	5.65	7.62	10.09	13.04	43.91
Non-ART care and prophylaxis	1.59	2.06	2.76	3.73	4.94	6.37	21.45
Program Management Activities	**5.50**	**7.82**	**10.66**	**14.10**	**18.20**	**23.01**	**79.29**
Policy, administrative, research, M&E	5.50	7.82	10.66	14.10	18.20	23.01	79.29

The high-estimate scenario (Table 11) used the high population estimates for MARPs, and all priority populations were targeted for 80-percent coverage by 2016. Program management cost was about 35 percent of total program cost as derived from the NASA.

Table 11. High Estimates of the 5th AMTP Investment Requirements, Yearly Projections from 2011 to 2016

Interventions	Year-on-Year Projection High Estimate (In US Mil)						Total
	2011	2012	2013	2014	2015	2016	
Total (In US$ millions)	**65.23**	**91.82**	**124.33**	**163.62**	**210.33**	**265.25**	**920.58**
Prevention Activities	**43.52**	**61.84**	**83.84**	**110.05**	**141.03**	**177.40**	**617.68**
Most-at-risk populations							
Female sex workers and their clients	3.33	3.98	4.73	5.60	6.60	7.75	31.99
Males who have sex with males	12.39	16.34	21.05	26.66	33.30	41.11	150.85
Injecting drug users	0.07	0.10	0.13	0.15	0.16	0.17	0.78
Other key affected populations							
Migrant workers	2.04	2.10	2.15	2.20	2.24	2.27	13.00
Local workforce	4.66	7.57	10.91	14.75	19.15	24.17	81.21
Young people	14.56	24.04	35.73	49.93	66.96	87.20	278.42
Other service delivery							
Public sector condom provision	3.09	3.97	5.02	6.25	7.69	9.37	35.39
STI management	0.10	0.14	0.17	0.18	0.18	0.16	0.93
HIV counseling and testing	0.09	0.15	0.22	0.29	0.38	0.48	1.61
Blood safety	3.19	3.45	3.73	4.04	4.37	4.72	23.50
Treatment and Care Activities	4.87	6.29	8.41	11.35	15.03	19.41	65.36
Antiretroviral therapy	3.28	4.23	5.65	7.62	10.09	13.04	43.91
Non-ART care and prophylaxis	1.59	2.06	2.76	3.73	4.94	6.37	21.45
Program Management Activities	16.84	23.69	32.08	42.22	54.27	68.44	237.54
Policy, administrative, research, M&E	16.84	23.69	32.08	42.22	54.27	68.44	237.54

5th AMTP Investment Requirements by Strategic Objectives

Table 12 summarizes resources required to implement the 5th AMTP in terms of its objectives, with the high, medium, and low estimate scenarios compared side by side. Objective 2's requirements are maintained at 65 million US dollars (2.8 billion Philippine pesos) across three scenarios, and Objective 1 is consistently above half of resource needs, percentage sharing only shrinking where program management cost reflected NASA.

Table 12. Summary of the 5th AMTP Investment Requirements by Strategic Objective, 2011 to 2016

5th AMTP Objectives and Activities Summary	Low Estimates (in Mil)			Medium Estimates (in Mil)			High Estimates (in Mil)		
	US$	PHP	%	US$	PHP	%	US$	PHP	%
Total Investment Required	**583**	**25,062**	**100%**	**684**	**29,431**	**100%**	**921**	**39,585**	**100%**
Obj. 1 – Prevention BCC: priority populations Direct HIV services Other health care	450	19,349	77%	540	23,211	79%	618	26,560	67%
Obj. 2 – Treatment, Care and Support ART Non-ART, prophylaxis	65	2,810	11%	65	2,810	10%	65	2,810	7%
Obj. 3 – Policy Environment ***Obj. 4 – PNAC Capacity*** ***Obj. 5 – Partnerships*** Policy, administration, research, M&E	68	2,903	12%	79	3,409	12%	238	10,214	26%

Objective 1 comprises activities that prevent transmission of HIV, including positive prevention activities for PLHIV and their significant others. The target by end 2016 is that HIV prevention programs will have reached universal access coverage of priority populations, including PLHIV among these populations. BCC activities among MARPs are mainly delivered through outreach education in communities while those for youth, migrant workers, and local workers are also delivered within institutions. BCC and outreach activities are supported by direct HIV services such as condom distribution, STI management, HIV testing and counseling, and blood safety.

Objective 2 comprises activities that address the needs of PLHIV, in particular, access to life-saving and sustaining treatment such as antiretroviral therapy. The target by end of 2016 is for TCS programs to have reached universal access coverage of PLHIV in need of ART, non-ART and prophylaxis care. Access to treatment is complemented with psycho-social support activities that are both facility- and community-based. The estimation is initially limited from costing impact mitigation activities such as support for affected families.

Objectives 3, 4, and 5 comprise activities that will strengthen governance and management of the national response to HIV and AIDS, particularly in establishing enabling policies, ensuring PNAC capacity to perform its oversight functions, and enabling and capacitating partnerships in the response. These objectives correspond with program management, defined in RNM to include policy, administration, research, and monitoring and evaluation. Collectively, the strategic objectives target that by the end of 2016, management activities, policy-making, programming and strategic information initiatives will have contributed to an enabling environment for universal access to prevention and TCS programs.

Limitations of the RNM and Recommendations for Planning the 5th AMTP Implementation

To facilitate the 5th AMTP development, the Health Policy Development Project (HPDP) has identified limitations in the use of the RNM for cost estimation, its key observations being that:

- The RNM seems to be formulated in the context of a generalized epidemic, and does not account for the country's uniquely concentrating epidemic;
- The RNM seems to be formulated towards an idealized, comprehensive package of services, and does not allow more judicious selection of cost-effective services that reflect the country's uniquely concentrating epidemic;
- The RNM calculates costs for each program separately, and does not allow integration as an approach in actual program implementation; and
- The RNM too distinctly segments priority populations' contexts of risk, which bloats estimated costs to an extent.

The HPDP's review also forwards recommendations for planning the 5th AMTP's implementation, as follows:

- Undertake rapid assessments, through Centers for Health Development, to gauge capacities of facilities (e.g. social hygiene clinics) in "hotspots" to deliver adequate services, including the necessity of establishing more facilities to anticipate the future trajectory of the epidemic.
- Define in operational plans the necessary capital investments in order for facilities to level up capabilities in delivering HIV and AIDS services.
- Utilize RNM as macro model for estimating national resource needs in resource mobilization with external partners. However, advocacy among LGUs will need to account for variations in local costs. Generate local data to come up with a range of realistic unit cost estimates.
- Focus more on costing implementation plans of agencies, sectors (or communities), and local governments, including capital costs and system requirements of expanded responses.

PART IV: MONITORING AND EVALUATION (M&E)

2010 M&E Assessment

The national HIV M&E assessment was essentially guided by the 2009 M&E System Strengthening (MESS) Tool that specifically looked into the 12 components of the M&E system. The assessment workshop was led by the Philippine M&E Assessment Team in collaboration with M&E advisers from UNAIDS Bangkok and Indonesia and with independent consultants from the country. The workshop was participated in by M&E practitioners in the country, including program managers and key individuals and organizations from the national, regional, and local government involved in the establishment and implementation of the Philippine M&E System on HIV. Unstructured interviews among key informants were also conducted by the PNAC prior to the assessment workshop. The facilitating team utilized and localized (created a Philippine version of) the 2009 MESS tool developed by the Global M&E Reference Group (MERG) based on the 12 components of a Functional M&E System. The MESS Tool was initially filled up by the M&E Assessment Team and some concerned agencies as part of the assessment process. Inputs from these interviews and preliminary filling-up of the instruments (i.e. questionnaire) were validated during the workshop.

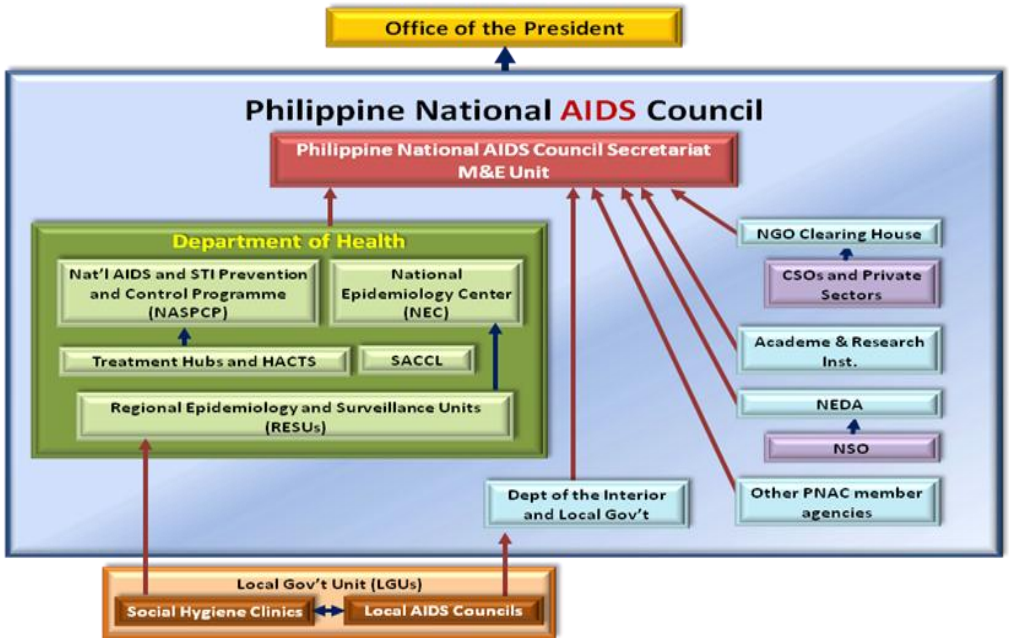
M&E Plan for the 5th AMTP

Formulation of the 5th AMTP operational plan will be defined in the first quarter of 2011. Major and sub-activities along with their agency targets will be identified by the PNAC member agencies (PMAs) who will lead the implementation. From the PMAs' operational plan, the agency M&E Plan will be formulated.

Each of the 26 PNAC member agencies (PMAs) will have their designated M&E representative, who will be the designated member in the PNAC Monitoring and Evaluation Working Group (MEWG). The existing agency M&E units (not necessarily devoted to HIV and AIDS) will serve as a possible point of integration for the establishment of an agency HIV and AIDS M&E system.

Monitoring of the 5th AMTP activities as planned by agencies for 2011-2013 will be conducted at different levels. Data flow will be coming from the municipal, provincial, and national levels to the central level wherein the MEWG member will collate all the data for submission to the PNAC M&E unit (Fig. 5).

Figure 5. HIV and AIDS Monitoring and Evaluation Flow



The Health Action Information Network (HAIN) as mandated by the PNAC during the 16th Plenary will remain the M&E Hub for the Civil Society Organizations (CSOs) implementing HIV and AIDS programs in the country. The PNAC will be providing support to HAIN in order to perform its function as a CSO M&E hub. Collated data from the CSOs will then be transmitted to the PNAC M&E unit quarterly, semi-annually, or on an annual basis.

Data reporting will be carried out quarterly, semi-annually or annually depending on the activities or deliverables of each agency. The PNAC M&E Unit will collate and analyse all the reports for the entire year and will be a critical part in the "PNAC's Annual Report to the President."

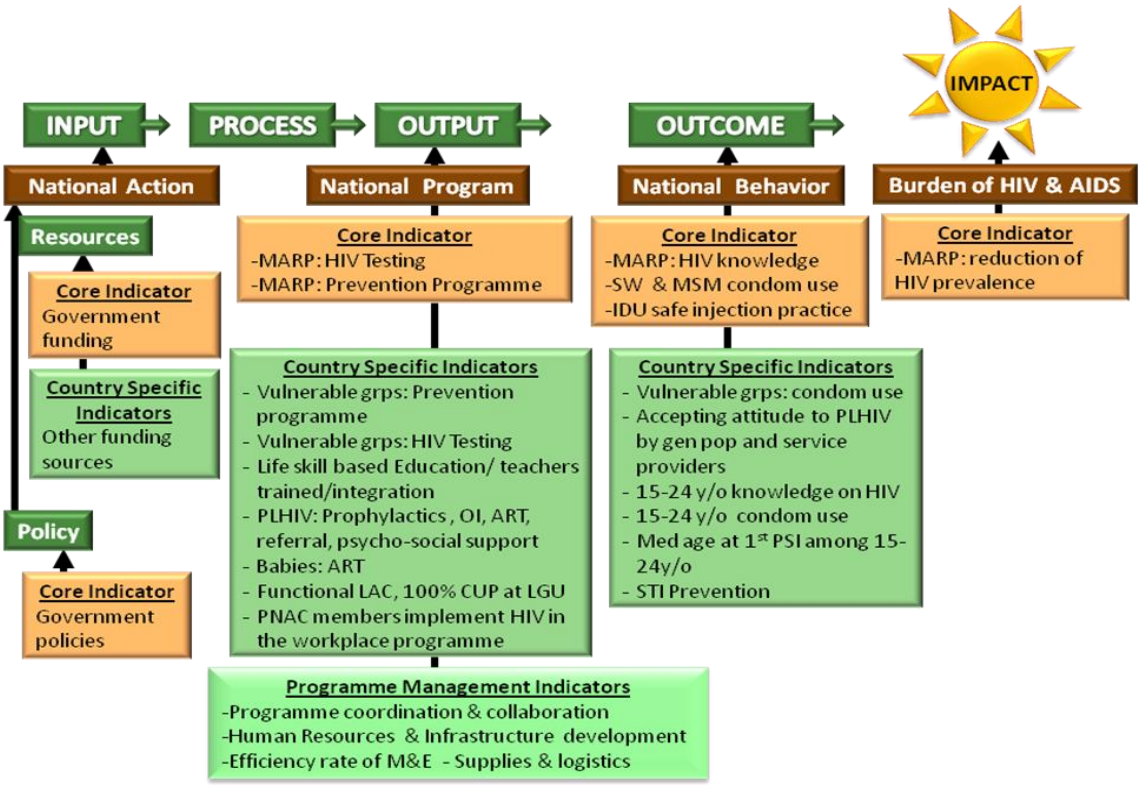
In order to ensure that we are attaining the goal of the of 5th AMTP which is to maintain the HIV prevalence in the Philippines at less than one (1) percent which is tantamount to maintaining the HIV cases at less than 66 cases per/100,000 population, further evaluation studies will be conducted. Evaluation of the 5th AMTP will be done through:

1. Conduct of Integrated Behavioral and Serologic Surveillance (IHBSS), which is being carried out by the National Epidemiology Center every two years;
2. Special surveys and program evaluation, which can be done by other institutions (like the academe, research institutions, etc.); and,
3. Mid- year evaluation of the 5th AMTP (to be conducted by an external body).

The results of the evaluation will have to be disseminated through audience (feedback) with local government unit (LGU) stakeholders, specifically decision makers, and/or by hosting fora in a timely manner to ensure proper data utilization.

Figure 6 below illustrates the M&E framework for HIV and AIDS with corresponding indicators to be collected during the course of the implementation of the AIDS plan. It shows the core indicators focusing on supportive policy guidelines and resources (multi-sectoral) allocated for the implementation of HIV initiatives. Equally important is that the system will also look into programs focusing on interventions, treatment, care, and support for those who are at risk for, vulnerable to, infected with, and affected by the virus.

Figure 6. M&E Framework for HIV and AIDS



With the M&E framework for HIV and AIDS having been presented, Table 13 in the next page summarises the indicators to be employed in monitoring the 5th AMTP. To appreciate the relationship of each indicator to the overall AMTP framework, the three outcomes of change expected to be achieved at the end of the implementation period as stipulated in the strategy framework for AMTP implementation serve as the stage for enumerating these indicators with corresponding expected reporting agencies.

Table 13. List of Indicators for the 5th AMTP

Indicators	Reporting Agency
- Number of reported new HIV infections	DOH
- HIV prevalence among PIP	DOH
- HIV prevalence among MSM	DOH
- HIV prevalence among PWID	DOH
- HIV prevalence among male clients of female SW	DOH
- Percentage of young people aged 15-24 who are HIV-infected	DOH
- Number of HIV-infected infants born to HIV-positive mothers	DOH
- Percentage of target population[1] who had sexual intercourse with multiple partners in the last 12 months	DOH
- Percentage of target population who had sexual intercourse with more than one partner in the last 12 months and reporting the use of condom during their last intercourse (UNGASS 17)	DOH
- Percentage of target population aged 15-24 years who exchanged sex for money, gifts, or favours	DOH
- Percentage of target population using condom during their last sexual contact in the past 12 months	DOH
- Percentage of female and male sex workers reporting the use of condoms with their most recent clients (UNGASS 18)	DOH
- Percentage of men reporting the use of a condom the last time they had anal sex with a male partner (UNGASS 19)	DOH
- Percentage of young women and men aged 15-24 years who have had sexual intercourse before the age of 15 (UNGASS 15)	DOH
- Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected drugs (UNGASS 20)	DOH
- Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected drugs (UNGASS 21)	DOH
- Number of teachers (formal/vocational) capacitated to provide HIV and AIDS basic information (HIV 101)	DOH
- Number of employees provided with HIV and AIDS basic information (HIV 101)	DOH, DepEd, CHED, TESDA, DFA, CSC (for gov't employees)
- Number of communities /persons provided with HIV and AIDS basic information (HIV 101) in the community	DOLE(OSH/OWWA/POEA), DOT LCM/LPP
- Number of persons provided with HIV and AIDS basic information (HIV 101) among the AFP & PNP	DILG (PNP&AFP Chiefs)
- Number of PLHIV still alive after 12 months of ART	DOH
- Percentage of PLHIV with new smear-positive TB who have been successfully treated	DOH
- Percentage of enrolled PLHIV who are retained after 12 months in ART	DOH
- Percentage of PLHIV gainfully employed (working for wages)	DOLE
- Percentage of PLHIV engaged in livelihood or income-generating activities	DOLE and DSWD
- National M&E system functional	PNAC
- Percentage of AMTP5 targets achieved	PNAC Scientific Committee
- Amount allocated for AMTP-5 by Government of the Philippines	NEDA
- Amount spent on AMTP-5	NEDA
- Amount allocated for AMTP-5 by partners	NEDA
- RA 8504 amended	Committee on Health Rep
- Harm reduction policy in place	DILG
- National condom policy in place	DILG
- National HIV in the Workplace policy in place	DOLE (c/o OSH)

PART IV: ANNEXES

A: HIV Intervention Package for Persons who Inject Drug (PWIDs)

Introduction

The rise of HIV infection among persons who inject drugs in the cities of Cebu, Mandaue, Lapu-Lapu, and Danao and elsewhere in the island of Cebu is a major cause of concern among both the national and local health and development stakeholders in the Philippines.

Cebu has registered 181 HIV+ cases from 1984 to the present, showing an increase of 84 reported cases from January to March 2010 and revealing a significant ascending trend from the usual 4 cases detected every year. The main modes of transmission are through unsafe injecting practices among injecting drug users (IDUs) or persons who inject drugs (PWIDs) and unsafe sexual practices.

Based on the population estimate made in 2007, there may be 5,000 PWIDs, aged 15 to 34 years, in the cities of Cebu, Lapu-lapu, and Mandaue, excluding other cities and municipalities in the island province of Cebu where some PWIDs have been outreached by the Global Fund Round 5 AIDS project.

In other cities like Zamboanga and General Santos on the island of Mindanao, some HIV-prevention initiatives focused on PWIDs have also been implemented.

The 2009 Integrated HIV Behavioral Serologic Survey or IHBSS (Table 14) reveals a prevalence in Hepatitis C cases of 35 percent among this sentinel population in Cebu, Zamboanga, and General Santos cities, out of which 95 percent alone is found in Cebu. Hepatitis B and C can both lead to liver cancer and cirrhosis. Often, this effect is immediate, as several PWIDs in Cebu have reported friends who have developed hepatitis, which is more feared than HIV.

Table 14. Prevention Coverage for Injecting Drug Use, IHBSS 2009

Indicators	Cebu	Site B	Site C
% Reached (Taught how to prevent HIV transmission when injecting)	60%	24%	51%
% Received free needles	47%	17%	2%
% Reached (Taught how to prevent sexual transmission of HIV)	56%	29%	53%
% Received free condoms	39%	25%	35%

A surveillance of persons injecting drugs (PWIDs) conducted by the Cebu City Health Office and the Department of Health-National Epidemiology Center in August 2010 yielded startling initial (still unofficial and incomplete as of the writing of this document) results that point to a continuing trend in the spread of HIV infection among PWIDs in Cebu. Such initial partial and unofficial results[2] are presented in Table 15.

[2] Per information from Dr. Ilya Abellanosa Tac-an – Social Hygiene Physician, Cebu City Health Office

Table 15. Results of Surveillance among People who Inject Drugs (PWID), Cebu City August 2010

Site	Number	Seropositive	Percentage
Cebu	300	156	52
Lapu-lapu	11	9	82
Mandaue	36	2	6
97% had their last injection in a shooting gallery			
47% used a service needle[3] in the past 12 months			
49% used a used needle during their last injection			

From a number of studies on PWIDs, the following practices give a glimpse of where the intervention for HIV prevention among this population can be focused:

- Early start in drug injecting - as early as 12 years of age, a median age of 19 years, and as late as 54 years of age - a finding that shows the intervention cannot be directed toward a particular age group like teen-agers but should include children and middle-aged persons.
- Early sexual debut - from as early as eight years of age, but the median age for first penetrative sex is at 16 years.
- Unprotected sex is another risky behavior pattern that has been documented in injecting drug users or IDUs.
- A high proportion of PWIDs also engage in commercial sex, with both men and women receiving payment for sexual services.
- The rate of condom use with sexual partners of IDUs is low.

The SHARP-IDU project reports an injecting pattern among PWIDS that range from three to seven times at most, and as high as ten (10) times among a few, per day. The reason for the high number of repeated injecting episodes per day among PWIDs in Cebu is that an ampoule of Nalbuphine is divided among three, seven, or 10 persons representing the amount each has raised to buy the drug. This routine of 'sharing' may also lead to a more extensive sharing of injecting equipment.[4]

While intervention activities to prevent HIV among Persons Who Inject Drugs (PWIDs) have been ongoing in Cebu since late 1995 – albeit a bit intermittently due to funding and commodity gaps – and were selected using a relatively comprehensive approach by the Global Fund Rounds 3 and 5 AIDS projects, efforts still fall short of what should be done due to the following **barriers to implementation:**

1. **Conflict with anti-drug policy**

The conflict with the national anti-drug legislation (R.A. 9165) tends to limit the scope of the response, omitting vital interventions like needle and syringe exchange or distribution.

There is a lack of operational guidelines and strategies for comprehensive harm reduction programs.[5] A *PNAC Resolution* directing that a Technical Working Group for HIV Prevention among PWIDs be convened to draft the guidelines remains frozen as of this time.

[3] Service needle with a certain amount of Nubain in it is provided by the shooting gallery to clients. This is usually unclean and shared among a number of clients.
[4] Cebu Tricity Actionable Plan, October 2010 RTI/HealthGov Project
[5] Fighting HIV and AIDS in the Pacific (RETA 6321) Subrpoject 5: Strengthening Country Response to HIV and AIDS Among High Risk Groups, p 40

2. Public perception of drug use and drug users

The public regards the drug user more as a criminal rather than a victim because drug use was criminalized in the past. It is only recently that the Philippine National Police turned over to the Department of Health jurisdiction over the rehabilitation of drug addicts, and it will take a long time to change public perception. Even today, police continue to carry out raids against drug users. As such, it is very likely that the harm reduction program would be perceived by the majority of our people and most of our decision makers as condoning drug abuse. [6]

3. PWIDs are a hidden population, discriminated against and hard to reach

Due to the prevailing public perception, drug users, particularly PWIDs, will remain in the shadows, hiding from the public while continuing to feed their habit. This makes them difficult to reach, unless a dedicated and trained cadre of peer educators helps program implementers conduct the intervention. Consequently, the prevailing legal and public perception leads to stigma and discrimination, making decision-makers and health service deliverers reluctant to approve, fund, or implement interventions.

4. The belief that harm reduction[7] is controversial and relatively expensive

There is a pervasive belief among decision-makers and programmers that the cost of doing a comprehensive harm reduction program will take away much needed funds from other more urgent and more worthwhile programs.

All the abovementioned barriers notwithstanding, providing services to prevent the spread of HIV infection and Hepatitis C infection among PWIDs is imperative. However, for any initiative to succeed, an enabling legal and social environment should be in place.

Conceptual Framework for Prevention Intervention for PWIDs[8]

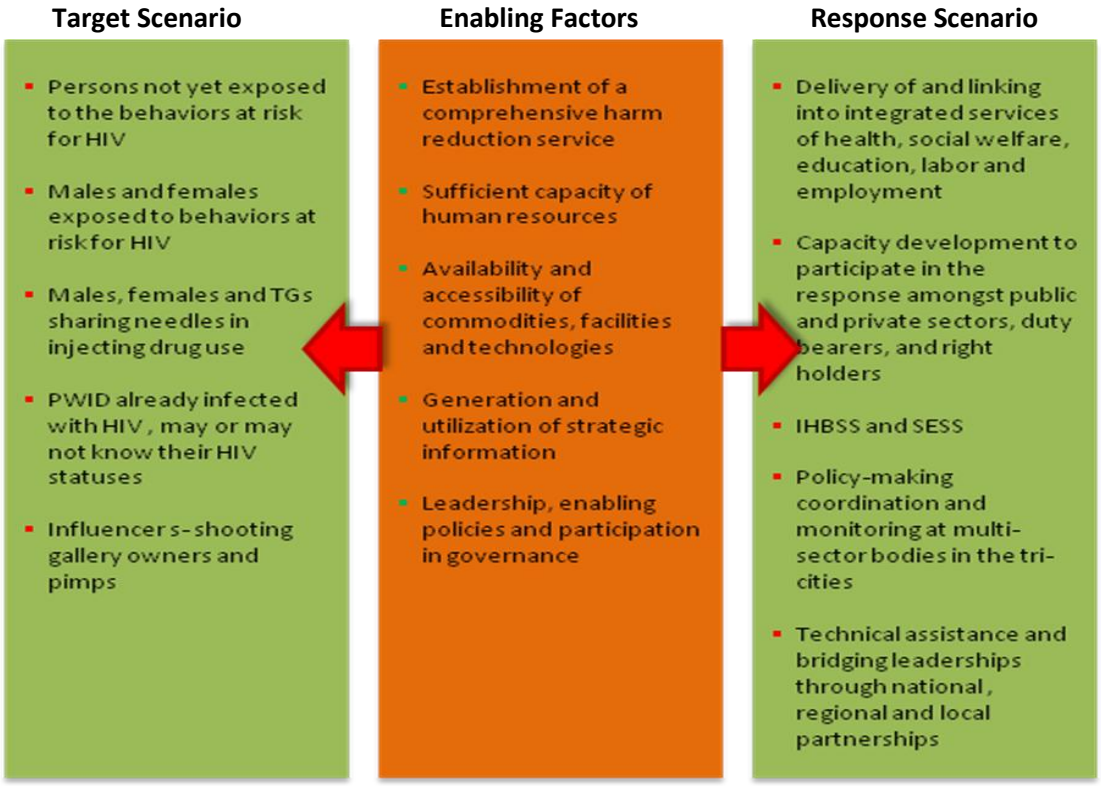
Problem: How can persons at risk (i.e., PWIDs) for, vulnerable to, and living with HIV be enabled to avoid behaviors associated with the risk of HIV infection?

[6] Cebu Tricity Actionable Plan, October 2010 RTI/HealthGov Project

[7] Defined by the International Harm Reduction Association as policies and programs, which attempt primarily to reduce the adverse health, social and economic consequences of mood-altering substances for individual drug users, their families and communities. This approach attempts to reduce drug-related harms without necessarily stopping drug use.

[8] Derived from the Conceptual Framework AIDS Medium Term Plan V Development, Philippine National AIDS Council, ppt. The conceptual framework itself is from the Cebu Tri-city Actionable Plan, October 2010 RTI/HealthGov Project

Population



A comprehensive package of intervention for PWIDs should include the following activities and services:

1. Community outreach and peer education activities for the targeted population groups (plain PWIDs, sex workers who are IDUs, MSM and transgender who are IDUs)
2. Peer education and counseling
3. Needle and Syringe Promotion (cleaning and distribution of N/S)
4. Setting up of a disposal protocol for used N/S
5. Condom promotion and distribution (through PEs)
6. Continuous provision of STI diagnosis and treatment (clinic-based and community-based)
7. Clinic-based Outreach
8. Continuous provision of Voluntary Counseling and Testing (VCT) and/or Provider-Initiated Counseling and Testing (PICT)
9. Psychosocial and Spiritual Intervention
10. Treatment, care and support for HIV-positive Injecting Drug Users (IDUs)

In addition, a harm reduction approach would also include the provision of primary health care; vein and abscess care; provision of bleach, cotton and alcohol swabs; clean water; education on the various effects of different combinations of drugs; counseling and referral to other services including drug dependence treatment and rehabilitation services; and the early detection and management of overdoses. However, numerous studies conducted on the selected components of comprehensive harm

reduction programs, such as the provision of needles and syringes, have shown that these do NOT increase drug use or drug injecting in the community.[9]

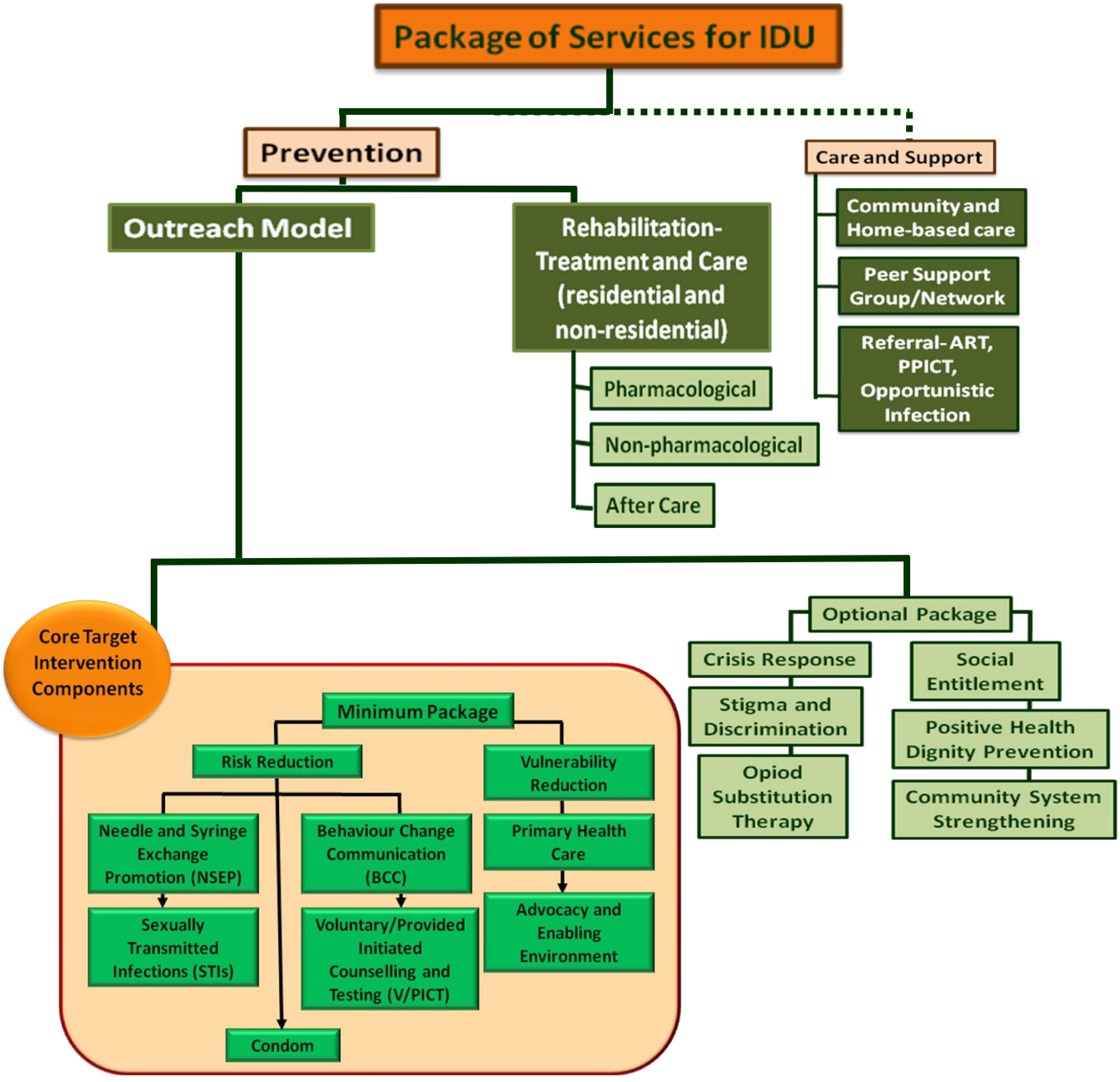
Table 16. Proposed Package of Intervention for People Who Inject Drugs (PWID)

Comprehensive Response	Key Components and Activities	Specific to IDUs with multiple risks like MSM, SWs
1. HIV Prevention	Peer outreach, peer education Promotion of and access to the means of HIV prevention, including needle and syringe exchange or distribution/ condom distribution; cleaning of needles and syringes Primary health care (vein and abscess care) STI prevention and treatment and other sexual health services Continuous provision of Voluntary Counseling and Testing (VCT) and/or Provider-Initiated Counseling and Testing (PICT) Shooting Gallery or Drop-in services (social marketing of needles and syringes, condoms; disposal protocol for used needles and syringes) Education of the various effects of different combinations of drugs, counseling, and referral to other services including drug dependence treatment and rehabilitation services	Access to information, counseling, and support on MSM, transgender, and SW issues
2. Access to HIV treatment, care, and support	Continuous provision of Voluntary Counseling and Testing (VCT) and/or Provider-Initiated Counseling and Testing (PICT) with strict confidentiality; provided at the right time, place, and environment Combined with prevention, counseling, and information that is linked to TCS Positive prevention Linked to psychosocial and spiritual support Linked to other prevention services, e.g. MSM, transgender, sex work services	An understanding of the effects of HIV antiretroviral medicines and HIV opportunistic infection Treatments for transgender people taking gender reassignment drugs Work to understand HIV risk in relation to gender re-assignment drug treatment and surgical procedures.
3. Enabling Environment for prevention and care services	Harmonize HIV policies with laws that impede the response Reduce harassment, violence, stigma Ensure continuity and consistency of programs and services Support PWID community-based organizations and nongovernment organizations Remove structural barriers to the use of services by PWIDs	The ability to change one's name and gender identity in official documents, and the legal right to live as another gender, free from stigma and discrimination
4. Strategic information	Population size estimation Geographic information on PWID watering holes, shooting galleries, and social networks Biological and behavioral surveillance Social and operational research Program and service monitoring and evaluation Policy/legislative review resulting to an official national HARM REDUCTION POLICY	
5. Supporting interventions	Civil society strengthening Community organization development Capacity building Sustainability	

[9] WHO, UNAIDS, UNODC. Policy Brief: Provision of Sterile Injecting Equipment to reduce HIV transmission. Evidence for Action Series, 2004

The diagram below illustrates the minimum core intervention package vital to preventing HIV transmission among PWIDs. This diagram is from the NEPAL Targeted Intervention Guidelines being drafted by SWASTI.

FIGURE 7. Targeted Intervention Guidelines for PWID drafted by SWASTI



B: Comprehensive Package of Services for Men who have Sex with Men (MSM) and Transgender (TG) Populations

Introduction

For the last two years, the AIDS Registry[10] recorded MSM as the predominant mode of HIV transmission (Figure 1).

FIGURE 8: A Comparison of the Proportion of Types of Sexual Transmission in 2010, 2009 & Cumulative Data (1984-2010)

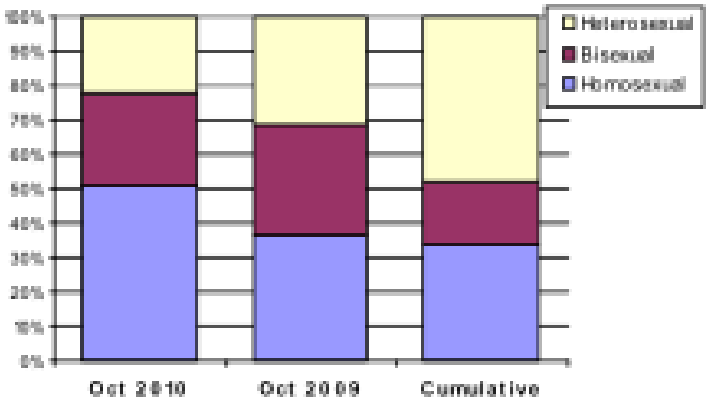


Table 17: Adult Population Estimates as of 2007[11]

Population	Population Size Estimate		Average number of adults living with HIV (15-49 yrs old)
	Low	High	
MSM[12]	223,042	669,323	2,439
Female partners of MSM[13]	26,332	83,932	112

The Integrated HIV Behavioral Serologic Survey *(*IHBSS) 2009 was able to record MSM who are also injecting drugs.

The Philippine HIV and AIDS Registry recorded a spike in the number of Men having Sex with Men who are also Overseas Filipino Workers (MSM-OFWs) in 2010, as shown in Table 18. From January to October 2010 alone, the prevalence of HIV infection among MSM (bisexual and homosexual) has increased 20 percent more than the 2009 figure, with homosexual transmission almost doubling for the said period.

[10] AIDS Registry. NEC, October 2010
[11] The MSM community has consistently maintained that the figures presented are an underestimation of the total MSM population. In the absence of any other estimate, this report will be forced to use these.
[12] 2007 Estimates. No estimates are available for transgender people (TG)
[13] Ibid.

Table 18: HIV Prevalence among MSM-OFWs

Mode of Transmission	2008 [n=123]	2009 [n=164]	2010 (Jan-Oct) [n=152]
Homosexual	20 (16%)	26 (16%)	47 (31%)
Bisexual	26 (21%)	36 (22%)	41 (27%)
Total MSM	46 (37%)	62 (38%)	88 (58%)

The number of people who self-identify as transgender (TG) has yet to be determined, given that no monitoring tool or survey has incorporated such a question to date. The qualitative study of HAIN in 2010[14] noted that TG is still an emerging identity; those who self-identify as "TG" or "transgender" are mostly in Metro Manila and are a small minority. For programmatic purposes, therefore, generating information on biological males who see themselves as women and not men will be a more strategic approach at this point. However, the next round of IHBSS to be conducted in 2011 will attempt to address this issue.

The study further noted that the diverse identities across sites and across time have varying risks and vulnerabilities, with some compounded by factors such as occupation and age as in the case of young prostituted men (e.g. *nelatch* in Cebu City and *ilogon* in Davao City).

Moreover, the focus on community-based interventions and campaigns for those in the lower income bracket has rendered the young MSM professionals in the middle- and high-income brackets invisible, often without access to appropriate services and messages.

Table 19: Status of MSM in the Philippines

Indicators	AMTP4 Targets[15]		Status[16]
	2008	2010	
Percentage of MSM who have received an HIV test in the last 12 months and who know the results	15%	30%	7% (296/4367)
Percentage of MSM reached by prevention programs	30%	60%	29% (1278/4367)
Percentage of MSM who both correctly identify and reject major misconceptions about HIV transmission	90%	90%	34% (1500/4367)
Percentage of male sex workers (MSW) engaged in anal sex	Not applicable		28% (1207/4367)
Percentage of (MSW) reporting the use of a condom with their most recent client	Not applicable		30% (366/1207)
Percentage of MSM who reported having had anal sex with a male partner in the last 6 months	Not applicable		67% (2929/4367)
Percentage of men reported to have used a condom the last time they had anal sex with a male partner in the last 6 months	85%	95%	32% (928/2929)

[14] Assessment of Risks and Vulnerabilities of MSM and TGs in Three Key Cities, HAIN, 2010.
[15] AMTP4 Midterm Assessment, 2008.
[16] IHBSS 2009

Channels for Reaching-out

Most Men having Sex with Men (MSM) and Transgenders (TG) go to places, both virtual and physical, that can provide a safe space to express themselves. These spaces may provide avenues for programmatic interventions.

The HAIN 2010 study noted that sites for partner selection are differentiated by economic status. Different establishments across the three sites were often found to be associated with a particular market. Participants from the lower-income bracket mentioned cruising areas like fiestas, discos, street corners, public gymnasiums, community villages, and other public events to find their sexual partners. Clearly, cost and accessibility are major considerations in opting for these venues.

Technology like the mobile phone and the internet has greatly facilitated the selection of partners. Unlimited texting has minimized the cost of setting up face-to-face meetings, group sex, and clans through mass sending of SMS (GM).

It is worth noting, however, that the concept of affordability and the perceived utility of these new technologies vary across sites. In Metro Manila, where internet access is more readily available and where lower income MSM are more willing to spend on internet usage, this platform is preferred. The scenario is rather different for the lower income MSM in Davao who would opt to spend their money on service boys found in cruising areas and in their communities instead of the internet.

Middle-income participants, on the other hand, obtain their partners through the internet, malls, and entertainment establishments (e.g. bars, massage parlors), while high-income MSM are a highly exclusive group mostly converging in parties and social events.

However, what is consistent among overt gay men, regardless of class, is the referral mechanism present among these circles. It greatly facilitates sexual networking particularly among this group.

The Comprehensive Package of Services for MSM and TG

The Comprehensive Package of Services for MSM and TG builds on the AMTP-IV Operational Plan 2009-2010 and draws from the document developed at the regional level entitled ***Developing a Comprehensive Package of Services to Reduce HIV among Men who have Sex with Men (MSM) and Transgender (TG) Populations in Asia and the Pacific***. The package highlights the need for a collaborative multi-sectoral response that goes beyond the institutionalization of prevention and treatment, care, and support programs. The presence of strategic information, an enabling environment, and an empowered Men having Sex with Men (MSM) community are necessary conditions for an effective response.

Prior to the implementation of the comprehensive response, an assessment of available resources and the readiness of the community in terms of responsibilities and accountabilities is necessary. Needless to say, local and national capacity and expertise must be ensured. Moreover, services must be age-appropriate, conscious of, and sensitive to the different needs of the various MSM and Transgender (TG) populations and the factors that may compound the risks experienced by these subgroups.

All the key elements listed in a comprehensive package must be present in any response targeting MSM and TG populations. However, specific activities and the components of each element must be determined based on the capacity and needs identified on the ground. Consultation with the MSM and TG communities is thus essential in determining appropriate responses.

This package was initially discussed with the MSM Task Force and harmonized with the comprehensive package for other Most-at-Risk Populations (MARPs).

Table 20. The Comprehensive Package of Services for MSM and TG

Comprehensive Response	Key Components and Activities	Specific to TG[17]
HIV Prevention	▪ Peer outreach, peer education ▪ Promotion of and access to the means of HIV prevention, including condom distribution ▪ STI prevention and treatment and other sexual health services ▪ HIV counseling and testing ▪ Drop-in services	Access to information, counseling and support on transgender issues
Access to HIV treatment, care, and support	▪ Voluntary testing with strict confidentiality; provided at the right time, place, and environment ▪ Combined with prevention, counseling and information linked to TCS ▪ Positive prevention ▪ Linked to psychosocial support ▪ Linked to other prevention services, e.g., IDU, sex work services	An understanding of the effects of HIV antiretroviral medicines and HIV opportunistic infection treatments for transgender people taking gender reassignment drugs Work to understand HIV risk in relation to gender reassignment, drug treatment and surgical procedures.
Enabling Environment for prevention and care services	▪ Harmonize HIV policies with laws that impede the response ▪ Reduce harassment, violence, stigma ▪ Ensure continuity and consistency of programs and services ▪ Support MSM and TG community-based organizations and non-government organizations ▪ Remove structural barriers to the use of services by MSM and TGs	The ability to change one's name and gender identity in official documents, and the legal right to live as another gender, free from stigma and discrimination
Strategic information	▪ Population size estimation ▪ Biological and behavioral surveillance ▪ Social and operational research ▪ Program and service monitoring and evaluation ▪ Policy/legislative review	
Supporting interventions	▪ Civil society strengthening ▪ Community organization development ▪ Capacity building ▪ Sustainability	

[17] UNAIDS Action Framework: Universal Access for Men who have Sex with Men and Transgender People, 2009.

C: Comprehensive Package of Services for People in Prostitution (PIP)

Introduction

Female sex workers are women who are born female and who receive payment in exchange for sexual favors. They can be generally classified into two broad groups: those who work in establishments such as bars, massage parlors, nightclubs, karaoke bars and are also referred to as establishment-based, and those who are not affiliated with an establishment and recruit their clients on their own or with the help of a pimp. The second group is commonly referred to as freelance sex workers (FSW).

As with the other Most-at-Risk Populations (MARPs), establishing the numbers of female sex workers in the Philippines poses a great challenge because sex work is for the most part illegal and taboo, although there is a tacit acceptance of its existence both among the general population and people in authority. In the 2007 Estimates of Adults living with HIV in the Philippines, various estimation procedures were attempted using different assumptions but the estimates emanated from an empirical base – the results of the 2007 Integrated HIV Behavioral Serologic Survey *(*IHBSS). Other sources for assumptions inputted into the estimates were the 2003 National Demographic and Health Survey (NDHS) and various research studies found in the literature. On the whole, the estimation exercise yielded an approximate figure of 71,067 establishment-based female sex workers. A rough calculation of the number of FSW ranged from a low to a high estimate in recognition of the fluid nature of this type of work, dependent on factors such as seasonal changes in the availability of clients. The number of FSWs was estimated at a low of 82,640 and a high of 103,419. In all, the total number of female sex workers in the country in 2007 was estimated to be within the range of 142,000 to 195,000.

These estimates do not include FSWs whose transactions are conducted using new means of communication that allow them to totally bypass cruising sites, hence their numbers are hidden and difficult to estimate. These are non-establishment based sex workers who transact with clients through the internet or text messaging. If this type of sex work is included in the estimates, the numbers will undoubtedly be much higher.

Sex work is illegal under the Revised Penal Code but, in actual practice, there is an unstated recognition that it exists and can pose a threat to public health. From the Spanish to the American period, the policy on sex workers has been to treat those among them who are infected with sexually transmitted disease in government facilities, giving it the character of a public health measure, even as the work itself is not officially sanctioned. The policy continues to the present with Social Hygiene Clinics which are set up in cities and municipalities where entertainment places abound and sex work is likely to occur. Through all the years of their existence, Social Hygiene Clinics SHCs) have become an acceptable venue for reaching sex workers in order to provide them with health services.

Establishment-based sex workers are required under the local ordinances in the areas where they work to undergo regular testing for STIs, typically via Gram stain to detect gonorrhea and other bacterial infections, weekly or bimonthly and blood tests for syphilis and hepatitis B every six (6) months or annually. HIV testing is supposed to be part of the regular package of tests but only those who give their consent are tested for HIV due to the law that prohibits mandatory HIV testing. The penalty for non-

compliance with regular testing is the withholding of the Social Hygience Clinic (SHC)-issued health card that gives them the license to work in the entertainment venue. Bar owners and managers are partners of the SHC in monitoring compliance because non-compliant establishments run the risk of having their license to operate revoked. Testing for STIs is conducted in the SHC as part of the mandate of local governments to provide health services. It is not openly acknowledged that the workers are offering sexual services; rather, it is presumed that sex work may occur outside of the entertainment venues.

Freelance sex workers (FSWs), on the other hand, are not affiliated with licensed establishments and thus are technically breaking the law. They are not easy to reach for health interventions because they are not based in places that are under the regulation of local governments. While SHCs may try to reach out to them by offering the same services as those given to establishment-based workers, there is no compelling reason for the SHCs to do so because freelance sex work is illegal to begin with.

Being exposed to multiple partners, sex workers are naturally at a high risk for sexually transmitted diseases, including HIV. In the early days of the HIV-AIDS pandemic in the 1980s when new cases were starting to be reported in the Philippines, the face of HIV was female and usually a sex worker. These were the days of Dolzura Cortes and Sarah Jane Salazar. But in more recent years that picture has receded in the popular consciousness as today's sex workers are too young to remember those early days. Now that the face of HIV is male and in the Men having Sex with Men (MSM) category, there is a danger that female sex workers no longer feel personally threatened by HIV-AIDS and are therefore less likely to feel the urgency to protect themselves against this infection.

Many studies have been done and continue to be done on the profile of this Most-at-Risk Population (MARP), especially on the common sources of risk for infection with STIs including HIV. The overall picture remains essentially the same.

Establishment-based female sex workers in general have fewer sexual encounters than their counterparts in other countries because they do not need to give actual sexual services to a client every time in order to earn. A system of commissions for ladies drinks and other allowances enable them to have some income without having to serve many clients per day, or work every day. Freelance workers, on the other hand, have more sexual partners because this is the only activity through which they can earn. Thus, freelancers have a higher exposure to risk.

In general, there is a high rate of STI infection among sex workers (USAID, 2005) but the rate is much higher among freelancers due to the combined effect of having more sexual partners and less likelihood of accessing the services of SHCs on a regular basis. One study found a higher rate of trichomonas infection among younger sex workers (aged 18-22 years) compared with older ones (23 years old and higher) (Ong and Rivera, 2010).

There is widespread recognition among female sex workers that condom use protects against the risk of STIs. However, condom use is not 100-percent protective for a number of reasons, the dominant one being client resistance to the practice because it reduces sensation. Other reasons for the non-use of condoms are the cost, especially among freelancers whose clients are from the lower socioeconomic classes, and embarrassment at procuring condoms from drugstores and convenience stores. There is also a tendency to be less vigilant with regular customers ("*suki*") because they are already known to the worker and an element of familiarity and trust has already been established. Female sex workers generally do not use condoms with their permanent partners (spouse or boyfriend). The likelihood of

condom use is likewise reduced when the sex worker is drunk or high on drugs during sex (Chiao, et. al.). Some workers in the national Consultative Workshop held on November 22, 2010 reported that there are clients who deliberately get them drunk so they will be less likely to insist on the use of a condom.

There is evidence to support the contention that enlisting the help of bar managers and owners in the promotion of condom use significantly increases the likelihood of the practice in their establishments, as does the creation of a work environment that enables and supports condom use. Peer education also increases condom use and the likelihood of undergoing HIV testing (Morisky, et.al. 2007).

Furthermore, larger establishments with a bigger number of sex workers are more likely to have a condom use policy while karaoke bars are significantly less likely to have one (Morisky, et.el, 2008).

Apart from the risk of infection, female sex workers are also more exposed to the risk of violence from clients. During the consultative workshop, establishment-based workers reported that the main advantage of working with an establishment is that it protects them precisely from this kind of risk because their bar managers can monitor their whereabouts when they ask for time release to meet a client. On the other hand, freelance sex workers (FSWs) are largely on their own. While some degree of protection may be provided by their pimp, if they have one, the level of safeguard from harm is not nearly as much as that provided by the more established bar or entertainment venue. FSWs also report harassment from the police who sometimes use their services for free and, on occasion, even rob them of their earnings or their possessions such as their cell phone. Some get harassed in the same way by barangay tanods. Because of their illegal status as sex workers, free lancers are not likely to report these instances of abuse, especially as the abusers are also the law enforcers.

At the national consultative workshop, it was learned that freelance and establishment-based workers who were gathered together in a focus group discussion have a high awareness of STIs because they know that these are tested for in SHCs. But even as they have heard of HIV, there is generally little awareness that HIV testing is not part of the compulsory tests conducted by the SHCs. Specifically, they assume that the blood tests conducted bi- or annually by the SHC already includes HIV. None of them remember being asked to give their consent to HIV testing. They also admit that unlike the other STIs whose symptoms they are familiar with, they have no clear picture of HIV or AIDS. Moreover, not having met or known anyone who has HIV and/or AIDS, they have no clear understanding of what this disease is about— except that, unlike the STIs they are familiar with like “tulo” or gonorrhea and genital warts (“kulugo”), HIV or AIDS is incurable and that it kills.

From the point of view of bar managers and the NGO community working with sex workers, much needs to be done in the larger environment in which sex work occurs. Specifically, they refer to the role of the police in hampering efforts to promote condom use because the police use condoms as evidence of prostitution when raiding an establishment or apprehending freelancers. Moreover, the local government should allocate funds for the SHCs and other local agencies providing health services to sex workers to make the response to the STI-HIV problem more consistent, sustainable, and effective.

The following is a list of strategic interventions that will comprise the package, namely:

1. Interventions to prevent STIs, including HIV among female sex workers
   - Peer educator programs to educate Freelance Sex Workers (FSWs) and establishment-based sex workers on STI/HIV
   - Counseling and health education programs through the Social Hygiene Clinics (SHCs)

- Public education campaigns for the general population in order to reach the clients of FSWs
- Condom distribution (free condoms from SHC, Mobile Clinics, NGOs, with sizes)
- Promotion of condom use policy in establishments
- LGU funding for SHCs so they can provide continuous services with adequate personnel, facilities, and supplies
- Collaborative programs with establishment owners and managers for STI-HIV prevention

2. Interventions to encourage regular testing for STIs and HIV among FSWs
   - Free or subsidized regular testing for STIs in SHCs
   - Free or subsidized regular testing for STIs in Mobile Clinics to be deployed near cruising sites or near establishments to improve access for establishment-based and freelance workers
   - Peer educator programs to encourage and monitor testing of free lance workers
   - Voluntary Counseling and Testing for HIV
   - Programs to promote compliance by bar managers with the policy to have their workers regularly tested for STIs
3. Interventions for the treatment of STIs among FSWs
   - Free or subsidized treatment of common STIs in SHC and Mobile Clinics
   - Initiation of a system of referrals, counseling, and other psychosocial support for FSWs who test positive for HIV
   - Enrolment of qualified HIV-positive FSWs in the ARV program
4. Partnerships, dialogue, and collaboration among SHCs, Mobile Clinics, and NGOs with police and the local government for an integrated response to STI-HIV prevention
5. Reproductive health services for female sex workers
   - Expansion of SHC services for female sex workers to encompass other reproductive health needs like contraception and non-STI-related health problems such as complications attendant to abortion
   - Inclusion of other RH services in Mobile Clinic services for FSWs
   - NGO-initiated programs for RH-related needs like dealing with abuse and violence
6. Livelihood programs for FSWs who wish to leave sex work

The Cornerstone of the Intervention Strategy

For an integrated response to the STI and HIV issue, the aforementioned strategic interventions 1, 2, 3, and 4 are crucial and should be implemented as a total program package.

Table 21. Proposed Intervention for People in Prostitution

Recommended activities	Intervention	Specific recommendations
Interventions to prevent STIs/ HIV	▪ Condom distribution ▪ Mobile Health Clinics ▪ Peer educators ▪ Information and education campaigns	▪ Condoms that are distributed should come in different sizes to encourage client use ▪ Operate Mobile Health Clinics close to cruising sites, offering testing, counseling, treatment, and other services ▪ Female peer educators should be sex workers or former sex workers themselves, close in age to current workers ▪ Explore new and innovative ways to present IEC materials to catch the attention of the target audience. IEC materials should be pre-tested on active FSWs to gauge the acceptability and comprehension of messages.

		▪ IEC campaigns should use the new media: internet, text messaging, etc. to target "hidden" sex workers, especially freelancers who transact their business through these means and are unreached by SHCs and Mobile Clinics. ▪ Conduct research to document the level of understanding of FSWs about STIs and HIV. There is a high level of awareness, but many misconceptions can lead to unsafe practices.
Interventions to encourage regular testing for STIs and HIV among FSWs	▪ Regular testing for STIs	▪ Research to determine level of understanding of FSWs about the nature of the tests conducted in the SHC and whether or not HIV is included in what they are tested for. FSWs do not seem to be aware that the regular blood test does not automatically include HIV, unless they sign a consent form. This creates a sense of complacency that can be dangerous. ▪ Mobile Health Clinic (or satellites of SHC) to operate near establishments or cruising sites to encourage testing ▪ SHC to offer other RH services for FSWs to encourage voluntary and regular testing
Interventions for the treatment of STIs among FSWs	▪ Treatment of STI	▪ Discourage self-medication ▪ Counseling of FSWs on proper treatment of STIs, addressing misconceptions that can lead to unsafe practice
Partnerships and collaboration among LGU, police, SHC and NGOs working with FSWs		▪ Health education campaigns for the police to enable them to understand STIs and HIV better and appreciate their role (both negative & positive) in STI and HIV prevention and control

D: Strategic Framework on the HIV Response on Children and Young People

Introduction:

The HIV and AIDS epidemic has posed an added challenge to the protection of the rights and well-being of Filipino children and young people. While the scale and spread of the HIV and AIDS epidemic in the Philippines has been kept low, the infection rate is rising at an unprecedented rate with a profile that is getting younger by the years. Since 2006, overall HIV infection increased five-fold among the total reported cases from 309 in 2006 to 1591 in 2010. During the same period, however, HIV infection among 15-24 year olds increased ten-fold from 44 in 2006 to 489 in 2010. The median age of initiation to sex and drug use among the most-at-risk populations was 14-19 years.

Due to the small transmission risk per heterosexual encounter and the low prevalence of sexual networks among the general population, AIDS epidemics in Asia are highly unlikely to be sustained independently of commercial sex, male-to-male sex, and injection drug use (UNICEF 2007: Responding to the HIV prevention needs of adolescents and young people in Asia: Towards (cost-) effective policies and programmes). This means that drastically expanded prevention efforts on populations engaging in commercial sex, male-to-male sex, and injection drug use is likely to bring the epidemic under control. In the Philippines, a substantive proportion of these most-at-risk populations are between 15-24 years of age (55-65% across the three high-risk groups identified, as per representative sample of the 2009 IHBSS). Adolescents engaging in commercial sex, male-to-male sex, or injection drug use may cause up to 95 percent of the infection in their age group, but receive less than 10 percent of the HIV funding allocated for their age cohort (AIDS Commission report).

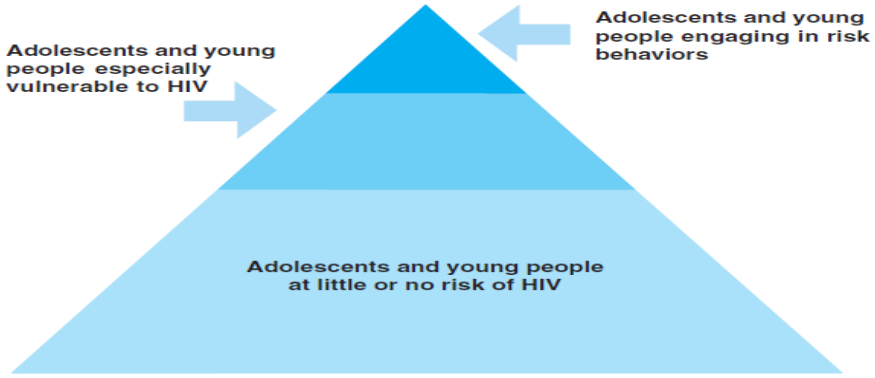
Following the recommendations of the AIDS Commission in Asia, the Philippines must focus efforts of the HIV response on HIV prevention targeting most-at-risk populations (MARPs), in order to achieve impact and be cost-effective. The blue triangle in Figure 1 below represents the recommended extent of the HIV programming efforts for children and young people, with the biggest portion going to interventions targeting MARPs, a lesser effort towards vulnerable populations, and HIV-related awareness messages targeting general youth population at low or no cost through integration into existing programs.

Thus, to ensure greater impact and achieve its intent, the 2010 National Strategy Framework on the Country HIV Response on Children and Young People has laid out approaches such as: rights-based, age-appropriate, gender-sensitive and -responsive design and implementation of HIV interventions and programmes based on proven cost-effective evidences and which ethically and meaningfully engage and empower children and young people at all stages of the HIV response form an integral part of each of the key strategies formulated. These are as follows:

1. implement HIV prevention interventions for children and young people with strong focus on those most-at-risk for and vulnerable to HIV infection;
2. ensure access of children and young people, particularly those living with and affected by HIV, to an agreed minimum set of appropriate services;

3. develop and implement policies that promote effective HIV responses that protect children and young people from all forms of abuse, exploitation, and violence and increase access to essential HIV-related health and other services at all levels; and,
4. improve coordination mechanisms, capacity of Child Caring institutions, and strategic information based on jointly agreed standards of quality for HIV prevention programming for children and young people, particularly the ones most-at-risk for HIV infection.

Figure 9: Pyramid of Risk and Vulnerability



Pyramid of risk and vulnerability. Source: Responding to HIV prevention needs of adolescent and young people in Asia: Towards cost effective policies and programmes, UNFPA Policy paper 2007

Strategy 1: Implement effective age-appropriate HIV prevention interventions for children and young people, with a strong focus on children and young people most at risk for HIV infection, in order to reduce sexual and injection-drug use transmission risk of HIV

The Philippines is one of the countries with a legal ban on sex work (Revised Penal Code; for children, Republic Act 7610) and drug use involving children (Dangerous Drugs Law). The Under 18 who are freelance sex workers are often accosted for vagrancy and herded off to police outposts. On the other hand, children and young people who are engaged in drug use are arrested and taken in under the Dangerous Drugs Law. The manner by which the laws are enforced denies them of basic health care and social protection services secondary to their exposure to risky behaviours underground. This, in turn, makes them more vulnerable to exploitation, abuse, all forms of violence, crime, and worsened health and social conditions. Providing appropriate prevention, health, and other services for children and young people, particularly those who are Under 18 and are engaging in high-risk behaviour, has always been extremely challenging ethically. While child protection systems aim at preventing child prostitution, drug use, and exposure to all forms of abuse and violence, acknowledging the existence of this phenomenon in children is the beginning of being able to reach out and prevent immediate harm to these young people. Most important, the strategy recognizes that most children in the above difficult situations are not there as a result of their free, informed, and voluntary consent. As such, removal and/or rescue of these children is still the first option. It has to be clear, however, that appropriate life-saving services are being offered and provided to these children in a sustained and effective manner if removal from the working conditions is inevitable.

In order to reduce sexual transmission of HIV among children and young people, as well as transmission risk through injection drug use, a dramatic increase in action at the community and national levels is required for the implementation of sexual and reproductive health and rights, and individual commitment to safer sex. Thus, the following priority actions must be focused in order to reach at least 60 percent to 80 percent of the most-at-risk adolescents.

Table 22: Proposed Minimum Set of Interventions

Target Population	Minimum Set of Interventions
Children and young people most-at-risk for HIV-infection who currently engage in behaviour which puts them at immediate risk of acquiring HIV, as identified in the Philippines, include: ▪ Children and young people in prostitution (male and female) ▪ Males having sex with Males (MSM) ▪ Injecting drug users (IDU) ▪ Sexually active children and young people	All most-at-risk children have the right to be provided the following: ▪ Access to HIV and STI prevention information, services and commodities, including where to access HIV-related services; ▪ Behaviour-specific life skills which empower young people to adapt safe behaviours, and motivation to translate skills into practice; ▪ Access to HIV testing and counselling, and STI screening and management; ▪ Referral to vocational training, in-school or out-of-school education opportunities, rehabilitation, shelters, and psycho-social counselling; ▪ For drug users, principles of harm reduction apply, similar to those that apply in adults
Children and young people vulnerable to HIV-infection who are more likely to start the abovementioned behaviours in the Philippines include: ▪ Street children and young people; ▪ Out-of-school children and young people; ▪ Urban and rural working children and young people; and, ▪ Children of people most-at-risk to HIV infection;	The following should complement the broader, less HIV-specific prevention approaches, namely: ▪ Key HIV and STI prevention information, including messages on where to access HIV-related services ▪ Strengthening life skills directed towards building the psycho-social and emotional resources of the child or young person ▪ Integration of HIV prevention and healthcare-seeking behaviours into intervention programmes that are already in place to respond to their broad needs ▪ Making health and essential HIV-related services and facilities accessible alongside the training of service providers, improving facilities, and implementing linking activities in the community
Children and young people at low risk and low levels of vulnerability comprise the majority of children and young people population in the Philippines. Less likely to have risky behaviours are those: ▪ Living in a fairly stable family environment; ▪ Enrolled in school, or regularly participating in alternative forms of education and learning; and, ▪ Living in communities with organized support mechanisms in place.	▪ Integration of age-appropriate and gender-sensitive HIV prevention education in the general school curriculum (formal and non-formal) ▪ HIV prevention education linked to other learning objectives related to: sexuality, reproductive health, relationships, personality-development, life-skills, substance abuse education, and prevention of STIs ▪ Inclusion of issues of drug use, sex work, and male-to-male sex in skill-based sexuality education; ▪ Provision of access of children and young people to HIV-related information, programmes and services; and, ▪ Integration of age-appropriate and gender-sensitive HIV prevention education in the Parents' and Teachers' regular assembly program.

Conducting HIV awareness campaigns to improve HIV knowledge alone is not sufficient when it overlooks the harsh realities in many children and young people's lives. Information-giving has not been enough to produce results in this area. Children and young people most-at-risk for HIV infection require behaviour-specific life-skills, motivation, and a supportive environment to adopt safe behaviours. A more effective approach would require the following: the availability of commodities (to include prophylactics, as appropriate) that go with safer behaviours; requisite protection measures for the educators and the young people being reached; support of the local governments for the programme; and, capacities of educators to reach as many as they could with their services in a non-judgmental and non-discriminating manner, among others. Life-skills as well as technical and vocational skills would be desirable to help these young people access these and other livelihoods.

Working directly with these children and young people as well as their gatekeepers is the key to

minimizing harm (for instance, the consequences of risk-taking behaviours). Outreach becomes possible and so with the promotion of policies, measures, and programmes that can prevent other peers from entering such risky and difficult situations.

Key principles for programmes and responses for adolescents and young people are:

(a) All children have a right to be protected from all forms of violence (such as sexual and other forms of exploitation) and abuse. Also, they have the right to standards of health. However, due to use of drugs or exposure to prostitution and male-to-male sex, these rights are challenged. In principle, children should not be put at risk for HIV due to their behaviour. In principle, interventions should aim at preventing abuse and exploitation and providing alternatives to the behaviours in question. For those children who engage in the above behaviours and do not (yet) wish to change their behaviour, the caseworker should protect the child from further harm of HIV infection and establish alternatives with the child.
(b) All interventions should consider the age, gender and development needs of the stage the young person is in – in the specific the target group.
(c) The best interest of the child and their views together with their caregivers, if they have any, should be considered in any response – be it in policy or programming.
(d) The development and implementation of child- and adolescent-friendly, age-specific policies are needed to ensure the rights of children to better health and social protection.
(e) In order to halt and prevent the further spread of HIV among young people with high-risk behaviours in the Philippines, it is critical that targeted programs geared towards protecting the rights of most-at-risk young people are implemented immediately.

The lack of consistency in the interpretation and implementation of the pertinent provision of the AIDS Law (R.A. 8504); the absence of supportive laws (The Comprehensive Reproductive Bill has yet to be approved); the presence of punitive laws (e.g., The Dangerous Drugs Act, the Sanitation Code, and relevant provisions of the Revised Family Code and the Penal Code, among others) negatively affecting access to good health; the lack of trained service and care providers; and, the absence of an active referral system of relevant social protection services are just some of the realities that have yet to be addressed so that more doors would open and serve these children and young people.

For *Children and young people vulnerable to HIV-infection*, the priority concern should be geared towards supporting these children and young people NOT to engage in behaviours which put them at immediate risk for HIV infection, i.e. transactional sex, unprotected sex with different partners, and injecting drugs with unclean needles. A wide range of child protection measures supports this prevention approach, aiming at improving the children and young people's direct environment, providing safe spaces to stay, education and vocational training opportunities, and parent-effectiveness, among others (Protecting Filipino Children from Abuse, Exploitation and Violence: A Comprehensive Programme on Child Protection, 2006-2010, Building a Protective and Caring Environment for Filipino Children, Special Committee for the Protection of Children – Department of Justice, December 2006). Due to various factors in their environment (e.g. physical, social, psychological, economic, political, etc.) children and young people are unable to fully defend and protect themselves.

Their vulnerability increases resulting from: lack of knowledge; inadequate protection by adults at home, school and workplace; lack of access to prevention information and reproductive health services; changing norms and values about sex among young people particularly in the cities (increasing importance of money as a status symbol among others); and, peer and social pressure among others.

While local plans and actions based on relevant national frameworks grounded on the UN CRC are keys to meeting the service delivery needs of families and communities, strengthening community action in support of children and young people most-at-risk for and vulnerable to HIV infection and designing interventions with local participation and ownership are equally important.

Most of the risk behaviours for HIV infection of *children and young people at low risk and low levels of vulnerability,* at present, are minimal and HIV prevalence is negligible. Nonetheless, *each child has the right to learn about protecting herself/himself from the virus.*

Contrary to the concern of many policy and decision makers, teachers and parents, there is strong evidence from around the world that learning about sexual health does not increase the likelihood that young people will start having sex earlier. Learning from three decades of HIV programming, there is sufficiently strong evidence of the effectiveness of HIV interventions in educational settings (formal and non-formal), particularly sexual relationships and HIV education interventions. Adult-led curriculum-based interventions incorporating key characteristics had the strongest evidence of effectiveness and showed positive reports of behaviour change.

Similarly, schools or educational settings and teachers play key roles in (1) removing stigma and discrimination against people living with HIV; (2) providing emotional support; and (3) helping children and young people to remain free from HIV. Therefore, HIV prevention education should be integrated into broader education approaches, instead of very narrow vertical short-lived HIV projects. It is expected that integrating HIV into the curriculum in schools and non-formal education or learning settings (from pre-school to vocational and tertiary) will comparatively be a low-cost intervention.

Finally, building the capacity of and supporting teachers, as imbedded in the mandate of the Department of Education and the National Early Childhood Care and Development Programme, will be a key to: improving educational quality; identification of vulnerable children and young people; providing support and counseling; and making curriculum more relevant to the daily needs of children and young people.

Strategy 2: Ensure access of children and young people, particularly those living with and affected by HIV, to an agreed minimum set of appropriate services

From among the growing number of children and young people living with and affected by HIV and AIDS, the 'silence' about their own or their loved ones' status still lingers; sufficient care is difficult to access; and support and treatment services have yet to be tailored to their needs.[18]

Article 65 of the Declaration of Commitment of the UN Special Session on HIV/AIDS calls for increased access to essential services and equality for children and young people affected by and living with, vulnerable to, and most at risk for HIV infection. "Access to essential services also includes equitable access for children, parents and carers' to 'appropriately formulated' life-prolonging therapy with ARVs. This is also reiterated by the Committee on the Rights of the Child, in its Concluding Observations.[19]

[18] "What is happening to children and young people", part of the result of the 1st National Young People's Forum held on 28-29 November, 2008 in Quezon City, Philippines.
[19] P 17, CRC/C/PHL/CO/3-4, UN, October 2009

Table 23: Proposed Minimum Set of Interventions

Target Population	Minimum Set of Interventions
Children and young people living with HIV Infection in the Philippines are those who were exposed to HIV either through mother-to-child or engagement in behaviours that put them at risk for HIV	In compliance with the recommendations of the Committee on the Rights of the Child, the following are crucial: ▪ Access to HIV information, age-appropriate and gender-responsive psychosocial counseling of the child and the family ▪ Access to comprehensive pediatric HIV management, including access to pediatric formulated medicine. ▪ Provision of services across a continuum of care (from prevention to TCS, from primary to tertiary level, from home and community base, clinic to hospital, and vice versa), through a structured referral mechanism.
Children and young people affected by HIV in the Philippines are either: ▪ Still under the care of loved ones (with both parents living or a close relative living with HIV); ▪ Have experienced loss of one or both parents or a loved one due to HIV; and/or ▪ Living in child-caring institutions or agencies.	▪ HIV prevention education ▪ Strengthening coping skills and child's emotional resources; and ▪ Ensuring safe and stable living conditions, ideally in the family environment

Strategy 3: Develop and implement policies that promote effective age-appropriate and gender-sensitive HIV responses that protect children and young people from all forms of abuse, exploitation, and violence and increase their access to essential HIV-related health and other services, at all levels

Supportive laws, policies, measures, and practices enable the effective delivery of programmes and services to children and young people at risk for HIV infection. The key to wider reach and increased coverage of interventions for children in this situation depends on the protective and caring environment created by the same policies, measures, and practices. These must be strengthened and more put in place as necessary. Punitive laws, policies, and practices that drive children at risk underground and making them even more inaccessible for services need to be reviewed and amended.

Table 24: Proposed Minimum Set of Interventions for Children and Young People

Target Population	Minimum Set of Interventions
Families, Communities, Local Government, National Government	▪ Develop and widely disseminate Child Protection Practice Guidelines (CPPG) i.e. on Access of Children and Young People to HIV-Related Health and Essential Services; Active Engagement of Children and Young People most-at-risk for and vulnerable to, affected and living with HIV in the various processes of the HIV and AIDS Response; and others as appropriate; ▪ Develop and implement national policies that will be reflected in sectoral policies, plans, and budgets for the protection and care of orphans and vulnerable children. (as per the UNGASS Declaration of Commitment signed by the GOP in 2005) ▪ Inclusion of children and young people affected by and living with, vulnerable to and most-at-risk for HIV infection in the roster of beneficiaries of public and basic services; and ▪ Implementation of mechanisms of redress and complaints for children and young people where children and young people can feel safe to express their views on the way their rights have been promoted and served. Feedback from children and young people play an important role in monitoring and improving programmes and services.

Strategy 4: **Improve coordination mechanisms, capacity of child caring institutions, and strategic information based on jointly agreed standards of quality for HIV prevention programming for children and young people, particularly those most-at-risk for HIV infection**

Mitigating the impact of HIV and AIDS on families, children, and young people requires active collaboration and coordination among stakeholders. There are not enough resources to adequately respond to all the needs resulting from the growing epidemic in the country.

Communities will benefit most from the implementation of a minimum set of interventions on HIV as part of their respective local plans of action with budgetary allocations. Aimed at preventing new infections and with focused interventions for children and young people most-at risk for and vulnerable to HIV infection, this minimum set of interventions recognizes the contribution of LGUs in making HIV Prevention, AIDS Treatment, Care and Support accessible to everyone in need of these. Most important, it acknowledges the varying capacities of communities to implement a holistic HIV Response.

At this very moment of the HIV Epidemic in the country, "trial and error" is history. Where children are concerned, **"urgency"** and **"minimum standards"** in the context of child and human rights protection and promotion is the present norm. Thus, in order to attain desired outcomes and impact, as well as meet its international commitments, the government, through the PNAC, the CCHA, and key duty bearers for children at local and regional level, must exert all efforts to develop, agree, adhere to, and implement internationally accepted standards of quality response for children and young people with focus on those most-at-risk for, vulnerable to, affected by and living with HIV infection.

The challenge to create the harmonized enabling environment to achieve Universal Access to HIV Prevention, Treatment, Care and Support in the backdrop of a fluctuating global economy is great. Particularly for the children and young people, the GOP must undertake a broad range of and be supported by multisectoral actions. Certain key areas of actions are proposed to activate convergence towards a unified HIV response for children and young people, namely:

- Strengthen existing mechanisms to ensure information exchange and collaborative action (Example: CCHA, PNAC, LAC, LCPC, and other coordinating mechanisms, among others);
- Strengthen the linkages of these mechanisms to mandated HIV response structures and systems (Example: network agencies of CCHA and CCHA to PNAC and vice versa, among others); and
- Enforcement and or enhancement of supportive legislative or policy measures in this regard that will ensure these mechanisms function as mandated in relation with each other in harmony with the National HIV Response Framework.

In order to achieve reforms in the needed legislations, policies and practices, pieces of evidence that will provide bases for said changes must be available and reliable. These will shape the standards of quality of the response on HIV for children and young people. The implementation of the targeted strategies outlined by this living guide will benefit further from these proposed key actions:

- Collection of age and gender disaggregated national data on children most-at-risk for, vulnerable to, affected by, and living with HIV infection;
- Operationalization of an M&E system for children, young people, HIV, and support for operations researches to document "effective practices and programmes, and strategies for children and young people at risk; and
- Integration of data and the progress of the HIV response for children and young people into a Periodic Report of the State Party to the Committee on the Rights of the Child.

Table 25: Proposed Minimum Set of Interventions

Target Population	Minimum Set of Interventions
National, sub-national and local government (policy/program implementers, service providers, etc.) and NGOs	▪ Promotion and implementation of the minimum set of interventions spelled out in this "living guide" ▪ Implementation of jointly agreed standards of quality (Policies, plans, programmes, services, delivery, facilities, and enjoyment of child rights among others); ▪ Improvement of coordination and joint planning between duty bearers by strengthening coordination and information-sharing platforms; ▪ Implementation of evidence-informed interventions and policies

Monitoring and Evaluation

As a rights-based "living guide" primarily for children and young people, a mechanism that will: (1) analyse the impact of the implementation of the response and the progress being made towards achieving its goal; (2) understand the factors that contributed to the change; and (3) generate lessons and evidences that can improve the response towards greater impact should be developed by CCHA and its partners. The indicators and tools that will be defined should reflect national priorities that are also consistent with global reporting requirements for and can be used by children and young people as well. Focused on the target population, and in close collaboration with the M & E Core Team of PNAC and development partners, the concerned agencies will have to put in place a more detailed, specific, and appropriate set of indicators. It is expected that the result will be an integral part of the National M & E system on HIV as well as harmonized with the National M & E System for Children and Young People in general.

E: Comprehensive Package of Services for People Living with HIV (PLHIV)

1. Introduction

Issues have been raised regarding the relevance of programs directed toward people living with HIV (PLHIV) in the Philippines. A primary issue is the lack of data on the needs of people living with HIV from the point of view of the PLHIV community. This lack of documentation on the needs of PLHIV in the Philippines raises concerns on the future of programs directed at this community and how adequately these programs can meet the needs of PLHIV in the future. Hence, this study seeks to address this gap by documenting the perspectives of people living with HIV in the Philippines, particularly the organized community of PLHIV.

"Understanding the Needs of People Living with HIV in the Philippines" is a study that explores: (1) the healing process of PLHIV; (2) the needs of PLHIV; and (3) the programs that can meet the needs of PLHIV. Through focused group discussions or FGDs with people living with HIV (PLHIV), seven (7) FGDs were conducted with PLHIV who were contacted through PLHIV organizations. Five of the seven FGDs were with men having sex with men (MSM) or gay men at different stages or length of diagnosis. One FGD was with straight males. One FGD was with heterosexual females.

2. Study Objectives

The overall objective of the study is to know the needs of the organized community of people living with HIV in the Philippines. It seeks to derive data that represents the population of organized people living with HIV in the Philippines. The specific objectives of this study are as follows:
To know the needs of people living with HIV;
To map the healing process of people living with HIV; and,
To identify programs that can meet the needs of people living with HIV.

3. Study Design

This study utilized qualitative research methodology. The data-gathering method used was the focused group discussion (FGD) or *kwentuhan* (storytelling). People living with HIV were chosen randomly from among PLHIV organizations. FGDs were conducted with seven groups of PLHIV. Each FGD was transcribed and the data analyzed following procedures for thematic analysis.

4. Study Participants

Nine (9) PLHIV organizations have been documented by the Philippine National AIDS Council (PNAC). The organizations are as follows: Angeles Plus (Pampanga), Babae Plus (Manila), Cavite Plus (Cavite), Pinoy Plus (Manila), Positive Action Foundation of the Philippines or PAFPI (Manila), Cebu Plus (Cebu), Crossbreed (Iloilo), Empowered (Bacolod), and the Mindanao Advocates Association (Davao). The people living with HIV who participated in this study were sampled from PLHIV organizations in Luzon groups.

In consultation with leaders of PLHIV organizations, namely Angeles Plus, Babae Plus, Pinoy Plus, and PAFPI, this study divided the PLHIV community into subgroups based on (a) their sex/gender and sexual orientation, and (b) their stage of diagnosis. The three subgroups according to gender and sexual orientation were: (a) MSM or men having sex with men, (b) straight/heterosexual and lesbian females, and (c) straight/heterosexual males. The two subgroups according to stage of diagnosis were: (a) later stage of diagnosis – around 5 to 10 years, and (b) early stage of diagnosis – around 0 to 2 years. A unique group identified were the MSM who are *tago* (not out) and are not part of any PLHIV organization, as opposed to the MSM who are *lantad* (out). Combining sex/gender/sexual orientation, stage of diagnosis, and *outness* produced six (6) subgroups shown in the sampling matrix below:

Table 26. Groupings for FGD Conducted

Type of PLHIV Group	Luzon
Number of FGDs*	6
MSM OLD (MSM in the later stage of diagnosis)	1
MSM NEW (MSM in the early stage of diagnosis)	1
MSM (*TAGO)* (MSM who are not part of a PLHIV organization)	1
FEMALE OLD (female, mostly straight, in the late stage)	1
FEMALE NEW (female, mostly straight, in the early stage)	1
STRAIGHT MALE (male, straight, in the late or early stages)	1

For this study, seven focused group discussions (FGDs) or *kwentuhan* were conducted with Luzon-based groups. Subsequent FGDs for the Visayas and Mindanao based groups will be conducted as part of the validation process. Each FGD had six (6) to nine (9) participants. The participants were purposively sampled through the PLHIV organizations. A total of 56 individuals living with HIV participated in the study. The profiles of the groups in the seven FGDs are shown below:

Table 27. Profiles of the Groups in Seven (7) FGDs Conducted

Type of PLHIV Group	Location
Number of FGDs conducted	7
MSM OLD (MSM in the later stage of diagnosis, 5 years up)	Cavite
MSM MID (MSM in the middle stage of diagnosis, 2-4 years)	Cavite
MSM NEW (MSM in the early stage of diagnosis, 0-1 year)	Cavite
MSM MIX* (MSM in different stages of diagnosis)	Manila
MSM MIX* (MSM in different stages of diagnosis)	Manila
Straight Female (In different stage of diagnosis)	Manila
Straight Male (In different stage of diagnosis)	Manila

****NOTE:** FGD was conducted with MSM in different stages of diagnosis as requested by the participants.*

5. Study Instrument

A set of guide questions for the FGD or *kwentuhan* was developed in consultation with leaders of PLHIV organizations, namely Angeles Plus, Babae Plus, Pinoy Plus, and PAFPI, together with PNAC. The questions were open-ended to allow responses that come from the participants themselves. The initial set of questions focused on: (1) the needs of people living with HIV, (2) the healing process of people living with HIV, and (3) programs for people living with HIV. The flow of the questions was revised to begin with the healing process. The final set of guide questions used in the FGDs is shown below:

5.1. The healing process of people living with HIV

- *Pakikuwento ang iyong karanasan/buhay mula nang malaman mong ikaw ay may HIV hanggang sa ngayon?*

- *Nasaan ka na ngayon?* (Self, Relationships, Family)
- *Saan ka patungo?* (Envisioning the Future, Dreams and Aspirations)
- The Positive Community (Role of Organization, Benefits of Organizing)

5.2. Needs of people living with HIV

- *Ano ang mga pangangailangan mo bilang isang PLHIV?* (What are your needs as a PLHIV?)
- Self
- Relationships
- Family
- Livelihood/Economic
- Others

5.3. Programs for people living with HIV

- *Ano ang mga programang ninanais mo bilang isang PLHIV ?* (What programs do you prefer as a PLHIV?)
- Identifying Who (Target Audience)
- Identifying What (Content)
- Research

6. Study Findings

6.1. The healing process of people living with HIV

The healing process of people living with HIV showed that their experiences could be mapped in seven thematic areas:

a) before the diagnosis,
b) reactions to the diagnosis,
c) life as a PLHIV,
d) disclosure and stigma,
e) acceptance of HIV diagnosis,
f) reframing HIV, and
g) empowerment.

Among the experiences before diagnosis were engaging in risky behavior, limited knowledge about HIV, denial about testing, ambivalence about testing, expecting the diagnosis and unique to heterosexual women, the expectation of fidelity from the husband. Initial reactions to diagnosis included disbelief, denial, risky or reckless behavior, the feeling of “dreams crashing” and that ‘life is over,” shock, difficulty in accepting the diagnosis, a sense of devastation, confusion, voluntary isolation, apathy, helplessness, and, for the straight women, anger because of the husband’s betrayal and the acquired condition of the child.

Life as a PLHIV was felt as a loss, a sense of “kawalan,” a life with restrictions, and a life of punishment from God. Issues in relation to disclosure were linked to disclosure of homosexuality for the MSM or gay men. There was expressed desire to disclose to family, friends, and children. Reactions to disclosure were either rejection or acceptance. The PLHIV also experienced discrimination and stigma upon disclosure of their HIV status.

The process of healing comes with accepting the HIV diagnosis, reframing HIV, and experiencing empowerment. Acceptance and support can come from family and friends, from keeping the faith, and from making connections. Reframing HIV is to see their new purpose as PLHIV and finding the positive aspects of their new life. Empowerment comes from being involved with NGOs and getting training and

support from other PLHIV. Unique themes also emerged for the MSM or gay men, from the heterosexual men, and from the heterosexual women.

6.2. Needs of people living with HIV

The people living with HIV who participated in the study, majority of whom were MSM or gay men, with one group of heterosexual men, and one group of straight women, expressed their needs as PLHIV, as follows:

- The need to be centered on God and to develop a positive outlook as a PLHIV;
- The need for self-empowerment, taking responsibility for oneself, and being functional in their community;
- (The majority felt) the need for additional information about HIV as well as information about HIV for their families, their community, and the general population;
- The need to disclose their condition to family and friends;
- (For some participants) the need to have an active role in advocacy;
- The need for support groups; and
- (As a general consensus) the need for the PLHIV as a community to have an active role in policymaking and needs assessment.

Among the needs expressed by the PLHIV participants were:

- a stable source of income or livelihood;
- a halfway house for PLHIV;
- a sustainable treatment plan for PLHIV including free ARV, access to medicine and treatment and the availability of treatment hubs in the provinces;
- counselling for families of PLHIV;
- interventions that can address the specific needs of family members, particularly children;
- assistance during cremation; non-disclosure of AIDS in the death certificate; and care for the families of PLHIV after their death.

Other needs mentioned include

- the need for a partner that can accept their diagnosis; and
- support in managing their depression, and other personal needs.

6.3. Programs for people living with HIV

To facilitate healing and to ensure that the psychological, social, and spiritual growth at each phase of the journey of a person living with HIV is given attention, it is essential to:

- Pay attention to the psycho-emotional and spiritual needs of the PLHIV at the different phases of the infection and in their life journey;
- Understand the psycho-emotional impact of the infection on decision-making, behavior, and relationships;
- Provide access to an integrated, holistic, reliable psychosocial program that is given on a long-term basis;
- Provide a parallel psychosocial program for caregivers, family members, children, partners, and loved ones of the PLHIV;
- Recognize the importance of the PLHIV community in the healing of the PLHIV and provide training and support for the PLHIV community;

- Recognize how crucial service providers and partner agencies/organizations are to the PLHIV's life, healing, and the need for these groups to keep in mind the psychological needs of PLHIV; and
- Create a psychosocial program that is based on the context, needs, and the phases in the life journey of the Filipino PLHIV.

The study concludes with a recommended psychosocial program developed from the experiences shared by Filipinos living with HIV who participated in this study. The psychosocial program involves counselling to accompany the person living with HIV:

a) before diagnosis,
b) during diagnosis, and
c) after diagnosis.

Clinical assessment and intervention follows. Intervention can take various forms depending on the need of the person living with HIV:

a) *Professional or Peer Counselling* – individual or group counselling, family counselling, psychological or psychiatric counselling;
b) *Education* – self-care, safe sex practice and risk intervention, HIV prevention; and,
c) Social Care – support group, legal services, medical assistance, job and livelihood.

7. Recommendations

7.1. General Recommendations

To facilitate true healing and to ensure that the psychological, social, and spiritual growth at each phase of the journey of a person living with HIV is given attention, it is essential to:

- Pay attention to the psycho-emotional and spiritual needs of the PLHIV at the different phases of the infection and in their life journey. On the individual level, each phase has its own characteristic and unique needs and, if these are not recognized and addressed properly, may lead to psychological distress that can compromise the PLHIV's well-being. The importance of self-care particularly at the beginning of the illness must also be understood and emphasized.
- Understand the psycho-emotional impact of the infection on decision-making, behavior, and relationships. There has to be realistic expectations on what one can give and do, especially during the early part of one's journey.
- Provide access to an integrated, holistic, reliable psychosocial program that is given on a long-term basis. The services in the program are individualized and tailored to the needs of the PLHIV. Psychosocial services are to be provided right at the start when the diagnosis is given and it is recommended that a psychologist or trained counsellor be present when the result is relayed to the person.
- Provide a parallel psychosocial program for caregivers, family members, and loved ones of the PLHIV to address their psychological needs to enable them to better provide support and care for the PLHIV.
- Recognize the importance of the PLHIV community in the healing of the PLHIV; hence, the community must be trained and supported so it can respond to the psycho-emotional, social, spiritual condition and needs of its members as well as teach the community how to provide a safe, accepting, empowering environment.
- Recognize how crucial service providers and partner agencies/organizations are to the PLHIV's life and healing. As such, these institutions have to recognize and respect the journey that the

PLHIV is going through, particularly in studies and researches about PLHIV. In addition, priority must be given to providing support and assistance to these PLHIV communities. Care must be taken so that the psychological needs of the PLHIV are not lost amid the numerous policy advocacies, greater involvement in society, and organizational issues.

- Create a psychosocial program that is based on the context, needs, and the phases in the life journey of the Filipino PLHIV.

To address the need for a psychosocial program that recognizes the context and needs of Filipinos living with HIV, a program is proposed in the succeeding section.

7.2. Proposed Psychosocial Program for PLHIV

One common need was reflected across the different groups of PLHIV: the need for psychosocial intervention. The conflicting and intense emotions, cognitive disruptions, and behavioral reactions must be taken care of. The need to have a professional listen and understand people living with HIV emerges even before their diagnosis and will continue throughout the rest of their lives.

When a person decides to test himself/herself for HIV, a trained counsellor/social worker must already be ready to counsel him/her. The counselling session can focus on handling the anxiety and fear of the client. It should also focus on other related issues like concern and guilt over having possibly infected their sexual partners or anger for having been possibly infected by them. Concerns about their families, sexuality, and religion can also be tackled. This could also be an opportunity to educate the client about HIV and how risky behaviours can contribute to their infection.

During their consultation/diagnosis, the psychological and mental stability of the client should also be taken care of. While the diagnosis is being shared to the client, the counsellor should monitor how the client is responding emotionally and physically to the news.

The counselling sessions after the diagnosis are crucial. Counselling right after diagnosis should be mandatory. No one should be allowed to leave without talking to a counsellor or social worker. The counsellor or social worker may start debriefing the client to help the latter process and understand the news he or she has just learned. The counsellor must understand that the client is feeling a wide range of emotions that need to be processed. These emotions will include disbelief, denial, devastation, shock, the feeling that “their life is over,” hopelessness, helplessness, etc. The counselling session/s will help the person living with HIV understand the feelings he/she is going through and guide him/her in making decisions. The social worker/counsellor will also assess if the client is in control psychologically or may need professional help. When the counselling session is already done, the counsellor will present the list of services available to the client. The counsellor and client will decide possible options available to them.

When the client and counsellor are about to start a counselling relationship, they must first assess what kind of counselling is appropriate for them. The counsellor should first assess the mental and emotional functioning of the client to find out if the client will benefit from clinical, individual, or group counselling.

The following types of counseling services must be available to the client, namely:

7.2.1 Individual Counselling – This kind of counseling will focus on an exclusive relationship between the client and counsellor. Confidentiality will be observed. Other types of individual counseling are as follows:

(a) Adult Individual Counselling – This kind of counselling service will cater to the PLHIV or any adult family member who wishes to avail of this kind of service. This will be handled by a professional.

(b) Peer Counselling – A counsellor with HIV will be the one to handle this kind of counselling.

(c) Youth Individual Counselling – This kind of counselling service will be available to infected youth (age 13-18 years old) or the family member of the PLHIV within the same age range.

(d) Child Individual Counselling – Children who are infected or having parents with HIV might have special needs that can be addressed by child counsellors.

(e) Counselling for Mothers infected with HIV – The focused group discussion (FGD) shows the unique emotions and ordeals an infected mother goes through. This kind of counselling will focus on the special needs of the mother which will center on taking care of herself and her family.

7.2.2 Group Counselling – This kind of service is available to PLHIV who are more comfortable processing their emotions and needs in a group. The following types of group counselling are suggested:

a) Couples Therapy – This kind of counselling is available to couples who need assistance in understanding the new dynamics of their relationship as a couple having to deal with a spouse or partner's infection with HIV.

b) Family Counselling or Support Group Other than Family – This is available to the families of PLHIV. This kind of counselling will help the family together with the client to understand one another and tackle issues. A professional counsellor will handle this kind of counselling.

c) Group Therapy – This kind of counselling is available to clients who are more comfortable in a group.

d) Pastoral Counselling – This kind of counselling is available to clients who want to center their counselling relationship on their religion.

e) Psychiatric/Psychological Counselling – This kind of counselling is available to clients who have serious psychological concerns resulting from their diagnosis. This could include depression, anxiety problems, phobias, and paranoia, among others.

Aside from the counselling services, the researchers also recommend information dissemination or education services as part of the program. This branch will take care of the self-care needs of the client that centers on how they can function independently with minimal help from others. This will also take care of disseminating information on how to have safe sex practices and risk intervention. It will focus on how clients can take care of themselves and their partners. Lastly, this branch will focus on how clients can live their lives as persons living with HIV, and explore their capabilities and limitations as members of this group.

The last part of intervention will be the social care services. This branch will take care of the availability and dedication of the different support groups. The client will have the option to belong to support groups, which can help them in dealing with their emotions and concerns. It will also attend to any legal concerns of the client pertaining to HIV. This branch will look out for the client in case the client experiences discrimination, stereotyping, and other legal offenses. It will also provide information about the different policies and legal updates on their human rights and the Philippine AIDS Prevention and Control Act (R.A. 8504).

Medical assistance is one of the most important services of the social care branch. This will tackle the different needs of the clients from accessing AVR medication, treating opportunistic infections (OIs), access to different treatment hubs, doctors and medical personnel, correct information dissemination on how to manage their condition, and rehabilitation needs to financial support for medical concerns and stronger support coming from the government. Lastly, the program will also answer the needs of the client when it comes to livelihood projects, better access to different jobs, and a stable income.

After accessing the different counselling, education, and social care services of the program, the counsellor/case worker will again assess the psychological and social functioning of the client. The counsellor will determine what services the client still needs. After evaluation, the counsellor will then share his/her analysis with the client and will apply the necessary changes to the client's treatment plan.

Figure 10. Psychosocial Services for PLHIV